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National Anti-drug Agency



**2011 NATIONAL REPORT (2010 data)
TO THE EMCDDA by the Reitox National Focal Point**

ROMANIA

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

REITOX

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SUMMARY

The National Report on the Drug Situation 2011 includes data referring to drug demand and drug supply in Romania in 2010, national policy and laws in the field, as well as the trends and developments recorded in the previous years.

The first chapter – ***Drug policy: legislation, strategies and economic analysis*** – shows the amendments brought to the anti-drug policy in Romanian in the reference year. In short, because of the ambiguous, constantly changing context, the lack of accurate coordination of public drug policy and the domestic and international economic situation, it can be stated that the anti-drug activity in 2010 was restricted to the maintenance of measures in the field of drug prevention and drug onset prevention, and especially, of drug treatment integrated services (including for prison in-mates) that have started in previous years.

The legal and institutional framework did not change significantly in 2010. In terms of law implementation, it should be mentioned that the technical rules implementing the health national programmes in 2010 were adopted and specify, at operational level, implementation tools and resources, and even though the exceptional legal provisions for drug users (namely possibility to replace prison sentence for drug users, upon their acceptance or inclusion in a specific medical-psychological-social care integrated programme) were not applied, which is the same as in the previous year, project regulation were put forward to ensure the enforcement of the provisions of the Criminal Code and of the Criminal Procedure Code. The National Interest Programme for tobacco, alcohol and drug use prevention 2009 – 2012, enacted in 2008, could not be implemented in the reference year because of the legal gap generated by inaccuracy between the legal provisions referring to public procurement. In relation to strategy and action plans, there is progress in the approach of the drug phenomenon: from a one-sided approach focusing on the fight of drug trafficking, to a diverse approach which includes drug use along drug trafficking, in line with the project of the new Strategy of national defence in which drug use was included among risks and threats to Romania, while the Public Order National Strategy considers the prevention and fight against illicit drug trafficking and use, as well as the improvement of the treatment services for victims, as main action line for reaching the strategic goals. The adoption of the second Action Plan for the implementation of the National Anti-drug Strategy 2010-2012 at the end of 2010 provided the legal framework for the actions taken by responsible institutions and authorities in a coordinated manner towards the strategic goals committed to until the end of 2012. More concretely, the new action plan is more synthetic and gives continuity to drug anti-drug management activities in line with strategic goals while also providing the link between drug demand reduction activities included in the National Interest Programme for tobacco, alcohol and drug use prevention 2009 – 2012 and the National programme of medical, psychological and social care of drug users – 2009-2012.

The following eight chapters include data and information related to drug use and the responses and measures adopted in this field. Thus, the second chapter – ***Drug use in the general population and among targeted groups*** – illustrates the drug use situation in the general population (15-64 years), based on the data resulted from the third national study conducted by the NAA in 2010 (sample of 5100 respondents). As compared to the previous GPS 2007, there is a decrease in tobacco and alcohol use and an increase of illicit drugs and sedatives and/or tranquilisers, and the occurrence of the use of new psychoactive substances (SNPP) traded as “legal highs” or “ethno-botanical plants”, which record the highest lifetime prevalence of 1.9% in the age group 15-64. Of the illicit drugs, cannabis is the most frequently used – 1.6%, followed by ecstasy – 0.7%, heroin – 0.3% and cocaine – 0.3%. To conclude, *lifetime prevalence of drug use* continues to focus on recreational drugs such as cannabis and ecstasy that are used mainly by young people aged 15 to 34, mainly male, located in Bucharest/ Ilfov and West euroregion. The novelty is the emerging worrisome use of new psychoactive substances (SNPP) traded as “legal drugs or ethno-botanical plants”, the first evidences of ketamine use at national level and a diversification of drug use in the adult generation, mainly women and in most regions of the country.

The 3rd Chapter – ***Prevention*** – is dedicated to drug prevention programmes that unlike the year 2010, were significantly influenced by the occurrence of the use of new psychoactive substances. Towards a standard drug prevention activity, the project *European standards in evidence for drug prevention* -

Prevention Standards & No 2007304 was implemented in 2010, coordinated by the National Collaborating Centre for Drug Prevention of Liverpool John Moores University, National Anti-drug Agency being the main partner. *Prevention programmes/projects* were implemented at national and local level and tackled *universal, selective* - among risk groups and areas - *and indicated prevention*. They were implemented in school units or penitentiaries, family, community or recreational settings (beaches, bars and clubs) and were intended to strengthen the influence of protection factors and reduce the influence of risk factors by drug knowledge transfer and building skills:

- information activities and direct transfer of skills to increase peer pressure coping skills and make informed decisions on how not to start drug use;
- information and education to strengthen family ties and adopt a healthy lifestyle by building communication skills of parents to pre-adolescent children and of parents with low education and family management skills or children at risk (adjustment problems, low school participation, early or persisting behaviour problems, that do not necessarily call for therapeutic intervention, and come from families with conflicts or dominated by frequent use of tobacco and alcohol)
- information and education on the risks of alcohol, tobacco and drug use and the short, medium and long-term effects of such use.

Many of the community-based activities at national level focussed on actions related to national and world days of the fight against tobacco, alcohol and drug abuse and training public order and safety police officers (familiarising officers with basic concepts used in drug prevention and efficient means of sending a prevention message) and also on *selective prevention among risk groups and areas*: prevention of and the use of alcohol and new psychoactive substances and driving, the alcohol abuse prevention national campaign (*Alcohol Caravan*), national and local media campaigns to inform of the risks of new psychoactive substances, anti-drug conference for teenagers and March of Solidarity against drugs, 3rd edition.

In addition, project *FreD goes net- Early Intervention for First Time Noticed Drug Users* continued to be implemented in 2010 and focused on early intervention for young people that were first time noticed as having alcohol/illicit drug issues (mainly by the school) and at reducing the risk of drug addiction.

Chapter 4 – **Problem drug use** – includes data on indirect estimations of the problem drug use – key epidemiologic indicator – (in absolute numbers and ratios) of the number of problem drug users in Bucharest, using the multiplier method. The use of syringe exchange programme beneficiaries as benchmark in computing the multiplier resulted in 18,297 problem drug users in Bucharest. As compared to previous years, there is a constant slight increase, as the availability of services/programmes in the rest of the country continues to be the main obstacle to a national estimation.

The same chapter includes data on SNPP use classification as problem drug use and the results of study conducted to evaluate the effects of these substances among heavy users in Romania. The study included 10 large cities in Romania and the target group was made up of children and young people who use legal highs, aged between 10 and 24 years. The specific goals of the study were: evidencing the situation of the use of new psychoactive substances in local communities; establishing the profile of the SNPP user namely the identification of the drug use patterns for SNPP users; identification of risk and protection factors related to the use and abuse of these substances; making proposals for harm reduction interventions based on scientific evidence.

Chapter 5 – **Drug related treatment**, another key epidemiologic indicator, reveals information on the treatment system (institutional and procedure framework, drug treatment services chart, criteria and methodology used to authorise centres that provide services for drug users, levels of care and therapeutic system etc) and the time evolution of the indicator (the analysis is done according to the two types of services: inpatient and outpatient). The same as in the previous year, an alpha-numerical code was assigned to each patient/client to avoid double-counting: Ministry of Health units, NAA centres, penitentiary units and three out-patient treatment facilities that provide addiction care in Bucharest (including substitution treatment): Arena, Psymotion and ANIT.

Although private facilities and penitentiaries were included for the first time in the data reporting process in 2009, there was a 14% decrease of demands for such services (the fact that aggregated data were no longer used to avoid double counting is a possible explanation) while in the reference

year there is a 28% increase of the total number of treatment admissions following the use of illicit drugs and SNPP (from 1689 to 2163), reaching the highest values in the last 10 years. This can be related to the emergence and escalation of the use of new psychoactive substances (as a result of increased availability) that added to the number of treatment demands following illegal drug use, or to the intervention capabilities of the NAA. Of the 2163 people who benefited from treatment in 2010 following the use of illicit drugs and new psychoactive substances, 64.2% were treated in-patient, 35.2% out-patient and the rest, in detention. Alike the information collected previously, although decreasing, treatment services continue to be concentrated mainly in the Municipality of Bucharest in the reference year. Although there is a slight decrease of the share of those seeking treatment for the first time, against the total number (3%), as compared to 2009, the number of first treatment demands increased (from 1008 to 1228) which cannot lead one to presume the incidence of drug use decreased (theory supported by the fact that in the reference period of time there were no major changes in terms of availability and accessibility of services and there were still waiting lists) but that treatment supply is insufficient and cannot meet all demands.

In addition, alike previous years, although opiates were the *main drug* for which treatment services were demanded in in-patient and out-patient setting (41.5%, namely 69.5%), there is skyrocketing use of SNPP, due to relatively lower prices and availability. Thus there is a change in the drug use pattern with a decrease of the use of heroin and increase of the use of SNPP (38.9% of the people who benefited from treatment in 2010 for SNPP use had been previously admitted to opiate treatment) and of other drugs: cannabis, cocaine, inhalants, stimulants, medication with hypnotic or sedative effects and hallucinogenic substances). In a manner similar to 2008 - 2009, the data might lead to two hypotheses: 1. the increasing availability of treatment for those who use drugs other than heroin; 2. change in the drug use pattern with a decrease of the rate of heroin users and increase of the rate of users of other drugs.

Poly-drug use was evidenced in over a third of treated people: the most frequent secondary drugs were SNPP and other drugs and opiates were the main drug most likely to be used in combination with a secondary drug. The average age of people in treatment was under 31 and higher for female users and lower for SNPP users. As compared to in-patient treatment demands, the average age was lower in out-patient treatment for all drugs (in-patient: 30.9 years, out-patient: 26.4 years) and for SNPP (in-patient: 25.3 years, out-patient: 19.1 years) and by comparison to previous years there is a decrease of the average age and gender differences.

As the trend was decreasing, most people in treatment presented daily drug use and mainly by injection. To conclude, it can be stated that:

- *in in-patient treatment* – demand is caused by several other drugs, beneficiaries belong to elder segments of population and the age of onset is over 20;
- *in out-patient treatment* - treatment is demanded mainly for opiates, cannabis and SNPP, most beneficiaries being aged younger than 40 and the onset age being under 24.

Joining the results of the GPS, in the planning of treatment services, the following is needed: diversification of treatment services for a large range of drugs; development of out-patient treatment services addressing young population (considering the higher prevalences for this group of population).

Chapter six – ***Health correlates and consequences*** – includes information on the other two key epidemiological indicators: drug related infectious diseases and drug related deaths, as well as data on the health correlates and consequences of drug use: non-fatal drug emergencies and drug related psychiatric pathology. The chapter includes analyses based on routine data, findings of the second *BSS-Behavioural Surveillance Survey among injecting drug users conducted by UNODC*, Romanian Angel Appeal and the NAA and the first cohort study conducted by the NAA.

In 2010, the ***prevalence of drug related infectious diseases*** among injecting drug users recorded by routine monitoring shows: slightly increasing values for HBV – 13.1% and HIV – 4.1% (although still below the European average), and slightly decreasing values for HCV although high levels are maintained – 63.9% (over the European average). According to the BSS survey, there is increasing trend of HCV among IDU and a slight decrease of HBV and HIV, alike the treatment admission indicator, while discrepancy between the surveys (2008 and 2010) is caused by the main drug of abuse, so that although heroin continues to be the main drug used by injection (97% in 2008 and

67.3% in 2010) in the last survey 30.6% of the respondents reported they injected SNPP most frequently without specifying the composition.

Though not an epidemiologic key indicator, **non-fatal drug emergencies** tend to reflect the changes of the drug use pattern at national level in real time. By comparison to the previous year, data was required from an enlarged number of medical units (from 46 to 65 emergency units) and there is an increase by 194% (three-fold) of the number of drug medical emergencies. As for the months of 2010, there is an increasing evolution, with one exception (March) following legal amendments and the introduction of a new category of substances under national control. Unfortunately, the legal regulations has short-term effects and the listing new substances in June did not have the same results, an explanation being the “reorganising” of the suppliers of such substances and the introduction on the market of other substances with similar effects that are not listed in national or international control regulations.

The increase of the medical emergencies caused by the use of psychoactive substances is greatly caused in 2010 by the large number of SNPP acute intoxication. This can be correlated with the significant decrease of intoxications by unknown substances (and can be explained by a better screening of emergency cases, in the context of improved knowledge on SNPP use effects) and with the significant decrease of the rate of emergency cases caused by the use of heroin/opiates, alike treatment admissions (almost 4 times lower), which might suggest a change in the pattern of heroin/opiate use. Additionally, the significant decrease of cases of injection use of psychotropic substances and the increase of those who used psychotropic substances by inhaling can be connected to the spectacular increase of emergency cases caused by SNPP use.

By comparison to 2009, the age distribution shows an increasing rate of people aged over 35 among those who reported to emergency intake units, with more visible differences among in the case of women, where there is a restructuring of this population by age: considerable increase of the population aged under 20: (from 12.5% to 34.5%) and a decrease of the population aged over 35 (42.4% to 20.6%).

Unlike 2009, there is a homogenous distribution of the drug related emergency cases, recorded by regions. A more detailed analysis of the distribution by the country's administrative territorial units, we should take note of delimitation at country level in five risk areas, as follows: very high risk area (proportion of over 10%) includes only Bucharest and the county of Iasi, but representing a third (33%) of the total recorded cases in 2010, high risk area (proportion from 5% to 10%) includes 5 counties (Cluj, Prahova, Constanța, Bihor, Galați) and account for another third (32.6%) and a low risk area that includes 12 counties and accounts for only 2.1%. We should note that: most of the counties contained in the high and very high risk areas are the counties where we find traditional university centres and great urban communities, three are border counties (situated in areas of high circulation), and the counties of Constanța and Prahova include the most frequented tourist and leisure resorts for young people. All this may highlight the existence in each economic development region of “problem nuclei” which induce an apparently uniform drug use at country level, the phenomenon being in fact less extended – drug use in recreational settings, mainly among young people – and thus, easily countered by focussed prevention programmes.

Drug related psychiatric pathology (personality disorders, depression, anxiety, emotional disorders etc.) – of the 2,163 unique cases recorded for the treatment admission indicator, 230 people were diagnosed with different psychiatric disorders, of which, the most frequent were mood disorders in 81 cases (3.7%) and behaviour and emotional disorders – 78 cases (3.6%).

The **drug related deaths** indicator (DRD – direct overdose deaths and indirect¹ drug related deaths) - reported data do not cover only Bucharest for the second year in a row, and there is coherent, homogenous reporting at national level (35 counties out of 41), with drug related deaths being reported only in Bucharest (except for one case in the county of Ilfov) and 3 drug induced deaths in the county of Constanța. Even though the main obstacle (lack of modern toxicology laboratories) is practically overcome and there is genuine improvement in declaring hospital deaths (left unreported

¹ Death caused by behaviour and mental disorders related to drug use, or by a diseases contracted by sharing injection equipment, namely somatic complications caused by the use of psychoactive substances

as being of medical-legal competence, especially in cases of comorbidity and non-toxicological evolution complications), drug related deaths continue to prevail in Bucharest, as no case was reported in the country. The fact that of the three million inhabitants in Bucharest there are 46 deaths (direct and indirect) and only 3 indirect death cases in the rest of the country (18 million) prompted experts to conclude there is significant under-reporting, as a result of the lack of experience in drug related death cases management, of the lack of medical, legal and juridical knowledge as well as financial limitations.

There are 34 cases recorded at national level in 2010 (33 in Bucharest, 1 in Ilfov) all of which confirmed toxicologically the presence of psychoactive products and 15 indirect cases (12 in Bucharest and 3 in Constanta) among known drug users (with elements of clinical examination – autopsy – eloquent medical history data and investigation) but whose cause of death was related to associate pathology or consecutive to chronic – acute drug use, and not to intoxication (cases of so-called “indirect causality”). Of the 34 cases reported as direct drug related deaths nationwide, 30 were male and 4 female, with an average age of 29.76 years. In only 5 cases there was no drug use history or known previous facts and in 29 cases of direct drug related deaths there were elements of chronic drug use. This confirms the fact that death occurs more rarely at first doses, but especially at long history chronic drug users who relate to chronic drug use generated stigma. For direct drug related death cases for which viral determinations were made: 14 were HCV positive cases and for indirect drug related deaths, serological detection revealed HIV – 2 cases, HCV 6 cases and one case of HBV, which confirms the high prevalence of HCV infection among IDU. In 10 cases opiate intoxication was the cause of death, more drugs lead to death for the rest of the cases.

Alcohol was found in combination with other substances than heroin (values of 0.65 g‰ – 1.1 g‰) and amphetamines/ metamphetamines and hallucinogens such as mescaline and phencyclidine were detected for the first time. At the same time, in spite of aggressive media, in many cases alarmist and poorly informed, “legal highs” were mentioned in only two death cases, but on each occasion in combination with other substances, which were held accountable for the cause of death². Facing solid investigation/history data that clearly result in the confirmation of the use prior to death of products bought at “dream shops” and with the toxicological detection in body fluids of such drugs, the hypotheses may lead either to simultaneous use of “legal highs”, or to drug distribution by this method.

As compared to previous years, after variations from 2001 to 2005 (against technical limitations due to insufficient laboratory equipment), there has been a variable tendency in the last 4 years, with figures significantly higher than in 2001-2005, an increase of deaths among women and of the average death age (2009: 27.4 years). Moreover, there is a high number of such deaths in hospitals, and thus an increase in medical units addressability of the terminal cases, as a result of increasing trust in medical services in parallel to diminution of fear concerning legal consequences and also because of measures taken for medical education among risk population, that have partially proved efficient. After the “homogenous” geographical distribution trend over the last 2-3 years which showed Rahova-Ferentari covered most of death cases, 2010 shows a polarisation of cases in Rahova-Ferentari, Pantelimon, Colentina – Doamna Ghica. The range of substances usually found in drug combinations is continues to be dominated by opiates – heroin and methadone, while tramadol and sedatives, anxiolytics and anti-psychotics have also been evidenced (with relatively constant presence in recent cases). Death cases which implied the use of substitution medication – methadone (11 cases – similar to 2009, but increasing than in previous years) show a need for a stronger control of the management of this treatment.

Mortality and causes of death among drug users (**Cohort study**) – is the first such study in Romania. The study included 5820 people admitted to treatment for opiate use from January 1, 2001 to December 31, 2006, in 5 health units in Bucharest. The cohort was finally built on 2707 single cases of which 118 death cases were identified from 2001 to 2010. Death cases people over 49 were excluded as well as those who died beyond national borders and finally the survey sample was made

² The difficulties in toxicological evidence of drug use represent worldwide the main impediment of legal medical objectifying. On the other hand, according to the limited available studies, taking into account the infinitesimal doses, the clinical and action mechanisms etc, associated to these substances, there were not deaths directly related to these substances.

up of 116 people that accounted for 4.29% of all subjects recruited for the cohort. Of the 116 cases, 105 were males and 11 females. The average age of the persons included in the cohort was of 23.37 years. The mean age upon death was 27.77, higher among women (29.84) as compared to men (27.43).

Chapter 7 – **Responses to health correlates and consequences** – describes the steps taken in the field. The implementation of the Programme *Towards Universal Access to Prevention, HIV/AIDS Treatment and to the Care and Social Assistance of Vulnerable and Disadvantaged Populations*, continued in 2010, being funded under the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. According to the 6th progress report of the HIV/AIDS programme, round 6, the prevention projects addressing vulnerable groups (IDUs, SWs, MSM, roma population, street children) focused on health improvement, healthy sexual behaviour and access to medical and social services in order to decrease the risk of HIV spreading.

Chapter 8 – **Social correlates and social reintegration** - tackles aspects related to the legal framework and policy in the field as well as social exclusion of drug users, in line with the findings of the 2010 study conducted among IDU in Bucharest. The data help outline the following profile of the socially marginalised and excluded IDU: no personal documents (and thus not access to health services), having lived in a orphanage or admitted to a re-education centre for underage people (correctional facility), with a low education level, having been arrested or convicted to custodial sentences, with a poor housing condition and no employment. The main income source in the last 30 days for the interviewed IDU was the family (39.2%). Over half of the respondents declared having children and 52.2% who are also parent reported children are taken care of by somebody else in the family while 10.2% reported the child is institutionalised. The results of previous studies continue to hold true: low rate of participation in education, high unemployment rate, criminal record and lack of housing conditions and a favourable family setting, personal documents and resources to raise children.

Prevention campaigns have been organised nationally against marginalisation and social exclusion for categories of young people considered vulnerable by governmental and non-governmental institutions, and the 47 Drug Prevention, Evaluation and Counselling Centres, the 5 Addiction Integrated Care Centres of the NAA continued to develop a social support network of public and private institutions to provide specialised rehabilitation and reinsertion to drug users. In addition, the civil society implements programmes intended to improve access to labour market for people with double vulnerability: roma ethnicity, women, former prison-inmates, victims of human trafficking, who are also injecting drug users.

Chapter 9 – **Drug law crime, drug law crime prevention and the prison system** – focuses on indicators such as: number of offences and investigated/convicted people, indicators analysed along the three stages of the criminal procedures, and on information on drug use in prison settings and the interventions in the judicial system.

As compared to preceding years, the data provided by DIICOT indicated:

- higher values for criminal cases settled by the prosecutor (3360), criminal cases referred to court towards further criminal proceedings (432), prosecuted people (6432) and for whom the prosecutors gave orders for court referral (1099, double the value of 2001), foreign citizen trialled at court for breaking the Law no. 143/2000 further amended and supplemented (39), convicted drug law offenders (718), convictions for drug trafficking (479) and final court decisions giving 705 offenders custodial sentences orders.
- Lower values for: criminal cases solved by dropping charges under art. 18¹ Criminal Code (1211), underage convicted offenders (17), convicted drug users (76) and offenders convicted to imprisonment (354).

The demographic and social-economic indicators of the people trialled at court in 2009 for breaking the drug law continue to be valid in 2010: male offender aged 21 to 54, from urban settings, with an average education and no occupation. At the same time, the increasing trend noticed in 2009 for repeat offenders maintained the same in 2010 and reached 13.5%, while offenders with criminal records accounted for 6.1% of the total convicted offenders, which accounts for the highest rates recorded so far.

The analysis of the values recorded in previous years, there is a decrease of the number of cases settled by court referral (12.8%), of the number of people sent to court (17.8%) and decreasing trend of people convicted for drug possession for personal use which can be correlated to the number of people convicted to drug trafficking.

In addition, although the total number of people convicted to imprisonment follows an upward trend (the highest levels ever), trends have been noted leading to a balance between people who received custodial sentences and serve sentence in the community and those who serve a custodial sentence in penitentiary. The decreasing number of people who received a prison sentence order is commensurate with the increasing number of people who received custodial sentences and serve sentence in the community. More concretely, 351 of the total 705 offenders who received a prison sentence in 2010 were not convicted in confinement. It should be noticed that the reversed ratio between conditional discharge orders and suspended sentence under probation has been effective since 2007, and has since reflected the tendency of courts to impose orders to comply with conditions and obligations including detoxification treatment, while considering all aspects of drug law offences, and less orders that are based on a single obligation, that is not to commit another offence. This conclusion seems to be supported by the evolution of offenders sentenced for drug law offences who are included in the records of the probation services within the Ministry of Justice.

Drug related offences – the data provided by the Traffic Police Directorate within the IGRP, show 40 drivers were caught driving under the influence of narcotic substances or products in 2010, which is almost twice the number in 2009 (23 drivers) and 5 times higher than in 2008 (8 drivers) and almost 20 times more than in 2007 (2 drivers). In addition, 836 drug users (621 men, 215 women) to whom the measure of remand in police custody was imposed following criminal act, were detained in the 12 detention centres of the Remand and Detention Service within the Directorate General of Police of the Municipality of Bucharest (there are no available data at national level). The analysis shows an increase by 27.2% than in 2009 and the analysis of offences committed under the influence of narcotics and psychotropic substances shows most cases were offences committed to gain money, namely contra patrimoniului (theft, robbery) and drug trafficking offences, which may lead to the conclusion that these offences were committed to gain material incomes to support drug use.

As for **drug use and problem drug use in penitentiary** – according to NAP data, in 2010 as compared to 2009, the number of prison inmates who self-reported as drug users doubled from 2001 to 2010 (from 1,065 to 2,043) while the total number of inmates in the penitentiary units in Romania dropped by half (from 50,035 to 26,721). Self-reports of substances used prior to incarceration show heroin is the first among drug use preferences (over two thirds) followed by cannabis and cocaine. Cocaine and ecstasy are on a downward trend as compared to the past year. These data are also confirmed by other indicators – general population surveys conducted in 2003, 2007 and 2010 and drug treatment admission, that place cannabis among the first drug use preferences and heroin as the first drug of abuse of people admitted to treatment. The almost 4-fold increase of statements related to poly-drug use in 2010 from 2.5% in 2009 to 12.2% in 2010 is noteworthy. Most drug users mentioned injection as the most frequent administration route for the main drug of abuse (71.16%), a pattern that was maintained later (according to the findings of the *“Behavioural and serologic survey on the prevalence of infectious diseases among IDU”* in 2010, 44% of the interviewed injecting drug users had been imprisoned before, while 19% injected drugs in penitentiary, during detention).

Chapter 9 also includes the preliminary results of the **second study on the scope and trends of the use of illicit drug, alcohol and other substances among prison inmates** (the first was conducted in 2006) conducted in 2011 by the National Anti-drug Agency in cooperation with the National Administration of Penitentiaries (NAP). There were 2100 respondents in the settled sample (2064 valid questionnaires), which is nationally representative for the institutionalised target population in the prison setting aged 64 and less and had a maximum deviation of +/-2.08%. The study was conducted in all 31 penitentiaries (50 locations) that exist at national level. The respondent selection was randomised.

The use of *medication (tranquilisers, sedatives, anti-depressants) without medical prescription* in prison population has been slightly increasing since 2006. The share neither of those who had never used drugs at large nor in detention decreased and the share of those who started drug use while in detention increased slightly. Half of the prison inmates who reported the use of medication without

medical prescription use medication that affects the central nervous system (diazepam, levopromazinum, carbamazepine, phenobarbital were most often mentioned). The data show an increase in age, as compared to previous study, and the following profile of the drug user: male, aged 25 to 34, not married, low education level, unemployed or no occupation at the time of arrest and having lived in Bucharest prior to detention.

Lifetime drug use prevalence (all types of illicit drugs and SNPP) among prison population aged 15-64, was 25.1%. There is an increase by comparison to the 2006 study (18.5%), except that SNPP was included in the 2011 study, and to the general population aged 15 to 64 (GPS, 2010-4.3%).

For drug use in the current custodial term differences account for up to 2.5%, the increase of drug use among prison population being more obvious if the prevalences of drug use prior to detention are considered (differences between 5.7% and 7.5%).

The analysis of the lifetime prevalence of drug use, by type of illicit drug use, shows that heroin is the most frequently used drug among prison inmates followed closely by cocaine, hashish and cannabis unlike the general population among which SNPP use is first, followed by cannabis and ecstasy. At least a third of the inmates (39.8%, slightly increasing than in 2006: 37.3%) declared that they knew persons who used drugs, most of them belonging to the drug user's peer group and heroin being the most used drug. Drug use by family members maintains at low levels (except for alcohol, especially among the fathers of respondents – 11.7%).

As compared to the previous study there is an increase in age and the following profile can be outlined: male, aged from 25 to 34, not married, high level of education, high school/university student at the time of the arrest, and having lived in Bucharest prior to detention, which differs from the profile of those admitted to treatment in terms of occupational status and education level which might suggest a need for *indicated and selective prevention programmes* for early intervention among young people that were noticed as having drug/alcohol problems (mainly at school) in order to reduce drug addiction.

Asked if they were under the influence of a substance (among those investigated in the study: alcohol, medication and drugs) when they committed the offence for which they had been imprisoned, 40.9% of the inmates declared they had used psychoactive substances when they committed the offence for which they were arrested (less than in 2006: 45.8%); alcohol being most often associated to criminal behaviour, followed by heroin, SNPP and medication without medical prescription or poly-drug use (mainly alcohol combined with other types of drugs). In addition, asked if they committed criminal offences (without mentioning whether they were caught or not) to get drugs, 11.3% said yes, and thefts and robberies were the most frequently mentioned offences.

In relation to the ***care provided to drug users in penitentiaries***, the data indicate a focus on psycho-social care, health education, peer education to prevent HIV, HBV and HCV and the specific treatment of drug related infectious diseases, drug prevent and support of social reinsertion after prison release. Although in an initial phase, there are concerns towards the extension of the therapeutic system: a methadone substitution programme was developed (13 treated people in 2010, 27 in 2008, 12 in 2008) and implemented with UNODC support, together with a prison-based syringe exchange programme (in 10 prison units and penitentiary hospitals in Romania and 18,383 syringes were distributed; there are 83 drug using prison inmates who benefited from these measures) and three detention units and therapeutic communities were developed in 2010.

Data referring to drug supply (drug availability, drug trafficking routes and seizures, drug prices at street level) are presented in chapter 10 – ***Drug markets***.

No clandestine laboratories used for drug manufacture were found on the national territory in the reference year and according to the data provided by responsible institutions, it can be stated that Romania is not an ***origin drug trafficking country***, as the few cannabis cultivations were not representative to estimate possible amounts. Cannabis and hashish continue to be the most trafficked/used drugs in Romania and mainly encountered in large university centres: Bucharest, Craiova, Constanța, Iași, Cluj-Napoca and Timișoara and come from countries such as Moldova, Serbia, Spain and the Netherlands. In relation to heroin trafficking, Romania continues to be a transit area and there is an intensification of the activities of organised crime groups by recruiting Romanian

citizens for the transport of significant amounts (10-80 kg). SNPP are a strong competitor on the illicit drug market in terms of availability and prices. Initially (2008) the trade in these substances was done through internet, but later increasing demand generated several “dream shops” to open under the name of „Weed Shops” that sell directly these products manufactured mainly in China and UK. Substances reach Romania mainly through express companies, distributors buy them at a relatively low price, of almost 2 euro/gram and sell them for up to 22 euro/gram.

The study conducted by the NAP in 2010 (including data from 2007 to 2009) in 39 prison units, included questions related to drug organised crime and use in the penitentiary setting (42 penitentiary managers and 55 crime prevention workers participated) and shows interesting data regarding this “market”. Most respondents estimate an increase of the number of prison inmates who participate in drug trafficking in the last 3 years and stated most cases were detected in Bucharest-Giurgiu area (Bucharest -Rahova, Bucharest -Jilava and Giurgiu penitentiaries) and less in Mărgineni and Ploiești penitentiaries. Most often prison-based networks are connected with organised crime groups outside the penitentiary and in 21% of the cases in which forbidden substances were detected participated Prison inmates convicted/arrested for breaking the Law no. 143/2000. Most respondents mentioned packages as the means to get forbidden substances into prison, while visits and prison staff are second and third on the list. 9 main factors that favour this penitentiary phenomenon were identified and classified in 4 categories: technological factors, human cause factors; regulation factors and macro-social cause factors (e.g. location of penitentiary in an area with a high crime rate). The study on the prevalence of drug use in prison settings in Romania (2011) showed that one in four respondents could obtain illicit drugs and SNPP inside penitentiary within a week’s time (SNPP and heroin are the most, and cocaine the least easy to get).

As compared to previous years, there were no seizures of drug precursors and essential chemical substances across Romania as mentioned in the official data of the National Police, in the year 2010 and there is a 70% increase of the total amounts of **seized drugs**. However, because 79.4% of the total amount of the seized drugs in 2009 was the result of a single noteworthy cocaine seizure, it can be stated that the decrease in seized amounts is less visible. In case of seizures of drug tablets there a 48.8%. The drug amounts seized at national level, by type of drug increased for heroin (27.2%) and decreased for cannabis, cocaine and Amphetamine type stimulants and derivatives. To conclude, drugs seized in 2010 do not exceed the average amounts for the period 2001-2009, with variations for heroin, cocaine and cannabis seizures and a descending trend of opium and synthetic drugs seizures. Once legal provisions made it possible to control 43 new substances in 2010, the operative structures impounded and seized the following amounts of drugs: *synthetic cannabinoids*: 57.024 kg; *catinone*: 50.091 kg and 324 tablets; *piperazine*: 6.506 kg and 15.094 tablets; *pirovalerone*: 1.800 kg and 6 tablets. The analysis of the number of seizures made in the last 5 years emphasises the extended availability of cannabis, competed only by heroin, while cocaine and synthetic drugs are less available. This conclusion of the market availability of certain drugs can be correlated with the outcome of the General Population Survey. In addition, the discrepancy between the number of seizures and the amounts seized, by type of drug, continues to be considerable, except for small variations from one year to another, which might indicate most seizures imply small amounts, generated mainly by street trafficking.

Drug prices did not show significant variations in 2010 as compared to 2009. The wholesale price continues to be stable for cannabis and heroin, while increasing for cocaine (since 2008) and slightly decreasing for ecstasy tablets. Retail price continues to be stable, with almost no variations, except for a low decrease (of almost 1.5 euro) for heroin price at street level and of purity while variations in prices were recorded by wholesale price of cocaine (increasing) and synthetic drugs (decreasing).

All participants in the 2011 study conducted in prison settings were asked about what was normally given in exchange for a drug dose, irrespective of their reports of drug use. 49.3% responded (1018) and most of them declared *money* (amounts ranging from 100 - 150 lei to 100-150 euro) and *cigarettes*. Alcohol, food and coffee, clothing and footwear („valuable, branded items,”), cell phones (ex: „a cell phone in prison is 3500-4500 ron”), gold jewellery (ex. earrings), watches, soap, shampoo, and even sexual services/favours, medication or drug trafficking in prison could also be offered.

The data reported by the Central Laboratory for Drug Analysis and Profiling within IGRP for **drug purity** showed the purity of heroin at street level ranged between 23.9% and 47.3 %, with an average

purity of 22.13% (dropping than in 2009: between 23.9 and 47.3%, average purity of 35.9%), while cocaine had an average concentration of 74.7% in case of large seizures, and *marijuana and average* THC concentration of 4.67% (extreme limits ranging from 0.06% and 10.09%), while cannabis resin has an average THC concentration of 4.15%.

The last part of the report includes two selected issues:

A. Chapter 11 - Drug related health policies and services in prison, which details on: the goals set in national policy documents (including an analysis of the Actions plans to implement the National Anti-drug Strategy 2005-2012 and of the strategic documents on HIV infection/AIDS prevention and control), data on the “illicit drug market” inside the penitentiary system (according to a study conducted in 2010 by NAP), epidemiologic data on drug using prison inmates and the provision of specialised drug treatment services (evaluation, information-education-counselling prevention services and social reinsertion services, psycho-social care, detoxification, opiate substitution treatment, harm reduction – syringe exchange and drug testing).

B. Chapter 12 - Drugs users with children (addicted parents, parenting, child care and related issues) shows the following: scope of phenomenon and its social consequences (based on GPS 2011 and data from the Drug treatment demand indicator), the risks children with drug using parents run (clinical experience and surveys of IOMC specialists and a summary of a pilot study conducted in 2011); the legal and policy framework in the field (regulations on prevention, medical care, child protection) as well as specific interventions for drug using parents: family-based tobacco, alcohol, and drug use prevention (local and national projects and campaigns) and specific treatment/intervention standards and recommendations (treatment of drug using pregnant women and of the new born to drug using mothers).

PART A. NEW DEVELOPMENTS AND TRENDS

Chapter 1 – Legislation, strategies and economic analysis

If 2009 was considered the year in which the National Anti-drug Agency – the institution that was supposed to give essence to the national drug policy and charged with the institutional coordination of the governmental partners participating in the implementation of the National Anti-drug Strategy – had a restricted role³, the year 2010 brought some major changes in the legal and institutional framework in the field of drugs.

In the year 2010, against the vigorous reaction of institutional partners, mainly NGO's, to the inactivity in terms of public policy and drug demand reduction, and to expanded trade of the new psychoactive substances on the national territory, the initiatives related to the re-organisation of the Agency taken by various ministries reduced, while the political interest towards the main reasons for which the agency was setup in the first place, and, by consequence, the need to relocate it increased.

Therefore, debates were launched in the Romanian Parliament in the second half of 2010 surrounding the re-organisation of the Agency as part of the Ministry of Administration and Interior⁴, which translated into facts a year later, when NAA regained its role of national drug policy coordinator. At the same time, the Governmental Decision no. 461/2011⁵ laid down the new organisational and functional structure of the NAA, by encompassing the key tasks and the organisational chart established by the governmental decision issued at the end of 2002⁶ and by which the Agency was setup.

To conclude⁷, because of the ambiguous, constantly changing context, the lack of accurate coordination of public drug policy and the domestic and international economic situation, it can be stated that the anti-drug activity in 2010 was restricted to the maintenance of measures in the field of drug prevention and drug onset prevention, and especially, of drug treatment integrated services, including for prison in-mates, that have started in previous years.

1.1 LEGAL FRAMEWORK

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

A range of legal documents have been formulated and adopted in 2010, providing for the implementation of the national public policy on drugs. Thus, in 2010, the following regulations were issued:

- Governmental Decision no.87 of 05.02.2010⁸ which completes the Governmental Decision no. 1102/2008 *approving the National programme of medical, psychological and social care of drug users – 2009-2012*, which were included in the eligible expenditure of the secondary program 8,

³ www.state.gov – State Department – Bureau of international narcotics and law enforcement Affairs – International Narcotics Control Strategy Report – March 2010, vol.I, page 527;

⁴ Law no. 38/ 28.03.2011 approving the Emergency Governmental Ordinance no. 20/2009 amending the art. 13 indent (2) and (3) of the Emergency Governmental Ordinance no. 30 laying down the groundwork for the organisation and functioning of the Ministry of Administration and Interior and for the reorganisation of several units subordinated to the Ministry of Administration and Interior (issued by the Romanian Parliament, published in the Official Gazette of Romania, Part 1, no. 215 of 29.03.2011)

⁵ Governmental decision no. 461/ 11.05.2011 laying down the groundwork for the organisation and functioning of the National Anti-drug Agency (issued by the Government of Romania published in Official Gazette of Romania, Part 1, no. 331 of 12.05.2011)

⁶ Governmental Decision no. 1489/2002 on the setup of the National Anti-drug Agency (issued by Government of Romania, published in Official Gazette of Romania, Part 1, no. 956 of December 27, 2002)

⁷ Several sources were used in the documentation process of this chapter (reports and surveys of public authorities, press clips, communication with the institutions participating in the implementation of the National Anti-drug Strategy (NAS) 2005-2012)

⁸ Governmental Decision no. 87 of 05.02.2010 supplementing the appendix to the Governmental Decision no. 1102/ 2008 *approving the National programme of medical, psychological and social care of drug users – 2009-2012* (issued by the Government of Romania published in Official Gazette of Romania no. 672 of 30.09.2008)

indent 3, as expenditures for building planning and remodelling, as a main step towards the operation of Dejeni Therapeutic Community, with 30 available seats.

- Governmental Emergency Ordinance no. 6 of 10.02.2010⁹ which placed under control 36 new psychoactive substances and simplified this procedure applicable to various substances for which a narcotic or psychotropic effect is evidenced;
- Governmental Decision no. 261 of 31.03.2010¹⁰ approving the Health National Program for 2010, further amended and supplemented, that continues to include drug prevention and addiction treatment secondary programs in the Mental health national program, exclusively funded by the Ministry of Health;
- Governmental Decision no. 575 of 16.06.2010¹¹ that updates the appendix to the Law no. 339/2005 on the legal status of narcotic and psychotropic plants, substances and preparations and the Law no. 143/2000 on countering the illicit drug trafficking and use, further amended and supplemented, which placed 8 new psychoactive substances under control;
- Law no. 135 of July 1st, 2010 laying down rules on the Criminal Procedure Code¹² that amends and expands the temporary measures that can be taken during prosecution and explicitly regulates the temporary non-voluntary treatment admissions of the culprit or defendant who chronically uses psychoactive substances (art.247, indent 1). Although approved by Parliament, the law was not effective at the time this report was written, as the law enforcing the Criminal procedure code, that would settle the time this code comes into force, was not yet enacted;
- Governmental Decision no. 1040 of 13.10.2010¹³ approving the Public Order National Strategy – 2010-2013, that considers the prevention and fight against illicit drug trafficking and use, as well as the improvement of the treatment services for victims, as main action line for reaching the strategic goal – *Reducing the impact of organised crime and terrorism*;
- Governmental Decision no. 1369 of 23.12.2010¹⁴ approving the Action Plan for the implementation of the National Anti-drug Strategy 2010-2012, which represents the second action plan of the National Anti-drug Strategy;
- Governmental Decision no. 1388 of 28.12.2010¹⁵ approving the Health national programs for 2011 and 2012.

Drug demand reduction in 2010 was characterised by progressing intensification of the phenomenon of new psychoactive substance trafficking and use, but also by an increased pressure of the civil society (non-governmental organisation, medical specialists, psychologists, media corporations etc.) in relation to an efficient management of the phenomenon. The limitations in the intervention regulated by the two regulations enacted in 2010, by which 43 new substances were placed under control through a simpler procedure, brought about a new reaction of the Government of Romania in early 2011 that will be elaborated upon from two points of view: the use of new psychoactive substances and the impact on the drug phenomenon.

Therefore, unlike the one-sided approach to drug phenomenon in 2010, mainly targeting coordination and monitoring of the activities carried out at national level to prevent new psychoactive

⁹ Emergency Governmental Ordinance no. 6 of February 10, 2010 amended and supplemented the Law no. 339/2005 on the legal status of narcotic and psychotropic plants, substances and preparations and the Law no. 143/2000 on preventing and countering the illicit drug use and trafficking (issued by the Government of Romania, published in the Official Gazette, Part I no. 509 of July 22, 2010)

¹⁰ Governmental Decision no. 261 of March 31, 2010 approving the Health national programmes in 2010 (issued by the Government of Romania, published in the Official Gazette, Part 1, no.205 of 01.04.2010)

¹¹ Governmental Decision no. 575 of June 16, 2010 which amended and supplemented the Law no. 339/2005 on the legal status of narcotic and psychotropic plants, substances and preparations and the Law no. 143/2000 on preventing and countering the illicit drug use and trafficking (issued by the Government of Romania, published in the Official Gazette, Part 1, no.509 of 22.07.2010)

¹² Law no. 135 of July 1st, 2010 on the Criminal Procedure Code (Issued by the Parliament of Romania, Romania, published in the Official Gazette, Part 1, No. 486 of 15/07/2010)

¹³ Governmental Decision no. 1040 of 13.10.2010 approving the National Strategy for Public Order – 2010 – 2013 (issued by the Government of Romania, published in the Official Gazette, Part 1, no.721 of 28.10.2010)

¹⁴ Governmental Decision no. 1369 of 23.12.2010 approving the Action Plan for the implementation of the National Anti-drug Strategy (issued by the Government of Romania, published in the Official Gazette, Part 1, no.38 of 17.01.2011)

¹⁵ Governmental Decision no. 1388 of 21.12.2010 approving Health National Programmes for 2011 and 2012 (issued by the Government of Romania, published in the Official Gazette, Part 1, no.893 of 31.01.2011)

substances/products, that are health damaging, and their spread at any cost, at the beginning of 2011, a Measure plan to counter the trade and use of new psychoactive substances/products that are health damaging no. 5/1194 of 18.02.2011, approved by the prime-minister of Romanian Government. This program represents a coordinated, integrated and balanced reaction of public authorities to the new phenomenon and puts forward organisation, legal, operative and prevention measures.

At legal level, the measures provided for in the mentioned programme, translated into tangible steps once the Joint order of the minister of health, of agriculture and rural development, minister of administration and interior, minister of public finance, president of the National Authority for Consumer Protection, of February 2011¹⁶ for the setup of joint team that will perform controls, according to competences, in locations and/or settings where new psychoactive substances and/or products that are health threatening are manufactures, traded, used, other than the ones regulated by law. Concretely, this order lays the groundwork for the compulsory joint intervention for all institutions charged with control over all legal provisions in the field of public health, over legal trade and sale of products, goods and services to the population or over financial legal provisions applicable to trade activities. As shown in the introduction to these methodological rules, enclosed to the mentioned document, the goal is to “lay the groundwork for increased efficiency of actions taken to prevent and counter the expansion of new psychoactive substances/products, that are health threatening, others than the ones regulated by law, as well as the prevention of the use of such substances/products”. As mentioned in the beginning of this chapter, the year 2010 featured an increasing interest of certain population categories towards the use of new psychoactive substances, and, consequently, of the political interest towards the means to counter this phenomenon. Therefore, from the 5 interpellations recorded in the Parliament of Romania on the topic in 2009, the parliamentary activity increased up to 65 interpellations, most of which focused on the policy of the government to ban the trade and use of the new psychoactive substances. The parliamentary control over the governmental policy to prevent and counter the trade and use of new psychoactive substances will continue as priority action in 2011, when 20 parliamentary interpellations have been recorded.

Table no. 1-1: Parliamentary legal initiative, focusing on the drug phenomenon, 2010

1.	Legal proposal no. b/721/17-11-2010 to amend and supplement the Law no. 143/2000	The legal proposal was submitted to the Romanian Senate. The document laid the groundwork for the amendment of the Law no. 143/2000 on preventing and countering the illicit drug use and trafficking, further amended and supplemented so as to enhance drug classification by introducing the concept of average risk drugs. Additionally, a proposal was made to increase sanctions settled for offences regulated by the Law no. 143/2000, and for the Ministry of health and National Anti-drug Agency to issue Methodologies establishing standard to set up specialised medical centres for the users of new psychoactive substances and to detect means to treat them. The legal proposal was rejected by the plenary session of the Senate, on May 4, 2011.
2.	Legal proposal no. nr.b/722 of 17-11-2010 to amend and supplement the Law no. 339/2005	The legal proposal was submitted to the Romanian Senate. The document laid the groundwork for banning all activities related to substances, plants and preparations listed in the schedules enclosed to the law and provided prison sentences for these offences. Additionally, the initiator considered harsher punishments for all activities related to substances, plants and preparations that pose a <i>high risk</i> to users. In amended form, the legal proposal received the votes of the plenary session of the Senate on April 27, 2011, and was submitted for consideration to the Chamber of representatives.

Source: NAA

The political interest towards the trade and use of the new psychoactive substances was an invariable of 2010 evidenced towards the end of the year another dimension of parliamentary activity, namely the right to legal initiative. The use of this right in the reference year translated into two legal

¹⁶ Joint order of the minister of health no. 121 of 16.02.2011, of the minister of agriculture and rural development no. 43 of 16.02.2011, of the minister of administration and interior no. 43 of 17.02.2011, of the minister of public finance no. 1.647 of February 16, 2011, the president of the National Authority for Food Safety no. 8 of February 16, 2011, of the president of the National Authority for Consumer Protection no.1/239 of February 16, 2011 for the setup of joint team that will perform controls, according to competences, in locations and/or settings where new psychoactive substances and/or products that are health threatening are manufactures, traded, used, other than the ones regulated by law (issued by the Ministry of health, Ministry of Agriculture and Rural Development, Ministry of Administration and Interior, Ministry of Public Finance, National Authority for Food Safety and National Authority for Consumer Protection, published in the Official Gazette, Part 1, no.123 of February 17, 2011)

proposals¹⁷ to amend and supplement the Law no. 143/2000 on preventing and countering the illicit drug use and trafficking, further amended and supplemented and the Law no. 339/2005 on the legal status of narcotic and psychotropic plants, substances and preparations.

There will be further attempts of parliament and government members to find a valid solution to prevent and counter the use of the new psychoactive substances starting with 2011, as 10 legal proposals were formulated in the first half of 2011, aiming at either the amendment of current drug legislation or the regulation on marketing narcotic, hallucinogens, euphoric, psychotropic plants, substances and preparations and their derivatives.

1.1.2 LAWS IMPLEMENTATION

The technical rules implementing the health national programmes in 2010¹⁸, were enacted and later amended by six joint orders throughout the year¹⁹, to put in practice the provisions of the Governmental decision no. 261 of March 31, 2010 approving the Health national programmes in 2010²⁰. They amend the national legal framework related to the implementation of the measures established by the mentioned regulation and specify, at operational level, implementation tools and resources. By the new technical rules of the health national secondary programmes, scheduled indicators were changed and, although the number of efficiency indicators is constant, physical indicators such as the number of people tested in body fluids and of those in after-care reduced, from 14,350 to 6,000, namely from 7,600 people to 4,000, while the number of patients in substitution treatment increased, from 1,800 people to 5,000 people. It should be noticed that by the Joint Order no. 1445 of November 24, 2010, the number of medical units that carries out the Secondary programme to prevent and treat drug addiction increased by four, namely the Municipal Hospital in Onesti – Psychiatry Ward, Psychiatric Hospital in Botosani, County emergency hospital in Targu Jiu - Psychiatry Ward and Emergency clinical hospital in Psychiatry Ward - Psychiatry Ward, the total number of such units amounting to 14.

The exceptional legal provisions for drug users, namely people prosecuted for drug possession for personal use, were not enforced in 2010. Thus, the legal gap continued to affect the possibility to replace prison sentence for drug users, upon their acceptance or inclusion in a specific medical-psychological-social care integrated programme (enforcement of art. 19²¹ and 19²² of the Law no. 522/ 2004²³), because of the same major obstacle, namely that the provisions of the Criminal Code²⁴ and of the Criminal Procedure Code²⁵ were not applied. Yet, during 2011, the Government of Romania formulated the enforcement proposal of the Criminal Code and proposals to amend special

¹⁷ Senate of Romania – Legal bulletin, September – December session, 2010, page 130

¹⁸ Joint order of the minister of public health no. 264/2010 and of the president of the Health Insurance National House no. /407 din April 1, 2010 approving the Technical regulations for the formulation of health national programmes in 2010

¹⁹ Order of the minister of public health and of the president of the Health Insurance National House no. 390 of 29.04.2010; Order of the minister of public health and of the president of the Health Insurance National House no. 881 of June 3, 2010, Order of the minister of public health and of the president of the Health Insurance National House no. 937 of 16.06.2010, Order of the minister of public health and of the president of the Health Insurance National House no. 1277 of 07.10. 2010, Order of the minister of public health and of the president of the Health Insurance National House no. 1445 of 24.11.2010, Order of the minister of public health and of the president of the Health Insurance National House no. 1532 of 22.12.2010 and Order of the minister of public health and of the president of the Health Insurance National House no. 1585 of 29.12.2010

²⁰ Amended and supplemented by: Decision no. 1054 of October 23, 2009 – M.Of. no.76/26.10.2010, Decision no. 1286 of December 18, 2010 – M.OF. no.853/20.12.2010, Decision no. 1331 of December 23, 2010 – M.Of. no. 871/27.12.2010

²¹ article 19¹(4) provides for „the pursuit of the criminal investigation in all cases according to the Criminal procedure code”

²² article 19² (4) mentions that “For the culprit or defendant who refuses the inclusion in an integrated care programme for drug users, the provisions of the Criminal code and of the Criminal procedure code shall apply”

²³ Law no. 522 of November 24, 2004 amending and supplementing the Law no. 143/ 2000 on preventing and countering the illicit drug use and trafficking (Issued by the Parliament of Romania, published in the Official Gazette no. 1155 of December 7, 2004)

²⁴ Law no. 286 of July 17, 2009 providing for the Criminal Code (issued by Romanian Parliament, published in the Official Gazette no. 510 of July 24, 2009)

²⁵ Idem 15

laws by criminal provisions, and the enforcement proposal of the Criminal Procedure Code, also amending and supplementing laws that include criminal procedure provisions. It should be mentioned that the enforcement proposals of the two codes also include a range of amendments of the fundamental drug law, namely the Law no. 143/2000, further amended and supplemented, with the aim of restricting the enforcement domain of the provisions referring to the inclusion in treatment integrated programmes.

The implementation of the National programme of medical, psychological and social care for drug users - 2009-2012²⁶ continued, while the National Interest Programme for tobacco, alcohol and drug use prevention 2009 – 2012²⁷, enacted in 2008, could not be implemented in the reference year because of the legal gap generated by inaccuracy between the legal provisions referring to public procurement. Thus, the Law no. 350/2005²⁸ on public funding for not-for-profit activities of general interest based on non-reimbursable financial support (included in the National Interest Programme for tobacco, alcohol and drug use prevention 2009-2012 – a.n.) makes specific reference to the provisions of the GEO no. 60/2001²⁹, regarding project selection procedure and transparency of procedures, but this document was repealed by GEO no. 34/2006³⁰, without correlations with the provisions of the Law no. 350/2005.

1.2 NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION

The year 2010 did not bring major changes to the legal and structural framework established in the first half of 2009, which prevented the NAA from committing to and taking upon its role as coordinator of national drug policy, as it lacked the legal personality to assume its role.

The interest of the administration towards the national issue of drugs translated into strategic planning by the adoption, at the end of 2010, of the GD no. 1369 of December 23, 2010³¹, namely of the second action plan for the implementation of the National Anti-drug Agency 2008-2012, which is highly important for the organisation, planning and evaluation of the strategic goals in the field.

However the assessment of the drug demand and supply policy in 2010 could not be performed due to the delays in approving this planning document and the conclusions of the Assessment report of the implementation stage of goals provided in the Action plan for the time interval 2010-2012 ensuring the implementation of the National Anti-drug Strategy 2005-2012.³² Accordingly, it can be noticed that repeated re-organisations, the location and re-location of the NAA in its relation to other institutions and organisations active in drug demand and drug supply reduction, and the continuing discrepancy between the status of the Agency and its role as national drug policy coordinator, have lead to an almost complete absence of any activity related to strategic planning, coordination and evaluation of current policy.

²⁶ Governmental Decision no. 1102/2008 approving the National programme of medical, psychological and social care of drug users – 2009-2012 (published in the Official Gazette no. 672 of 30.09.2008)

²⁷ Governmental decision no. 1101/September 18, 2008 approving the National interest programme to prevent tobacco, alcohol and drug prevention 2009 - 2012 (issued by the Government, published in the Official Gazette no. 672 of September 30, 2008)

²⁸ Law no. 350/2005 on public funding for not-for-profit activities of general interest based on non-reimbursable financial support (published in the Official Gazette no. 1128 of 14.12.2005)

²⁹ Emergency Governmental Ordinance no. 60 of 25.04.2001 on public procurement (published in the Official Gazette no. 241 of 11.05.2001)

³⁰ Emergency Governmental Ordinance no. 34 of 19.04.2006 on awarding public procurement contracts, public works lease, service lease, as amended and supplemented (published in the Official Gazette no. 418 of 15.05.2006)

³¹ Idem 17

³² Evaluation report on the implementation stage the objectives set in the Action plan for the time period 2005 – 2008, to implement the National Anti-drug Strategy 2005 – 2012, formulated by the NAA in 2009

1.2.1 NATIONAL ACTION PLAN AND/OR STRATEGY

The National Anti-drug Strategy (NAS) 2005-2012³³ was the main strategic document of the national policy of drug demand and drug supply reduction in 2010. By contrast with the previous year, in 2010 the Government of Romania succeeded into formulating and enacting the second policy regulation aimed at reaching strategic goals, namely the Action Plan for the implementation of the National Anti-drug Strategy 2010-2012³⁴. Other strategic document that include drug related provisions were formulated and enacted in 2010 along with the two strategic documents, essential to the approach of drugs at national level.

Thus, June 22, 2010, the president of Romania submitted to the Parliament of Romania, the new Defence national strategy, a document endorsed by the Supreme Council of National Defense³⁵. Even if by the time of this report, the strategy was not approved, it should be mentioned the issue of drug trafficking and use was included among vulnerabilities, in the risks and threats to Romania, and the measures to fight against the illicit drug trafficking and use, along with the improvement of the services attending to victims is one of the main domestic action lines, in the field of public order.

Additionally, October 13, 2010, the Government of Romania approved the National Strategy of public order and safety³⁶ that institutes “**knowing, preventing and fighting illicit drug trafficking and use and improvement of treatment services for victims**” as intervention domain included under the strategic goal no. 3 (in Chapter VII – Courses of action – *Reducing the impact of organised crime*), as well as *strengthening the institutional capacity of the National Anti-drug Agency* as main action line.

The domain of applicability of the new National Strategy of Public Order – 2010-2013 extends to drug use, as opposed to the former document, Strategy of the Ministry of Administration and the Interior for ensuring public order and safety, for increasing citizens’ safety and for preventing street crimes³⁷, that was restricted to the fight against drug trafficking. The difference between the old and new strategic approach to drugs in the context of public order and safety is given by the Strategic plan of the Ministry of Administration and the Interior for 2010-2012, which is characterised by a balanced monitoring of drug demand and supply reduction, and by the acknowledgement of the role of the NAA as national drug coordinator by enhancing its institutional capacity.

At the same time, the Strategic plan of the Ministry of Administration and the Interior was formulated for the period 2010-2013³⁸ to institute measures towards reaching the strategic goal of public order and safety: “**reducing the impact of cross-border organised crime and terrorism**”: measures to implement national programmes to prevent drug trafficking and use and means for sustainability, as well as to intensify international cooperation facilitating the identification and dismantling of drug trafficking networks that influence Romania.

The new documents show a progress in approaching the drug phenomenon. Thus, from a one-sided approach focusing on the fight of drug trafficking, as provided in the Strategy of National Security of Romania³⁹, the current approach is diverse as it includes drug use along drug trafficking. Additionally, as mentioned before, drug use was included among risks and threats to Romania, as provided in the proposal of the new Strategy of national defence.

³³ Governmental Decision no. 73 of January 27, 2005 on the approval of the National Anti-drug Strategy 2005-2012 (published in the Official Gazette no. 112 of February 3, 2005)

³⁴ See footnote 17

³⁵ www.presidency.ro

³⁶ See footnote 16

³⁷ Governmental decision no. 196 of 17.05.2006 approving the Strategy of the Ministry of Administration and the Interior for ensuring public order and safety, for increasing citizens’ safety and for preventing street crimes (published in the Official Gazette no. 243 of 23.05.2006)

³⁸ www.mai.gov.ro/index15.htm

³⁹ Decision of Supreme Council of National Defence no. 62 of 17.04.2006 approving the National Security Strategy of Romania

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

As mentioned in the previous report and earlier in this one, the absence of an action plan towards reaching the strategic aims in 2009 and 2010, with tangible measures and deadlines, impeded the implementation of the national anti-drug strategy.

The adoption of the second action plan for implementing the National anti-drug strategy 2010-2012⁴⁰ at the end of 2010 created the legal framework for coordinated activities lead by institutions and authorities active in drug demand and supply reduction towards the goals to be reached by the end of 2012. Building on the structure of the previous action plan and in line with the strategic vision for 2005-2008, this action plan for implementing the National anti-drug strategy 2010-2012 aims at ensuring continuity of the general and specific goals of the national strategy, by reducing supply and demand, strengthening international cooperation and developing a global information-evaluation system of the drug phenomenon, with a focus on drug policy coordination, in line with the recommendations of the European Commission.

In concrete terms, the new action plan is more synthetic, as only those activities that manage the phenomenon in line with strategic goals were kept, while activities such as legal and institutional building were eliminated, as being already achieved. Additionally, there is a link between activities in the field of drug demand reduction and the activities in the National Interest programme for tobacco, alcohol and drugs prevention 2009 - 2012⁴¹, and in the National programme of medical, psychological and social care for drug users - 2009-2012⁴². The new action plan provides a better delineation of activities in the field of information an devaluation that should be carried out by the National Focal Point (Romanian Monitoring Centre for Drugs and Drugs Addiction), mainly related to the research component. In line with European policy trends, activities such as the formulation of a range of key indicators for data collection in the field of drug related crime, drug markets and drug supply interventions are also included.

It should be mentioned that the new Action Plan settles the necessary budgets for the planned activities and maintains the general provision that *“activities are funded under the budgets earmarked to institutions for the current year”* and highlights specific assessment indicators.

In the year 2010, even against the absence of a key regulation in the field of drugs, activities aiming at implementing sectoral policy such as: public order and safety, education-learning, youth, health etc continued along with activities that started in the previous period.

1.2.3. COORDINATION ARRANGEMENTS

As mentioned in this chapter, the year 2010 has brought no significant changes in the existence and performance of the role of national coordinator of the drug demand and drug supply reduction policy as compared to the last year. Thus, in 2010, the National Anti-drug Agency continued to be unable to ensure efficient and effective mechanisms to cooperate and coordinate the actions of other institutions and bodies responsible for drug policy implementation.

There were no significant structural and functional changes among the rest of the public institutions and bodies involved in the activities provided in the Action plan for the implementation of the National Anti-drug Strategy 2010-2012, in 2010, except for the Directorate General for Early Education, School, Performance and Programs within the Ministry of Education, Research, Youth and Sport that has been re-organised as Directorate General for Education and Lifelong Learning. A single post was maintained for the coordination of information and health national programmes in partnership with civil society structured, which also include an education component in the field of interest for this report.

⁴⁰ See footnote 17

⁴¹ Governmental decision no. 1101/September 18, 2008 approving the National interest programme to prevent tobacco, alcohol and drug prevention 2009 - 2012 (issued by the Government, published in the Official Gazette no. 672 of September 30, 2008)

⁴² Governmental Decision no. 1102/2008 approving the National programme of medical, psychological and social care of drug users – 2009-2012 (published in the Official Gazette no. 672 of 30.09.2008)

1.3 ECONOMIC ANALYSIS – PUBLIC BUDGET AND EXPENDITURES

We should mention that in drafting this subchapter, the proposed methodology could not be used for public expenditures because the state budget does not comply in structure with the COFOG European standard referred to in the proposal. Moreover, specific expenditures for drug-related activities are not earmarked and cannot be identified separately in the budgets of the institutions that carry out drug related activities. The annual expenditures earmarked for drug specific programmes, initiated or implemented by public authorities or in partnership with civil society bodies, are the only “visible” expenditures in the annual budgets of public authorities. Collected data shown in this chapter refer to non-standard public expenditures.

1.3.1 PUBLIC EXPENDITURES, BUDGET AND SOCIAL COSTS

The funding earmarked to drug policy implementation at national level was from state budget sources or extra-budgetary sources:

The budget earmarked to the NAA followed an upward trend, as compared to previous years. By contrast with 2009, there were more nationally financed programmes than internationally funded programmes (mainly PHARE funded projects and technical and financial support granted by the UNODC).

Table no. 1-2: Budget earmarked to the National Anti-drug Agency⁴³, 2006 – 2010

	2006 ⁴⁴		2007 ⁴⁵		2008 ⁴⁶		2009 ⁴⁷		2010 ⁴⁸	
	Lei	Euro	Lei	Euro	Lei	Euro	Lei	Euro	Lei	Euro
Staff costs	10408000	2956818	13210000	3966967	14998000	4075543	30992757	7309613	31313906.53	7437982.54
Goods and services	1956000	555682	1223000	367267.3	1393000	378532.6	536231.05	126470	662881.08	157453.93
PHARE co-financing and contribution to international bodies	366000	103977	742000	222822.8	656000	178260	927189.40	218677	89549.43	21270.64
National programmes			2453000	736636.6	1475000	400815	70870.07	16715	1693062.28	402152.56
Total	12730000	3616477	17628000	5293694	18522000	5033150	32527047.52	7671473	33759399.32	8018859.67

Source: NAA, Budget-Accountancy Directorate - IGRP

Budget allocations and the extensive use of available funding ensured the success of most of the activities carried out by the agency to reach the objectives foreseen in drug policy documents for the year 2010. For the rest of the institutions that manage drug demand and drug supply reduction activities it's worth mentioning that:

⁴³ The earmarked budget included the amounts earmarked to the NAA and the Anti-drug services (territorial units) within IGRP, similarly to 2010

⁴⁴ Average annual rate in 2006: 1Euro = 3.52 RON

⁴⁵ Average annual rate in 2007: 1Euro = 3.33 RON

⁴⁶ Average annual rate in 2008: 1Euro = 3.68 RON

⁴⁷ Average annual rate in 2009: 1Euro = 4.24 RON

⁴⁸ Average annual rate in 2010: 1Euro = 4.21 RON

Table no.1-3. Programmes/projects implemented by participating institutions, 2010

Name of institution	Description of programmes/projects carried out	Earmarked amounts in lei	Earmarked amounts in euro
Ministry of Education, Research, Youth and Sport	Directorate General of Education and Lifelong Learning - Drug specific activities during competitions and extracurricular activities	60	14.251.78
	Directorate General of Education and Lifelong Learning - <i>Inclusive educational offers, extracurricular and extra scholarly, for creating a healthy lifestyle and active citizenship for children in disadvantaged communities, mainly rural in pre-university education – financed by the Social European Fund</i>	3.200	760095.01
	National Authority for Sport and Youth -12 local and regional drug specific projects	9.125	2167.45
National Administration of Penitentiaries	<i>The project "Increasing the access of prison inmates to harm reduction programmes" financed by the UNODC-Romanian office within the Programme "HIV Prevention among injecting drug users in prisons" HIV and HCV volunteer testings were carried out along with building skills among the medical-social staff in order to provide counselling and volunteer testing services within the programme Increase of access of prison inmates to HIV and HCV testing, funded by the Global Fund</i>	107.178	25457.95
		0	54770
Ministry of Health	<p><i>Mental health national programme</i> as one of the Non-communicable diseases national programmes, is coordinated by the Mental Health National Centre and aims at:</p> <ul style="list-style-type: none"> • Ensuring access, continuity and quality of services for people with diseases related to the use of psychoactive substances; • Drug use prevention and provision of specific treatment to drug-addicted people. <p>One of the secondary programmes of this programme was exclusively dedicated to drug users. Thus, the <i>Prevention and drug-addictions treatment</i> secondary programme included the following activities:</p> <ul style="list-style-type: none"> • Providing substitution treatment based on opiate agonist medication to drug-addicted people; • Testing narcotic metabolites, in all specialized medical units, for adults and children; • Detoxification treatment for drug-addicted people. <p>The following efficiency and physical indicators have been included among assessment indicators field:</p> <ul style="list-style-type: none"> • Average cost/drug urine tested person: 20 lei; • Average cost / patient in methadone substitution treatment: 120 lei; • Average cost / patient in after-care: 320 lei; • Number of drug urine tested people: 6.000; • Number of people in after-care: 4.000; • Number of patients in substitution treatment: 5.000; 	1303481 ⁴⁹	309615.439
	<p><i>Communicable Diseases National Programme (HIV/AIDS infection, tuberculosis, sexually transmissible diseases and other priority communicable diseases)</i> including the component <i>Secondary programme for HIV infection monitoring and control</i> and coordinated by the Infectious Diseases National Institute "Prof.Dr. Matei Bals". One of the objectives of the secondary programme is to prevent HIV infection transmission among injecting drug users by supporting substitution programmes. The <i>National Programme for Monitoring Modifying Factors of living and working environment</i> is another component of the <i>Communicable Diseases National Programme</i>, which includes activities such as the identification, and measurement of the specific health risks posed by certain risk behaviours (drugs, smoking, alcohol, food behaviour etc.)</p> <p>Several campaigns against alcohol and drug use have been foreseen in the <i>National Programme for health and health education promotion</i>, namely in the <i>Secondary programme for healthy lifestyle promotion</i></p>	171541 ⁵⁰	40.746
		8183 ⁵¹	1.943.70

Source: NAA

⁴⁹ The amount is the total budget allocated for Communicable Diseases National Programmes

⁵⁰ The amount is the total budget allocated for Communicable Diseases National Programmes

⁵¹ The amount is the total budget allocated for the National Programme for health and health education promotion

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

2.1. DRUG USE IN THE GENERAL POPULATION

2.1.1 METHODOLOGY

The National Anti-drug Agency conducted the third general population survey in 2010 with the purpose of obtaining information on the scope and trends of the use of different drugs in the general population.

The sample was set to 5100 respondents, which is nationally representative for the not-institutionalised target population aged 15 to 64. Within this sample, over-sampling was established for the age group 15-34. At national level, the sample had a maximum deviation of +/-1.4% against a confidence interval of 95%

Table no. 2-1 GPS sample population, 2010 (no. of people)

Age group	population	sample	Over-sampling (1000 people.)
15-34 YEARS	6451557	2191	3191
35-64 YEARS	8568402	2909	1909
TOTAL	15019959	5100	5100

Source: NAA

The study was based on a random, stratified and multi-phase sampling procedure and the stratification variables were:

- the 8 euro-areas of Romania: N-E, N-V, V, S-V, S, S-E, C and Bucharest-Ilfov;
- each county – household setting: urban (2 categories: town – county capital and the other towns) and rural;
- age group: 15-19 years, 20-24 years, 25-29 years, 30-34 years, 35-39 years, 40-44 years, 45-49 years, 50-54 years, 55-59 years and 60-64 years;
- gender: male and female.

The towns were selected randomly in each layer, and the respondents were selected randomly for each town, age group and gender, in the list of people that met the needed features in the selected places.

Questionnaire and data collection:

- data were collected by a private institute of sociologic research and marketing in Romania⁵² and was funded through the Grant agreement signed between EMCDDA and GIRP/ NAA.
- a 215 – item questionnaire (400 variables) was used that refers to the knowledge, attitudes and drug use patterns and was applied in 50-60 minutes among people with a drug use history and almost 30 minutes among people who never used drugs. The questionnaire included 5 units (alcohol, tobacco, tranquillisers, barbiturates and anti-depressants, new psychoactive substances and illicit drugs, social-demographic data). The questionnaire was applied face to face, by trained interview operators⁵³.

⁵² Centre for Market and Opinion Polls (CSOP)

⁵³ The questionnaire was structured in two distinct units: all questiones related to the evaluation of substance use could be answered by a self-applied questionnaire, placed in a separate envelope, except for cases of illiteracy or major physical and psychological disorders, when a face to face interview would be applied. The envelope with all records, closed and sealed, could be given to the operator or taken by the respondent to the nearest mail box.

2.1.2 RESULTS⁵⁴

I. Prevalence of legal drug use

A. Alcohol

The highest prevalence of drug use in Romania was recorded for the use of alcoholic beverages: over 80% of the population experimented the use of alcohol and almost two thirds (64.6%) of the respondents used such beverages recently which confirms the theory that alcohol is a largely accepted social drug.

Table no. 2-2 Alcohol use prevalence, by age group and gender, comparison between 2004, 2007 and 2010 (%)

Alcohol prevalence	use	Age group (years)					gender		Total 15-64 years
		15-24	25-34	35-44	45-54	55-64	male	female	
lifetime	2004	81.8%	89.0 %	91.1%	88.4%	85.7%	93.4%	80.8%	87.1%
	2007	71.5%	83.4%	84.7%	86.5%	84.8%	91.4%	72.7%	82%
	2010	70.8%	79.2%	81.9%	83.9%	83.3%	87.8%	71.5%	79.6%
In the last year	2004	69.1%	77.4%	75.0%	72.2%	62.0%	83.7%	59.9%	71.7%
	2007	62.2%	73.4%	71.8%	69.7%	61.1%	81.3%	54.9%	68.1%
	2010	58.8%	64.3%	71.7%	67.3%	59.6%	76.6%	52.7%	64.6%
In the last 30 days	2004	54.6%	66.7%	63.0%	58.7%	49.3%	73.9%	44.3%	59.0%
	2007	46.8%	58.9%	60.6%	58%	49.4%	72.1%	38%	55%
	2010	40.9%	47.9%	55.9%	54.5%	47.5%	65.4%	33.5%	49.4%

Source: NAA

Comparing to previous surveys, the following can be noticed:

- decrease of the three prevalences for all age groups,
- alike previous years, the lowest prevalences were recorded for the age groups 15-24 and 55-64, and the highest prevalences of recent use (in the last year) and the current use (in the last 30 days) for respondents aged 24 to 44.
- There is statistically significant relation between recent alcohol use and gender: males tend to be heavier users than females. It is worth mentioning that in 2007, male were by 3.4 time more likely to use alcohol than women, and in 2010 the male/female OR⁵⁵ drops to 2.9 (2.44 – 3.54 pt. CI 95%);
- By residence: the urban area records the highest values of lifetime and recent prevalence and the rural setting records the highest values for current use.
- By geographic area, for current use: Moldova recorded the highest values in 2004 and 2007 (66.3% namely 59.9%) and Bucharest (61.7% namely 63.1%), while the eastern part of Romania recorded the highest values in 2010 (N-E- 53.2%, S-E – 55.5%).

The results of the last survey shows one in three respondents (31.1%) experimented drunkenness at least once in his/her life, and one in 10 (9.6%) used alcohol excessively in the last 30 days until experiencing drunkenness. Comparing to the first general population survey (2004) there are significant diminutions of the three prevalence indicators for both age groups and genders.

Analysing drunkenness following excessive use of alcohol based on the demographic variables of gander and age group it can be noticed that:

- the highest values are recorded for the three prevalence indicators among male users aged 35 to 64;
- as opposed to the male situation, drunkenness prevalence in the last year and last 30 days is higher among young female users than adult users. It is noticed that as regards the lifetime prevalence of excessive alcohol use there is an ever smaller difference between the value

⁵⁴ The final report has not been published yet, but intermediate results are available on the website of the NAA, www.ana.gov.ro

⁵⁵ odds ratio, OR – the higher the value over 1, the higher the likelihood of the risk to occur, and by contrast, the closer the value is to 0, the higher the protection; in this situation, the likelihood that a male subject uses alcohol at least once a year is higher (3.4 >1) than of a female subject to use alcohol at least once a year (CI – Confidence Interval)

recorded for the age group 15 to 34 and the one recorded for the age group 35-64 (2004 – 9.2%, 2010 – 0.9%).

Table no. 2-3 Prevalence of excessive alcohol use by age group and gender, comparison between 2004 and 2010 (%)

Drunkenness prevalence		Age group				Total
		15-34 years		35-64 years		
		Male	Female	Male	Female	
lifetime	2004	61.6%	23.0%	71.7%	13.8%	36.7%
	2010	46.1%	9.1%	59.9%	8.2%	31.1%
In the last 12 months	2004	37.5%	11.2%	44.7%	4.5%	16.8%
	2010	24.1%	4.2%	26.3%	2.5%	14.3%
In the last 30 days	2004	22.3%	3.4%	24.1%	2.0%	9.3%
	2010	15.4%	2.3%	18.8%	1.7%	9.6%

Source: NAA

Although beer is the first choice of alcoholic beverage among Romanians, similar to the last survey of 2004, being mentioned by 33.5% of the recent users (dropping than in 2004: 49.4%) there is an increase by 9.8% of those who prefer wine (2004 – 17.5%, 2007 – 27.3%). Another important element of the survey is the motivation behind the use of alcohol. Comparable to the survey in 2004, the most frequent causes were stress reduction⁵⁶; the wish to change mood for one in 4 respondents⁵⁷, external motivation (“Because it is usual in the group”) as mentioned by 22.1% of the subjects, and an avoidance motivation (“To forget my problems”) is mentioned by 19.4% of the respondents.

In reference to the distress alcohol use causes on social safety: one in three respondents (36.2%) reports verbal abuse by a person under the influence of alcohol, one in 4 subjects was psychologically/physically disturbed by people under the influence of alcohol⁵⁸, one in 10 was physically abused by people under the influence of alcohol (11.8%), and 3.3% were involved in traffic accidents caused by a person under the influence of alcohol.

B. Tobacco

While decreasing than in 2004 and increasing than in 2007, smoking tobacco products records the second level of drug use prevalence in the Romanian population: more than half of the interviewers (56.9%) smoked at least once in their lifetime. A third of the subjects reported smoking in the last 30 days (30.3% - decreasing than in previous years: 36.5%, namely 33.7%) and one in four reported daily smoking (24.7%).

As compared to previous surveys, it can be noticed that:

- by age groups – the highest value for lifetime drug use (63.4%) for the 35-44 age group and increase as compared to previous survey; the lifetime prevalence of smoking continues to drop, and alike the year 2004 and 2007, the highest prevalence rates for recent use (35.8%) and current use (35.5%) were recorded for the age group 25 to 34,
- the ratio between male smoking population and female smoking population is approximately 2:1;
- by living settings the trend recorded in previous surveys persists, namely highest values for the three prevalence rates in large urban areas and the lowest in the rural areas.
- there are no major differences between the results of the three surveys in relation to the number of cigarettes smoked daily among respondents who reported smoking in the last 30 days.
- the average onset age for tobacco use records the same trend: decrease of the average onset age for the young population (15-34 years) as compared to the adult generation (35-64 years) and a lower value for male users (in 2010 – 17.57 years) as compared to female users (in 2010 – 19.46 years).

⁵⁶ “to relax” – 42.7%, “to be happier” – 42.2%, “to improve my spirit” – 14.6%, “to gain the energy to work” – 12.8% and “to improve capacity to think” – 3.5%

⁵⁷ “to have the energy to dance, have fun” – 24.4%, “to be more outgoing” – 23.4%

⁵⁸ was: disturbed at night by people under the influence of alcohol (26.6%), made to take another road to avoid drunk people (24.9%), part of a dispute between drunk people (24.8%), unsafe in a public place including means of transport (24.4%), disturbed by people under the influence of alcohol who vomited, urinated or threw garbage (22.2%)

Table no. 2-4 Prevalence of tobacco use, by age and gender, comparison between 2004, 2007 and 2010 (%)

Prevalence of smoking	year	Age group (years)					Gender		Total
		15-24	25-34	35-44	45-54	55-64	male	female	15-64
lifetime	2004	61.8%	70.5%	65.0%	62.7%	44.2%	75.4%	48.7%	62.1%
	2007	52.6%	61.8%	60.7%	56.6%	42.9%	67.7%	43.7%	55.7%
	2010	50.5%	59.4%	63.4%	59.6%	49.6%	70.4%	43.3%	56.9%
In the last year	2004	33.3%	46.0%	40.0%	39.3%	20.3%	48%	25.5%	36.8%
	2007	39.9%	45.6%	43.3%	36.6%	20.1%	47.7%	28.7%	38.2%
	2010	28.5%	35.8%	34.8%	30.4%	20.8%	40.2%	21.1%	30.6%
In the last 30 days	2004	32.9%	46.0%	40.0%	38.7%	19.7%	48.7%	25.3%	36.5%
	2007	32.8%	40.6%	38.9%	33.7%	17.6%	42.5%	25%	33.7%
	2010	28.3%	35.5%	34.2%	30.0%	20.8%	39.8%	20.9%	30.3%

Source: NAA

Regarding the attitude towards smoking and perception of its consequences, the data of the last survey indicate an increase of social tolerance towards tobacco use as compared to the results of the first survey (2004):

- The share of those who consider smoking less than 10 cigarettes/day does not pose health risks is over 20% (there are higher differences among young people: 15-24 years – from 38.3% to 23.7% and 25-34 years – from 30.7% to 22.9%);
- At least one in three respondents consider “People should not be allowed to smoke”; the largest differences are recorded for the age group 35-44 (according to table 2-4 – there is a higher lifetime prevalence – 63.4%) and the age group 55-64 (as shown in table 2-4, there is an increase of lifetime prevalence: from 44.2% in 2004 to 49.6% in 2010);
- The impact of smoking on the others` health – most of the respondents agreed passive smoking causes health problems (over 80%); as compared to the previous survey there is a decrease of the rate of those who consider that staying close to a smoker might cause health problems, among all age groups: between 3.6% (for age group 15-24) and almost 10% for the other age group (25-34 years – 9.1%; 35-44 years and 45-54 years – each of 9.9%; 55-64 years – 11.6%);
- and the last statement “Everybody can quit smoking, if willing” gained the largest agreement among survey participants, with over 85% of them agreeing (as compared to the 2004 survey there are decreases from 3.2% to 11.2%).

Table no. 2-5 Perceived risk and attitude to smoking, by age group, GPS – 2010 (% - agreement)

		Age group (years)				
		15-24	25-34	35-44	45-54	55-64
„smoking less than 10 cigarettes/day does not pose health risks”	2004	38.3%	30.7%	20.7%	25.6%	24.7%
	2010	23.7%	22.9%	22.3%	23.6%	19.8%
„people should not be allowed to smoke”	2004	38.5%	34.2%	40.2%	37.9%	48.7%
	2010	36.6%	33.6%	35.6%	39.4%	43.8%
„staying close to a smoker might cause health problems”	2004	87.0%	93.0%	91.2%	92.8%	92.7%
	2010	83.4%	83.9%	81.2%	82.9%	81.1%
„everybody can quit smoking, if willing”	2004	88.7%	90.1%	90%	93.4%	88%
	2010	85.5%	85.2%	81.9%	82.2%	81.4%

Source: NAA

II. Prevalence of the use of medication (tranquillisers, sedatives, anti-depressants) without medical prescription, of SNPP – new psychoactive substances (traded as “ethno-botanical plants”) and of illicit drugs

Lifetime prevalence of drug use

Drug use lifetime prevalence in the population aged 15 to 64 years is 4.3% for all types of illicit drugs but also for psychoactive substances traded as “legal drugs or ethno-botanical plants”: marijuana, ecstasy, inhalants, cocaine, crack, amphetamines, ketamine, hallucinogens, heroin or opiates, mephedrone, spice, other ethno-botanical plants (increasing than in 2007 when the lifetime prevalence of drug use in the population aged 15 to 64 was 1.7%). If medication (tranquillisers,

sedatives, anti-depressants) administered without medical prescription is considered the percentage reaches 8.3% (while in 2007 – 8.6%).

According to the data in the 2010 survey, cannabis is the most frequently used among the illicit drugs, up to 1.6%, followed by ecstasy – 0.7%, heroin - 0.3%, cocaine – 0.3%. If we included psychoactive substances traded as “legal highs” (and whose licit or illicit character depends on the substance it refers to), lifetime drug use prevalence for the age group 15-64 is 1.9%, which is the highest prevalence (0.6% report the use of substances containing synthetic cannabinoids – “Spice”, and 1.6% mention the use of other substances from the category of the so-called “ethno-botanical plants”).

As compared to the previous survey it can be noticed that:

- Except for SNPP (whose use has become an issue in recent years), the hierarchy by type of psychoactive substance used is maintained: 1. sedatives and/or tranquilisers, 2. cannabis, 3. ecstasy, 4. heroin and cocaine (in both forms – base or crack), 5. solvents/inhalants and 6. other drugs.
- Increases both for the use of sedatives and/or tranquilisers and illicit drugs (cannabis, ecstasy, heroin, cocaine, solvents/inhalants, amphetamines and other hallucinogens) and emergence of SNPP and ketamine use;
- By type of drug and gender – the use of sedatives and/or tranquilisers and methadone is higher among female users than male users, and there are higher prevalence rates of all illicit drugs (SNPP, cannabis, ecstasy, heroin, cocaine, solvents/inhalants and hallucinogens) among male users. The situation resembles the 2007 situation.
- By type of drug and age group – the highest prevalence of sedatives and/or tranquilisers and solvents/inhalants is recorded for the adult generation (45-64 years) as compared to the young one (15-34 years) which records a higher prevalence of SNPP, cannabis and cocaine use. Heroin use is higher in the age group 25-44 years and ecstasy use has relatively equal values for the age group 15-54 years. The situation differs from the 2007 situation when the use of sedatives and/or tranquilisers reached the highest values in the adult generation (45-64 years), while the use of the other drugs was a characteristic of the young population (15-34 years).

Table no. 2-6 Lifetime prevalence of medication use (tranquilisers, sedatives, anti-depressants) without medical prescription, of SNPP - new psychoactive substances (traded as “ethno-botanical plants”) and of illicit drugs, by age group and gender, comparison between 2007 and 2010 (%)

Year	Type of drug	Age group (ani)					Gender		Total
		15-24	25-34	35-44	45-54	55-64	Male	Female	
2007	sedatives and/or tranquilisers	1.1	2.4	3.8	5	5.8	2.1	4.8	3.5
	Any illicit drug*	4.1	2.4	1.2	0.3	0.1	2.6	0.9	1.7
	Cannabis	3.7	2.1	0.8	0.1	0.1	2.3	0.7	1.5
	Ecstasy	0.7	0.5	0.4	0	0	0.5	0.2	0.3
	Heroin	0.1	0.2	0.1	0	0	0.2	0	0.1
	solvents/inhalants	0.2	0.1	0	0.1	0.1	0.1	0.1	0.1
	Cocaine	0.1	0.1	0	0	0	0.1	0	0.1
	Amphetamines	0.1	0.1	0	0	0	0.1	0	0
	Methadone	0	0	0.1	0	0	0	0	0
2010	sedatives and/or tranquilisers	1.8	2.5	4	7.3	8.2	2.5	6.5	4.5
	Any illicit drug*	9.0	6.8	2.3	0.8	0.6	6.0	2.1	4.3
	SNPP	5.1	3.3	0.9	0.3	0	3.0	0.9	2.0
	Cannabis	3.1	2.9	0.9	0.3	0.3	2.2	1.0	1.6
	Ecstasy	0.9	0.8	0.9	0.8	0	1.1	0.3	0.7
	Heroin	0.2	0.4	0.4	0	0.3	0.5	0.1	0.3
	Cocaine	0.7	0.5	0	0	0.3	0.5	0.2	0.3
	solvents/inhalants	0.2	0.1	0	0.5	0.3	0.3	0.1	0.2
	Amphetamines	0.2	0	0	0	0.3	0.1	0.1	0.1
	LSD	0	0	0	0.3	0	0.1	0	0.1
	Other hallucinogens**	0.2	0	0.2	0.3	0	0.2	0.1	0.1
	Methadone	0	0	0.2	0	0	0	0.1	0

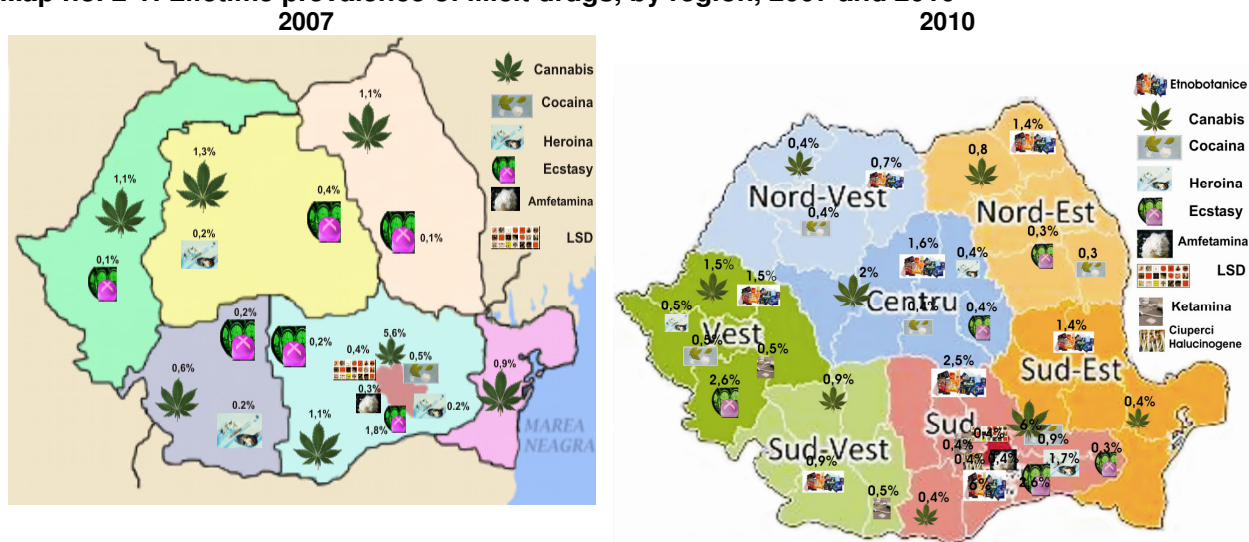
Note: * - no sedatives and/or tranquilisers, ** - hallucinogenic mushrooms and ketamine

Source: NAA

By region:

- *psychoactive substances* traded as “legal highs” or “ethno-botanical plants” are used in all regions of the country. Bucharest/Ilfov rank first with 6.0%, followed by the southern region with 2.5%, central area with 1.6%, western area with 1.5%, north-eastern area with 1.4%, south-eastern area with 1.4%, south-western area with 0.9% and north-western area with 0.7%.
- *cannabis* is used in all the regions of the country, with the following percentages: 6% in Bucharest/Ilfov, 2% in the Centre; 1.5% in the West, 1.4% in South-east; 0.9% in South-west, 0.8% in North-east, 0.6% in South and 0.4% in North-west. The situation presents relative resemblance to the 2007 situation: 5.6% 5.6% in Bucharest, 1.3% in Transilvania, 1.1% in Muntenia, Moldova, Banat-Crişana-Maramureş, 0.9% in Dobrogea and 0.6% in Oltenia
- *Ecstasy* is also used in most regions of the country except for the south-west area, south-east and north-west. A 2.6% use is recorded in Bucharest/Ilfov and the western areas, while 0.4% was recorded in the centre and 0.3% in north-east and the south. Again, there is a similar situation to the one recorded in 2007.
- *Heroin* is most frequently used in Bucharest/Ilfov (1.7%) followed by the West (0.5%) and Centre (0.4%) and cocaine is present in most of the country regions: Bucharest/Ilfov (0.9%); west (0.5%); centre and north-west (0.4%) and north-east (0.3%). In 2007, cocaine (crack or base) was only used in Bucharest (0.5%) and lifetime use of injected heroin or cocaine recorded the following values: Bucharest – 0.3% of the respondents and 0.2% of the respondents in Transilvania and Oltenia.
- *Amphetamines, hallucinogenic mushrooms and LSD* are only present in Bucharest/Ilfov area with a lifetime prevalence of 0.4%. Again, there is a similar situation to the one recorded in 2007: only in Bucharest - 0.3% of the capital's population aged 15 to 64.
- *Solvents, inhalants and sniffing glue* is most frequently used in the west and south-west with 0.5%, Bucharest and north-west area with 0.4% and N-E with 0.3% (alike the situation in 2007: Bucharest – 0.3%, Oltenia – 0.2% and Transilvania – 0.1%).
- *Ketamine* is the most frequently found in the western and south-western area with 0.5% and in Bucharest/ Ilfov with 0.4% (ketamine was not evidenced in 2007).

Map no. 2-1: Lifetime prevalence of illicit drugs, by region, 2007 and 2010



Source: NAA

Fourteen was the youngest age reported by a respondent for cannabis use onset, the mean onset age reaching 22. Sixteen was the youngest onset age for ecstasy use and the mean onset age reached 23⁵⁹.

⁵⁹ In 2007 – the youngest age reported by a respondent for cannabis onset was 11, 76.6% of cannabis users mentioning an onset age of up to 24. Fourteen was the youngest onset age for ecstasy use and the oldest was 30.

Comparison between 2004-2007-2010:

Lifetime prevalence of drug use continues to focus on recreational drugs such as cannabis and ecstasy that are used mainly by young people aged 15 to 34, most of whom are male users from Bucharest/Ifov and the western area. The emerging phenomenon that increases public concern is the so-called “legal highs” and the diverse drug use in the adult generation, among female users and in most regions of the country. Ketamine use was evidenced for the first time at national level.

Table no. 2-7 Lifetime prevalence of psychoactive substances, comparison between 2004-2007-2010 (%)

	2004	2007	2010
SNPP - „legal highs” or „ethno-botanical plants”	-	-	2.0%
Cannabis	1.7%	1.5%	1.6%
Ecstasy	0.8%	0.3%	0.7%
Cocaine	0.4%	0.1%	0.3%
Heroin	0.2%	0.1%	0.3%
Amphetamines	0.3%		0.1%
LSD	0.2%		0.1%
Ketamine	-	-	0.1%

Source: NAA

B. Illicit drug use prevalence in the last 12 months (recent use) – this pattern of drug use could be analysed only for SNPP (1.1%), cannabis (0.3%) and ecstasy (0.2%) because of the low number of cases recorded for the other drug categories. Comparable to lifetime prevalence, drug use prevalence in the last 12 months continues to focus on recreational drugs such as cannabis and ecstasy that are used mainly by young people aged 15 to 34 years, mostly men, and from Bucharest/Ifov and the western area. The emerging phenomenon that increases social concern is the so-called “legal highs”.

C. Prevalence of illicit drug use in the last 30 days (current use) – this pattern of drug use could be analysed only for SNPP (0.6%), cannabis (0.1%) and ecstasy (0.1%) because of the low number of cases recorded for the other drug categories. The values recorded for drug use prevalence in the last 30 days continue to be low and generally statistically insignificant, alike the ones recorded in 2004 and 2007. There is yet a diversification of drug use at this prevalence level that generally suggests problem drug use. However, the emergence of the “legal highs” (SNPP) at this level of analysis can be a cause of concern.

*Illicit drug use prevalence in Bucharest*⁶⁰ - lifetime prevalence of any illicit drug amounted to 14.4%. It should be mentioned that, unlike the rest of the country, respondents in Bucharest reported they had used all types of illicit drugs mentioned in the questionnaire:

- SNPP: lifetime – 6% (1.1% spice and 5.3% other “ethno-botanical” products), in the last year – 3.3%, and in the last month – 2.1%;
- cannabis: lifetime – 6%, in the last year – 1.3%. in the last month – 0.4%;
- ecstasy: lifetime – 2.6%, in the last year – 0.9%. in the last month - 0.9%;
- heroin: lifetime – 1.7%, in the last year – 0.8%
- cocaine/ crack: lifetime – 0.9%, in the last year – 0.5%;
- amphetamines: lifetime – 0.4%;
- inhalants: lifetime – 0.3%;
- hallucinogens: lifetime – 0.3%.

Attitudes towards drug use and drug users – over 15% of the investigated population agreed to cannabis being used for medical purposes. The evaluation of the attitude to “the use of cannabis for recreation” the percentages are much lower, namely 3.18%, which indicates people aged 15 to 64 in Romania is mostly against the legalisation of soft drugs. The attitude towards heroin use is far more clear-cut: only 1.6% of the population aged 15 to 64 agrees to using heroin without limitations. Tolerance towards drug users is quite low, only 8.6% of the respondents agree with the statement “Drug users should be accepted, like any other person”.

⁶⁰ Because data recorded for all key epidemiologic indicators reach high values in Bucharest, the study included a separate analysis to determine drug use behaviours among the population aged 15 to 64.

Table no. 2-8 Respondent distribution by attitude towards drug use and drug users (% - in agreement)

	% - I agree
"Cannabis use for medical purposes should be legal"	15.55
„People should be allowed to use cannabis for recreation"	3.18
„People should be allowed to use heroin"	1.64
„Drug users should be accepted, like any other person"	8.64

Source: NAA

Perception of the risk of drug use – questioned about the risk of those who use drugs to harm themselves, almost 87.7% of the respondents consider there is a high risk of adverse effects following regular use of cannabis, as compared to 72.3% in the case of ecstasy and 76.4% in case of experimental cocaine use. It was noticed that an important share of the general population tends to pay less importance to the risk of the fast transition from experimental use to problem use, even if the used drug is known to cause addiction right from the first doses. It can also be noticed that the lowest level of risk perception is not in the capital city where there might be more drug information and prevention programmes; the low levels of risk perception are recorded in regions such as the Centre, South-West and West.

Table no. 2-9 Respondent distribution by drug risk perception, total and by geographic area (% - high risk)

	N-E	N-V	V	S-V	S	S-E	C	BUC-IF	Total
„Smoking cannabis regularly"	89.7%	93.4%	79.6%	82.4%	83.7%	89.7%	89.4%	91.1%	87.7%
„Experimenting with ecstasy once or twice"	78.3%	72.2%	63.3%	62.0%	68.7%	83.7%	62.2%	82.6%	72.3%
„ Experimenting with cocaine once or twice"	84.2%	75.5%	67.0%	66.1%	76.9%	84.4%	65.7%	84.3%	76.4%

Source: ANA

2.2. DRUG USE IN THE SCHOOL AND YOUTH POPULATION

The surveys in this field are presented in detail in chapter 4 (target population: children and young people, users of new psychoactive substances), chapter 6 (target population: injected drug users) and chapter 9 (target population: prison inmates).

Chapter 3 – Prevention

Introduction

Against the overall societal evolution, through the public policy assumed by the institutions of each state, the European Strategy settled as tangible prevention results „*measurable reduction of the use of drugs, of dependence and of drug-related health and social risks through the development and improvement of an effective and integrated comprehensive knowledge-based demand reduction system including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration measures within the EU Member States. Drug demand reduction measures must take into account the health-related and social problems caused by the use of illegal psychoactive substances and of poly-drug use in association with legal psychoactive substances such as tobacco and alcohol*”.

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

The activities and project implemented in 2010 in the field of drug use prevention, were influenced by the emerging phenomenon of the use of new psychoactive substances. It brought about several selective prevention projects aiming both to inform and build skills so as to reduce the influence of risk factors and increase protection factors.

Towards a standard drug prevention activity, the project *European standards in evidence for drug prevention - Prevention Standards & No 2007304* was implemented in 2010, and was highly relevant for the future national prevention programmes, tailored to European standards and recommendations.

Project activities consisted in:

- on-line Delphi survey (84 specialists participated).
- Focus group session following on-line survey.
- Technical session to validate quality standards for drug prevention programmes.

The project was coordinated by the National Collaborating Centre for Drug Prevention of and funded by PHEA (Public Health Executive Agency). The National Anti-drug Agency was the main partner in the project. The research goal was to formulate a set of quality standards for drug prevention programmes applicable in Romania, as part of the set which is valid in the 5 countries participating in this project (Great Britain, Italy, Spain, Hungary and Poland), and in the EU also, based on the link between science, public policy and practice. The definition of *quality standards*, essential for the research, is the one used by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA): “generally accepted principles or sets of rules for the best/most appropriate way to implement an intervention. Frequently they refer to structural (formal) aspects of quality assurance, such as environment and staff composition. However they may also refer to process aspects, such as adequacy of content, process of the intervention or evaluation processes” (EMCDDA 2010).

The research methodology included 3 stages:

1. Review – summary of special literature in the field of drug prevention in the EU and extra-community space, focussing on standards, rules and guides referring to standards of drug prevention programmes. The legally regulated standards were evaluated during the first stage. Romania was, at that point, one of the few member states that possessed standards applicable to school-based drug prevention projects. The result of this stage, which included 19 European and extra-community documents, was a first draft of the standards, structured by 3 levels:
 - a. The first level included the stages of the cycle of drug prevention projects,
 - b. The second level – the constituents of the project cycle – emphasises the action needed to implement each stage of the cycle of drug prevention projects.

- c. The third level focuses on the features of the constituents and stages of the project cycle in the field of illicit drug prevention.
2. the Delphi survey, which was conducted in Romania also, in two stages, included a 38-item (1st stage) and 10-item (2nd stage) *online* questionnaire and 46 respondents (professionals in medical, psychological services etc) and was aimed at validating the structure of the *draft* of the standards, which resulted from the first stage and a hierarchy of the stages of project cycle in the field of drug prevention and of the stage components.
3. the focus group survey, organised with 9 participants having previously participated in the Delphi survey, was aimed at improving/completing the draft of the quality standards for illicit drug use prevention programmes, based on the analysis of the data resulted from the review and Delphi research. The project cycle stages were reconsidered, as well as their components, hierarchy, and focus was laid on the feature of each constituent (3rd level of standards). The proposals and debates focused on three dimensions: relevance, usefulness and feasibility. The information produced by the focus group was used in selecting the list/final form of the standards.

The project outcome document will be published on the EMCDDA website awaiting validation.

3.1 UNIVERSAL PREVENTION

Most drug prevention programmes were aimed at providing information, educating and raising awareness of the risks of alcohol, tobacco and drug use, as well as on the short and long-term effects of drug use. At the same time, there is higher medium and long-term efficiency of prevention programmes that target training and building personal skills as protection factors against drug use (assertive communication skills, emotion management, stress and anger management, problem solving, making decisions etc).

Information-based programmes continue to play a key role in drug use prevention. The most recent trend, which can be linked back to EU member states experience as having proved highly efficient, was to focus on harm reduction messages in information programmes, being based on the belief that cognitive skills are more important than behavioural approaches in teaching young people on how to make informed life decisions and choices. The best way is to provide young people with the needed cognitive tools by making information available. Thus, healthy lifestyle behaviour, focusing on the drug use risks, is considered a personal, rational choice, although in medical sciences there is large consensus about social factors (entourage, peers, rules) and personal factors (temper, education and emotional conduct) as having greater influence than cognition in shaping healthy lifestyle behaviour in relation to drug use.

3.1.1 SCHOOL-BASED PREVENTION

In Romania as well as most member states, schools are considered as the most important setting for universal prevention, and there is increased focus on school-based prevention throughout the implementation and evaluation of policy documents (National Anti-drug Strategy 2005-2012 and Action Plan to implement the NAS) and on a structured approach in this field. This tendency reflects the extension of school-based demand reduction policy and the development of specific drug prevention module-based programmes, designed for schools and specialised teacher training.

School-based prevention programmes/projects were carried out in 2010 by the Ministry of Education, Research, Youth and Sport and the territorial network of the National Anti-drug Agency through the 47 Drug Prevention, evaluation and counselling centres, as national and local drug prevention programmes.

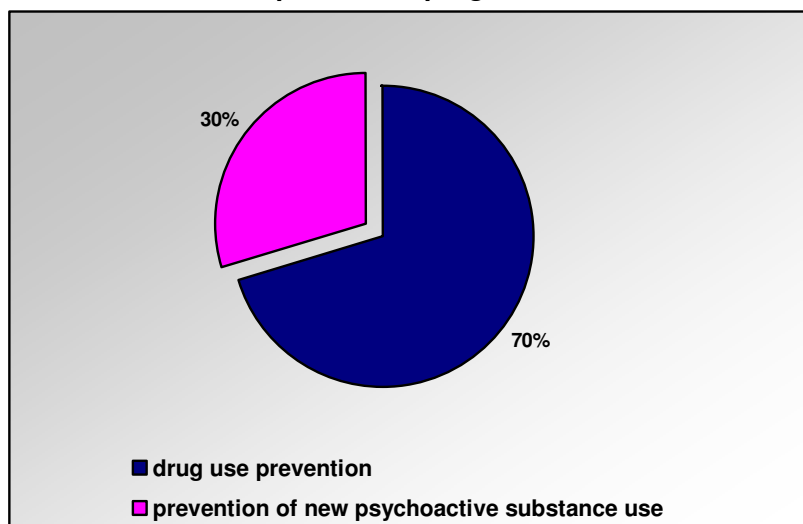
There were 6 national projects implemented at national level: *Health Education in the Romanian School, Inclusive extra-curricular and extra-scholastic Education options for a healthy lifestyle and active citizenship for children from disadvantaged communities, mainly rural and in pre-university settings in Romania, Calendar of Education Activities, Unplugged, My message against drugs – 8th edition, Addicted to freedom.*

- **Health Education in the Romanian School** aimed at creating a healthy lifestyle by involving pupils and teachers in extra-school and extra-curricular activities. The project was implemented from January 1st to June 6th, 2010 and from September 15th to December 31st, 2010 and included 1,000,000 direct beneficiaries, pupils and teachers. The partners of the Ministry of Education, Research, Youth and Sport were the Ministry of Health, Global Fund and Young for Young Foundation.
- The project Inclusive extra-curricular and extra-scholastic **Education options for a healthy lifestyle and active citizenship for children from disadvantaged communities, mainly rural and in pre-university settings in Romania**, is carried out in the period 2009-2011. The following activities were implemented in 2010: completion of research, institutional analysis, organisation of summer school for pupils and teachers, training for specialised inspectors, school and school inspectorate management, school counsellors, delivery of inclusive, extra-curricular and non-formal education options. There were 20,000 pupils, teachers, parents, school inspectors, school counsellors who benefited from the project in 2010. The 2010 project budget amounted to 3,200,000 lei. The partners of the Ministry of Education, Research, Youth and Sport were Young for Young Foundation, Totem Communication, and Centre for Health Policy and Services Foundation.
- **Calendar of Education Activities** was implemented in the school year 2009-2010 and was aimed at providing healthy leisure alternatives and involved 50,000 beneficiaries – school students, teachers and parents. The project budget amounted to 1,100,000 lei.
- **Unplugged project** - is part of an EU – DAP programme for drug addiction in Europe, promoted by “Mentor” International Foundation and funded by IKEA Social Initiative. The project was implemented in 5 countries: Romania, Croatia, Lithuania, Kyrgyzstan and the Russian Federation, our country recording the highest number of beneficiaries: 1,200 school students aged 12 to 14 in 7 counties (Buzău, Cluj, Constanța, Iași, Timiș, Tulcea and Bucharest). Pre and post-project implementation questionnaires were applied. They focused on the knowledge, attitudes and patterns of tobacco, alcohol and drug use and were included in a survey conducted later by the „Piemonte” study institute of the University in Torino. Study results will be released to public in 2011.
- **My message against drugs – 8th edition**, an anti-drug theme competition, gaining tradition in Romania, included the following sections: literary essay, web page, visual arts (graphics, drawing, poster, short films, spot, digital photography), sports (county level). The activities were planned, organised and coordinated in each county by the Drug Prevention, evaluation and counselling centres and were implemented by learning units through education counsellors together with partner organisations. 180,000 school students were the direct beneficiaries of the project, 68 of them receiving awards and honourable mentions.
- **Addicted to freedom** project, conducted from May 1st to June 30, 2010, and was the first national project aimed at informing secondary school and high-school students, their families and communities, of the harm caused by the new psychoactive substances, generically named “ethno-botanical plants” Several communication channels were used in project implementation with the goal of changing the false image promoted by the sellers of such products that these substances are “natural” and have no negative effects, either somatic or psychological. The project was implemented by the National Anti-drug Agency in partnership with the Institute for Prevention and Psycho-sociology and Public Order Directorate. Information sessions were delivered to school students in 95 schools and 157 high-schools. They were attended by 49,029 school students, and 11,098 letters were distributed, informing 29,123 parents. Project objective promotion was ensured in 66 TV and radio shows, 55 press releases and 67 printed press clips.

759 project-programmes were implemented at national level to inform, educate and raise the awareness of the school population of the effects of drug use and addressed 562,500 people – pupils, teachers, school counsellors and parents. The projects were implemented by County/District School Inspectorates, National Anti-drug Agency, Teachers` Houses, Children`s National Palace, Children`s clubs, County police inspectorates, local administration, NGO`s, governmental organisations, Youth

and sport county directorates and local partners. Of the 759 local projects/interventions, 226 had as main goal the prevention of new psychoactive substances (30%).

Graph no. 3-1: Classification of local prevention programmes, conducted at local level in 2010



Source: NAA

One of the school-based local prevention projects that can be recommended as good practice is the school-based drug use prevention project by direct transfer of skills, *I know I can do it*, launched by ALIAT. The programme has been conducted in Bucharest since 2010.

General goal: school-based drug use prevention by direct transfer of skills

Specific goal: the transfer of knowledge on drugs and skills to prevent drug use onset among 9th grade classes in four highschools in Bucharest

Target group: 9th graders in highschools in Bucharest

Estimated results: increase of the level of information on the consequences of drug use among participants; building individual skills of highschool students to deal with peer pressure and invitation to drug use; pilot testing an intervention based on the transfer of skills in order to implement it at national level, in a future project.

The project focuses on the transfer of 4 types of skills that will play an important role in increasing the capacity of highschool students to make informed decisions related to not starting drug use.

The 4 skill transfer sessions will be held in each classroom by a team of 2 trainers (1 ALIAT member and the school counsellor).

The content of the four sessions cover the following fields:

Session 1 – Evaluation of the knowledge highschool students already have on drugs, needs and motivation evaluation, transfer of correct information of the consequences of drug use,

Session 2 – Communication skills (among peers, with parents and teachers)

Session 3 – skills to cope with peer pressure (discussing the need of teenagers to belong to a group, cognitive correction, assertiveness, assertive non-verbal behaviour)

Session 4 – decision-making skills and problem solving skills (advantage/disadvantage balance, how to make a decision).

The competition “My drug experience” was launched in this session. The highschool students were invited to write a random essay describing the meeting with a drug user or, generally, the contact with the drug phenomenon and their reaction. Data related to the implementation of this project have not been made available yet.

Local campaigns

The project ***Born to be free III*** – drug prevention campaign implemented from March to June 2010, through selective prevention interventions against marijuana and ecstasy use among students in Cluj aged 13 to 17. It was coordinated by Preventis Association in cooperation with Caritas Association in Cluj – Anti-drug unit and the project partners were: *Teen Challenge* Romania, UBB Cluj – Psychology Faculty, School Inspectorate in the County of Cluj, Cluj County Council. The project was conducted in 28 7th to 10th grades in 6 schools in Cluj Napoca, The 19 1st and 3rd year students in the Psychology

Faculty – UBB Cluj, who carried out school semester practical activities and participated as programme facilitators, interacted with 635 high-school students. The campaign activities consisted in: 3 drug information and education sessions in each classroom and a meeting in each classroom in which debates were held over the confessions of two former drug users in rehabilitation in the residential centre *Teen Challenge*.

The local campaign for changing attitudes of teenagers and young people surrounding the effects of the new psychoactive substances, ***Born to be free II***, implemented from November 200 to March 2010, in the municipality of Cluj, was intended to send accurate information on the two most used drugs in Cluj – marijuana and ecstasy. Preventis Association in cooperation with Caritas Association in Cluj – Anti-drug unit, Babeş Bolyai University in Cluj - Psychology Faculty, School Inspectorate in the County of Cluj, Cluj County Council and *Challenge* România implemented the campaign. There were 1,135 7th to 10th graders (age group 13-17) from 6 secondary schools and high-schools in Cluj Napoca benefited directly from the campaign, together with 24 2nd year students of the Psychology Faculty – UBB Cluj. They carried out their school semester practical activities and participated as programme facilitators for the high-school students.

3.1.2. FAMILY- BASED PREVENTION

The project *Family training for building education skills for alcohol and tobacco abuse prevention* developed at national level, as good practice example in the field, aimed at developing protection factors for 1000 parents with low education and family management skills or children at risk (adjustment problems, low school participation, early or persisting behaviour problems, that do not necessarily call for therapeutic intervention, and come from families with conflicts or dominated by frequent use of tobacco and alcohol and a minimal education level – primary school completed). The project was implemented by 68 school counsellors – education specialists in education resource and assistance centres in 3 counties (Bihor, Iaşi, Ilfov).

They implemented 8 interactive activities with the parents participating in the programme based on a methodological guideline and a training manual formulated by specialists of the NAA and the Ministry of Education, Research, Youth and Sport. The 9 activities ended in November and each school counsellor was supervised in at least one activity by an NAA, IGRP and MECTS expert. A good practice exchange was carried out 12 to 15 December 2010 aiming at disseminating the results and improving the guideline.

30 programmes/projects were implemented at local level (e.g. “Together for a better family, Responsible parents, Taboo topics, Say no to drugs, choose life, Healthy mother, healthy child, Informed young mothers, Drugs, a dangerous game) which involved 418 parents. 123 activities were implemented during these programmes/projects by the National Anti-drug Agency in partnership with County school inspectorates, County Psychological assistance centres, public health authorities, proximity police, County administrations. Most of the programmes were aimed at informing of the risks of the use of alcohol, tobacco and drugs and the short, medium and long-term effects of the use, and at building parent skills, as protection factors against drug use.

3.1.3. COMMUNITY-BASED PREVENTION

Many of the community-based activities at national level focussed on actions related to national and world days of the fight against tobacco, alcohol and drug abuse.

Unfortunately, because of scarce financial and human resources, universal and selective prevention programmes implemented in the community did not cover the tangible needs evidenced by scientific drug use prevalence studies and qualitative surveys on the phenomenon or drug related social aspects (in other vulnerable groups according to the classification used in the Joint Memorandum on Social Inclusion (JIM), ratified also by Romania).

As an example of good practices in community-based drug prevention, in order to mark the ***World no tobacco day***, the Drug prevention, evaluation and counselling centres carried out street information activities (17) and information sessions (in 49 schools, 9 school groups, 53 high-schools, 4 universities, 12 penitentiaries, 3 Children’s palaces, 7 hospitals, 8 parks, 13 half-way houses, 3 libraries, 1 culture dome). 6 competitions, 2 fares, 4 marches, 4 shows/festivals, 1 exhibit and 2 round

tables were also organised. The number of beneficiaries of these activities amounted to 17,300 pupils and students. Media coverage was ensured in three press conferences, 9 press articles in central and local media and 3 TV shows.

The national campaign ***Get involved! In your life, in you community, there no place for drugs!*** intended to mark the ***International Day against Illicit Drugs Trafficking and Use*** was implemented by the county Drug prevention, evaluation and counselling centres through 49 information sessions (in 3 secondary schools, 4 highschoools, 4 school groups, 1 after-graduate school, 16 penitentiaries, 2 Children's palaces, 7 half-way houses, 4 hospitals, 3 libraries, 5 school camps) and through local cultural-art events (7 shows/festivals, 3 Open doors day events, 2 exhibits). Additionally, 14 competitions, 8 round tables, 8 trainings/symposia were also organised. 18 materials and press releases were sent and DPECC specialists participated in 17 shows at country level.

The Drug prevention, evaluation and counselling centres implemented the project ***Protect children: do not let them inhale your smoke*** to mark the ***National No Tobacco Day*** through street information activities and information sessions in 92 schools, 21 school groups, 104 highschoools, 10 universities, 12 penitentiaries, 3 Children's palaces, 9 hospitals, 3 parks, 3 libraries). 11 competitions, 4 marches, 1 exhibit and 11 round tables on the topic of tobacco use were also organised, gathering 8520 direct and indirect beneficiaries.

The National Anti-drug Agency conducted a training session for public order and safety police officers in order to launch and develop prevention programmes addressing drug use and trafficking. 104 activities were conducted in 113 units (gendarmerie, local police, rural police, municipal police, and police units) which targeted an estimated number of 2000 direct beneficiaries. The activities were aimed at familiarising police officers with basic concepts used in drug prevention (risk factors and protection factors, drug laws), efficient means of sending a prevention message, and video and printed materials were used in the process, which can be later used by the beneficiaries in future prevention sessions.

54 projects/interventions took place at local level (e.g. *Enjoy your spring; Anti-drug tent, Do you think you know all about drugs?, Anti-drug trained military, Risk free childhood, Alcohol use and workplace, No alcohol/drugs and driving, I make the decision!*) through 809 public information activities in different settings – parks, assistance centres, family medicine wards, trade companies – and targeted 41,000 direct beneficiaries. 528 brochures, 523 posters, 780 flyers, 621 T-shirts, pens and other promo materials were used in these information activities.

The Drug prevention, evaluation and counselling centre in Bacau implemented the Safe Driving project – a project to prevent alcohol use and the use of new psychoactive substances and driving, in partnership with Interactive Association, Road Traffic Service Bacau (CPI), School Inspectorate in the County of Bacau and Grafit Invest. It aimed at preventing the use of alcohol and new psychoactive substances among drivers. The project was implemented from September to November 2010 and had 700 highschool students in 8 highschoools as direct beneficiaries. The basic theory in setting the project concept was that special conditions a person is in (most often a young men) when driving – responsibility for one's own life, for the vehicle and the other road traffic participants – should cause higher responsibility and life should be indeed a main priority. The logo chosen by the initiators – *When the mind is not alert, LIFE is not important!* – was a means to raise awareness of the influence of alcohol, narcotics and medication on the driver's choices for oneself and the others, and that these substances make the call instead of the driver.

The project was implemented from September to November 2010 and included 4 types of activities:

- Information sessions on the negative effects of the use of alcohol and "legal highs" while driving for the young drivers and future drivers in 8 high-schools (11th and 12th grade) and 6 driving schools in Bacău;
- Alcohol testing in traffic, made by the partners of the Traffic Police Service in Bacău,
- Distribution of information materials in the community with the held of anti-drug volunteers from the Drug Volunteer Centre (DPECC Bacău) and of the police officers in the Traffic Police Service in Bacău,
- Information and awareness campaign on the negative effects of the use of alcohol and new psychoactive substances and driving.

The awareness project focusing on the effects of drugs among teenagers, young people and community, as a whole, called ***Illusion growers***, had 80 teenagers as direct beneficiaries aged 14 to 18, who attended an anti-drug event in a unique arrangement. During four 8-hour sessions, the beneficiaries debated the issue of substance use interactively. The topic, highly promoted in the media because of the activity of the so-called “dream selling shops” or “legal drug shops” proved to be both worth discussing and timely. The indirect project beneficiaries were members of the local community in Cluj, and the implementers were *Teen Challenge Romania Association* in partnership with Baptiste Christian Church no.1 – Cluj, Noua Speranță Romania Foundation, Christian Aid Foundation, Cluj. The debated topics were:

- *Twilight zone* (drugs between dream and reality): history of drug use in Romania, statistical data, types of drugs, causes of drug use, stages of addiction. .
- How heroin withdrawal looks like (snapshots of “Christiane F” movie)
- Quiz test including questions such as “If alcohol is a drug, why is it legal?”, “What are the main types of mental clichés related to drug use?”
- Critical overview of media messages on drugs – “*Drugs will make you cool*” commercial.
- *Dreams allowed under the law* (when drugs are sold in shops or dream-selling shops): the truth about ethno-botanical plants and marijuana.
- Education movie proposed by NIDA *Drugs and the brain – cannabis*.
- Live confession of 4 young Romanians, former drug users, in rehabilitation treatment in the Residential centre of the *Teen Challenge Association*, Bucharest.
- Competition – the longest chain of reasons “I would not use drugs because...” – reflexive-projection debate.

3.2 SELECTIVE PREVENTION IN AT-RISKS GROUPS AND SETTINGS

3.2.1. COMMUNITY-BASED PREVENTION⁶¹

Because the vulnerable groups addressed by selective prevention often have significant experience with drugs, both legal and illicit, most selective prevention interventions consist in the provision of customised information, individual therapy and alternatives based on arts and sports. It should however be mentioned that the techniques used in extensive programmes of social influence characteristic for universal prevention are equally efficient, if not more efficient if applied as selective prevention measures. Normative restructuring (e.g. learning that the majority of the population in the same category disapproves of drug use), training by self assertiveness, motivation and goal setting, as well as demystifying have proved to be highly efficient among vulnerable groups of young people.

The alcohol abuse prevention national campaign – ***Alcoholhelp Caravan***, the second stage of the programme developed by ALIAT NGO on the topic of problem alcohol use focuses on raising the awareness of the problematic abuse of alcohol and on increasing accessibility of prevention and treatment interventions against problem alcohol use, by organising community-centred actions. The caravan reached the following towns in 2010: June 30 – Târgoviște, July 24, 25 - Vama Veche, Mamaia, August 29 - Miercurea Ciuc, Odorheiul Secuiesc, September 5 – Vaslui, September 18, 19 - Timișoara, Arad and September 25, 26 - Ploiești, Bucharest. The caravan implies the presence of a team of addiction specialists and ALIAT volunteers in the selected towns. Tents were put up in each location and ALIAT specialists and volunteers distributed information materials on the use of alcohol to people who have alcohol problems or their relatives/family, provided counselling to interested people and made available an AUDIT questionnaire which helps assess the hazard of the personal use of alcohol.

3.2.2. PREVENTION IN AT-RISK GROUPS

Harm reduction activities were carried out by the DPECC, most of which in school units or penitentiaries. 32 such projects were implemented in the counties of Alba, Brașov, Botoșani, Brăila, Galați, Giurgiu, Prahova, Harghita, Mureș, Satu-Mare, Sălaj, Sibiu, Tulcea, Vâlcea and in Bucharest. Information-education materials were formulated and distributed on the medical risks of injecting drug use ((abscesses, gangrene and overdose); specific risks related to the use of certain substances (heroin, ketamine); available types of treatment services.

⁶¹ See structured questionnaire SQ26

3.2.3. PREVENTION IN RECREATIONAL SETTINGS

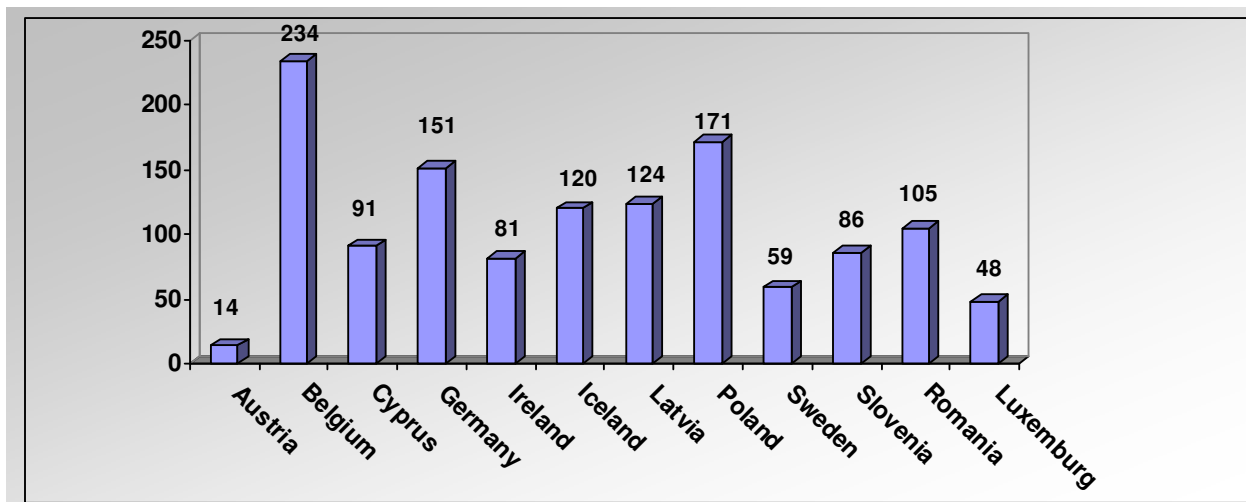
As part of the general courses of action that fall under the management of public order and safety activities, the National Anti-drug Agency, through the Drug Prevention, Evaluation and Counselling Centre Constanța implemented „Litoral 2010” campaign - ***Get involved! In your life, in you community, there no place for drugs!*** The Mobile Gendarmerie Unit Constanta, „Alături de Voi” Foundation – Constanta Branch Office, Regional Centre for NGO Assistance ***CENTRAS Constanța*** and Radio Constanta were all campaign partners. The campaign included community information activities on the Romanian seaside (beaches, bars and clubs) targeting young tourists mainly in Mamaia, Costinești and Vama Veche resorts. The campaign was implemented with the financial support of UNODC Romania.

The programme was aimed at informing, educating and raising the awareness of the tourists of the effects and risks related to the use of alcohol, illicit drugs and substances called “ethno-botanical” plants. The topics raised curiosity and interest towards the issue of drugs, physical and psychological health, and of the role of the society and specialised institutions in preventing and countering drug use. 2000 campaign materials were distributed – 2000 fliers - and 80 prizes were awarded.

3.3 INDICATED PREVENTION

The project *FreD goes net- Early Intervention for First Time Noticed Drug Users* continued to be implemented in 2010 by the National Anti-drug Agency as an indicated and selective prevention project based on European model – aiming at developing early intervention for young people that were first time noticed as having alcohol/illicit drug issues (mainly by the school) and at reducing the risk of drug addiction. The project was developed simultaneously in 12 European countries: Austria, Belgium, Cyprus, Germany, Ireland, Island, Latvia, Poland, Sweden, Slovenia, Romania, Luxemburg from 2007 to 2010 and was funded by the Public Health Executive Agency. In this pilot project, Romania participated with 105 young people of a total of 1284 included in the European project. The average age of both the Romanian and European participants was 16.9.

Graph no. 3-2: Participation of Romanian pupils in *FreD goes net* project, comparing to the other participant states (no. of participants)



Source: *FreD goes net* project

Following the participation in FreD courses, as compared to European level, the young Romanians recorded very good levels of satisfaction, as follows: very satisfied – 54.4% (Romania) as compared to 34.5% (European level), satisfied – 41.8% (Romania) as compared to 47.9% (European level), partially satisfied – 3.8% (Romania) as compared to 14.8% (European level), not satisfied – 0% (Romania) as compared to 1.7% (European level), unsatisfied – 0% (Romania) as compared to 1.7% (European level).

98.7% of the Romanian participants reported they would recommend FreD courses to friends as compared to 84.6% of the young people who took part in the European project.

17 additional Fred trainers were trained in 2010 and steps have been taken to implement the course at national level through the 47 DPECC.

The project ***Participation of vulnerable groups in social economy*** in which National Agency for Roma People is the main recipient, the National Anti-drug Agency is partner together with the National Penitentiary Administration, National Agency for Family Protection, Criminal Justice Reform Foundation, GRADO, Foundation for Roma Social Development "RAMSES" and TRANSCENA Association. The project was applied within the Sectoral Operational Programme Human Resources Development, priority axis 6 "Promoting social inclusion", key area of intervention 6.1. "Development of social economy" and aims to increase the capacity of local sustainable and inclusive development at the level of local communities across the country (including of vulnerable groups in these communities).

The specific goals of the project:

1. development of the capacity, competences, knowledge, self esteem and social support for 20,000 members of vulnerable groups, so as to increase their chances of participating in social economy and becoming integrated on the labour market;
2. launching, building capacity, maintaining and promoting 30 social economy structures developed by vulnerable groups as a flexible and sustainable tool of economic development, welfare and the creation of jobs, at local level.

The target groups of the project consist in inactive people, as well as people who are looking for opportunities and support to maintain and develop professional and entrepreneurial skills and education, to become integrated on the labour market and who belong to one or several vulnerable groups at the same time:

1. roma people subject to social exclusion, who have limited access to health and education services, as compared to the majority of the population, and are homeless (9,800 people);
2. prison in-mates awaiting release that do not benefit from support from family or community outside of prison and who are trying to participate in labour activities during detention, as well as former prison inmates who are job searching (7,000 people);
3. drug-addicted people who have completed detoxification treatment in specialised clinical hospitals or therapeutic communities and need help to get socially reintegrated (1,200 people);
4. victims of family violence: women that do not benefit from the financial contribution of the aggressor and who need help to support the remaining family (1,000 people);
5. young people over 18 who leave the institutionalised child protection system and who are job searching (1,000 people).

The total duration of the project is 3 years and 2010 is the second year of implementation.

As part of the professional training and personal development activities for people included in the target vulnerable groups and in line with operational obligations, the National Anti-drug Agency, through the DPECC provides at least one counselling session in order to identify employment for their centre beneficiaries.

3.4 NATIONAL AND LOCAL MEDIA CAMPAIGNS

The national television Antena 1 conducted an information campaign on the risks of the new psychoactive substances in 2010. This campaign included three episodes broadcast in the morning show *Neatza cu Răzvan&Dani*.

Drug prevention activities were reflected in the local media as follows: 1452 printed press clips, 735 radio shows and 767 TV appearances.

The efficiency assessment of prevention projects/interventions implemented on different fields, and correlated with the needs and trends of drug use, we consider necessary to:

- increase school-based selective interventions, mainly psychological and/or family crisis interventions along with the identification of the pupils that show drug use risk factors with the aim to identify comprehensive solutions for school dropout, truancy and abuse.

- Enhance prevention programmes targeting vulnerable families based on the concept that families presenting emotional-affective disorders or are economically and socially disadvantaged are a significant risk factor for addiction behaviour among children and teenagers. **PROTEGO** is a project that proved efficient in the past years in Romania and that can be tailored to the current social-cultural and economic conditions.
- Increase indicated prevention interventions, in numbers and quality, and keep a focus on building skills of cognitive and social resistance to drug use among children and teenagers. Greater emphasis should be laid on interventions addressing dual diagnosis beneficiaries, considering that certain early indicators of an atypical behaviour (hyperactivity and attention disorders, anxiety concurrent with emotional problems, food disorders, post-trauma stress symptoms etc) are essential and highly predictive. There has never been such a project in Romania.

Chapter 4 – Problem drug use

4.1. ESTIMATES OF INCIDENCE OF PROBLEM DRUG USE

The multiplier resulted from the „Behavioural and serologic survey on HIV, hepatitis B and C prevalence among injecting drug users (IDU) in Bucharest - Behavioural Surveillance Survey 2010⁶²” made by UNODC Romania in partnership with National Anti-drug Agency, was used to estimate the problem drug use prevalence in 2010.

Benchmark: beneficiaries of syringe exchange programmes

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

The analysis of the data resulted from the „Behavioural and serologic survey on HIV, hepatitis B and C prevalence among injecting drug users (IDU) in Bucharest - Behavioural Surveillance Survey 2010” indicated 48.95% (0.4895; 95% CI: 0.4398 – 0.5395) of the people included in the survey were beneficiaries of the syringe exchange programmes (SEP). The division of the number of people included in syringe exchange programmes (SEP) in 2010 (namely 8.966) to the mentioned percentage, resulted in an estimated number of 18.316 (17.767 in 2009, 95% CI: 16.343 – 19.464) problem drug users in Bucharest.

Table no. 4-1: Estimation (in absolute figures and ratio) of the number of problem drug users in Bucharest, using the multiplier method (2007- 2010)

Year	Estimated number of problem drug users (PDU)	Ratio at 1000 people. aged 18 to 49
2007	16 867	17.4
2008	17 387	17.5
2009	17 767	18.0
2010	18 316	19.2

Source: ANA

There is a slight increase of the estimated number of problem drug users in Bucharest in 2010, as compared to previous years. The availability of services/programmes at national level continues to represent a major obstacle in making national estimations.

The mentioned estimation was selected as the most representative (the sampling was adequate, namely, the collection of the sample began in a treatment centre, which made the intersection with clients in SEP more relevant).

Questions were introduced in the study conducted in 2010, which allowed for indirect assessment of problem drug use prevalence based on multiplier method. The values of the assessment resulted from data analysis are shown in the table below.

Table no. 4-2: Results of the use of rapid assessment techniques over PDU number in Bucharest

Assessment technique	Multiplier method	Multiplier method
Surveys	Behavioural and serologic survey on HIV, hepatitis B and C prevalence among injecting drug users in Bucharest	Behavioural and serologic survey on HIV, hepatitis B and C prevalence among injecting drug users in Bucharest
Town /Region	Bucharest	Bucharest
Benchmark	Clients of syringe exchange programmes in Bucharest	IDU admitted to treatment in 2010
Estimation	18.316; 95% CI: 16.619 – 20.386	11.733; 95% CI: 8.776-15.856

Source: ANA

⁶² The study is described in chapter 6

The analysis of the data resulted from the „Behavioural and serologic survey on HIV, hepatitis B and C prevalence among injecting drug users (IDU) in Bucharest - Behavioural Surveillance Survey 2010” for the multiplier based on CDI treatment admissions (namely 1,198 cases in Bucharest), indicates that 10.21% (0.1021; 95% CI: 0.0756– 0.1365) were people included in substitution treatment programmes.

It can be noticed that the multiplier technique by type of services used as *benchmark* in computing the multiplier, results differ significantly: almost 11,733 problem drug users, when using the treatment beneficiaries as indicator, and 18,297, when the beneficiaries of syringe exchange programmes were used.

4.2. DESCRIPTION OF THE FORMS OF USE FALLING OUTSIDE THE EMCDDA’S PDU DEFINITION

This year’s assessment was made based on users recorded in syringe exchange services. Of the 8966 injecting drug users recorded in syringe exchange programmes, 76.7% were males and 23.3% females.

Relevant data on the profile and drug use patterns of injected drug users are detailed in chapter 6, namely in the survey „Behavioural and serologic survey on HIV, hepatitis B and C prevalence among injecting drug users (IDU) in Bucharest - Behavioural Surveillance Survey 2010”. According to the study, the main drug reported by injected drug users in the metropolitan area of Bucharest is heroin (67.3%) and the following consists in the category of psychoactive substances sold as legal drugs or “ethno-botanical plants” (30.6%). The latter are most often substances that mimic or have content similar to amphetamines. The frequency of injection upon the last time the main drug was used is over 3 times in 44.9% of the cases, 2-3 times in 41.8% of the cases, while only 13.2% reported a single injection.

4.3. PREVALENCE ESTIMATES OF INTENSIVE, FREQUENT, LONG-TERM AND OTHER PROBLEMATIC FORMS OF USE

Because of the different PDU structure in 2010 by type of main drug, namely the decrease of those who reported heroin as main drug from almost 90% to 67.3% and of the emergence of the new category of substances (new psychoactive substances, sold as “ethno-botanical plants”) used by 30.6% of PDU, we consider as highly relevant the data resulted from the study by which the effects of these substances among intensive drug users in Romania were evaluated, as a form of problem drug use.

In partnership with Romanian Harm Reduction Network (RHRN) and with the financial support of UNICEF, the National Anti-drug Agency carried out a research project “*Source: Survey “Risks Assessment of the use of new psychoactive substances among children and young people in Romania”, 2011*”, focusing mainly on heavy users of new psychoactive substances sold as legal drugs.

Evaluation goals

General objective:

Evaluation of the knowledge, attitudes and patterns of use and abuse of psychoactive substances sold as “legal highs” in 10 large cities in Romania in order to implement harm reduction interventions, tailored to young people aged 10 to 24 years.

Specific objectives:

- evidencing the situation of the use of new psychoactive substances in local communities;
- establishing the profile of the SNPP user namely the identification of the drug use patterns for SNPP users;
- identification of risk and protection factors influencing the use and abuse of these substances;
- making proposals for harm reduction interventions based on scientific evidence.

Research methods and techniques used:

- analysis of the content of different sources: reports, surveys, analysis of on-line sources – social networks, forums, press monitoring. The study focused on websites, search engines, forums and social networks that include information on the new psychoactive substances and target the Romanian population (registered as on-line entity in Romania or other countries);
- sociologic investigation (questionnaire applied to sellers and users of new psychoactive substances);
- semi-structured interview or focus group among drug specialists.

Coverage – the survey was conducted in 10 large cities in Romania – selected by number and inhabitants and representation out of the eight euro-regions. The cities were Bucharest, Constanța, Timișoara, Cluj, Iași, Ploiești, Galați, Craiova, Brașov, Oradea.

Target group

- The research target group was made up of children and young people who use legal highs, aged between 10 and 24 years.

Scope of research

- Physical, chemical and pharmacological content;
- Abuse and addiction potential;
- Drug use prevalence;
- Health risks;
- Social risks;
- Configuration of organised crime networks participating in SNPP trade and manufacture.

Social-demographic characteristics of the respondent samples

A. Representatives of local and central authorities and civil society

24 semi-structured interviews and 6 focus-groups were conducted among 73 professionals, members of:

- DPECC and NGO`s that provide services;
- Medical units (emergency hospitals, psychiatry hospitals, infectious diseases hospitals, drug treatment centres etc.), First aid services, Police, DGASPC;
- Learning units;
- Recreational settings (bars, clubs, discos).

B. Users of “legal highs”

120 questionnaires filled in by SNPP users in 10 cities were analysed. “Local mapping” was the main method used in selecting survey participants.

Table no. 4-3: Social-demographic characteristics of the SNPP users` sample

Gender	male	female			
	80 (66.6%)	40 (33.3%)			
Average age	18.2 years	At least 10 years	24 years at most	mean 17 years	
Education	No education	Primary education not completed	Secondary education not completed	Highschool/vocation school not completed	12 grades or more
	3%	4%	13%	52%	21%
Occupation	Unemployed/No occupation	Illegal employments	Legal employment	Highschool student	University student
	25%	4.2%	8.3%	47.5%	10.8%

Source: Study „Risk evaluation of the use of new psychoactive substances, among children and young people in Romania”, 2011

The **selection sources** of “legal highs” users who participated in the survey were:

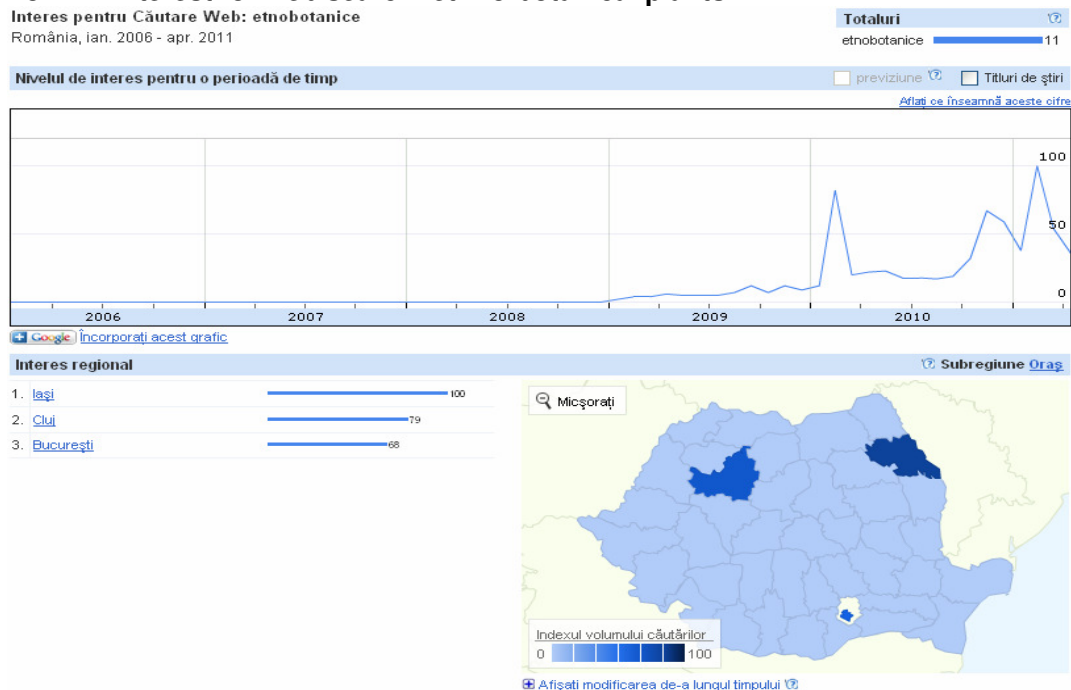
- Social networks;
- Treatment programmes provided by the DPECC;

- Shops that sell “legal highs/ethno-botanical plants”
- Streets, parks and public areas;
- Therapeutic community,
- Syringe exchange programmes;
- Clubs;
- Friends/peers of drug users.

Results:

- The use of new psychoactive substances (incorrectly named “ethno-botanical plants” or “legal highs”) became manifest in 2008 and expanded and diversified in the last years, while showing downward trends and then recovery following the legal steps taken by government to control these substances.

Graph no. 4-1: Interest for web search: ethno-botanical plants



Source: Survey “Risks Assessment of the use of new psychoactive substances among children and young people in Romania”, 2011

- From the marketing point of view, the new psychoactive substances sold as “ethno-botanical plants” fall under two large categories:
 - A) mixtures of plants and chemical substances intended for smoking – “spice”-type products;
 - B) mixtures of chemical powders that can be sniffed or injected – synthetic psychoactive substances that have energising or hallucinogen effects, and are traded under different names and mixed with known energisers: caffeine, creatine, etc.
- the two options tend to be balanced: interviewed users mainly use “Spice” products (56.1%) while energising mixtures record lower rates of use, even if very similar (43.9%).
- The most popular brands at national level (throughout the survey) were Diesel, Pure, Katana and Magic as established by triangulation and data source confirmation,
- The psychoactive substances described in the research are just a part of the substances available on the market. These products are altered daily, in terms of concentration and composition within the same commercial brand, but also in terms of trade name, which makes any correlation between a substance and a brand a difficult task.
- There are not conclusive data on the constitution of organised crime networks participating in SNPP trade and distribution, but organised structures that are trafficking in controlled substances might appear. There are confessions referring to cases of highschool students that became connected with the underworld in order to sell this type of substances.

Characteristics of users:

- There is high visibility of drug use and users are mainly socially integrated young people with a good financial situation. This category of users is likely to experiment with different combinations of substances, in the context of a “gap” in the regulations regarding the status and sale of these substances.
- There are conclusive proofs of the poly-drug use of psychoactive substances among heavy users. Over half of the respondents reported having used several types of SNPP in the last 30 days. Illicit drugs and medication such as heroin, amphetamines, sniffing glue, cocaine, marijuana, inhalants, *Diazepam*, *Valium*, *Rofedex*, *Tusin* are used in combination with SNPP,
- The street and personal home are the preferred places where drugs are used. Most often drug use depends on material resources but also on how often the users go out with friends. Most of the interviewed drug users reported they prefer to use with friends, in group.
- The amounts spent daily by regular users of SNPP ranges from 10 to 300 lei. The average amount spent amounts to almost 53 lei/day.
- There are several and diverse selling points. Most drug users reported they would buy legal substances from “*spice shop/ weed shop*”.
- The new psychoactive substances are mixed and bagged before being sold by prescriptions and concentrations that are not verified.
- There is insufficient or no information on the real content of the products or their health effects. The scientific documentation available in this cases show these products show substantial health risks.
- The reactions to such products when used in combination with alcohol, medication, illicit drugs etc are not known.
- Interviewed experts stated there is high epidemiologic risk following the spread of SNPP use because SNPP users have different education levels in using new communication media (forums, *blogs*, *chat* etc), where they can share experiences, place orders of substances that are promoted by on-line marketing.
- The injecting use of SNPP represents a significant trend: 1 in 6 respondents reported injected SNPP use. Most of them live in Bucharest. As for the self-reported serologic status of blood-borne and/or sexually transmissible diseases, the major risk they run is blood-borne viruses after sharing syringes.
- The use of new psychoactive substances can cause serious health problems: weight loss, personality disorders, psychotic disorders, loss of appetite, insomnia, and physical exhaustion.
- Experts mentioned cases of injecting drug users who died after the *transition* from heroin to SNPP. These death cases were not confirmed by medical-legal analyses mainly because of the limited analysis capacity (lack of technical equipment to conduct conclusive analyses).
- The data on the social risk of SNPP use are limited.
- Workplace activities and/or education can be affected by the regular use of these substances. On long terms, there is a risk of social exclusion and self-marginalisation, school dropout, ruining professional carrier and affecting morals. Crime can appear following the imperative need to increase costs to maintain use or because of psychotic disorders.
- Over 25% of the respondents reported having sought medical care following the use of legal highs. Most of them needed medical emergency services. Other services were mentioned such as detoxification, psychiatry and psychological counselling.
- The availability and access to social and medical services are low, which increases the risk of deterioration of medical and social problems of drug users on average and long term.

Risk behaviour of subjects who use injecting SNPP

These risks were documented based on the information gathered following the application of questionnaires among people who use new psychoactive substances. Because of the low number of subjects, results will not be described by percentages. Of the 31 SNPP users who reported having used these substances by intravenous route:

- 30 lived in Bucharest (30 respondents) and one in Ploiești;
- 24 reported „Pure” as the most frequently used drug; one respondent used „Pure” combined with heroin, 5 reported they use „Magic” the most frequently, and one „3Dvision”;
- Almost one in three reported not knowing the health risks related to injecting drug use;
- 8 in 10 respondents report having used needles, syringes in sharing SNPP or other drugs and even one in 4 of the injectors reported having used syringes frequently.

Half of SNPP injecting users reported having used condoms occasionally during sexual contact, and 2 in 5 reported not having used any while 1 in 6 respondents reported no sexual contact in the last 12 months, and 2 in 3 injecting drug users reported having had sexual intercourse with more than one partner (in the last 12 months).

More than 1 in 3 injecting SNPP users were not tested for HIV, HBV and HCV in the last 12 months. As to the self-reported serologic status of blood-borne HIV, HBV and HCV, 1 in 3 injecting drug users of the tested persons were positive for C hepatitis, 3 for B hepatitis and 1 for HIV.

10 (1 of 3) respondents – SNPP injectors reported having demanded medical care following the use of legal substances/mixtures. Almost half of the injecting users reported having had complications (acute infections, gangrene) because of the injecting use of “ethno-botanical substances”.

Chapter 5 – Drug related treatment

The data used in this chapter were based on the Standard European Protocol for the treatment of drug-addicted (Standard protocol 2.0). This is provided in the national legislation in the Joint order issued by the Ministry of Public Health and Ministry of Interior and Administrative Reform⁶³ laying down the legal framework for the collection of data approached in this chapter. In line with the methodology used for filling in the drug treatment admission personal record, several categories of providers of medical, psychological and social services are included in the data reporting system and each time a patient starts treatment in a centre is reported as treatment admission episode, irrespective of his/her previous admissions in the same centre or another, in the same year or a different year⁶⁴.

One case is represented by a person who starts drug treatment in a treatment centre along one calendar year, from January 1st to December 31st⁶⁵ and it can be either:

- a new case (first treatment admission in a centre) – case in which the patient seeks treatment for the first time in a reporting centre where an observation chart or beneficiary record is opened in the presence of a qualified professional (physician, psychologist, social worker or nurse etc) so as to start psychoactive substance use/addiction treatment;
- relapse (treatment re-admission) – when a person, who has previously benefited from one or several treatments, is admitted to treatment, irrespective of the outcome of treatment: provision of medical, psychological or social services, exclusion or dropout.

An alpha-numerical code is assigned to each person who starts drug treatment in a treatment facility along a calendar year to avoid double-reporting.

5.1 STRATEGIES/ POLICY

Due to the changes in the organisation and functioning of the National Anti-drug Agency, mandated to formulate, coordinate, evaluate and monitor at national drug policies⁶⁶, no major changes were recorded in the integrated system of services addressing drug use. As a consequence, drug users are treated within a complex and integrated system based on case management principles, alike previous years.

In spite of the legal proposals have been addressing the development of the prevention and integrated care of drug users⁶⁷ in 2008, and of the extensive number of agonist-based maintenance treatment programs, waiting lists⁶⁸ continue to be in place at the level of addiction integrated care

⁶³ Joint order MPH and MIAR no. 770 and 192 of 2007 approving the Methodology regarding the completion of the standard records and the transmission of data to be included in the personal emergency chart for drug use, personal chart for drug treatment admission, recorded HCV and HBV cases among injecting drug users and the prevalence of HIV, HBV and HCV infections among injecting drug users

⁶⁴ The following cases are not reported as treatment admission episodes: contacts, in person or by phone, to ask for information regarding treatment nor treatment demands on waiting lists; contacts that aim solely at seeking social services or welfare; treatments aiming solely at treating organic complications caused by drug use such as the treatment of an overdose or infection; interventions consisting exclusively in exchanges of syringes or other injection materials, condom distribution etc; treatment admissions for which variables such as date of treatment admission or main drug of abuse are not known.

⁶⁵ If a person continues the treatment which he/she has started the year before, that person shall not be recorded again

⁶⁶ In line with GD no. 461 of 2011 laying down rules for the setup and functioning of the National Anti-drug Agency

⁶⁷ For example: Medical, psychological and social care national programme – 2009-2012 approved by Governmental Decision no. 1.102 of September 18, 2008 which proposes concrete interventions for completing the national system of service for preventing and treating drug users, delivered in an integrated approach and constantly tailored to the needs of the beneficiaries and local communities (out-reach services, participation of families and communities in therapy, and funding the operation of specialised services run by NGO's) and the Order no. 1.389/4.08.2008 – approving the Criteria and methodology to authorise drug service providers and the Compulsory minimum standards of the organisation and operation of the centres that provide services for drug users

⁶⁸ NAA President's decision no. 13/2007 – laying down the legal framework for the setup and management of the waiting list

centres within the NAA, which might be indicative of the underdevelopment of addiction integrated care services. Additionally, the integrated system of medical, psychological and social care services is partially completed, as links such as the therapeutic community, social services for underage drug users and dual pathology facilities continue to miss.

5.2 NATIONAL TREATMENT SYSTEM

The institutional and enforcement framework of the drug addiction care system is outlined by the following provisions:

- **Legal framework:** Decision no. 860/2005 approving the Enforcement regulation of the Law no. 143/2000 on preventing and countering the illicit drug use, further amended and supplemented,
- **Methodological framework:** Standards of the national system of medical, psychological and social care for drug users⁶⁹.

Thus, the provision of the GD no. 860/2005 lay down the *standard functioning rules of the drug treatment system* referring to:

- *stages of medical, psychological and social care and context of provision of care* (upon demand of the user or legal representative; upon the decision of the prosecutor or other criminal body; emergency case),
- *domains subject to assessment* (personal medical history and drug use record, biomedical conditions and current complications, psychological and/or psychiatric co-morbidity and complications, social and family conditions, legal situation),
- *patient eligibility criteria* for selecting the treatment programme tailored to the user's personal profile,
- *types of drug treatment integrated programs*.

The regulation sets the institutional framework in which treatment is provided⁷⁰:

- drug prevention, evaluation and counselling centre (DPECC) (out-patient) - medical, psychological and social care and case management,
- day-time centre (12-hour out-patient care),
- therapeutic community, half-way housing, social housing and others (hotel-type) – care services,
- centre for integrated care of addictions (out-patient) – medical, psychological and social care,
- in-patient detox centres, units and departments (in hospital care) – medical detoxification services,
- harm reduction centres (out-patient or mobile units) – harm reduction services,
- mental health laboratory⁷¹ with a service running in the day-time – out-patient substitution treatment (methadone maintenance),

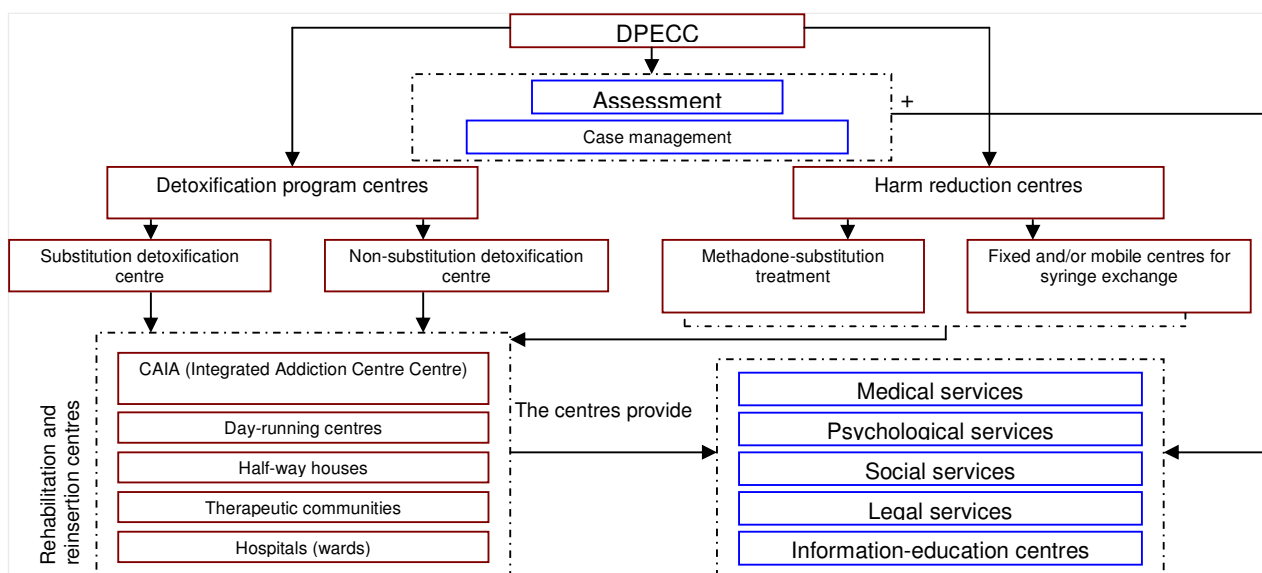
⁶⁹ No reference to: alcohol, psychoactive substances based on medical prescription, people under 18, care provided in detention

⁷⁰ The provision of care services for drug users, without the authorisation provided by the legal regulations, is considered misdemeanour and is punishable by a fine ranging from 10,000 RON to 15,000 RON; in order to strengthen the medical, psychological and social care integrated system for drug users, a range of regulations were issued to ensure the activities carried out by service providers are standardised: Decision no.16 of October 2, 2006 approving the Minimum compulsory standards on case management in the field of assistance for drug users (NAA, OG no. 899/06.11.2006) and Decision no. 17 of October 2, 2006 approving the Methodology for the formulation, amendment and implementation of the customised care plan for the drug users (NAA, OG no. 899/06.11.2006). Thus, the provision of services in the field of drug assistance should be done through several integrated services: medical, psychological and social care, and all services should be coordinated by case management. Case management is a service applied continuously throughout the treatment process by the case manager, a specialist in the DPECC structure. This method helps coordinate the services provided to drug users: evaluation of the user, setting up an integrated care programme, formulating the customised care plan and implementing measures according to the plan, monitoring and evaluating the measures of the customised care plan, re-evaluation, resumption of the programme by changing the plan or the integrated care programme, if necessary, and collaboration between providers, *advocacy*.

⁷¹ The Ministry of Public Health (MPH) issued the Order no. 372/2006 which lays down measures for the promotion and protection of mental health and for the prevention of psychiatric diseases. The order lays down rules on how to evaluate mental health and initiates the territorial organisation of mental health services in geographical areas, referred to as psychiatric units that provide the following services: out-patient services,

- other types of public and private services⁷², provided for in the law.

Map no. 5-1: Chart of drug treatment services in Romania



Source: National Anti-drug Agency – Standards of the National system of medical, psychological and social care for drug users

According to the *Standards of the national system of medical, psychological and social care for drug users*, the coordination of the users' care and the overall management of each case along different services are structured on the following assistance levels:

- **1st level** – identification and referral of drug users to specialised services and treatment attending to basic medical and social needs (emergency services, primary medical care, general social services, *harm reduction* services);
- **2nd level** – made up of specialised units of the public health system and drug prevention, evaluation and counselling centres and provides for specialised care (multi-disciplinary evaluation, formulation of the plan of care, specialised care, both simultaneous and continuous), monitoring, coordination between all levels of intervention and referral to the 3rd level. It is the heart of the entire treatment system.
- **3rd level** – ensures specific care and a high level of specialisation (detoxification, therapeutic communities, centres running in day-time etc) and social-professional reinsertion.

The Order no. 1389/513/282 of August 4, 2008 approving the Criteria and methodology used to authorise centres that provide services for drug users and the Compulsory minimum standards of the organisation and operation of the centres that provide services for drug users⁷³ lays down the *Specific criteria for the organisation and operation of the detoxification*⁷⁴: admission/hospitalisation⁷⁵ awaiting

mobile assistance, rehabilitation, inpatient treatment and residential services. The re-organisation of the mental health services aims at increasing the quality and accessibility of this type of services and at ensuring community-based psychiatric assistance, for adults, teenagers and children, as separate categories.

⁷² The most important NGO's (with branches in other cities except for Bucharest) are: Anti-AIDS Romanian Association – ARAS, Association for the Fight against Alcohol and Drugs – ALIAT, Samusocial Romania, PARADA Foundation, Fundația Familia și Ocrotirea Copilului – FOC, Integration Association, Health policy roma centre–SASTIPEN.

⁷³ Issued by: MPH (No. 1.389 of August 4, 2008), Ministry of labour, family and equal opportunities (no. 513 of August 15, 2008) and Ministry of Interior and Administrative Reform (No. 282 of August 24, 2007), published in the OG no. 830 of December 10, 2008

⁷⁴ Detoxification centre – Minimum criteria regulating the staff structure and professional skills: the Centre has the following full-time staff: a psychiatrist, a psychologist, a social worker, nurses and medical aid. a) the physician has graduated a higher education institution and is licensed in medicine, psychiatry specialisation and a member of the Romanian College of Physicians b) the psychologist has graduated a higher education institution and is licensed in psychology or equivalent, has an individual practice certification for one of the professional specialisations: psychology, psychological and psychotherapy counselling, in line with current regulations. One psychologist is ensured for 6 to 8 beneficiaries. c) the social worker has graduated a higher

detoxification is decided by the doctor of the detox centre based on the recommendation of the drug prevention, evaluation and counselling centre, family practitioner or other drug service providers⁷⁶. In case treatment demands outnumber available beds in the detoxification centre, a waiting list is made up by the centre's physician. Detoxification can begin only after the addiction diagnosis is confirmed, according to the Diagnose and statistical manual for mental disorders IV/International code of diseases no. 10 (DSM IV/ICD 10), and once drugs are detected in the beneficiary's body fluids. Detoxification period is established based on the condition and evolution of the beneficiary, but no more than 30 days. Detoxification period is established based on the beneficiary's health condition and progress, but shall not be more than 30 days. In case of refusal of prescribed medication by the beneficiary throughout hospitalisation, treatment will be re-assessed together with the physician, and if the beneficiary continues to refuse the proposed plan of care, he/she will be discharged.

The Order no. 1389/513/282 of August 4, 2008 lays down the specific organisation and operation criteria for the detoxification centre and the specific organisation and functioning criteria of the services that provide substitution treatment based on opiate agonist medication:

1. Substitution treatment inclusion criteria:

- a) age over 18 or 16, when the benefits of treatment exceed secondary effects and only upon the written consent of the legal representative;
- b) DSM IV/ICD 10 diagnosis of opiate addiction;
- c) positive result for opiate after test in body fluids.

2. Eligibility criteria for substitution treatment inclusion:

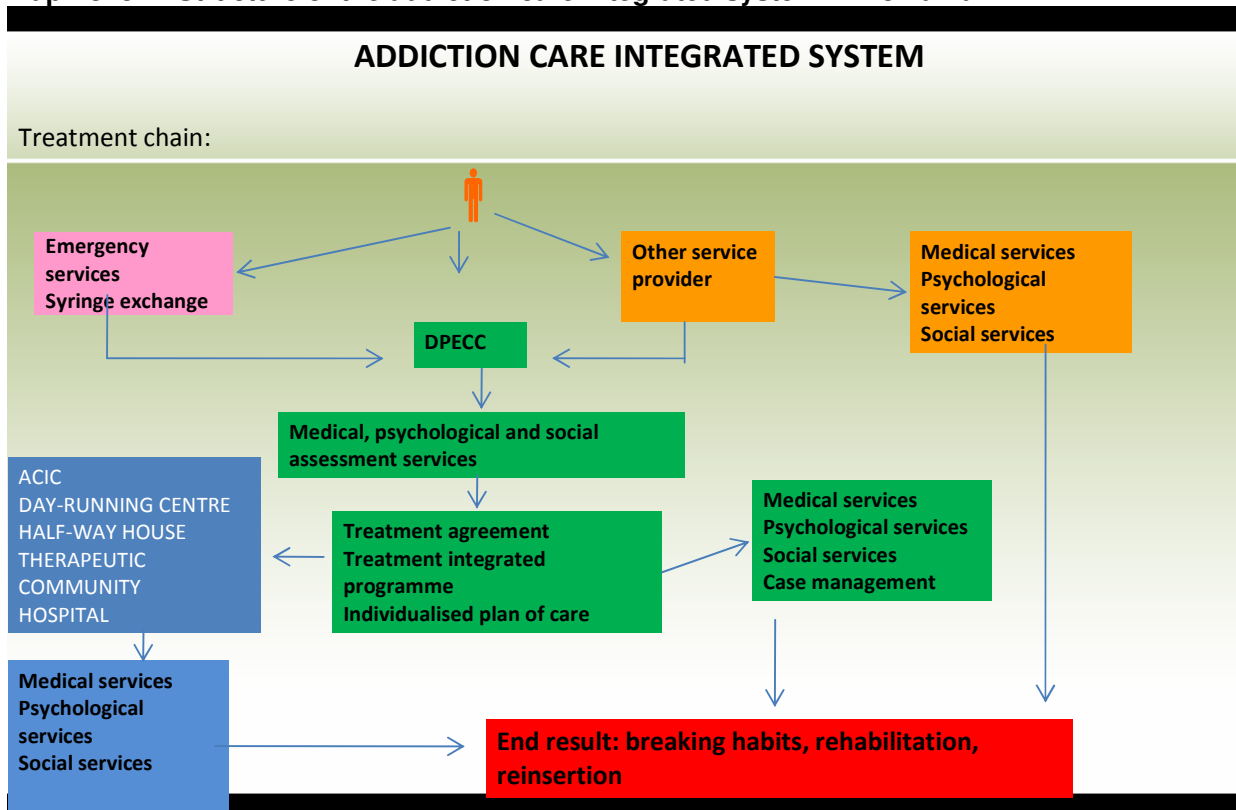
- a) repeated attempts to cease drug use;
- b) drug use risk behavior;
- c) HIV/AIDS;
- d) pregnancy;
- e) serious organic or psychiatric pathology;
- f) poly-addiction.

education institution and is licensed in social work, is a member of the Social Workers' National College in Romania. There should be one social worker for 10 to 12 beneficiaries. d) the medical assistant is a member of the Medical assistants' College and has an individual practice certification. There should be one nurse for 6 beneficiaries. Nurses should be continuously present, and continuance should be ensured in shifts, according to the law. e) medium education nurse; there should be one nurse for 20 beneficiaries.

⁷⁵ Hospitalisation procedure is provided for in the organisation and operation rules of the centre

⁷⁶ During hospitalisation the beneficiary shall observe the internal regulation of the centre, that he/she is notified of upon admission. To this aim, the beneficiary signs a document by which he/she has been informed and assumes that during hospitalisation he/she shall comply with the provisions of the regulation. In case of detoxification, the beneficiary shall sign a medical care agreement, applicable during hospitalisation; failure to comply with the regulation brings about treatment termination due to lack of discipline or re-assessment of therapeutic interventions. In case of beneficiaries under the age of 18, the agreement shall be signed by a legal representative.

Map no. 5-2: Structure of the addiction care integrated system in Romania



The provision of social care services to drug-addicted users was regulated in 2008, once NAA in cooperation with the Ministry of Labour, Social Solidarity and Family and the Ministry of Public Health formulated the *Compulsory minimal standards of the organisation and operation of the centres that provide services for drug users and the authorisation methodology for these centres*⁷⁷. The services provided by the DPECC⁷⁸ and public and private medical units, along after-care and psychosocial rehabilitation are: individual, family and group psycho-therapy; occupational therapy and treatment of drug related psychiatric diseases.

The Romanian network of medical, psychological and social care

1. Services provided by the National Anti-drug Agency⁷⁹ (out-patient):

- *Medical, psychological and social assessment* towards the inclusion in a treatment integrated program (TIP)⁸⁰ and the formulation of the Individualised plan of therapeutic, psychological and social care - IPC⁸¹.

⁷⁷ Social care services are stipulated in the Framework regulation for the organisation and operation of social care institutions (G.D. no. 1434/2004 laying down the tasks and the Framework regulation for the organisation and operation of Directorate General of Child Social Care and Protection, issued by the Government, OG no. 869/23.09.2004) and in the methodological enforcement rules of the legal provisions on social services (GD no. 68/2003 on social services, issued by the Government of Romania, OG no. 619/30.08.2003)

⁷⁸ The Ministry of labour, social solidarity and family authorised the 41 DPECC as social services providers in 2006

⁷⁹ The network of medical, psychological and social care network of the National Anti-drug Agency is made up of: 47 Drug Prevention, Evaluation and Counselling Centres – DPECC and 5 Addiction Integrated Care Centres – CAIA, 3 in Bucharesti, 1 in Iași, 1 in Oradea.

⁸⁰ a) *lower level detoxification programme – PIT 1* which provides: basic and specialised medical services; abstinence support based on opiate antagonist medication; psychological and/or psychotherapeutic counselling; drug testing; social care; legal advice; information, education and training to reach an education, cultural and relationship level that would allow for social participation and the access to community-support services; b) *detoxification programme – PIT 2* which, in addition to PIT 1, provides: substitution or non-substitution detoxification, outpatient or inpatient; c) *detoxification and stabilisation programme – PIT 3* which provides the medical/psychological or psychiatric/social and legal services specialised for drug related diseases and/or diseases caused by drug use, which call for immediate intervention; d) *harm reduction programme – PIT 4*, with 50

- *Medical services*: pharmacological treatment for achieving abstinence (methadone, suboxone, naltrexone), rapid drug tests in body fluids, testing for HIV, HBV, HCV.
- *Services of psychological and social counselling* to achieve psycho-social reinsertion and rehabilitation (individual and group-based).
- *Case management* – coordination to ensure the implementation of the IPC and assessment of the measures provided for in the plan and their results.

As part of the National program for medical, psychological and social care for drug users 2009-2012⁸² – secondary programme 7 – 2nd level care services – Addiction care integrated centres (ACIC)⁸³ was ensured in 2010 based exclusively on state budget (estimated budget for 2010: 1,050,000 lei, lower than in 2009: 1,500,000 lei⁸⁴).

2. Services provided by the Ministry of Health

- In-patient: *detoxification, overdose treatment*,
- out-patient – treatment centres: medical and psychological assessment, pharmacological treatment to maintain abstinence (methadone, suboxone, naltrexone), rapid drug tests in body fluids, testing for HIV, HBV, HCV, *Services of psychological and social counselling and case management*.

3. Services provided by the Ministry of Justice (National Administration of Penitentiaries)⁸⁵

- Harm reduction services – syringe exchange
- Substitution services – methadone.
- Therapeutic community – like services.

4. Services provided by other service providers

- Private or NGO-run out-patient treatment centres⁸⁶.
- Private or NGO-run after-care treatment centres⁸⁷.

the following options: substitution programme based on opiate agonist medication (methadone prescription and administration), syringe exchange and/or other harm reduction measures, providing counselling services for a risk-free drug use, information provision on current treatment services; coverage of basic needs: food, hygiene, clothing, rest.

⁸¹ The individualised plan of care for drug users consists of: general information on the beneficiary, programme goals, main issues and priority issues, strengths/ weaknesses, objectives and expected deadlines, intervention schedule, responsible staff and treatment grid. The plan of care clarifies four goals: the means to provide care, the types of services, treatment options, and the selection of adequate and available procedures. Treatment procedures differ by the intensity of the intervention, according to the degree to which it corresponds to the needs of the drug users, and can be: emergency, low or high intensity out-patient treatment, residential or inpatient treatment. Characteristics are settled for each type of care and clear indications are provided to support the choice of a certain type of care. The provided services and interventions can be medical, psychological and social, while the structure, adequate and available to drug users, is directly connected to the treatment centres.

⁸² Approved by Governmental Decision no. 1.102 of September 18, 2008, approving the Medical, psychological and social care national programme – 2009-2012 (issued by the Government, published in the Official Gazette no. 676 of October 1st, 2008);

⁸³ Main services: methadone, buprenorphine+naloxone substitution treatment; abstinence maintenance treatment (for opiate and alcohol addicted people) based on naloxone; outpatient detoxification; drug testing in body fluids; HIV and hepatitis rapid testing; condom distribution; pre and post-test counselling, vaccination against A and B hepatitis; occupational therapy (ergo-therapy); psychiatric care; individual, group and family psychotherapy; pre-assessment standard testing.

⁸⁴ Not an effective decrease, as in 2010 it was not needed to purchase medical equipment already in stock.

⁸⁵ For incarcerated in-mates (arrests/penitentiaries) who use drugs, the medical, psychological and social care services are provided based on: joint order of the Ministry of health, ministry of Justice, ministry of Administration and Interior no. 1.216/C of May 18, 2006, regarding the functioning of the medical, medical, psychological and social care integrated programmes for drug using prison in-mates and the Joint order of the ministry of health and ministry of justice no. 898/2002 on medical and education measures for drug-addicted prison inmates.

⁸⁶ ARENA centre (ARAS), PSYMOTION clinical hospital, ANIT centre and D&C Medical

⁸⁷ Coaliția împotriva Abuzului de Substanțe și a Adicțiilor din România (Romanian Substance Abuse and Addiction Coalition - ROSAAC) is a joined effort of christian organisations of different denominations towards the rehabilitation of addicted people <http://www.rosaac.ro/index.php>

5. Harm reduction services⁸⁸ - provided by NGO's, most of which function under the RHRN umbrella. The Romanian harm reduction network (RHRN)⁸⁹ is an informal network of NGO's and state institutions that promote the reduction of drug-related harm by increasing communication between partner organisations and improving the quality of services for drug users, at national level.

As recent development, due to the limited funding earmarked to this type of projects, harm reduction services reduced. On the other hand, budget-funded projects that supported such services, have always succeeded concrete needs. Another feature of the harm reduction services in Romania is the concentration of these services mostly around Bucharest. In spite of this, a maximum of 50% of the total number of injected drug users is estimated to have benefited from harm reduction services in Bucharest.

5.3 CHARACTERISTICS OF TREATED CLIENTS

Starting with 2009, along with the medical units of the Ministry of Health and the centres of the NAA and the prison system, three specialised out-patient treatment centres were added in the drug treatment services reports: ARENA (centre run by an NGO, ARAS) and two private centres: PSYMOTION and Asociația Națională de Intervenții în Toxicomanii⁹⁰ (Drug Addiction Intervention National Association- ANIT) that provide addiction care in Bucharest (including substitution treatment based on methadone/suboxone/naltrexone for opioid addiction). Additionally, since 2009 aggregated data have no longer been used and double-counting has been avoided in counting treatment admissions in MH facilities once an alpha-digit code started to be used for each patient⁹¹.

2163 people⁹² benefited from treatment⁹³ in 2010 following the use of illegal substances and new psychoactive substances (sold under the name of "ethnobotanical plants"):

- In-patient⁹⁴ - 1,389 people⁹⁵ (1700 admissions : mean = 1,22; min =1 and max = 6);
- Out-patient⁹⁶ - 761 people⁹⁷ (786 admission: mean = 1,03; min =1 and max = 3);
- In the prison system - 13 people (described in chapter 9).

For 2010, the data reveal the following:

- The highest number of treatment admissions in the last 10 years, to a level similar to the one recorded in 2001;
- An increase by 28% of the total treatment admissions (from 1689 to 2163) as compared to last year;
- An increase in numbers of those who demanded treatment for the first time (from 1008 in 2009 to 1228 in 2010), but a slight decrease in rates: from 59.7% in 2009 to 56.8% in 2010.

Thus, in 2010, the number of people who demanded treatment for drug use reached levels comparable to the ones recorded 10 years ago. This can relate to the emergence and appreciation of the use of new psychoactive substances that added to the number of treatment demands following

⁸⁸ Harm reduction activity was regulated by the Governmental Decision no. 860/2005 approving the Enforcement regulation of the provisions of the Law no. 143/2000 on preventing and countering the illicit drug use, as further amended and completed, provided in chapter I, art. 1, letter v.

⁸⁹ <http://www.rhrn.ro/index.php?l=ro>

⁹⁰ <http://www.psymotion.ro> și <http://www.anit.ro/>

⁹¹ For out-patient treatment admissions and in the penitentiary system reporting was based on single codes (double counting was avoided once an alpha-numerical code was used for each patient/client)

⁹² There was a total of 2499 admissions for the 2163 people (average = 1.56, min =1 and max = 6)

⁹³ The total number of people admitted to treatment following psychoactive substance use amounted to 4419, of which 48.9% (2163 people) were for illicit use and new psychoactive substances and 51.1% (2256 people) were for alcohol and tobacco use.

⁹⁴ Medical units of the Ministry of health

⁹⁵ The total number of people admitted to in-patient treatment following psychoactive substance use reached 2,836 people of which 1389 people used illicit drug use and new psychoactive substances and 1,447 people used alcohol and tobacco use, as main drug

⁹⁶ NAA (DPECC and IACC), Arena, PSYMOTION and ANIT and MH centres

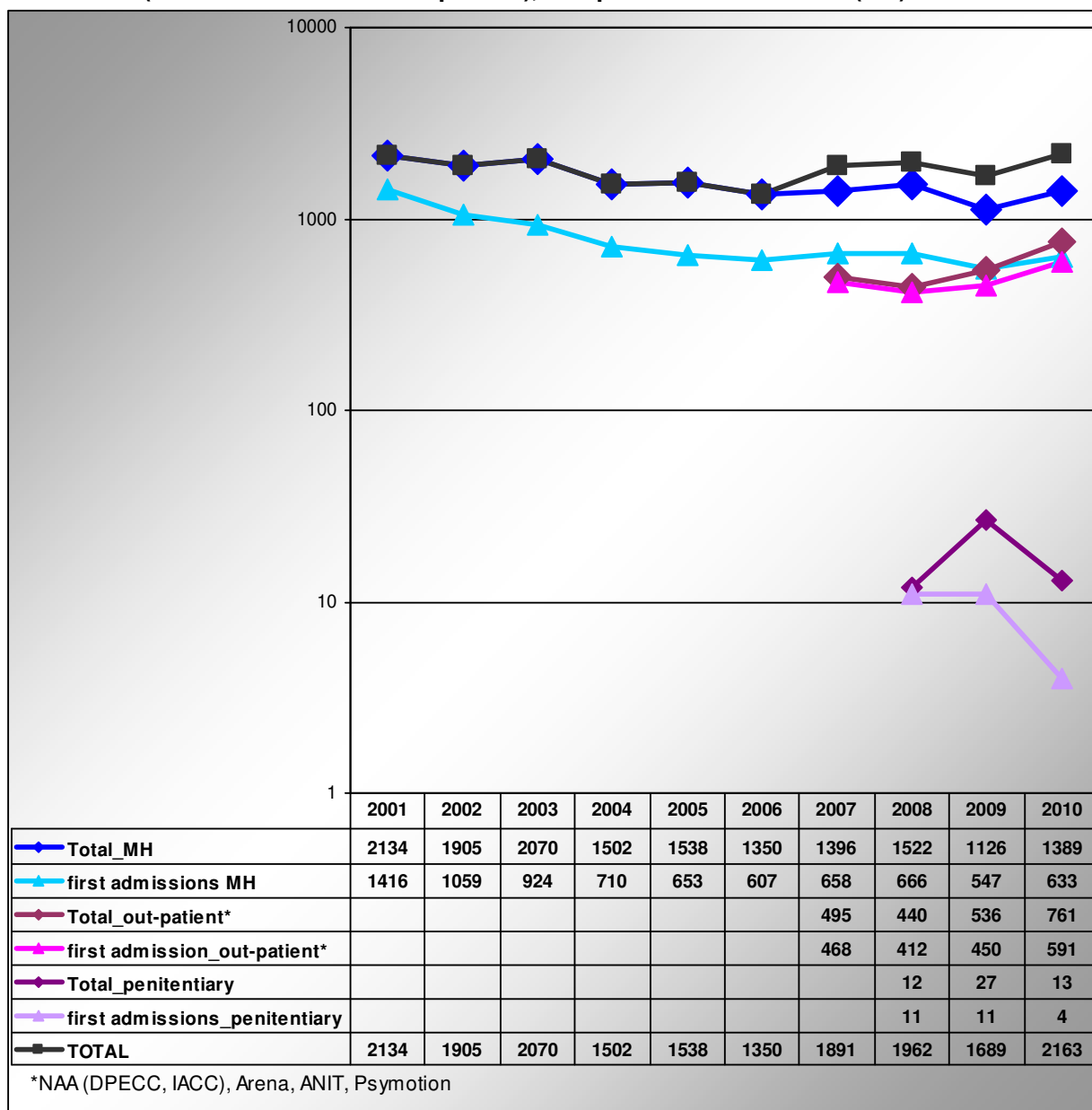
⁹⁷ By joining data bases, the total people admitted to out-patient treatment following the use of psychoactive substances, reached 1570, of which 761 were new psychoactive substances users and 809 alcohol and tobacco users.

illegal drug use, or to the intervention capabilities of the NAA, reduced by numerous re-organisations starting with 2009.

In addition, the following can be added in the overall analysis of the trends of the indicator:

- Decrease of the rate of new treatment demands against the total number of people referred to treatment (it does not include the decrease in numbers of those who started drug use because there have been no major changes in service supply and availability in the reference time interval – with long-standing waiting lists) and
- Another feature is the use of new psychoactive substances (sold as “ethnobotanical plants”) ⁹⁸ that escalated among users of other drugs (mostly opiates) and people who have not used before, apparently due to the relatively lower price and larger availability.

Graph no. 5-1: Treatment admission following the use of illicit drugs and new psychoactive substances (sold as “ethnobotanical plants”), compared data 2001-2010 (no.)



Source: NAA⁹⁹

⁹⁸ Blowwash/ Blue Wash, Bonsai, Crystal, Diesel, Energy One, Euphoria, Explosion, Flower Magic, Ganja H, Generation 2012, Golden Spice, Insomnia, Magic, Magic Flower, Magic Gold, Magic Powder, Pure by Magic, Special Gold (sold as bath salt, plant fertiliser and aromatherapy)

⁹⁹ Based on data reported by National Centre for the Organisation and Provision of the IT and Information System in the Health Field, ANIT, PSYMOTION, Arena, NAP

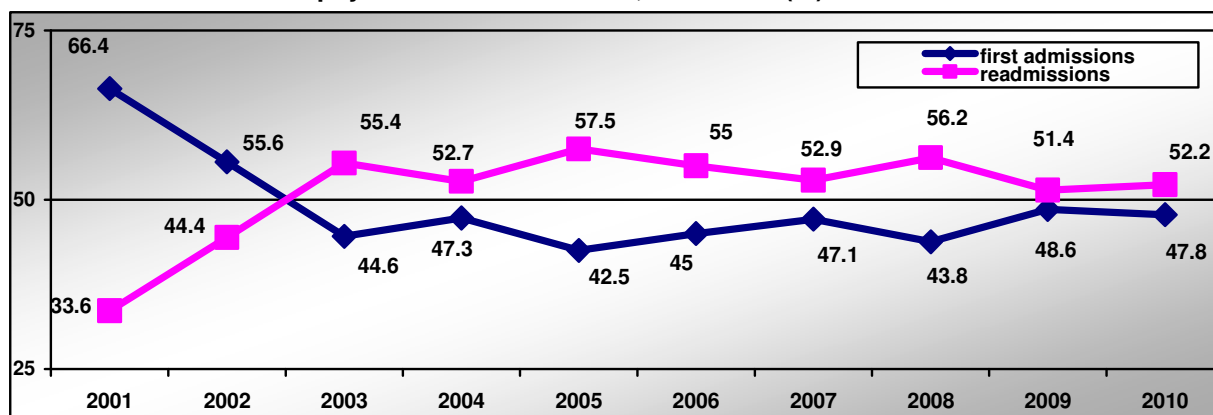
A. Admissions to in-patient illicit drug treatment¹⁰⁰

According to the data provided by the National Centre for the Organisation and Provision of the IT and Information System in the Health Field (CNOASIIDS) within the Ministry of Health, 1,389 treatment admissions were recorded in 2010 following the use of illicit drugs and of new psychoactive substances (sold under the name of “ethnobotanical plants”).

As compared to the previous year, the following trends can be noticed in 2010:

- Decrease by 23% of treatment demands following the use of illicit drugs and of new psychoactive substances (from 1,126 cases to 1,389 people)¹⁰¹
- Decrease by 0.8% of the rate of first treatment demands (from 48.6% to 47.8%¹⁰²).

Graph no. 5-2: Trend in the rate of first admissions and readmissions against the total in-patient treatment admissions for psychoactive substances, 2001-2009 (%)



Source: NAA¹⁰³

The analysis of the rate of new versus re-admissions shows the ratio of the first treatment admissions was higher only from 2001 to 2002 (2001 – 1.9 new cases to one readmission and in 2002 – 1.2 new cases to one case of treatment readmission). Since 2003, the situation has been reversing and the ratio of treatment admissions for those who had been treated before exceeded that of users seeking medical treatment for the first time.

Table no. 5-1: First treatment admissions vs. readmissions, data from 2001 to 2010

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Ratio of first treatment admissions/readmissions	1.9:1	1.2:1	0.8:1	0.9:1	0.7:1	0.8:1	0.9:1	0.8:1	0.9:1	0.9:1

Source: NAA¹⁰⁴

The distribution by main drug of abuse (2010): 41.5% were opiates use cases, 40.4% - other substances (of which 32.3% - new psychoactive substances (sold under the name of “ethnobotanical plants”), 8.7% - for hypnotic or sedative medication, 5% - cannabis, 1.6% - volatile inhalants, 1% - cocaine and less than 1% - stimulants, cocaine and hallucinogens.

¹⁰⁰ Alcohol and tobacco (as main drug) are not included in this analysis

¹⁰¹ No aggregate data were used and double counting was avoided once an alpha-numerical code was used for each patient/client

¹⁰² For 2010, computed based on the 1325 cases for which the type of admission was recorded (for 64 cases, the type of admission was not recorded)

¹⁰³ Based on data reported by CNOASIIDS

¹⁰⁴ Based on data reported by CNOASIIDS

Table no. 5-2: Distribution of in-patient treatment admissions, according to the main drug for which treatment was demanded and type of admission, 2008-2010 (%)

	first treatment admissions			Readmissios			TOTAL		
	2008	2009	2010	2008	2009	2010	2008	2009	2010
heroin	60.6	57.1	21.8	80.8	81.5	51.4	72	69.6	38.9
other substances	14.5	18.8	51.0	6.5	6.7	32.5	10.1	12.6	40.4
hypnotics and sedatives	15.4	12.4	10.1	8.8	4.5	7.7	11.7	8.3	8.7
cannabis	3.5	6.6	8.8	1.5	1.6	2.0	2.4	4.0	5.0
other opiates and methadone	3.2	2.7	2.3	1.5	4.5	3.2	2.2	3.6	2.6
volatile inhalants	1.1	0.9	2.2	0.4	0.9	1.2	0.7	0.9	1.6
stimulants	0.9	0.7	0.9	0.2	0.2	0.9	0.5	0.4	0.9
hallucinogens	0.3	0.5	0.9	0.1	0.2	0.7	0.2	0.4	0.8
cocaine	0.5	0.2	1.7	0.1	0.0	0.4	0.3	0.1	1

Note: the new psychoactive substances traded as "ethnobotanical plants" are included under "other substances" (in line with the reports to the OEDT)

Source: NAA¹⁰⁵

According to the main drug for which treatment was demanded, the analysis of the treatment admission distribution in the time frame 2008-2010 shows a continuation of previous situation: people re-admitted to treatment (relapses) demanded care mainly for heroin (2008 – 80.8%, 2009 – 81.5% and 2010 – 51.4%) and in the case of first treatment admissions, the ratio of heroin users decreases (2008 – 60.6%, 2009 – 57.1% and 2010 – 21.8%), while increasing for the use of other substances (from 14.5% in 2008 to 51% in 2010). There is seemingly a diversification of drug use:

- decrease of heroin use (33.9% of the people who benefited from treatment following the use of new psychoactive substances in 2010 had been treated before for opiate use¹⁰⁶) and
- significant increase of the use of new psychoactive substances traded as "ethnobotanical plants" (2008 - 0 cases, 2009 - 6 cases and 2010 - 448 cases), and of other drugs (as compared to 2009 by maximum 1% for: cannabis – 1%, cocaine -0.9%, inhalants– 0.7%, stimulants – 0.5%, medication with hypnotic or hallucinogenic effects – each by 0.4%).

In a manner similar to 2008 - 2009, the data might lead to two hypotheses:

- the increasing availability of treatment for those who use drugs other than heroin;
- change in the drug use pattern with a decrease of the rate of heroin users and increase of the rate of users of other drugs.

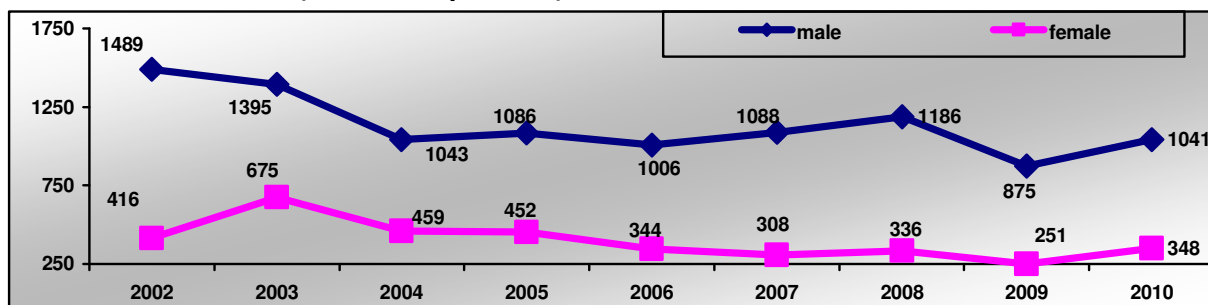
Alike the information gathered in preceeding years referring to the territorial distribution of people who benefited from treatment for psychoactive substance use, we should notice a stable concentration in the Municipality of Bucharest (2009 - 71.49%, 2010 – 66%), although slightly decreasing. We should however consider that general provision of such services is more developed in the capital city, in terms of type of care and number of centres.

Alike previous years, gender distribution of treatment admissions from 2002 to 2009 shows an increased male ratio – (857 people), as compared to female – (251), with a slight increase in female users seeking treatment and, implicitly, a decrease of male demands for treatment (2010: males – 74.9% and female – 25.1% as compared to 2009: males – 77.7% and female – 22.3%). The total number of users is lower than in 2002 irrespevctive of gender, yet it should be mentioned that in 2002 the only available form of treatment was inpatient, while in the reference year inpatient, out-patient and prison-based treatment is provided.

¹⁰⁵ Based on data reported by CNOASIIDS

¹⁰⁶ 53.8% accounts for people experiencing first treatment admission, 9.8% for people who had been treated before for the use of new psychoactive substances traded as „ethno-botanical plants”, 1.6% for cannabis/marijuana, and 0.9% for other drugs (amphetamine, ketamine, rivotril and sibutramină)

Graph no. 5-3: Gender distribution of inpatient treatment admissions psychoactive substances, 2002-2010 (number of persons)



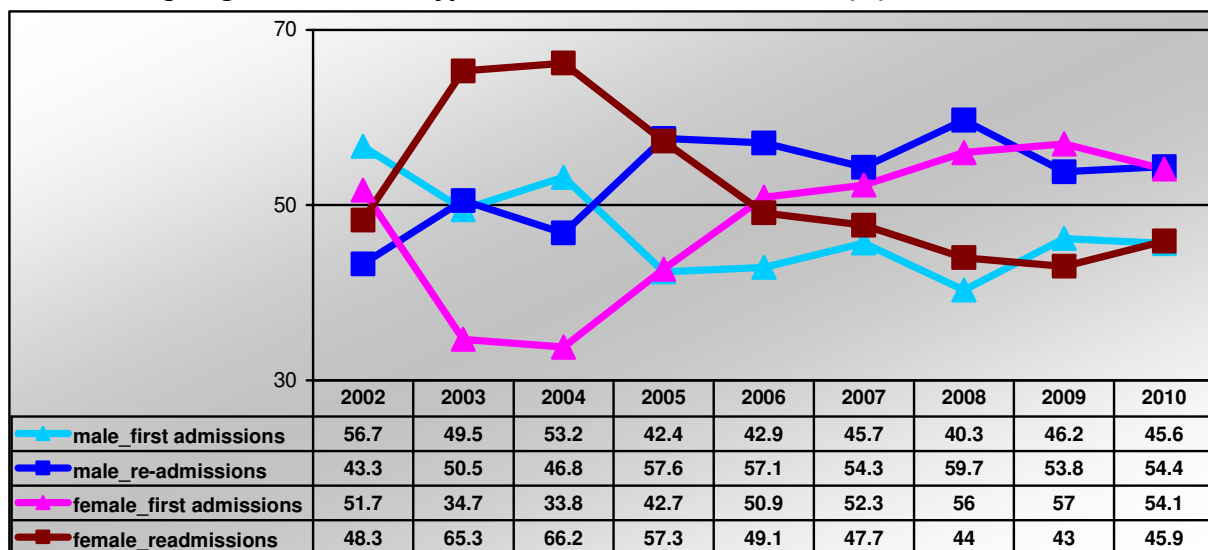
Source: NAA ¹⁰⁷

45.6% of male cases are new treatment demands (decreasing as compared to the previous year: 46.2%) and 54.4% cases are re-admissions. The situation is reversed for female drug users: the ratio of the first treatment admissions for illicit substances is higher – 54.1% (a decrease comparable to 2009: 57%) than of treatment re-admissions – 45.9%.

The analysis of treatment admissions from 2002 to 2009 by gender and type of admission shows:

- for male drug users – since 2005 the rate of first treatment admissions is lower than re-admissions, the highest difference becoming evident in 2008 – 19.4%;
- for female drug users – after an exceeding percentage of relapses than new cases in the time frame 2003-2005 (e.g. the relapse vs. first admissions ratio was 1.96:1 in 2004), starting with 2006 the ratio has been changing and first treatment admission outnumbered re-admissions.

Graph no. 5-4: Evolution of the admissions to inpatient treatment for psychoactive substance use according to gender and the type of admission, in 2002-2010 (%)



Source: NAA ¹⁰⁸

Although the stable trend originating in the previous years persists (male/female ratio below 1), there is a decrease in the ratio of first treatment demands by gender both among people who demanded inpatient treatment and those who sought treatment for the first time (comparing to 2009). An increase of male/ female discrepancy becomes manifest.

¹⁰⁷ Based on data reported by CNOASIIDS

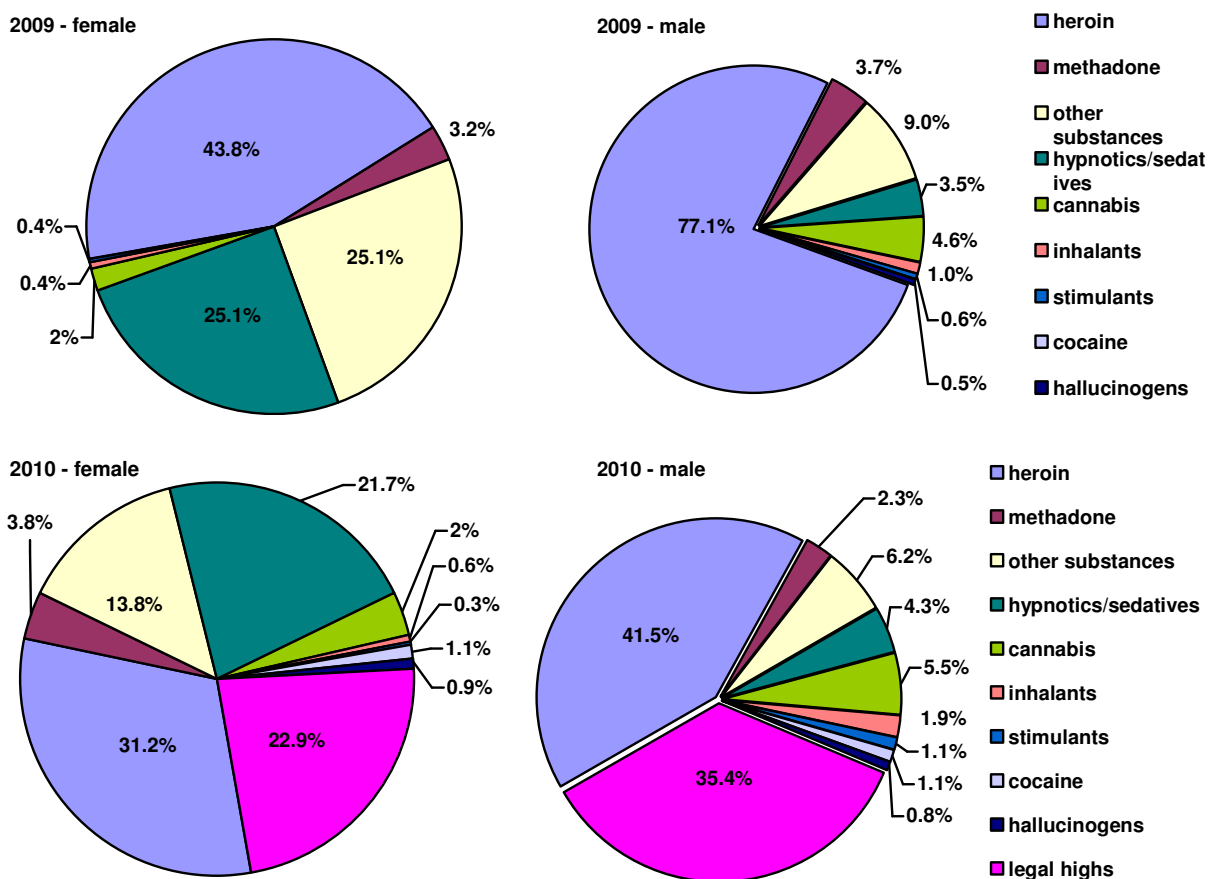
¹⁰⁸ Based on data reported by CNOASIIDS

Table no. 5- 3 Male/ female ratio in inpatient treatment, 2001- 2010

Male/female ratio	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Persons seeking treatment for the first time	4.6:1	3.9:1	2.9:1	3.5:1	2.3:1	2.4:1	3:1	2.5:1	2.8:1	2.4:1
Total persons undergoing treatment	5:1	3.5:1	2:1	2.2:1	2.4:1	2.8:1	3.5:1	3.5:1	3.5:1	3:1

Source: NAA¹⁰⁹

If in 2009, the distribution by main drug of use showed more than ¾ of men sought opiate treatment (77.1%), and less than half of the women (47%) demanded the same, while one in four demanded treatment for hypnotics and pain killers (25.1%) or other substances (25.1%), a diversifying trend emerged in 2010 for both genders while the gender distribution by type of drug used became homogenous.

Graph no. 5-5: Distribution of treatment admissions by main drug for which assistance has been demanded and gender, 2009-2010

Source: NAA¹¹⁰

Thus¹¹¹:

- (significant) decrease is detected among male users who use opiates and other substances¹¹² and an increase for hypnotics/sedatives, cannabis, volatile inhalants, stimulants, cocaine and hallucinogens, while the use of heroin and other substances decreased among female users and increases were recorded for cannabis, inhalants and cocaine but also for stimulants and hallucinogens. In addition, the use of new psychoactive substances (traded as “ethnobotanical

¹⁰⁹ Based on data reported by CNOASIIDS

¹¹⁰ Based on data reported by CNOASIIDS

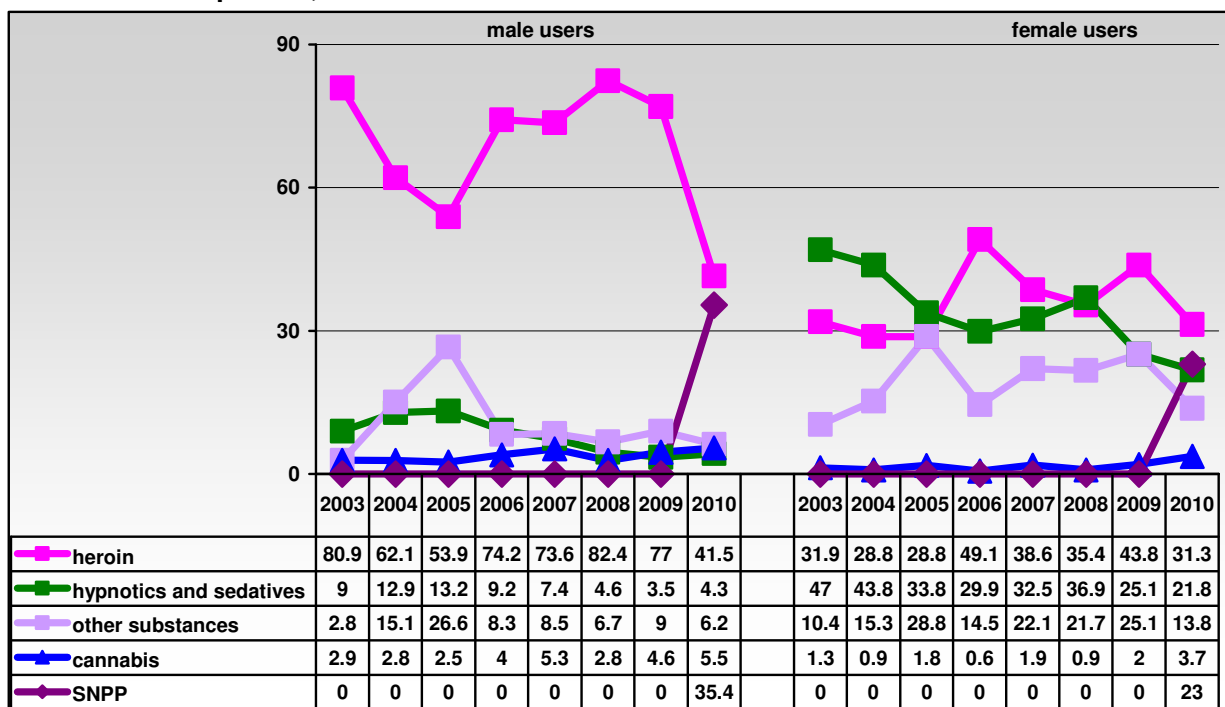
¹¹¹ According to the reporting to the OEDT, new psychoactive substances sold as „athno-botanical” plants (SNPP) are included under „other substances”; in this report, given the high rate of users of such substances, SNPP was included as a separate category when needed or considered necessary.

¹¹² Ex: Anxiolitics, Antalgics (Antinevralgic, Algocalmin), Augumentin, BCT, Carbamazepine, Clonidina, Chil Aut, Caffeine, Depakine, Ketonal, Meprobamat, Medrol, Regenon, Piafen, Stancin, Tussin forte

plants")¹¹³ is detected for both genders in high rates: male users – more than a third (35.4%) and female users – more than 1/5 (22.9%);

- If in 2009 there was a 33.3% difference between male and female users who demanded treatment for heroin addiction, in 2010 the difference lowered to 10.3%, and for the use of other substances the difference of 16% (2009) decreased to 7.6% in 2010. In addition, the difference between genders is 12.4% when it comes to the use of new psychoactive substances (traded as "ethnobotanical plants").

Graph no. 5-6: Gender distribution of admissions to inpatient treatment for heroin, hypnotics and sedatives, other substances, cannabis and new psychoactive substances sold as "ethnobotanical plants", in 2003-2010



Notă –1. SNPP - new psychoactive substances (traded as "ethnobotanical plants").

2. the rest up to 100% represents treatment admissions for the use of cocaine, stimulants, hallucinogens, volatile inhalants and other opiates

Source: NAA¹¹⁴

The analysis of the treatment cases by the user's age, the treatment admission distribution in 2010 indicates the following:

- Almost a third (31.7%) of the total treatment admissions in the reference year were made for users of at least 24, and 29.1% for users aged 25 to 29; the mean age was 30.9 (decreasing than in the previous year – 31.7 years), with 6 years more for women (35.5 years of age as compared to 29.4 years for men; lower than in 2009, when the difference in years was almost 10: 39 for female users as 29.5 for male users) and lower by 5.6 years for SNPP as compared to the age upon the use of all drugs;
- treatment admissions rate among men: the rate of treatment admissions for all drugs was higher for the age group 20 - 39 (81.5 % as compared to 59.5 % - women); most users of SNPP (98%) were aged 15 to 39 (average age 25.8 years);
- treatment admissions rate among women: the rate of treatment admissions for all drugs was much more higher for 14-year olds and below (1.4% as compared to 0.2% - men) and over 45 (28.7% as compared to 7.7% - men); most female patients who used SNPP (97.5%) were under 35 (average age 23.3).

¹¹³ Blowwash/ Blue Wash, Bonsai, Crystal, Diesel, Energy One, Euphoria, Explosion, Flower Magic, Ganja H, Generation 2012, Golden Spice, Insomnia, Magic, Magic Flower, Magic Gold, Magic Powder, Pure by Magic, Special Gold (sold as bath salt, plant fertiliser and aromatherapy)

¹¹⁴ Based on data reported by CNOASIIDS

Table no. 5-4: Gender and age distribution of inpatient treatment admissions, 2010 (%)

		<15 years	15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years	50-54 years	55-59 years	60-64 years	>=65 years	Mean age
Total admissions	Total	0.5	7.7	23.5	29.1	17.5	5.9	2.8	1.4	4.0	2.9	0.9	3.7	30.9
	Male users	0.2	7.7	24.2	31.2	19.7	6.4	2.9	0.9	2.0	1.9	0.8	1.9	29.4
	Female users	1.4	7.8	21.6	22.7	10.9	4.3	2.6	2.9	9.8	5.7	1.1	9.2	36.5
Admissions for SNPP only	Total	1.3	13.8	29.5	32.8	16.3	4.2	1.3	0.2	0	0.2	0	0	25.3
	Male users	0.3	13.3	28.8	32.6	17.9	5.2	1.1	0.3	0	0.3	0	0	25.8
	Female users	6.3	16.3	32.5	33.8	8.8	0	2.5	0	0	0	0	0	23.3

Source: NAA¹¹⁵

- the youngest minimal age was recorded for people admitted to treatment following the use of new psychoactive substances (SNPP), for both genders, and the oldest minimal age was recorded for the use of stimulants, hypnotics and sedatives, in both genders; the youngest mean ages among men were recorded for inhalant users (22.1 years of age) and cocaine users (23), while among female users for those who demanded treatment for inhalants (20 years) and stimulants (21 years of age).

Table no. 5-5: Distribution of inpatient treatment admissions by age (minimal and mean), main drug and gender, 2010 (%)

Type of drug	Age (years)			
	minimal		mean	
	male	female	male	female
new psychoactive substances (SNPP)	13	12	25.8	23.3
Volatile inhalants	14	16	22.1	20
cocaine	15	19	23	21.3
cannabis	16	17	24.2	20.5
opiates	16	18	28.3	27.5
Other substances	18	23	51.1	53.5
hallucinogens	19	26	24.5	30.3
stimulants	20	21	24.9	21
Hypnotics and sedatives	20	20	51.3	53.6

Source: NAA¹¹⁶

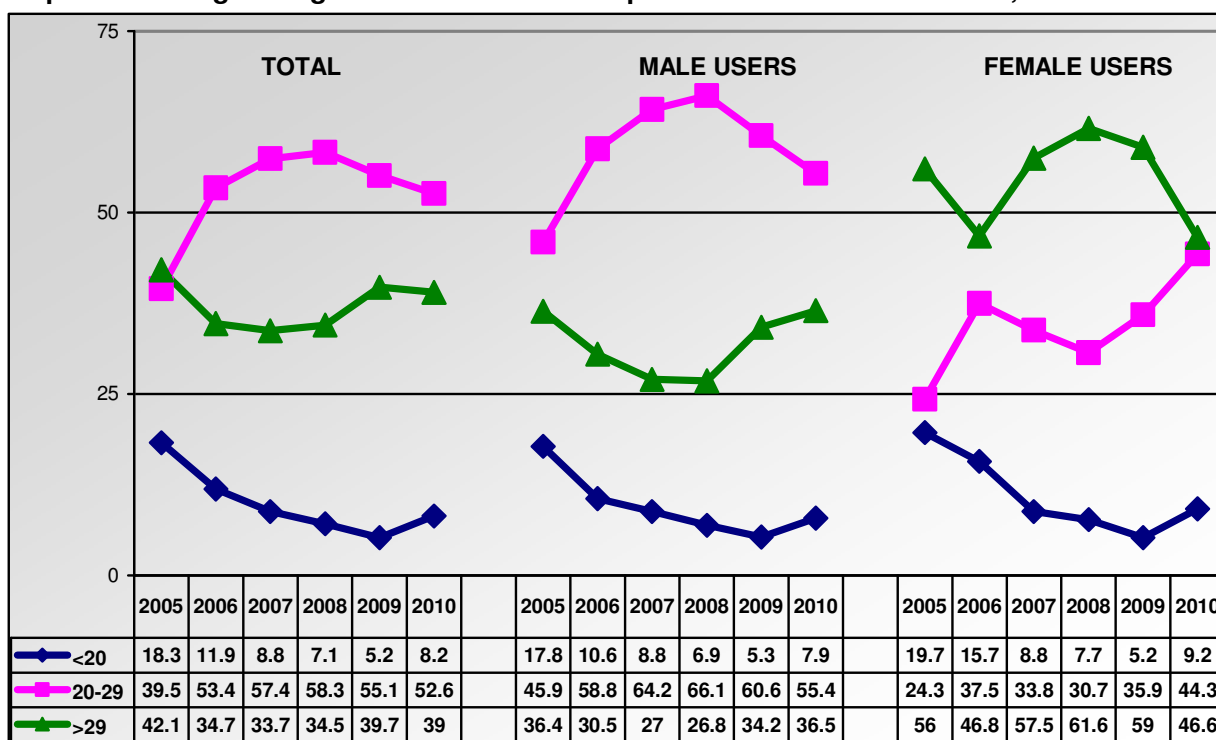
From 2005 to 2010, the evolution of treatment admissions by age and gender indicated the following:

- total/male – most treatment admissions were for people aged 20 to 29 and less for people under 20 years old; a decreasing trend is noticeable for people of 20 to 29 years old and an increase in the numbers of beneficiaries aged 20 and below;
- female – most drug treatment admissions were for people over 29 and the fewest admissions were recorded for people under 20; the trend that originated in the previous year is preserved: increase among people aged 20 to 29 and decrease among people over 29.

¹¹⁵ Based on data reported by CNOASIIDS

¹¹⁶ Based on data reported by CNOASIIDS

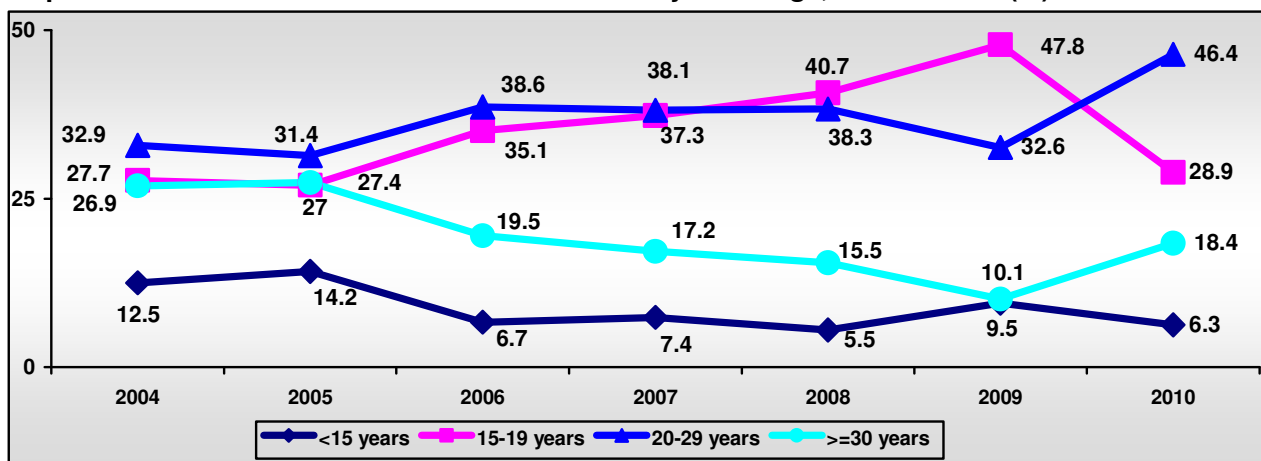
Graph no. 5-7: Age and gender distribution of inpatient treatment admissions, 2005-2010



Source: NAA ¹¹⁷

In terms of onset age (for the main drug of abuse) ¹¹⁸, 4 out of 5 people began drug use at ages below 30 and, comparing to the previous year, there was a decrease in the rate of people under 19 who started drug use (2009-57.3%, 2010-35.2%) and an increase of those over 20 years (2009-42.7%, 2010 64.8%).

Graph no. 5-8: Evolution of treatment admissions by onset age, in 2004-2010 (%)



Source: NAA ¹¹⁹

¹¹⁷ Based on data reported by CNOASIIDS

¹¹⁸ The cases for which onset age was mentioned were considered (2004 - 1384, 2005 - 1460, 2006 - 1269, 2007-1294, 2008 - 1289, 2009 - 929 și 2010 - 976 cases)

¹¹⁹ Based on data reported by CNOASIIDS

Table no. 5-6: Evolution of in-patient treatment admissions by onset age and type of drug, in 2009-20010 (%)

	Main drug	Onset age			Total	
		by 2009	2009	2010	No.	%
Treatment admission by 2009	opiates	782	13		795	85.6
	cocaine	0	1		1	0.1
	stimulants	2	2		4	0.4
	hypnotics and sedatives	46	7		53	5.7
	hallucinogens	1	2		3	0.3
	inhalants	2	2		4	0.4
	cannabis	21	9		30	3.2
	other substances	33	6		39	4.2
	Total	887	42		929	100
Treatment admissions in 2010	opiates	404	35	9	448	45.9
	cocaine	5	2	0	7	0.7
	stimulants	6	2	1	9	0.9
	hypnotics and sedatives	28	10	7	45	4.6
	hallucinogens	6	1	0	7	0.7
	Inhalants	6	2	2	10	1.0
	cannabis	23	11	7	41	4.2
	other substances	31	5	2	38	3.9
	SNPP	73	70	229	372	38.1
	Total	582	138	257	977	100

Note: The cases for which the onset age was mentioned were considered (2009 - 929 and 2010 – 977 cases)

Source: NAA ¹²⁰

Considering onset age¹²¹ and type of drug the following can be noticed:

- for 2009 – 85.6% of the treatment admissions followed opiate use and most of the 759 cases (namely 762) followed drug use of more than one year;
- for 2010 – only 45.9% for opiate use (most of them with a drug use history of at least two years) and 38.1% are SNPP users (of which 2/3 started drug use in 2010).

In the reference year, polydrug use is frequent in 469 cases (33.8% of the treatment admissions). The most frequent secondary drugs in 2010 are: other substances – 39.9% (of which 31.3% - SNPP), opiates (27.5%), hypnotics and sedatives (12.4%), cannabis (8.7%) and alcohol (4.9%). According to the main drug for which treatment has been demanded, the highest ratios for the use of a secondary drug are for opiate user – 50.7% (of which heroin – 46.5%)¹²² and other opiates – 39% (of which SNPP – 38%).

¹²⁰ Based on data reported by CNOASIIDS

¹²¹ The cases for which onset age was mentioned were considered (2009 - 929 and 2010 – 977 cases)

¹²² Decreasing than in 2009 when the highest rate for the use of a secondary drug was recorded among opiate users - 88.6% (of which: heroin – 84.1%)

Table no. 5-7: Evolution of the rate of poly-drug users, total and by types of drugs, in 2005-2010 (%)

		2005	2006	2007	2008	2009	2010
No. of users presenting secondary drugs		366	176	185	597	464	469
% users presenting secondary drugs out of total admissions		23.8	13.0	13.3	39.2	41.2	33.8
Secondary drug type	Other substances	57.9	17.0	9.2	6.0	8.2	39.9
	If which SNPP	-	-	-	-	-	31.3
	oouates (total)	3.3	9.1	6.5	37.5	37.1	27.5
	Of which methadone	0.3	4.5	2.2	27.1	24.4	11.7
	Other opiates	2.7	3.4	2.7	8.9	10.8	5.3
	heroin	0.3	1.1	1.6	1.3	1.9	10.4
	Hypnotics and sedatives	32.0	29.0	28.1	35.8	37.5	12.4
	cannabis	3.0	6.8	7.6	5.7	6.5	8.7
	alcohol	0.0	21.0	33.5	6.7	4.3	4.9
	cocaine	0.8	5.1	0.5	5.7	3.9	2.8
	stimulants	0.5	5.7	8.1	1.2	1.1	2.3
	halucinogene	0.0	0.6	1.6	0.7	1.3	1.5
	notatile Inhalants	2.2	5.7	4.3	0.7	0.2	0
	not mentioned	0.3	0	0.5	0	0	0

Source: NAA¹²³

In comparison to the 2008 and 2009, the rate of those having used a secondary drug has decreased in 2010. Polydrug use with methadone and opiates other than heroin, as well as with hypnotics and sedatives, cocaine and volatile inhalants decreased in 2010 as compared to 2009; SNPP appears as secondary drug and there is also an increasing rate of those who use as secondary drug: heroin, cannabis, stimulants and hallucinogens.

According to the frequency of use of the main drug, of the number of drug users admitted to treatment in 2010: 61.8% used drugs daily, 15 % used drugs several times per week, 6.3% at least once a week, and 2.5% occasionally. Male drug users would use more frequently than female drug users (e.g. daily use: 65.2% than 51.7%). According to the type of drug: opiates are most frequently used (75,2% of the people admitted to treatment for opiate use who reported daily use) and hypnotics and sedatives (62% of the hypnotics and sedative users), while stimulants are the least frequent: only 16.7% for daily use and 33.3% for occasional use.

Table no. 5-8: Treatment admissions by frequency of drug use, 2010 (%)

		Frequency of use			
		daily	2-6 days/ week	Once a week or less	No use in the last month/occasional
Total		61.8	15	6.3	2.5
gender	Male users	65.2	11.5	6	2.3
	Female users	51.7	25.6	7.2	3.2
Type of drug	opiates	75.3	9.0	3.1	0.7
	Hypnotics and sedatives	62.0	17.4	2.5	8.3
	SNPP	59.2	9.6	10.5	1.8
	Hallucinogens	45.5	36.4	0	0
	Other substances	44.2	46.0	1.8	0
	Volatile inhalants	36.4	27.3	0	9.1
	cocaine	28.6	14.3	14.3	14.3
	cannabis	21.4	35.7	20.0	7.1
	stimulants	16.7	33.3	8.3	33.3

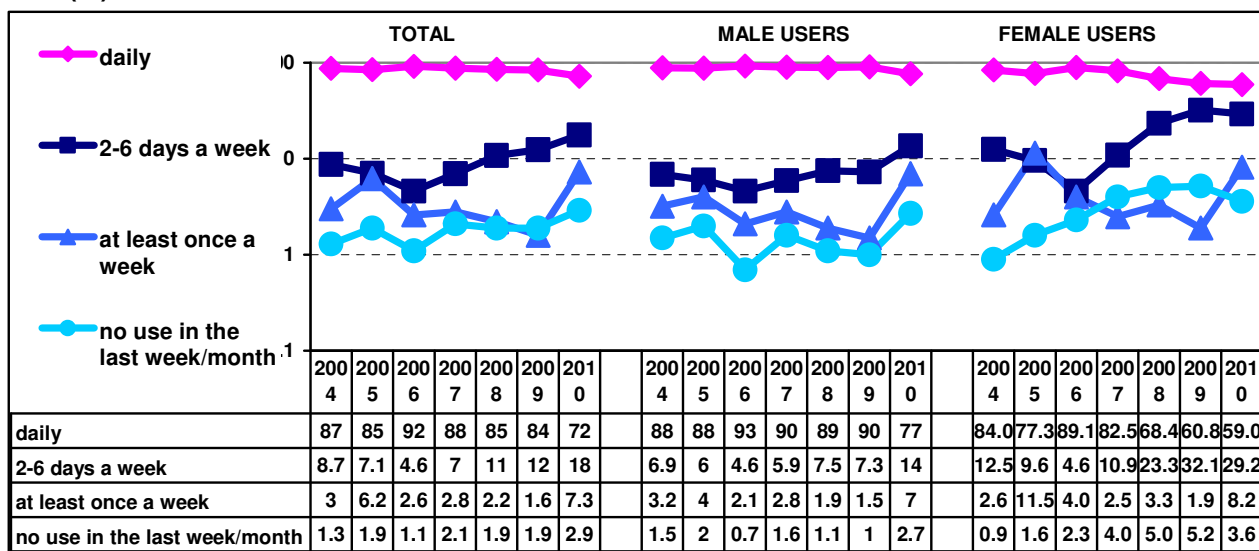
Note: difference up to 100% - not specified

Source: NAA¹²⁴

¹²³ Based on data reported by CNOASIIDS

¹²⁴ Based on data reported by CNOASIIDS

Graph no. 5-9: Distribution of treatment admissions by frequency of use and gender, 2004-2010 (%)



Note: The cases for which the frequency of use was mentioned were considered (2004 – 1334, 2005- 1432, 2006 – 1254, 2007 – 1265, 2008- 1446, 2009 - 1022 and 2010 – 1190 cases)

Source: NAA/GIRP ¹²⁵

The evolution of treatment admissions¹²⁶ from 2004 to 2010, by frequency of use indicates the following:

- daily use is the most frequent. Although from 2004 to 2008, the rate of daily use out of the total cases is relatively stable (varying from 77.2% and 85.2%), a decreasing trend has been noticed from 2008 to 2010 among daily users (2008-80.8%, 2009-76.3% and 2010 – 61.8%),
- there are differences of the frequency of use by gender and also by type of drug use. Thus, daily use varies between 76.7% and 92.5% and occasional use between 0.7% and 2.7% among male users (who use heroin 41.5% and SNPP 35.4%), while daily use varies between 59% and 89.1% and the occasional between 0.9% and 5.2% among female users (who use heroin 31.3%, hypnotics and sedatives 21.8% and SNPP 23%).

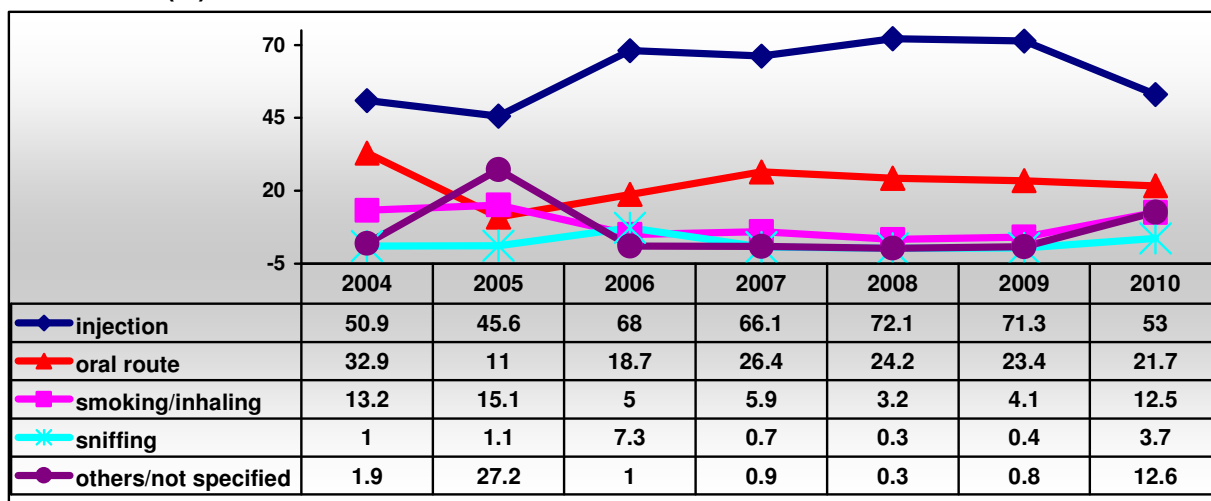
According to the administration route of the main drug it should be noticed that:

- although decreasing as compared to past years, intravenous route prevails: 53% in 2010, 72.1% in 2008/2009, namely 71.3%. Opiates (83%) and SNPP (55%) are the substances that are most frequently used intravenously.
- In rates, oral administration comes next, with lower levels since 2007. Hypnotics and sedatives are those substances most frequently used orally (95.9%) in the reference year;
- smoking/inhaling and sniffing are higher than in 2009. cannabis (85.7%) and volatile inhalants (81.8%) are most frequently used by smoking/inhaling, while cocaine is most frequently sniffed (35.7%).

¹²⁵ Based on data reported by CNOASIIDS

¹²⁶ The cases for which the frequency of use was mentioned were considered (2004 – 1334, 2005- 1432, 2006 – 1254, 2007 – 1265, 2008- 1446, 2009 - 1022 and 2010 – 1190 cases)

Graph no. 5-10: Evolution of treatment admissions by route of administration of the main drug, in 2004-2010 (%)

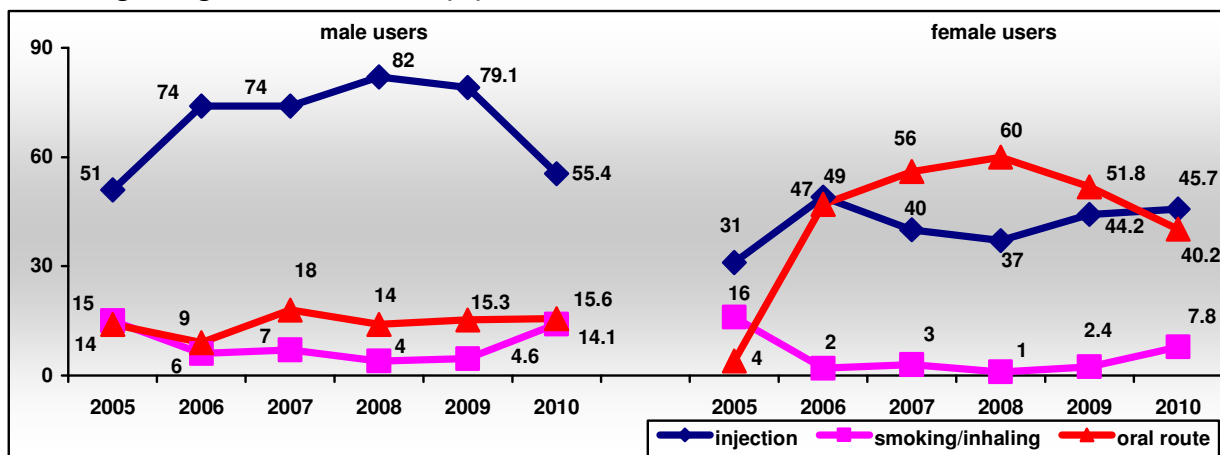


Source: NAA ¹²⁷

The evolution of the treatment admissions by administration route of the main drug and gender indicates the following:

- intravenous route is used mainly by male users, slightly decreasing, while smoking/inhaling and oral administration is increasing;
- high values are recorded among women both for oral use (slightly decreasing) and injection use. Upwards trends are recorded for the use of new psychoactive substances (sold under the name of "ethnobotanical plants") as well as for cannabis, volatile inhalants and cocaine (see chart 5.5.).

Graph no. 5-11: Evolution of inpatient treatment admissions by route of administration of the main drug and gender, 2005-2010 (%)



Note: difference up to 100% is represented by sniffing/others/not specified

Source: NAA ¹²⁸

Regarding the rate of drug users with an injection history, irrespective of the type of used drug, for the injecting drug use pattern it was determined that in the reference year:

- the rate the percentage (and number) of drug injectors was higher than in 2004,
- although the number of drug injectors was higher than in 2009, their rate was lower.

To conclude, the evolution of injecting use is significantly influenced by the evolution of heroin treatment admissions (which is mainly injected) and less by the use of other substances, such as SNPP.

¹²⁷ Based on data reported by CNOASIIDS

¹²⁸ Based on data reported by CNOASIIDS

Table no. 5-9: Evolution of inpatient treatment admissions for drug users with drug injection history (all drugs) and of those using heroin and SNPP (irrespective of the route of administration), in 2004- 2010 (no. of persons and %)

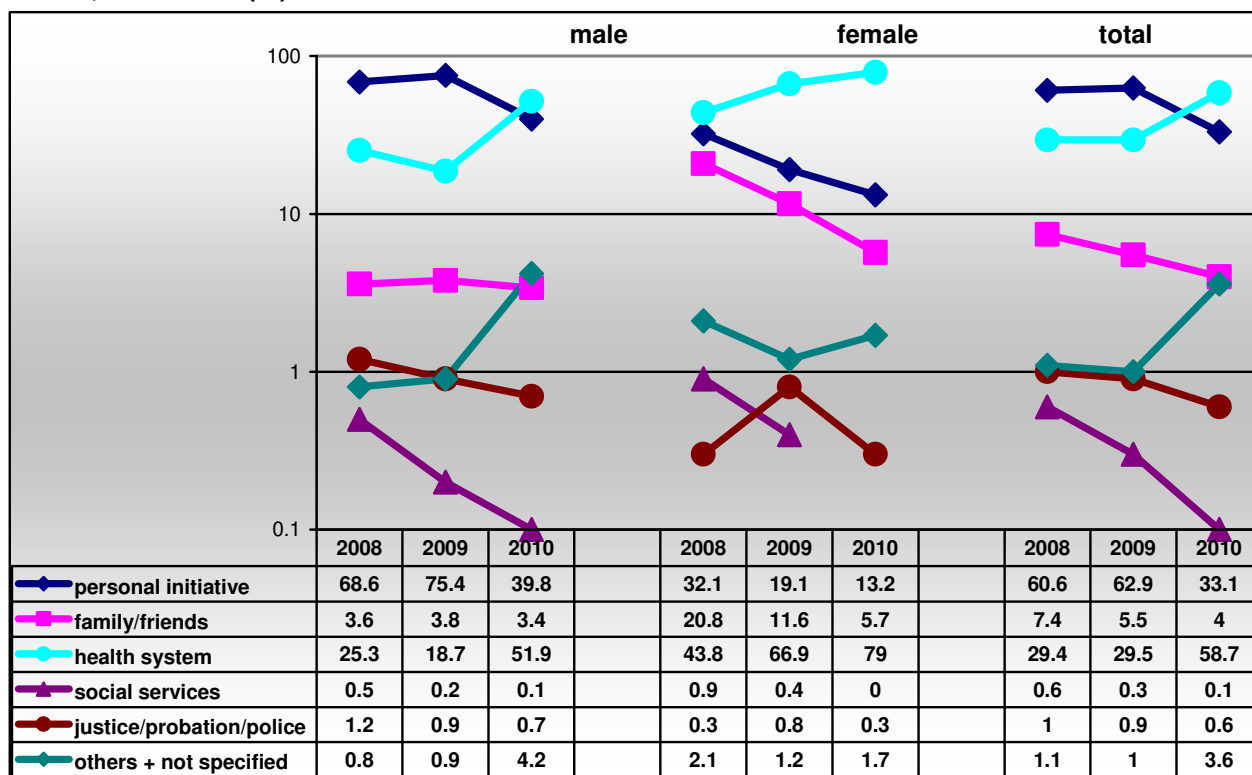
	No. of people							% of the total admissions						
	004	005	006	007	008	009	010	004	005	006	007	008	009	010
History of injecting use (irrespective of the drug)	68	67	48	83	076	77	05	1.1	3.4	2.8	3.3	0.7	9.0	7.9
admissions for heroin use (irrespective of the route of administration)	80	15	15	20	096	84	41	1.9	6.5	7.8	5.9	2.0	9.6	8.9
admissions for SNPP (irrespective of the route of administration)							48							2.3

Source: NAA ¹²⁹

Case distribution analysed by referral source shows:

- drug users demanded treatment on their own will or were referred to treatment through the health system (family/general practitioners, hospital, emergency unit or another treatment centre), and rarely by other social services or through the justice/probation/police system; family/friends acting as facilitators is less common;
- by gender: if in previous years mainly male users demanded treatment on their own will and female users were referred by the health system, in 2010, most referrals were made by the health system for both genders (family/general practitioners, hospital, emergency unit or another treatment centre).

Graph no. 5-12: Evolution of in-patient treatment admission, by source of referral and gender of user, 2008-2010 (%)



Source: NAA ¹³⁰

The data reported for the year 2010 by the treatment centres of the Ministry of Health, for the indicator *Drug Treatment Admission*, provided information about the unemployment rate among drug users, upon treatment admission:

- 11.2% were highschool or university students;

¹²⁹ Based on data reported by CNOASIIDS

¹³⁰ Based on data reported by CNOASIIDS

- 13.3% were employed (contract over a limited or unlimited period of time),
- and 70.4% were unemployed/without occupation (53.4%), economically inactive (14.1% - retired or housewives) or working without having signed an employment agreement¹³¹ (2.9%)¹³².

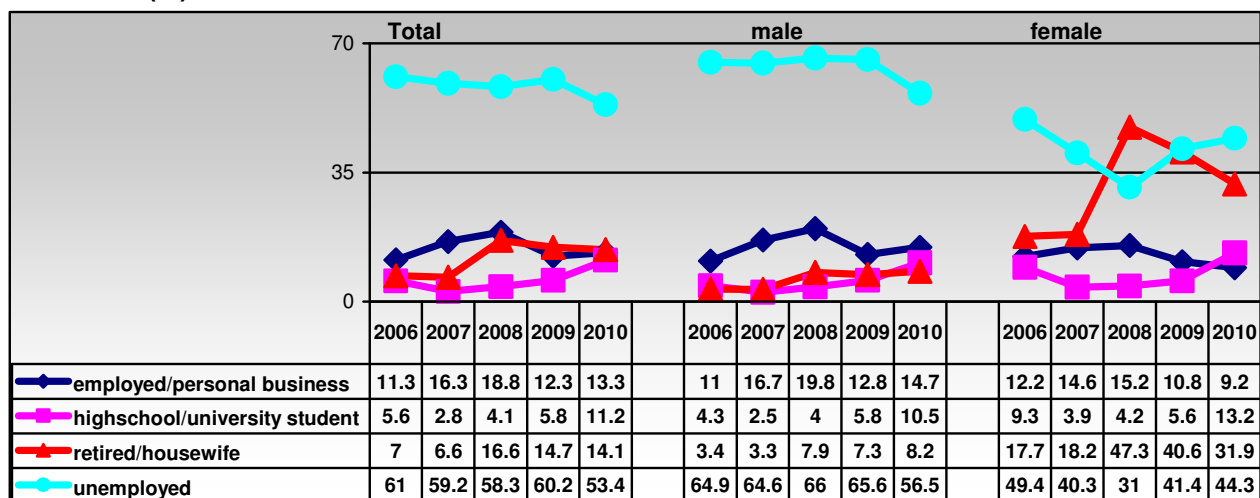
As compared to the past year, the rate of unemployed people decreased (from 60.2% to 53.4%) as well as of the economically inactive (from 14.7% to 14.1%) while the rate of people with a contract or personal business increased by 1% as did the rate of those included in a form of education by 5.4% (the decrease of the mean age and increase of the rate of people under 20 who demanded treatment for drug use in 2010 are factors favouring this situation; see chart no. 5-7).

According to the gender and occupation variables the following conclusions are valid for 2010:

- 56.5% of the male users are unoccupied/unemployed, 14.7% have a job, 8.2% are economically inactive and 10.5% are highschool or university students¹³³;
- 44.3% of the female users are not occupied/unemployed, and 31.9% are economically inactive, while only 9.2% have a job and 13.2% are highschool or university students¹³⁴.

Analysing the social consequences of drug use, in 2010 it was noticed that both the share of employed and the share of unemployed/unoccupied people is higher among male users than female users, the latter apparently compensating with a higher proportion of economically inactive or people in an education system (highschool or university students).

Graph no. 5-13: Distribution of in-patient treatment admissions, by employment and gender, in 2006- 2010 (%)



Note: other cases/not specified make up the difference up to 100%

Source: NAA¹³⁵

Of the total number of people in inpatient drug treatment units of the Ministry of Health in 2010, 3.2% had never attended school nor completed primary education, almost half of them (47%) completed vocational schools at most, one third (32.7%) completed average education and 7.6% completed higher education.

As compared to previous years:

- as compared to 2009 – there is a stable rate of the users with a low education level, there is an increasing level of those with average or higher education level and the rate of users with completed vocational studies at the most decreases (from 63.4% to 47%);
- as compared to 2005 - increasing rate of users with a low/very low education level or higher education and a dropping ratio of users with an average education as compared to the situation as it was in 2005.

¹³¹ Which implies the lack of social or health insurances

¹³² Other situation/not specified accounts for the difference up to 5.1%

¹³³ 3.8% - works without a contract and 6.4% - other situation/not specified

¹³⁴ 1.4% - not specified

¹³⁵ Based on data reported by CNOASIIDS

Table no. 5-10: Distribution of admissions to in-patient treatment by education and gender, 2005, 2008, 2009 and 2010 (%)

	Total				Male users				Female users			
Level of education	2005	2008	2009	2010	2005	2008	2009	2010	2005	2008	2009	2010
has never attended school/has not completed elementary school	0	3.7	3.7	3.2	0	4.1	4.1	3.6	0	2.4	2.4	2
primary/secondary/vocational studies	31.8	48.8	63.4	47.0	34.9	51.6	65.0	49.8	24.3	38.7	57.8	38.8
Graduate/undergraduate studies	48.2	36.9	25.5	32.7	43.7	35.2	23.8	28.4	58.8	43.2	31.5	45.4
Higher/post-university studies	5.9	8.0	3.9	7.6	5.7	6.4	3.4	6.3	6.2	13.7	5.6	11.5
Not specified	14.2	2.6	3.5	9.5	15.7	2.7	3.7	11.9	10.6	2.1	2.8	2.3
Total	100	100	100	100	100	100	100	100	100	100	100	100

Source: NAA ¹³⁶

The gender distribution of the users admitted to treatment shows that women have a higher level of education. Thus, as indicated below, the rate of those who:

- had never attended school or have completed primary education – is almost double for men than women, and vocational studies have completed almost half of the male drug users and only a third of the female users;
- have an average education level amounts to 45.4% among women and only 28.4% among men, and a higher level of education - of 11.5% among women and of only 6.3% among men.

Considering housing conditions in 2010, almost two thirds of the drug users admitted to outpatient drug treatment lived with their parents, 17.7% lived with their partners/partner and children, 10.3% lived alone or with children, 0.7% with friends and 8% in other locations or the housing status was not specified. The gender distribution of the users admitted to outpatient treatment, according to their housing conditions, was different:

- two out of three male users (67.7%) and only three in 5 female users (58.3%) lived with their parents;
- over one in ten male users (13.6%) and over a fifth of male users (21.8%) lived with a partner or a partner and children;
- 8.5% of the male users and 15.5% of the female users lived alone or together with children.

Against the situation as it was one year ago and five years ago, it becomes obvious that:

- For all subjects – there is an increase of the users that live alone or only with children (2005 – 7.3%, 2009-8.2% and 2010 – 10.3%) and a dropping percentage of those who live only with a partner or with partner and children (2005 – 26.3%, 2009 – 20.6% and 2010 – 15.7%),
- For male subjects – there is a dropping percentage of those who live only with a partner or with a partner and children (2005 – 20.1%, 2009 -15.8% and 2010 – 13.6%);
- For female subjects – there is a dropping percentage of those who live only with a partner or with a partner and children (2005 – 41.2%, 2009 – 37.4% and 2010 – 21.8%) and an increasing percentage of those who live with parents or family (2005 – 37.2%, 2009 – 39.,8% and 2010 – 58.3%), either single or as single parents (2005 – 9.7%, 2009 – 15.2% and 2010 – 15.5%).

¹³⁶ Based on data reported by CNOASIIDS

Table no. 5-11: Distribution of admissions to inpatient treatment by housing and gender, 2005, 2008, 2009 and 2010 (%)

Housing	Total				Male users				Female users			
	2005	2008	2009	2010	2005	2008	2009	2010	2005	2008	2009	2010
With parents and family	54.1	66.4	65.6	65.4	61.1	74.4	73.0	67.7	37.2	38.1	39.8	58.3
only with a partner	26.3	11.2	11.9	8.6	20.1	8.1	8.8	7.1	41.2	22.3	22.7	12.9
with a partner and children	0	9.1	8.7	7.1	0	6.2	7.0	6.5	0.0	19.6	14.7	8.9
single	7.3	6.1	6.7	9.1	6.4	5.2	5.7	8.1	9.7	9.2	10.4	12.1
single parent	0	1.3	1.5	1.2	0	0.4	0.6	0.4	0.0	4.5	4.8	3.4
with friends	0.6	0.7	1.2	0.7	0.6	0.7	1.0	0.7	0.4	0.6	1.6	0.9
other cases	7.0	2.5	2.1	1.5	6.8	3.0	2.1	1.5	7.3	0.9	2.4	1.4
not specified	4.7	2.7	2.2	6.5	5.0	2.1	1.8	8	4.2	4.8	3.6	2.0
Total	100	100	100	100	100	100	100	100	100	100	100	100

Source: NAA ¹³⁷

Profile of the persons admitted to inpatient treatment following drug use/addiction (in MH treatment centres)

According to the main drug which has been used¹³⁸, the statistical data for 2010 indicate the following profile of the persons admitted to addiction treatment caused by the use of:

Heroin - male, aged between 20 and 29 (67.5%), using heroin daily (90.1%), and by injection (99.1%). Also uses, as a secondary drug, mainly SNPP, and other opiates (mainly methadone), hypnotics and sedatives (mostly benzodiazepines) and, at lower levels, cannabis, cocaine and amphetamines. The onset age ranges between 15 and 19 for 40% of them and for 20.4% it ranges between 20 and 24. Most of them have been treated before (76%) and demand treatment mainly on their own (64.5%) or following doctor's recommendation (17.3%). They have stable housing (91.2%), live with parents or family (75.9%), a low education level (48.4% completed secondary education) and are generally unemployed (68.9%).

SNPP (new psychoactive substances sold under the name of "ethnobotanical plants") - male, aged under 29 (77.4%). Most of them (62%) started SNPP use in 2010, and the onset age is under 19 for 21.5%, between 20 and 24 for 28.8% and 25 and 29 years of age for 28.3%. He uses SNPP daily (60%), mainly by injection and orally, and as secondary drug he uses opiates (mostly heroin), other SNPP and cannabis, and in lower amounts hypnotics and sedatives (mostly benzodiazepines), alcohol, hallucinogens, stimulants and cocaine. He demands treatment following referral from emergency services (54.6%) or personal initiative (20.1%) or upon the recommendation of the family doctor (12.8%). Over half of these users (50.2%) demand treatment for the first time. They have a low education level (43.7% completed secondary education at most), have no occupation (54.3%), are highschool or university students (16.5%), generally have stable housing (81.5%) and live together with parents or their own family (71.2%) or alone (7.3%).

Hypnotics and sedatives - female, aged over 35 (89%), with daily oral use of drugs, especially benzodiazepines (59.2%) (e.g. Alprazolam, Diazepam, Medazepam, Nitrazepam, Rivotril, Tranxene and Xanax). Half of them are first treatment admission and demand treatment at their own will (32.9%) or following referral by the family doctor (30.3%) or psychiatric services (18.4%). She would start using drugs when over 30 years old, has an average education level (43.4%) or high (21%), is a housewife/retired (71%) or has no occupation (10.5%), lives with partner and children (25%)/ only with partner (23.7%) or alone (21%) and has stable housing (93.4%).

Cannabis - male, aged between 15 and 34 (95%), also using other drugs in small amounts. The male user graduated vocational school (24.6%) or high school (50.9%), has no occupation (45.6%) or is a highschool or university student (26.3%). The onset age is under 29. He smokes/inhales marijuana

¹³⁷ Based on data reported by CNOASIIDS

¹³⁸ There is a low number of cases for other types of drugs: volatile substances – 1.6%, cocaine -1%, stimulants and hallucinogens – less than 1%

several times a week and demands treatment for the first time (78.9%). He is referred by emergency services (40.4%), but can also demand treatment on his own will (22.8%) or referred by family/friends (15.8%) or the family physician (10.5%). Generally, they have stable housing (86%) and live together with parents and family (66.7%) or alone (15.8%).

B. Distribution of admission to outpatient treatment following illicit drug use

761 users of illicit drugs and new psychoactive substances (*sold under the name of "ethnobotanical plants"*) demanded out-patient¹³⁹ treatment following drug use¹⁴⁰, in 2010. The analysis of the incidence of treatment admissions in the reference year in comparison to previous years shows:

- increasing numbers of people admitted to treatment,
- dropping rate of first treatment admissions and of male users admitted to treatment,
- increasing rate of people re-admitted to treatment and female users admitted to treatment.

Table no. 5-12: Out-patient treatment admission for illicit drug use, 2007-2010

		2007		2008		2009		2010	
		No.	%	No.	%	No.	%	No.	%
Total		495	100	440	100	536	100	761	100
of which*	First admission	468	94.5	412	93.6	450	83.9	591	77.7
	relapse	16	3.2	17	3.9	81	15.1	162	21.3
	male	451	91.1	387	88.6	452	84.8	610	80.2
	female	44	8.9	50	11.4	81	15.2	131	17.2

Note: for cases up to 100%, the characteristic was not specified

Source: NAA¹⁴¹

The comparative analysis of out-patient treatment admissions from 2007 to 2010 reveals the following:

- the first vs. repeated admissions ratio is below 1 for people in in-patient treatment and over 1 for people in out-patient treatment, with a slightly dropping tendency; the recently available treatment in out-patient settings might be a possible cause;
- male/female ratio – is below 1 in both cases, but with higher values and a dropping trend among people admitted to out-patient treatment.

Table no. 5-13: Ratio between first/repeated admissions from 2007 to 2010

Type of admission		2007	2008	2009	2010
In-patient setting	First/repeated admissions	0.9:1	0.8:1	0.9:1	0.9:1
	Male/female ratio	3.5:1	3.5:1	3.5:1	3:1
Out-patient setting	First/repeated admissions	29.3:1	24.2:1	5.6:1	3.6:1
	Male/female ratio	10.3:1	7.7:1	5.6:1	4.7:1

Source: NAA¹⁴²

The territorial distribution of users, who have benefited from drug treatment in a hospitalised setting, shows most of these users are concentrated mainly in the Municipality of Bucharest – 67.8% of the treatment demands (decreasing as compared to 2009: 75.7% of the treatment demands and increasing than in previous years: 2008 – 43.6% and 2007 – 41%).

According to the main drug of abuse, in 2010, 69.5% of the drug users have demanded treatment for opiate addiction, 13.3% for cannabis, 9.6% for other substances (SNPP – new psychoactive substances sold as "ethno-botanical plants"), 2.5% for inhalants, 2.5% for stimulants, 1.3% for cocaine, and 1.3% for other substances (hallucinogens and hypnotics and sedatives).

¹³⁹ NAA (DPECC and IACC), Arena, PSYMOTION and ANIT and centres of MH (Mental Health Laboratory, Psychiatry hospital TITAN „Dr. Constantin Gorgos")

¹⁴⁰ 1570 people were reported at national level, of which 761 for illicit drugs and new psychoactive substances and 809 for alcohol and tobacco, as main drug, that have been treated by the DPECC

¹⁴¹ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

¹⁴² Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

Table no. 5-14: Distribution of admissions to out-patient treatment by main drug of abuse, 2007- 2010 (%)

	2007	2008	2009	2010
opiates	79.4	74.3	84.0	69.5
cannabis	15.8	19.3	11.0	13.3
other substances (SNPP)	0.2	0.2	0.2	9.6
inhalants	0.8	1.1	1.1	2.5
stimulants	1.2	3.2	0.4	2.5
cocaine	1.4	1.6	2.2	1.3
hallucinogens	0.2	0.2	0.9	0.9
hypnotics and sedatives	1.0	0.0	0.2	0.4
Total - %	100	100	100	100
Total – no of persons	495	440	536	761

Source: NAA¹⁴³

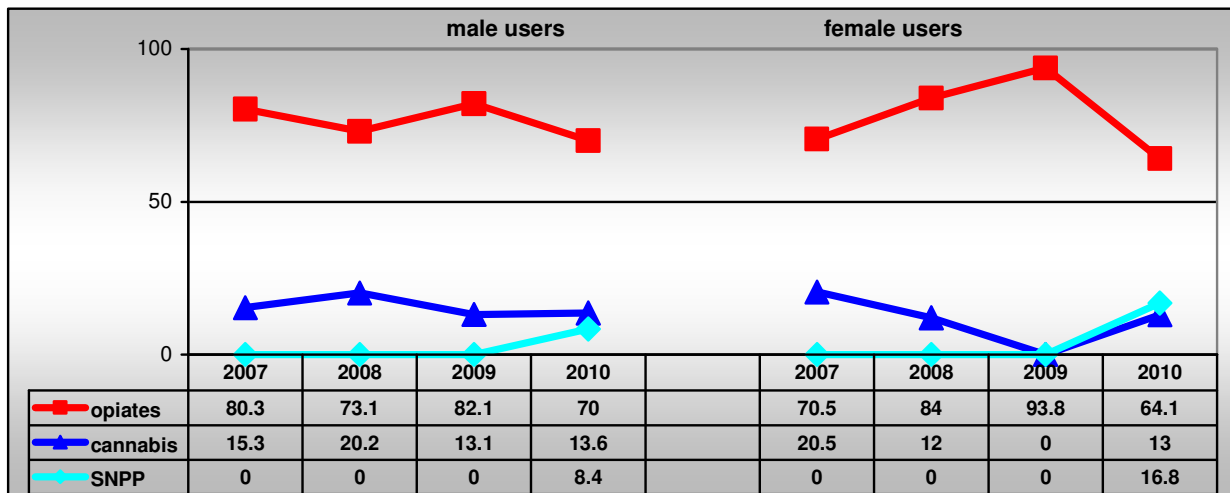
Comparable to in-patient treatment admissions, out-patient treatment admissions in 2010 show drugs use is likely to diversify. Thus, considering out-patient treatment admissions:

- one in 10 people demanded treatment for the new psychoactive substances sold as “ethno-botanical plants”¹⁴⁴ in 2010, which is different from the time interval 2007-2009 when SNPP was unheard of among treatment demands,
- opiates and cocaine treatment admissions decreased as compared to 2009, while the demands for treatment following cannabis, inhalants, stimulants, hypnotics and sedatives increased.

The trend of treatment admissions from 2002 to 2010, by gender and drug category, shows that:

- for in-patient treatment admissions – if by 2009 male users showed predominantly heroin use and female users who demanded treatment recorded levels similar to demands for heroin addiction, hypnotics and sedatives use and the use of other substances, in 2011 heroin and SNPP use becomes a feature of male users and, in a similar manner, the use of heroin, hypnotics and sedatives and SNPP became characteristic for female users,
- for out-patient treatment admissions – there is a similar pattern for both genders: heroin as the most frequent drug followed by cannabis by the year 2009, while in 2010 prevailed heroin followed by cannabis and SNPP.

Graph no. 5-14: Trend of out-patient treatment admission for opiates, cannabis and new psychoactive substances addiction by gender, 2007-2010



Source: NAA¹⁴⁵

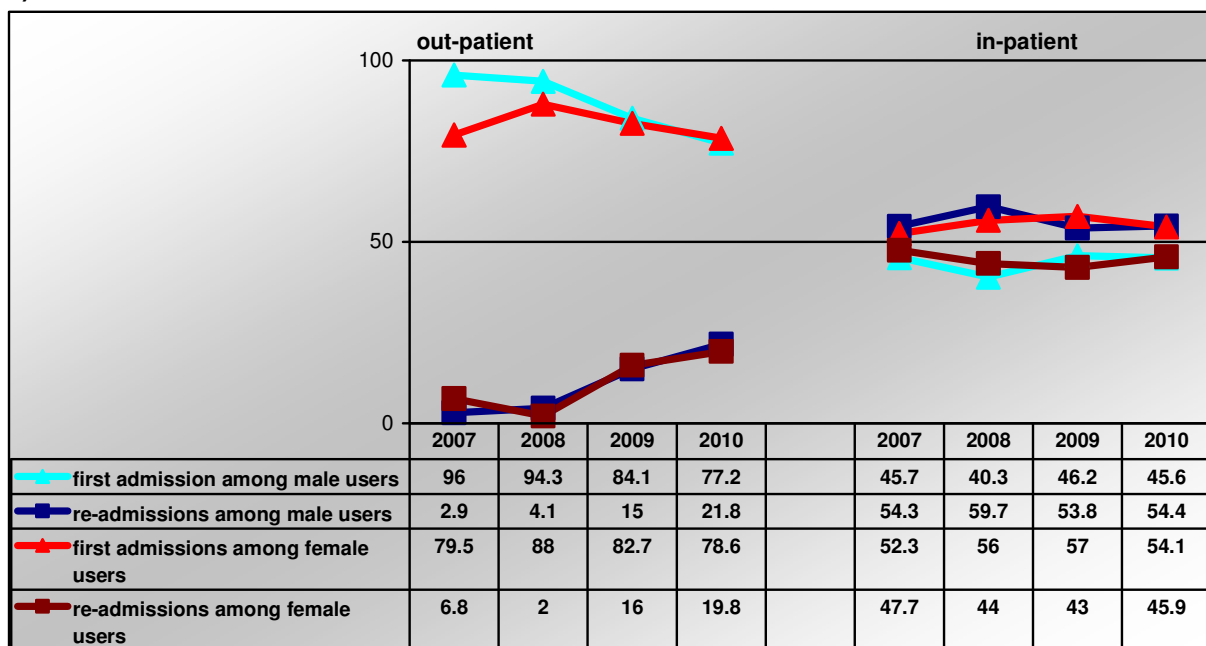
¹⁴³ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

¹⁴⁴ CATANA, CHILL, Magic, Pure By Magic, Special Gold, Spice, Stone, Pure by Magic (sold as bath salt, plant fertiliser and aromatherapy)

Considering the progress of treatment admissions from 2007 to 2010, by gender and type of admission, it can be stated that:

- for in-patient treatment admission – first treatment admissions are lower than re-admissions among male users, while the situation is completely inverted among female users;
- for out-patient treatment admissions – the pattern is similar for both genders: more first admissions than re-admissions and a continuously smaller difference.

Graph no. 5- 15: Trend in treatment admissions for psychoactive substance use by type of care (out-patient/in-patient), type of admission (first/repeat admission) and gender, 2002 -2010 (%)



Source: NAA¹⁴⁶

The following hypothesis can be outlined based on data analysis:

- 1. increase of drug use among women, for both in-patient and out-patient treatment the rate of first treatment demands exceeded re-admissions or 2. gender differences between first treatment admissions and re-admissions are the result of “drug use” preferences: male users prefer heroin (long-term use) and SNPP, and treatment admissions among female users is diversified: for heroin, hypnotics and sedatives, SNPP, cannabis and other substances;
- 2. the out-patient treatment system begins to strengthen and attract beneficiaries with longer drug-use records, while the treatment facilities in both systems almost reach maximum capacity and are unable to offer but limited treatment to those who never demanded treatment before, if we consider the waiting lists.

In 2010, the distribution of out-patient treatment admissions by the user's age shows the following:

- more than a third (35.9%) of the total treatment admissions were for people up to 24 years of age and another third was for people aged 25 to 29; the mean age was 26.4 (dropping as compared to the past year – 27 years) and 3-years higher than for male users (26.8 years while 23.8 years for women) and 7-years lower than for SNPP treatment admissions (all drugs – 26.4 years, SNPP – 19.1 years);
- for male users: treatment admissions for all drugs was higher in the age group 25-59 (65.2% as compared to 44.3% - women); 20.1 was the mean age for SNPP treatment admissions and the rate of treatment admissions was higher in the age group 20-39 (41.2% comparing to 13.6% - women); the youngest minimal age was recorded for users of volatile inhalants and the oldest for cocaine users; the youngest mean age – hallucinogens and the oldest for cocaine;

¹⁴⁵ Based on data provided by DPECC/IACC, PYMOTION, Arena and MH centres

¹⁴⁶ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and CNOASIIDS (MH centres)

- for female users: treatment admissions for all drugs was higher for users up to 24 years of age (54.2% as compared to 32.8% - men); all SNPP female users were under the age of 24 (mean age 16.9); the youngest minimal age – SNPP and the oldest – benzodiazepines; the youngest mean age – volatile inhalants and the oldest – opiates.

Table no. 5-15: Out-patient treatment admission distribution, by age, type of drugs and gender, 2010 (%)

		<15 years	15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years	50-54 years	55-59 years	Mean age
Total admission	Total	0.8	12.6	22.5	33.6	20.1	5.8	1.6	0.4	0.1	0.1	26.4
	Male	0.7	10.2	22.0	35.7	21.0	6.1	1.6	0.5	0.2	0.2	26.8
	Female	1.5	26.0	26.7	24.4	15.3	3.8	0.8	0	0	0	23.8
SNPP admissions only	Total	4.1	58.9	21.9	8.2	1.4	1.4	0	0	0	0	19.1
	Male	2.0	52.9	25.5	11.8	2.0	2.0	0	0	0	0	20.1
	Female	9.1	72.7	13.6	0	0	0	0	0	0	0	16.9

Note: for cases up to 100%, the characteristic was not specified, and mean age was computed based on cases for which age was specified

Source: NAA¹⁴⁷

Table no. 5-16: Out-patient treatment admission distribution, by age (minimal and mean), type of drug and gender, 2010

Type of drug	Minimal age (years)		Mean age (years)	
	male	female	male	female
New psychoactive substances (SNPP)	14	13	20.1	16.9
Volatile inhalants	11	15	19.1	15.5
cocaine	24	18	30.5	22
cannabis	16	15	24.4	20.3
opiates	16	17	28.6	26.5
hallucinogens	16	16	18.3	16
stimulants	17	18	23.3	18.5
Hypnotics and sedatives (benzodiazepines)	20	34	30	34

Source: NAA¹⁴⁸

By comparison to previous years there is an increase of the share of people under 19 years of age and in the age group 30-39, and a decreasing share of people aged 20 to 29 and over 40.

Table no. 5-17: Distribution of admissions to out-patient treatment by age group, 2007-2010 (%)

Year	Age group (years)							Mean age (years)
	<15	15-19	20-24	25-29	30-34	35-39	>=40	
2007	0.4	8.9	32.3	36.6	13.5	4.2	2.0	20
2008	0.0	5.7	31.8	31.6	19.3	7.5	2.7	27.1
2009	0.4	6.5	27.2	37.9	18.7	4.9	3.5	27
2010	0.8	12.6	22.5	33.6	20.1	5.8	2.2	26.4

Note: for cases up to 100%, the characteristic was not specified, and mean age was computed based on cases for which age was specified

Source: NAA¹⁴⁹

By comparison to in-patient admissions, out-patient treatment admissions show:

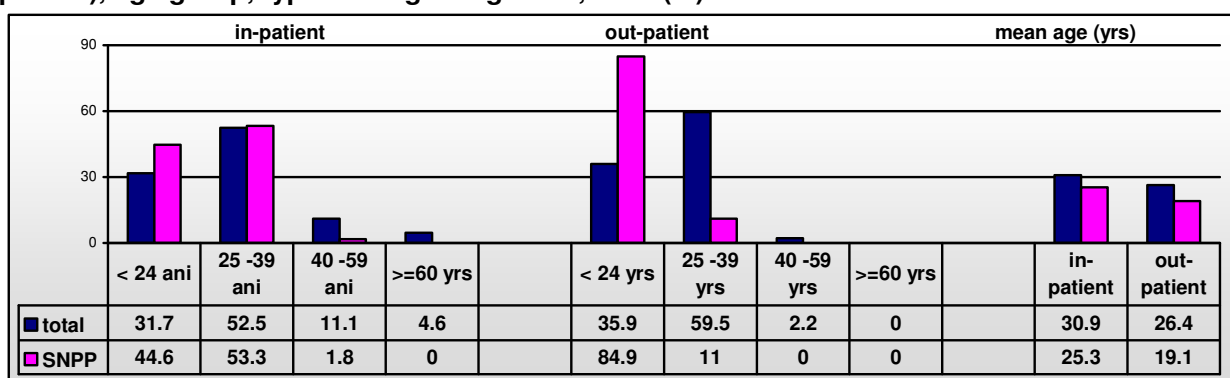
- a lower maximum age for all drugs (in-patient: >=65 years, out-patient< 59 years) and for SNPP (in-patient: < 59 years, out-patient: < 39 years),
- a lower mean age for all drugs (in-patient: 30.9 years, out-patient< 26.4 years) and for SNPP (in-patient: 25.3 years and out-patient: 19.1 years).

¹⁴⁷ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

¹⁴⁸ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

¹⁴⁹ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

Graph no. 5-16: Distribution of drug treatment admission, by type of treatment (out-patient/in-patient), age group, type of drug and gender, 2010 (%)



Source: NAA¹⁵⁰

The distribution by drug use onset age reveals an increase of the rate of early onset (age under 15) and between 15 and 19 and a decreasing rate of drug use onset in ages over 20.

Table no. 5-18: Distribution of out-patient drug treatment admission, by onset age, 2007-2010 (%)

Year	Age group (years)				
	<15	15-19	20-24	25-29	>=30
2007	10.5	42.0	25.3	7.7	5.9
2008	11.1	43.0	25.0	10.5	5.0
2009	12.5	41.2	25.4	7.5	3.0
2010	14.6	46.4	23.4	6.2	3.0

Note: for cases up to 100%, the characteristic was not specified

Source: NAA¹⁵¹

Considering the onset age¹⁵² and type of drug it can be noticed that:

- in 2009 – 82.6% of the treatment admissions were for opiates use and of the 400 cases, 398 were cases of drug use record of more than one year;
- in 2010 – only 68.8% were opiate users (most of them had a drug use history of at least 2 years) and 9.6% were SNPP users (of which almost 4/5 started drug use before 2010).

By comparison to in-patient treatment admissions, the situation is similar except for SNPP treatment admission in 2010:

- admissions for in-patient treatment – 61.6% started drug use in 2010,
- admissions for out-patient treatment – 80% started drug use before 2010.

Of the total treatment admissions, 36.5% reported poly-use of psychoactive substances. The most frequent secondary drugs were: SNPP (102 cases), other substances (39 cases), cannabis (36 cases), opiates (methadone – 27 cases and other opiates – 6 cases), hypnotics and sedatives (25 cases) and cocaine (18 cases). Polydrug use is most frequent among heroin users (173 cases – 62.2%) and cannabis (45 cases). By comparison to previous years there is an increasing range of people who used a secondary drug and a tendency to change it (increase of SNPP as secondary drug, of other substances, cannabis and cocaine, stimulants, hypnotics and sedatives and alcohol and decrease of methadone).

¹⁵⁰ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

¹⁵¹ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

¹⁵² The cases for which onset age was mentioned were considered (2009 - 484 and 2010 – 728 cases)

Table no. 5-19: Progress of out-patient treatment admissions, by age of onset and type of drug, 2009-2010

	code_main_drug		Onset year			Total	
			before 2009	2009	2010	No.	%
Treatment admissions in 2009	Opiates		398	2		400	82.6
	Cocaine		12	0		12	2.5
	Stimulants		2	0		2	0.4
	Hypnotics and sedatives		0	1		1	0.2
	hallucinogens		5	0		5	1.0
	Volatile inhalants		5	1		6	1.2
	cannabis		55	2		57	11.8
	Other substances		1	0		1	0.2
	Total	No.	478	6		484	100
		%	98.8	1.2		100	
Treatment admissions in 2010	Opiates		492	5	4	501	68.8
	Cocaine		7	1	2	10	1.4
	Stimulants		4	14	1	19	2.6
	Hypnotics and sedatives		2	0	1	3	0.4
	hallucinogens		2	5	0	7	1.0
	Volatile inhalants		12	6	1	19	2.6
	cannabis		79	18	2	99	13.6
	SNPP		16	40	14	70	9.6
	Total		614	89	25	728	100
			84.3	12.2	3.4	100	

Note: The cases for which the onset age was mentioned were considered (2009 - 484 and 2010 – 728 cases)

Source: NAA¹⁵³

The ratio of treatment admissions for which polydrug use was recorded had similar values by type of admission (in-patient – 33.8%, out-patient – 36.5%). SNPP and other substances are most frequently used as secondary drugs, and considering the main drug for which treatment was demanded, opiates were recorded the highest rates as secondary drug. Data examination showed:

- in-patient treatment – by comparison to past years there is a dropping rate of people using a secondary drug; opiates and hypnotic and sedative substances were most frequently used as secondary drug;
- out-patient treatment - by comparison to past years there is a increasing rate of people using a secondary drug; cannabis and cocaine were most frequently used as secondary drugs.

Table no. 5-20: Distribution of out-patient treatment admissions, for patients who reported the use of a main and secondary drug, 2007-2010 (no. of people)

		Second drug				Main drug			
		2007	2008	2009	2010	2007	2008	2009	2010
opiates (total)		20	64	41	33	57	30	95	173
Of which	heroin	2	63	2	2	47	2	91	173
	methadone	16	0	33	27	0	27	2	0
	Other opiates	2	1	6	4	10	1	2	0
cocaine (total)		12	0	13	18	0	12	5	2
stimulants (total)		0	2	10	13	2	7	1	12
Hypnotics and sedatives (total)		0	0	21	25	1	3	1	0
hallucinogens (total)		0	0	1	0	1	1	3	5
Inhalants		0	0	0	1	4	1	4	11
cannabis (total)		18	8	17	36	9	17	17	45
alcohol		16	1	3	11	-	-	-	-
Other substances		9	0	24	39	1	4	5	0
SNPP		0	0	1	102	0	0	0	30
Total		75	75	131	278	75	75	131	278
total admitteri		495	440	536	761	495	440	536	761
% din total admitteri		15.2	17.0	24.4	36.5	15.2	17.0	24.4	36.5

Source: NAA¹⁵⁴

¹⁵³ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

According to the frequency of use, case distribution in 2010 shows over half of the users used drugs daily and almost ¼ occasionally. By comparing to the situation in 2009, there is a decrease in the frequency of use (daily use decreases and weekly/monthly use increases). By comparing to in-patient admissions, although daily use is present in both cases, low frequency use accounts for higher rates in in-patient settings (e.g. occasional, in 2010: in-patient – 2.9%, out-patient – 23.5%, once a week or less, in 2010: in-patient – 7.3%, out-patient – 10.4%).

Table no. 5-21: Out-patient treatment admissions by frequency of drug use, 2007-2010 (%)

	No use in the last month/occasional	Once a week or less	2-6 days/ week	daily
2007	36.0	6.1	7.7	43.6
2008	34.1	7.3	8.0	43.2
2009	23.5	7.3	9.5	55.0
2010	23.5	10.4	12.4	51.9

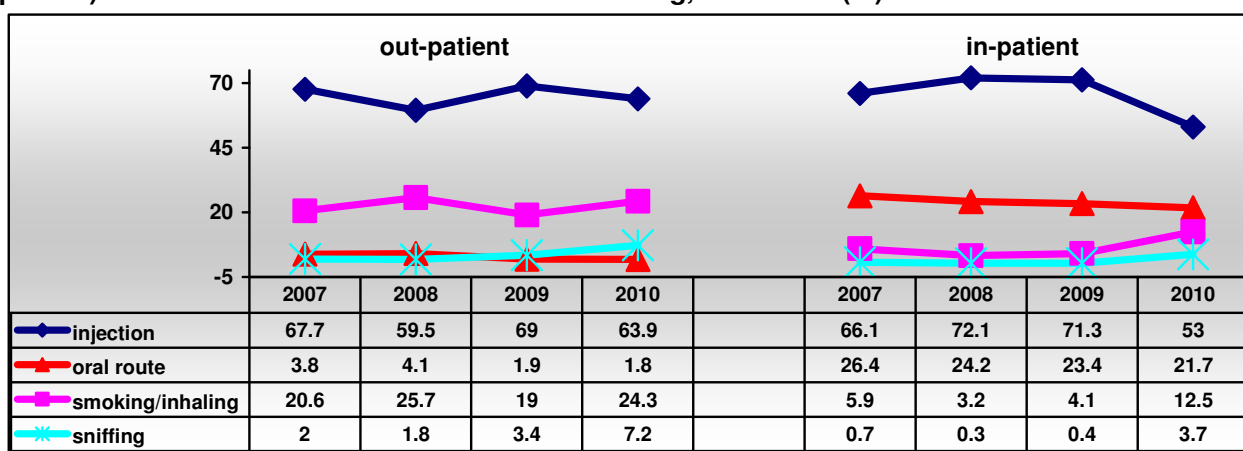
Note: for cases up to 100%, the characteristic was not specified

Source: NAA¹⁵⁵

According to the administration route of the main drug it should be noticed that:

- although decreasing as compared to 2009, intravenous route prevails. Heroin is the most frequently injected substance in the reference year (98.8%).
- smoking/inhaling follow in rank, as it is increasing than in the last year. Cannabis (53.5%), opiates (19.5%) and SNPP (15.1%) are most frequently used by smoking/inhaling in the reference year.
- the least used are sniffing (7.2%, but still double the level of 2009) and oral administration (1.8%).
- by gender: injecting route prevails among male users, while smoking, sniffing and oral administration are frequent among female users. They account for higher rates as compared to in-patient treatment admissions and there is a bigger gender difference in terms of oral administration of drugs, while for out-patient settings, higher rates are recorded among female drug users and between genders in terms of sniffing.
- Comparing to 2009, smoking/inhaling and sniffing increased. Cannabis (85.7%), volatile inhalants (81.8%) are most frequently used by smoking/inhaling and cocaine (35.7%) by sniffing in the reference year.

Graph no. 5-17: Evolution of treatment admissions by type of admission (in-patient/out-patient) and route of administration of the main drug, 2007-2010 (%)



Note: other and unspecified cases make up the difference up to 100%

Source: NAA¹⁵⁶

- As compared to out-patient treatment admission: injection remains the most frequent administration route (because most admissions were for opiates, for both types of treatment: out-patient – 70%, in-patient – 42%). Differences exist between oral administration, smoking/inhaling and sniffing, that can be explained by the ratio of the other types of drugs for which care was

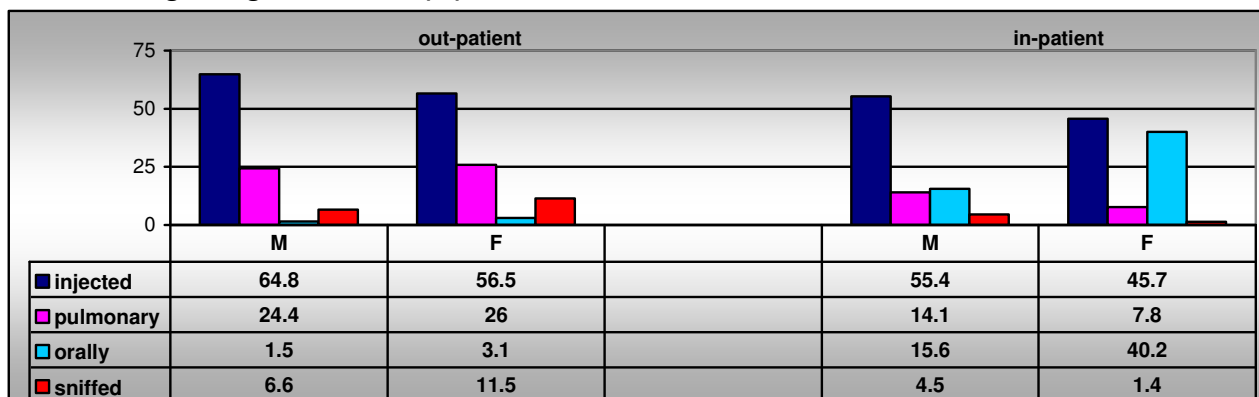
¹⁵⁴ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

¹⁵⁵ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

¹⁵⁶ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

provided (out-patient: cannabis – 13% and SNPP – 10%, and in-patient: SNPP – 32.3%, hypnotics and sedatives – 8.7% and cannabis – 5%). SNPP have the main influence because in case of in-patient admissions they were injected up to 55%, smoked – 16.7%, used orally – 10% and sniffed – 8%, and in the case of out-patient care: sniffed – 46.6%, smoked/inhaled – 38.4%, used orally – 5.5% and injected – 1.4%.

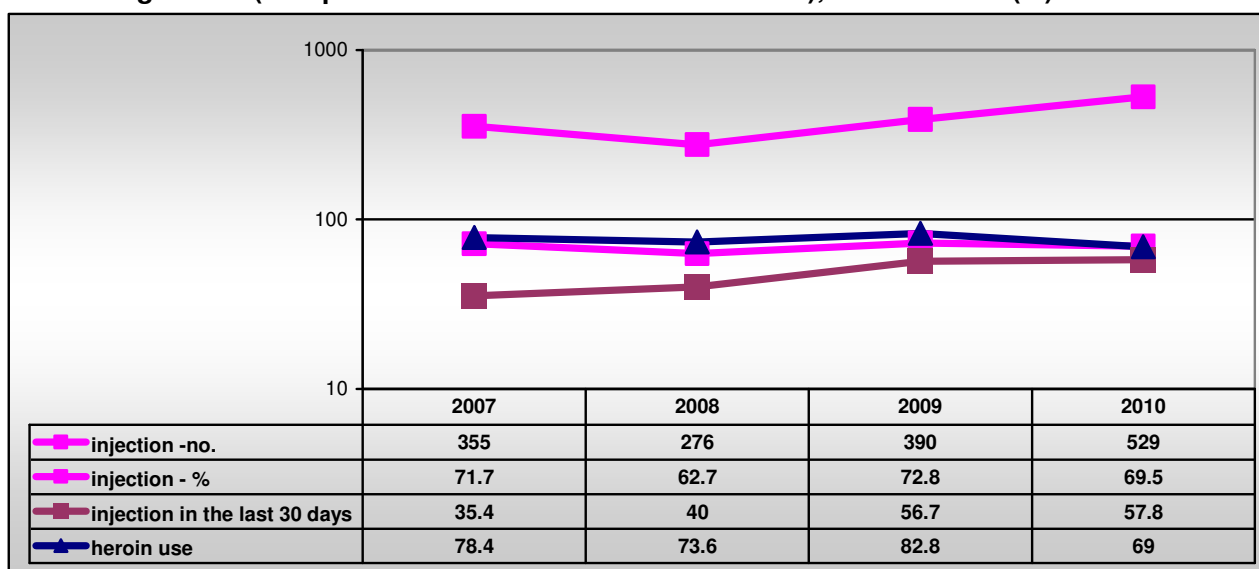
Graph no. 5-18: Evolution of treatment admissions by type of care, route of administration of the main drug and gender, 2010 (%)



Note: other and unspecified cases make up the difference up to 100%

Source: NAA ¹⁵⁷

Graph no. 5-19: Evolution of out-patient treatment admissions: total number, for drug users with drug injection history (all drugs) and recent injection record (in the last 30 days) and of those using heroin (irrespective of the route of administration), in 2007- 2010 (%)



Source: NAA ¹⁵⁸

Regarding the proportion of drug users with an injection history, irrespective of the type of used drug, for the injecting drug use pattern it was determined that:

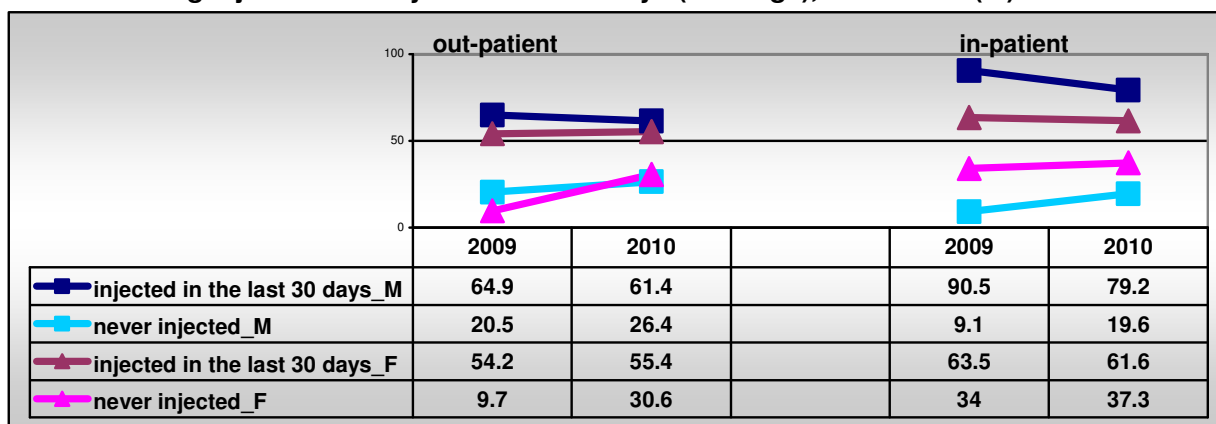
- by difference to 2009, although the number of persons using injecting drugs increased, their rate is lower;
- by difference to 2007, the rate (and number) of those using injecting drugs increased,
- the rate of those using injecting drugs in the last 30 days increased steadily from 2007 to 2010.

¹⁵⁷ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

¹⁵⁸ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

Alike in-patient treatment admissions, the ratio of injecting drug users in the last 30 days increased steadily from 2007 to 2010 and the progress of injecting use is significantly influenced by the evolution of treatment admissions for heroin use (mainly by injection route) and less by the use of other substances.

Graph no. 5-20: Evolution of treatment admissions by type of admission and gender for drug users with drug injection history in the last 30 days (all drugs), 2009- 2010 (%)

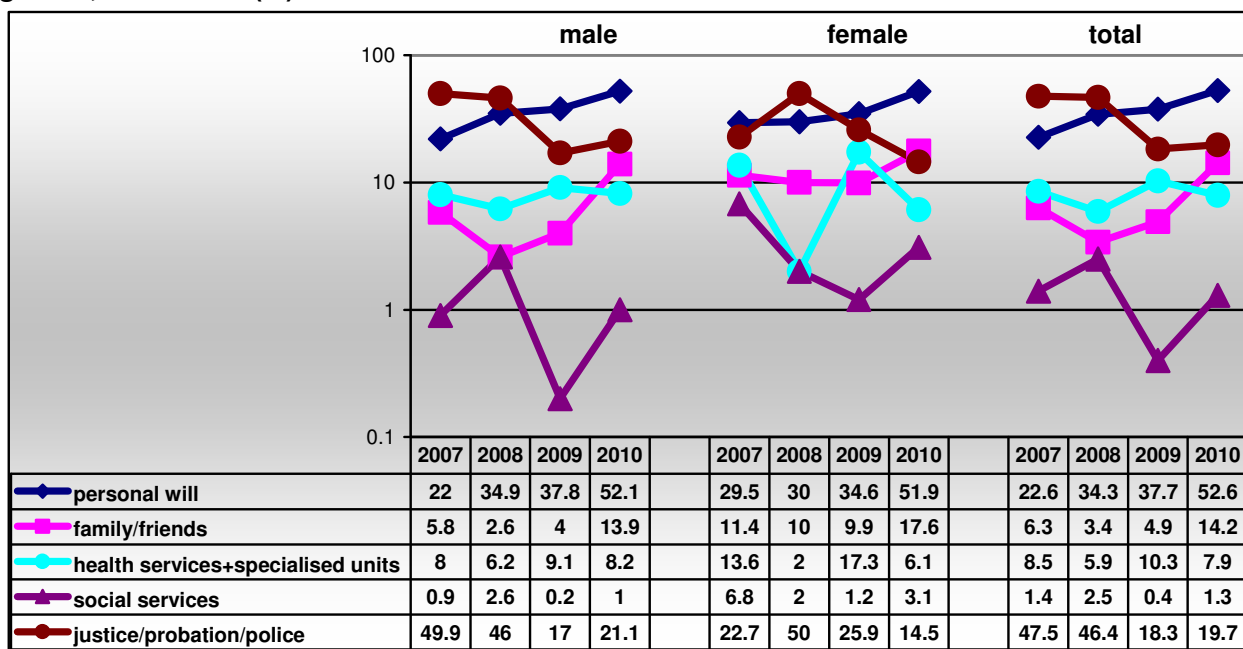


Note: only those cases for which the value was specified were computed, and the rate of those, who injected but not in the last 30 days, make up for the rest up to 100%

Source: NAA ¹⁵⁹

Additionally, by type of admission, there are higher injection rates in the last 30 days for both genders among people admitted to in-patient treatment, and by comparing to previous year, there is a slight increase for female users attended to in out-patient settings (with a decrease of the rate of those with an injection history, but not in the last 30 days) although there are overall increases of those who never injected for both types of admissions and genders.

Graph no. 5-21: Evolution of out-patient treatment admissions by source of referral and gender, 2007- 2010 (%)



Note: other and unspecified cases make up the difference up to 100%

Source: NAA ¹⁶⁰

¹⁵⁹ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

¹⁶⁰ Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

The case distribution analysed by referral source showed:

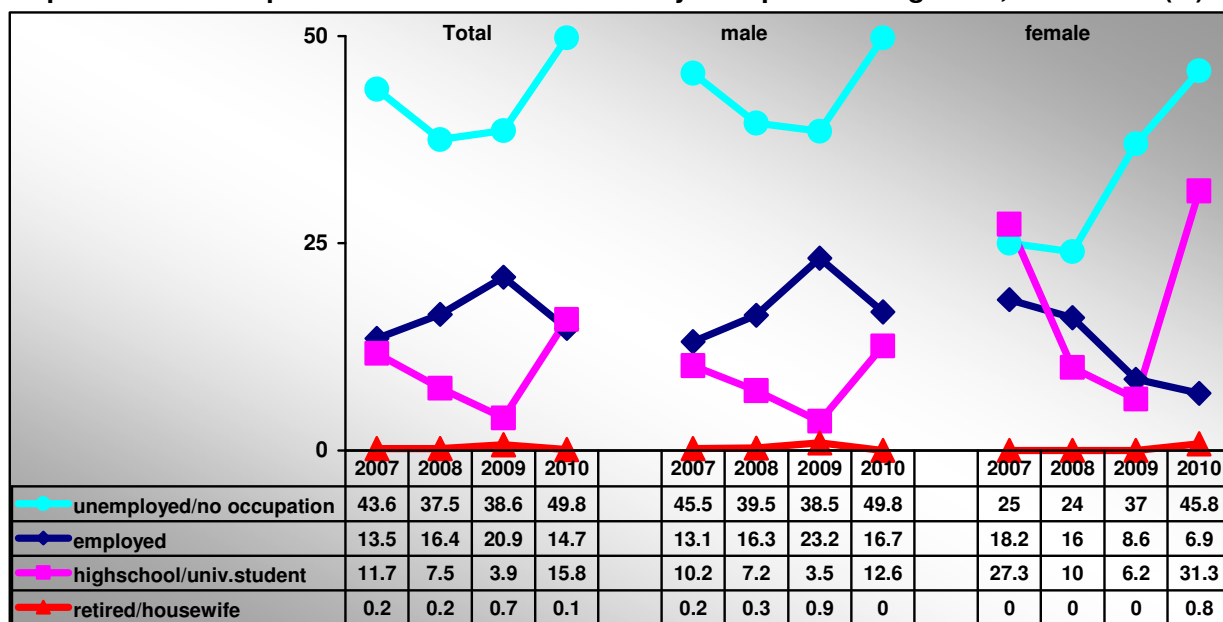
- the great majority of drug users demanded out-patient care on their own will or are referred to drug treatment by justice/probation/police; family or friends act as facilitators (increasing since last year) as well as the health system: family/general practitioners, emergency or other treatment centre (decreasing since 2009) and seldom upon the request of other social services,
- for male users: if in previous years treatment demand followed referral from justice/ probation/ police prevailed, in the last two years they were outnumbered by demands upon personal initiative; for female users: except for 2008, personal initiative prompted treatment demands, and family/friends started to gain greater importance than among men; the referral from social services seems to have the lowest rate,
- as compared to in-patient treatment admissions, the situation is quite similar, except for referrals made by the health system (family/general practitioners, hospital) and other specialised centres, that record a higher ratio in case of in-patient admissions, and of those made by justice/probation/police that account for a higher rate among out-patient admission.

The examination of the 761 cases of out-patient treatment admission in the reference year, by occupational status, yielded the following results: 49.8% were unemployed/ had no occupation, 14.7% - employed, 15.8% - university/ highschool students and 0.1% - economically inactive¹⁶¹.

Comparing

- with previous year, there is an increasing rate of unemployed and of those in a form of education (highschool/university student) and a decreasing rate of the employed or economically inactive; drug users with no occupation/ unemployed rank first in the analysed time interval, while the economically inactive rank last;
- by gender: there are more employed male users (though less than in 2009), while more women attend a form of education in 2010;
- by type of care: unemployed users account for the highest rates in both types of care. The difference is made by the share of people attending a form of education (highschool/ university student), which is higher in out-patient care and of the economically inactive, which is higher for people in out-patient treatment.

Graph no. 5-22: Out-patient treatment admissions by occupation and gender, 2007-2010 (%)



Note: other and unspecified cases make up the difference up to 100%

Source: NAA¹⁶²

¹⁶¹ Difference up to 100% other situation (worked illegally or were imprisoned/arrested)/not specified

¹⁶² Based on data reported by DPECC/IACC, ANIT, PSYMOTION, Arena and MH centres

Of the total people admitted to out-patient treatment in 2010: 5.4% have never attended school or completed primary education, almost half (47.6%) completed vocational school, almost a third (29.8%) had average education, and 7.8% completed higher/post-university studies¹⁶³.

Comparing:

- by gender – there are noticeable higher rates for male users with a very low education level (5.7% - never attended school/incomplete primary education), but also for average and higher education, unlike more than half of women who completed a low level of education: 58% - completed vocational school,
- in-patient treatment admissions – relatively similar situation.

Table no. 5-22: Treatment admissions by education, type of admission and gender 2010(%)

Level of education	out-patient			in-patient		
	Total	male	female	Total	male	female
Never attended school/ incomplete primary education	5.4	5.7	3.8	3.2	3.6	2
primary/ secondary/vocational education	47.6	45.2	58.0	47.0	49.8	38.8
Highschool studies	29.8	32.0	20.6	32.7	28.4	45.4
High/post-university studies	7.8	7.9	7.6	7.6	6.3	11.5
Not specified	9.5	9.2	9.9	9.5	11.9	2.3
Total	100	100	100	100	100	100

Source: NAA ¹⁶⁴

Considering housing conditions in 2010, over two thirds of the drug users admitted to outpatient drug treatment lived with their parents, 15.4% lived with their partner/partner and children, 3.8% lived alone or with children, 12.1% in other locations (e.g. 64 people – detention/arrest inmates, 10 people – colleagues in social/minor/placement centre or with legal representative; 6 people – room/student dorm mates, 4 people – homeless)¹⁶⁵.

The housing condition of people admitted to out-patient treatment by gender showed differences:

- 69.7% - men and only 63.4% of women lived with parents or family and 3.4%- men and only 2.3% of women lived alone,
- 12.2% of women lived with a partner and only 7.7% of men while 2.3% of the women and only 0.2% of the men were single parents.

As compared to in-patient treatment admissions, the following conclusion can be illustrated:

- most drug users lived with parents or family, in both cases;
- higher rates of people living alone/alone with children/with partner and children/with friends among in-patient treatment admissions.

Table no. 5-23: Distribution of admissions to treatment according to housing and gender, 2010 (%)

	Out-patient			In-patient		
	Total	Male	Female	Total	Male	Female
with parents and family	68.7	69.7	63.4	65.4	67.7	58.3
only with partner	8.7	7.7	12.2	8.6	7.1	12.9
with partner and children	6.7	6.9	6.9	7.1	6.5	8.9
alone	3.3	3.4	2.3	9.1	8.1	12.1
with children	0.5	0.2	2.3	1.2	0.4	3.4
with friends	0	0	0	0.7	0.7	0.9
other cases	12.1	12.1	13.0	1.5	1.5	1.4
not specified	0	0	0	6.5	8	2.0
Total	100	100	100	100	100	100

Source: NAA ¹⁶⁶

¹⁶³ No comparison can be made to last year because in 65.3% of the cases the level of education was not mentioned

¹⁶⁴ Based on data reported by CNOASIIDS

¹⁶⁵ No comparison can be made to last year because in 2009 in 76.7% housing conditions were not mentioned

¹⁶⁶ Based on data reported by MH centres, DPECC/IACC, ANIT, PSYMOTION, Arena

Profile of the persons admitted to in-patient treatment following drug use/addiction¹⁶⁷ in 2010

Heroin - male, aged between 25 and 29, who uses heroin daily and by injection. He also uses, as a secondary drug, mainly SNPP but also methadone, benzodiazepines, cannabis, and cocaine. Two thirds of the users started drug use before the age of 19. The great majority injected drugs in the last 30 days. He is experiencing the first drug treatment admission and comes at his own will, but can also be sent by family/friends or by the prison system/re-education or closed in-patient centre for underage people/probation service. More than half has completed secondary education at most and most of them live with parents or partner in stable housing.

Cannabis - male, aged between 20 and 24, who started drug use before the age of 20.

The male user graduated vocational school or high school, is a highschool or university student or has no occupation, and lives with his parents. The onset age is before the age of 29. He uses the drug occasionally, by pulmonary route (smoked/inhaled). He is experiencing the first drug treatment admission and is sent by the prison system/re-education or closed in-patient centre for underage people/probation service, but also by his own will, or sent by specialised drug service or upon family/friends` demand. He also uses, as secondary drug, SNPP and other substances, cocaine or MDMA and derivatives. Most of them never injected. Half of them completed secondary school at most and live with parents in stable housing.

SNPP (new psychoactive substances traded as „ethno-botanical plants“) - male, aged from 15 to 19, who started drug use before the age of 20. He uses SNPP several times per week, by pulmonary route (smoked/inhaled) or sniffing. He is experiencing the first drug treatment admission and is sent often sent by family/friends but can also come at his own will, or is referred by the legal medicine institute/prison system/ re-education or closed in-patient centre for underage people. As secondary drug, he can use other SNPP or MDMA and derivatives. Most of them never injected. Over two thirds of them completed secondary school at most and the great majority lives with parents in stable housing.

C. Substitution treatment

The need for more accessible working tools, tailored to the requirements of the specialists in the field, has prompted opiate addiction experts to formulate in 2010 a good practice guide: *Clinical guide on substitution treatment for opiate addiction*¹⁶⁸, as part of a UNODC-funded project. The guide is approved by the Ministry of Health, the Medical Board in Romania, Romanian Psychiatry and Psychotherapy Association and certified by the National Administration of Penitentiaries.

The topics approached in the guide refer to: pre-treatment assessment, substitution-based detoxification (on long and short term); buprenorphine-naloxone substitution treatment: maintenance programme (induction, stabilisation, discontinuance/detoxification, transfer from one substitute to another); methadone substitution treatment: maintenance programme (induction, stabilisation, discontinuance/detoxification, transfer from one substitute to another); drug related psychiatric pathology and substitution treatment – dual diagnosis; methodology for maintenance programme based on substitution medication; complementary psycho-social interventions in the substitution treatment for opiate addiction.

Thus, the guide contains:

- instruments for pre-treatment clinical assessment of drug addiction, and for case supervision: screening instruments, diagnosis instruments, instruments for the evaluation of drug related problems, instruments for diagnosing psychiatric co-morbidity (dual disease or pathology) and instruments for motivation and mood evaluation to;
- Indications/contra-indications of a certain type of detoxification or treatment (based on buprenorphine-naloxone and methadone), treatment inception rules, induction, stabilisation, discontinuance/detoxification, maintenance treatment, dosage change, transfer from one substitute to another and completion of treatment.

¹⁶⁷ There is an insufficient number of cases to build a profile: volatile inhalants – 2.5%, stimulants – 2.5%, cocaine – 1.3%, hallucinogens – 0.9% and hypnotics and sedatives – 0.4%

¹⁶⁸ prof. dr. Dan Prelipceanu, dr. Gabriel Cicu – Bucharest : publishing of the Romanian Psychiatric Association, 2010

Target groups: heroin users, patients infected with HIV/HBV/HCV, underage patients, pregnant women, patients with a dual diagnosis and poly-addiction. The guide specifies that: launching a substitution treatment for patients with indication should not be delayed, but if the delay is unavoidable, the following categories have priority in accessing substitution treatment programmes: pregnant women, HIV infected people and their partners who are opioid users; HBV infected people (positive for anti-HBs and anti-Hbe) and their partners who use opioids.

Over half of the 2163 people admitted to treatment for illicit drugs and SNPP in 2010 (51.7%) used opiates, and of them 359 were already in methadone-based substitution treatment or based on other opioids (buprenorphine, suboxone, naltrexone). As compared to the previous year, the number of people admitted to treatment increased (from 1689 to 2163) as did the numbers of those already in substitution treatment, from 168 to 359 patients, although the rate of opiate use among people admitted to treatment dropped from 77.1% to 51.7%.

Table no. 5-24: Admission to treatment for illicit drug (opiate) use and distribution of users already in substitution treatment, by type of treatment centre, 2009- 2010 (no. of people)

		Type of centre						Total	
		In-patient		Out-patient		penitentiary		2009	2010
Treatment admissions	Total	2009	2010	2009	2010	2009	2010		
	Of which opiates (main drug)	825	578	450	529	27	11	1302	1118
	Of which heroin	784	541	444	525	27	11	1255	1077
	methadone	25	20	3	1	0	0	28	21
	Other opiates	16	17	3	3	0	0	19	20
Patient/beneficiar aflat deja în tratament de substituție	Total	80	234	82	116	6	9	168	359
	Of which methadone	53	177	53	103	6	9	112	289
	Other opiates (buprenorphine. suboxone. naltrexone)	22	17	9	10	0	0	31	27
	Not specified	5	40	20	3	0	0	25	43

Source: NAA¹⁶⁹

Table no. 5-25: Admission to treatment for illicit drug use, by type of treatment centre and type of care, 2009- 2010 (no. of people)

Type of care		Type of centre						Total					
		In-patient		Out-patient		penitentiary		No.		% patients		% services	
		2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
		1060	1139	520	741	27	13	1607	1893	95.1	87.5	33.8	30.8
Assessment													
Pharmacological detox in in-patient settings	Based on opiate substitute	68	83	0	0	8	6	76	89	4.5	4.2	1.6	1.5
	Symptomatic	932	1103	0	0	0	0	932	1103	55.2	50.8	19.6	17.9
	Not specified	4	10	0	0	0	0	4	10	0.2	0.5	0.1	0.2
Pharmacological detox in out-patient settings	cu substitut opiaceu	0	0	10	5	0	0	10	5	0.6	0.2	0.2	0.1
	simptomatică	0	0	2	10	0	0	2	10	0.1	0.6	0.0	0.2
	neprecizat	0	0	0	11	0	0	0	11	0.0	0.5	0.0	0.2
Non-pharmacological detox		0	672	0	6	0	0	0	678	0.0	31.3	0.0	11.0
Psychological care		614	533	194	404	26	12	834	949	49.4	43.9	17.5	15.4
Treatment of psychiatric co-morbidity		280	161	2	3	4	3	286	167	16.9	7.7	6.0	2.7
Referral to social services. legal services for underage people. vocational services		219	218	24	214	0	0	243	432	14.4	20.0	5.1	7.0
Long-term supervision		214	5	112	167	0	0	326	172	19.3	8.0	6.9	2.8
Abstinence maintenance treatment	Based on opiate agonist	59	171	245	379	19	5	323	555	19.1	25.7	6.8	9.0
	Based on opiate antagonist	25	5	72	39	0	0	97	44	5.7	2.0	2.0	0.7
	Not specified	2	0	0	2	0	0	2	2	0.1	0.1	0.0	0.0
Not specified		13	20	1	10	0	0	14	30	0.8	1.4	0.3	0.5
Total – no. of patients		1126	1389	536	761	27	13	1689	2163	100	100	-	-
Total – no. of services provided		3490	4120	1182	1991	84	39	4756	6150			100	100

Source: NAA¹⁷⁰

¹⁶⁹ Based on data reported by MH centres, DPECC/IACC, ANIT, PSYMOTION, Arena

Considering the type of care provided, in 2010:

- 1.6% of the total services were for pharmacological detox based on opiate substitutem in-patient or out-patit (in 2009: 1.8% of the total services). 94 people benefited from these services (4.4% of the patients), slightly decreasing in numbers than in 2009, 86 people (5.1% of the patients);
- 9.7% of the services provided were anstinence maintenance treatments based on agonist/antagonist opiates (in 2009: 8.9% of the total services). 601 people (27.8% of the patients) benefited from these services, which is more than in 2009: 422 people (24.9% of the patients);
- Other types of services: assessment – 30.8%, symptomatic detox – 18.1%, psychological care – 15.4%, non-pharmacological detox – 11%, referral to social services, for minors and vocational services – 7%.

Table no. 5-26: Distribution of opiate users who benefited from abstinence maintenance treatment based on opiate agonist/antagonist medication, by several features, 2009-2010 (%)

		abstinence maintenance treatment based on opiate agonist/antagonist medication	
		2009	2010
If already in substitution treatment	yes	29.4%	43.6%
	no	68.4%	55.1%
Main source of referral	own will	44.3%	53.1%
	family doctor/primary care	12.6%	19.8%
	specialised services for drug users	7.6%	1.3%
	psychiatric/psychological care/emergency services/other hospital wards	5.7%	11.8
	court/prosecution/probation/arrest/penitentiary/legal medicine institute	5.2%	3.8/
	family/friends	4.8%	8.7%
gender	male	84.5%	80.5
	female	15.5%	17.0
Age group (yrs)	15 -19 yrs	2.9%	1.5%
	20 -24 yrs	26.9%	18.1%
	25 -29 yrs	40.7%	40.3%
	30 -34 yrs	21.7%	30.3%
	35 -39 yrs	4.5%	7.0%
	40 yrs and over	2.8%	1.7%
Drug use record (yrs)	≤ 2 yrs	8.3%	3.7%
	3-5 yrs	13.8%	16%
	6-8 yrs	17.6%	9.2%
	9-11 yrs	42.1%	17.9%
	12-14 yrs	13.9%	23.6%
	≥ 15 yrs	3.2%	10.2%
Onset age (yrs)	< 15 yrs	11.0%	12.1%
	15 -19 yrs	45.0%	47.9%
	20 -24 yrs	26.0%	26.4%
	25 -29 yrs	5.2%	9.4%
	30 yrs and over	2.6%	4.1
Frequency of use	Daily	61.9%	59.1%
	Less than 6 days/week	27.1%	27.2%
occupation	Employed	27.4%	25.5%
	pupil/student	3.6%	3.8%
	retired/housewife/invalid	1.2%	0.2%
	unemployed/unoccupied	46.2%	61.6%
	work without contract/other situation	8.6%	7.3%

Note: other cases/unspecified make up the rest to 100%

Source: NAA¹⁷¹

¹⁷⁰ Based on data reported by MH centres, DPECC/IACC, ANIT, PSYMOTION, Arena

¹⁷¹ Based on data reported by MH centres, DPECC/IACC, ANIT, PSYMOTION, Arena

Of the 601 opiates users who benefited from abstinence treatment based on agonist/antagonist in 2010:

- almost half of them was already in substitution treatment (increase than in 2009 – 29.4%);
- more than half demanded treatment on their own (increase than in 2009 – 44.3%);
- the great majority consists of male users (dropping rate as compared to 2009 – 84.5%) which is influenced by the higher ratio of male opiate users than female; decrease for male users is a results of the rate of heroin users in 2010 and the increase of the number of people who use other substances, mainly SNPP;
- most users are young people aged 25 to 29 (as compared to 2009 there is a 10% increase of the rate of people aged 30 to 39);
- almost two thirds (60.9%) use opiates for at least 5 years (dropping rate comparing to 2009 – 76.8%);
- over 1 in 10 beneficiaries started drug use at ages below 15, and almost half at “highschool” age: 15-19 years (both ratios are slightly decreasing than in 2009: 9.4% as compared to 5.2%, namely 4.1% comparing to 2.6%);
- almost two thirds used opiates daily (59.1% decreasing as compared to 2009: 61.9%);
- almost two thirds are unemployed/have no occupation (61.6% increasing than in 2009: 46.2%) and only one in four is employed (25.5%, dropping than in 2009: 27.4%).

5.4. TRENDS OF CLIENTS IN TREATMENT

In 2010, the main tendencies for the treatment demand epidemiologic key indicator indicated the following :

- as compared to the past year there a 28% increase of the total *number of admissions* (from 1689 to 2163), accounting for the highest number of treatment admissions in the last 10 years, reaching levels comparable to the ones recorded in 2001. The increase is true for both in-patient (by 23%) and out-patient treatment admissions (by 42%). This can be related to the emergence and appreciation of the use of new psychoactive substances (as a result of increased availability) that added to the number of treatment demands following illegal drug use, or to the intervention capabilities of the NAA, reduced by numerous re-organisations starting with 2009¹⁷².
- *first admissions/re-admissions*: as compared to 2009, although the number of first treatment demands increased (from 1008 to 1228), there is a slight decrease as ratio against the total number of people (from 59.7% to 56.8%). The rate of first admissions decreased for in-patient setting (by 0.8%) an out-patient setting (by 6.2%). Yet, the rate of first admissions as compared to repeat admission is below 0 for in-patient setting and over 0 for out-patient settings, although decreasing (as a result of the recent expansion of out-patient service providers)¹⁷³. Alike previous years, opiates were the main drug for which treatment services were demanded in in-patient and out-patient setting (41.5%, namely 69.5%). If in 2008, among in-patient care hypnotics and sedatives and cannabis were second, in 2009 and 2010: 12.6%, namely 40.4% of the demands were for other substances (mainly SNPP new psychoactive substances traded as „ethno-botanical plants”). Cannabis continues to be secondary drug among out-patient admissions with 13.3% (increasing than in the last year) and SNPP, by 9.6%, ranks third. There is a stable trend as shown by data collected from 2008 to 2010: re-admissions are mainly for heroin addiction, while heroin is decreasing in the cause of first treatment admissions, making space for other substances. Thus, there is a change in drug use pattern, decrease of heroin use (38.9% of the people who benefited from treatment for SNPP in 2010, had benefited previously from opiate treatment) and significant increase of the use of new psychoactive substances traded as „ethno-botanical plants” but also of: cannabis, cocaine, inhalants, stimulants, hypnotics and sedatives and hallucinogens¹⁷⁴. In a manner similar to 2008 - 2009, the data might lead to two hypotheses: the increasing availability of treatment for those who use drugs other than heroin and a change in the drug use pattern once the rate of heroin users decreased and the rate of users of other drugs increased.
- *territorial distribution* – alike the data collected in previous years, the 2010 data showed a constant concentration in the Municipality of Bucharest (62.2% and 66% - in-patient and 67.8% - out-

¹⁷² See graph 5-1

¹⁷³ See graph 5-1 and 5-2, table 5-12 and 5-13 and standard tables 4.1.1

¹⁷⁴ See tables 5-2 and 5-14 and standard table 11.1

- patient), in spite of significant decreases as compared to 2009 (71.5% - in-patient and 75,7% - out-patient).
- *gender*: the share of male users is decreasing for both types of treatment while the share of female users is increasing¹⁷⁵.
 - *Gender and drug uses* – the trend of treatment admissions from 2002 to 2010 shows:
 - for in-patient treatment admissions: SNPP use has been present among male users since 2010 along with heroin use (prevailing until 2009); heroin, synotics and sedatives and SNPP have been present among female users in 2010 (other substances prevailed in 2009).
 - for out-patient treatment admissions – similar pattern for both sex categories: predominantly heroin use followed by cannabis up until 2009, and mainly heroin followed by cannabis and SNPP in 2010¹⁷⁶.
 - *Gender and type of admission* – the in-patient treatment admissions from 2007 to 2010 show: first admissions among male users is lower than re-admission, and higher than re-admissions for female users; similar pattern in out-patient treatment admissions for both genders: more first admissions than re-admissions and the difference is decreasing¹⁷⁷. Theories:
 - increase of drug use among women, for both cases (in-patient and out-patient treatment) the rate of first treatment demands exceeded re-admissions or 2. gender differences between first treatment admissions and re-admissions are the result of “drug use” preferences: male users prefer heroin (long-term use) and SNPP, and treatment demands among female users is diversified: for heroin, hypnotics and sedatives, SNPP, cannabis and other substances;
 - the out-patient treatment system begins to strengthen and attract beneficiaries with longer drug-use records, while the treatment facilities in both systems almost reach maximum capacity and are unable to offer but limited treatment to those who never demanded treatment before, if we consider the waiting lists.
 - *Age of user admitted to treatment* – the 2010 distribution shows that: almost a third of the total treatment admissions were for people younger than 24, and a third for people aged 25 to 29. By comparison to in-patient admissions, out-patient treatment admissions show a lower maximum age for all drugs (in-patient: ≥ 65 years, out-patient < 59 years) and for SNPP (in-patient: < 59 years, out-patient: < 39 years). As opposed to the previous time interval, in-patient treatment admissions among male users: show a decreasing trend of users aged 20 to 29 and increase of people under 20 years of age; for in-patient treatment among female users: alike the past year, an upward trend of those aged 20 to 29 and decreasing numbers of people over 29; for out-patient treatment there an increase of the rate of people under 19 and in the age group 30 to 39 and a decreasing rate of people aged 20 to 29 and over 40¹⁷⁸.
 - *Average age*: for in-patient treatment demands it is 30.9 years (decreasing than in the previous year – 31.7 years), with 6 years more for women (35.5 years of age as compared to 29.4 years for men; lower than in 2009, when the difference in years was almost 10: 39 for female users as 29.5 for male users) and lower by 5.6 years for SNPP as compared to the age upon the use of all drugs. For out-patient treatment demands: the mean age was 26.4 (dropping as compared to the past year – 27 years) and 3-years higher than for male users (26.8 years while 23.8 years for women) and 7-years lower than for SNPP treatment admissions (all drugs – 26.4 years, SNPP – 19.1 years); as compared to in-patient treatment admissions, out-patient treatment admissions show a much lower average age for all drugs (in-patient: 30.9 years, out-patient: 26.4 years) and for SNPP (in-patient 25.3 years, out-patient – 19.1 years)¹⁷⁹. For male users: treatment admissions for all drugs was higher in the age group 20-39 years (81.5% as compared to 59.9% - female users); most SNPP users (98%) were aged from 15 to 39 (average age 25.8 years).
 - *Age and gender of drug user*¹⁸⁰:
 - 25.8 is the mean age of SNPP male users who demanded treatment, and 23.3 is the mean age for female users, and even 20.1 namely 16.9 for out-patient demands,

¹⁷⁵ See graph 5-3, table 5-12 and standard table 4.1.1

¹⁷⁶ See graph 5 – 5, 5-6 and 5 -14

¹⁷⁷ See graph 5 - 4 and 5 - 15

¹⁷⁸ See standard table 14.1, tables 5- 4, 5-15 and 5-17 and graph 5-16

¹⁷⁹ See tables 5- 4, 5-5, 5-15, 5-16 and 5-17 and graph 5-16

¹⁸⁰ See standard tables 12.1 și 13.1 and tables 5- 4, 5-5, 5-15 and 5-16 and graph 5-7

- *the youngest minimal age* was recorded for *SNPP* users: for both genders and out-patient treatment demands: the youngest mean ages among men were recorded for inhalant users, while among female users SNPP was the cause of treatment.
- *the oldest minimal age* – in-patient: for both sex categories treatment demand was for stimulants and hypnotics and sedatives; out-patient: for cocaine among male users and benzodiazepines among female users.
- *The youngest mean age* - in-patient: for volatile inhalants and cocaine male users, and for volatile inhalants and stimulants female users; out-patient: for hallucinogens male users and volatile inhalants for female users.
- *onset age* (for the main drug of abuse): in-patient, in the reference year, 4 out of 5 people began drug use at ages below 30 and, comparing to the previous year, there was a decrease in the rate of people under 19 who started drug use (2009-57.3%, 2010-35.2%) and an increase of those over 20 years (2009-42.7%, 2010 64.8%); out-patient, in the reference year, 9 out of 10 people began drug use at ages below 30 and, comparing to the previous year, there was an increase of early drug use onset (ages below 15) and between 15 and 19, and a dropping rate of the onset age over 20 (2009 – 35.9% and 2010 – 32.6%)¹⁸¹.
- *onset age and type of drug – relatively similar for both type of treatment centres in 2009*: over 80% of admissions for opiates (most of which for a drug record of over a year); in 2010, the situation differs: only 45.9% for opiate use in in-patient treatment (most of them with a drug use history of at least two years) and 38.1% are SNPP users (of which 2/3 started drug use in 2010); out-patient treatment: only 68.8% were opiate users (most of them had a drug use history of at least 2 years) and 9.6% were SNPP users (of which almost 4/5 started drug use before 2010)¹⁸².
- *Poly-drug use* – for both types of treatment admissions: similar values for polydrug users (in-patient – 33.8%, out-patient – 36.5%), the most frequent secondary drugs were SNPP and other drugs and opiates were the main drug most likely to be used in combination with a secondary drug. By contrast to previous years, for in-patient treatment demands, there is a decreasing trend of people using a secondary drug, and opiates and hypnotics and sedatives were largely used as secondary drug, while for out-patient care, there is an upward trend of people who used a secondary drug, while cannabis and cocaine are largely used as secondary drugs¹⁸³.
- *Frequency of use*: daily use is common both in in-patient and out-patient services, but with on a decreasing trend; higher rate of low frequency drug use in out-patient admissions – occasional (e.g. in 2010: in-patient – 2.9%, out-patient – 23.5%) and once a week or less (e.g. in 2010: in-patient – 7.3%, out-patient – 10.4%)¹⁸⁴.
- *administration route*: although decreasing as compared to past years, intravenous route prevails, and opiates (83%) and SNPP (55%) are the substances that are most frequently used intravenously among the in-patient treatment admissions, while heroin ranks first (98.8%) among out-patient treatment admissions. Among in-patient treatment admissions, in rates, oral administration comes next, with ever lower levels since 2007, while smoking/inhaling and sniffing are higher than in 2009. Smoking/inhaling, that have been increasing since 2009, rank second among out-patient treatment admissions, opposite to sniffing (7.2%, but double the value recorded in 2009) and oral administration (1.8%). Comparing the two types of care, intravenous route continues to be the most frequent administration route (in correlation with the type of drug for which treatment was demanded, opiates: out-patient – 70%, in-patient – 42%). There are significant differences between oral administration, smoking/inhaling and sniffing, correlation with the type of drug for which treatment was demanded (out-patient, cannabis – 13% and SNPP – 10%, and in-patient: SNPP – 32.3%, hypnotics and sedatives – 8.7% and cannabis – 5%). SNPP largely influences the differences between the two treatment categories being injected up to 55% of in-patient treatment admissions, while for out-patient treatment admissions, drugs administered by sniffing/smoking/inhaling reached 85%. The gender distribution of out-patient treatment demands

¹⁸¹ See standard tables 23.1, graph 5-8 and table 5-18

¹⁸² See tables 5-6 and 5-19

¹⁸³ See standard tables 24.1 and tables 5-7 and 5-20

¹⁸⁴ See standard tables 18.1, 19.1 and 20.1, tables 5-8 and 5-21 and graph 5-9

shows higher values as compared to in-patient and bigger differences in terms of oral administration, while there are higher rates of female users who demanded out-patient treatment and more female users who use drugs by sniffing¹⁸⁵.

- *Injecting drug use history (irrespective of drug used):* the progress of injecting drug use, for both types of treatment admissions, by the trend of heroin treatment admissions (mainly injected heroin) and less by the use of other substances. In addition, although the number of those who inject drugs is higher, their rate is lower, for both types of admissions in 2009, and the share of those who injected drugs in the last 30 days has been increasing steadily from 2007 to 2010. There are noticeable higher rates of injection in the last 30 days among people admitted to in-patient treatment, for both sex categories by types of admission, and comparing to last year, there is a slight increase among female users in out-patient care, in spite of increases of the shares of people who never injected, by types of admission and sex category (along with an decrease of people with an injection history, but not in the last 30 days)¹⁸⁶.
- *Source of referral:*
 - for in-patient treatment admissions: drug users demanded treatment on their own will or were referred to treatment through the health system (family/general practitioners, hospital, emergency unit or another treatment centre); by gender: if in previous years mainly male users demanded treatment on their own will and female users were referred by the health system, in 2010, most referrals were made by the health system for both genders.
 - for out-patient treatment admissions: the great majority of drug users demanded out-patient care on their own will or are referred to drug treatment by justice/probation/police; according to gender, for male users: if in previous years treatment demand followed referral from justice/probation/police prevailed, in the last two years they were outnumbered by demands upon personal initiative; for female users: except for 2008, personal initiative prompted treatment demands, and family/friends started to gain greater importance than among men;
 - considering the type of admission, the situation is quite similar, except for referrals made by the health system (family/general practitioners, hospital) and other specialised centres, that record a higher ratio in case of in-patient admissions, and of those made by justice/probation/police that account for a higher rate among out-patient admission¹⁸⁷.
- *occupational status:* there is continuously growing share of unemployed people for both cases of treatment. The difference is given by the share of those who attend a form of education (highschool/university students), which is higher for out-patient care and of those who are economically inactive among in-patient beneficiaries. The share of unemployed and economically inactive decreased in 2010 as compared to 2009 in terms of in-patient treatment admission, while the number of people who work or have their own business and of those attending a form of education increased; the gender distribution in 2010 shows that, alike the year 2009, the share of working people and as well as unemployed was higher among men; there are more economically inactive and more school attendancy among women. In addition, there is an increase of unemployed and people attending a form of education among out-patient treatment demands, as compared to past year, and a decrease of those who are employed and of the economically inactive; the gender distribution shows more employed people among men (dropping than in 2009), while there is a greater tendency among women to attend a form of education¹⁸⁸.
- *Education level* – similar situation for both types of admission, with vocational school being the maximum level of education for half of the people admitted to treatment in 2010, and a third reported average education. There is a higher rate of people with average or high education as compared to 2009 and dropping levels for drug users having completed vocational school. The gender distribution of people admitted to treatment shows that women tend to have higher education levels.¹⁸⁹

¹⁸⁵ See standard tables 15.1, 16.1 și 17.1 and graphs 5-10, 5-11, 5-17 and 5-18

¹⁸⁶ See standard tables 25.1 și 26.1, table 5- 9 and graphs 5-19 and 5-20

¹⁸⁷ See standard tables 5.1.1 and graphs 5-12 and 5-21

¹⁸⁸ See standard tables 9.1.1 and graphs 5-13 and 5-22

¹⁸⁹ See standard tables 10.1 and tables 5-10 and 5-22

- *Housing conditions*¹⁹⁰ - for both types of care, almost two thirds of the drug users admitted to outpatient drug treatment lived with their parents, and almost 15% with partner/partner and children; many of those admitted to in-patient treatment reported living alone/with partner and children; and many of those receiving out-patient treatment share housing (detention/arrest unit, institution, student dorm) or did not have a home. The gender distribution shows different results in terms of housing conditions: high rates of male users report living with parents or family, while women reported living with partner/partner and children and alone or as single parents. Comparing to past years there is growing trend among those who live alone or only with children and a decrease of those who live only with partner or with partner and children; there is a dropping rate of male users who live only with partner or with partner and children, and a dropping rate of women who live only with partner or with partner and children, while the number of those who live with their parents, alone or as single parents increased.
- *Profile of people* admitted to treatment following drug use/drug addiction to:
 - heroin - similar for the two types of care, with the difference that most people under in-patient treatment had been treated before for drug use, while many of the out-patient beneficiaries experienced their first admission.
 - SNPP (new psychoactive substances traded as „ethno-botanical plants”) – there are differences between the two types of care, mainly by age, year and onset age, frequency, administration route, secondary drug and source of referral.
 - cannabis – between the two types of care there are differences related to age, onset age, frequency and source of referral.
- *Substitution treatment* – the number of people already in substitution treatment increased as compared to past year from 168 to 359 patients. According to the type of care provided in 2010, 1.6% of the total services were pharmacological detox based on opiate substitute, from which benefited 4.4% of the patients (increasing as compared to 2009) and 9.7% were abstinence maintenance treatment based on agonist/antagonist medication from which benefited 27.8% of the patients (in 2009: 8.9% of the services provided and 24.9% of the patients).

To conclude, considering the results of the analysis of the treatment admission data, by type of care, type of drug, age group of users, the following can be noticed:

- *in-patient* – treatment is demanded for a large scale of drugs, beneficiaries are mainly elder, and the onset age is over 20,
- *out-patient* - treatment is demanded mainly for opiates, cannabis and SNPP, most beneficiaries being aged younger than 40 and the onset age being under 24.

Joining the results of the study on *Drug use prevalence in the general population* (see chapter 2) in the planning of treatment services, the following is needed:

- diversification of treatment services for a large range of drugs;
- development of out-patient treatment services addressing young population (considering higher prevalences for this group of population).

¹⁹⁰ See standard tables 7.1 and tables 5-11 and 5-23

Chapter 6 - Health Correlates and Consequences

6.1 DRUG RELATED INFECTIOUS DISEASES

6.1.1 HIV/AIDS, VIRAL HEPATITIS, STIs, TUBERCULOSIS, OTHER INFECTIOUS MORBIDITY

General framework

In 2010 the prevalence of drug related of infectious diseases indicated¹⁹¹:

- slightly increasing values for HVB;
- slightly decreasing values for HVC although high levels are maintained (over the European average);
- slightly increasing values for HIV (although prevalence is still below the European average).

Recorded values are in line with regional trends: low HIV prevalence and high HCV prevalence, extensive sharing of injection paraphernalia, limited addressability of the medical-social services.

Data were collected through routine monitoring systems based on the drug treatment admission indicator. The reporting system contains:

- 47 Drug Prevention, Evaluation and Counselling Centres/5 Integrated Addiction Care Centres,
- 14 specialised units of the Ministry of Health,
- penitentiary treatment units and
- three private care centres for drug users.

The data show that the tendencies recorded by the prevalence of drug use infectious disease are generally unchanged, the recorded new cases of infectious disease associated with the injecting drugs being greatly attributed to drug users from Bucharest.

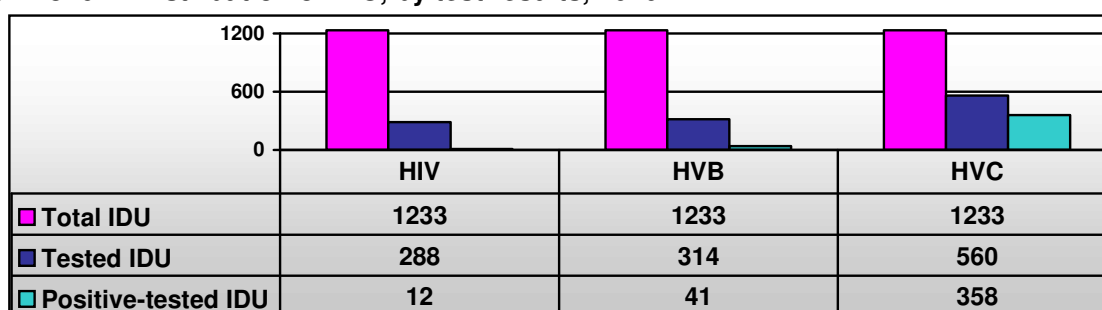
Drug related infectious diseases – by routine monitoring

Thus, in 2010, 1.233 cases of injecting drug users (IDU) were recorded in the above mentioned data base. Heroin was the main drug of abuse for IDU (953), other substances being recorded as main drug for the rest of the cases: 247 new psychoactive substances, sold under the name of “ethno-botanicals” (without specifically indicating the active substance – in other cases the commercial denomination has been specified: *Pure by Magic* in 24 cases, *Special Gold* in 11 cases), methadone (11), other opiates (7), amphetamine (4), unspecified hallucinogen substances (8), ketamine (5), MDMA (1).

According to gender, 79.6% of the total analyses cases were male users and 19.0% female users (1.4% unidentified).

Of the 1.233 people recorded as injecting drug users, 560 reported having been tested for HCV, 314 for HBV and 288 for HIV. No additional data have been reported on the confirmation tests.

Graph no. 6-1: Distribution of IDU, by test results, 2010



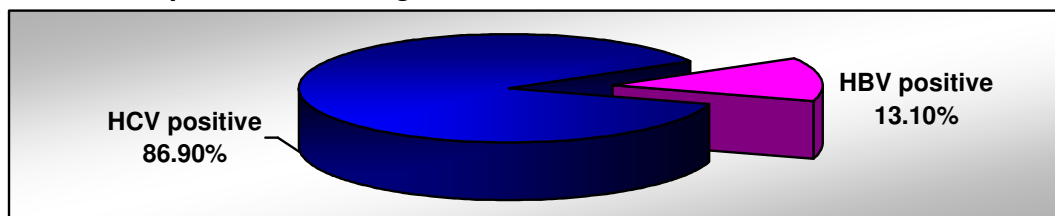
Source: NAA

¹⁹¹ See standard tables ST9_RO1002, routine data, 1/2 HCV; HBV; HIV.

a) B and C virus hepatitis infections

The prevalence of HBV infection reached 13.1% in 2010 (of 314 tests, 45 cases were positive of which: 40 male and 1 female).

Graph no. 6-2: HBV prevalence among IDU, 2010



Source: NAA

As compared to the previous years, there is a decrease in the prevalence of HBV among female users, and at the same time, a significant increase of HBV prevalence among males.

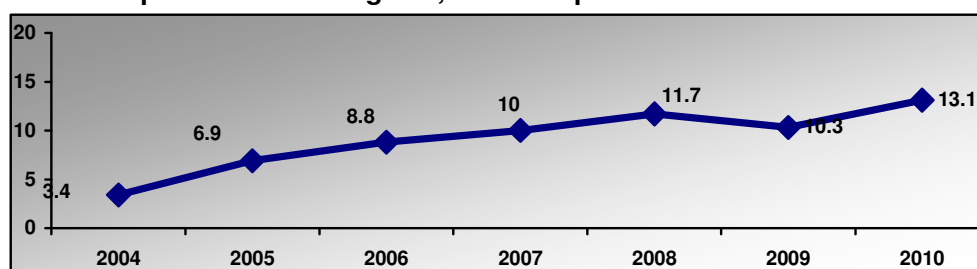
Table no. 6-1: HBV prevalence among IDU by gender, 2008-2010

Gender	2008	2009	2010
Male	13.18	10.9	26.1
Female	3.22	8.1	0.6

Source: NAA

The analysed data referring to the time interval 2004-2010 shows an increasing tendency of the HBV prevalence of the IDU as compared to the previous years. The HBV prevalence among IDU is likely to be under-reported because of the loss of patients from public records over time and the lack of technical and above all financial means to support the comprehensive examinations of AgHBc and HBe viral infections for HBV.

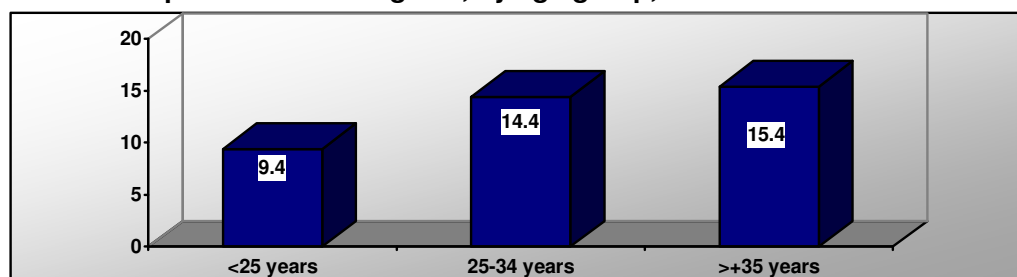
Graph no. 6-3: HBV prevalence among IDU, data comparison 2004-2010



Source: NAA

The age distribution indicates the highest prevalence was recorded among IDU aged over 34 (15.4%), followed by those aged 25 to 34 (14.4%). The lowest HBV prevalence was noticed among IDUs under 25 years of age (9.4%).

Figure no. 6-4: HBV prevalence among IDU, by age group, 2010



Source: NAA

The report over the last 3 years shows a decrease in HBV prevalence in the age group 35+, but also an increase in the age group 25-34 years.

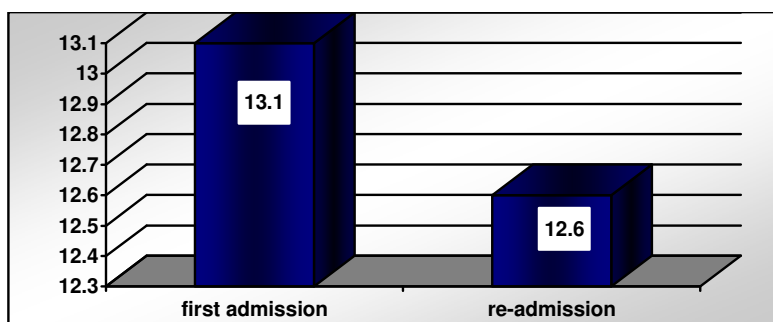
Table no. 6-2: HBV prevalence among IDU, by age group, 2008-2010

Age group	2008	2009	2010
< 25 years	10,46	9,6	9,4
25-34 years	12,29	10	14,4
>+35 years	33,33	17,4	15,4

Source: NAA

HBV prevalence recorded relatively similar values for first treatment admissions (13.1%) as compared to re-admissions (12.6%), with a very low difference (1%).

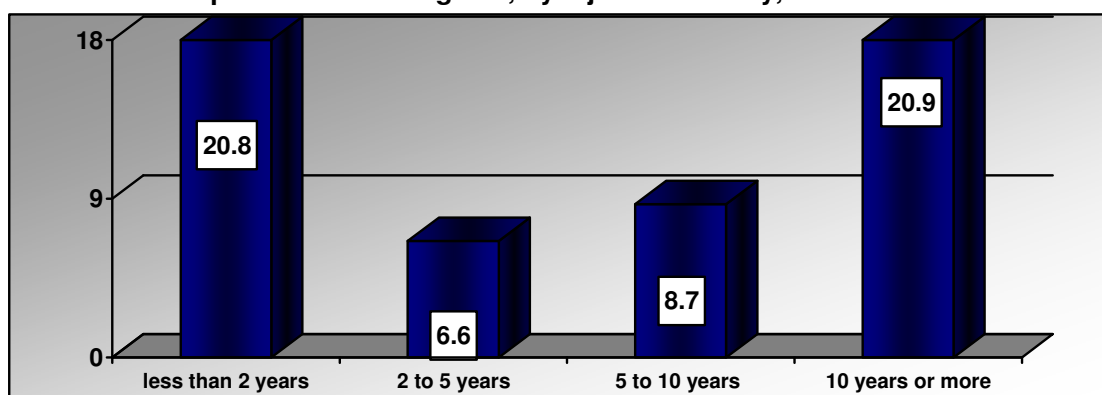
Figure no. 6-5: HBV prevalence among IDU, by type of admission (first admission/re-admission), 2010



Source: NAA

The in-depth analysis of the data included the HBV distribution among IDU by injecting history. Thus, of those who were tested, the highest infection rate was situated within the limits of the interval respectively among injectors with an injection history of less than two years (15.8%) and among injectors with an injection history of more than 10 years (20.9%), the increasing prevalence of HBV among IDU with an injection record under two years representing a constant problem as of late.

Figure no. 6-6: HBV prevalence among IDU, by injection history, 2010



Source: NAA

At the same time, the HBV prevalence has doubled among injectors with an injection history of more than 10 years as compared to the previous year (20.9% compared to 9.9%), but also a decrease by half in the group of injectors with an injecting history of 2 to 5 years, from 12.8% to 6.6%).

Table no. 6-3: HBV prevalence among IDU, by injection history, 2008-2010

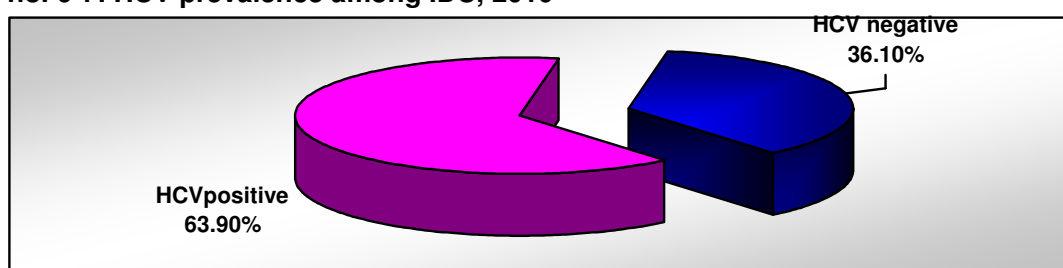
Injection history	2008	2009	2010
Less than 2 years	0	15.8	20.8
2 to 5 years	4.76	12.8	6.6
5 to 10 years	13	9.7	8.7
10 years or more	17.64	9.9	20.9

Source: NAA

By the main drug used, HBV prevalence among tested IDU is of 13.4% for heroine users and of 12.1% among users of SNPP.

Unlike HBV infection prevalence, HCV infection prevalence among the 560 tested IDU recorded much higher levels. The available data for 2010 indicate a 63.9% prevalence of HVC infection (380 tested people), which locates Romania among the European countries with a high prevalence for HCV infection.

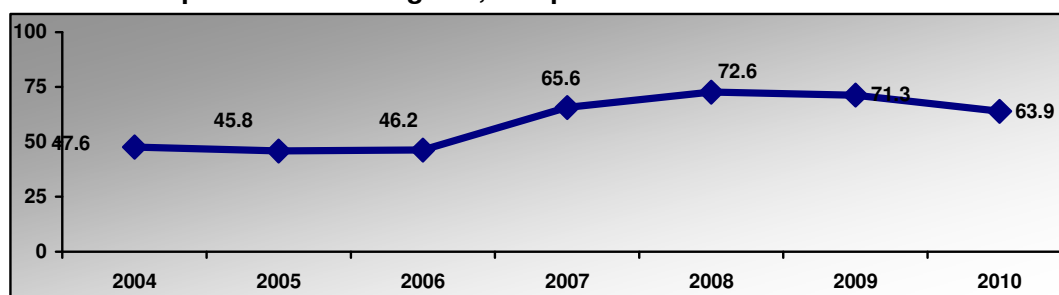
Graph no. 6-7: HCV prevalence among IDU, 2010



Source: NAA

The multi-annual perspective of the distribution of HCV prevalence rates illustrates a decreasing trend after a stabilising period at high levels for HVC infected people among IDU. The values recorded over the last years are still high, and the high values of HCV prevalence among IDU (confirmed by previous and recent¹⁹² studies), may have direct causes, namely the extensive use of shared injection paraphernalia and the lack of sterile injection tools or of information on the risks associated to drug injection, but also indirect causes such as greater availability of HVC testing services. It remains to be seen whether the decreasing trend will be maintained also over the coming years, as a consequence of implementing the *harm reduction* programs addressed to IDU.

Graph no. 6-8: HCV prevalence among IDU, compared data 2004-2010



Source: NAA

The gender distribution shows HCV infection prevalence was significantly higher among male patients (84.9%) than the female users (38.1%) which is similar to the trend recorded for HBV. As compared to the previous years' tendencies, there is a decrease in the proportion of female HCV positive patients, along with an increase in the male patients' proportion.

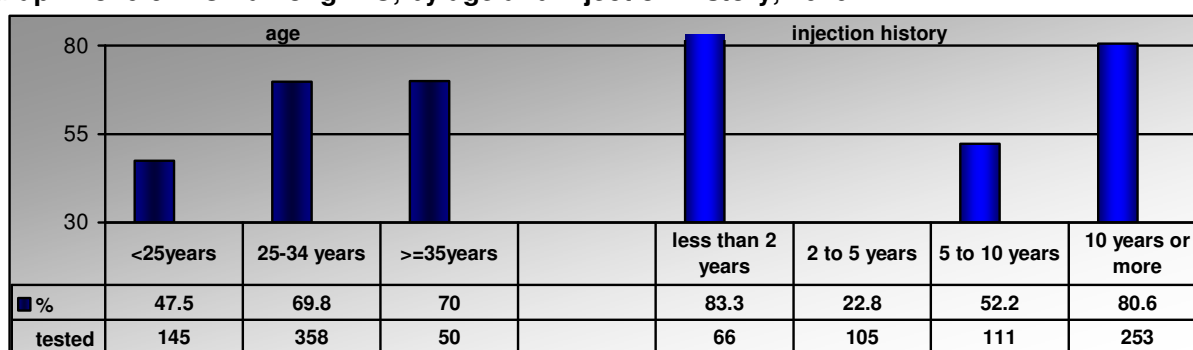
¹⁹² See unit *Studies on the prevalence of drug related infectious diseases* in this chapter

Table no. 6-4: HCV prevalence among IDU gender, 2008-2010

Gender	2008	2009	2010
Male	74.91	77.5	84.94
female	51.5	38.1	21.1

Source: NAA

The studied age categories that show high HCV prevalence rates among IDU were 25-34 years – 69.8%, respectively >34 years – 70%. As in the case of HBV, the highest prevalence rate was recorded among users with an injection history of less than 2 years (83.3%), respectively more than 10 years (80.6%).

Graph no. 6-9: HCV among IDU, by age and injection history, 2010

Source: NAA

The high HCV prevalence rates among relatively recent injecting users represents a new trend, thus the prevalence rate has doubled for this analysis group, as compared to the previous year. 83.3% as compared to 38.1% in 2009. Part of the explanation of this situation may be that in absolute figures the number of tested cases with injection history of less than 2 years is much smaller than that of other groups.

Table no. 6-5: HCV prevalence among IDU, by injection history, 2008-2010

Injection history	2008	2009	2010
Less than 2 years	37.5	38.1	83.3
2 to 5 years	46	57.6	22.8
5 to 10 years	77.35	70.7	52.2
10 years or more	84.15	77.1	80.6

Source: NAA

There is an accentuated HCV prevalence decreasing trend among people aged younger than 25.

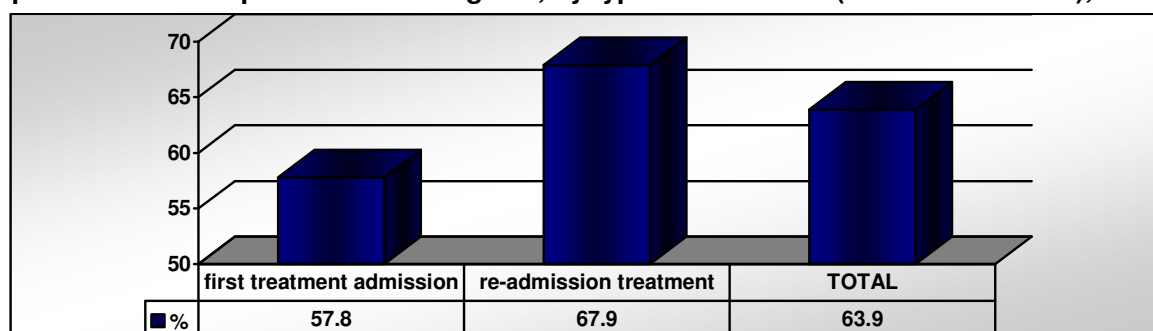
Table no. 6-6: HCV prevalence among IDU, by age, 2008-2010

Age group	2008	2009	2010
< 25 years	73.64	67.3	47.5
25-34 years	70.27	73.7	69.8
>=35 years	88.88	69.2	70

Source: NAA

By the main used drug, the highest HCV prevalence is found among opiates injection users 65.5%. The other substances together (the majority of which is represented by new psychoactive substances sold under the name of „legal highs“, HCV prevalence is 58.1%. Moreover, HCV prevalence was almost 10 percent higher among treatment re-admissions (67.7%) as compared to first treatment admissions (57.8%), maintaining the trend recorded in the previous years.

Graph no. 6-10: HCV prevalence among IDU, by type of admission (first/re-admission), 2010

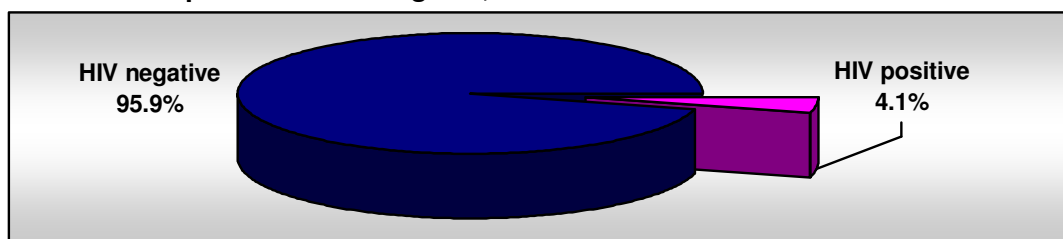


Source: NAA

b) HIV infection

In 2010, 12 HIV positive cases were recorded (4.1%) out of a total of 288 injecting drug users who reported having been tested for HIV in specialised facilities.

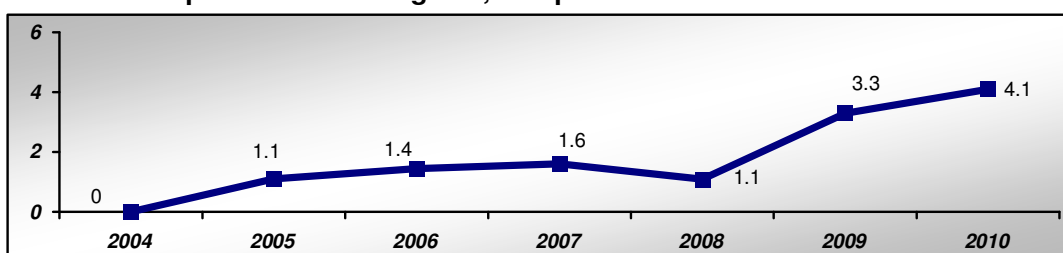
Graph no. 6-11: HIV prevalence among IDU, 2010



Source: NAA

As presented in the graph, the multi-annual graphic distribution of HIV prevalence rates shows an increasing level of HIV infected people among IDU. Although in absolute figures the number of cases is low, a strict monitoring of this possible tendency is called for.

Graph no. 6-12: HIV prevalence among IDU, compared data 2004-2010



Source: NAA

Gender distribution shows the prevalence of HIV infection recorded higher levels among male (7.9%) than female users (1.3%). There is a doubled prevalence in male users as compared to the previous year, this prevalence showing an increasing trend, while in the case of female users there is a decreasing HIV prevalence, from 3.8% in 2009 to 1.3% in 2010.

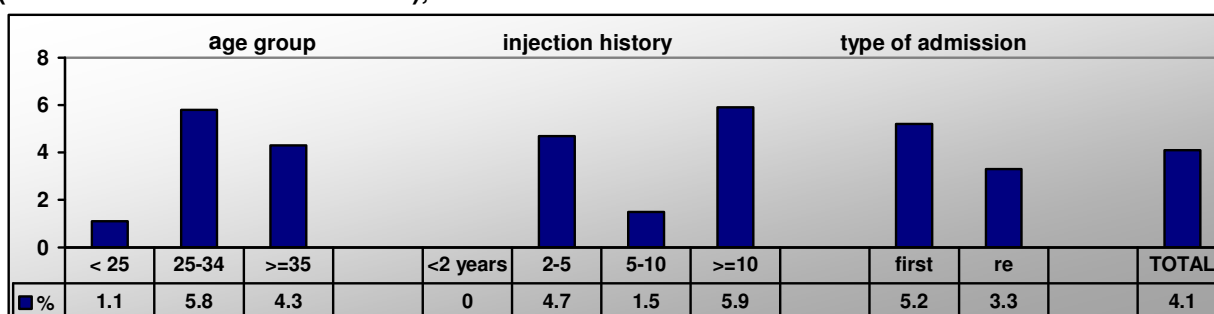
Table no. 6-7: HIV prevalence among IDU, by gender, 2008-2010

Gender	2008	2009	2010
male	1.29	3.21	7.9
female	0	3.8	1.3

Source: NAA

The highest prevalence rate has been recorded in the group with an injection history of more than 10 years (5.9%).

Graph no. 6-13: HIV prevalence among IDU, by age, injection history and type of admission (first admissions/re-admissions), 2010



Source: NAA

The age group 25-34 recorded the highest HIV prevalence among IDU, respectively 5.8%.

Table no. 6-8: HIV prevalence among IDU, by age group, 2008-2010

Age group	2008	2009	2010
< 25 years	0	1.8	1.1
25-34 years	2	4.5	5.8
>=35 years	0	0	4.3

Source: NAA

A higher infection rate is to be noted in the ranks of users with an injection history of 2 to 5 years (4.7%), as compared to the previous years.

Table no. 6-9: HIV prevalence among IDU, by injection history, 2008-2010

Injection history	2008	2009	2010
Less than 2 years	0	0	0
2 - 5 years	0	0	4.7
5 - 10 years	1.17	1.6	1.5
10 years or more	2.56	4.8	5.9

Source: NAA

Similar to the year 2009, HIV prevalence has been higher in the group of first treatment admission for drug using patients (5.2%), by comparison to re-admission treatment patients (3.3%).

By main drug use, HIV prevalence among tested IDU is of 5.2% (11 cases) for heroine users and 1.6% (1 case) among users of SNPP.

The differences resulted from the in-depth analysis of positive HIV cases among IDU¹⁹³, show most cases were first treatment admissions for patients in the age group 24-34, with a long-term drug use history (10 years or more). A significant prevalence level is recorded among the age group 35 years or more (4.3%) although in the previous year HIV prevalence within this group was 0.

An injection history of 10 or more years is a favorable element for HIV prevalence; therefore 5.9% of those who are tested in this group are declared HIV positive, a trend confirmed also in 2009. The 2 to 5 years injection history group shows a prevalence of 4.7%, which is significantly higher than the rate recorded in the previous year for the same group, respectively 1.6%.

These differences could be partially explained by the development of the national services addressing drug users which resulted in a greater number of monitored and tested IDU in 2009. This may lead us to conclude this indicator was under-reported due to the insufficient coverage of the treatment and monitoring network.

¹⁹³ The low number of cases is to be taken into consideration.

The HIV/AIDS Monitoring and Evaluation Department, within the National Anti-AIDS Agency, the Ministry of Health, reports for Romania, in 2010 one HIV positive case (1.93%), out of a total of 97 injection drug users tested in the specialized medical units.

By comparison to other risk groups the situation is the following:

Table no. 6-10: HIV testing among risk groups, 2010

Risk group	Total	Positive tests	% positive	Risk group	total	Positive tests	% positive
Upon request	117345	918	0.78	Drivers	46	2	4.35
occasional	20619	996	4.83	Prison inmates	65	7	10.77
TBC	13451	128	0.95	Sailors	4560	4	0.09
Pregnant women	111037	117	0.11	Work abroad >6 months	351	3	0.85
HIV contacted	976	78	7.99	Holiday abroad >6 months	31	0	0
STD	4019	27	0.67	Homosexuals	51	4	7.84
Motherhood	739	24	3.25	Hemodialysis patients	2380	0	0
Drug users	97	1	1.03	Transfused	194	0	0
Pre-nuptial check	6025	7	0.12	Commercial sex workers	89	0	0
				Medical staff	10016	0	0
				Total	285948	1895	0.66

Source: HIV/AIDS Monitoring and Evaluation Department in Romania – „Matei Balș” Infectious Diseases Institute in Bucharest

Conclusions:

- the prevalence rates of HBV and HCV among IDU have an increasing trend, partially caused by the extensive IDU monitoring and testing capacity;
- the HVB prevalence has doubled among IDU with injection history of more than 10 years as compared to the previous year, but it has also decreased by half at the level of the group with 2 to 5 years injection history. At the same time, prevalence in male users has doubled as compared to the previous years, this prevalence showing a strong increasing tendency, while in the case of female users HIV prevalence has decreased;
- HCV prevalence among IDU outlined a decreasing trend in 2010 after a stabilising tendency recorded in the previous years; nevertheless, HCV represents a major public health issue because of the prevalence rate which is still very high;
- The multi-annual perspective of the distribution of HCV prevalence rates illustrates a decreasing trend after a stabilising period at high levels for HCV infected people among IDU. The values recorded over the last years are still high, and the high values of HCV prevalence among IDU (confirmed by previous¹⁹⁴ and recent¹⁹⁵ studies), may have direct causes, namely the extensive use of shared injection paraphernalia and the lack of sterile injection tools or of information on the risks associated to drug injection, but also indirect causes such as greater availability of HCV testing services. It remains to be seen whether the decreasing trend will be maintained also over the coming years, as a consequence of implementing the *harm reduction* programs addressed to IDU.
- By comparison to the previous years, the proportion of HCV positive female patients shows a decreasing trend, at the same time with an increase in the proportion of male patients.

¹⁹⁴ National Report on Drug Situation, 2008

¹⁹⁵ See unit *Studies on the prevalence of drug related infectious diseases* in this chapter

6.1.2 MAIN RESULTS OF NEW RESEARCH, STUDIES AND SURVEYS

Serologic and behavioural survey on the prevalence of infectious diseases among IDU

UNODC, Romanian Angel Appeal and NAA conducted in 2010 (October-December) a second study from the *category of serologic and behavioural surveys (BSS-Behavioural Surveillance Survey)* among injecting drug users in Bucharest, using the internationally available UNODC¹⁹⁶ methodology.

The study focused on the provision of a systemic means of data collection among injecting drug users in Bucharest to monitor and assess the impact of HIV prevention programmes in this population, with the final aim to develop and streamline the operation of these services.

The objectives of the study:

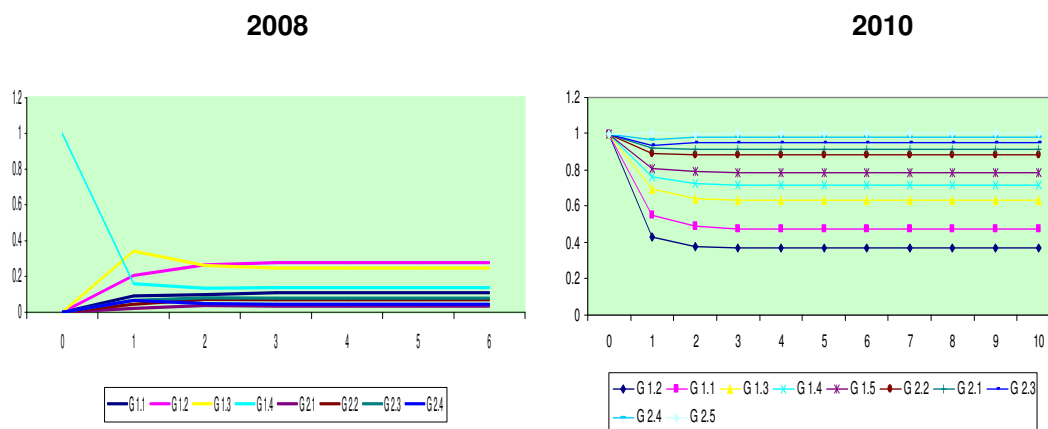
- assessment of risk behaviours among injecting drug users in relation to HIV and B and C hepatitis;
- assessment of the prevalence of HIV and B and C hepatitis infectious diseases among IDU;
- reaching a standard data collection layout that would enable the comparison between the resulted data and the data that would result from the in 2008.

Target population - BSS focused on the selection of IDU population (with an injection history in the last 12 months) over 18, living in Bucharest, and the surrounding area.

Sampling – based on the RDS technique (Respondent driven sampling – chain-referral sample based on the respondents' recommendations). The number of respondents amounted to 385 people. 15.6% of the respondents declared that they had participated in a similar study from 2008.

4 selection waves were necessary in order to obtain a balance for the analyzed dimensions, a situation similar to the previous status recorded in the previous study.

Graph no. 6-14: Number of selection waves



Source: *Serologic and behavioural survey on the prevalence of infectious diseases among IDU, UNODC Romania*

Features of the selection process related to the serologic status

The results have been computed for a trust interval of 95%.

For Hepatitis C, as in the previous study, the group of the positive cases recruited the highest number of participants, 301 (90.4% probability to recruit participants from the same group – positive cases) while the group of negative cases for all 3 viruses recruited 37 IDU. Among this category of participants there is also a high probability to recruit positive tested cases.

¹⁹⁶ *Family Health International, 2000*

The situation is different for HIV and HBV, where negative tested cases recruited the highest number of participants: 322 persons HBV negative (with 97.3% probability to select from the same group) and 335 persons HIV negative (with 99.9% to select from the same group).

Table no. 6-11: HIV testing with risk groups, BSS 2010

	Persons that have recruited	Recruited		
		Negative HIV/HBV/HCV	Positive HIV/HBV/HCV	Total
HCV	Negative Group_ HCV	7.0	30.0	37.0
		0.189	0.811	1.0
	Positive Group_ HCV	29.0	272.0	301.0
		0.096	0.904	1.0
HBV	Negative Group_ HBV	322.0	9.0	331.0
		0.973	0.027	1.0
	Positive Group_ HBV	10.0	1.0	11.0
		0.909	0.091	1.0
HIV	Negative Group_ HIV	335.0	3.0	338.0
		0.991	0.009	1.0
	Positive Group_ HIV	4.0	0.0	4.0
		1.0	0.0	1.0

Source NAA

In the selection chain, the selection efficiency has not been uniform among groups. The group of HCV positive cases recruited more than the negative cases, while for HBV and HIV the situation has reversed.

Data collection tool

The questionnaire had 10 units and 89 questions. They focused on the drug use history and pattern, sexual behaviour, knowledge on HIV/AIDS, namely B and C hepatitis, testing for infectious diseases, referral to medical services, drug related crime and detention (including risk behaviours in prison settings), other vulnerabilities.

Social-demographic characteristics of the selected sample

The 385 selected subjects through the RDS technique fall in the age group 18-55, with an age ratio of 28 years and an average of 27 years. The IDU group in Bucharest metropolitan area consists mainly of young people, 59.4% were aged 18 to 29. 79.2% were men and 20.8% were women.

Table no. 6-12: Education distribution of the subjects, BSS 2010

Education level	%
No education	19
Elementary school (1-4)	32.5
Secondary school (5-8)	31.2
High school	14.5
Higher education	2.6

Source: Serologic and behavioural survey on the prevalence of infectious diseases among IDU, 2010

The education level is low: 19% of the survey subjects have no education, and 32.5% have only elementary school.

55.1% of the IDU had a stable sex partner at the time of the survey, and of them 41% reported the partner is an injecting drug user. In addition, two in ten respondents did not possess identification documents (and could not benefit from social welfare), and 19.7% of the male and 8.8% of the female users had a job at the time the interview was taken. 46.4% had an injection history of more than 10 years

Relevant results

Heroin and SNPP have been the main drugs of abuse for the last 30 days. 75.3% reported having used SNPP and 74.8% reported having used heroine. 51.2% reported having used both substances in the last 30 days. Other drugs used are cocaine 3.4%, cannabis 6.2%, amphetamine 0.8%, LSD 0.5%, tranquilisers 4.4%, ketamine 1.8%, others 9.6%.

15.7% of the IDU declared having used in the last 30 days syringes previously used by another person, and 24.2% declared having shared injection paraphernalia (needles/syringes) with another person. Moreover, 74.2% of the respondents declared having used the same syringe again. 96.8% of the IDU reported having bought/received sterile injection paraphernalia from authorised suppliers upon the last intravenous use (pharmacy or syringe exchange programmes).

The first drug intake age ranges from 10 and 46, with a ratio of 20 years, the average being 18, and the most frequent starting age for injection drugs is 16. All the 385 respondents declared having injected drugs during the last 30 days. By the main drug of abuse reported, 67.3% declared having injected heroin, 32.1% SNPP, 0.3% ketamine and 0.3% cocaine. The injection frequency on the latest use of the main drug is of at least 4 times in 44.9% of the cases, 2-3 times in 41.8% of the cases, while only 13.2% report a single injection.

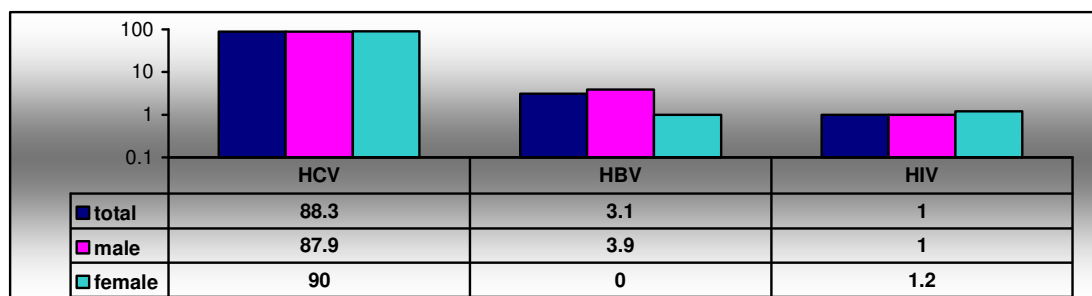
In relation to the sexual behaviour, 25.4% of the respondents reported having used a condom upon the last sexual intercourse either with the main partner or occasional partners. Generally 13.5% of the IDU (11.5% male and 21.2% female) had sexual intercourse in exchange for money, drugs or other goods.

48.8% of the respondents reported having been admitted in a syringe exchange programme, by comparison to the previous study, in which more than three quarters of the respondents (76.4%) reported having been admitted in syringe exchange programmes. 79% were seen by a family doctor and about 20% benefited from emergency medical care. Approximately 10.1% reported being admitted in a substitution programme, and 37.7% of the IDU have previously approached one of the specific treatment facilities (detox and substitution).

In terms of the prevalence of drug related infectious diseases the serological tests indicated: a very high rate of HCV prevalence, 88.3% of the respondents being HCV infected and a relatively low HBV prevalence (3.1%), namely HIV prevalence (1.1% positive results for HIV infection). Generally, 85% of the tested injecting drug users had at least one of the 3 infections.

The gender distribution of the respondents shows the prevalence of infectious diseases is slightly higher among male users, and more accentuated for HCV - 87.1% as compared to 68%.

Figure no. 6-15: Prevalence of infectious diseases among IDU in Bucharest, by gender, BSS 2010



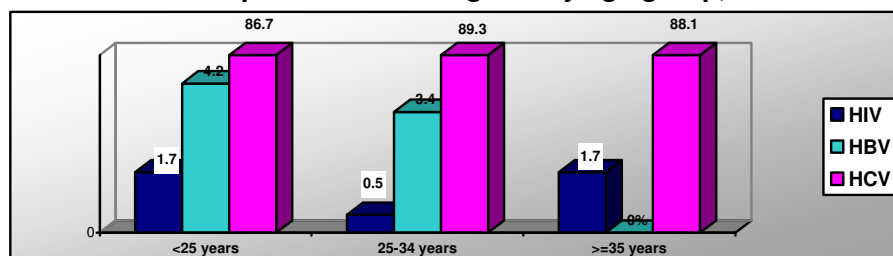
Source: Serologic and behavioural survey on the prevalence of infectious diseases among IDU, 2010

The distribution of positive HCV cases by age group shows an increased prevalence among IDU over 25 years of age.

The distribution of positive HCB cases by age group shows an increased prevalence among IDU under 25 years of age.

The distribution of positive HIV cases by age group shows a similar prevalence among IDU within the analysed age limits, 1.7% for IDU under 25 years of age and over 35 years of age.

Graph no. 6-16: HIV/HBV/ HCV prevalence among IDU by age group, BSS 2010



Source: Serologic and behavioural survey on the prevalence of infectious diseases among IDU, 2010

Table no. 6-13: Compared results of the two Serologic and behavioural survey on the prevalence of infectious diseases among IDU type studies conducted

Variable	2008	2010
Sample	Sample (N=449) built on the Respondent driven sampling technique RDS.	Sample (N=385) built on the Respondent driven sampling technique RDS.
Sex of respondent	Of the total analysed cases, 78% were made up of male population and 22% of female population.	Of the total analysed cases, 79.2% were made up of male population and 20.8% of female population.
Age	The selected subjects were aged 18 to 55. 64% of the surveyed IDU fall in the age category 18-29, the age ratio is 27.6 years and the average age is 27 years old.	The selected subjects were aged 18 to 55. 59.5% of the surveyed IDU fall in the age category 18-29, the age ratio is 28 years and the average age is 27 years old.
Education level	72% of the IDU graduated at least 8 grades and 9% are illiterate.	63.7% of the IDU graduated at least 8 grades and 19% are illiterate.
Type of drug used and frequency of injection use	Most IDU use injecting heroin (97%), 19% at least 4 times a day.	For the last 30 days, most IDU used injecting heroin and SNPP 75.3% and reported having used SNPP and SNPP and 74.8% reported having used heroin. The main injection drug is heroin (67.3%), second come new substances sold under the name of "ethno-botanicals" (30.6%). The latter are substances with effects and composition similar to amphetamines. The frequency of injection use on the last time they used the main drug is of at least 4 times a day in 44.9% of the cases, 2-3 times in 41.8% of the cases and only 13.2% declared having injected only once.
Drug use pattern.	When asked about the last injection, 15% of the IDU reported having shared needles/syringes. 85% of the IDU reported having bought/received sterile injection paraphernalia from pharmacies or syringe exchange programmes	When asked about the last injection, 15.7% of the IDU reported having shared needles/syringes. 96.8% of the IDU reported having bought/received sterile injection paraphernalia from pharmacies or syringe exchange programmes.
Prevalence of drug related infectious disease	82.9% of the IDU tested positive for HCV, 4.7% tested positive for HBV, while 1.1% tested HIV positive.	88.3% of the IDU tested positive for HCV, 3.1% tested positive for HBV, while 1% tested HIV positive.
HCV by age group	According to age groups, HCV prevalence is high: 87%% for users aged 25-34.	According to age groups, HCV prevalence is high: 89.3%% for users aged 25-34.

HCV prevalence by sex of respondent user	The prevalence of HCV infection seems to be slightly higher among male users: 87.1% positive HCV male users and 68% in the case of female users.	The prevalence of infectious disease seems to be slightly higher among female users, more accentuated in the case of HVC. The HCV prevalence is 87.9% for male users 90% for female users.
HBV prevalence by age group	The age distribution of HBV positive users shows a high prevalence of among IDU over 34: 6.5%.	The age distribution of HBV positive users shows a high prevalence of among IDU under 25: 4.2%.
HBV prevalence by sex of respondent user	There is a noticeable higher prevalence of infectious diseases among male users, especially of HBV. More specifically, there is a 87.1% HBV prevalence among men and 68% among women.	HBV prevalence by gender is slightly higher for male users: 4.9% for male and 4% for female users.
HIV prevalence by age group	According to age groups, HIV prevalence is higher among IDU aged 25 to 34: 1.8%.	According to age groups, HIV prevalence is higher among IDU aged under 25 and respectively over 34: 1.7%
HIV prevalence by sex of respondent user	The prevalence of HIV infection seems to be slightly higher among male users: 1.1% for male users and 1% for female users.	The prevalence of HIV infection seems to be slightly higher among female users: 1% for male users and 1.2% for female users.

Source: Serologic and behavioural survey on the prevalence of infectious diseases among IDU, 2010

- there are significant differences between the prevalence rates of drug related infectious diseases between the two studied samples. Thus, for all three types of tested infections – HCV, HBV and HIV, there are lower prevalence rates for the IDU in treatment facilities than for the RDS selected drug users` group;
- the biggest differences have been recorded for HBV and HIV infection among randomly selected IDU who have indicated four-fold higher prevalence rates than among IDU in treatment facilities (4.01:1 for HBV and 3.79:1 for HIV), which might lead us to presume the prevalence rates for both types of infections are much higher actually.
- Comparing with the prevalence of the three types of infectious diseases in the case of treatment admissions (routine monitoring), significant differences arise: if in the two studies there is an increased prevalence of HCV infection (78.36% - 1st study, 82.9% - 2nd study), the prevalence of HCV infection is almost three-fold lower for treatment admissions (28.77%); the prevalence of HBV infection is low in both studies (1.17% - 1st study, 4.7% - 2nd study) while it amounts to almost 10.3% for treatment admissions, which is nine, respectively, two-fold higher than in the two studies; lower levels have been noticed for HIV infection in both studies as compared to the prevalence recorded for treatment admissions (0.29% - 1st study, 1.1% - 2nd study, as compared to 3.3% in the case of treatment admissions).

Conclusions:

- there are not significant differences in terms of the sex and age of injecting drug users included in the two surveys: male users prevailed in both samples and the age group was 18-29;
- the education distribution of the IDU shows, in both surveys, a low level of education among the selected subjects;
- there are differences between the prevalence rates of drug related infectious diseases between the two studied samples. From a time lapse point of view, there is an increasing trend for HCV among IDU from 82.3% to 88.9% and a slight decrease for HBV from 4.7% and 3.1% and for HIV from 1.1% to 1%.
- The biggest difference has been recorded with the main drug of abuse, in the sense that heroin remains the main injection drug (97% in 2008 and 67.3% in 2010), in the last survey, 30.6% of the respondents reported that they use most frequently new psychoactive substances sold under the name of “ethno-botanicals” without mentioning their composition.

6.2 OTHER DRUG RELATED HEALTH CORRELATES AND CONSEQUENCES

6.2.1 NON-FATAL OVERDOSES AND DRUG-RELATED EMERGENCIES

In 2010, the National Anti-drug Agency, through the Romanian Monitoring Centre for Drugs and Drug Addiction, started an ample process of collecting data regarding medical emergencies caused by the use of psychoactive substances and at the same time it conducted a campaign intended to inform on the provisions of the above mentioned legal document and on the Methodology of monitoring the non-fatal drug emergencies, approved by Joint Order MSP and MIRA no.770 and 192 from 2007. As a consequence of these actions the first national report on this subject contained retro-active data concerning the medical drug related emergencies reported in 2009 and in the first 6 months of 2010 by county emergency hospitals in Municipality of Bucharest. In 2010 the data collection continued (case by case, in comparison to the previous year, as specified in the legal document), with the difference that the basis of reporting medical units has been enlarged by including, besides county emergency hospitals and units from Bucharest, other municipality hospitals of city hospitals having an emergency department. Moreover, starting with 2011, the data referring to drug-related emergencies have been collected by a Standard Emergency File.

Data collecting method

The following types of medical service suppliers **have been included** in the reporting system for drug related medical emergencies:

- a) General public hospitals having an emergency unit department that admit all medical emergencies;
- b) Psychiatry hospitals admitting emergencies.

Maternity hospitals or hospitals with another specific domain **have been excluded** from the data reporting system.

For the report only the emergency hospitalised cases with a medical file containing the use of at least one of the psychoactive substances, except for alcohol and tobacco, falling under the three including criteria and none of the excluding criteria **have been selected and recorded**.

Including criteria:

- a) the patient was seen by a doctor from an emergency medical unit. Medical care consisted also of monitoring and observing vital functions or procedures of medical assessment and treatment. Only medical care services provided in the emergency department of hospitals have been recorded. The emergency medical care performed in an ambulance or in an emergency department of a unit not belonging to a hospital have not been included;
- b) the existing of non-medical drug use or the use of other psychoactive substances. It was considered that there is a non-medical drug use when the substance had not been prescribed by a medical doctor or the prescribed substance had not been used to the conformity of the correct dosage or schedules;
- c) the treatment of medical, psychological and trauma complications, that is the emergencies caused by accidents of self-inflicted lesions or trauma, aggression and other external causes have been included at all time when the non-medical use of psychoactive substances was mentioned;

The reporting system **excluded** the emergency cases in which the medical record contained:

- a) The patient died in the emergency medical unit;
- b) Pregnancy and complications of pregnancy, when the medical file mentioned drug use;
- c) Emergencies caused by adverse reaction to medicine used in according to the dose and schedule recommended by the doctor, except for the cases caused by opiates prescribed as substitution treatment;
- d) Emergencies caused exclusively by abuse of alcohol, nicotine, tea, coffee or their combining;

We mention that the collected data have methodological limitations owed especially to the precarious technical means of the medical units concerning the equipment necessary to toxicological determination in general and quantity in special. Thus, part of the emergency diagnoses is based only

on clinical assessment made by the specialist medical doctor, while others do not mention the active substance which caused the medical emergency.

Moreover, the category of new psychoactive substances (called “ethno-botanicals”) contains all the products found on-line and in the street in *weed shops* or *smart shops*. According to the screening, the substances found in these products belong to the group of chemical products, such as synthetic cannabinoids, methadone, MDPV, amphetamine, metamphetamine etc. At present, the exact identification and classification of the substances at the level of Romanian medical units is very difficult as, in many cases, there is no appropriate technical basis. On the other hand, even in the case in which the medical unit has a modern toxicological laboratory, the collection of substance samples, the analysis methods and the knowledge of toxicology specialist need to be updated on a permanent basis at high costs.

Results

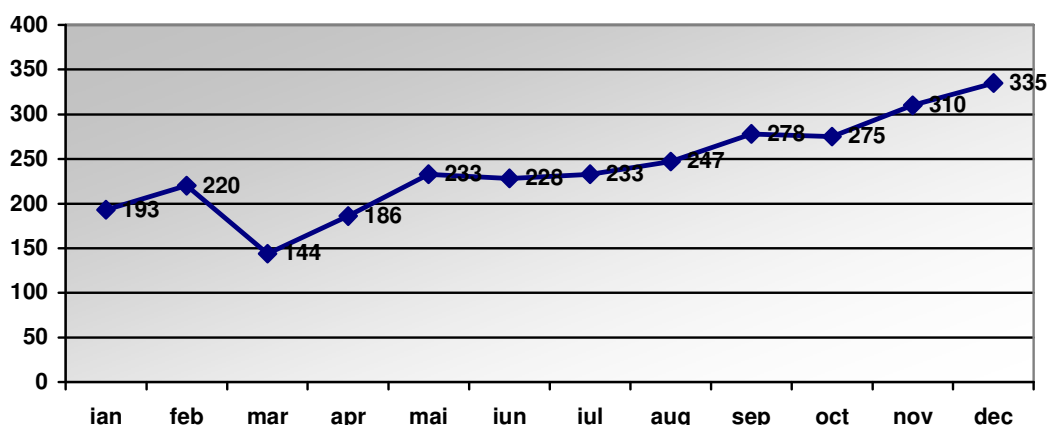
The data collecting system

In 2010, data was required from 70 emergency hospitals from the administrative territorial units in Romania, out of which 41 are located in counties, 11 in the Bucharest and 18 municipal emergency hospitals, psychiatric hospitals and hospitals for children. The analysis of the resulted data showed 2941 drug related emergency cases on a national level, out of which 7 cases have been excluded (5 were cases caused by pregnancy complications induced by drug use and 2 cases were caused exclusively by nicotine and coffee), 2935 have been validated. Out of the 70 units, 65 hospitals gave a report. By comparison to the previous year, data was required from an enlarged number of medical units, from 56 units to 70 units, and implicitly data collecting capacity has improved, the number of reporting medical units increased from 46 units in 2009, to 65 units in 2010.

Unlike in 2009, when 999 drug emergency cases were reported, in 2010 an increase in number by 194% (3 times higher) is to be noted. The increasing trend is confirmed for the number of drug related medical emergencies mentioned the previous year, the number of cases recorded throughout 2009 being 3 times higher than the number for the first 6 months of 2010.

As for the months of 2010, the drug related medical emergency problems recorded at the level of emergency medical units in Romania represent, with one exception (March), an increasing evolution, the number of emergency cases recorded in December being 1.73 times higher than the number recorded in January.

Graph no. 6-17: Non-fatal drug use emergency cases evolution, on a monthly basis, in 2010(no. of cases)



N.B.: the difference to 100% is represented by other situations /unspecified

Source: NAA

Taking into account the prevalence of drug use related medical emergencies caused by new substances (the so-called “ethno-botanicals”) on the whole of the analysed cases, we can correlate this months which is the exception to the rule and one of the decisions made by the parliament to

change the law respective to the legal status of plants, substances and psychotropic preparations. Thus, by Emergency Government Ordinance no.6 from the 10th of February 2010, a new type of substances, called “plants and substances under national control”, has been introduced, a category including a series of plants and substances that are not under international and national control and which, in the opinion of the Government, represent a risk for public health on account of their psychoactive properties. As it can be noticed, in the figure presenting the evolution of drug use related medical emergencies, the effects of this legal document have been short lived. The introduction of these new substances on the list of national control, by issuing Decision 575 from the 16th of June 2010, did not have the same results, an explanation being the “reorganising” of the suppliers of such substances and the introduction on the market of other substances with similar effects that are not listed in national or international control regulations.

Characteristics of the population examined in the emergency medical units as a consequence of drug use

A study by gender and age of the characteristics of the analysed population can be made according to the data from the reporting medical units.

Similar to the year 2009 (men/women ration 2:1), by sex, the distribution of the emergency cases recorded in 2010, shows the same male predominance – 72.0% (2114 persons), by comparison to women – 27.9% (820 persons). On the whole, there is a 2.57 ratio in favour of the men who presented to drug emergency intake units to a woman.

According to the sex of the patient, the evolution of drug use emergency cases between 2009-2010 outlines the following aspects:

- The total of male patients examined in the emergency units has an increasing trend, 2114 persons recorded in 2010 (3 times bigger than 2009);
- The total of female patients examined in the emergency units also has an increasing trend, 820 persons recorded in 2010 (2.57 times bigger than 2009);

Table no. 6-14: Distribution of drug related medical emergencies, by sex and age, 2010 (no. of cases)

Age group	2010			
age (years)	M	F	unspecified	Total
under 14	63	60		123
15-19	433	223		656
20-24	739	175		914
25-29	416	113		529
30-34	220	75		295
35-39	106	47		153
40-44	51	27		78
<45	73	95		168
unspecified	13	5	1	19
Total	2114	820	1	2935

Source: NAA

The analysis of the medical case distribution by age of drug related emergencies in 2010 shows that:

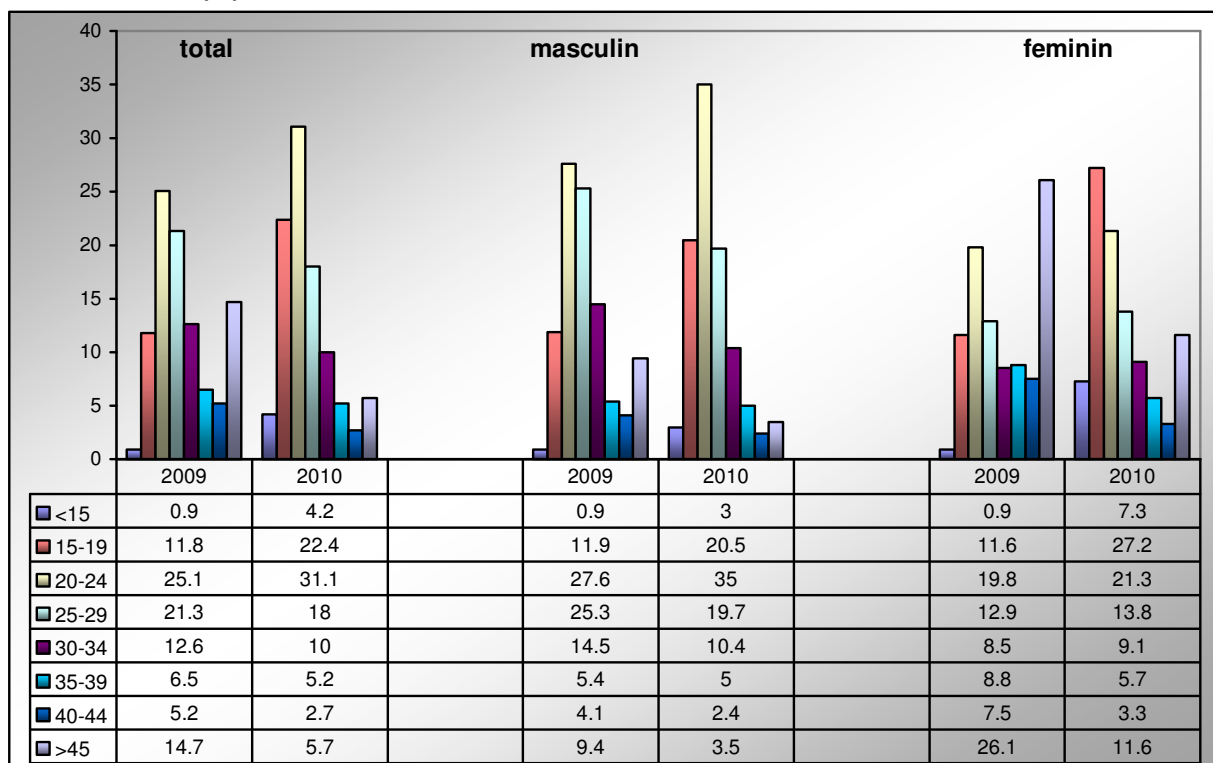
- approximately 3/5 (57.7%) of the total number of patients of the drug emergency units in 2010 are aged 24 or less, almost a quarter (28.1%) are aged 25 to 34 and the remaining 13.6% are aged over 35 (the difference up to 100% refers to persons of unreported age); the average age of the persons who came to the emergency medical units as a consequence to drug use is of 25.56 years, and it is higher by 2.18 years for women, whose average age is 27.13 years, as compared to 24.95 years for men;
- in the case of men, the higher predominance is represented by persons from the age group 20-24 years (35.0 % as compared to 21.3% for women);
- in the case of women, the biggest proportion is represented by the persons from the age group 15-19 years (27.2% as compared to 20.5% for men).
- The modal value is equal to 20 years of age, the average is 23 years of age, and the standard deviation is 10.62 years of age, which indicates a high dispersion of values around the average

and the concentration of a very large segment of the analysed population in the age group 15-39 years.

By comparison to 2009, the distribution by age shows an increasing trend for the prevalence of people aged under 35 who came to the emergency units: 87% in 2010 as compared to 72% in 2009.

While there is no major change for men compared to the previous year respective to the of age distribution (in 2010, 89% of the men recorded in the emergency units as a consequence to drug use were aged under 35 by comparison to 80% in 2009), in the case of women, there is a restructuring of this population by age, with a considerable increase of the population aged under 20: in 2010, 34.5%, as compared to 12.5% in 2009 and a decrease of the population aged over 30: from 50.9% to 29.7%. By age groups, the ratio men/women is in favour of the men for persons aged under 45 (with a maximum of 4.22:1 for the age group 20-24). For persons aged over 45, the ratio is in favour of women – 1.30 women to 1 man.

Graph no. 6-18: Distribution of drug related medical emergencies, by sex and age, compared data 2009-2010 (%)



Obs.: the difference up to 100% is represented by other situation/unspecified

Source: NAA

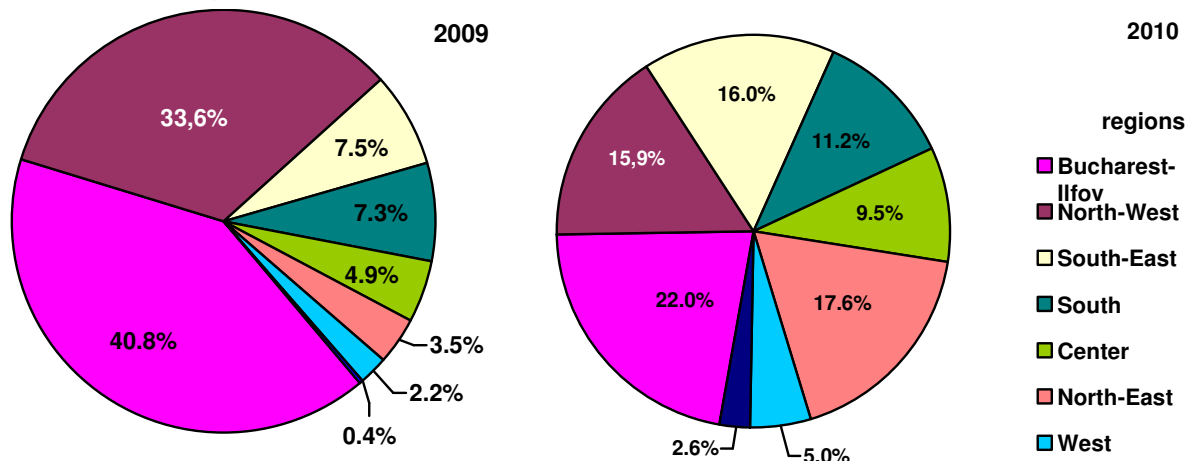
The distribution according to the economic development regions

According to the economic development region in which the non-fatal drug emergency was recorded the 2009's situation is the following¹⁹⁷:

- **North-West** (counties: Bihor, Bistrița Năsăud, Cluj, Maramureș, Sălaj, Satu Mare) - 9 units;
- **West** (counties: Arad, Caraș Severin, Hunedoara, Timiș) - 7 units;
- **North -East** (counties: Botoșani, Suceava, Iași, Neamț, Bacău, Vaslui) - 12 units;
- **South-East** (counties: Vrancea, Galați, Buzău, Brăila, Constanța, Tulcea) - 9 units;
- **Centre** (counties: Mureș, Harghita, Alba, Sibiu, Brașov, Covasna) - 6 units;
- **South-West** (counties: Gorj, Vâlcea, Olt, Mehedinți, Dolj) - 5 units;
- **South** (counties: Argeș, Dâmbovița, Prahova, Ialomița, Călărași, Giurgiu, Teleorman) - 7 units;
- **Bucharest-Ilfov** (Bucharest and the county of Ilfov) – 10 units.

¹⁹⁷ The list of reporting emergency units by counties is presented in Annexe 1

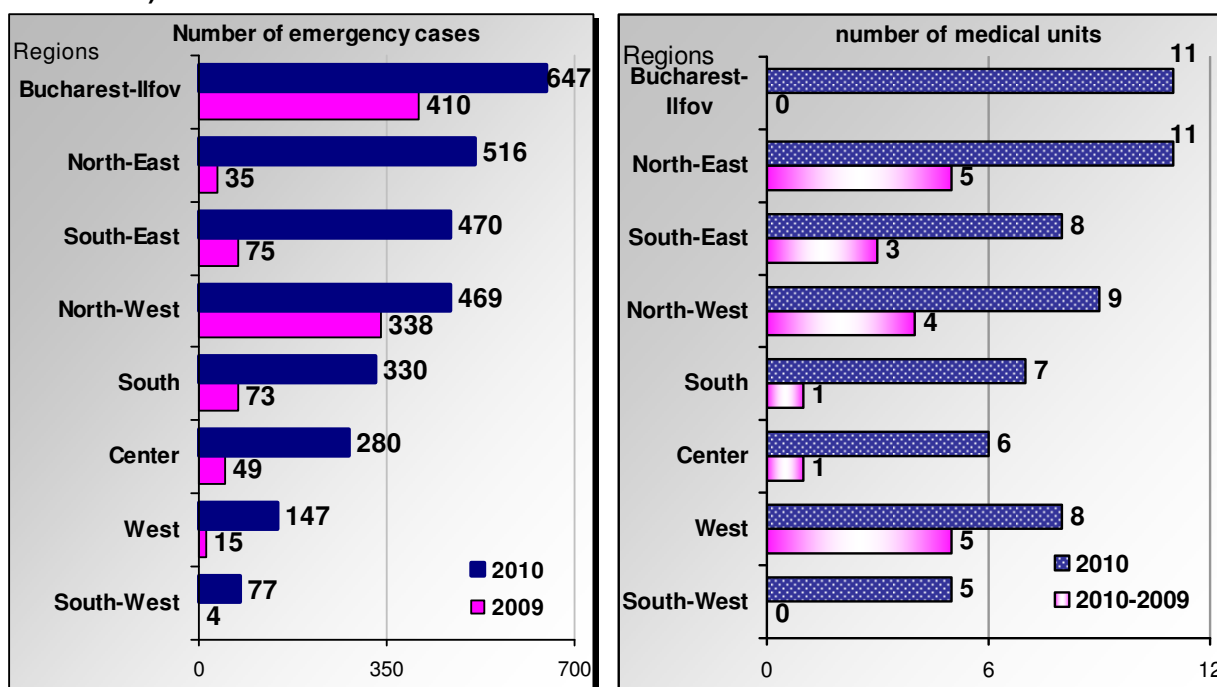
Graph no. 6-19: Distribution of drug use medical emergencies recorded in emergency units, by economic development region in 2009-2010 (%)



Source: NAA

Unlike 2009, in the first 6 months of 2010 there is a homogenous distribution of the drug related emergency cases, recorded by regions, as follows: 22.0% Bucharest-Ilfov (40.8% in 2009), 17.6% North-East region (compared to 3.5%), 16.0% South-East region (compared to 7.5%), 15.9% North-West region (compared to 33.8%), 11.2% South region (compared to 7.3%), 9.5% Centre region (compared to 4.9%), 5.0% West region (compared to 1.5%), 2.6% South-West (compared to 0.4%).

Figure no. 6-20: Distribution of drug use medical emergencies recorded in emergency units and the reporting medical units in 2009-2010, by economic development region (no. of cases/ no. of units)



Source: NAA

Thus, in the case of economic development regions in 2010 there is an increase in the number of drug related medical emergencies, a partial explanation for this increase may be the enlargement of data collecting and the improvement of the collecting system:

- 2009-2010 the same no. of reporting units: Bucharest-Ilfov region – 11 and South-West -5. In the first case there is an increase by 1.58 times (but the starting point is a high value: from 410 to

647). In the second case the increase is by 19.25 times (but the starting point is a low value in 2009: 4 cases).

- 2010 the number of reporting units increases by one: Centre (from 5 to 6) and South region (from 6 to 7). The increase is by 5.71 times for the Centre region (from 49 to 280 cases) and only by 4.52 times for the South region (from 73 to 330 cases), but the starting point is a different number of cases.
- 2010 an increase of 3-4 units for the reporting units: South-East region (from 5 to 8) and the North-West region (from 5 to 9). In the first case there is an increase by 6.27 times (but the starting point is a low value: from 75 to 470). In the second case the increase is only by 1.39 times (but the starting point is a high value: from 338 in 2009 to 469 in 2010).
- 2010 an increase of 5 units of the reporting units: North-East region (from 6 to 11) and the West region (from 3 to 8). In the first case there is an increase by 14.74 times (and the starting point is 35 cases), and in the second case the increase is by 9.8 times (and the starting point is a low number of cases: 15)

In conclusion, the distribution homogenisation at the country level of drug related emergency cases may be explained only partially by enlargement of reporting units number and by improvement of data collecting, at the same time indicating a uniform dissemination of drug use at country level, with a significant increase in some regions as compared to the previous year:

- on one hand: the South-West region with the smallest number of reporting units is the region with the smallest number of cases, and North-East and Bucharest-Ilfov with the biggest number of cases are also the regions with the biggest number of reporting units;
- on the other hand: the West, South-East and North-West regions have a similar number of reporting units (8-9), and the number of cases varies from 147 to 470 and for the North-East the increase by 5 units of the number of reporting units results in the increase by 15 times of the number of cases, so that the classification order changes and from the last positions it gets in 2010 to the second position for number of cases, after Bucharest-Ilfov region.

After a detailed analysis of medical emergency distribution at the level of the country's administrative territorial units, by their preponderance, we should take note of delimitation at country level in five risk areas, as follows:

Table no. 6-15: Delimitation of risk areas at county level, by number of non-fatal emergency cases recorded in 2010

County	Area
Bucharest, Iasi	VERY HIGH RISK AREA (proportion of over 10%)
Cluj, Prahova, Constanța, Bihor, Galați	HIGH RISK AREA (proportion from 5% to 10%)
Brăila, Bacău, Alba, Timiș, Sibiu, Brașov, Maramureș, Mureș, Dâmbovița, Vâlcea, Harghita	MODERATE RISK AREA (proportion from 1% to 5%)
Tulcea, Neamț, Hunedoara, Suceava, Dolj, Arad, Giurgiu, Vaslui, Ialomița, Călărași, Vrancea, Caraș-Severin	LOW RISK AREA (proportion from 0.5% to 1%)
Ilfov, Botoșani, Olt, Mehedinți, Buzău, Argeș, Covasna, Gorj, Satu Mare, Sălaj, Teleorman, Bistrița Năsăud	VERY LOW RISK AREA (proportion under 0.5%)

Source: NAA

The analysis of drug related medical emergency distribution at country level shows that only a small part of the country's territory (2 counties) the drug related medical emergencies have been recorded in a very high number.

One third (33%) of the total number of emergencies recorded in 2010 falls under this territorial segment, while other 5 counties cumulate another third (32.6%), in 11 counties, 23.5% of the drug use medical emergency cases are to be found in the moderate risk area, in other 12 counties we find 8.8% of the emergency number and in the remaining 12 counties only 2.1% of the drug related medical emergencies recorded in 2010.

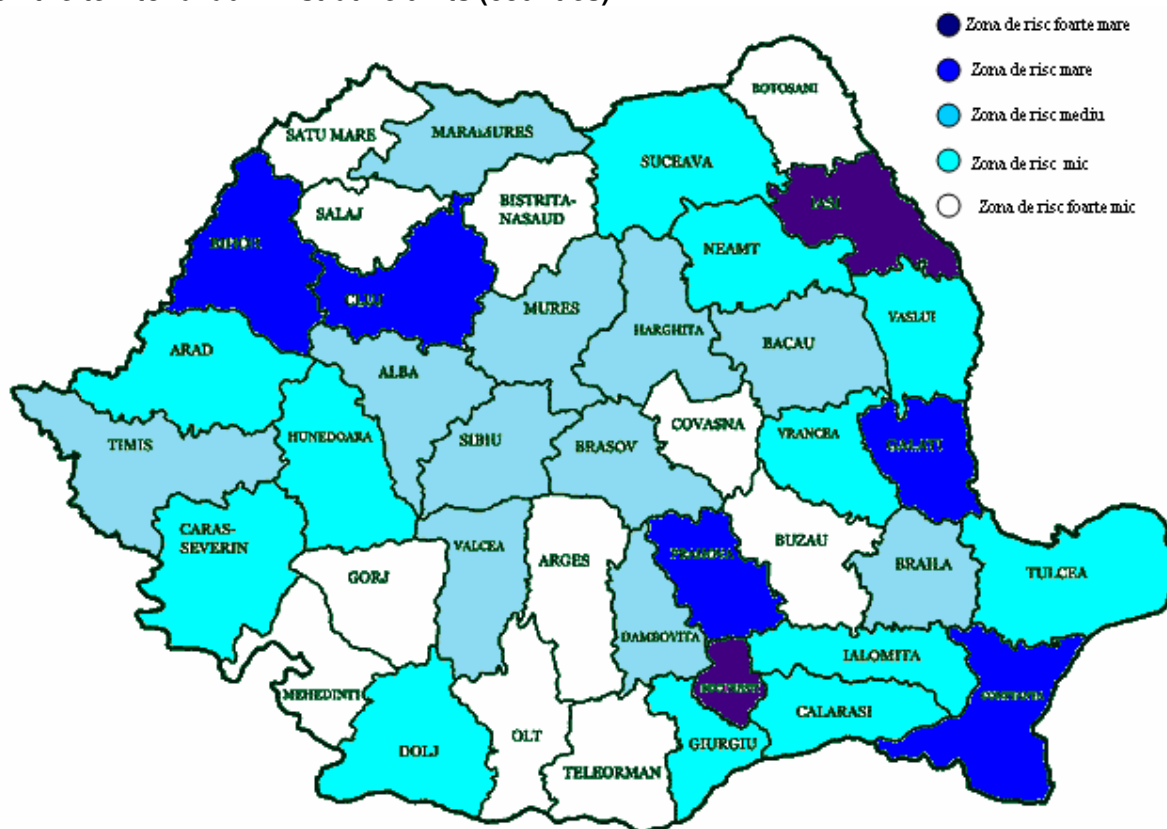
We should note that most of the counties contained in the high and very high risk areas are the counties where we find traditional university centres (Bucharest, Iași, Cluj, Constanța, Galați) and great urban communities (the Municipality of Bucharest – with approximately 2 million inhabitants, the municipalities of Iași, Cluj, Constanța, Galați – each of them with approximately 300,000 inhabitants, the municipalities of Ploiești and Oradea – each of them with approximately 200,000 inhabitants).

Moreover, out of these counties three (Iași, Constanța, Galați) are border counties, situated in areas of high circulation, and the most frequented tourist and leisure resorts for young people are found in the counties of Constanța and Prahova.

By comparison to the population distribution in these territorial units, we find that in the areas considered to be of a high and very high risk there is only 28.9% of the Romanian population¹⁹⁸, while 25.6% of the population is cumulated in the moderate risk area, and 45.5% of the population is in the low and very low risk area.

This situation highlights the existence in each economic development region of “problem nuclei” which induce an apparently uniform drug use at country level.

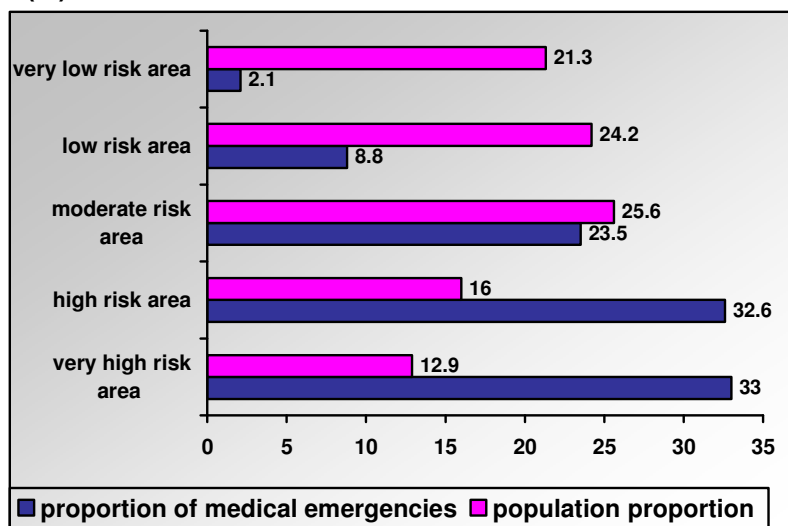
Map no. 6-1: Risk areas by predominance of drug use medical emergencies, recorded in 2010 on the territorial administrative units (counties)



Source: NAA

¹⁹⁸ Romanian population on 01.07.2009, National Statistics Institute

Graph no. 6-21: Medical emergency distribution, by comparison to population distribution, on the five risk areas (%)



Source: NAA

Typology of medical diagnosis

In relation to reported emergency diagnosis, of the 2935 cases, 89.3% (2622 cases) were caused by acute intoxication with different substances (medicines included), 5.7% presented withdrawal syndrome – 168 cases, 1.6% were caused by overdose – 46 cases, 1.4% presented symptoms of coma – 41 cases, and 1.9% presented other diagnoses determined by use of psychoactive substances (self-induced lesions and trauma, accidents and other external causes, harvest of biological testing material) - 58 cases.

As compared to 2009, the following facts result:

- the increased number of cases of acute intoxication, from 77.3% in 2009, to 89.3% in 2010;
- the maintained low number of withdrawal cases (6% in 2009, 5.7% in 2010);
- the significant decrease in the number of overdose cases, from 14% in 2009 to 1.6% in 2010, and also in the number of cases of coma, from 3.1% in 2009 to 1.4% in 2010;
- the increase in the number of cases of diagnoses induced of caused by psychoactive substance use (self-induced lesions or trauma, accidents and other external causes), from 0.2% in 2009 to 1.9% in 2010.

Analysing the types of diagnosis, by comparison to the situation recorded in 2009, the findings are:

- the significant increase in the number of intoxication with ethno-botanical substances, from 8.6% in 2009 to 38.9% in 2010.
- a slight increase in the number of cases of acute medicine intoxication with one or several medicines, from 12.2% in 2009 to 17.6% in 2010
- the decrease of the number of emergency cases caused by use of heroin/opiates (intoxication, overdose, withdrawal), from 25.8% in 2009 to 6.7% in 2010 and of cases caused by use of cannabis/marijuana, from 4.6% to 3.2%;
- the significant decrease of the cases recorded as unknown substance intoxication from 33.1% in 2009 to 11.5% in 2010

The following findings result after a more detailed analysis conducted of diagnosis categories: de diagnostic:

- **Acute intoxications** : out of the 2622 cases of acute intoxications, the highest number preponderance is held by acute new substances intoxication (“ethno-botanicals”) – 43.6%, followed by acute medicine intoxication – 17.5%, acute intoxications with unknown substances – 12.0%, poly-drug use – 8.8%, acute intoxication with heroin/opiates – 6.1%, acute drug intoxication (unspecified active substance) – 3.1%, cannabis/marijuana acute intoxication – 3.3%, ethanol acute intoxication – 1.9%, acute poly-drug intoxication – 2.2%. The other types of acute intoxication with amphetamines, cocaine, methamphetamine, volatile chemical solvents, ketamine, ecstasy, toxic substances) hold a percentage of under 1%.
- **Withdrawal**: in relation to the recorded withdrawal cases, out of the 168 cases, the highest number are the cases of opiates withdrawal – 32.%, followed by the cases of medicine withdrawal

- 17.3%, then the unknown psychoactive substance withdrawal – 16.7%, by poly-drug withdrawal 15.5%, the so-called „ethno-botanical” withdrawal – 11.3%, cannabis/ marijuana withdrawal – 4.8%, cocaine withdrawal – 1.2% and amphetamine withdrawal – 0.6%.
- **Overdose:** out of the 46 recorded cases of overdose, 40 have been reported as opiate overdose, 4 medicine overdoses and one cocaine overdose, respectively one marijuana overdose.
- **Coma-** in 2010, out of the 41 coma cases, 26 cases were caused by the use of a single psychoactive substance, the rest of 15 cases being attributed to poly-drug use. From the identified self-reported substances in these cases, we mention: benzodiazepine – 9 cases barbiturates – 9 cases, tri-cyclic antidepressants – 4 cases, unknown substances – 4, heroin/ opiates – 3 cases, 'ethno-botanic" substances – 2 cases, MDMA (ecstasy) – 1 case, metamphetamine – 1 case, amphetamine – 1 case, cannabis/ marijuana – 1 case, toxic substances – 1 case, ethanol – 1 case, other medicines -1 case.
- **Other diagnoses:** out of the 58 patients who presented other diagnoses induced or determined by drug use (self-induced lesions and trauma, accidents and other external causes, harvest of biological testing material), 39 cases presented for harvest of biological material (usually parents bringing their children to test for drug use), 5 cases of tachycardia with psychomotor restlessness, 1 case of forearm boil (resulted from drug injection), 1 head trauma, 2 valerian intoxication cases.

Table no. 6-16: Distribution of non-fatal drug use emergencies recorded by emergency diagnosis, compared data 2009- 2010 (%)

Emergency diagnosis	2009	2010
Acute intoxication with ethno-botanical substances	8.6	38.9
Acute pharmaceutical intoxication	8.3	15.6
Acute intoxication with unknown substances	33.1	11.5
Acute poly-drug intoxication	6.2	8.2
Heroin/opiate acute intoxication	9.4	3.5
Acute cannabis/ marijuana intoxication	4.6	3
Acute intoxication with illicit drugs (unspecified active substance)	1.4	2.7
Acute poly-pharmaceutical intoxication	3.9	2
Opiate withdrawal	3.8	1.9
Acute alcohol intoxication	0.6	1.7
Coma	3.1	1.4
Opiate overdose	12.6	1.4
Harvesting of biologic material for testing	0	1.3
Pharmaceutical withdrawal	1.2	1
Withdrawal following psychoactive substance use	0	1
Poly-drug withdrawal	0.2	1
Withdrawal following ethno-botanical substance use	0	0.7
Others	0.2	0.6
Acute cocaine intoxication	0.2	0.5
Acute intoxication with volatile chemical dilution agents (glue)	0.6	0.5
Acute met-amphetamine intoxication	0.3	0.4
Acute ecstasy intoxication	0	0.3
Acute amphetamine intoxication	0.2	0.2
Acute toxic substance intoxication	0	0.2
withdrawal following use of cannabis/ marijuana	0	0.2
Acute ketamine intoxication	0.3	0.1
Cocaine withdrawal	0	0.1
Pharmaceutical overdose	0	0.1
Acute LSD intoxication	0.1	0
Amphetamine withdrawal	0.1	0
Cocaine overdose	0.4	0
Cannabis/ marijuana overdose	0.2	0
Poly-drug overdose	0.3	0

Source: NAA

We specify that in 101 cases, the emergency diagnosis also mentioned suicidal attempt (in 77% of these cases pharmaceuticals had been used), and in 670 cases, the drug use medical emergency also had other implications and consequences on the patient's health, such as: self-aggression (wounds, concussions), head trauma, behaviour or personality disorders, depression syndrome, psychomotor distress, panic attack, tachycardia, vertigo, infectious disease (HIV, HBV, HCV), cardiac and respiratory arrest, traffic accident, acute respiratory insufficiency, post-injection infected wounds, neurological dystonia, etc, and in over a third of these situations (34%) the medical record mentioned drug use ("ethno-botanicals").

The analysis of the medical emergency diagnosis distribution, at economic development regions, shows:

- The acute amphetamine intoxication cases prevail in North-East region (40% of the total of cases), while the rest is evenly distributed in the Regions of Bucharest-Ilfov, South and South-West (20% each).
- According to the number of non-fatal drug emergencies with acute cannabis/marijuana intoxications, although they are to be found in all economic development regions, the prevalence is in Bucharest-Ilfov region (25,5% out of the total of intoxication cases) and the South region (20%). A similar situation is found in the case of acute cocaine intoxication, which are recorded nationwide (with the exception of the South-West Region), but they are more numerous in the regions of North-East and North-West (each with 25% of the total) and in Bucharest-Ilfov (18.8%).
- Regarding ecstasy use medical emergencies, they are concentrated in only 3 regions (Centre, South, North-East), and they prevail in North-East region (62.5% of the total of these intoxications).
- Heroin/opiate acute intoxications are distributed in all regions, but they prevail in Bucharest-Ilfov region, where more than half of the cases are concentrated (50.3%) and in the West (20.1%).
- Ketamine acute intoxications, amphetamine and cocaine withdrawal and also cocaine overdose emergencies, though less numerous, are characteristic only to the North-West region. The same happens with toxic substance intoxication and cannabis/marijuana overdoses, which are found only in Bucharest-Ilfov region.
- Medical emergencies diagnosed with withdrawal following use of opiates, respectively opiate overdose are concentrated especially in two regions: Bucharest-Ilfov (47.3% of the total of opiate withdrawal, respectively 70% of the opiate overdose cases) and North-West (30.9% of the total of opiate withdrawal, respectively 22.5% of the opiate overdose cases). A similar situation is to be found in the cases of cannabis/marijuana withdrawal medical emergencies which prevail in Centre and South-West regions, where 37.5% of this diagnosis total is recorded.
- Though not very numerous, metamphetamine acute intoxications seem to be a feature of the regions of Centre (35.7% of this type of intoxication), North-East (28.6%) and South (28.6%). Alcohol use intoxication medical emergencies are characteristic for the South-East region, where we find 62.7% of the total cases, while pharmaceutical abuse medical problems, although found all over the country, prevail in North-East region (26.8% of the total pharmaceutical intoxication cases) and in the South region (23.3%).
- In relation with new drug acute intoxications ("ethno-botanicals"), they are present nationwide and are distributed evenly at the level of four regions – North-West (21.7% of the total cases), Bucharest-Ilfov (21.2%), South-East (16.5%) and North-East (16.2%).

At the level of each economic development region, the distribution of emergency cases according to diagnosis type is the following:

- Though one of the characteristics of **Bucharest-Ilfov region** remains the heroin/opiate use (in 2010, approximately 27% of the emergency cases recorded in this region have been diagnosed as heroine/opiate acute intoxication cases, opiate overdoses, withdrawal cases and coma), there is significant decrease in proportion of this type of emergencies in this region's case record (from 64% of the total number of non-fatal cases recorded in 2009 in this region to 27% in 2010). On the other hand, there is an increase in proportion for the new drug ("ethno-botanicals") acute intoxication cases recorded, from 7% in 2009 to 33% in 2010, which could explain the shifting of an important segment of possible heroin/opiate users to the area of new drug ("ethno-botanicals") use.
- In the **North-West** region, the most important proportion of medical emergencies in 2010 were caused by pharmaceutical use (over 41%); by comparison to the previous year, there is a significant proportion decrease for the segment "unknown substance acute intoxication" (from

58% to 9%), associated with a spectacular increase in proportion of the new drug (“ethno-botanicals”) acute intoxication cases, from 3% in 2009 to 19% in 2010. In addition, we observe the doubled proportion of poly-drug use acute intoxication cases (from 8% to 15%), and the decreased proportion in cannabis/marijuana acute intoxication cases – from 5% in 2009 to 1% in 2010;

Map no. 6-2: Distribution of drug use emergency diagnosis, by economic development region, recorded in 2010



Source: NAA

- In the **South-East region**, the distribution of non-fatal drug use emergencies, by emergency diagnosis, shows a slight increase of new drug (“ethno-botanicals”) intoxications – from 24% in 2009 to 30% in 2010, at the same time with a significant decrease of unknown substance acute intoxication (from 76% in 2009 to 26% in 2010), and also the introduction in a very high proportion of pharmaceutical acute intoxication – from 0% in 2009 to 21% in 2010);
- In the **West region**, by comparison to the previous year, there is a significant decrease in the proportion of “unknown substance acute intoxication” (from 27 % of total cases recorded in this region to 8%), associated with the spectacular increase in the proportion of new drug (“ethno-

botanicals”) acute intoxication cases, from 0% in 2009 to 66% in 2010. We must also note the spectacular decrease in proportion of the cases of pharmaceutical intoxication medical emergencies – from 73% in 2009 to 5% in 2010.

- In the **Centre region**, although the proportion of unknown substances intoxication cases (from 55% of the total cases recorded in this region in 2009 to 37% in 2010), it still is high. Other diagnoses that characterise this region are new drug (“ethno-botanicals”) acute intoxication (18%) and alcohol acute intoxication (16%).
- In the **South region**, though pharmaceutical abuse medical emergencies continues to be the main problem of the region (from 35% of the total cases recorded in this region in 2009 to 34% in 2010), there is a spectacular decrease of cannabis/marijuana use intoxications (from 25% in 2009 to 4% in 2010), at the same time with an increase of the new drug (“ethno-botanicals”) acute intoxication (from 4% in 2009 to 26% in 2010).
- **The South-West region** seems to be characterised by new drug (“ethno-botanicals”) medical emergencies whose proportion of the emergency cases in this region has greatly increased (from 25% in 2009 to 71% in 2010). At the same time, there is a drastic decrease of acute intoxication by illicit drugs of unspecified active substance (from 25% in 2009 to 1% in 2010), of poly-drug use intoxication (from 25% to 0%) and of heroin/opiate acute intoxication (from 25% to 1%). Moreover, there is an increased proportion of unknown substance intoxication – from 0% in 2009 to 18% in 2010.
- In the **North-East region**, the new drug (“ethno-botanicals”) acute intoxication are predominant, these intoxications having a spectacular increase (from 45% from the total emergency cases recorded in 2009 to 75% in 2010), in the conditions of better diagnosing for unknown substance acute intoxication (decrease from 21% to 1%) and for illicit drugs with unspecified active substance (decrease from 15% to 3%).

Toxicological findings and identified substances

In view of determine the presence in the human body of the substances used by the patient, the testing was made only for 1023 patients (34.9%), for whom the accountability of drug use for the emergency case could be shown. In 512 of these cases (50% of the total of cases toxicologically tested and 17.4% of the whole total), the tests were positive, showing the presence of substances such as: metamphetamine, amphetamine, cocaine, cannabis/ marijuana, ethanol, ecstasy, heroin, methadone, other opiates, benzodiazepine, barbiturates hypnotics and sedatives, other pharmaceutical substances. out of the 512 toxicologically tested cases, in 391 cases a single substance was found, in 98 cases two substances were found, in 19 cases 3 substances, and in 4 cases 4 substances were found.

Table no. 6-17: Toxicological results related to drug emergencies, compared data 2009-2010 (no. of cases, %)

	2009		2010	
	Nr.	%	Nr.	%
No. of cases	999	100	2935	100
No. of cases for which toxicological results were determined	275	27.5	1023	34.9
No. de cases with positive results	191	19.1	512	17.4

Source: NAA

By comparison to 2009, although there is an increase in the number of cases tested for toxicological determinations (from 275 to 1023) and implicitly of the number of cases in which various substances were found (from 191 to 512), the proportion of cases in which toxicological tests are made is of only one third of the cases, which shows that in most situations the doctor on call is forced to establish a diagnosis only based on inquiry and symptoms

On the other hand, in most toxicologically tested cases, they were quality tests (the used tests sometimes had a limited range of control substances) which explains why the emergency diagnoses does not agree with the identified substances, the quality methods having a high degree of uncertainty. In addition the new psychoactive substances (“ethno-botanicals”) may test false positive, indicating the presence of substances such as: cannabinoids, amphetamine, metamphetamine.

Drug administration route

According to the drug administration route, the oral and the injecting route, prevail in the overall non-fatal emergencies' picture as reported in 2010 – 33.5%, respectively 28.6% of the cases, taking into consideration that in one third of the cases (31.6%) this specific information does not exist. By comparison to 2009, there is a significant decrease in the proportion of the cases in which the injecting route was used – from 25.5% in 2009 to 3.1% in 2010, at the same time with an increase in the proportion of those who came to the emergency units for drug use by inhaling route – from 13.6% in 2009 to 33.5% in 2010.

Table no. 6-18: Distribution of patient with non-fatal drug emergencies by drug administration route, in 2009 – 2010 (no. of cases)

Administration route	2009	2010
Oral	335	839
Unspecified	266	928
Injected	255	91
Inhaled	136	983
Injected, oral	3	3
Inhaled, oral	2	17
Sniffed	1	44
Inhaled, injected	1	20
Inhaled, sniffed		8
oral, sniffed		1
oral, inhaled, injected	0	1
Total	999	2935

Source: NAA

Conclusions:

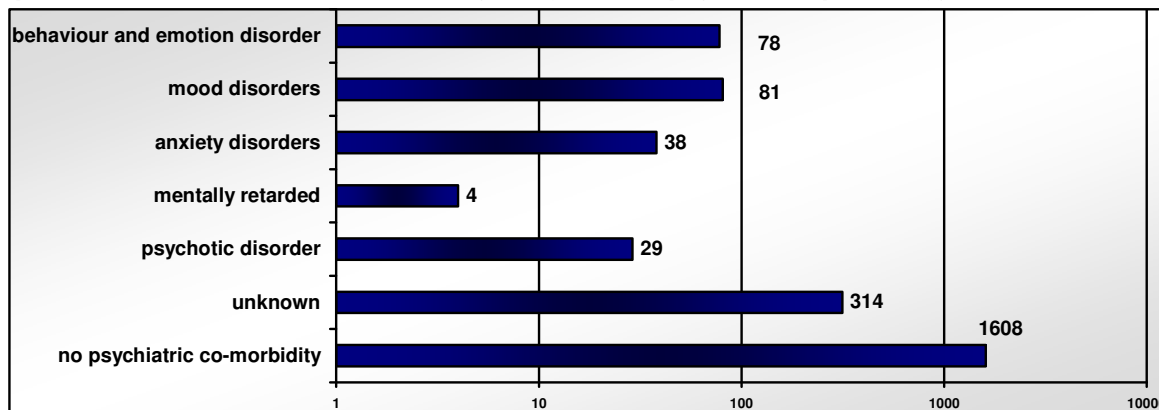
- The spectacular increase in the number of new drug ("ethno-botanicals") acute intoxications correlates with the significant decrease of unknown substance intoxication cases (case proportion is almost 3 times higher than the previous year) and with the decrease of heroin/opiate use emergency cases (case proportion is almost 4 times lower than the previous year). This fact may mean change in heroin/opiate users' behaviour and user segment migrating to new drugs, and also an improvement in diagnosing drug use emergency cases in general and of the new drug cases ("ethno-botanicals") in particular.
- Though at economic development region level there is a uniform distribution of the drug related medical emergencies, an in-depth data analysis shows only restricted areas where the health consequences of drugs, resulting in medical emergencies, are more numerous.
- Correlating the age of the persons who needed emergency services in 2010 for drug causes (the average age is 25.56, 49.1% being 20 to 29 years of age), and concentrating two thirds of the drug use medical emergencies (65.5%) in the counties with large urban settings, with university centres, with leisure facilities and transit areas, and also where new drug ("ethno-botanicals") emergency diagnosis prevails, the idea of drug use in leisure activities settings may be induced, especially regarding youngsters.
- New drug ("ethno-botanicals") medical emergencies recorded in 2010 fall under the diagnosis "acute intoxication" – out of the total of 2622 drug use related acute intoxications in 2010, 42.6% have been ethno-botanical acute intoxication cases, less out of the ranks of withdrawal cases – 11.3% of 168 cases, while among the overdose cases, none was caused by the use of ethno-botanicals, and out of 41 diagnosed cases of coma, only in 0.7% of the cases the diagnosis was the result of such substances' use;
- The significant decrease in the proportion of cases in which psychoactive substances have been injected – from 25.5% in 2009 to 13.6% in 2010 and the increase in the proportion of inhaling of substance cases – from 13.6% in 2009 to 33.5% in 2010, this increase may also be associated with the spectacular increase in the number of new drug ("ethno-botanicals") medical emergencies;
- At the level of Romanian territory, the phenomenon of psychoactive substance use is less extensive and it can be successfully neutralised by focused prevention programmes.

6.2.2 PERSONALITY DISORDERS, DEPRESSION, ANXIETY, EMOTION DISORDERS ETC

For this sub-chapter 2163 unique cases were analysed and extracted from the data base on the Drug Treatment Demand Indicator as reported by the 47 DPECC / 5 IACC, 14 units of the Ministry of Health's network and 3 outpatient private centres.

The analysis of the data showed 230 people (10.6% of the cases) were diagnosed with different psychiatric disorders. Of these, the most frequent were *behaviour and emotional disorders* in 81 cases (3.7%), followed by *mood disorders* – 78 cases (3.6%).

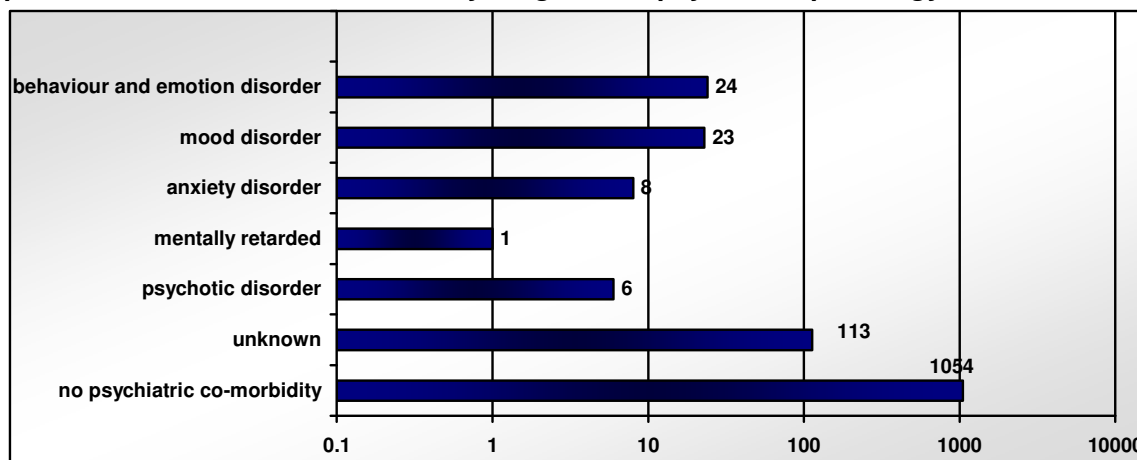
Graph no. 6-22: IDU case distribution by drug related psychiatric pathology, 2010



Source: NAA

Out of the 2163 recorded people, 1233 were injecting drug users (IDU), and the analysis of these cases according to the associated psychiatric pathology resulted in 62 people who had used injected drugs and had several psychiatric disorders (5%). *Behaviour and emotional disorders* was the most frequent diagnosis for 24 cases (1.9%), followed by *anxiety disorders* – 23 cases (1.8%) and *mood disorders* – 8 cases (0.6%).

Graph no. 6-23: IDU case distribution by drug related psychiatric pathology, 2010



Source: NAA

6.3 DRUG RELATED DEATH AND MORTALITY OF DRUG USERS

6.3.1. DRUG-INDUCED DEATHS (OVERDOSES/POISONINGS) AND SPECIFIC CAUSES OF MORTALITY INDIRECTLY RELATED TO DRUG USE

Drug related deaths are of violent cause, in which a role is played, directly or conditionally, by a chemical traumatic factor – used substances – or the act of administering it and its consequences. Death directly as a consequence of drug use is part of the group of suspected and/or violent deaths and legal inquiry is necessary, under the provisions of the law in force, and it results in forensic autopsy¹⁹⁹.

The national legal-medicine network is made up of 53 legal-medicine units:

- Legal Medicine National Institute Mina Minovici Bucharest;
- 5 Legal Medicine Institutes in: Iași, Cluj-Napoca, Craiova, Târgu-Mureș, Timișoara;
- 36 Legal Medicine County Services (SJML) in each county municipality (except for the university centres holding Legal Medicine Institutes and for Bucharest).
- 11 Legal Medicine Clinics subordinated to a corresponding County Service and located in towns or municipalities: Lugoj, Cîmpulung-Argeș, Comănești, Făgăraș, Petroșani, Sighetul Marmăției, Mediaș, Cîmpulung Moldovenesc, Rădăuți, Bârlad, Onești.

The Special Mortality Record contains data that reflect the case experience of the Legal Medicine network in the whole country, mainly of the LMNI “Mina Minovici” Bucharest, of the legal-medicine institutes and of all county legal-medicine institutes. As the deaths resulted from drug use are cases that include a traumatic component, according to law, all such cases impose of a compulsory manner, the forensic autopsy.

The data presented in this sub-chapter are cases recorded in the legal medicine institutions that are the only entities entitled to manage such cases. All forensic cases, once established as legal cases, shall be tested toxicologically (except for the selected cases – of post-intoxication long term survival, with medically documented investigation). Forensic autopsy files – around 20,000 annually nationwide – represent the selection basis for the Special Mortality Record afferent to drug related deaths.

Case centralising is made on the basis of National Network of Legal Medicine internal protocols, and it implies standard reporting files, with data processing at LMNI Mina Minovici level. The methodology of death case inclusion in the group of drug use associated deaths implies the legal and evidence analysis and the corroboration of the data with toxicological results – performed in such cases and with the data resulted from the medical inquiry, including conclusion adjusting after complete documentation of the case, thus avoiding the classification (or not) of the case only on the basis of immediate information available at the moment of death record.

For 2010, the analysis is based on the case record from the national network of legal medicine of Romania. This year, besides at LMNI Mina Minovici from Bucharest, the other legal medicine institutions have provided information, the case reporting was made from 35 counties and Bucharest (only 6 counties did not send data). This time there were no reports of drug related deaths outside Bucharest (except for one case from the surrounding area reported by SML Ilfov). In addition to this there are 3 cases from Constanta county which belong to the group of drug related cases, but from the group of indirect deaths.

¹⁹⁹ Based on the provisions of Ordinance no. 1/2000 regarding legal medicine institutions organising and functioning, as further amended and supplemented

The experts consider that the under-reporting degree is significant, and it is a consequence of lack of experience in case management for drug related deaths, of legal and forensic knowledge, and also of financial limitations.

Though the main impediment in identifying drug related deaths in the past period of time – lack of performance toxicological laboratories – at this moment has been surpassed, the reporting level seems unchanged.

In conclusion, in 2010, 34 cases have been reported at national level (33 in Bucharest, 1 case in Ilfov County) as drug related deaths. All the 34 cases have confirmed by toxicological testing the presence of psychoactive products, the tests have been conducted in the Toxicology Laboratory of LMNI Mina Minovici (at present, practically, the reporting of a drug related death is based on viable toxicological tests, as an objective evidence element, thus limiting the importance of subjective circumstantial selection factors). For 6 of the cases, the relevant toxicological examination was conducted in the laboratories of the hospital in which the patients had been admitted over a long period of time, which did not allow for relevant toxicological examinations upon autopsy even though a negative result was expected considering that hair examinations, the only biological test relevant in toxicological examinations, were not performed on account of technical difficulties. The improvement of technical resources of specific emergency medical units from Bucharest is to be noted, units able to carry out viable, performance toxicological tests.

15 drug related deaths were also recorded of known drug users (with elements of clinical examination – autopsy – eloquent medical history data and investigation), but whose cause of death was related to associate pathology or consecutive to chronic – acute drug use, and not to intoxication (cases of so-called “indirect causality”).

The high number of *indirect death* cases – comparative to the previous years – most probably represents the expression of the medical and investigation staff understanding the necessity to classify these cases as legal-medical cases (considering the role that drug use has in the cause ration of death).

But there is, from the point of view of the increase in number of the cases identified within the legal-medical network as indirect drug related deaths, an inevitable analogy with the cases of *direct drug related deaths*. In around a third (10 cases) of the cases of drug related deaths (death which is a direct consequence of psychoactive substances) element of severe pathology have been identified, similar to that of indirect case - most ailments being represented by septic complications (pneumonia, broncho-pneumonia, injecting place upper limb cellulites, boils; sever chronic hepatitis).

A special attention must be given to the increase in the incidence of infectious endocarditis with drug users in Romania: about 10% of the cases, both direct drug related deaths, and indirect mortality (while worldwide statistic data presents a percentage varying from 10 to 25% of the IDUdin CDI), but also complications from the act of drug injection (tromboflebitis) or generated by the injected dose (the street dose is a mix of substances with or without psychoactive potential, the compound are able to generate complications independent of the drug it dilutes – pulmonary granuloma, tromboemboli generated by the insoluble products – talcum.

As for the previous years, the practice of methadone injection originating in dissolving pills and injection of a wide spectrum of pharmaceuticals in the form of tablets/pills, are an important source of insoluble products introduced intravenously, the compounds of these medicines usually include talcum.

The acute aspects of some of the above mentioned pathologies (other than lethal intoxication) sustain the low quality of street drug doses, *unhygienic injecting*, ignoring/not complying to minimal precautions for reduction of risks related to drug use.

Chronic pathology, corroborated with the ever increasing number of cases, shows the aging of drug using population, with an ever longer history of a use/abuse/addiction, which allowed for complications and progressive deterioration.

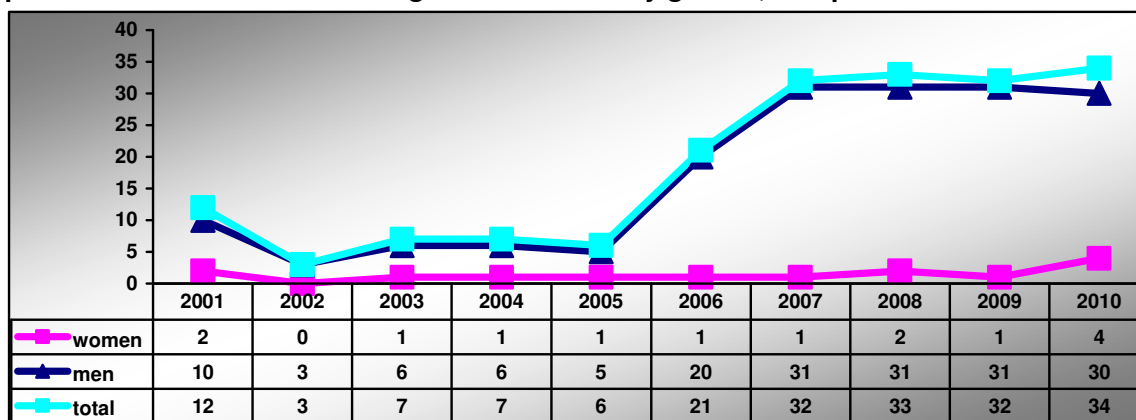
An empiric, almost colloquial aspect showed by the immediate family of the deceased persons, but with arguments that might call for future in-depth study, is the frequent accounting of a very rapid deterioration and progressively accelerated of old users' health, once they supplemented the main drug of abuse with products from the group of "legal highs". Either their origin (sometimes plants) is a source of bacteria/fungi, or by amphetamine type action.

Three of the indirect drug related death cases were suicide by hanging cases (two cases in which investigation showed a heroin/alcohol combination, and flurazepam respectively), and drowning (caused by cocaine, THC and alcohol).

In conclusion, in 2010, the following data have been recorded:

- 34 cases reported as direct drug related deaths nationwide (except for non-reporting 6 non-reporting counties) - 33 from Bucharest and one from Ilfov county – all having a positive toxicological testing. Out of these cases, 30 were male and 4 female.
- 15 cases of indirect drug related deaths: 12 from Bucharest, 3 from Constanța.

Graph no. 6-24: Distribution of drug related deaths by gender, compared data 2001-2010

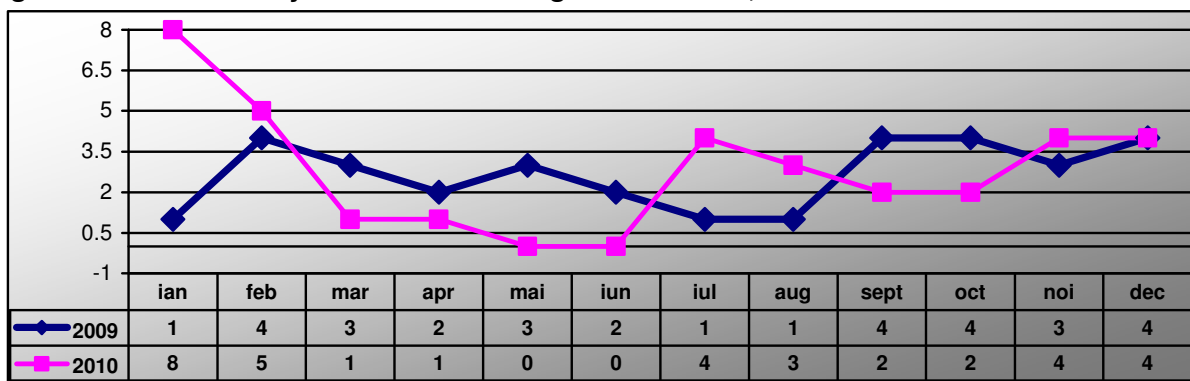


Source: LNMI Bucharest

We should note that:

- After variations from 2001 to 2005, there has been a variable tendency in the last 4 years, with figures significantly higher than in 2001-2005, as an evidence of continuously increasing detection capacities – selection – legal-medical management – toxicological detection (corresponding to the implementation of drug related death algorithms and the re-engineering of the toxicology laboratories in parallel with staff training)²⁰⁰.
- The increasing number of deaths among women.

Figure no. 6-25: Monthly distribution of drug related cases, 2009-2010

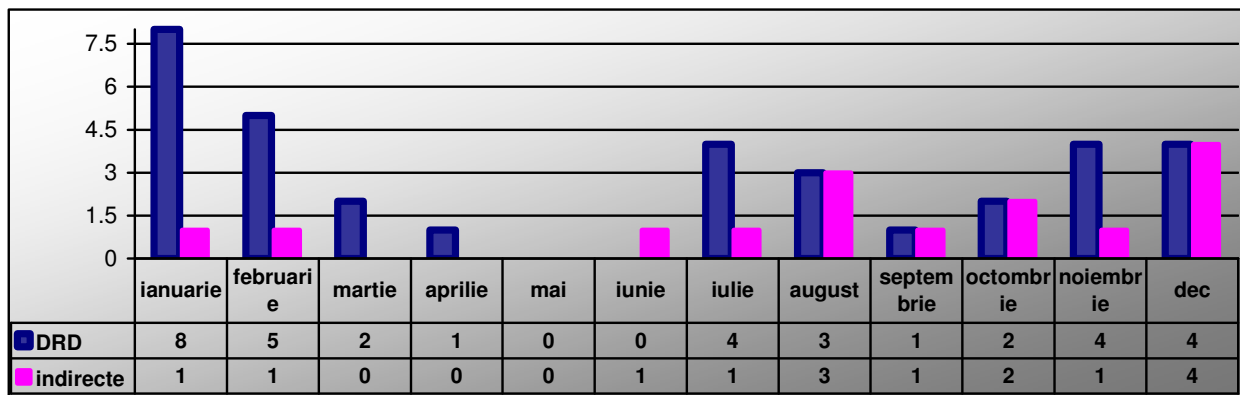


Source: LMNI Bucharest

²⁰⁰ See standard table ST6

Regarding the monthly distribution of drug related deaths, we note peaks of incidence, the highest is January 2010, with double values as compared any other month of 2010, but also as compared to the previous years.

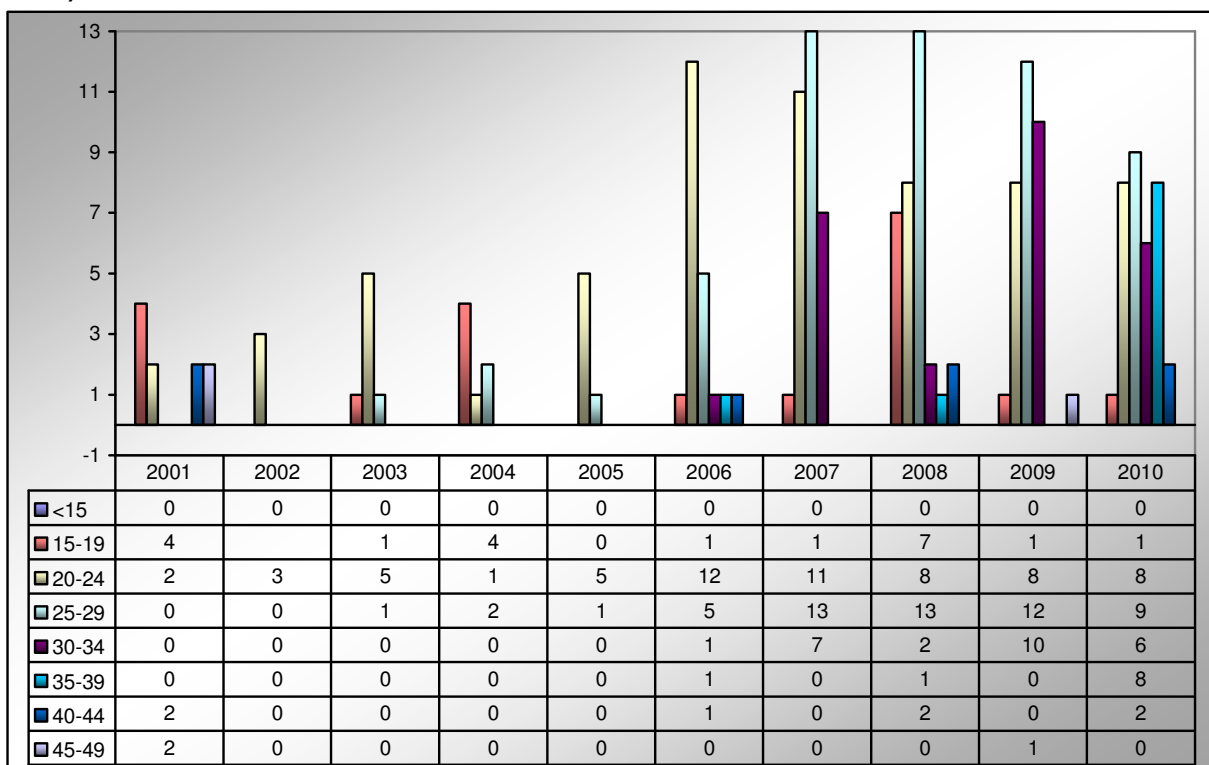
Graph no. 6-26: Monthly distribution of drug related cases, by direct or indirect death type, 2010 (no. of cases)



Source: LMNI Bucharest

As for the drug related deaths' age, we observe that all cases of drug related deaths recorded from 2001 to 2010 were persons aged 15 to 49, most of them belonging to the age group 20-34.

Graph no. 6-27: Distribution of drug related deaths by age, compared data 2000 - 2010 (no. of cases)

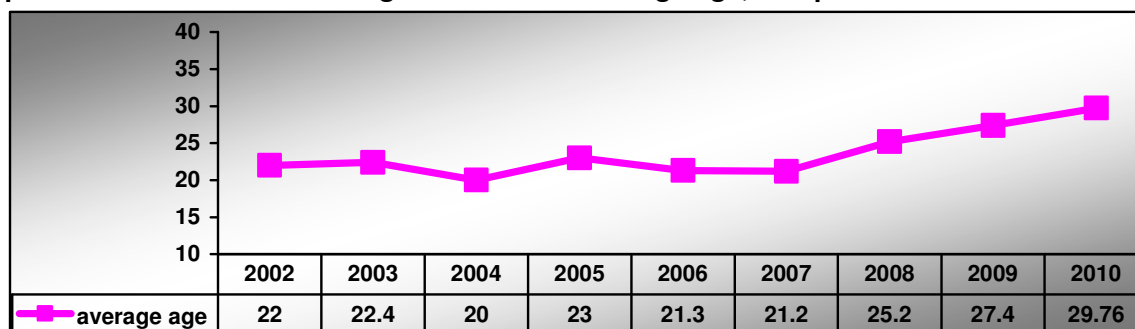


Source: LMNI Bucharest

If in 2008 an important number of drug related deaths was registered among very young people (15 to 19 years, with a short drug use record), while the average age increased pointing to a longer drug use history as an indicator of the "aging" of the users, starting with 2009 (increasing in 2010), there was a considerable increase of drug related deaths among adult users aged 30 to 34, with a long drug use history and with a progressive accumulation of pathology and risks.

Average age of direct drug related death has an increasing trend, for 2010 it is 29.76 years of age (as compared to 27 years, the indirect drug related death age), possibly by prevention through better information on the risks of death on first drug use (first doses).

Graph no. 6-28: Evolution of drug related death average age, compared data 2002-2010



Source: LMNI Bucharest

In 2010, the place of death shows that:

- 11 persons died at home,
- 3 users died in public places (street, waste land, park),
- 1 person died other residencies,
- 19 deaths in hospital units.

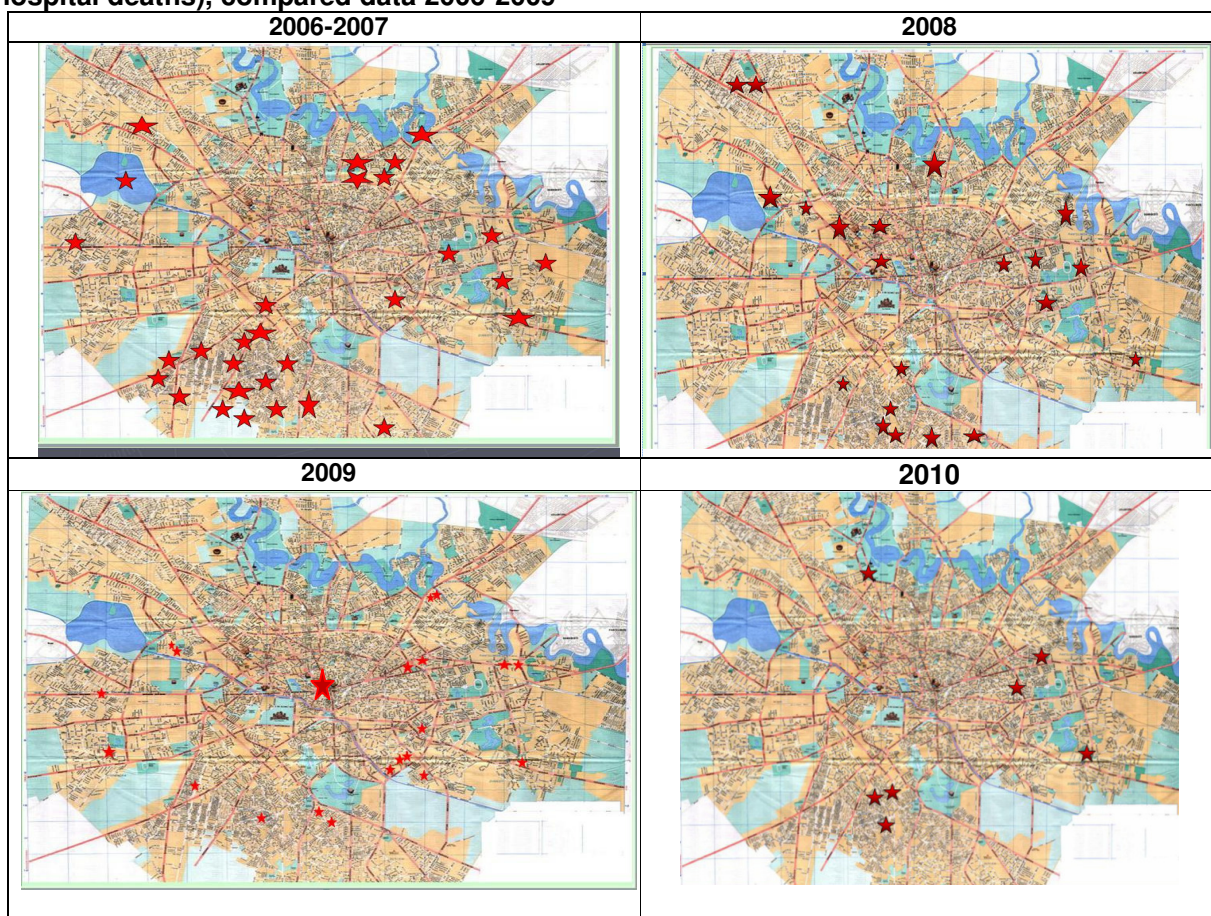
Data similar to the previous years: it can be stated that there is no major change in use habits (across the street from user places). There is, however, an increase in medical units addressability of the terminal cases. The drug user is frequently brought to medical units by family or friends, possibly as a result of increasing trust in medical services parallel to diminution of fear concerning legal consequences and also because of measures taken for risk population medical education.

As for drug related death distribution recorded in Bucharest, at the beginning of the monitored period, the risk area Rahova-Ferentari covered most of death cases. After the "homogenous" geographical distribution trend over the last 2-3 years, 2010 shows a polarisation of cases in Rahova- Ferentari, Pantelimon, Colentina – Doamna Ghica. For this change we must take into account the high number of such deaths in hospitals, which may contribute to masking the exact distribution of drug use places, based on death place criterion.

Based on the information obtained during investigation data collection, in only 5 cases there was no drug use history or known previous facts. It is necessary to inform and train drug users on the administration technique (dose, concentration and frequency) in view of mimetic administration within user group and decreasing of first use (first dose/doses) death. The possible recruiting by dealers by offering of high quality first doses increases the risk of first use death.

In 29 cases of direct drug related deaths there were elements of chronic drug use – (upon autopsy drug use susceptible elements were found, some of marker-stigma value) – superficial peripheral vascular scleroses and repetitive post-injection granuloma in 13 cases, post-infection scars at injection places and or self mutilation – 17 cases, tattoos – 21 cases, cachexy in 5 cases. This confirms the fact that death occurs more rarely at first doses (possibly caused by low concentration in street doses), but especially at long history chronic drug users who relate to chronic drug use generated stigma.

Map no. 6-4 – Geographic distribution of drug related deaths recorded in Bucharest (excluding hospital deaths), compared data 2006-2009

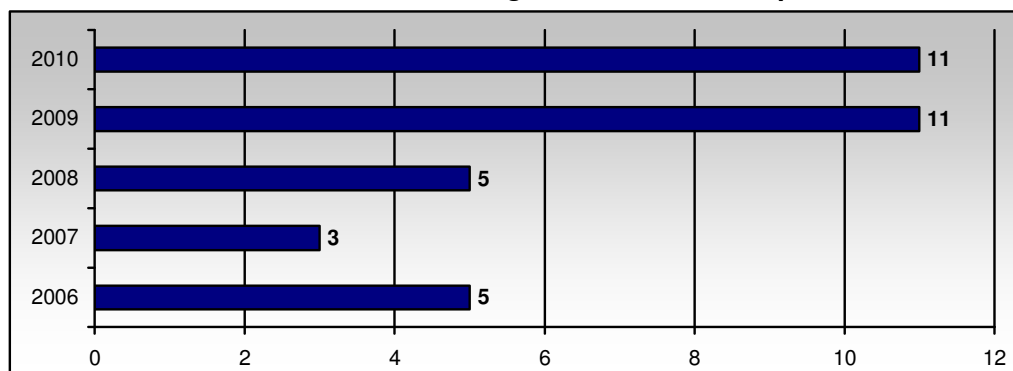


Source: LMNI Bucharest

Only two cases implied non-injection – inhaling-sniffing and ingestion, all the other cases were only injection drug users – only intra-venous route. This indicator shows injection route to be the main drug use route in Romania (in 2010 95.12% of drug related deaths, comparative to 87.5% in 2009). This correlates to the high incidence of associated pathology, mainly infectious-chronic type (especially HCV and HBV infection) or acute-sub-acute type (endocarditis, sepsis).

The substitution treatment death cases – methadone (found in 11 cases – similar to 2009, with an increasing trend as compared to previous years, 3 cases in 2007, 5 cases in 2006) – shows the necessity of a firm control for this treatment – under direct supervision and in liquid form.

Graph no. 6-29: Detection of methadone in drug related cases, compared data 2006-2010

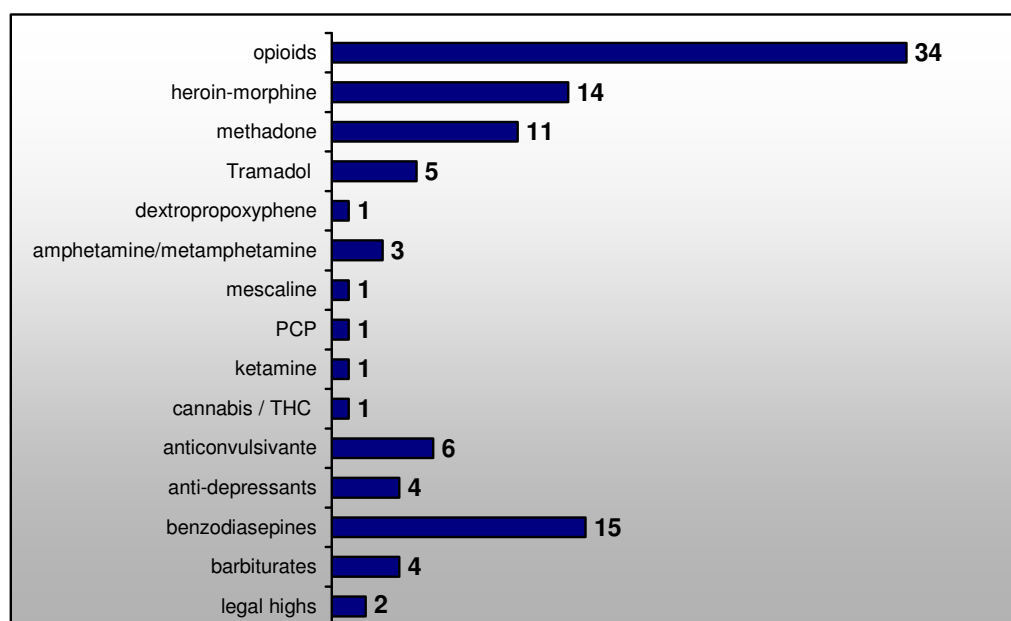


Source: LMNI Bucharest

In 11 cases, drug paraphernalia was identified on the site – 10 syringes, 2 bags of lemon salt, improvised spoon, 3 vials, “legal highs”. This evidence was not always provided to the forensic doctors. The toxicology test gave positive results in all cases. In all cases in which the forensic doctors were presented with drug use paraphernalia, the toxicology results in corpse body fluids were correlated to the ones on the injecting tools. This strengthens the need of the forensic doctor to be provided with the data resulted from the forensic and toxicology investigation of paraphernalia elements.

The range of substances usually found in drug combinations continues to be dominated by opiates – mainly heroin and methadone, but a new entry is tramadol. There were no significant changes in the range of substances found as compared to the previous years, but there is a decrease in use of ketamine (possibly due to increased pharmacological vigilance and control upon sale in pharmacies), and also the use of amphetamines/metamphetamines detected in death cases. There is also the association with alcohol in the case of substances other than heroin (alcohol blood contents of 0.65 to 1.1g%).

Figure no. 6-30: Death case distribution by substance detected in toxicological examinations, 2010



Source: LMNI Bucharest

Only 10 cases of opiate intoxication accounted for the cause of death, for the others, several drug combination caused death.

The range of substances usually found in drug combinations is limited (sedatives, anxiolitics and anti-psychotics have disappeared – possibly due to increased pharmacological vigilance and control upon sale in pharmacies) similarly to illicit drugs – there were no more instances of amphetamines, cocaine. Opiates intoxications prevail (81.25%) at levels higher than the previous years when the rate was around 79% - 2008, 73% - 2007 and 53% in 2006. At the same time, there is a decrease of the rate of pharmaceuticals that are diverted from the medical use and used for psychoactive purposes.

Sedatives, anxiolitics, anti-psychotics and anti-convulsion drugs have been detected (their presence has been constant lately). At the same time, in spite of aggressive media, in many cases alarmist and poorly informed, the new drugs (sold by the name of “legal highs” or “ethno-botanicals”) were mentioned in only two death cases, but on each occasion in combination with other substances, which were held accountable for the cause of death²⁰¹. No direct new drug related deaths (sold by the

²⁰¹ The difficulties in toxicological evidence of drug use represent worldwide the main impediment of legal medical objectifying. On the other hand, according to the limited available studies, taking into account the infinitesimal doses, the clinical and action mechanisms etc, associated to these substances, there were not deaths directly related to these substances.

name of “legal highs” or “ethno-botanicals”) have been reported, the cases presented by the media, investigation officials, members of the immediate family, etc. In these cases death was toxicologically confirmed as being caused by illicit drug/pharmaceutical use, and death has been connected to their use. Facing solid investigation/ history data that clearly result in the confirmation of the use prior to death of products bought at “dream shops” and with the toxicological detection in body fluids of such drugs, the hypotheses may lead either to simultaneous new drug use (sold by the name of “legal highs” or “ethno-botanicals”), or to drug distribution by this method.

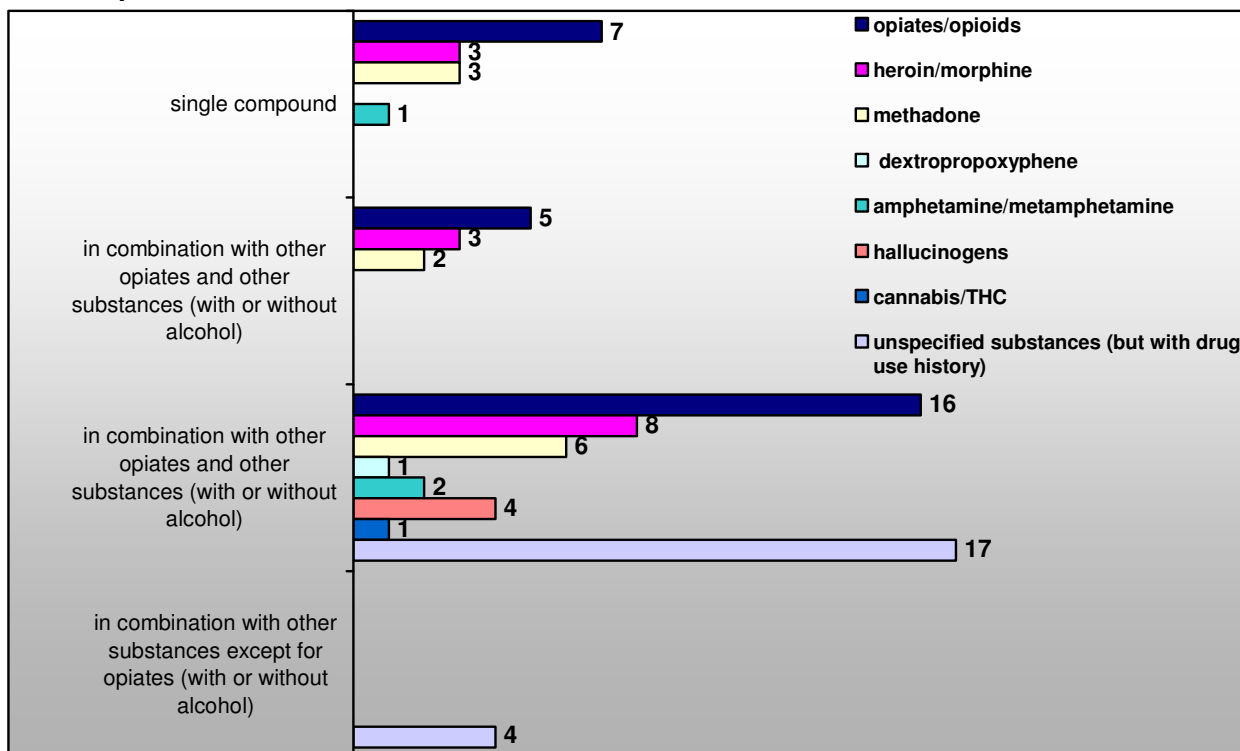
Most death cases were recorded as being the result of opiate use (76.47%), a relatively constant percentage as compared to the previous years, 81% in 2009, 79% in 2008, 73% in 2007.

In only 10 cases the concentration of the toxic substances varied between toxic and lethal, which is further proof of the medication association potency, but also the necessity of a flexible toxicological thinking in cause of death assessment. Toxicological determinations, another important process of Romanian forensic toxicology, allowed for detailed and differentiated detection and interpretation.

Toxicological examination made only at LMNI Bucharest (the other laboratories in the country, including those created in 2010, did not report direct drug related deaths for 2010) revealed the presence of opiates in 26 cases (11 methadone, 14 heroin/morphine and metabolits, 5 tramadole, 1 dextropropoxyphene), benzodiazepine – 15 detections, anti-epileptics – 6 detections, barbiturate – 4 detections, ketamină - 1 detection, anti-psychotics/ anxiolitics/ sedatives - 4 detections. These substances appeared in variable combinations, in 8 cases only one substance was detected (3 heroin, 3 methadone, 1 tramadole 1 case of amphetamine). Alcohol was detected in 4 cases with values of 0.65 g ‰ – 1.1 g ‰. For the first time hallucinogen substances such as mescaline and phencyclidine – 2 cases.

For direct drug related death cases for which viral determinations were made: 14 HCV positive cases (determinations were targeted to the cases where medical history or anatomic-pathological examination were suggestive). The high prevalence of HCV among IDU is confirmed also by this indicator. For indirect drug related deaths, serological detection revealed HIV – 2 cases, HCV 6 cases and one case of HBV.

Graph no. 6-31: Death case distribution by substance detected in toxicological examinations, sole compound or combination, 2010



Source: LMNI Bucharest

Conclusions:

- Geographic drug related case distribution – showing cases in Bucharest, Ilfov an “indirect” cases in Constanta – indicates a high level of under-reporting; under-reporting may be the result of lack of experience for the legal medical drug related death case management, legal knowledge deficiency of the medical staff, lack of drug related toxicological examination funding;
- Number of drug related death cases shows a stabilising trend for the last 4 years – as a consequence of drug use stabilising, and also of better laboratory detection capacity of and implementation of the algorithms of identification-selection-legal-medical management of these cases;
- Administration route continues to be mainly injection route, with all the inherent risks, implicitly “syringe” pathology;
- There is a significant increase in drug use related pathology – acute, sub-acute or chronic infection that justifies the need for more efficient measure implementation for drug use related risk reduction and medical training among drug users;
- The highest prevalence of drug related death cases is still in the group of opiates, but often in association with pharmaceutical products;
- There are new products on the market within the toxicological range of drug related deaths – hallucinogens, amphetamines/metamphetamines;
- There is an extension of pathology consequent to insoluble product injection;
- The number of “indirect deaths” has significantly increased – possibly due to a more strict law enforcement for death record as a necessity of forensic medicine implication;
- The death average age has increased significantly – as result of old user “aging”, of longer onset period by using “light drugs” (possibly by accessibility to new drugs emerging under the name of “ethno-botanicals” or “legal highs”, drugs of a lower implied death risk) or onset of drug use at older age by comparison to the previous years;
- Reporting is no longer limited to Bucharest, there is a unified nationwide reporting which brings forth cases from 2 other counties;
- The low number of cases from outside Bucharest is still a question mark as to the possibility of correct information - management of drug related death cases nationwide;
- The tendency of geographic agglutination for drug related death cases on the territory of Bucharest appears again;
- The emerging of new incidence peaks on a month’s period from the previous year may bring to attention a possible street dose quality fluctuation or special circumstances;
- By comparison to previous years, the quality of data reported by the main source institutions for the indicator of drug related deaths has been greatly improved and it led to increase the reported deaths, and it is connected rather to *visibility* increase of these deaths. The use of a unitary algorithm for drug related death definition and recognition, algorithm legal medical management, data collection and reporting to the conformity of the protocol established in partnership with NAA, and the significant improvement in implementing the drug use related death indicator;
- Training sessions, repeated scientific reports, experience exchanges start to prove useful by identifying a growing number of cases, even in the absence of suggestive investigation data.

Recommendations:

1. supporting the medical-legal network in attracting governmental and European funding to improve the equipment of the toxicology laboratories across the country, and extend the identification-reporting area,
2. taking further steps to implement the already made legislative proposals to report drug related deaths according to a single methodology;
3. creating a single basis of legal-medicine criteria to define drug related deaths;
4. implement an IT system to collect DRD data regarding drug related deaths;
5. dissemination at domestic and international level of the case management capacity related to drug related deaths in the medical-legal network; in order to reach a homogenous quality of toxicological detections, methodological recommendations have been sent to Legal-medicine County Services, laying down toxicological safety rules and obligations that must be observed, in line with the academic findings following intensive training and the recommendations of sample transfer to better equipped laboratories in the selected cases;
6. enabling the access of legal-medicine doctors to scientific events, workshops, experience exchange in order to bring DRD methodology to a single layout in the case of drug related deaths;

7. implementing procedure amendments in line with efficient practices – data collection and reporting circuit;
8. establishing the criminal evidence custody and/or the information flow on the results of forensic, toxicological examinations etc;
9. updating the list of psychoactive substances with a special pharmaceutical status or of those that are incompatible with certain activities
10. large-scale toxicological analysis of traumatic deaths;
11. familiarising the medical and investigation staff with the low provisions regarding compulsory legal medical approach in the drug related death case;
12. more efficient measures aimed at reducing drug use risks and medical training.

6.3.2. MORTALITY AND CAUSES OF DEATH AMONG DRUG USERS (COHORT STUDIES)

Methodology

The surveyed population in this cohort study²⁰² is made up of 5830 people admitted to treatment for opiate use from January 1st 2001 to December 31st 2006, in five treatment centres in the Municipalities in Bucharest: Psychiatry Hospital “Alexandru Obregia” – Unit 16, Psychiatry Hospital “Alexandru Obregia” – Unit 17, Mental Health laboratory no. 4, “Sfântul Stelian” Hospital, “Constantin Gorgos” Hospital – Titan. We should mention that partial data were processed for two treatment centres, namely “Sfântul Stelian” Hospital and “Constantin Gorgos” Hospital – Titan. Those people were excluded whose age was beyond the cohort inclusion age (15-49 years). The cohort was finally built on 2707 single cases, out of which 83.2% were male cases and 16.8% female.

Of the 118 death cases people over 49 were excluded as well as those who died beyond national borders. Eventually, there were 116 people included in the base, of which 105 were males and 11 females. The average age of the persons included in the cohort was of 23.37 years. The death cases accounted for 4.29% of all subjects recruited for the cohort. The mean age upon death was 27.77 years, higher among females (29.84 yrs) than males (27.43 yrs).

For each reported death, the causes of death were recorded based on the International classification of diseases ICS 10, recommended by the WHO.

Of the 116 cases:

- 74 (63.8% of the total death cases) were classified in the S00-T98 category, entitled “Injury, poisoning and certain other consequences of external causes”. Of these, 39 cases were caused by intoxication by narcotics and psychodysleptics (hallucinogens).
- 14 (12,1%) of the reported deaths were caused by diseases of the blood system (category I00-I99,
- 3 (2,6%) digestive (category K00-K99),
- 9 (7,8%) respiratory system (category J00-J99),
- 7 (6,0%) infectious and parasitical – 6.0% (A00-B99); of these four deaths were caused by HIV, which is 3.45% of the total number of deaths,
- 3 (2,6%) of the skin and subcutaneous tissue – 2.6%,
- 1 (0,9%) neoplasm – 0.9%.
- 5 (4,3%) unspecified cause of death

The cohort person-years for each person (“persons-years”) were computed based on the time of inclusion in the cohort (i.e. hospitalisation day), and on the day of death. Those who survived were surveyed until September 15, 2010.

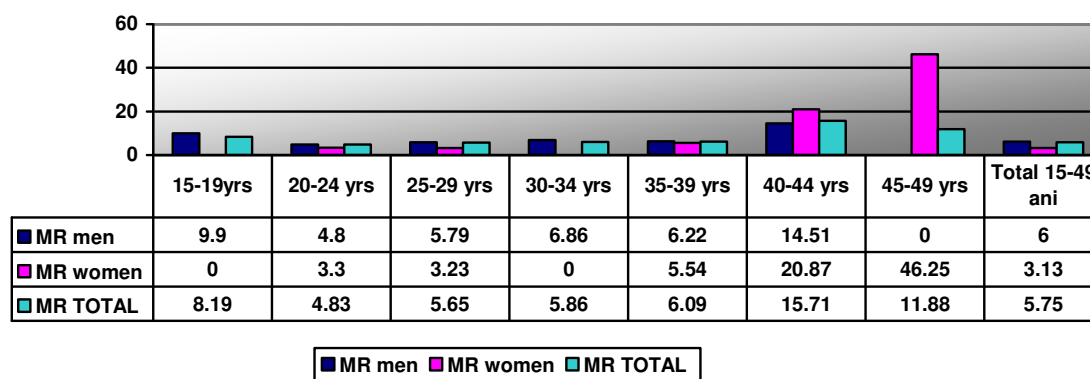
Results

1. Non-standard mortality rates

The gross mortality rate for the drug users included in the cohort was computed as the ratio between the number of recorded deaths and the total amount of cohort years that were surveyed. Additionally, the specific mortality rates for men and women were computed, as well as mortality rates by age groups.

²⁰² Andrei Botescu (coord.), Aurora Lefter, Ruxanda Iliescu, Milica Georgescu (2010) – A study of drug users mortality treated in medical units from Bucharest in 2001-2006

Graph no. 6-32: Non-standard mortality rates, by gender and age categories



Source: NAA

The **gross mortality rate** of the cohort population, throughout the observation time, amounted to 5.75 in 1000 person-years (PY); 6.00 in 1000 PY for men and 3.13 in 1000 PY for women. The lowest age-specific gross mortality rate was noticed in the age group 20-24 (4.83 in 1000 PY) while the highest age-specific gross mortality rate was noticed in the cohort population aged 40-44 (15.71 in 1000 PY). Generally, mortality rate increases with the age in the case of female population, recording distressing values for the age groups 40-44 yrs (20.87 in 1000 PY) and 45-49 yrs (46.25 in 1000 PY).

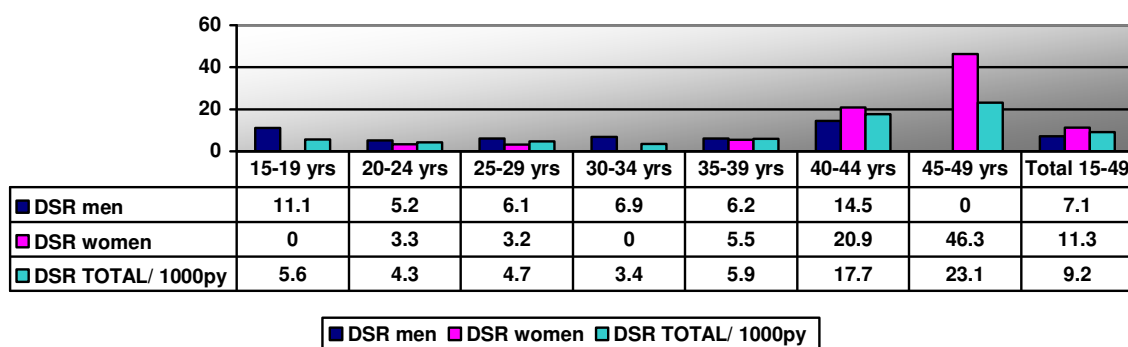
The highest mortality rate in the total population was noticed in 2001 (9.41 in 1000 PY), which does not necessarily mean there was a large number of deaths in this year but can be explained by the presence of a low number of persons in the cohort, and the lowest in 2010 (5.47 in 1000 PY).

2. Standard mortality rates

• Standard direct mortality rate

The standard direct mortality rate by age and gender were computed based on the non-standard mortality rates, which resulted from the specific cohort population subgroups, by gender and age, and which were adjusted to the European standard population.

Graph no. 6-33: Direct standard mortality rates, by gender and age groups



Source: NAA

As for the distribution of the direct standard mortality rates by age and gender, as indicated by the figure above, the direct standard mortality rates in the total cohort population and the male, respectively, female-specific population, indicate relatively similar values: DSR=9.23 in 1000 PY for the total population, DSR=7.1 in 1000 PY for the male population and DSR=11.3 in 1000 PY for the female population even though there are significant differences between genders, by age categories. The highest mortality rate in the total population was noticed for the age group 45-49 yrs and the lowest in the age group 30-34 yrs.

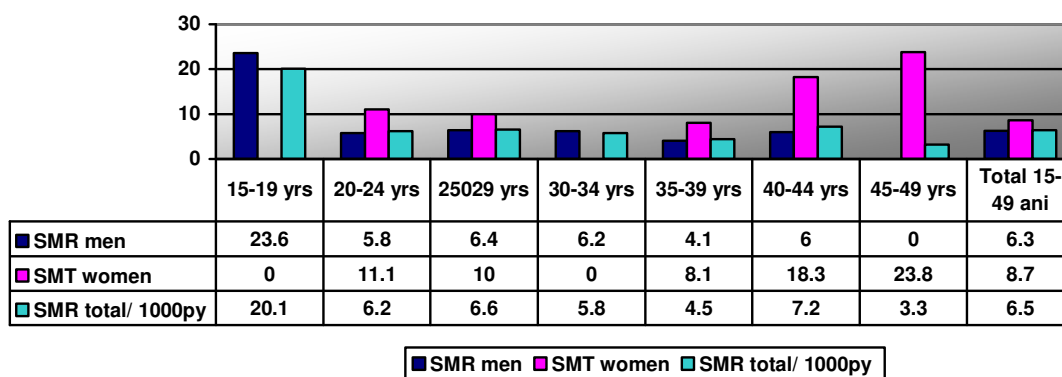
The gender distribution indicates that among men, the highest DSR was recorded in the age category 40-44 and the lowest in the age group 45-49 yrs, and that among women, the highest DSR was noticed in the age group 45-49 yrs, and the lowest in the age categories 15-19 yrs and 30-34 yrs. The

highest direct standard mortality rate in the total population was noticed in 2001, which does not necessarily mean there was a large number of deaths in this year but can be explained by the presence of a low number of persons in the cohort, and the lowest in 2004

- **Indirect standard mortality rate**

The indirect standard mortality rate (SMR) in this study reflects the risk of death among drug users in terms of mortality in the standard population.

Graph no. 6-34: Indirect standard mortality rates, by gender and age categories



Source: NAA

The highest indirect standard mortality rate (SMR=6.5 in the total population) was noticed in the age group 15-19 yrs (SMR=20.1) and the lowest in the age category 45-49 yrs (SMR=3.3). It results in a 20.1 times higher death risk for the cohort population in the age category 15-19 yrs as compared to the standard European population of the same age.

The mortality rate in the studied population the mortality rate (SMR=6.5 for the total population) is 6.5 times higher than the mortality rate in the general standard population (i.e. Europe's population). The highest indirect standard mortality rate in the total population was noticed in the age group 15-19 yrs (SMR=20.1) and the lowest in the age category 45-49 yrs (SMR=3.3). It results in a 20.1 times higher death risk for the cohort population in the age category 15-19 yrs as compared to the standard European population of the same age. There are significant gender differences: SMR=6.3 for the male population and SMR=8.7 for the female population as compared to the European situation: the male mortality rate in the cohort is 6.3 times higher than the male European population mortality rate and the female mortality rate in the cohort is 8.7 times higher than the female European standard population.

The cohort male population in the age group 15-19 yrs shows a 23.6 higher death risk than the standard male population of the same age, and the most at risk age group among women is the 45-49 age category, which stands for a 23.8 higher risk than the standard European female population of the same age. The highest indirect standard mortality rate in the total population was noticed in 2001 (SMR=0.90) and the lowest in 2004 (SMR=0.37).

3. Mortality incidence – the gender distribution of the cases throughout observation time shows the incidence of the death cases in the cohort male population is higher than the one recorded for females: 4.7% as compared to 2.4%.

4. Cohort survival probability

Based on the test of the differences using the **Kaplan-Meier survival analysis** model, the gender differences between the death risks are statistically significant ($\chi^2(1)=4.921$ for a significance level $p=0.027<0,05$). The cohort observation time was January 1st 2001 – September 15, 2010, amounting to a 9.7 years (confidence interval: 9.380 - 9.481). The mean survival time estimated for the cohort is 9.405 yrs for men (confidence interval: 9.347 – 9.463) as compared to 9.553 for women (confidence interval: 9.463 – 9.644).

5. Mortality related factors

5.1. Influence of drug use infectious diseases on mortality

Mortality among drug users in the cohort is higher when associated with the positive serologic status caused by drug-related transmissible infectious diseases (C and B hepatitis and HIV), as follows:

- **HIV infection**

Thus, the death incidence among cohort members was almost 5.5 higher than among HIV positive subjects, as compared to the HIV negative subjects: 22.2% as compared to 3.9%; Of the HIV-tested subjects, the average survival time estimated for the cohort is 8.257 years for the HIV-positive subjects and 9.477 years for the HIV-negative subjects.

- **HCV infection**

The mortality rate among drug-addicted people who are HCV positive amounts to 3.9%, which is higher than the rate recorded among HCV negative people – 2.6%.

- **HBV infection**

Mortality incidence amounting to 4.8% among HBV-positive subjects as compared to 3.7% among the HBV-negative subjects.

5.2. Influence of the social-economic factors on mortality

- **Marital status** – the highest mortality rate was recorded among the single subjects 4.5% (irrespective of those who did not respond to this question and whose mortality incidence is 4.8%).
- **Level of education** - there is a higher mortality incidence among those who completed at least 8 grades (4.2-4.5), as compared to those with an average education level (high school: 3.5) or high education (university level: 2%).
- **Occupation status** – there is a high mortality incidence among the unemployed (11.1%) although the rate of the unoccupied is higher among the death cases (29.3%). For the death cases there are higher rates of economically inactive (retired, house wife, invalid)/unemployed/others (no occupation) – 53.4% vs. 48%, as compared to survival cases, which account for a high rate of hired/school/university student – 25.5 vs. 23.3.

5.3. Influence of drug use patterns on mortality

- **The age at the time of recruitment (first admission)** – the mean age of the people included in the cohort was 23.37 yrs, most of them being aged 20 to 24 (46.4%).
- **Drug use onset age** – it was noticed that more than half of the users (54.8%) started drug use when less than 19, and ¼ between the age of 20 and 24 (27.7%). According to the Kaplan-Meier survival analysis, the death risk by drug use onset shows significant variations ($\chi^2(2)= 7.669$, for a significance level of $p=0.022<0.05$). The mean survival time estimated within the cohort is higher for those who started at younger ages than those who started drug use after the age of 30 (9.448 years for onset ages between 1 and 18 yrs, 9.471 years for those with an onset age between 19 and 29, as compared to 9.104 for onset ages between 30 and 49).
- **Previous treatment and number of entries** – one in three users (35.2%, namely, 32.8%) had demanded treatment for drug use on previous occasions. The number of cohort entries varies between 1 and 23 for the general cohort population (with a 1.6 mean and a sum of 4385) and between 1 and 7 among the death cases (a 1.8 mean and a sum of 213), more than half being entered only once in the cohort (68.5%, namely, 58.6%). According to the results shown in the following table, although there are statistically significant links between the vital status and the number of admissions, the relation between variables is still weak; the death/survival cases ratio (*Odd Ratio*) is 1.56.

Table no. 6-19: Link between the vital status of the subjects and the number of admissions throughout cohort length (2001-2006)

vital status		Number of admissions during cohort length (2001-2006)			Significance test
		At least 2 admissions	one admission	Total	
Death cases	% within VITAL_STAT	41.4%	58.6%	100%	$\chi^2 = 5.42$; DF= 1; p=0.014 ϕ (phi)= 0.045; p=0.020 OR death/survival cases =1.563 (1.07 - 2.28 pt. CI 95%)
	Adjusted Residual ²⁰³	2.3	-2.3		
Survival cases	% within VITAL_STAT	31.1%	68.9%	100%	
	Adjusted Residual	-2.3	2.3		
Total	% within VITAL_STAT	31.5%	68.5%	100%	

Source: NAA

- **Administration route, frequency of use and injection history** – most subjects would use drugs intravenously (91.9%, namely 94.8%), on a daily basis (94.5%, namely 96.6%), and, consequently, have an injection history in the last 30 days prior to treatment admission (90.6%, namely, 95.7%). It has been noticed that for all the mentioned items, the ratios for death cases are higher as compared to the total cohort population (and, consequently to living people). The mortality incidence is higher among those with a limited drug injection history.
- **Treatment** – it has been noticed that for the death cases subpopulation there is a higher ratio of in-patient symptomatic medical detoxification (79.3% vs. 75.11%) and for out-patient medical detoxification based on opiate substitution (5.2% vs. 3.2%) as compared to the entire cohort population which shows high ratios for maintenance treatment based on opiate agonist (methadone – 14.3% vs. 11.2%), out-patient symptomatic detoxification (4.8% vs. 2.6%) and psychological counselling (48.7% vs. 47.4%).

5.4. The analysis of the risk factors regression on mortality

Joining several possible variables (frequency of use, social-demographic variables, onset age, drug use history at cohort entry and release, HIV, HCV and HBV serologic status) that can affect the relative risk (RR) of death among drug-addicted people in treatment, we have made use of the COX regression analysis. As a result of the use of this regression model, only two factors were selected as significant for explaining the phenomenon, namely gender and onset age. The model built on 104 deaths of the 116. Thus, the results of the COX regression analysis show that male users run a 2-time higher death risk as compared to women. Additionally, those who started drug use after the age of 29 seem to show a relatively higher death risk (2.86 times higher as compared to those who started drug use between 19 and 29 and 2.44 times higher than those up to 18).

6. Causes of death analysis

Most of the 116 death cases were caused by intoxication by narcotics and psychodysleptics (hallucinogens), not elsewhere classified - T40 code (33.62% of the total death cases), being followed by self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism drugs, not elsewhere classified - T42 code (9.48%). Among the causes of death we should mention cardiomyopathy -I42 code (6.9%), viral pneumonia (unspecified) - J18 code (6.03%), poisoning by drug medicaments and biological substances (5.17%), mechanical asphyxia by hanging (4.31%), VIH, not specified (3.45%), multiple fractures of skull and facial bones (3.45%). For five of the deaths recorded in the cohort the causes of death could not be determined (4.31%).

For the cohort death cases, there is a different gender breakdown of the deaths by cause. Thus, considering even a lot lower number of deaths among female drug users, they tend to cover a limited range of death causes (7 types of deaths), as follows: intoxication by narcotics and psychodysleptics (hallucinogens), not elsewhere classified – T40 code, viral pneumonia (unspecified) – J18 code, self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism drugs, not elsewhere

²⁰³ Standard adjusted residuals: if the values do not fall into the interval [-2, 2], than, there is a significant difference between the observed values and the expected ones (Sava, F. A., 2004 – Analiza datelor în cercetarea psihologică. Metode statistice complementare (Data analysis in psychological research. Complementary statistical methods), ASCR, Cluj-Napoca)

classified – T42 code, HIV, not mentioned, cellulitis of upper limb – L03 code, foreign body in respiratory tract – T17 code and unspecified causes.

Unlike the deaths among female drug users, those among cohort male population were linked to a larger number of causes (25 types). Among the notable differences between genders we should mention: an increased ratio of the deaths among men and caused by cardiomyopathy (7.6% vs. 0.0%) or mechanical asphyxia by hanging (4.8% vs. 0.0%).

The case distribution by age categories shows the following: for the cohort members whose age of death is between 15 and 19 years, death was caused the following disorders: viral pneumonia (unspecified) and by intoxication by narcotics and psychodysleptics (hallucinogens) in equal sizes (22%) and cardiomyopathy, tuberculosis of lung without mention of bacteriological or histological confirmation, self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism drugs, not elsewhere classified, mechanical asphyxia by hanging in equal proportions – 11.1%. in relation to this age category, it becomes worrisome the ratio of young people who died of cardiomyopathy (which is not age specific), and of those who died of mechanical asphyxia by hanging, which can be related to suicide.

Chapter 7 - Responses to Health Correlates and Consequences

7.1 PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES²⁰⁴

7.1.1 TYPES AND AVAILABILITY OF INTERVENTIONS

Up until now, most preventive interventions of drug related infectious diseases, as well as some of the substitution treatment interventions were supported by international funding (Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, UNODC), mainly for NGO-run programmes. The end of the mentioned programmes in 2010 in connection with the lack of feasible governmental measures might be a future cause of the radical reduction of this type of services.

Although by National Interest programme for tobacco, alcohol and drugs prevention was approved the Governmental Decision no. 1.101/2008²⁰⁵ for the time interval 2009-2012, its implementation was not possible in 2010. The programme provides for tangible intervention measures to complete the national system of prevention and care services for drug users (outreach services, NGO-run specialised services funded from public funding). Even though, proper funding was earmarked for programmes provided for in the G.D. no. 1101/2008, the current legal framework did not allow for awarding grant schemes to non-governmental organisations that intended to implement projects meant to ensure the access of drug users to harm reduction services by way of adequate interventions.

The implementation of the Programme *Towards Universal Access to Prevention, HIV/AIDS Treatment and to the Care and Social Assistance of Vulnerable and Disadvantaged Populations*, continued in 2010, being funded under the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. One of the goals of the Programme was to extend prevention interventions among vulnerable groups and improve services that can help reduce vulnerability to HIV/AIDS infection. These interventions also focused on the amendment and implementation of national HIV/AIDS policy and strategy at national and local level, in the communities that are most affected.

According to the 6th progress report of the HIV/AIDS programme, round 6, formulated by of the *Romanian Angel Appeal Foundation* (as main recipient)²⁰⁶, the prevention projects addressing vulnerable groups (IDUs, SWs, MSM, roma population, street children) focused on health improvement, healthy sexual behaviour and access to medical and social services in order to decrease the risk of HIV spreading.

Implementing parties in the programme: ARAS, ALIAT, INTEGRATION Association, SAMUSOCIAL Association, PARADA Association, SASTIPEN Association.

The results are described below by category of vulnerable group addressed by the programme:

- **Injecting drug users**

In the case of injecting drug users, the beneficiaries were selected from four counties of Romania (Bucharest, Ilfov, Dolj, Timiș), and were aged 16 to 28. They were generally in poor health and were school dropouts, which explained their low education level, the fact that they were unemployed and their repeated offences.

Services and activities:

- syringe exchange – through outreach activities and in fixed centres (low threshold clinics);
- psychological counselling – available in fixed centres;
- training of trainers selected from IDUs (peer),
- referral to medical and psychological services;
- condom distribution in outreach sessions and fixed centres;

²⁰⁴ See standard table ST10

²⁰⁵ Governmental decision no. 1101/September 18, 2008 approving the National interest programme to prevent tobacco, alcohol and drug prevention 2009 - 2012 (issued by the Government, published in the Official Gazette no. 672 of September 30, 2008);

²⁰⁶ http://www.fondulglobal.ro/plain/files/FinalReport_ROM-607-G03-H_Year3_Closeout_03Feb2011.pdf

- distribution of informative documentation during outreach activities;
- HIV counselling and testing during outreach activities and fixed centres; positive clients are referred for confirmation to specialised centres;
- HBV/HCV vaccination during outreach sessions and in fixed centres;
- *lobby* and *advocacy* (in conferences, workshops, press releases) to increase access of IDUs to prevention services: prevention of HIV/HBV/HCV transmission, access to sterile injection kits.

Difficulties:

Despite numerous reports (drafted by: the police, local NGO's, witness statement or other drug users etc) indicating a local phenomenon in the counties of Dolj and Timiș regarding injecting drug use, the *outreach* team members found it difficult to identify IDU's in Craiova (county of Dolj) and Timisoara (county of Timis), which resulted in the failure to reach the proposed target. Additional difficulties arose from IDU access to health services: many injecting drug users do not have personal identification documents, medical insurance nor the possibility to access medical facilities such as: ELISA conformation for a positive result of an HCV rapid test, HCV treatment, sexually transmissible testing and treatment.

Despite of this, outreach workers noticed that in Bucharest:

- increased use of HIV prevention services among IDU, more confidence in such services;
- distribution of more condoms among IDU, more frequent HIV, HCV/HBV testing among interviewed IDU,
- higher rate of used syringe collection;
- increase of knowledge on HIV and condom use among IDU.

As described in the mentioned report, the main results of the syringe exchange projects implemented with the financial support of UNODC/Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria from 2007 to 2010 were:

- 16,539 IDU included in the programme;
- 3,314,884 distributed syringes to IDU;
- 1,133,178 collected syringes from programme beneficiaries;
- 1,033,178 distributed condoms,

Similar activities were also implemented in projects funded through the programme *HIV/AIDS prevention and care among injecting drug users in community and penitentiaries in Romania*, carried out with the financial and technical support of the United Nations Office for Drugs and Crime, Romania.

Following these activities, in syringe exchange programmes funded by Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria and UNODS, these benchmarks were reached:

- 8,966 IDU included in HIV/AIDS prevention programmes, less than the last year (9,417)
- 946,820 distributed syringes²⁰⁷ accounting for almost half of the syringes distributed last year (1,730,776)
- 348,897 returned syringes in 2010 which is almost a third of the syringes returned last year.

Table no. 7-1: Number of IDU beneficiaries that contacted syringe exchange services in 2010, by service providing NGO

	Total number of IDU beneficiaries	Of the total,no. of male IDU	Of the total,no. of female IDU
ALIAT	1680	1291	389
ARAS	5667	4208	1459
Integration	457	385	72
PARADA	50	35	15
Samusocial	88	63	25
SASTIPEN	1024	895	129
Penitentiaries	61	61	0
TOTAL	9027	6938	2089
Of which: TOTAL community-based services	8966	6877	2089

Source: UNODC, Romania

²⁰⁷ See standard table no.10 – Syringe availability

Table no. 7-2 Number of syringes/condoms distributed during syringe exchange programmes, by service providing NGO

	Total number of IDU beneficiaries	Number of returned syringes	Number of distributed condoms
ALIAT	243800	139280	94300
ARAS	623171	188211	0
Integration	28555	4563	3500
PARADA	2000	0	500
Samusocial	3000	0	432
SASTIPEN	46294	16843	5470
Pententiaries	18383	9232	8000
TOTAL	965203	358129	112202
Of which: TOTAL community-based services	94682	348897	104202

Source: UNODC, Romania

- **Female commercial sex workers**

NGO's provided serviced to this vulnerable group through the Programme *Towards Universal Access to Prevention, HIV/AIDS Treatment and to the Care and Social Assistance of Vulnerable and Disadvantaged Populations, funded by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria*²⁰⁸.

The activities included harm reduction services, as it is known that there are many injecting drug users among commercial sex female workers:

- Condom distribution
- Syringe exchange programmes addressing commercial sex female workers who inject drugs
- HIV counselling and testing during information sessions
- Vaccination against HCV/HBV during information sessions.

Results:

- 5,848 commercial sex workers included in HIV/AIDS prevention programmes
- 283,345 distributed syringes
- 55,337 collected syringes
- 1,957,650 distributed condoms
- 1,255 commercial sex workers benefited from pre-testing counselling, were tested and received test results
- 9 commercial sex workers were vaccinated against HCV and HBV

- **„Street children and young people”**

Considered as a group vulnerable to HIV infection/AIDS, “street children and young people” benefited from harm reduction projects²⁰⁹:

- Peer education
- outreach interventions
- condom distribution

Intervention programmes. Good practice examples of the organisations that implemented harm reduction projects

1. „No risk Outside” – implemented from January 2010 to June 2010 by Integration Association

Project goal: - Increase access of vulnerable and poor population to prevention and treatment services

Obiectives

- O1.1. access to HIV prevention services by implementing syringe exchange programmes for 500 drug users in Bucharest;
- O1.2. capacity buiding for 500 drug users in Bucharest and their sexual partners to prevent HIV, hepatitis, other infectious diseases, by health education and harm reduction counselling.

²⁰⁸ http://www.fondulglobal.ro/plain/files/FinalReport_ROM-607-G03-H_Year3__Closeout_03Feb2011.pdf

²⁰⁹ http://www.fondulglobal.ro/plain/files/FinalReport_ROM-607-G03-H_Year3__Closeout_03Feb2011.pdf

Target group

- IDU, their sexual partners and the community.

Activities:

Syringe exchange: this activity aimed at introducing 500 active injecting drug users in the syringe exchange programme, who received 50,000 sterile insulin syringes, 4000 distilled water vials, 25,000 alcohol pads and 5000 condoms in 2010, and returned almost 5,000 used syringes.

Increase access to medical and social services: drug users were referred to existing medical and social services. The project team set up contacts with service providers in related fields of activity: testing and counselling centres, maintenance treatment, hepatitis diagnosis and testing etc. The team collected and updated information related to the rules and procedures of these services. The aim of this activity was to refer at least 100 injecting drug users and their partners to existing medical and social services.

Harm reduction information and counselling sessions

- Information sessions took place in the street, during face-to-face meetings and group meetings. The short information sessions included topics of discussion adjusted to the features of the target group: HIV/AIDS, general information (transmission means, prevention methods, testing, diagnosis and treatment) on A, B and C hepatitis; safe injection, the risks of sexual behaviour, interaction between sexual behaviour and drug use; availability of HIV prevention services; specific availability and conditions; other information required by the beneficiaries. To increase the level of knowledge of HIV/AIDS and drug related risks, each outreach session included the provision of information to at least 10% of the clients registered in a day.
- At least 160 injecting drug users benefited from harm reduction counselling sessions.

Results

- 500 users benefited from syringe exchange services
- 50,000 distributed syringes,
- 4000 distributed vials of distilled water
- 25000 alcohol pads distributed
- 5000 distributed condoms
- 5000 used syringes recovered
- 100 CDI referred to existing medical and social services
- 172 CDI benefited from harm reduction counselling sessions.

Budget: 30,000 EURO

2."Medical-social care centre SASTIPEN" – implemented between March 2009 – June 2010, of the Roma centre for health policy SASTIPEN, in partnership with the Administration of the 5th District

The goals of the project consisted in: enabling access to medical and social services for vulnerable groups; reducing the risk of HIV/AIDS among vulnerable groups living in the 5th district in Bucharest and prevention of HIV/AIDS; enabling access of vulnerable groups including MARA people (IDU and SW – injecting drug users and commercial sex workers) to medical and social services; implementing a lobby campaign targeting local authorities and aiming at providing long-term sustainability to the Care centre activities.

Main activities:

- First aid and primary medical care
- Referral of beneficiaries to specialist physicians
- Information, education and awareness raising among beneficiaries of the importance of health
- Information, support and counselling for people at risk (injecting drug users, people infected with TBC, HIV/AIDS, hepatitis, chronic diseases etc)
- Distribution of sterile equipment to prevent sexually transmissible diseases
- Harm reduction activities.

The Medical-social care centre is located in a module container and its staff is made up of a coordinator, two specialised physicians (who examine the centre beneficiaries daily and make monitoring calls of the patients who need medical care at home), three health educators (who encourages the beneficiaries to attend information, education and awareness raising sessions on HIV infection risk) and a social worker, who provides specialised counselling to people with social problems. The centre provides charge free primary medical care (including monitoring and treatment of patients with TBC, STD), social care and information, education and counselling services in order to prevent HIV, B and C hepatitis and other drug related risks, unprotected sex, commercial sex etc. By

information, education and awareness raising and material distribution on HIV prevention among injecting drug users, carried out daily by the team centre, the aim is to change behaviours and promote a health conducts in the target group.

Buget 102 700 USD

Finanțatori: UNICEF, United Nations Office on Drugs and Crime (UNODC)

Upon the completion of funding, the activities continued and were supported by SASTIPEN Association.

3. HIV prevention among teenagers at high risk for infection in Romania II – launched in October 200 by the Romanian Harm Reduction Network (RHRN) and is being carried out

Goals:

- Evaluation of the capacity of service providers to attend to teenagers at high risk for infection;
- Monitoring and evaluating the capacity of the pharmacies in Bucharest to provide access to sterile injection equipment;
- Advocacy with national stakeholders to approach gaps in legal framework, policy and practices referring to teenagers at high risk for infection;
- Strengthening RHRN capacity to enable communication between its members and coordinate harm reduction interventions.

Activities:

- setting up an updated data base of harm reduction and social services in Bucharest;
- development of an instrument to be used in the evaluation of the capacity of social services providers in Bucharest;
- writing a research report on the capacity of services providers attending to teenagers at high risk for infection based on outreach data;
- writing a research report on the current situation of the access to sterile injection equipment in Bucharest;
- developing a joint database on the beneficiaries of harm reduction services;
- creating a set of 3 compulsory minimal standards for harm reduction services addressing teenagers at high risk for infection;
- authorising a harm reduction training curriculum;
- coordination of technical meetings between RHRN members and partners;
- coordination and facilitation of technical meetings between social service providers and local decision-makers in 3 cities in the country (Timișoara, Iași, Constanța).

Results:

- updated data base of harm reduction and social services;
- evaluation report on the capacity of harm reduction and social service providers in Bucharest;
- report on the access to sterile injection equipment and treatment in pharmacies in Bucharest;
- data base of active pharmacies in Bucharest;
- 3 compulsory minimal standards for harm reduction services addressing teenagers at high risk for infection;
- coordination and technical meetings enabled by RHRN.

Budget: 42,955 USD

Funding party: UNICEF

4. Harm Reduction Summer School and Scholarships Program 2010 – implemented from June 2010 to March 2011 by the Romanian Harm Reduction Network

Goals

- identification of future roma activists in the field of harm reduction and opening new opportunities for their personal and professional development;
- development of the capacity of young roma to work in the field of harm reduction and share working practices to the community and their organisations;
- increase of knowledge and build harm reduction and HIV prevention skills among future professionals in the social-medical field;
- build sustainable partnership between harm reduction service providers and future professionals in the social-medical field.

Activities:

- the second edition of the Harm Reduction Summer School in partnership with Bucharest University, addressing mainly roma students and master students across the country;

- develop a scholarship programme for roma students and master students in the social-medical field to enable access to service providing organisations attending to groups at risk for HIV.

Results:

- 25 participants to the 2nd edition of the Summer School “Risk groups and support social services”
- 5 scholarship grants for roma students and master students, to enable access to service providing organisations that address groups at risk for HIV.

Funder: Open Society Institute (OSI), partners: UNODC, SAS

Budget: 38,511 USD

5. Emergency Support for HIV Prevention Services among IDUs in Bucharest- implemented from October 2010 to January 2011 by the Romanian Harm Reduction Network (RHRN)

Goals: Provision of emergency aid to support NGO's active in HIV prevention among drug users to continue harm reduction activities

Activities

- Purchase of sterile injection equipment and distribution to 5 RHRN member and partner organisations
- Setting up a database with trainers in the harm reduction field.

Results

- Distribution of 255 000 syringes (1 ml.) to ALIAT, ARAS, Integration, Parada and Sastipen.

Budget: 42,000 USD

Funder: UNODC

7.1.2 Characteristics and drug use patterns among IDU

The following trends were identified in the drug use behaviours of the IDU, as described by the findings of the two studies²¹⁰ conducted by UNODC and NAA in 2008 and 2010 among injecting drug users in Bucharest:

Table no. 7-3: Compared results of the two studies on drug use behaviour conducted in 2008 and 2010 among injecting drug users in Bucharest

	<i>Serologic and behavioural survey on the prevalence of infectious diseases among IDU 1st Study</i>	<i>Serologic and behavioural survey on the prevalence of infectious diseases among IDU 2nd STUDY</i>
Age of injecting drug use onset	<p>Mean age of injecting use onset was 19.85, and 17 was the most frequently mentioned age (mean). 58.4% of the IDUs in Bucharest began using drugs over the age of 18; 6.7% of the respondents injected drugs for the first time when aged between 8 and 13, and 35% of them between the age of 14 and 17.</p> <p>Statistically significant differences were noticed in relation to the HCV positive serologic status, by onset age: 87.7% of those who started injecting when under 18 were positive for HCV, while 79.4% were found HCV positive of those who started injecting when over 18 ($\chi^2 (1) = 5.305, p=0.021 < 0.05, \phi = -0.109$ pentru $p = 0.021 < 0.05$).</p> <p>There are no significant gender differences in relation to the age of injection use onset: 44% of the female IDU started injecting when under than 18 as compared to 41% of the male IDU.</p>	<p>Mean age of injecting use onset was 19.61, and 16 was the most frequently mentioned age (mean).</p> <p>55.6% of the respondents began using drugs at the age of 18 or older; 8.6% of the respondents injected drugs for the first time when aged between 8 and 13, and 34% of them between the age of 14 and 17.</p> <p>As for the link between injection onset age and HCV infection prevalence, the following can be noticed: 90.2% of those who started injection at ages under 18 tested positive, while 86.9% of those who started injection use at ages over 18 tested positive for HCV. There are no longer statistically significant differences between the two categories ($\chi^2 (4) = 1.637, p=0.809 > 0.05, \phi = -0.065$ pentru $p = 0.809 > 0.05$).</p> <p>There are no significant gender differences in relation to the age of injection use onset: 41.2% of the female IDU started injecting when under than 18 as compared to 43% of the male IDU.</p>

²¹⁰ Descrierea metodologică se regăsește în sub-capitolul 6.1.2 Studii privind prevalența bolilor infecțioase asociate consumului de droguri

Drug history	<p>35.6% of the IDU had an injection history of more than 10 years, while only 33.2% of the IDU had an injection history of 6 to 10 years, and 18.3% had an injection history of 3 to 5 years. Only 12.9% of the IDU had an injection history of less than 3 years.</p> <p>There are statistically significant differences in relation to the HCV positive serologic status, by drug use history: $\chi^2 (3) = 58,940$, $p=0.000<0.05$, $\phi = 0.362$ pentru $p = 0.000<0.05$, which means there is moderate link between a bigger drug use history and the HCV positive status.</p> <p>For the rest of the infections, there are no statistically significant differences by drug use history. But, there are statistically significant gender differences by drug use history: $\chi^2 (3) = 17,237$, $p=0.001<0.05$, $\phi = 0.196$ pentru $p = 0.001<0.05$, with a moderate link between the two variables.</p>	<p>35.3% of the IDU's had an injection history of more than 10 years, 35.6% had an injection history of 6 to 10 years, while 16.6% use drugs by injection for 3-5 years. Only 10.6% had a history of less than 3 years.</p> <p>There are no statistically significant differences in relation to the HIV, HBV and HCV positive serologic status by drug use history. This also holds true for the link between the history of drug use and gender.</p>
Frequency of use	<p>Only a few IDU (4.7%) did not inject in the week before the interview. Over half of the users who used drugs the day before the interview (53.3%) injected twice or three times, and relatively few (18.9%) injected 4 or 5 times, one in four IDU (25.4%) injected once a day, and very few IDU (2.4%) injected at least 6 doses per day.</p> <p>There is moderate link between the time elapsed since the last injection and the frequency of injection ($\phi = 0.326$ for $p = 0.000<0.05$).</p>	<p>Only a few IDU (2.6%) did not inject in the week before the interview. Over half of the users who used drugs the day before the interview (57.4%) injected twice or three times and relatively few (16.7%) injected 4 or 5 times. One in four IDU (16.7%) injected once a day, and very few IDU (9.3%) injected at least 6 doses per day.</p> <p>There is moderate link between the time elapsed since the last injection and the frequency of injection ($\phi = 0.347$ for $p = 0.000<0.05$).</p>
Drug use patterns	<p>59.2% of the IDU reported generally using syringes once, while 38.3% use it 2-3 times, and 8.9% over 4 times.</p> <p>14.9% of the respondents declared not having shared sterile syringes or personal drug paraphernalia. 80.6% of the respondents declared having shared drug paraphernalia with friends, and 11.9% with strangers.</p> <p>By contrast, 13.1% reported sharing other IDU's injection paraphernalia after injection.</p> <p>There is moderate link between those who reported having shared borrowed injection paraphernalia ($\phi = 0.293$ for $p = 0.000<0.05$), and 35.8% of those who used a syringe used previously by another and shared it with other IDU.</p> <p>Most IDU (92.4%) used 1 ml syringes with fixed needle (insuline type), while only 5.8% of the respondents reported having used 2-10 ml syringes and removable needle. Very few IDU (1.8%) reported the use of both fixed needle and removable needle syringes.</p>	<p>Only 21.8% use a syringe once, while 43.1% use it 2-3 times, and 20.5% over 4 times.</p> <p>15.7% of the IDU declared having shared syringes that had been previously used by another user upon the last injection. 83.3% of them reported having borrowed injection equipment from friends, while 13.3% from strangers.</p> <p>At the same time, 24.2% declared having given one's own syringe to another IDU.</p> <p>There is moderate link between those who reported having shared borrowed injection paraphernalia and those who borrowed them from other IDU ($\phi = 0.232$ for $p = 0.000<0.05$), 45% of those who used other IDU's equipment and shared it with another IDU.</p> <p>Most IDU (90.9%) used 1 ml syringes with fixed needle (insuline type), while only 9.1% of the respondents reported having used 2-10 ml syringes with removable needle.</p>
Means to procure injection paraphernalia	<p>37% of the IDU reported having bought/received sterile injection paraphernalia in pharmacies, and 45.9% from syringe exchange programmes (outreach centre or worker) upon the last injection.</p>	<p>52.5% of the IDU reported having bought/received sterile injection paraphernalia in pharmacies, and 29.4% from syringe exchange programmes (outreach centre or worker) upon the last injection.</p>
Sexual behaviour	<p>Most respondents (90.6%) were sexually active in the last 12 months. 61% of them had only one partner, while 39% had different sexual partners. 72.6% of the respondents had one stable sexual partner at the time of interview. 39.2% of them had sexual partners among injecting drug users, and there is strong link between the two variables ($\phi = 0.618$ for $p = 0.000<0.05$).</p> <p>There are significant gender differences: 78% of the female users are involved in a stable sexual relation with an IDU, by contrast to only 26.6% of male IDU, who have a stable partner a female IDU.</p> <p>Upon the last sexual intercourse, only 18.4% of the</p>	<p>Over half of the IDU (53%), were sexually active in the last 30 days. 79.4% of them had only one partner, while 20.6% had different sexual partners. 55.1% of the respondents had one stable sexual partner at the time of interview. 41% of them had sexual partners among injecting drug users, and there is strong link between the two variables ($\phi = 0.496$ for $p = 0.000<0.05$).</p> <p>There are significant gender differences: 80.1% of the female users are involved in a stable sexual relation with an IDU, by contrast to only 30.1% of male IDU, who have as</p>

	<p>IDU with a stable sexual partner reported the use of condom. Additionally, 80.6% of those who reported their partner used injecting drugs did not use condom upon the last sexual intercourse with the stable partner, and 41.9% did not use protection upon random sexual contacts with occasional partners. By contrast, over half of those whose sexual partner is an IDU without being a stable partner (53%) did not use protection with random sexual partners. There are gender differences between users who reported having a stable relationship with an injection drug user and who use protection during random sexual experiences: while 47.7% of males used condom, only 23.4% of women used condoms, which resulted in a strong link between the two variables ($\phi = 0.345$ for $p = 0.002 < 0.05$).</p> <p>Only 12.1% of the responding IDU (12.3% male, 14% female) had sexual intercourse in exchange for money, drugs or other goods.</p>	<p>stable partner a female IDU ($\phi = 0.428$ for $p = 0.000 < 0.05$).</p> <p>Upon the last sexual intercourse, only 28.8% of the IDU with a stable sexual partner reported the use of condom. Additionally, 75.9% of those who reported their partner used injecting drugs did not use condom upon the last sexual intercourse with the stable partner. Only 13.5% of the interviewed IDU (11.5% male, 21.2% female) had sexual intercourse in exchange for money, drugs or other goods.</p>
Access to treatment services	<p>Over half of the respondents (53.2%) were admitted in a drug treatment programme in the last 12 months, while over a third (35%) were seen by a family doctor, 17.8% had been in detoxification, 18.9% under substitution treatment, 20.5% called the ambulance, and 18.3% ended in an emergency ward, (26.7% sought care in emergency wards or ambulance)</p>	<p>Less than the respondents (48.8%) were admitted in syringe exchange programme in the last 12 months, 21% were seen by a family doctor, and 22.6% demanded emergency medical care (ambulance or emergency wards) on account of overdoses.</p>

Notă: the rest up to 100% are non-responses

Source: Serologic and behavioural survey on the prevalence of infectious diseases among IDU, 2008, 2010

Conclusions:

An analysis of the two samples illustrates the following:

- Although numerically insignificant, there is a reversed relation between the two samples as regards the gender distribution of the onset age: in the 1st study, 44% of the female IDU started injecting before the age of 18, as opposed to 41% of the male IDU while in the 2nd 41.2% of the female IDU started injecting before the age of 18, as opposed to 43% of the male IDU.
- There is a dropping average and mean age upon the onset of injecting use (19.85 years in 2009 and 19.61 years of age; 17 years of age in 2010, by contrast with 16 years of age in 2010);
- Decrease of the number of IDU with an injection history of less than 3 years (12.9% in 2009, as opposed to 10.6% in 2010) and of those with an injection record between 3 and 5 years (18.3% in 2009 as opposed 16.6% in 2010). These results indicate the existence of an IDU population with a long drug use record (most of them over 5 years) and a change in drug use patterns for those who had started drug use in the last 2-3 years.
- There is a significant increase of the number of those who share a syringe at least 4 times: 35.1% in 2010 and 8.9% in 2009. If the shares of those who share syringes 2-3 times is almost the same in both samples (43.1% in 2010, 38.3% in 2009), there are significant changes in drug use patterns among those who use it a single time: 21.8% in 2010, as opposed to 52.9% in 2009.
- Increase of the share of those who after use lend their injection equipment to another user: from 13.1% in 2009 to 24.2% in 2010.
- There is a moderate link between those who reported having shared borrowed injection equipment and of those who lent their equipment to others in both studies.
- Increase of the share of IDU who reported having bought injection equipment in pharmacies upon the last injection (from 37% in 2009, to 52.5% in 2010) and decrease of those who received equipment from outreach workers from 27.6% in 2009 to 9.6% in 2010.
- In terms of access to specialised medical care services, there is a decrease in the rate of IDU who demanded care from family practitioner (from 35% in 2009 to 21% in 2010), increase of those in substitution treatment (from 18.9% in 2009 to 22.6% in 2010), decrease of those who demanded emergency services (from 26.7% in 2009, to 9.9% in 2010, with the only mention that in 2010, the question referred to demanding emergency services for overdose cases).
- Although there are not major changes among IDU, there is a significant increase of female IDU who had sexual intercourse in exchange for money, drugs or other goods (from 14% in 2009 to 21.2% in 2010);
- Increase of the rate of IDU who use condoms although in a stable relationship: from 18.4% in 2009 to 28.8% in 2010.

Chapter 8 - Social correlates and social reintegration

8.1 SOCIAL EXCLUSION AND DRUG USE

8.1.1 SOCIAL EXCLUSION AMONG DRUG USERS

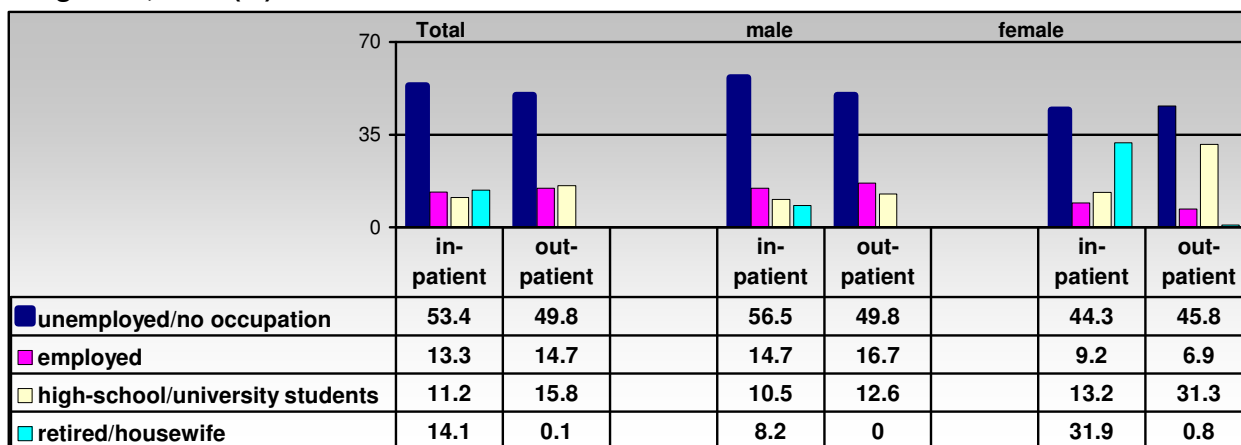
8.1.1.1 Treatment admission indicator data

Occupational status of people admitted to treatment 2010

The data obtained at the time of *treatment admission indicator* for 2010 illustrated the following statements related to occupational status at the time of admission:

- Almost half of drug users (52.1%) who sought treatment services were unemployed/without occupation (53.4% in in-patient treatment, 49.8% out-patient treatment);
- Over a tenth (12.8%) is made up of high school or university students (11.2% in in-patient treatment, 15.8% out-patient treatment). In this category there are large differences in terms of gender, as almost a third (31.3%) of the high school or university students seeking out-patient treatment were female users;
- 13.9% were employed and had a contract over a limited or unlimited period of time (13.3% in in-patient treatment, 14.7% out-patient treatment), while this category is less representative for women (9.2% in in-patient treatment, 6.9% out-patient treatment)
- The economically inactive (retired or housewives) record levels of 9.2% of the total population admitted to drug treatment, with differences between the two types of treatment (14.1% in in-patient treatment, 0.1% out-patient treatment), and between genders (male: 8.2% in in-patient treatment, 0% out-patient treatment ; female: 31.9% in in-patient treatment and 0.8% out-patient treatment)
- illegal workers (no contract) account for 4.6% of the total population admitted to drug treatment in 2010 (2.9% in in-patient treatment, 7.8% out-patient treatment),
- other categories (ex: former prison-inmates/arrestees) are less represented in the population admitted to drug treatment in 2010.

Graph no. 8-1: Distribution of in-patient and out-patient treatment admissions, by employment and gender, 2010 (%)



Note: other cases/not specified make up the difference up to 100%

Source: NAA²¹¹

The analysis of the data resulted from treatment admission indicator²¹², regarding the **occupational status** of people admitted to drug treatment in 2010, as compared to 2009, illustrates the following trends:

- **for in-patient treatment admissions:**

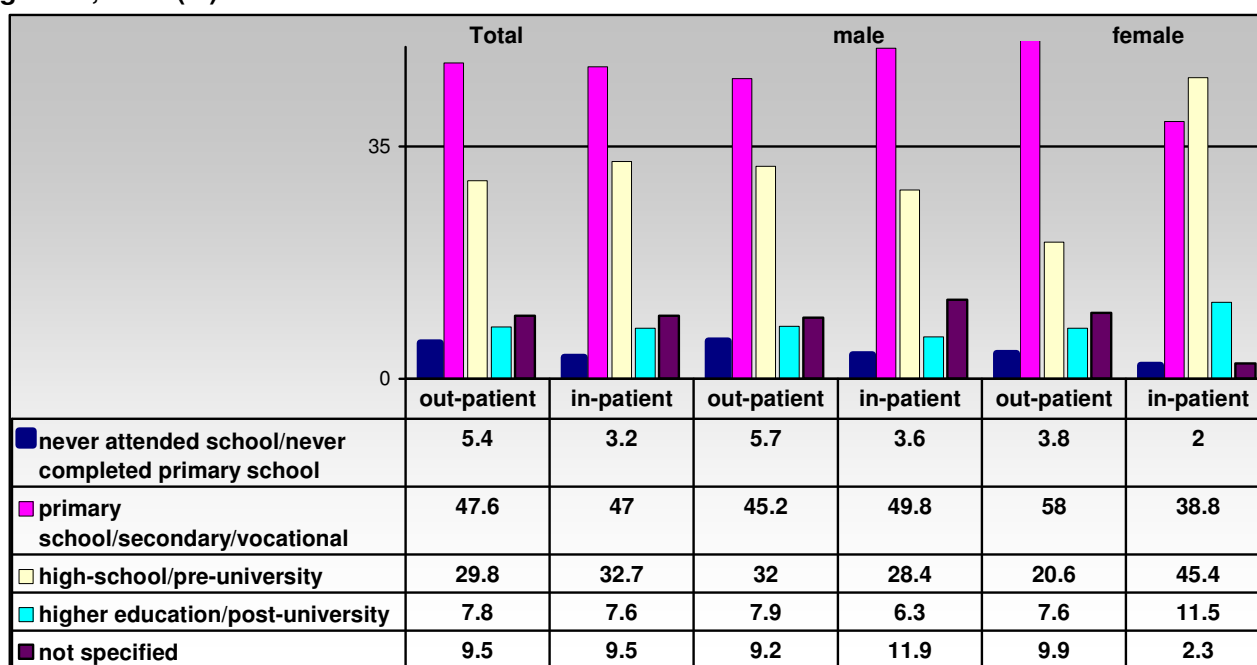
²¹¹ Based on the data reported by CNOASIIDS and sent by DPECC, ANIT, PSYMOTION Arena and MH centres

²¹² See chapter 5 Treatment admission

- The share of unemployed and economically inactive decreased, while the share of people who work or have their own business and of those attending a form of education increased;
- By gender, the share of working people and as well as unemployed/no occupation was higher among men; women account for more economically inactive and more of those who attend school (highschool/university students).
- **for out-patient treatment admissions:**
 - there is an increase of unemployed and people attending a form of education (highschool/university students), and a decrease of those who are employed and of the economically inactive;
 - more employed people among men (dropping than in 2009), while there is a greater tendency among women to attend a form of education.

Education of people admitted to treatment in 2010

Graph no. 8-2: Distribution of treatment admissions by education, type of admission and gender, 2010 (%)



Source: NAA ²¹³

As for the completed level of studies among people admitted to drug treatment, a low education level is evidenced, as the majority has completed secondary education at most (over 45%).

By completed level of education, in 2010 the situation is as follows:

- 4% had never attended school nor completed primary education (3.2% in-patient, 5.4% out-patient),
- less than half of them (41.2%) completed vocational schools at most (37.7% in in-patient treatment , 47.6% in out-patient treatment)
- one third (35.5%) completed average education (38.6% in in-patient treatment , 29.8% in out-patient treatment) ;
- and 9.9% completed higher education (11.1% in in-patient treatment , 7.8% in out-patient treatment) ;

The analysis of the data resulted from the treatment admission indicator²¹⁴ as regards the **education level** of people admitted to drug treatment in 2010 as compared to the last year, illustrates the following trends:

²¹³ Based on the data reported by CNOASIIDS and sent by DPECC, ANIT, PSYMOTION Arena and MH centres

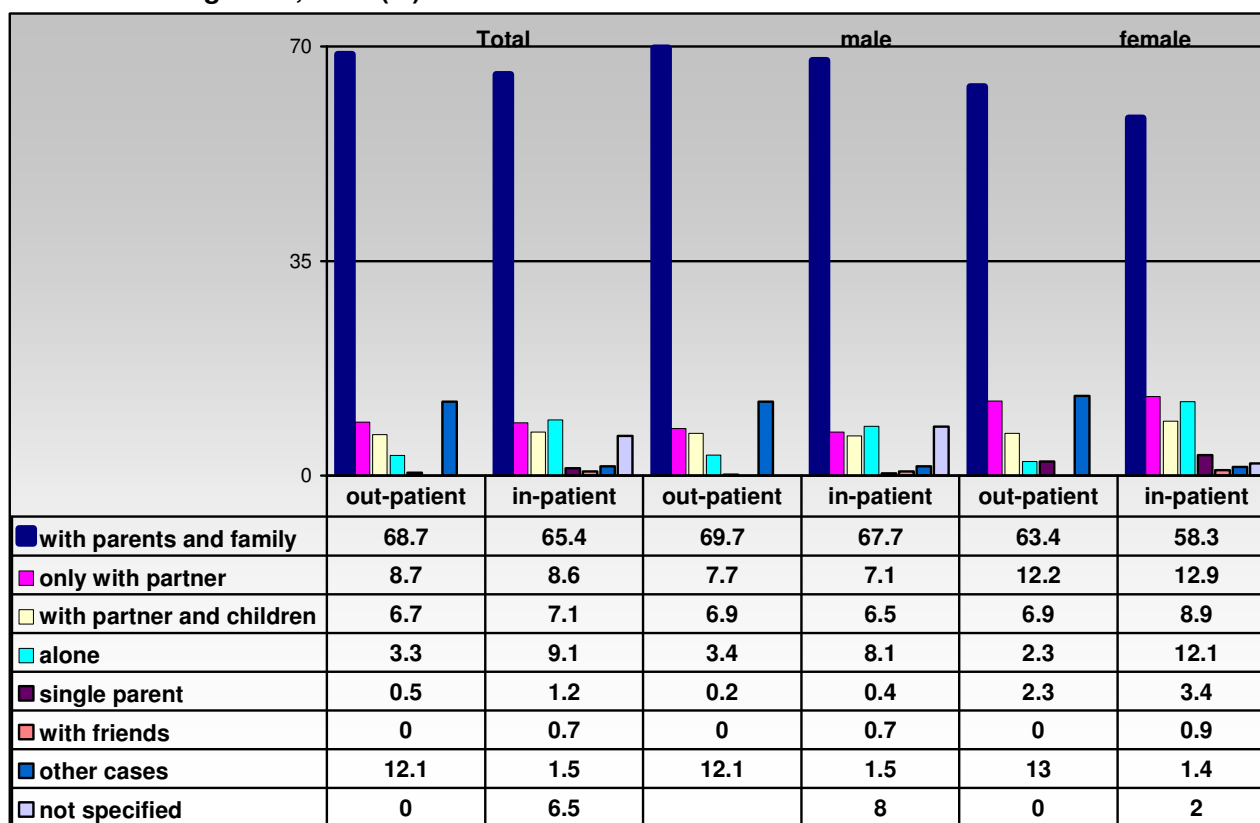
²¹⁴ See chapter 5 Treatment admission

- similar situation for both types of admission, with vocational school being the maximum level of education for half of the people admitted to treatment in 2010, and a third reported average education.
- the gender distribution of people admitted to treatment shows women tend to have higher education level (only 2.5% of women never attended school/never graduated primary education as compared to 4.4% of men, while 15.4% of them completed higher education as compared to 8.3% of men, and 41.2% of them completed high-school as opposed to 34.0% of men);
- there is a higher rate of people with average or high education as compared to 2009 and dropping levels for drug users having completed vocational school.

Housing conditions of people admitted to treatment in 2010

As regards housing conditions, over two thirds (66.6%) of the people admitted to treatment lived with parents in 2010 (65.4% in in-patient treatment, 68.7% in out-patient treatment), 15.6% only with partner/with partner and children (15.7% in in-patient treatment, 15.4% in out-patient treatment), 7.9% alone or only with children (10.3% in in-patient treatment, 3.8% in out-patient treatment) and 5.3% in other places (1.5% in in-patient treatment, 12.1% in out-patient treatment)²¹⁵.

Graph no. 8-3: Distribution of in-patient and out-patient treatment admissions by housing conditions and gender, 2010 (%)



Source: NAA²¹⁶

The analysis of the data resulted from the treatment admission indicator²¹⁷, as regards **housing conditions** of people admitted to drug treatment in 2010 as compared to the last year, illustrates the following trends:

²¹⁵ As compared to the last year/ a trend cannot be outlined because housing conditions were not specified for 76.7% of the cases in 2009

²¹⁶ Based on the data reported by CNOASIIDS and sent by DPECC, ANIT, PSYMOTION Arena and MH centres. The cases in which housing conditions were not mentioned make up the rest to 100%.

²¹⁷ See chapter 5 Treatment admission

- for both types of care, almost two thirds of the drug users admitted to outpatient drug treatment lived with their parents, and almost 15% with partner/partner and children; many of those admitted to in-patient treatment reported living alone/with partner and children; and many of those receiving out-patient treatment share housing (detention/arrest unit, child care institution, student dorm) or did not have a home.
- the gender distribution shows different results in terms of housing conditions: high rates of male users report living with parents or family, while women reported living with partner/partner and children and alone or as single parents.
- comparing to past years there is growing trend among those who live alone or only with children and a decrease of those who live only with partner or with partner and children; there is a dropping rate of male users who live only with partner or with partner and children, and a dropping rate of women who live only with partner or with partner and children, while the number of those who live with their parents, alone or as single parents increased.

8.1.1.2 Survey outcomes

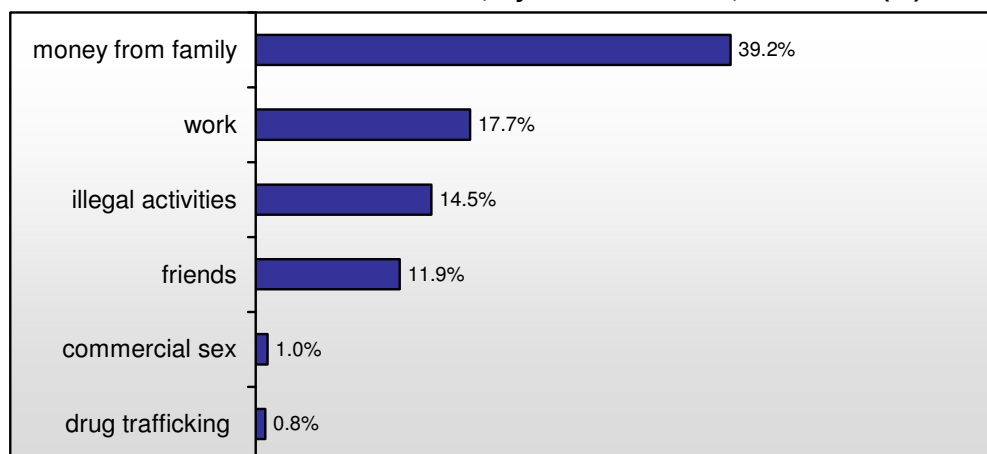
Because injecting drug use is indicative of problem drug use, the level of social exclusion among injecting drug users was analysed based on the surveys available in 2010 for this target group.

Thus, according to the *Serologic and behavioural survey (BSS-Behavioural Surveillance Survey)* conducted among injecting drug users in Bucharest²¹⁸ in 2010, 2 in 10 respondents did not have personal identification documents at the time of the study, medical insurance nor the possibility to access treatment services, 17.4% of the respondents were employed (19.7% of the male users and 8.8% of female users), 27% of them reported having lived in a orphanage, and 24.9% were admitted to a re-education centre for underage people (correctional facility), while 52.7% had been arrested or convicted to custodial sentences and 7.8% reported being paroled/bailed/under probation and 2.1% reported being prosecuted for criminal offences.

In response to question on the social-professional status, 50% of the interviewed IDU reported being unemployed, almost 30% did not have a contract (over limited or unlimited period of time) and 11.4% work illegally.

The main income source in the last 30 days for the interviewed IDU was the family (39.2%), salary – 17.7%, other illegal activities – 14.5%, friends – 11.9% and commercial sex – 1% and drug trafficking – 0.8%.

Graph no. 8-4: Distribution of interviewed IDU, by income source, BSS 2010 (%)



Source: *Serologic and behavioural survey on the prevalence of infectious diseases among IDU, 2010*

There is a low education level, with 19% of the subjects having never attended school and 32.5% only primary school.

²¹⁸ The methodology is described in sub-chapter 6.1.2 studies on the prevalence of drug related infectious diseases

Table no. 8-1: Distribution of interviewed IDU, by education level, BSS 2010

No education	19%
Primary school (1-4)	32.5%
Secondary school (5-8)	31.2%
High school	14.5%
Higher education	2.6%

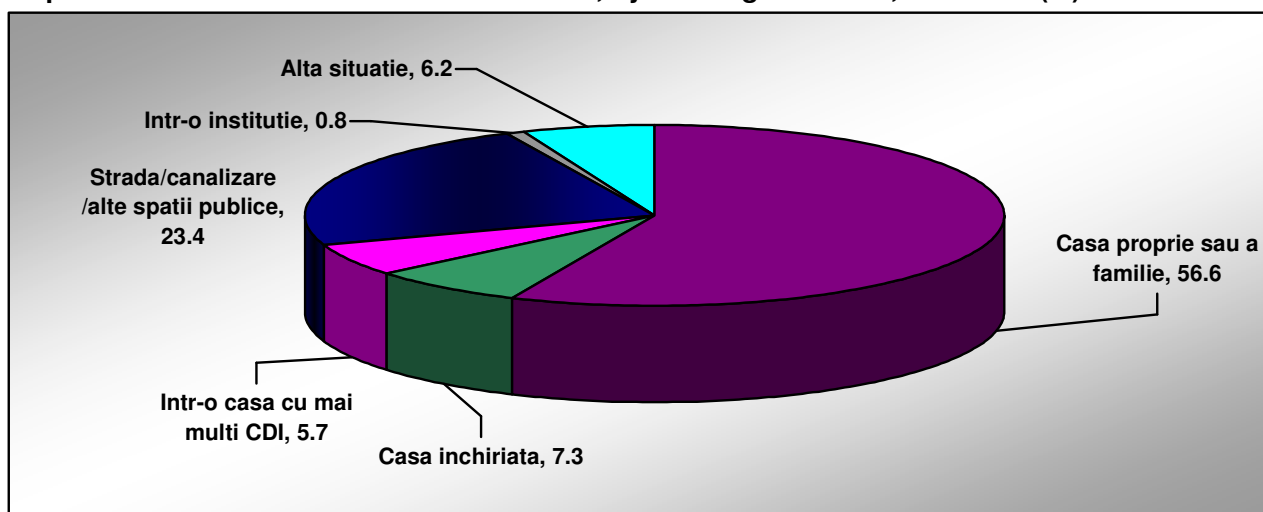
Source: *Serologic and behavioural survey on the prevalence of infectious diseases among IDU, 2010*

53.2% of the respondents declared having in average 2 children, with 1 child being the most frequently mentioned. Those who mentioned children were asked about the current provider: 52.2% replied somebody in the family, 22% themselves, and 10.2% replied the child is in foster care. 14.1% are in this situation and 1% refused to answer.

As shown in the following graph illustrating housing conditions, this situation is a difficult one for the interviewed IDU: 23.4% are “homeless”, 5.7% live with injection partners and 7.3% live in rented houses.

The outcomes of the *Serologic and behavioural survey on the prevalence of infectious diseases among IDU*²¹⁹, confirm the low participation in education of the IDU in Bucharest, namely a high unemployment rate. The same was concluded as a result of previous studies. The lack of housing, personal documents, resources to support children add to all these problems along with the problematic legal status of IDU.

Graph no. 8-5: Distribution of interviewed IDU, by housing condition, BSS 2010 (%)



Source: *Serologic and behavioural survey on the prevalence of infectious diseases among IDU, 2010*

8.1.2 LEGAL CONTEXT AND POLICY

As described in the introduction to the National Anti-drug Strategy²²⁰ the 3rd layer of integrated treatment system designed for drug users to be developed in Romania should ensure the social reinsertion of drug users through specific interventions and highly specialised services. To this aim, the final target of the general goal set for medical, psychological and social care and social reinsertion is the social reinsertion of drug users, which implies specific objectives such as:

- Increase service availability, in types, multi-disciplinary approach, territorial coverage and adjustment to the individual needs of users and type of use (single use or poly-drug use);
- Build and implement a legal framework to develop and define specific and specialised roles of the 3rd layer resources, as constituent of the public system of medical, psychological and social care towards the social rehabilitation and reinsertion of drug users in out-patient centres;

²¹⁹ Idem 218

²²⁰ enacted by GD no. 73 of 2005 on the approval of the National anti-drug strategy for the period 2005-2012

- Develop an integrated treatment system medical, psychological and social that should ensure a network of resources and guarantee access and availability of all drug users in the prison system towards the aim of social reinsertion.

The following activities were planned to achieve the specific goal “Increase availability of the services, in types, multi-disciplinary approach, territorial coverage and adjustment to the individual needs of users and type of use (single use or poly-drug use)” of the Action Plan to implement the National Anti-drug Strategy for the period 2010-2012²²¹:

- Activity 2.3., develop day-running centres for the social reinsertion of drug and alcohol users”
- Activity 2.5 Develop therapeutic community-like residential centres.

National Anti-drug Agency, Ministry of Labour, Family and Social Protection, Ministry of Health, local public authorities and NGO`s are responsible for the setup of these centres.

Additionally, the National interest programme to prevent tobacco, alcohol and drug prevention 2009 - 2012²²² includes two secondary programmes that focus exclusively on the social care of drug users:

- Secondary programme *Development of half-way housing services (3rd care layer) for former drug users*. The aim is to develop specific and specialised services in counties where drug issues have been identified through annual evaluations, and the overall goal of the programme is to create and develop integrated services for former drug users as a means to improve their chances of social, professional integration and prevent relapses among former drug users through the system of half-way housing. Some of the specific aims of the secondary programme are:
 - setup of 6 half-way social housing, equipped according to the minimal compulsory standards in the field, and located in risk areas such as Bucharest, Iași, Cluj-Napoca, Constanța,
 - social-professional reinsertion of 40 former drug users, beneficiaries of integrated care services;
 - a set of specific procedures for the treatment of former drug users in half-way housing.
- Secondary programme *Development of shelters for drug users* – the aim is to develop local crisis services that might provide basic medical, psychological and social care for the drug user who is not in contact with the treatment system. The primary goal of the secondary programme is to create and develop integrated services to increase availability of the services intended to help homeless drug users get socially reintegrated and to prevent drug related risks and social exclusion and ensure welfare of homeless drug users. The specific goals of the programmes are:
 - develop two shelter services equipped according to the minimal compulsory standards in the field and located in risk areas such as Bucharest, Iași, Cluj-Napoca, Constanța, that will ensure mainly housing and basic medical, psychological and social care;
 - provide housing, treatment and basic medical, psychological and social care for 40 drug users, beneficiaries of integrated care services;
 - a set of specific procedures for the treatment of drug users in social shelters.

The priority axes and specific intervention domains included in structural programmes, that provide funding for projects intended for the social reinsertion of drug users add to these secondary programmes.

- Regional Operational Programme (ROP) aims at laying the groundwork for ensuring key services to the population, among others, contributing to reaching the European social and economic cohesion, by improving infrastructure of health, education, social services and emergency public safety. The programme includes as priority action “improvement of the social, health and emergency public safety infrastructure; upgrading the educational infrastructure”. Some of the intervention areas for this priority action are:
 - Rehabilitation/modernisation/endowment of the health services infrastructure;
 - Rehabilitation/modernisation/endowment of the social services infrastructure;
 - Improving equipment of operational intervention basis for emergency situations;
 - Rehabilitation/modernisation/endowment of the infrastructure of pre-university/university education and continuous professional training.

²²¹ enacted by GD no.1.369 of 2010 approving the Action plan to implement Planului de acțiune the National anti-drug strategy for the period 2010-2012

²²² Approved by Governmental decision no. 1101/September 18, 2008 approving the National interest programme to prevent tobacco, alcohol and drug prevention 2009 - 2012;

To this aim, funding is provided for the rehabilitation/modernisation/endowment of multi-functional and residential centres that can contribute to relieving active family members of the care for addicted people, during normal working hours and increase labour and living quality of the active members and of the addicted people. The multi-functional social centres include centres with a primary social care component and can provide a range of services to help disadvantaged people, starting from intake to solving specific problems including the organisation of workshops for building independent life skills and professional competences.

The development of these social centres is completed by investments in existing residential centres that ensure long-term housing services and an adequate housing and treatment setting for people in difficulty. Therefore, the implementation of such projects can have positive results, from the point of view of humanitarian aid and labour reinsertion of disadvantaged people. The following types of centres and services can be funded from this programme: social centres setup/upgraded for beneficiaries of social services, including former addicted-drug users and remodelled social housing for beneficiaries of social services. The two types of services should exist and function in each county and the state should participate in funding them through a functional partnership between public institutions and NGO's that implement activities in the field of drug use. These services are included in the social-professional reintegration of drug users and are absolutely necessary to a positive completion of the therapeutic process.

- Sectoral Operational Programme Human Resources Development is a document proposed by Romania and approved by the European Commission that defines the development strategy, the intervention of the European Social Fund being intended to support the achievement of human resources development goals. One of the specific goals is to "enable the access of people in vulnerable groups to education and labour market", with the priority axis "Promoting social inclusion". Drug addicted people fall in the category of vulnerable groups. The key areas of intervention for this priority axis are:

- Development of social economy;
- Improvement of access and participation of vulnerable groups on the labour market;
- Promotion of equal opportunities on the labour market;
- Cross-border initiatives for an inclusive labour market.

One of the priorities of this intervention area will be to create Social Inclusion Centres that implement activities such as: building competences allowing people in vulnerable groups to assume social and economic roles, acquire professional skills and training in order to get hired, re-qualification and further professional training.

8.2 SOCIAL REINSERTION OF DRUG USERS²²³

Prevention campaigns have been organised nationally against marginalisation and social exclusion for categories of young people considered vulnerable. Of the organisers we can mention governmental institutions such as the National Anti-drug Agency (NAA), Ministry of Education, Innovation and Research (MEIR) together with education institutions and representatives of non-governmental organisations such as: INTEGRATION Association, ARAS, Alaturi de voi Foundation, SATIPEN.

In 2010, the National Anti-drug Agency through the 47 Drug Prevention, Evaluation and Counselling Centres, the 5 Addiction Integrated Care Centres continued to provide social care session to support the social reinsertion of drug users in treatment. Social reinsertion of drug users as a final aim in based on the following criteria defined by the social care standards provided to drug users:

- Is part of a global plan to understand the approach of biological, psychological and social aspects of the drug issues and the intervention on the individual, the individual's environment and the community,
- It should build on the personal and social resources of the subject, acquired previously, recovered or strengthened.
- stakeholders, resources, community services and the active citizen participation are indispensable to any socialising action.

To this aim, intervention areas in the social reinsertion processes as developed by the NAA centres staff are:

²²³ See structured questionnaire SQ28

1. personal and social: acquiring co-habitation rules, strengthening positive attitudes towards non-users and promoting the use of community resources;
2. professional training. Development and improvement of professional knowledge and techniques;
3. employment: seeking and getting a paid job;
4. education and culture: reaching a level of education, culture and social participation so as to understand and take part in social life;
5. a clear civil and legal situation;
6. community intervention: coordination, technical support and collaboration with public and social initiative bodies: strengthening community social services.

The activity of the DPECC/AICC was aimed at developing vocational/ergo-therapy groups (music, sports, pc, film, healthy alternatives) that might contribute to the reinsertion of beneficiaries included in integrated treatment programmes. In addition, to help treatment beneficiaries reintegrate, DPECC/AICC developed a social support network made up of public and private institutions that provide specialised rehabilitation and reinsertion to drug users. A first evaluation of these social care services for people in treatment was the results of the specific monitoring of the Addiction Integrated Care Centres in Bucharest (AICC Pantelimon, AICC Pericle, AICC Obregia) in the first six months of 2010:

Table no. 8-2: Evaluation of social care services provided by AICC in Bucharest, first six months, 2010

Program me type	No. of beneficiari es	No. of beneficiarie s who resumed studies	No. of beneficiaries who rebuilt family bonds	No. of beneficiaries who found a job	No. of beneficiaries who completed a training course	No. of beneficiaries who have a family physician	No. of beneficiarie s who completed the treatment programme
PMB	55	4	41	18	5	37	0
PMM	173	13	126	85	16	91	1
PMN	100	6	73	33	4	51	4
TOTAL	328	23	240	136	25	179	5

Note: PMB: buprenorphine and naloxone-based treatment; PMM: methadone treatment; PMN: naltrexone treatment

Source: NAA

Of the National Anti-drug Agency's projects that focused on avoiding social exclusion of drug users in 2010, we should mention:

- **Create and make a therapeutic community operational.** 1st component of the twinning project RO2006/IB/JH-07 Strengthening the system of medical, psychological and social care for drug users in Romania, carried out with Finnish technical assistance. It aimed to create and open a therapeutic community, as a key link in the provision of social reintegration to drug users. Because the twinning contract RO/06/IB-JH-07 ended November 30, 2009, the goal of the 1st Component was partially achieved. In the first halfyear of 2010, rehabilitation and remodelling works continued in Dejeni Therapeutic Community, and were supervised by the Logistics Services of the County Police Inspectorate in Brasov. The organisation and functioning of Dejeni Therapeutic Community were also included in the *National programme of medical, psychological and social care of drug users – 2009-2012*, approved by H. G. no.1102/2008, secondary programme 3rd layer treatment services. In order to ensure the financial resources needed for Dejeni Therapeutic Community, the appendix of the GD no.1102/2008 approving the *National programme of medical, psychological and social care of drug users – 2009-2012*, secondary programme 8, was amended by GD no. 939/2009 and GD no. 87 of February 5, 2010. These legal documents lay the groundwork for financial allocations needed to achieve the investment objective "Dejeni Therapeutic Community" and to ensure its operation.

- **Participation of vulnerable groups in social economy**

The specific goals of the project:

- support of the setup and development of social enterprises that provide employment to vulnerable group members;
- professional qualification and training and private enterprise training for vulnerable group members;

- training in the field of social services that support social inclusion for specialists in the public and private sectors.

Activities:

As project partner, the National Anti-drug Agency provides support and expertise in staff training.

• **Democracy, cities and drugs – II**, carried out from May 2008 to April 2011 by the National Anti-drug Agency in partnership with the Portuguese forum for Urban Security, IREFREA Network in Italy, European EuroTC network in Germany, International Association of Interventions and Drug Addiction ANITEA (France), ABD-Basics Association (Spain), University in Padova (Italy), ACCES 13 Association (France), was intended to make a methodology for the integrated care of underage drug users. Funded by the European Commission through the Executive Agency for Public Health, as main recipient, European forum for Urban Security (FESU), France, the project intended to achieve the following specific goals:

- organising trainings for professionals in 10 towns,
- making a national good practice guide for the professionals working in the field of integrated care for underage drug users,
- evaluating the national working methodology after an period implementation of 6 months,
- formulating a joint order to sustain the national legal framework regarding specific interventions of care for underage drug users – methodology formulated within the project,
- promoting the project and its outcomes.

Civil society projects

• **Second chance**

The Romanian Anti-AIDS Association in partnership with Integration Association, Sens Pozitiv Association and the “Prof. Matei Balș” Infectious diseases institute launched the **Second chance** programme, funded by the European Commission based on the structural programmes granted to Romania, Priority action: 6 “Promotion of social inclusion”.

The programme is implemented over a three-year period and mainly aims to improve access to labour market for people with double vulnerability: roma ethnicity, women, former prison-inmates, victims of human trafficking, who are also injecting drug users in Bucharest, county of Ilfov, and counties of Timis and Constanta, through:

- increase of social-professional reinsertion level
- enhancing self-esteem;
- promotion of a healthy setting;
- sensitising the public and employers of the problems and needs of injecting drug users.

Specific goals:

- O.1 improving the economic, social, psychological and medical situation through integrated services of psycho-medical-social care and vocational counselling for beneficiaries through fixed centres and mobile services that would: social care, substitution treatment for injecting drug users, psychological counselling, prevention of sexually and blood-borne disease, referral to other services;
- O.2 motivating and encouraging the participation of beneficiaries through recruitment and peer training;
- O.3 informing the public and employers of drug use and drug users through an information campaign.
- O.4 Gathering the experience of project implementation and replicating it in other cities/regions.

The project addresses a target group at high risk for social exclusion, made up of injecting drug users, who also present one of the following vulnerabilities: roma ethnicity, women, former prison-inmates, victims of human trafficking. This diverse social group is difficult to approach and need special attention, because it is the cause of problems that affect the entire society: large costs for the health system, petty crime, human trafficking, major difficulties in labour market reinsertion, low labour productivity, severe poverty, low level of education. Project activities aim at increasing labour reinsertion chances for the target group, and at reducing harm while also encouraging openness of the local community towards this category of vulnerable people, in order to avoid marginalisation and discrimination.

The project activities implemented in the first 6 months (July 1 – December 31, 2010) recorded the following results:

- 185 vulnerable people who are also drug users benefited from care during the project;
- 49 roma ethnics;
- 90 people affected by disease that affect personal and professional life;
- 32 women;
- 40 former prison-inmates;
- 185 of beneficiaries received vocational counselling,
- 44 drug users were included in substitution treatment;
- 44 injecting drug users were contacted during the reporting period.

- ***Free qualification courses towards social reinsertion***

Getting a job for a former drug user is extremely difficult and often impossible. Most drug users have scarce financial resources and cannot pay for qualification courses.

In this context, Association for the Fight against Alcohol and Drugs (ALIAT) supports the social reintegration of people who succeeded into fighting alcohol or drug addiction by organising free qualification courses addressing drug users in Bucharest. In addition, drug users can also access services of evaluation and certification of professional competence, which help interested people obtain a certificate of professional competence recognised in Romania and EU states, after gaining a qualification based on skills and knowledge provided for in an occupational standard. The certificates of professional competence are equally valid as a graduation or qualification certificate obtained after completing a professional training course.

Chapter 9 – Drug law crime, drug law crime prevention and the prison system

9.1 DRUG RELATED CRIME

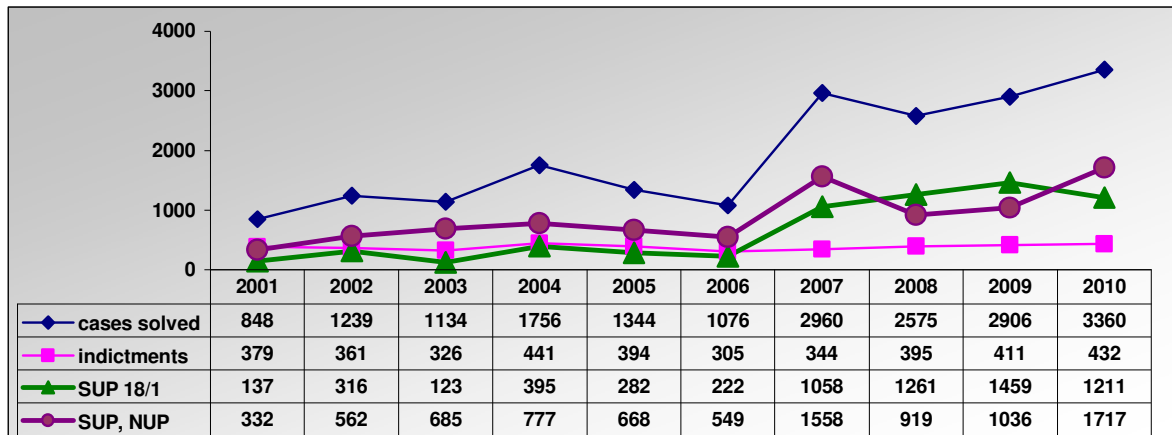
9.1.1 DRUG OFFENCES (ARRESTS/ CRIMINAL REPORTS FOR DRUG USE TRAFFICKING/ PRODUCTION/ CULTIVATION ETC.)

A. SITUATION OF CRIMINAL CASES SOLVED BY THE PROSECUTOR'S OFFICES RELATED TO DRUG AND PRECURSOR LAW OFFENCES

There is a 15.6% increase of criminal cases solved by DIICOT (central unit and 15 territorial services) in 2010 for drug law criminal offences and the law on precursors used in manufacturing high risk drugs²²⁴. Thus, if 2,906 criminal cases were solved in 2009, the number increased to 3,360 in 2010. It should be mentioned that all criminal cases solved in 2010 were breaches of the Law no. 143/2000 on countering the illicit drug trafficking and use, further amended and supplemented and no precursor law offences were identified. From the point of view of type of case decision, of the total 3,360 solved cases, 2928 were settled in the prosecution stage (1,211 criminal cases were solved by dropping charges under art. 18¹

Criminal Code – the act does not show risk to the public), while 432 criminal cases were referred to court towards further criminal proceedings. The longitudinal analysis of this indicator shows that the year 2010 falls in the upward trend of the last two years, emphasised by an increase of criminal cases solved by prosecution offices, and ending a succession of increases and decreases recorded over no less than 8 years, since the effect of the Law no. 143/2000. In addition, the same upward trend was noticed in the number of criminal cases settled by court referral, the numbers recorded in 2010 being the highest, if the year 2004 is excepted.

Graph no. 9-1: Dynamics of criminal cases settled by prosecution offices from 2001 to 2010 (no.)

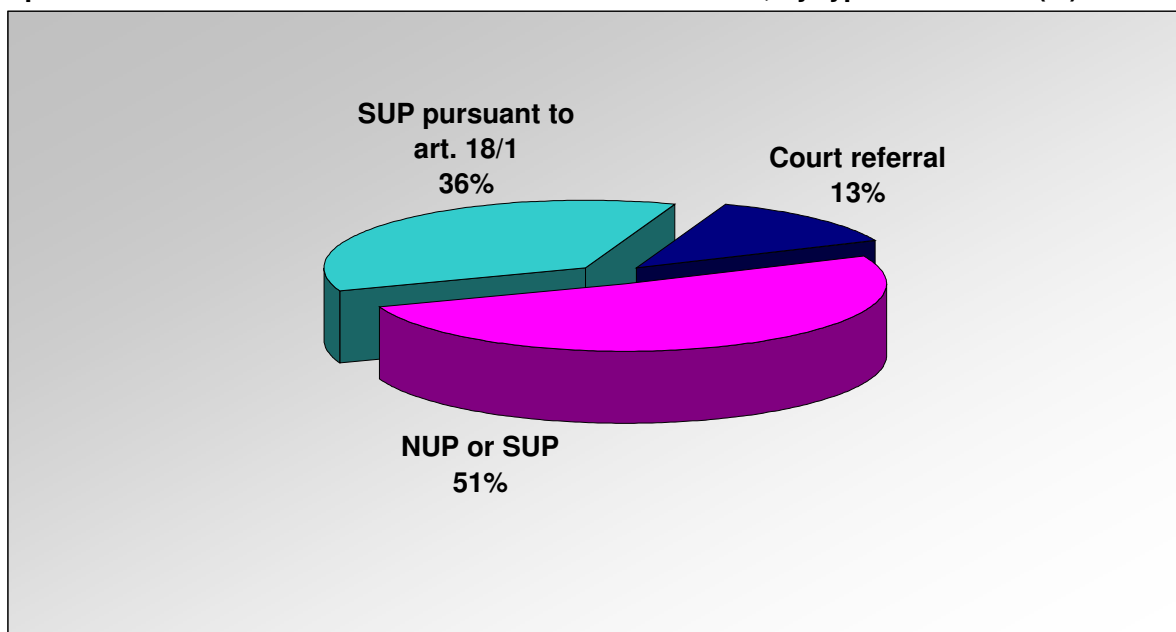


Source: Prosecutor's Office with the High Court of Cassation and Justice, DIICOT

In addition, 2010 does not bring major changes in comparison to previous years, in relation to the progress of solved criminal case, by type of decision passed by prosecution offices. Thus, although the number of cases solved by referral to court level has been increasing steadily from one year to another, they continue to represent a small share of cases solved, and only 12.9% in 2010.

²²⁴ Statistical data in this unit are provided Directorate for Investigation of Organized Crime and Terrorism Offences (DIICOT), within the Prosecution Office with the High Court of Cassation and Justice

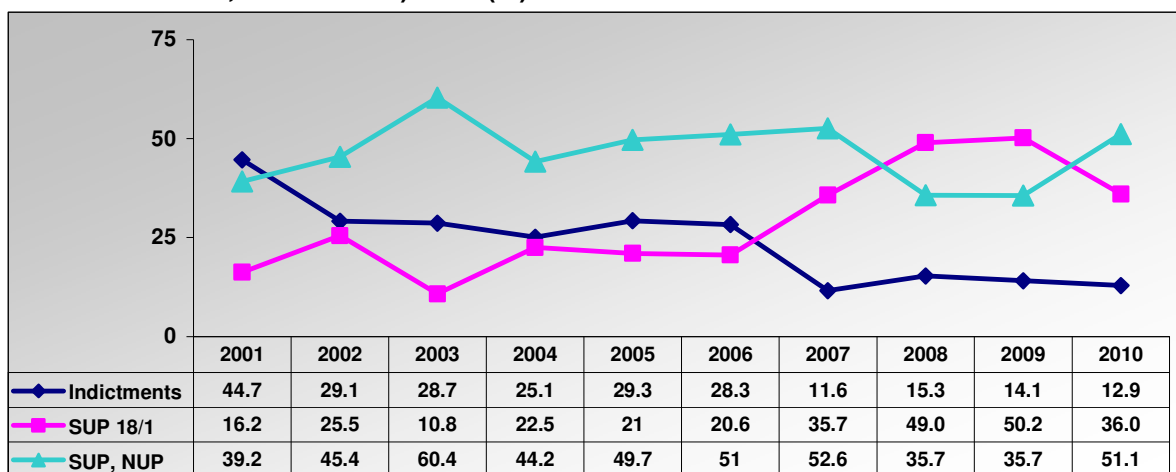
Graph no. 9- 2: Distribution of criminal cases settled in 2010, by type of decision (%)



Source: Prosecutor's Office with the High Court of Cassation and Justice, DIICOT

Yet, unlike past years, there a reversed ratio of the number of cases solved by the prosecutor's decision to waive prosecution (SUP or NUP) and of the number of cases solved by the same decision without being grounded by the seriousness of the offence (pursuant to art. 18¹Criminal Code).

Graph no. 9-3: Evolution of the rate of settled cases by type of decision (court referral, SUP pursuant to art. 18¹, NUP or SUP) 2010 (%)



Source: Prosecutor's Office with the High Court of Cassation and Justice, DIICOT

The illicit drug trafficking and use clusters in large urban communities which is confirmed by the number of cases settled by the territorial units of the DIICOT. Thus, the unit in Bucharest settled 2,217 criminal cases (66%) followed by Constanta unit with 138 cases (4.1%) and Timisoara with 90 criminal cases. There are significant changes in the upward trend of settled criminal cases recorded in the central unit (126 cases in 2010, as compared to 62 in 2009) and in Ploiesti unit (128 cases in 2010, as compared to 50 in 2009), Galati unit (from 34 in 2009 to 94 in 2010) and Iasi unit (from 47 in 2009 to 96 in 2010).

Table no. 9-1: Distribution of the number of criminal cases settled by different DIICOT units, in 2010

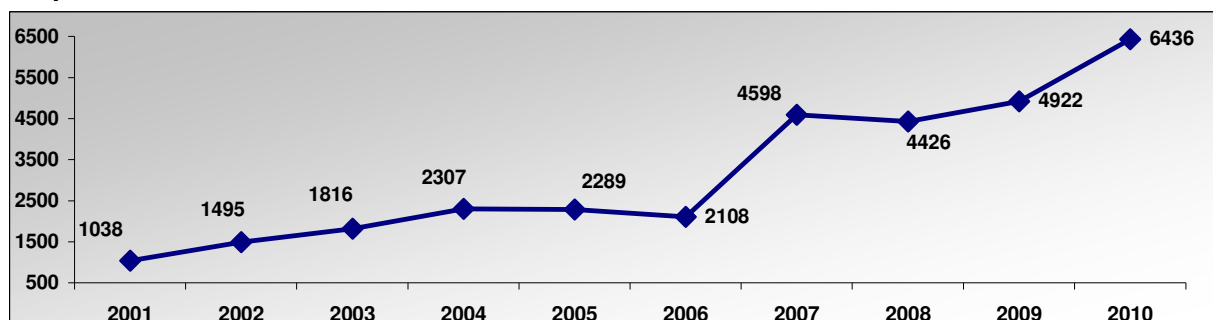
Territorial service	Settled cases											
	2008				2009				2010			
	Indictment s	SUP 18 ¹	SUP/NUP	Total	Indictment s	SUP 18 ¹	SUP/NUP	Total	Indictment s	SUP 18 ¹	SUP/NUP	Total
Alba Iulia	10	5	21	36	12	17	25	54	15	20	36	71
Bacău	11	5	17	33	10	10	10	30	8	8	29	45
Braşov	13	3	20	36	17	6	22	45	17	7	24	48
Bucharest	175	1085	621	1881	184	1258	699	2141	151	974	1092	2217
Cluj	13	24	9	46	25	21	29	75	25	31	33	89
Constanţa	27	55	35	117	24	56	46	126	23	34	81	138
Craiova	25	12	43	80	18	18	43	79	18	24	68	110
Galaţi	14	4	12	30	14	0	20	34	24	3	67	94
Iaşi	8	28	15	51	12	18	17	47	11	40	45	96
Oradea	12	2	4	18	13	6	11	30	17	9	13	39
Piteşti	8	3	13	24	10	3	12	25	6	9	15	30
Ploieşti	11	13	38	62	9	9	32	50	29	13	86	128
Suceava	6	2	15	23	10	6	5	21	2	1	5	8
Tg. Mureş	13	5	8	26	8	6	10	24	10	3	18	31
Timişoara	23	14	15	52	25	23	15	63	30	27	33	90
Central unit	26	1	33	60	20	2	40	62	46	8	72	126

Source: Prosecutor's Office with the High Court of Cassation and Justice, DIICOT

B. SITUATION OF THE OFFENDERS INVESTIGATED AND REFERRED TO COURT BY THE PROSECUTOR'S OFFICES

The upward trend of the number of criminal cases settled by prosecution offices from 2001 to 2010 for drug law offences, illustrates the link with the number of prosecuted people, which indicates a 30.8% increase in 2010 as compared to the last year, from 4,922 to 6,436 people.

Graph no. 9-4: Trend in the offenders charged/prosecuted by the prosecutor's offices for drug and precursor law offences from 2001 to 2010



Source: Prosecutor's Office with the High Court of Cassation and Justice, DIICOT

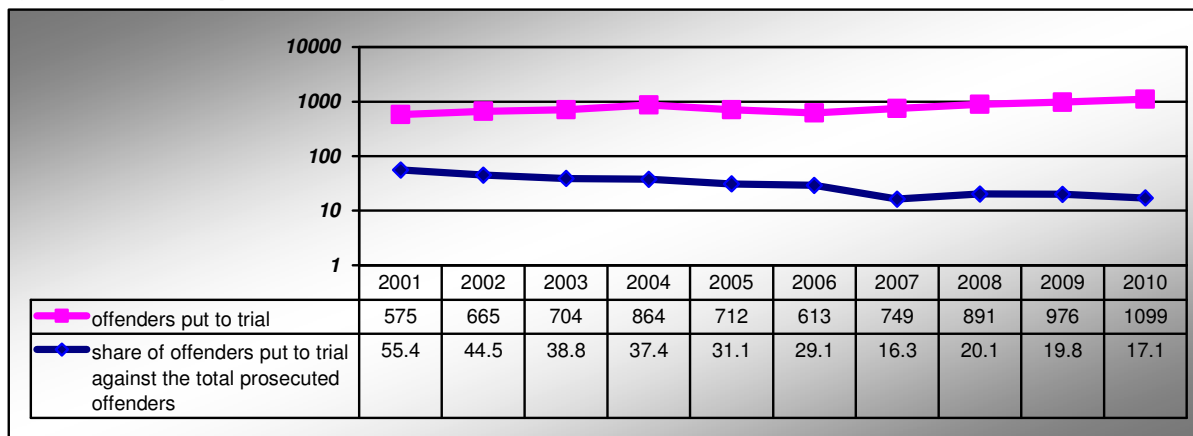
The analysis of the territorial distribution of the prosecuted offenders in settled cases shows a link with the territorial distribution of the settled cases, as most offenders were prosecuted at the level of territorial services in Bucharest (2,993 people, namely 50% of the total prosecuted people), followed by the territorial service in Cluj (6.3%) and Ploieşti (6%).

In addition, the statistical data recorded for 2010 do not show significant changes in the trends recorded throughout the reference year, as to the number of people against whom legal proceedings were instituted and their proportion against the total number of prosecuted people.

Thus, the upward trend of the cases referred to court by prosecution decision continues in 2010 up to reaching the value of 1,099 offenders, which is double the value recorded at the beginning of the time period, namely 2001.

On the other hand, the correlation between the two indicators, namely the number of prosecuted offenders and number of offenders put to trial, shows a rate of 17.1% which continues along an upward trend that has characterised the entire period of time, except for the year 2007.

Graph no. 9-5: Trend in the offenders put to trial for drug law offences and their proportion against the total prosecuted offenders from 2001 to 2010



Source: Prosecutor's Office with the High Court of Cassation and Justice, DIICOT

The demographic and social-economic indicators of the people put to trial in 2009 for breaking the drug law continue to be valid in 2010. Thus, the profile outlined in the last years namely: male offender (85.4%) aged 21 to 54 (88.1%), from urban settings (90.2%) with an average education (47.8%) and no occupation (68.6%).

As compared to 2009, the situation of people put to trial for breaking the drug law shows an increase in the number of foreign citizen put to trial for breaking the Law no. 143/2000 further amended and supplemented from 23 to 39 offenders in 2010.

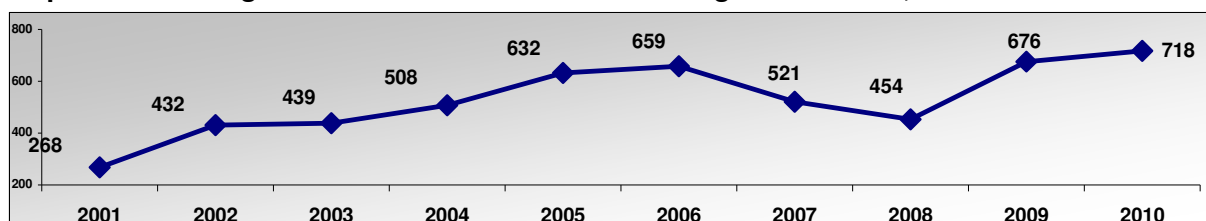
C. NUMBER OF PEOPLE CONVICTED BY THE COURTS OF LAW

In 2010, the courts of law have passed conviction decisions for 718 drug law offenders (663 men and 55 women), of which 701 offenders aged 18 and over (650 men and 51 women) and 17 underage offenders (13 men and 4 women), which represents a 6.3% increase as compared to 2009. There are 13.5% (97 people) repeat offenders among convicted people and a 6.1% of people with prior convictions (44 people). The upward trend evidenced in 2009 is also valid for 2010, the latter accounting for the highest values ever recorded.

Out of a total of 718 people, 479 people (66,7%) of whom 463 offenders aged 18 and over (416 men and 47 women) and 16 underage offenders (13 men and 3 women) were convicted for drug trafficking, pursuant to art.2 of the Law 143/2000 on preventing and countering drug use and trafficking, further amended and supplemented. By analogy to 2009, there a 4.8% increase, from 457 to 479 offenders who were convicted for drug trafficking. The number of drug users convicted by the courts of law amounts to 76, on a downward trend since 2009, when 78 convicted offenders were recorded.

The evolution of the indicator throughout previous years may confirm a noticeable upward tendency of people convicted for drug possession for personal use and, by correlation, an increase of the number of people convicted for drug trafficking offences.

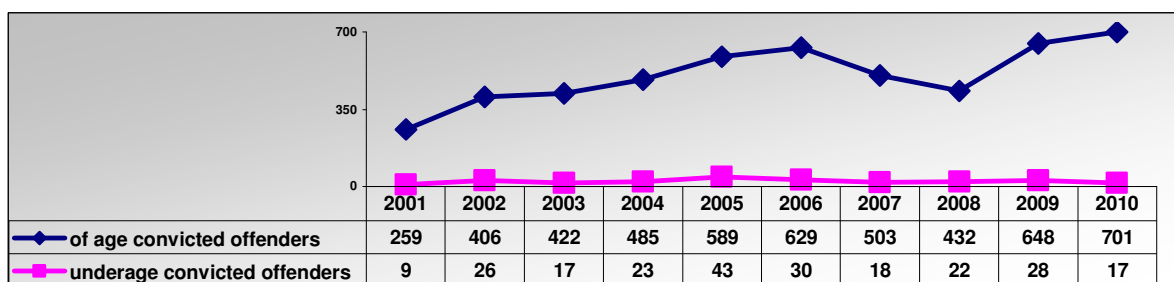
Graph no. 9-6: Progress of offenders convicted for drug law offences, 2001-2010



Source: High Council of Magistracy

In addition, the downward trend of the last two years related to underage offenders being convicted for drug law offences, continued in 2010, with a decrease from 28 (in 2009) to 17 underage offenders in 2010 (decrease by 39.3%). As for the types of drug law offences for which conviction sentences were passed, the year 2010 does not bring major changes by analogy to last years, most underage offenders (94.1%) being convicted for drug trafficking, for two consecutive years, and no drug possession conviction was recorded.

Graph no. 9-7: Evolution of the number of offenders convicted for drug law offences, by age, 2001-2010



Source: High Council of Magistracy

The courts of law did not pass decisions in criminal cases related to precursor law offences in 2010.

Number of people convicted to custodial sentences

Of the total 718 convicted offenders, the courts of law passed custodial sentences to 705 people of which 688 adult and 17 underage offenders, and criminal fines to 13 offenders²²⁵. Of the total 705 offenders that were given custodial sentences, 354 were given a prison sentence (50.2%), 124 (17.6%) were given a conditional discharge order and 227 (32.2%) were given a licence supervision order.

The distribution by custodial terms shows the sentence of 1 to 5 prison years is the most frequent among adult offenders (350 people) accounting for 52% of the total custodial sentences. The custodial term ranged from 5 to 10 prison years among 32.2% of convicted adults.

If there is an increase of the total offenders convicted to custodial sentences (up to the highest levels since 2001), on the whole custodial sentences and prison sentences tend to reach the same levels since 2006.

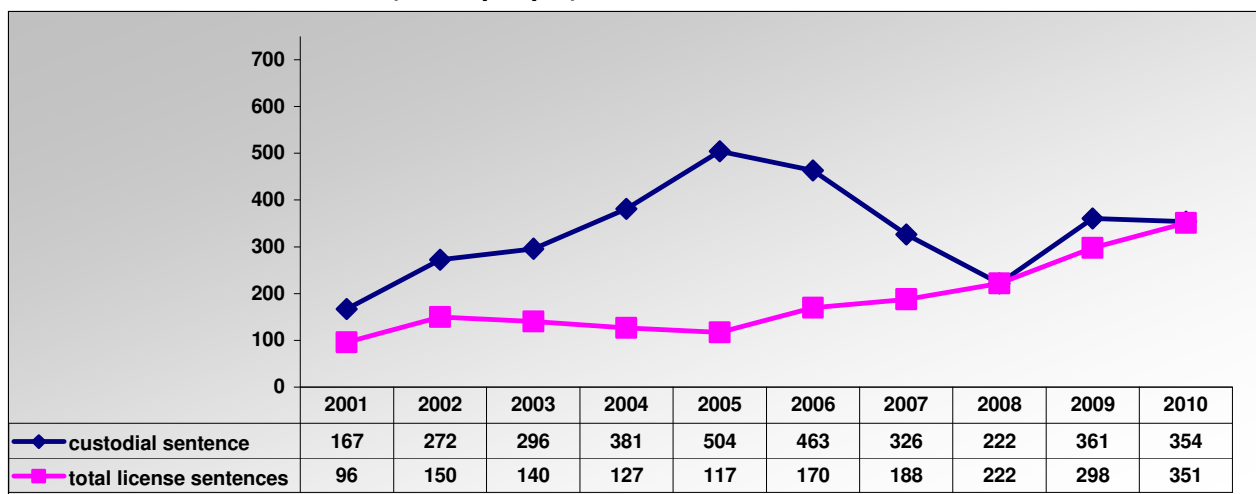
The decreasing number of people sentenced to prison is commensurate with the increasing number of people who received custodial sentences and serve sentence in the community on licence. More concretely, 351 of the total 705 offenders who received a prison sentence in 2010 were not convicted in confinement.

- 354 offenders were sentenced to prison, and of them 241 for drug trafficking and 32 for drug possession for personal use;

²²⁵ The amount of the fine as prison alternative, only for possession of high risk drugs for personal use, pursuant to art. 4, indent.1 of the Law no. 143/2000 on countering the illicit drug trafficking and use, further amended and supplemented, while a custodial sentence is imposed for the rest of offences

- 124 offenders (115 adults and 9 youths) received orders of conditional discharge. Of them, 79 offenders participated in drug trafficking and 19 in illegal activities such as drug possession for personal use;
 - 227 offenders (223 adults and 4 youths) were given a licence supervision order.
- The distribution by type of committed offence shows 153 offenders participated in drug trafficking and 19 in illicit activities for personal use.

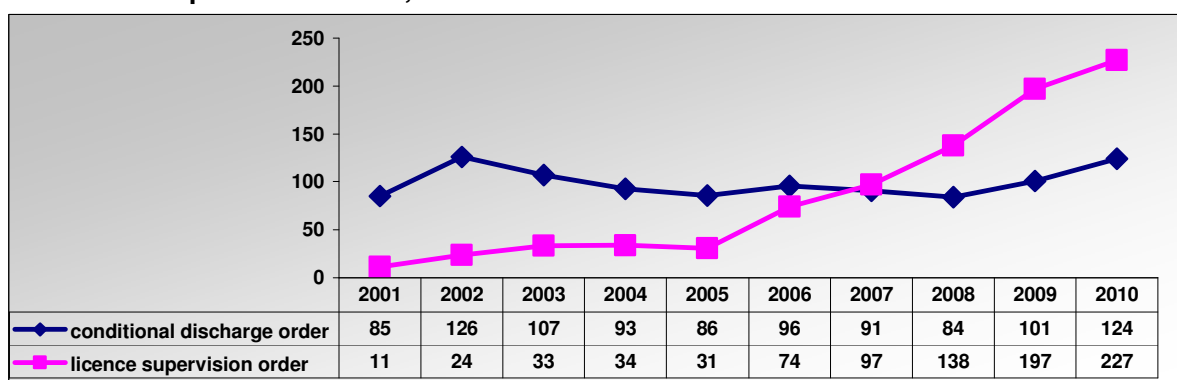
Graph no. 9-8: Progress of the number of offenders with custodial sentence and licence sentences, from 2001 to 2010 (no. of people)



Source: High Council of Magistracy

It should be noticed that the reversed ratio between conditional discharge orders and licence supervision orders has been effective since 2007, and has since reflected the tendency of courts to impose orders complying with conditions and obligations that include detoxification treatment, while considering all aspects of drug law offences, and less orders that are based on a single obligation, i.e. not to commit another offence.

Graph no. 9-9: Progress of the number of offenders who received conditional discharge orders and licence supervision orders, from 2001 to 2010



Source: High Council of Magistracy

This conclusion seems to be foregrounded by the progress of the number of people convicted for drug law offences that are included in the record of the probation services of the Ministry of Justice. Thus, in 2010, the statistical data related to drug law convicted offenders included in the records of the probation services show an increase by 28.5% of the number of people given discharge orders and an order to comply with conditions pursuant to art. 86³, indent 1, letter a-d Criminal Code²²⁶, and

²²⁶ Article 86³, indent 1, letter a – d of the Criminal code mentions that while sentences the convicted offender should comply with licence supervision measures such as: *show up upon the term set by the supervision or probation commission, notify any change in residence in advance, as well as any travel over 8 days, notify and justify the change of employment and communicate information that enable control of living conditions.*

an increase by 49.1% of the number of people given an order to comply with obligations under art. 86³, indent 3, letter a-f Criminal Code²²⁷.

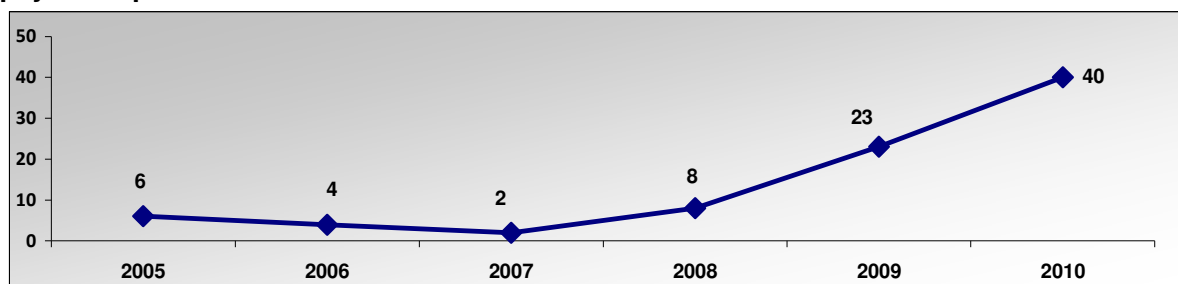
9.1.2 OTHER DRUG RELATED CRIMES (E.G. PROPERTY CRIMES, ILLEGAL PROSTITUTION, PRESCRIPTION OFFENCES, VIOLENCE UNDER THE INFLUENCE; DRIVING OFFENCES, ETC.)

DRIVING OFFENCES

40 drivers were caught driving under the influence of narcotic substances or products in 2010, which is 73.9% more than in 2009. 20% of them (8 drivers) were identified in the county of Dâmbovița, 15% (6 drivers) in Bucharest and 12.5% (5 drivers) in the county of Maramures.

The same limitations that have been noticed previously in relation to testing drivers for narcotic substances or products use, were valid for 2010, namely endowment, lack of training and of a clear testing procedure.

Graph no. 9-10: Progress in the number of drivers caught under the influence of narcotic or psychotropic substances in the time interval 2005-2010



Source: Traffic Police Directorate, Inspectorate General of Romanian Police

It should be mentioned that the data are the outcomes of random traffic controls made by the Traffic Police, as alcohol tests were the only tests conducted in case of traffic accidents.

DRUG RELATED OFFENCES

836 drug users (621 men, 215 women) to whom the measure of remand in police custody was imposed following criminal act, were detained in the 12 detention centres of the Remand and Detention Service within the Directorate General of Police of the Municipality of Bucharest. The analysis shows an increase by 27.3% of the people in police custody for offences committed under the influence of narcotics and psychotropic substances totalling 657 in 2009 and 836 people in 2010. The analysis of the offences committed by the drug users detained in the above-mentioned detention centres shows most cases are offences committed to gain money, namely property crime (theft, robbery) and drug trafficking offences, which may lead to the conclusion that these offences were committed to gain material incomes to support drug use.

Table no. 9-2: Situation of arrestees, by type of offence, 2006-2010 (no.)

Type of offence	Legal classification	Number of people				
		2006	2007	2008	2009	2010
Theft and aggravated theft	Art. 208,209 CC62	278	323	378	221	414
Drug trafficking	Law no. 143/2000	224	217	183	264	303
Robbery	Art. 211 CC	47	112	125	100	119
Manslaughter	Art. 174–178 CC	6	2	1	0	0
Assault	Art. 181 CC	1	0	3	0	0
Procuring	Art. 329 CC	2	2	2	30	0
Criminal damage	Art. 217 CC	1	0	4	0	0
Fraud	Art. 215 CC	1	3	13	42	0
Illegal confinement	Art. 189 CC	1	0	3	0	0

Source: Detention and Remand Service, Directorate General of Police of the Municipality of Bucharest

²²⁷ Article 86³, indent 3, letter a – f of the Criminal code mentions that while sentences the convicted offender should comply with one of several obligations: *carry out an education activity or attend a course, not change residence unless approved by commission, not attend certain places, not contact certain people, not drive a vehicle or certain vehicles or allow measures of examination, care, treatment, especially for detoxification purposes.*

The age distribution shows there is 1.2% share of people under 18 that have been arrested for offences under the influence of drugs which in numbers would equal 10 youths (3boys and 7 girls). They were aged 16 to 18. By comparison to 2009 data, there is a 76.7% decrease in the reference year totalling 10 underage offenders from 43 in 2009. It should, however, be stated that the communicated data reflect the situation of drug users arrested for having committed offences in the municipality of Bucharest and the county of Ilfov and there are not data available at national level. Arrested self-reported drug users benefit from specialised medical care provided by the Medical Service of the Directorate General of Police of the Municipality of Bucharest.

9.2 INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

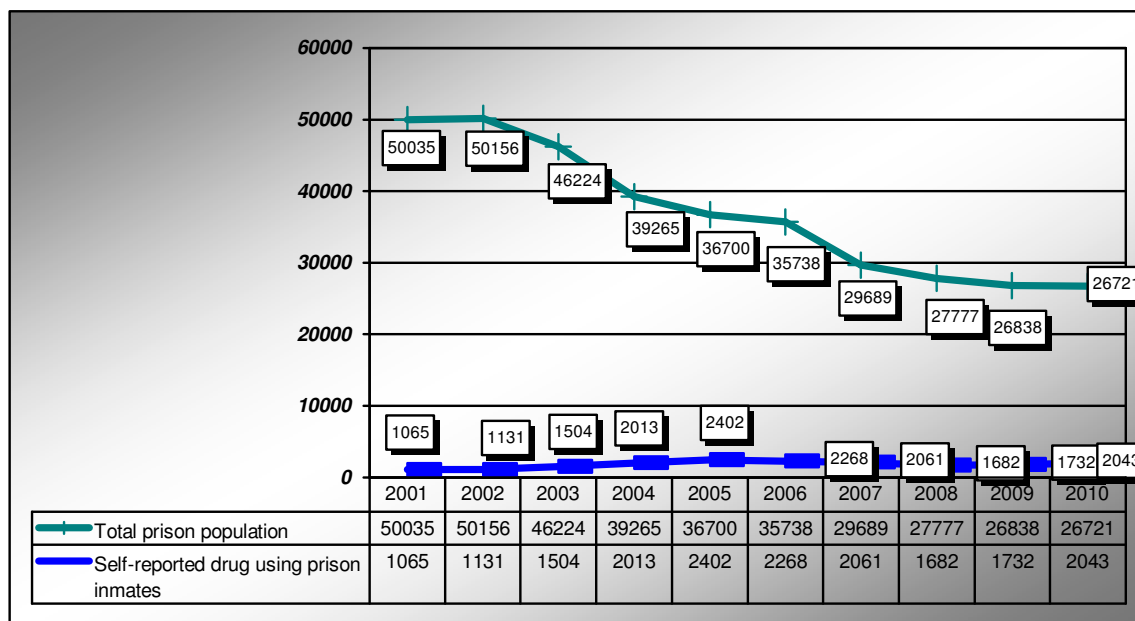
9.2.1 ALTERNATIVES TO IMPRISONMENT

See alternatives to imprisonment elements for people prosecuted for drug possession for personal use mentioned in Chapter I – National context and policies, sub-chapter 1.1.2 – Law implementation.

9.3 DRUG USE AND PROBLEM DRUG USE IN PRISONS

According to the data provided by the National Administration of Penitentiaries (NAP) for 2010, of a total 26,721 inmates, 2,043 self-reported as drug users upon prison admission. It should be noticed that the number of prison inmates who self-reported as drug users doubled from 2001 to 2010 (from 1,065 to 2,043) while the total number of inmates in the penitentiary units in Romania dropped by half (from 50,035 to 26,721).

Graph no. 9-11: Distribution of self-declared drug using inmates against the total prison population, 2001-2010



Source: NAP

The demographic features of the self-reported drug using prison inmates upon prison incarceration did not change in 2010, and there are no significant changes than in previous years, with over 80% of male inmates. In addition, there are no significant changes of the age groups of the self-reported drug using prison inmates except for slight variations around average values.

Table no. 9-3: Gender and age distribution of self-declared drug using inmates, 2007-2010

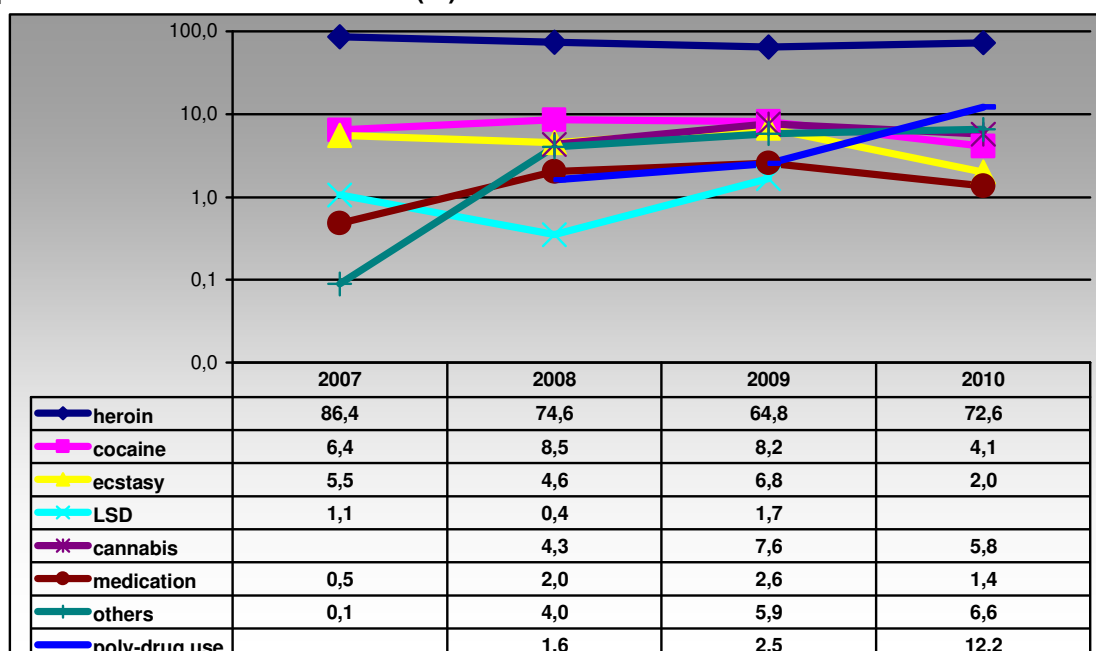
		2007	2008	2009	2010
Gender	male	88	78.3	84.9	82.9
	female	12	21.7	15.1	17.03
Age group	15-19	6.11	4.39	4.27	3.27
	20-24	27.46	24.67	32.9	29.22
	25-29	40.61	36.26	39.26	33.43
	>= 30	25.81	34.66	23.55	34.16

Source: NAP

Self-reports of substances used prior to incarceration show heroin is the first among drug use preferences, with an average of 70%, followed by cannabis and cocaine, in the time period 2007-2010. Cocaine and ecstasy are on a downward trend as compared to the past year.

These data are also confirmed by other indicators – general population surveys conducted in 2003, 2007 and 2010²²⁸ and drug treatment admission, that place cannabis among the first drug use preferences and heroin as the first drug of abuse of people admitted to treatment. The economic crisis and the decreasing buying power might underpin for the decrease in cocaine preference, although the retail price has been constant since 2007. The statements given upon incarceration show most drug users mentioned injection as the most frequent administration route for the main drug of abuse (71.2%).

The almost 4-fold increase of statements related to poly-drug use in 2010 from 2.5% in 2009 to 12.2% in 2010 is noteworthy as the increase from 2008 to 2009 was much lower (from 1.6% to 2.5%).

Graph no. 9-12: Distribution of self-declared drug using inmates, by used substance, comparison between 2007 and 2010 (%)

Source: NAP

The findings of „Behavioural and serologic survey on the prevalence of infectious diseases among IDU²²⁹, conducted from January to March 2010 by UNODC, *Romanian Angel Appeal* and NAA, showed 44% of the interviewed injecting drug users had been imprisoned before, while 19% injected drugs in penitentiary, during detention. Based on these data, the survey authors recommended the development and extension of HIV, HBV and HCV prevention programmes among IDU, and of the community-based and prison-based drug services.

²²⁸ See National Reports on drug situation – 2004 and 2008, and Chapter 2 of this report

²²⁹ The study methodology is described in sub-chapter 6.1.2. Studies on the prevalence of drug related infectious diseases

SURVEY ON THE USE OF DRUGS, ALCOHOL AND OTHER PSYCHOACTIVE SUBSTANCES IN THE PRISON SETTING IN ROMANIA, 2011

The National Anti-drug Agency conducted in 2010 the second survey²³⁰ on the scope and trends of the use of illicit drug, alcohol and other substances among prison inmates, as well as on the consequences of addictive behaviour on the health of prison inmates, in cooperation with the National Administration of Penitentiaries (NAP).

Methodology

There were 2100 respondents in the settled sample which is nationally representative for the institutionalised target population in the prison setting, aged 64 and less. 2,064 questionnaires were confirmed. The sample had a maximum deviation of +/-2.08% and a 95% confidence level. The sampling method was randomised, multi-staged, and multi-layered and the stratification variables were:

- type of penitentiary: maximum security/ closed circuit/ remand, half-open and open, for underage and young people, re-education institution and hospital;
- age group: underage inmates (<18 years), youths (18 -21 years) and adults (22- 64 years);
- gender: male and female.

Table no. 9-4: Survey sample, 2011 (no. of people)

		population	sample
TOTAL of which:		29284	2064
Type of penitentiary	maximum security/ closed circuit/ remand	14783	1042
	half-open and open	11570	815
	underage and young people	1835	129
	re-education institution	165	12
	hospital	931	66
Gender	male	28082	1979
	female	1202	85
Age group	underage (<18 yrs)	416	30
	youths (18 -21 yrs)	1666	117
	adults (22- 64 yrs)	27202	1917

Source: NAA

The study was conducted in all 31 penitentiaries (50 locations) that exist at national level. The respondent selection was randomised, for each type of penitentiary, age group and gender, and the list of people had those features.

Questionnaire and data collection:

- data collection was funded under the Grant agreement signed between the NAA and the EMCDDA,
- a 87-item questionnaire was used (300 variables) referring to the knowledge, attitudes and patterns of drug use and it included 5 units (alcohol, tranquilisers, barbiturates, anti-depressants, new psychoactive substances and illicit drugs, social-demographic data). The questionnaire was applied directly, using trained interview operators.

Outcomes²³¹

A. Medication (tranquilisers, sedatives, anti-depressants) without medical prescription

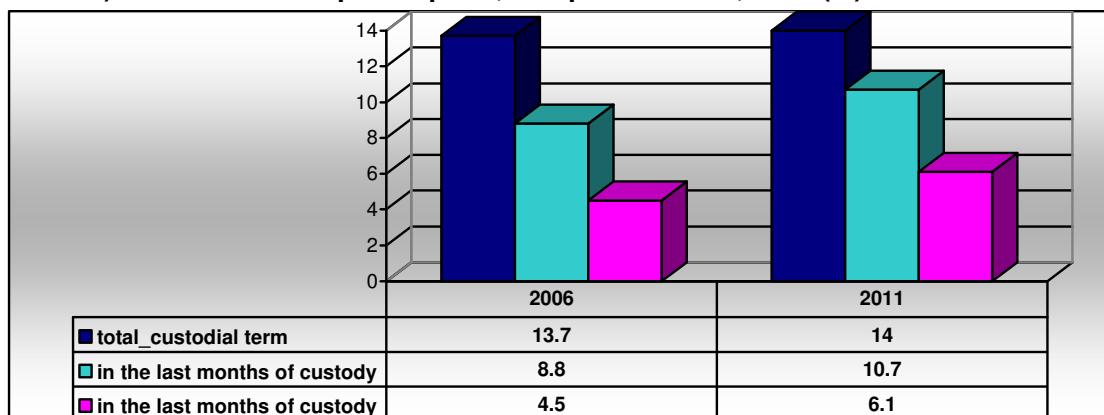
The recent use (last year) and current use (last 30 days) of medication without medical prescription in the prison settings is slightly increasing than in 2006. It should also be noticed that:

- the share of those who had never used drugs at large nor in detention decreased and the share of those who started drug use while in detention increased (from 6% to 4%);
- the share of those who had not used drugs in detention though having used at large doubled, and there is a 3% higher share of those who have used at large and continued to use in prison.

²³⁰ The first study was conducted in 2006 (www.ana.gov.ro/studii/studiupenitenciare.pdf)

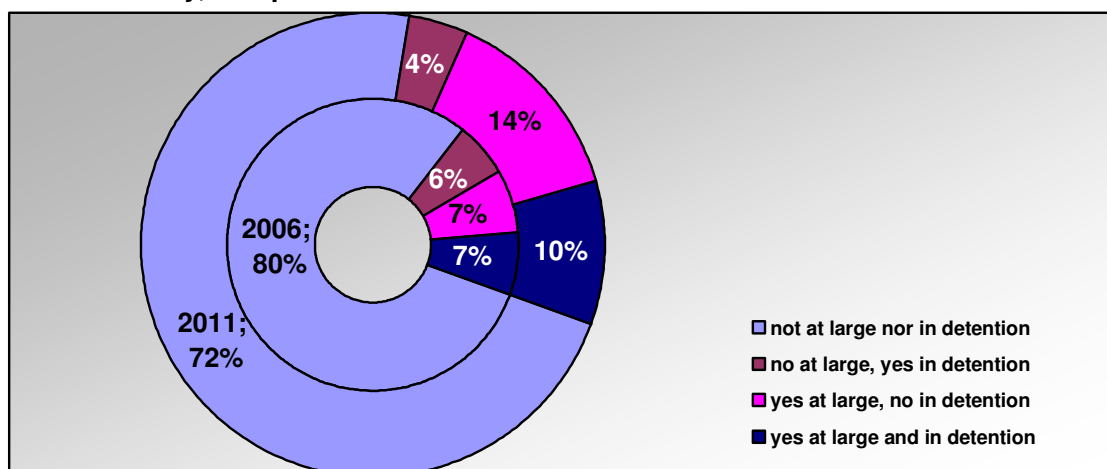
²³¹ The survey final report has not been made public yet, but results will be soon posted on the website of the National Anti-drug Agency

Graph no. 9-13: Prevalence of the use of medication (tranquilisers, sedatives, anti-depressants) without medical prescription, comparison 2006, 2011 (%)



Source: NAA

Graph no. 9-14: Prevalence of the use of medication without medical prescription, by behaviour at liberty, compared data 2006 - 2011

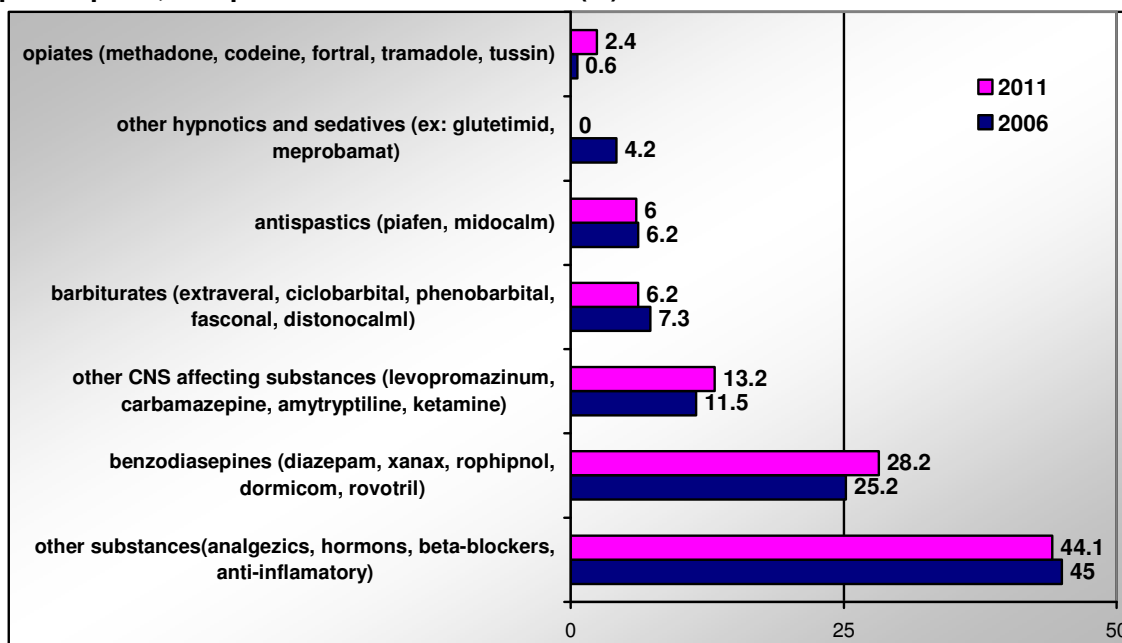


Source: NAA

Half of the prison inmates who reported the use of medication without medical prescription use medication that affects the central nervous system (increase as compared to 2006: 50% as compared to 44.6%):

- 1 in 4 - benzodiazepines (most often mentioned, diazepam);
- 1 in 10 – other medication that affect the central nervous system (levopromazin and carbamazepine were most often mentioned)
- 6.2% - barbiturates (fenobarbital was most often mentioned)
- 2.4%-opiates (methadone, codeine, fortral, tramadol).

Graph no. 9-15: Distribution of inmates that use medication in detention without medical prescription, comparison from 2006 to 2011 (%)



Source: NAA

3.1% (2006-4.1%) of the inmates declared having used mixtures/combinations of medication and/or other substances. Tooth paste, tobacco, alcohol and coffee are among the most frequently "ingredients" used in mixtures and diazepam, carbamazepine, levopromazinum and phenobarbital the most frequent among the medication.

Examples of combinations/mixtures of medication and/or other substances used in prison:

- alcohol + pills (algocalmin, aspirin, paracetamol); diazepam + tobacco, sleeping pills + soothing medicine (pounded and smoked);
- carmazepine + diazepam, carmazepine + levomepromazinum, carmazepine + diazepam + phenobarbital + levomepromazin, carmazepine + diazepam + levomepromazinum + depakine + tramadol, etc.
- diazepam + alcohol, diazepam + methadone, diazepam + tramadol, diazepam + romparkin + neuroptil, diazepam + levomepromazinum + xanax, diazepam + heart pills + antibiotics
- methadone + dormicum, methadone + rohipnol.

The analysis of the correlation between the prevalence of medication use in prison without medical prescription and the social-demographic features of the inmates indicate the following profile of the drug user:

- male,
- aged 25 to 34 (increasing than in 2006: 15-24 years),
- not married/ co-habitation,
- low education level (incomplete highschool/faculty),
- unemployed or no occupation at the time of arrest (in 2006: highschool/university student),
- has lived in Bucharest prior to detention.

Table no. 9-5: Prevalence of the use of medication without medical prescription, by social-demographic feature of the respondent, comparison from 2006 to 2011 (%)

		2006	2011
Gender	male	14.2	14.1
	female	7.9	10.6
Age group (years)	15-24 ani	17.5	16.0
	25-34 ani	15.1	17.1
	35-44 ani	11.3	11.8
	45 years and over	6.9	4.8
Marital status	not married/separated/divorced/widow	14.5	14.6
	married/co-habitation	12.9	11.7
Level of education	primary studies/no studies	13.1	12.1
	secondary education/10 grades/vocational school	14.8	16.2
	high and higher education	12	10.7
Occupation prior to detention	no occupation	18.3	20.0
	highschool/university student	24.3	18.4
	stable employment	11.6	11.6
	unstable employment (temporary)	12.1	11.7
	unemployed	13.2	21.3
	other situation	13.4	15.0
Residence prior to arrest	in Bucharest	17.9	20.6
	county capital	*	14.4
	other town	15.7	14.0
	village	9.2	9.2
	other country	16	16.1

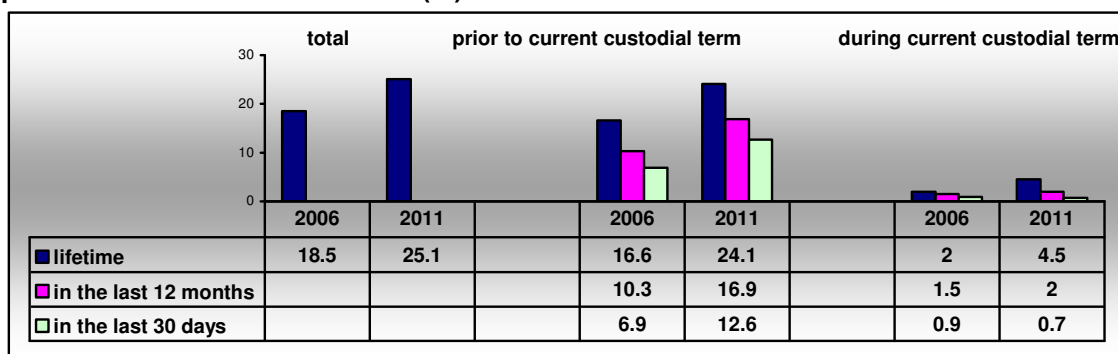
Source: NAA

B. SNPP use prevalence – new psychoactive substances (sold as “ethnobotanical plants”) and illicit drugs

Lifetime prevalence of drug use in the prison population aged 15 to 64 was 25.1%, and included all types of illicit drugs, but also psychoactive substances sold as “ethnobotanical plants or legal drugs”: marijuana, ecstasy, inhalants, cocaine, crack, amphetamines, ketamine, hallucinogens, heroin or opiates, mephedrone, spice, other ethnobotanical plants. There is an increase by comparison to:

- the 2006 study (18.5%), except that SNPP was included in the 2011 study,
- to the general population aged 15 to 64 (GPS, 2010-4.3%)²³².

Graph no. 9-16: SNPP use prevalence – new psychoactive substances (sold as “ethnobotanical plants”) and illicit drugs, prior to and during the current custodial term, comparison between 2006 and 2011 (%)



Source: NAA

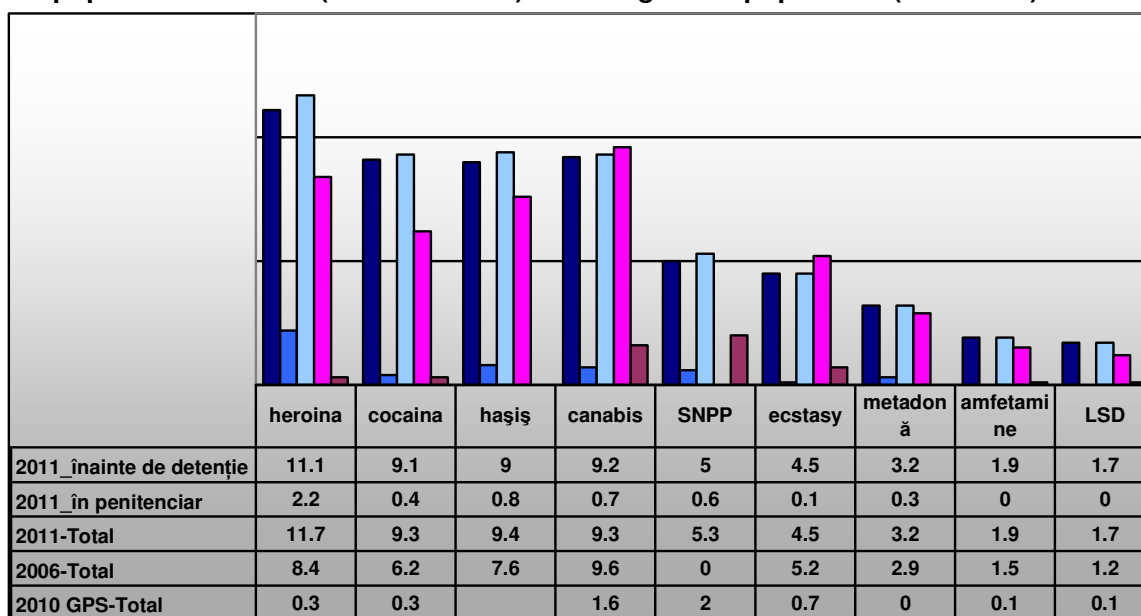
The increase of drug use among prison population is more obvious if the prevalence rates of drug use prior to detention are considered: lifetime prevalence – 7.5%, recent use – 6.6% and current use – 5.7% (for drug use in the current custodial term the differences rise up to 2.5%).

²³² See chapter 2

The analysis of the lifetime prevalence of drug use, by type of illicit drug use, shows that:

- heroin is the most frequently used drug among prison inmates in 2011 (11.1%, namely 2.2%) followed closely by cocaine, hashish and cannabis; although at different values, there is a hierarchy by type of drug: a intermediate group made up of SNPP, ecstasy and methadone followed the mentioned three substances while amphetamines and LSD are the least used drugs (actually used before the current custodial term);
- SNPP has been noticed along with increases in all types of drug as compared to the previous study (2006), while ecstasy use dropped,
- Relatively similar values exist in comparison to the general non-institutionalised population but another hierarchy is evidenced: SNPP ranks first, followed by cannabis and ecstasy.

Graph no. 9-17: Lifetime prevalence of drug use, by type of drug used, compared data for prison population between (2011 and 2006) and the general population (GPS-2010)



Source: NAA

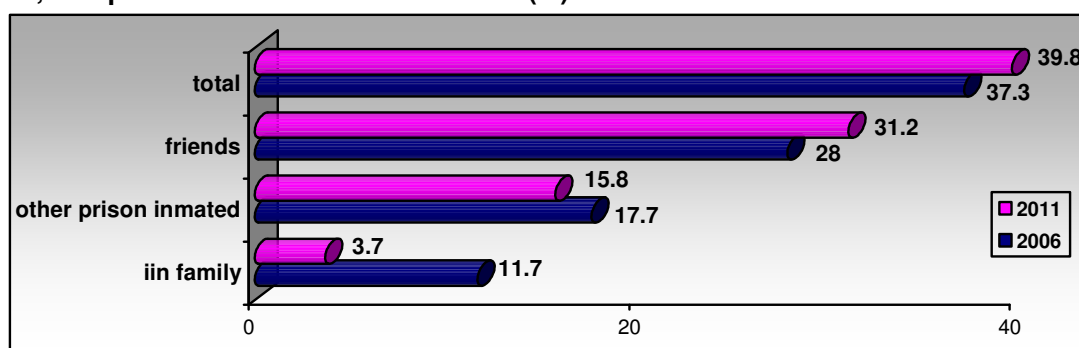
At least a third of the inmates (39.8%, slightly increasing than in 2006: 37.3%) declared that they knew persons who used drugs, most of them belonging to the drug user's peer group:

- 31.2% of the inmates reported that they had close acquaintances outside the prison who use drugs (2006-28%),
- 15.8% of the inmates declared they knew drug users within the prison (people in detention at the time of the interview),
- 3.7% that they had drug users in the family (less than in 2006: 11.7%).

By type of drug used:

- for other people in detention – heroin prevails,
- although heroin continues to be the most frequently used drug among other people, family members and friends of the user, there is a noticeable diversification of the pattern of use, with large rates for cannabis/hashish, SNPP, cocaine, ecstasy and LSD; as compared to the previous study there is a decrease in the preference for all drug categories and occurrence of the SNPP use to a very large extent (19.4%).

Graph no. 9-18: Illicit drug use among peers/family, according to the statements of the prison inmates, comparison between 2006 and 2011 (%)



Source: NAA

Table no. 9-6: Illicit drug and SNPP use according to the prison inmates' statements, by type of used drug, 2011 (%)

		heroin	SNPP	cocaine	cannabis	hashish	ecstasy	others	methadone	amphetamines	LSD
Other prison inmates	2011	62.8	19.4	16	14.5	10.4	7.1	6.8	3.8	1.1	0.8
	2006	68.2	-	25	21	15.4	11.1	5.1	2.8	2.2	1.4
Friends	2011	40.5	35.6	28.1	33.4	30.7	12.7	6.3	4.3	5.1	5.2
Family members		45.5	38.3	23.7	17.7	20.7	4.7	5.9	3.4	0	1.5

Source: NAA

As mentioned before, the medication use without medical prescription, of illicit drugs and SNPP and/or combinations of such substances, among the respondent's family members is very low. However, alcohol use reaches high levels especially among the fathers or interviewed people (11.7%).

Table no. 9-7: Distribution of respondents by addiction to alcohol, medicines without medical prescription and illicit drugs/SNPP 2011 or combinations of these substances among family members, 2011 (%)

	alcohol	Medication without medical prescription	Illicit drugs and SNPP	alcohol and illicit drugs/SNPP	alcohol and medication without medical prescription	Type of drug
Father	11.7	0	0.1	0.1	0	heroin, ethno-botanical plants, marijuana, glue
Mother	2.2	0.3	0	0	0	antidepressants, pain killer, distonocalm
Siblings	4.1	0	2.1	0	0	cannabis, hashish, heroin, cocaine, special, special gold, glue
Husband/wife or partners	0.7	0.1	0.5	0	0	heroin, SNPP, xanax, diazepam
Children	0	0.1	0	0	0	heroin, SNPP
Other relatives/roommates	3.9	0.2	0.7	0.2	0.1	heroin, cocaine, amphetamine, ecstasy, hashish, cannabis, SNPP diazepam

Source: NAA

Connection between substance use and crime – the research subjects were asked if they were under the influence of a substance (among those investigated in the study: alcohol, medication and drugs) when they committed the offence for which they had been imprisoned:

- 40.9% of the inmates declared they had used psychoactive substances when they committed the offence for which they were arrested (less than in 2006: 45.8%);
- 29.4% of the inmates were under the influence of a psychoactive substance at the time they were arrested.

Alcohol was most often associated to criminal behaviour, being mentioned by 70.7% of the subjects in relation to the time the offence was committed (75.2% of the mentions; less than in 2006: 86.3%) and 64.4% of the subjects for the moment of arrest (69.5% of the mentions).

Heroin ranks second being mentioned by 13.6% of the subjects (more than in 2006: 9.7%) in relation to the time the offence was committed and 17% for the time of arrest, followed by SNPP and medication without medical prescription, while the rest of the substances had lower values. By analogy to the year 2006, it can be noticed that there are:

- similarities – although dropping than in the last study, alcohol use continues to have an important role in criminality and poly-drug use is recorded (mainly alcohol mixed with other types of drugs), increasing than in the previous study: the total psychoactive substance rate is 106.4% - 2011, namely 103% - 2006;
- differences - SNPP use and increase of the rate of illicit drug and medication use (e.g. increase from 9.7% to 14.5% for heroin and from 1.7% to 3.6% for medication).

Table no. 9-8: Distribution of respondents by the use of drugs, alcohol, medication without medical prescription and psychoactive substances (multiple answer) at the time the offence was committed or the time of arrest, comparison between 2006 and 2011 (%)

	% - total psychoactive substances		% - total subjects	
	at the time of the offence		at the time of arrest	
	2006	2011	2011	2011
alcohol	86.3	75.2	69.5	70.7
heroin	9.7	14.5	18.4	13.6
SNPP	-	3.9	6.1	3.6
medication without medical prescription	1.7	3.6	4.2	3.3
hashish	1.6	2.6	2.8	2.4
other type of drug	0.6	2.1	2.8	2
cannabis	1.4	1.2	1.6	1.1
cocaine	1	1	0.9	1
ecstasy	0.1	0.9	0.9	0.8
amphetamine	0.1	0.3	0.2	0.2
other type of substance	0.5	0.2	0	0.2
Total (%-psychoactive substances)	103%	106.4%	108%	-
Total (%-respondents)	-	-	-	100% (N= 899)

Source: NAA

During the 2011 study, the subjects were asked if they committed criminal offences (without mentioning whether they were caught or not) to get drugs. 11.3% said yes, 0.4% refused to answer and the rest of 88.3% denied.

Thus, of the 328 respondents who gave a positive response:

- 43.5% were involved in theft and 15.5% in robbery,
- 30.8% became *dealers*,
- 3.6% participated in commercial sex, and 4.3% in procuring,
- 2.3% committed other offences (breach of confidence, forgery, damage, extortion, fraud, cyber crime).

In addition, almost half of the 328 respondents committed several criminal offences, mainly thefts (62.6% of the responses) and drug trafficking (44.3% of the responses) in connection with other crimes²³³.

The analysis of the links between the prevalence of illicit drug and SNPP use and the social-demographic features of the respondents illustrate the following profile of the users:

- Male (in 2006: female);

²³³ 11 subjects responded affirmatively to all 5 choices (prostitution, procuring, theft, robbery and drug trafficking), and one declared he would do "anything" to get drugs.

- Aged from 25 to 34 (in 2006: 15-24 years),
- Not married/separated (in 2006: cohabitation)
- High level of education - completed highschool at least (in 2006, low – primary studies at most),
- Highschool/university student at the time of the arrest,
- Had lived in Bucharest prior to detention.

By comparing with the profile of people admitted to treatment (see chapter 5) it can be noticed that there are:

- similarities in terms of drug used (heroin), gender (male), age (up to 30 years) and residence (Bucharest)
- differences in *occupational* status: (prison setting - highschool/university student at the time of the arrest; treatment admission – unemployed upon treatment admission) and *education level* (prison setting – highschool level at most; treatment admission – almost half completed vocational school and a third an average education level)

Table no. 9-9: Prevalence of drug use and SNPP, during detention, by the social-demographic features of the respondent, comparison between 2006 and 2011

		2006	2011
TOTAL		18.5	25.1
Gender	male	18.4	25.2
	female	20.1	23.8
Age group (years)	15-24 years	27.2	33.5
	25-34 years	21.0	33.5
	35-44 years	10.7	15.5
	45 years and over	4.7	3.0
Marital status	not married	22.2	33.0
	separated	18	30.8
	cohabitation	28.8	28.2
	divorced	12.4	12.7
	married	10.3	15.2
	widow	5.9	7.0
Level of education	primary studies/no studies	24	22.2
	secondary education/10 grades/vocational school	15.1	25.4
	high and higher education	20.3	27.2
Occupation prior to detention	highschool/university student	35.9	55.3
	no occupation	30.2	36.0
	stable employment	15.0	20.5
	unstable employment (temporary)	21.1	19.8
	unemployed	15.2	30.7
	other situation	9.8	20.3
Residence prior to arrest	in Bucharest	45.2	56.8
	county capital	-	25.2
	other town	18.9	19.1
	village	18.9	9.1
	other country	35.1	30.1

Source: NAA

9.4 DRUG USE AND PROBLEM DRUG USE IN PRISONS

9.4.1 DRUG TREATMENT IN PRISONS (including numbers of prisoners receiving opioid substitution treatment)

1,006 prison inmates were included in the *Specific psychological-social care programme* designed to drug using prison inmates or inmates with a drug use record (multidisciplinary approach – educator, psychologist, social worker and physician) in 2010.

The project *Creation of three therapeutic communities in penitentiaries in Jilava, Rahova and Târgșor* aims to support the social reinsertion of former heroin users after prison release and has been carried out from 2009 to 2012 by the National Administration of Penitentiaries, Probation Directorate of the ministry of justice, National Anti-drug Agency and its territorial network, namely the DPECC, Phoenix

Haga Foundation and the Ministry of Justice – Norway. The following activities were completed in 2010: development of therapeutic communities, staff training (15 penitentiary specialists and 3 probation services specialists), formulation of a working methodology for the staff working with people included in therapeutic communities, and evaluation of 225 prison inmates which will result in the future beneficiaries of the therapeutic communities.

A methadone substitution programme was developed and reached 68 prison inmates as part of the project Increase access of prison inmates to harm reduction programmes funded by UNODC. According to NAP, once the international financial assistance ends in 2012, methadone will be acquired from the budget of the Ministry of Justice, because, in spite repeated efforts of the NAP, none of the penitentiary-hospitals was included in the schedule of health units that undergo the drug-addiction prevention and treatment secondary programme, within the Mental Health National Programme, funded by the Ministry of Health. This measure should have been implemented in 2011 but was deferred because UNODC funding allowed for the continuation of the HIV/AIDS prevention programme in prison settings for one more year.

13 users were treated in prison settings within substitution programmes in 2010 (27 users in 2009 and 12 users in 2008), after demanding treatment services for psychoactive substance use²³⁴. Similarly to community-based treatment admissions, it can be noticed that such admissions focused mainly in Bucharest.

The analysis of the treatment admission incidence shows that a third, of the total treatment admissions, consists of first drug treatment admissions in the reference year (less than in the past years). The gender distribution of people admitted to treatment in 2010 shows that similarly to 2008 one of those who benefited from treatment is a woman. If in the last years treatment admissions followed heroin use as main drug of abuse, in 2010, there two of the 13 admissions were for SNPP – new psychoactive substances and 11 for heroin.

Table no. 9-10: Distribution of in-prison treatment admission, compared data 2008-2010 (no. of people)

		2008		2009		2010	
		M	F	M	F	M	F
Total number of people		11	1	27	0	12	1
Of which	First admissions to treatment	5	1	11	0	4	0

Source: NAP

Similarly to previous years, most treatment admissions in 2010 were for people aged 25 to 34. There is an increasing average age (from 28.9 to 31 years) as compared to 2008 and 2009. Regarding the onset age, there are no examples of users who started drug use when aged less than 15 by contrast to 2009 and there is a decrease for the age group 15-19, 5 cases (as compared to 16 cases, 59.3%).

Table no. 9-11: Distribution of prison-based treatment admission, by age group, compared data 2008-2010 (no. of people)

Age	Year s	Age group (years)									Total	Average age
		<15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	>= 50		
Upon treatment admission	2008	0	0	2	5	4	1	0	0	0	12	28.9
	2009	0	0	4	9	9	2	0	3	0	27	30.5
	2010	0	0	2	4	6	0	0	0	1	13	31.0
Of drug use onset	2008	2	2	6	1	1	0	0	0	0	12	20.3
	2009	1	15	6	4	0	1	0	0	0	27	19.6
	2010	0	5	7	0	0	0	1	0	0	13	21.8

Source: NAP

Most people admitted to prison-based treatment used injecting heroin (2008 – 11 people, 2009 – 25 people, 2010 – 11 people). The case distribution by frequency of use in the last 30 days prior to

²³⁴ There are 32 penitentiaries in the penitentiary system (of which 2 in Bucharest), 2 penitentiaries for underage and young offenders, 6 penitentiary hospitals (of which 2 in Bucharest). Methadone substitution programme has been carried out in five prison units since 2008, with UNODC support: Penitentiary hospital Bucharest – Rahova, Penitentiary hospital Bucharest – Jilava, Penitentiary Bucharest – Rahova, Penitentiary Bucharest – Jilava and Penitentiary Giurgiu.

treatment admission in the reference year showed: 3 people used several times weekly, 5 people at least once a week and 5 occasionally (daily use was recorded in the last years: 2009 – 7 people and 2008 - people).

Psychoactive substance poly-drug use was recorded for 3 cases of the total treatment admissions (in 2009 – 9 cases and 2008 – 5 cases): amphetamines (1 case) and benzodiazepines – 2 cases²³⁵.

For the 13 prison-based treatment admission analysed in the reference year in terms of occupational status prior to admission, the distribution was the following: 9 unemployed people, 2 – employed and highschool and university students or arrested – one case each, which is similar to past years (in 2008: 18 unemployed, 5 – employed, 3 – arrested/imprisoned and one – economically inactive).

The distribution by education level shows most of the total 13 treatment admissions were for people with a low level of education (2 people had never attended school/never completed primary school and 8 people completed primary/secondary studies) while 5 completed highschool education. There is a situation similar to previous years: 6 people completed primary/secondary studies, 4 completed highschool education and only one completed higher education²³⁶, while in 2009 – 2 had never attended school/never completed primary school, 18 - completed primary/secondary studies, 4 - completed highschool education and only one completed higher education²³⁷.

9.4.2 PREVENTION AND REDUCTION OF DRUG RELATED HARM

According to NAP, a methadone substitution programme was developed together with a prison-based syringe exchange programme as part of the project *Increase access of prison inmates to harm reduction* programmes funded by UNODC. The project was carried out in 10 prison units and penitentiary hospitals in Romania in 2010 and reached 61 drug using prison inmates, who received 18,383 syringes. The project also contributed to training the medical-health, surveillance and staff in order to prepare future similar projects and set up a *peer-to-peer* education network.

The Social Reinsertion Directorate within NAP created a needs and risk assessment tool that includes a distinct unit dedicated to drug use. In addition, the specialised directorate distributed the *Manuals of education programme, psychological and social care* in the units subordinated to NAP. The *Good practice guide of the psychologist working in the prison system* was formulated and completed in 2010, which includes a unit dedicated to activities of psychological care to prison inmates with a drug addiction record.

Several drug prevention activities took place as part of the programmes carried out in partnership with non-governmental organisations such as: distribution of fliers, of comic brochures, playing cards, and posters containing information on the consequences of drug use, theme exhibits, community outings, TV shows and articles in penitentiary magazines.

Thus, *Imagine a drug free health* campaign was carried out in 2010 in the county of Ialomita, by a consortium made up of the Probation Service with the Court of Ialomita, DPECC Ialomita, Penitentiary in Slobozia, Public Health Directorate in Ialomita, Police Inspectorate, *Floarea Ialomiteană* Foundation. The aim of the campaign was to inform pupils and young people in custody of Slobozia Penitentiary and of the young people assisted by the Probation service of the negative effects of the new psychoactive substances known as *ethno-botanical plants*, by means of all communication media. 905 people benefited from the project interventions (5 were in probation). Additionally, DPECC Botosani specialists conducted several information activities for inmates and their families on the effects of tobacco, alcohol and drug use in 2010 with the support of the County probation service (almost 200 informed beneficiaries).

DPECC implemented a project that will end in December 2011 together with the County Probation Service of the Penitentiary in Tulcea which aims at motivating prison inmates with a drug use record to maintain abstinence through counselling and information services. The project addresses former

²³⁵ in 2009: hypnotics and sedatives - 6 cases and other opiates, amphetamines and hallucinogens – one case each; and in 2008: amphetamines - 2 cases and cocaine, benzodiazepines and hallucinogens – one case each

²³⁶ The level of completed education was not mentioned in one case

²³⁷ The level of completed education was not mentioned in two cases

drug users, has a target group of 15 beneficiaries and implies 1000 information and counselling interventions.

9.4.3. PREVENTION, TREATMENT AND CARE OF INFECTIOUS DISEASES

A significant number of prison inmates were trained as *peer-educators* and started playing their role in educating and informing the other inmates of the HIV infection risks and measures to prevent it, throughout programmes that benefited from the financial support of the Global Fund. Most *peer-educators* gained relevant experience in starting and delivering information sessions on HIV prevention among prison inmates.

The 6th progress report of the HIV/AIDS Round 6 shows that the indicator “Number of inmates who benefited from HIV/AIDS prevention programmes” set for the prevention component exceeded the target set initially (110%). Thus, 1368 inmates were trained as *peer-educators*, and 28.632 attended information-education-communication group sessions delivered by health educators throughout project implementation, organised by the Romanian Harm Reduction Network, ALIAT, ARAS, INTEGRATION, Alături de Voi (*Inițiativa 38* project). The project was implemented in all penitentiaries in the country. In relation to the HIV prevention and counselling component, for the indicator “inmates who benefited from pre-testing, were tested for HIV and received the test result” (which counts the number of individuals who benefited from counselling and voluntary –rapid testing or ELISA) it should be mentioned that the project “*Increasing access of prison inmates to HIV and HCV testing*” funded by the *Romanian Angel Appeal*, and continued in the 2nd phase by NAP, made up for the delays of the 1st phase and reached 100% of the indicators in the 2nd phase related to HIV testing. In addition, 100 specialists (physicians, psychologists, social workers) were trained. The project totalling 54,770 euro was implemented by the National Anti-drug Agency (1st phase) and NAP (2nd phase) and addresses 38 penitentiaries across the country. The specific treatment of drug related infectious diseases is conducted in line with the regulations of the national programmes that tackle these diseases, and is available to prison inmates through the same set of rules applicable to any insured person.

9.4.4. PREVENTION OF OVERDOSE-RISK UPON PRISON RELEASE

There are not special education programmes to prevent the risk of overdose upon release from prison. This type of activity is performed by prison inmates who attend as beneficiaries opiate substitution treatment programmes/services, in those penitentiaries where they are available. Training programmes that should enable this type of prevention are under preparation.

9.5 REINTEGRATION OF DRUG USERS AFTER RELEASE FROM PRISON

Prison inmates included in the methadone substitution programme may continue, upon prison release, the treatment in the Addiction Integrated Care Centres, on voluntary basis.

After the launch of the NAP’s proposal to make up a working group – that might include the National Anti-drug Agency, NGO’s or other civil society members, that play a part in after-judicial assistance – the draft of the National Strategy for the Social Reinsertion of Prison Inmates was formulated in 2010 in 3 sessions of the working group and 7 subgroup sessions (substantiation and operational plan), that will be promoted and implemented by the end of 2011.

The project Strengthening the operational capacity of the integrated services provided to current and former drug-addicted people through the development of innovative tools and working methods and training, co-funded by the Social European Fund through the Sectoral Operational Programme Human Resources Development Invest in people!, was launched at the end of 2010. The project is implemented by the University in Bucharest in partnership with Health Right Promotion Association, Siveco Romania and Go Business Solutions, and aims at providing medical and psychological counselling to drug-addicted people and counselling towards reinsertion of former drug-addicted people on the labour market. The project aims at providing specialised counselling for almost 1200 such people by the end of September 2012 and training for almost 400. A social inclusion centre for people in detention, either current or former drug users, will start operating October 2011.

The National Anti-drug Agency continued the implementation of the project MATRA MPAP PROJECT-MAT09/RM/9/1 "Continuing the creation of the national integrated system for rehabilitating drug using offenders" in cooperation with specialists of the Public Ministry, Probation Directorate, NAP and Inspectorate General of Romanian Police. Cooperation protocols were signed between partner institutions and the Dutch Probation Service and 4 workshops were organised from April to September to identify integrated services and the legal possibility to provide these services to drug using offenders. The outcome of the group work was a specific procedure manual that was submitted for endorsement to all participants, and should take effects soon after the approval in the two pilot centres, setup in two districts of Bucharest.

In a manner similar to previous reports, this unit analyses the indicators referring to drug law offences, broken down by number of criminal cases and people prosecuted/convicted along the three phases of the criminal proceedings: prosecution stage, court stage and the effect of court decisions, which are final and cannot be repealed.

Chapter 10 - Drug market

INTRODUCTION

There are several institutions charged with drug seizing in Romania: Anti-drug service within the Inspectorate General of Romanian Police, Anti-drug Department within the National Customs Authority or National Administration of Penitentiaries within the Ministry of Justice for prison units and DIICOT prosecutors. It should be mentioned that the task to fight the illicit drug trafficking has been totally transferred from the Romanian Border Police to the National Police since May 2009. Official data on the amounts of seized drugs, purity, and composition are provided by the Central Laboratory for Drug Analysis and Profiling within the Inspectorate General of Romanian Police, that used sampling and analysis methods authorised and recognised at international level. In addition, the data on drug origin, trafficking routes, modus operandi and drug prices are generally provided by the Anti-drug service, based on the outcomes of criminal investigations. However, data on drug prices and availability can also be obtained from general population surveys²³⁸ and other specialised studies.

Additionally, according to the data provided by responsible institutions it can be stated that Romania is not an origin drug trafficking country, as the few cannabis cultivations were not representative to estimate possible amounts.

The drug market continues to be characterised by a constant prices and low purity, with variations of the wholesale price of cocaine, where there is an increase, and a decrease of the price of synthetic drugs.

The new psychoactive substances are a serious competitor of the traditional illicit drugs in 2010, in terms of both availability and price.

10.1 AVAILABILITY AND SUPPLY

10.1.1. DRUG ORIGIN²³⁹

The traditional Balkan route continues to play a decisive role in *heroin* trafficking. Due to its geographic location, the great heroin trafficking routes included Romania in the northern branch of the Balkan route along with Bulgaria, Hungary towards Western Europe. Additionally, there is information leading to a possible inclusion of Romania in a new transit route from Afghanistan towards western countries along with Turkmenistan, Uzbekistan, Kazakhstan, Russian Federation and Ukraine. More concretely, from the warehouses in Ukraine heroin leaves towards Western Europe through three routes: Poland, through Hungary and Romania. There are 5 main itineraries used in linking the entry points to Bulgaria and Ukraine and the exit points to Hungary. In addition, there is an intensification of the activities of organised crime groups by recruiting Romanian citizens for the transport of significant amounts (10-80 kg) and buying cars registered in Romania, that, are offered as payment to the carrier at the end of transport.

Cocaine continues to be a drug of the large cities, without significant changes from the last years when the use of this drug was identified in *Bucharest, Constanța, Timișoara, Cluj-Napoca, Râmnicu-Vâlcea, Deva, Sibiu and Brașov* at level of over 75%. The main market for cocaine is Bucharest, with over 45%. In over 80% of the operations carried out in the analysed time period, connections were settled across the country with the groups operating at the level of the capital. Carriers and express companies are used in over 90% of the cases. Lately, a tendency of South-American traffickers has been noticed of using the sea to transport large amounts of cocaine to Europe. Constanța harbour is one option to getting large amounts of cocaine, from South American countries to the European territory, which was also one of the reasons for the setup of the Service to Fight Organised Crime – Sea Ports Constanța in 2010.

Cannabis and *hashish* represent the most trafficked/used drugs in Romania, being met mainly in university centres: Bucharest, Craiova, Constanța, Iași, Cluj-Napoca and Timișoara. Drugs on the domestic market mainly come from countries such as Moldova, Serbia, Spain and the Netherlands. There is however a growing phenomenon of growing cannabis in small amounts as a result of the

²³⁸ See Chapter 10 – *Drug market*, of the National report on drug situation – 2008, Romania

²³⁹ Based on documents made available by Anti-drug Service within the Directorate for Fighting Organised Crime, IGRP

experience gained by the Romanian or foreign citizens, interested in cannabis trafficking, or due to internet resources.

Additionally, *synthetic drugs* (amphetamines, ecstasy, MDMA) transit Romania, and there is also a demand for these drugs. They originate in West-European countries and are destined for the Near and Middle East. Mail services, air transport and road transport (personal car) are used in synthetic drug trafficking while drug use has been mainly located in recreational settings – bars, discos, clubs.

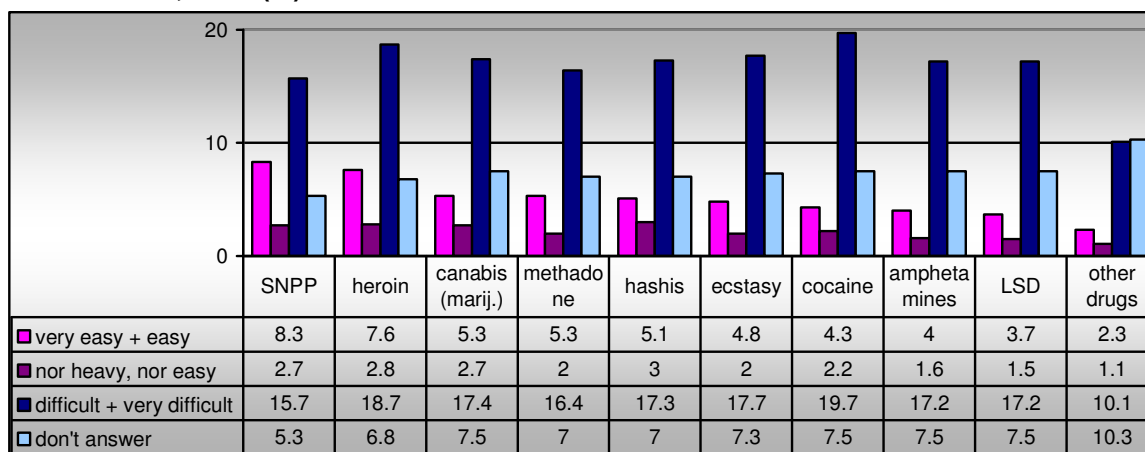
The first information on the trade and use of the *new psychoactive substances* initially known as “ethno-botanical plants” appeared in 2008 – substances that mimic the effect of not controlled drugs, and later extended to a phenomenon dimension in 2009 and 2010. Initially traded through the internet, increasing demand generated several “dream shops” to open under the name of „Weed Shops” where these products were directly sold. The investigations performed by the responsible unit of the Romanian Police established these products are mainly manufactured in China and there were large imports from Germany and England. Substances reach Romania mainly through express companies, distributors buy them at a relatively low price, of almost 2 euro/gram and sell them for up to 22 euro/gram.

10.1.2. DRUG AVAILABILITY IN PRISONS

The National Anti-drug Agency conducted in 2010 the second study²⁴⁰ on the prevalence of drug use in the Romanian penitentiaries, which also included questions related to drug availability.

The study showed at least one in 4 respondents could get psychoactive substances in the penitentiary within a week: heroin – 29.1%, new psychoactive substances (SNPP) – 26.7%, cocaine – 26.2%, cannabis/ hashish -25.5%, ecstasy- 24.5%, methadone – 23.7%, amphetamines – 22.8%, LSD – 22.4% and other drugs (ketamine, special key) – 13.5%. SNPP – 8.3% and heroin – 7.6% are the most easily to get and cocaine – 19.7%, the least.

Graph no. 10-1 Respondent distribution by view on drug availability in the prison setting in one week's time, 2011 (%)



Note: The rate of those who stated they did not know nor were interested because they do not use drugs or drug cannot be obtained makes up for the rest to 100%

Source: NAA

The analysis of the share of respondents who reported being able to get psychoactive substances quite/very easy in the prison setting within a week's time, by age group, shows the new psychoactive substances are the most available, among all age groups, followed by:

- cannabis and methadone (6.7%) for underage inmates (<18 years);
- heroin (7.7%) – for adults (22- 64 years);
- similar values for all types of drugs (the highest values is for cannabis), except for opiates – young people (18 -21 years).

These values are linked with drug use preferences, according to the rest of the indicators.

Table no. 10-1: Age distribution of respondents who reported being able to get psychoactive substances quite/very easy in the prison setting within a week's time, 2011 (%)

	Underage (<18 years)	Young (18-21yrs)	Adults (22- 64yrs)	Total
SNPP	10.0%	14.5%	7.9%	8.3%
heroin	3.3%	6.0%	7.7%	7.6%
cannabis (marijuana)	6.7%	8.5%	5.1%	5.3%
methadone	6.7%	5.1%	5.3%	5.3%
hashish	3.3%	6.8%	5.0%	5.1%
ecstasy	3.3%	7.7%	4.6%	4.8%
cocaine	0%	5.1%	4.4%	4.3%
amphetamines	3.3%	6.0%	3.9%	4.0%
LSD	0%	4.3%	3.7%	3.7%

Source: NAA

All participants in the second study were asked about what was normally given in exchange for a drug dose, irrespective of their reports of drug use. The responses of the 1,018 subjects (49.3%) could be broken down into categories:

- *money* (amounts ranging from 100 - 150 lei to 100-150 euro, probably by drug demanded and are given by/to the family: "money outside to the family", "money transferred outside in accounts", "charged by family", "bank transfers") and
- *cigarettes* (heroin is sold for 5 cigarette packages, SNPP – 1 package, "1 million or a box of cigarettes")
- *other products*: alcohol, food and coffee, clothing and footwear („valuable, branded items,"), cell phones (ex: „a cell phone in prison is 3500-4500 ron"), gold jewellery (ex. earrings), watches, soap, shampoo, and even sexual services/favours, medication (ex: „levo and diazepam", „pills, diazepam") or drug trafficking in prison.

10.2 SEIZURES

10.2.1 Quantities and numbers of seizures of all illicit drugs

1. DRUGS

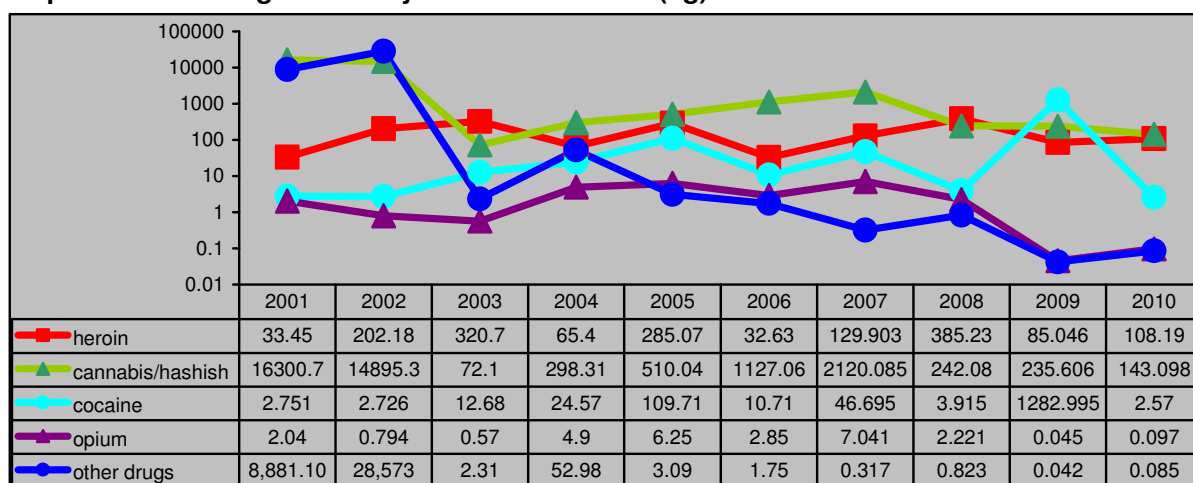
485.0049 kg, 32,844 pills, 19 doses and 11.182 litres of drugs were seized and retained in legal custody, of which:

- high risk drugs: 309.35 kg, 31,075 tablets, 19 doses and 0,159 litres;
- risk drugs: 175.66 kg, 1,769 tablets and 11,023 litres.

There is a decrease by 70% of the total amount of the drugs seized in the reference year in comparison to 2009, from 1,615.09 to 485.0049 kg. However, the decrease of seized amounts is less considerable as 79.4% of the total amount of the seized drugs in 2009 was the result of a single noteworthy seizure. In case of seizures of drug tablets there a 48.8% increase from 22,079 to 32,844 tablets²⁴¹.

²⁴¹ The total number of tablets includes tablets with psychoactive substance content

Graph no. 10-2: Drug seizure dynamics 2001-2010 (kg)



Source: Central Laboratory for Drug Analysis and Profiling - IGRP

Thus, the drug amounts seized at national level, by type of drug are:

- **Heroin:** 108.19 kg, 27.2% more than in the previous year when 85.046 kg were seized
- **Cannabis/ hashish:** 143.09 kg, of which 80.82 kg of marijuana and 62.278 kg of hashish, 39.3% less than in 2009, when 198.591 kg were seized and 37.01 kg hashish:
- **Cocaine:** 2.57 kg. 99.8% less than in 2009 when a record amount of 1,282.995 kg, was seized, 84.2% of which in a single cocaine seizure.
- **Amphetamine type stimulants and derivatives:** 3,709 tablets, 70.8% more than in 2009.

Drugs seized in 2010 do not exceed the average amounts for the period 2001-2009, with variations for heroin, cocaine and cannabis seizures and a descending trend of opium and synthetic drugs seizures.

In addition, the discrepancy between the number of seizures and the amounts seized, by type of drug, continues to be considerable, except for small variations from one year to another, which might indicate most seizures imply small amounts, generated mainly by street trafficking.

Table no. 10-2: Number of seizures and seized amounts by type of drugs

Drugs	2006		2007		2008		2009		2010	
	Seizures	Amount	Seizures	Amount	Seizures	Amount	Seizures	Amount	Seizures	Amount
Heroin(kg)	642	32.636	984	129.9	1,055	385.23	1,038	85.046	962	108.19
Cocaine	36	10.714	62	46.695	91	3.91	103	1,282.99	72	2.57
Marijuana	276	1116.96	412	6.31	596	208.66	777	198.59	986	80.82
Hashish	145	10.097	338	2114.72	506	33.42	594	37.01	321	62.278
Synthetic drugs (pills)	94	17314	168	29280	225	55,455	58	12,730	80	3,709
LSD (samples)	5	59	3	9	n.d.	71	18	308	3	19

Source: Central Laboratory for Drug Analysis and Profiling - IGRP

The analysis of the number of seizures made in the last 5 years emphasises the extended availability of cannabis, competed only by heroin, while cocaine and synthetic drugs are less available. This conclusion of the market availability of certain drugs can be correlated with the outcome of the General Population Survey²⁴².

In line with legal provisions, the following amounts of drugs were destroyed in 2010, in Romania: 297.606 kg cannabis, 107.23 kg cannabis resin, 85.797 kg of cocaine, 522.234 kg of heroin, 218.525 kg of MDMA, 16.161 kg of amphetamines, 0.328 kg of morphine, 0.898 kg of opium, 850 tablets of

²⁴² See chapter II – Drug use in the general population and specific targeted groups

barbiturates, 2,958 tablets of benzodiazepines, 30 vials of petidine, 2,451 tablets of methadone, 266 tablets of amphetamine derivatives and 9.987 kg, 1,278 bags, 467 envelopes and 434 cigarettes of new psychoactive substances.

In addition, at the end of 2010, the following amounts were available in the storage areas of the National Police: 89.91 kg of cocaine, 485.85 kg of heroin, 154.88 kg of cannabis resin, 576.81 kg of cannabis, 9.62 kg of opium, 255 LSD doses and 130.60 kg of new psychoactive substances that were to be destroyed following court decisions.

2. NEW PSYCHOACTIVE SUBSTANCES

Romania was genuinely attacked by the trade in the new psychoactive substances, which started to compete against illicit drugs. Once legal provisions made it possible to control 43 new substances in 2010, the operative structures impounded and seized the following amounts of drugs:

- *synthetic cannabinoids*: 57.024 kg;
- *cathinone*: 50.091 kg and 324 tablets;
- *piperazine*: 6.506 kg and 15.094 tablets;
- *pyrovalerone*: 1.800 kg and 6 tablets.

Shops selling these new psychoactive substances extended throughout 2010 and in February 2011 reached the number of 160, across Romania.

10.2.2. PRECURSORS AND CHEMICAL SUBSTANCES USED IN THE MANUFACTURE OF ILLICIT DRUGS

There were no seizures of drug precursors and essential chemical substances across Romania as mentioned in the official data of the National Police, in the year 2010.

10.2.3. ILLICIT LABORATORIES

After almost 5 years, two improvised locations were identified in 2010, one in Bucharest and the other one in Cluj, where people without chemical knowledge manufactured in an empirical manner substances that are included in the category of new psychoactive substances. Investigations showed the new psychoactive substances were not manufactured on the national territory but imported and the two locations were for portioning and packaging before selling.

10.3 PRICE/ PURITY

10.3.1. Price of illicit drugs at street level

The selling price of drugs (wholesale and retail) did not show significant variations in 2010 in comparison to the last year.

Table no. 10-3: The lowest and the highest prices for the most frequently trafficked drugs on the illicit market in Romania, 2004-2010

Wholesale prices (in Euro/kg, litre or 1000 doses)

Type of drug	2004	2005	2006	2007	2008	2009	2010
Hashish (cannabis resin)	600-800	1600-2500	1600-2500	2,200 – 2,400	8,000 – 10,000	4,000 – 7,000	4,000 – 7,000
Cannabis herbal (marijuana)	1600-2500	600-800	1300 - 1500	1300 - 1500	-	2,000 – 5,000	2,000 – 5,000
Cocaine	35,000-50,000	35,000-50,000	35,000-50,000	42,000 – 44,000	35,000 – 55,000	40,000 – 60,000	45,000 – 90,000
Heroin	10,000-15,000	13,000-17,000	15,000-20,000	12,000 – 15,000	15,000 – 16,000	12,000 – 20,000	12,000 – 20,000
Amphetamines	3,000-4,000	3,000-4,000	3,000-5,000	5,000	5,000	-	-
Ecstasy (MDMA)	3,000-4,000	3,000-4,000	8,000-10,000	-	-	3,700 – 7,500	3,560 – 7,130

Retail price (in Euro/g or dose)

Type of drug	2004	2005	2006	2007	2008	2009	2010
Hashish (cannabis resin)	4-6	4-6	4-6	7-9	7-9	15 - 20	14.25 - 19
Cannabis herbal (marijuana)	2-4	5-7	2-4	6-7	8-14	10 – 20	9.5 - 19
Cocaine	60-120	80-120	80-150	80-120	80-120	80 - 120	80 - 120
Heroin	15-25	25-40	25-60	30-35	46-55	37 - 49	35.63 – 47.51
Amphetamines	5-10	7-13	7-13	10	-	-	-
Ecstasy (MDMA)	5-10	13-15	10-15	7-12	5-8	10 - 20	9.5 - 19
LSD (blotter)	20-30	20-30	30-35	33	33	20 - 37	19 – 35.63

Source: Anti-drug Service, IGRP

Wholesale price continues to be stable for cannabis and heroin, while increasing for cocaine (since 2008) and slightly decreasing for ecstasy tablets.

Retail price continues to be stable, with almost no variations, except for a low decrease (of almost 1.5 euro) for heroin price at street level.

10.3.2. PURITY AND COMPOSITION OF TABLETS/PILLS

The purity of heroin at street level ranged between 23.9% and 47.3 %, with an average purity of 22.13%. Lab analyses evidenced a higher concentration of heroin in large seizures ranging between 43.07% and 57.12%, with an average of 50.66%. The most frequent added agents in heroin samples are: caffeine, paracetamol, diazepam, dextromethorphan, pentazocine and griseofulvin. These data confirm the very poor quality of heroin at street level.

MDMA concentration of ecstasy pills determined for two samples in 2010 was 0.6% and 0.5%. Other substances were also evidenced in MDMA pills, among which caffeine and chlorinephenylpiperazine.

Cocaine concentration determined for large seizures by the analysis laboratory specialists ranged from 71.20% to 79.90%, with an average concentration of 74.70%. The substances usually evidenced in cocaine samples: phenacetine, diltiazem, levamisole and tetracaine.

THC concentration of cannabis herbal (*marijuana*) sold at street level ranged between 0.06% and 10.09%, with an average of 4.67%. THC concentration of *cannabis resin* sold at street level showed values ranging from 3.15% to 5.47%, with an average of 4.15%.

Table no. 10-4: Purity of drugs at street level (%)

Concentration in	Heroin	Cocaine ²⁴³	MDMA	Cannabis resin (hashish)	Cannabis herbal (marijuana)
Minimal value	3.25	71.20	0.5	3.15	0.06
Maximal value	38.49	79.90	0.6	5.47	10.09
Average value	22.13	74.70	0.55	4.15	4.67

Source: Central Laboratory for Drug Analysis and Profiling - IGRP

10.4 ANNUAL REPORT TO EARLY WARNING SYSTEM

The Romanian monitoring centre for drugs and drug addiction is part of the “European early warning system”²⁴⁴ in the field of new substances that are included in narcotic trafficking and use and is coordinated by EMCDDA.

To this aim, a national network of early warning was setup to collect and disseminate data on new psychoactive substances emerging on the market. Several meetings were organised with representatives of Europol, Drug analysis laboratory of the IGRP, INML „Mina Minovici” in Bucharest, Toxicology Laboratories of Emergency Hospitals, treatment centres and psychiatric clinical hospitals,

²⁴³ Cocaine concentration in large seizures

²⁴⁴ EU Council Decision 11 (art. 5.1, Decision 2005-387-JHA)

NGO's that provide harm reduction services. The aim of the meetings was to exchange information, good practice and host debates on the evaluation of the phenomenon and of the risks these substances might cause.

The conclusions of the working groups were:

- difficulty to determine in biological samples the presence of new compounds and issues related to the technical equipment of laboratories, namely staff training, outdated because of the novelty of the phenomenon and the increasing speed of occurrence and expansion of these substances;
- issues related to the technical equipment toxicology laboratories in the emergency wards and statements were made on the scope of the phenomenon of new psychoactive substances;
- lack of structured approach of the treatment of disorders caused by SNPP;

In addition, the market of the new psychoactive substances was monitored by specific tools of qualitative and quantitative sociologic research. Thus, the study *Risks Assessment of the use of new psychoactive substances among children and young people in Romania*²⁴⁵ illustrated the following:

Physical, chemical and pharmacological content – classification of SNPP categories

This component included searches of substance mixtures that have proved to be most searched for and used among children and young people included in searches, and testimonials detected on-line, on different forums that tackle these specific topics.

a. Mixtures of plants and chemical substances intended for smoking

The "spice"-type substances are the most common categories of psychoactive substances sold as "legal highs". A large number of products designed for inhaling/smoking branded as "spice" was detected such as *Spice Silver*, *Spice Gold*, *Spice Diamond*, *Spice Arctic Synergy*, *Spice Tropical Synergy*, *Spice Egypt*, *Spice Maraciuca*, *Ganja*, *M6*, *Diesel*, *Katana*.

The speed by which the names change and new mixtures emerge on market makes scheduling efforts difficult and often redundant against the dynamics of drug supply.

The products sold as Spice are regularly mixtures of plants destined for smoking (ex: *Turnera Afrodisia*, *Passiflora Incarta*, *Rata Graveolens*) sprayed with synthetic cannabinoids²⁴⁶. Although these cannabinoids are largely banned by law, new combinations continue to emerge and escape legal restrictions.

Spice mixtures started to be searched for in the last 4-5 months of 2008, with a rapid increase in 2009, followed by a decrease once the Emergency ordinance appeared and placed 36 plants and psychoactive substances under national control²⁴⁷.

Soon after the effect of the ordinance, a new type of "Spice" emerged fast on market, namely „Spice Maraciuca" that might not have contained a synthetic cannabinoid incriminated by the Romania law. Additionally, the term "spice" has been used for psychoactive plants before the term "ethno-botanicals" became largely accepted.

It could be concluded that spice-type mixtures tend to have a short life and are rapidly replaced by new products because of legal restrictions but mainly because of the great number of new synthetic cannabinoids with ever-diverse effects. The emerging substances that can be smoked bring a major change on the market of the so-called "designer drugs" or „research chemicals", until recently associated only with ecstasy or amphetamines.

Another SNPP category is made up of plants such as *Kratom*²⁴⁸ and *Salvia Divinorum*²⁴⁹ defining a category of plant mixtures destined for smoking. These substances were banned and the current

²⁴⁵ See chapter 4

²⁴⁶ A few examples: JWH-018, JWH-019, JWH-210, *JWH-250*, *JWH-203*, *JWH-081*, *JWH-073*, HU-210, CP-47,497).

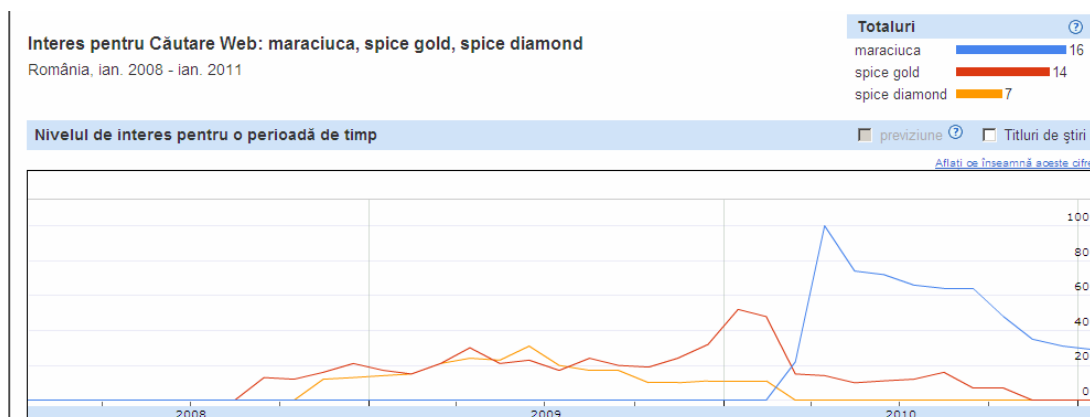
²⁴⁷ Emergency governmental ordinance no. 6 of February 10, 2010 amending and supplementing the Law no. 143/2000 on countering the illicit drug trafficking and use and supplementing the Law no. 339/ 2005 on the juridical regime of plants, substances and preparations with narcotic and psychotropic contents (issued by the Romanian Government, published in the Official Gazette no. February 15, 2010)

²⁴⁸ *Understanding the 'Spice' phenomenon*, EMCDDA, Luxembourg: The Publications Office of the European Union, 2009.

²⁴⁹ <http://www.fortesys.ro/ethno/?q=node/19>

information does not reveal any demands. *Salvia Divinorum* is probably the first psychoactive substance included among “ethno-botanicals”. On-line interrogations in Romania show the interest for this plant at the end of 2006 and beginning of 2007.

Graph no. 10-3: Interest for web search: maraciuca, spice gold, spice diamond²⁵⁰



Source: Risks Assessment of the use of new psychoactive substances among children and young people in Romania (2011)

b. Mixtures of energising chemical powders (amphetamine type stimulants)

Mixtures of chemical powders that are synthetic psychoactive substances, have energising or hallucination effects, and are traded under different names and mixed with known energisers: caffeine, creatine, etc. Most psychoactive compounds detected in these mixtures fall in the category of cathinones and piperazines.

The data of the Central Analysis Laboratory within IGRP referring to the time period from January 2009 to February 2010 showed they generally contained mephedrone.²⁵¹ The most popular products were sold under the brands *Special Gold* and *Magic*. A similar content has products such as “*Flower Magic Powder*”, “*Flower Magic Powder+*”, “*Charge+*”, “*Flower Power*”, “*Crush*”, “*Crystal bath*”, “*Dark+*”, “*Special Diamond*”, “*Special Original*”.

Other products with a similar content are Mephedrone and some of its derivatives partially vanished from the “legal highs” shops once the first ordinance took effect²⁵² and placed legal highs under national control.

²⁵⁰ The figures in the graph show the number of searches for a certain word, as compared to the number of total searches on Google in time. These do not account for absolute volume of searches, because the data are standardised and shown on a scale from 0 to 100. Each point in graph is divided by the highest value or by 100. if there is no sufficient data, 0 is visible. Figures that appear near search words above the graph are a summary or totals.

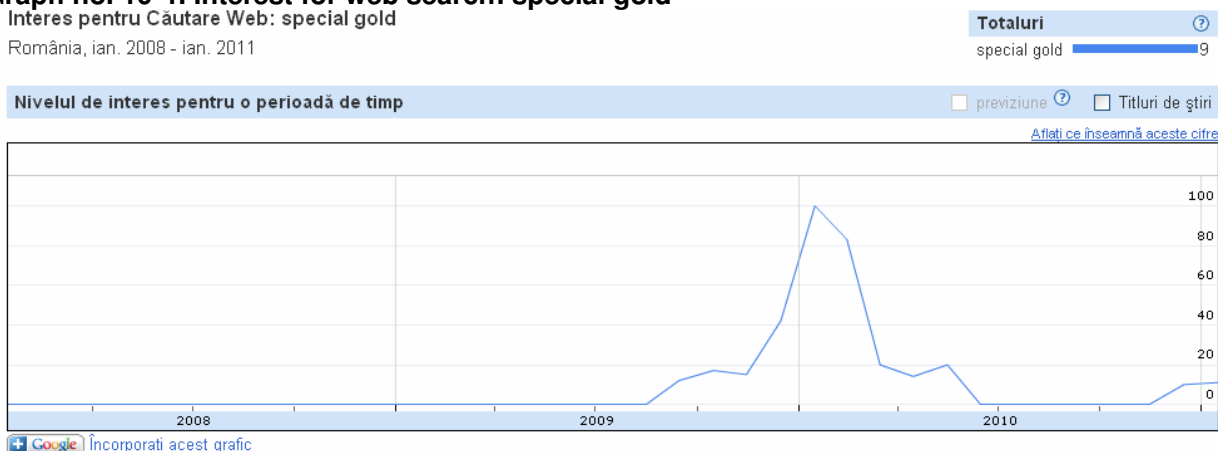
²⁵¹ 4-MCC or 4-methylmetcathinone or 1-(4-methylphenyl)-2-methylaminopropan-1-ona) and other products with a similar chemical compounds (cathinone)²⁵¹, namely fluorometcathinone, etcathinone, methoximetcathinone, butylone or beta-ceto-MBDB (butylone) = 1-(1,3-benzodioxol-5-il)-2- (metilamino) butan-1-ona), metylona beta-ceto-MDMA (metylone) = 2-metilamino-1-(3,4- metylendioxiphenyl) propan-1-ona as crystals or powder

²⁵² Emergency governmental ordinance no. 6 of February 10, 2010 amending and supplementing the Law no. 143/2000 on countering the illicit drug trafficking and use and supplementing the Law no. 339/ 2005 on the juridical regime of plants, substances and preparations with narcotic and psychotropic contents (issued by the Romanian Government, published in the Official Gazette no. February 15, 2010)

Graph no. 10-4: Interest for web search: special gold²⁵³

Interes pentru Căutare Web: special gold

România, ian. 2008 - ian. 2011



Source: *Risks Assessment of the use of new psychoactive substances among children and young people in Romania (2011)*

Products such as MDPV – *metylendioxyprovalerone* were developed later (the most popular product is sold as *Generation 2012*) similarly to products based on psychedelic triptamines such as *5-MEO-DALT N,N-dialil-5-metoxitriptamina*. They have lost rapidly in popularity when they were placed under control by another Governmental decision²⁵⁴.

Graph no. 10-5: Interest for web search: generation 2012²⁵⁵

Interes pentru Căutare Web: generation 2012

România, ian. 2008 - ian. 2011



Source: *Risks Assessment of the use of new psychoactive substances among children and young people in Romania (2011)*

A product sold as "White Sensation" and promoted as a substitute for "Special gold" became the most popular drug in the second half of 2010, after the ban on MDPV and *5-MEO-DALT*, according to the forum „*droguri101.ro*”.

There is no accurate information on the active substance but according to the on-line forum this product contains *2-(Etylamino)-1-(4-mety/phenyl)propan-1-ona* or 4-MEC, which is similar to mephedrone4-MCC in terms of effects and chemical composition. The *Google Insights* could not be used in establishing the popularity of the product because „*White Sensation*” is the name of the most popular house party that has been used for recreational events.

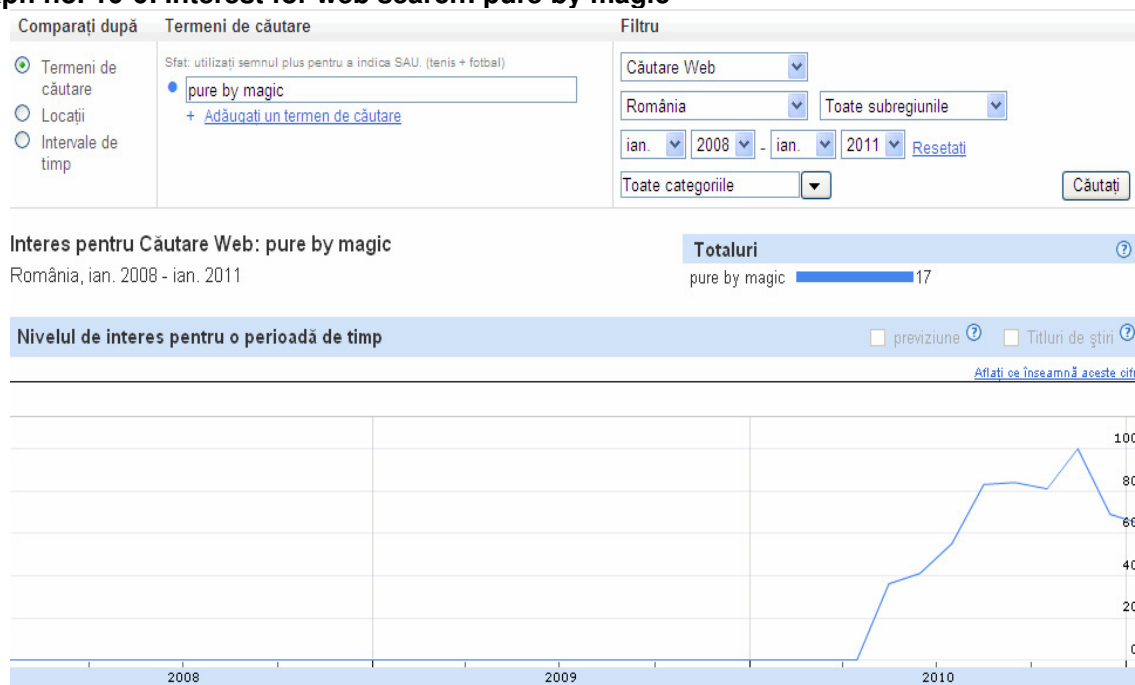
²⁵³ Idem 250

²⁵⁴ Decision no. 575 of June 16, 2010 updating the schedule of the Law no. 339/ 2005 on the juridical regime of plants, substances and preparations with narcotic and psychotropic contents and of the Law no. 143/2000 on countering the illicit drug trafficking and use and supplementing the (issued by Romanian Government, published in the Official Gazette of Romania, Part I no. 509 of July 22, 2010)

²⁵⁵ Idem 250

Another mixture of energising substances called „*Pure by Magic*” was probably more popular among drug users after the effect of the two legal documents. No accurate information are available for the active substance, but empirical evaluations make it similar to a relatively new product NRG1, that might, according to the mentioned source, consist of Naphyrone (O-2482 or naphthylpyrovalerone). This is a derivative of MDPV/ pyrovalerone and has similar effects.

Graph no. 10-6: Interest for web search: pure by magic²⁵⁶



Source: *Risks Assessment of the use of new psychoactive substances among children and young people in Romania (2011)*

As shown by the graph above, the product gained in popularity in the second half of 2010, peaked at the end of the year, after which it declined showing a trend similar to “ethno-botanical plants”.

The psychoactive substances described in the study are just a part of those present on the market. These products are changing from one day to another as so does the concentration and ingredients that compose the sold brand. In addition, the trade name changes rapidly, which make the association between a substance and a certain brand difficult.

The new psychoactive substances identified by the Central Laboratory for Drug Analysis and Profiling within the IGRP in 2010 and the seized amounts were:

Based on the European model, the methods described are used in the National early warning system to detect as fast as possible and triangulate data related to the threats posed by the incidence and spread of the use of new psychoactive substances and more specifically by the risks associated to this category of use.

Table no. 10-5: New psychoactive synthetic substances determined by the Central Laboratory for Drug Analysis and Profiling within IGRP in 2010 and seized amounts

Substance	Physical description	Number of cases	Weight (g). (no.). (ml)
MDPV-Pyrovalerone	powder	54	1800
MDPV-Pyrovalerone	tablets	1	6
Triptamine (5 MeO-Dalt)	powder	2	8.932
4 MMC	powder	245	28787.75
4 MMC	tablets	12	164
Methoximetcatinone	powder	4	19.07
Beta-ceto-MBDB (butylone)	powder	8	9990.32
Beta-ceto-MBDB (butylone)	tablets	2	11
Metedrone	tablets	3	67
Cathinone	powder	2	35.25
Metedrone	powder	45	204.39
Metylone (beta-ceto-MDMA)	powder	12	64.77
Fluorometicathinone/flefedronă	powder	54	1276.54
Ethcathinone	powder	57	5903.69
Methanone	powder	1	1.2
bk - PMMA	tablets	1	1
metcathinone	powder	1	2.5
BZP + TFMPP	powder	7	10.29
BZP + TFMPP	tablets	13	1465
Piperazine	tablets	1	15
CPP chlorynephylpiperazine	tablets	17	4399
CPP	powder	3	5.57
TFMPP	powder	1	0.07
CPP+TFMPP	tablets	2	35
TFMPP	tablets	10	176
BZP	tablets	2	622
BZP	powder	2	1.8
Fluorophenylpiperazine	tablets	5	37
JWH-018	Herbal mix	271	43030
JWH-018	cigarettes	38	6512
JWH-250	Herbal mix	48	3615.58
JWH-073	Herbal mix	14	2047.96
CP 47. 497-C8	Herbal mix	15	410.5
GHB	liquid	3	15
dihydrocodeine bitartrate	liquid	1	100
2 C-B	powder	2	5
2 C-B	liquid	1	3
2 C-I	powder	1	6
2 C-C	powder	1	62.22

Source: Central Laboratory for Drug Analysis and Profiling - IGRP

PART B. SELECTED ISSUES

Chapter 11 – Drug related health policies and services in prison

11.1. OVERVIEW

Similar to most European countries, there is an obvious trend in the Romanian penitentiary system to understand and become aware of the fact that people in custody enjoy the same rights as the rest of the population in relation to the access to medical treatment services, including prison-based drug treatment. The issue of illicit drug use and trafficking in prisons is at present recognised and assumed by the Romanian authorities charged with direct tasks in the field, and as such it is mentioned in the introduction to the most recent report of the National Administration of Penitentiaries²⁵⁷.

The scope of the phenomenon is also recognised²⁵⁸, and the risks related to its escalation have been examined, but, because of scarce resources (that is more intensely felt lately due to the economical-financial crisis) and the unreactiveness which characterises some of its structures of the prison system (a closed system dominated by the safety of detention) in acquiring good practice in the field, policy development and response mechanisms in terms of the medical-psychological-social care for drug using prison-inmate is time-consuming, shows drawbacks and delays, several pilot stages, and attempted solutions.

The process is correctly guided under the national strategic goals of the fight against drugs and the institutional strategies for the development and upgrade of the prison setting, and it focuses mainly on diversification of current services and on strengthening and extending them in order to progressively increase availability in the prison system.

11.1.1. CONSTITUTION AND CHARACTERISTICS OF THE ROMANIAN PRISON SYSTEM

The Romanian prison system is working based on the G.D. no. 1849/October 28, 2004 which defines the National Administration of Penitentiaries as an institution belonging to the national system of safety, defence and public order²⁵⁹, directly subordinated to the Ministry of Justice.

The Law no. 275/2006 on serving sentences and measures ordered by judicial bodies during criminal trial and its Enforcement regulation laid the groundwork for the modern application of custodial sentencing in line with European recommendations, approximating the Romanian prison practice to the European one and introducing new elements, such as seconded judge to order sentences and individualised custodial sentences.

The Law no. 275/2006 was amended and supplemented by the Law no. 83/2010, and the GD 1897/2006 approving the Enforcement regulation of the law on custodial sentences was amended and completed by GD no. 1113/2010. These amendments defined the offences specific for the prison system and a separated component was outlined for the commissions that decide upon or change the way sentences are served, awards are given, upon conditional release and discipline.

In addition, the Law no. 202/2010 enacted at the end of 2010 outlined some measures to enhance case settlement and influenced significantly the prison system because it includes additional measures related to the direct access of the courts to electronic data bases and communication systems.

²⁵⁷ <http://www.scribd.com/doc/49328311/Bilant-ANP-2010>,

²⁵⁸ See the most recent epidemiologic data described in Chapter 9

²⁵⁹ The Romanian prison system was demilitarised by the Law no. 239 on the status of public servants in the National Administration of Penitentiaries, June 28, 2004. The activity in the prison system complies with human right principles and international documents: Universal declaration of Human Rights, United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted in New York, December 10, 1984. Additionally NAP complies with the UN resolution 35/177 of December 15, 1980- Body of principles for all persons under any form of detention or imprisonment, Resolution no.663 C (XXIV) of July 31, 1957, by which the Social and Economic Council adopted a the Standard minimal rules for the treatment of prisoners, the Recommendation no. R (87) 3 adopted by the Committee of Ministers of the Council of Europe, 12 February 1987, European Prison Rules, Recommendation no. R (89) 12 Committee of Ministers of the Council of Europe, adopted October 13, 1989 on education in prisons.

The institution includes 32 penitentiaries, 4 penitentiaries for underage and young offenders (Bacău, Târgu Mureş, Craiova and Tichileşti), one women penitentiary (Târgşor), 6 hospital penitentiaries (Bucharest-Jilava, Bucharest -Rahova, Colibaş, Dej, Poarta Albă and Târgu Ocna) and 3 re-education centres (Buziaş, Găeşti and Târgu Ocna).

11.1.2. THE ORGANISATION OF THE MEDICAL CARE SYSTEM IN PENITENTIARY

The medical care is provided in the penitentiary system in line with the provisions of the Joint Order of the Ministry of Health, Ministry of Justice on providing medical care to prison inmates in custody of the National Administration of Penitentiaries no. 1016/2007, which promotes equality between the medical services provided to inmates and those provided in the public health system. Thus, art 3 guarantees the right to medical care of people in custody and the free access to medical care and medication.

A health network is in place within the National Administration of Penitentiaries to ensure medical care to prison inmates. It consists of: basic medicine care units, dental medicine wards, infirmary, out-patient units and penitentiary hospitals endowed according to standards of the Ministry of Health and institutional standards of the NAP. Every penitentiary includes units that provide basic medical care for prison inmates²⁶⁰.

There are 6 penitentiary hospitals in the health network which includes specialised integrated out-patient units:

- Rahova penitentiary hospital with 120 beds and its own general surgery ward, thoracic and urology, obstetrics-gynaecology, orthopaedics, ENT, ophthalmology, anaesthesia-intensive care and detoxification;
- Bucharest (Jilava) penitentiary hospital, with 391 beds, provides treatment to inmates with internal and chronic diseases, STD, infectious diseases, tuberculosis and psychiatric problems;
- Dej penitentiary hospital, with 156 beds, its own general surgery ward, internal medicine and abdominal laparoscopy, ophthalmology, and intensive care;
- Colibaşi penitentiary hospital, with 200 beds, and the following units: chronic internal diseases, SDT and pulmonary infections;
- Poarta Albă penitentiary hospital, with 160 beds, and the following units: internal disorders, chronic disorders, SDT, psychiatry, infectious diseases, pulmonary infections and intensive care;
- Tg. Ocna penitentiary hospital, with 175 beds, specialised in diagnosing and treating tuberculosis and other chronic diseases.

The 2010 report of the NAP mentioned significant limitations in resources, mainly human, at the level of intra-penitentiary care network - 777 people²⁶¹ (physicians, medical assistants and auxiliary staff), for an inmate population of 26,838 (1/35 ratio).

Art. 64 of the Joint order mentioned before explicitly regulates the provision of medication in the penitentiary system²⁶². In addition there is a legal framework laying the groundwork for the prevention and fight against communicable diseases, supervision and control of sexually transmissible diseases²⁶³, including HIV/AIDS²⁶⁴.

²⁶⁰ Some of the tasks of the medical ward staff are:

- a) Emergency medical care in case of disease or accident;
- b) Medical examination upon prison intake, transfer, release
- c) Measures to counter and prevent communicable diseases in line with the health law;
- d) Recommends hospitalisation, in case there are no means to diagnose and treat, as for communicable diseases for which hospitalisation is mandatory;
- e) Supervises the strict application of health rules in all units and workplaces,
- f) Performs activities of health education so that prison inmates gain the needed knowledge and skills on personal and collective hygiene and prevention of diseases

²⁶¹ <http://www.scribd.com/doc/49328311/Bilant-ANP-2010>,

²⁶² The administration of medication such as antidiabetes, antiepileptics, antipsychotics, anxiolitics, hypnotics and sedatives and other medication prescribed by physician is performed under strict supervision. The inmate signs upon receipt, upon each administration, in a special record.

²⁶³ Prison inmates submit to serologic examination upon intake and during detention. Inmates who test positive for HIV undergo investigations for the detection of sexually transmissible infections.

The measures used most frequently to prevent HIV infection in penitentiaries are:

- a) dissemination of information materials, making health education programmes focusing on HIV infection prevention, transmission means, the prevention of discrimination towards infected people;
- b) compliance with universal cautions in all penitentiary wards and penitentiary hospitals;
- c) provision of means to sterilize and sanitise medical instruments;
- d) collection of septic waste;
- e) use of condom to prevent HIV sexual transmission;
- f) enable HIV testing and counselling prior to and after testing; in this case, the written consent is compulsory and is kept in the prison inmate's medical file;
- g) enabling testing for pregnant women, ensuring counselling prior to and after testing and antiretroviral treatment of infected pregnant women, as well as of the newly born.

Chapter III²⁶⁵ - "Prophylactic and health - antiepidemic activity", unit 6 – "Medical, psychological and social care of drug using prison inmates" generally describes the way in which treatment services are provided, and the procedure is repeated in other internal documents of the National Administration of Penitentiaries. The process can be described in stages as follows:

1. Upon penitentiary admission, following epidemiologic selection, the inmate shall receive information on the availability of medical, prophylactic and emergency care, and information on the available specific care for drug users.
2. If the inmate reports to be a drug user or the medical doctor suspects a drug use case, the specialist shall inform the user of the possibility to contact the DPECC of the National Anti-drug Agency, that is the closest to the detention place, in view of evaluation and inclusion in an integrated specialised care programme. A case manager shall be appointed in each DPECC and he/she shall see the user and assess him/her.
3. Assessment shall be done by the case manager together with the staff that provides medical, psychological and social care in penitentiaries, namely, the multi-disciplinary drug treatment team.
4. By consultation with the medical, psychological and social care staff in penitentiary, the case manager shall settle a treatment integrated programme (TIP) that includes an individualised plan of care (PIA) and the assessment report. The report shall be shown to the user together with the treatment integrated programme and the user shall sign a programme inclusion agreement.
5. If the user signs the programme inclusion agreement, the staff that provides medical, psychological and social care in penitentiary will ensure programme implementation together with DPECC staff. The case manager shall coordinate, monitor and regularly evaluate the implementation of the programme.

Special cases of the medical practice related to prison-based drug addiction treatment are also mentioned:

- a. in case a harm reduction programme – TIP 4 was set for a drug using prison inmate consisting of substitution programme based on opiate agonists, transfer is provided for the dose stabilisation phase (induction) to a specialised unit of the health network of the National Administration of Penitentiaries or Ministry of Health, that are appointed to carry out such a programme, and maintenance should be ensured by the physician.
- b. In case the drug user is in a emergence situation – complicated withdrawal, overdose, complicated related disorders – the staff attending the case shall immediately notify the management in order for the emergency transportation be ensured to a medical unit in a public health network.
- c. In case of withdrawal, the physician will take all necessary steps to reduce withdrawal symptoms, if he is authorised to do this, or minimal steps to provide support and contact a Drug Prevention, Evaluation and Counselling Centre to ensure necessary medical measures and assign a case manager. If a case manager has already been assigned, he/she will be contacted.

²⁶⁴ Art. 104 – Medical directorate of the NAP promotes in all units methods and procedures that are in line with the National programme to prevent and fight HIV infection/AIDS and the recommendations of the European Council in the field

²⁶⁵ Order on providing medical care to prison inmates in custody of the National Administration of Penitentiaries no. 1016/2007

- d. In case the drug user is already being included in a treatment programme upon prison admission, the territorial Drug Prevention, Evaluation and Counselling Centre will be notified to continue the treatment programme,
- e. When the drug user that has already been included in a treatment programme is transferred to another custodial location, the territorial Drug Prevention, Evaluation and Counselling Centre will be notified and it will contact the DPECC with jurisdiction over the new custodial location for case continuation.
- f. If a drug users included in a treatment programme is released from the custodial location, the territorial Drug Prevention, Evaluation and Counselling Centre will be ensured immediately and the treatment programme will be continued post-release for those included in substitution programme based on opiate agonists (methadone).

11.1.3. GOALS RELATED TO DRUG USING PRISON INMATES AS REFLECTED BY NATIONAL POLICY

Drug use in penitentiaries is a priority of Romanian authorities, which has been proved by the mention in the current fundamental policy regulations, approved by higher level legal documents that aim at controlling the drug phenomenon at national level. In all these documents, institutional development is a priority, as well as progressive expansion and strengthening drug treatment services for prison inmates in parallel with immediate prevention measures and psychological and social support.

The need for new services of social, family and community reintegration of former drug using prison inmates has been felt lately as the link needed to complete the range of current services and to work in coordination to prevent relapses. To this aim, the National Administration of Penitentiaries started to take steps to formulate and implement a National Strategy for the social reinsertion of prison inmates. The key strategic documents that include goals referring to drug using prison inmates are:

- **National Anti-drug Strategy 2005-2012**, adopted by Governmental Decision no. 73/2005 – includes general strategic and specific goals focusing on the prison setting such as:
 - Chapter II.1. Drug use prevention, C. Drug prevention in the community, specific target 8: “Broadening education programmes for a healthy lifestyle and drug use prevention among all prison inmates”.
 - Chapter II.2 Medical, psychological and social care, harm reduction and social reinsertion, A. Harm reduction, specific target 1 “Creating and continuously improving organizational framework in order to ensure all harm reduction measures (exchanges of sterile medical equipment, including needles and syringes, psychological and pre/post-test counselling, substitution treatment programmes, etc.), for drug users and drug-addicted people in the medical care system, outside it and in penitentiaries”.

National Anti-drug Strategy 2005-2012 has two consecutive Action Plans that make strategic goals referring to drug use in prison settings operational, by translating them into actions.

Table 11-1: Comparison between policy documents for the implementation of the National Anti-drug Strategy 2005-2012

Chapter		<i>Action Plan for the implementation of the National Anti-drug Strategy in the time period 2005-2008, approved by Governmental Decision no. 323 of April 14, 2005.</i>	<i>Action Plan for the implementation of the National Anti-drug Strategy in the time period 2010-2012, approved by Governmental Decision no. 1.369/2010</i>
Chapter II.1. Drug use prevention	C. Drug prevention in the community	Activities: 10.1. Raising the awareness of the decision making bodies regarding the increased vulnerability of the inmates to drug use. 10.2. Developing prevention programmes and activities in penitentiaries focused on the use of drugs and its consequences. 10.3. Outlining training curriculum regarding drug use prevention among inmates in penitentiaries. 10.4. Implementing a training curriculum for specialists in the penitentiary system. 10.5. Creating and distributing informative, educational and awareness materials. 10.6. Implementing drug use prevention campaigns in penitentiaries. 10.7. Annually implementing the prevention and education activity plan among inmates.	Specific target 9: <i>Extending education programmes that promote a healthy lifestyle and prevent drug use among prison inmates</i> Activity 9.1. Organising addiction training sessions for the social-educational penitentiary staff in order to disseminate information through peer to peer education Activity 9.2. Development and implementation of at least one national-local drug prevention project in penitentiary

Chapter II.2 Medical, psychological and social care, harm reduction and social reinsertion	A. Harm reduction	<p>Specific target 1 <i>Creating and continuously improving organizational framework in order to ensure all harm reduction measures (exchanges of sterile medical equipment, including needles and syringes, psychological and pre/post-test counselling, substitution treatment programmes, etc.), for drug users and drug-addicted people in the medical care system, outside it and in penitentiaries.</i></p> <p>Activity 1.2. Creating the legislative framework to implement a prescription system for substitution treatment (methadone, buprenorphine etc) in penitentiaries according to the trends in drug addiction in prisons (methadone maintenance, syringe exchange, pre and post-testing counselling for infectious diseases HIV, B/C hepatitis, vaccination against B hepatitis).</p> <ul style="list-style-type: none"> - 1st phase – developing pilot programmes - 10% of the penitentiaries - 2nd phase – evaluation and enlargement of the programme - 20% of the penitentiaries <p>Activity 1.3. Creating conditions for the proper running of the psychological and social services (in-patient or out-patient) with the goal of reducing drug use related risks.</p> <ul style="list-style-type: none"> - 1st phase – 50% of the penitentiaries - 2nd phase - 50% of the penitentiaries. 	Specific target 1, Activity 1.1 – Development of harm reduction programmes and campaigns among drug users in treatment system, outside it and in penitentiaries
Medical, psychological and social care and social reinsertion	Medical, psychological and social care and social reinsertion	<p>Overall target: To ensure universal access of drug users to programmes of medical, psychological and social care, through the development of adequate programmes and policies targeting the general population, the drug users' population in the care system, outside it and in prisons, with a view to the social reintegration and reinsertion of drug users.</p> <p>Specific target 2. <i>Enhanced availability of services (with respect to their diversity, multi-disciplinary character and territorial spread) and tailoring these services to the users' individual needs and to the type of use (single use or poly drug abuse).</i></p> <p>Activity 2.2. Developing in each county and in the districts of Bucharest a public and/or private network integrating the services in the medical care system and/or services provided by the NAA and/or social services, comprising of the four types of integrated care programmes and programmes targeting specific groups, children, pregnant women, double diagnose drug users, inmates etc.</p> <p>Specific target 8. <i>Development of an integrated programme of medical, psychological and social care, providing a network of resources and guaranteeing the general access and availability for all drug users in the penitentiary system, with a view to their social reintegration;</i></p> <p>Activities:</p> <ul style="list-style-type: none"> 8.1. Developing and implementing in each county and each district of the capital one-two caregiving programmes for drug users in provisional arrest. 8.2. Improving the legislative framework to allow larger access of drug users in penitentiaries to integrated care giving services. 8.3. Developing the institutional framework to permit access of inmates to such programmes (centres/evaluation units, detoxification units, post-care centres, drug free units, etc) and providing specific therapeutic interventions for drug users in the penitentiary system. 8.4. Developing the legal framework for ensuring 	Specific target 8, Activity 8.1 – Development of a national integrated treatment programme for drug using prison inmates

the access of ONGs into penitentiaries in order to provide caregiving services to drug users.
8.5. Implementing in penitentiaries vocational guidance and training programmes for drug users.

Source: NAA

- The **Strategies for the prevention and control of HIV/AIDS** can be included among the policy documents addressing drug using offenders, the first, applicable for the period 2004-2007, being already implemented and, the second, for the time period 2008-2012, at proposal stage.

Table no. 11-2: Comparison between policy documents for the prevention and control of HIV infection/AIDS

<i>Major intervention areas</i>	<i>National Strategy for the monitoring, control and prevention of HIV infections/AIDS 2004 -2007</i>	<i>National Strategy for the monitoring, control and prevention of HIV infections/AIDS 2008 -2013 (PROPOSAL)</i>
1.3 – transmission prevention among injecting drug users	A. demand reduction (by constant information and education campaigns among young people at risk)	
	B. harm reduction (based on legislative building and improving public funding mechanisms and extension of syringe exchange services, substitution based on opiate agonists, of the medical care services and social-professional reinsertion integrated services)	A.Harm reduction (extending syringe exchange programmes, in numbers and capacity, through outreach activities and participation of pharmacies; including HIV prevention programmes among IDU in public national and local programmes; Ensuring universal access of IDU to HIV, ITS, B and C hepatitis testings) B.Injection drug use reduction (estimation of the IDU group in the intervention areas; information and education campaigns for preventing the onset of injecting drug use; carrying out accessible programmes of substitution treatment for heroin and opioid users; correlation and coordination of activities in the field of drug use prevention, harm reduction and addiction treatment). Even if not necessarily referring to penitentiary setting, the activities described fall under the category of prison-based drug use (most prison inmates with a drug use record, are drug injectors)
1.4 – transmission prevention in penitentiaries	A. building the framework for the implementation of tailored programmes (focus on institutional and legal framework of cooperation between DGP and Ministry of Health)	
	B. Information, education, communication activities and increase of the access to services (training of at least 60% of the staff and almost 400 peer educators, starting syringe exchange services and opiate-based substitution treatment, as well as condom distribution).	

Source: NAA

- After the public launch of the National Administration of Penitentiaries of the proposal to setup a working group – involving members of public institutions, NGO's and of the civil society, with a possible role to play in after-judicial assistance – the project a **National Strategy for the social reinsertion of prison inmates** (substantiation and operational plan) was formulated during three sessions of the extended group and 7 sessions of smaller groups, and it should be promoted and enacted by the end of 2011.

The legal and procedure framework of the drug treatment system at national level is defined by the following regulations:

- **Legal framework:** Law no. 143/2000 on countering the illicit drug trafficking and use; Law no. 522/ 2004 amending and supplementing the Law no. 143/ 2000; Governmental Decision no. 860/2005 approving the Enforcement regulation of the provisions of the Law no. 143/2000, further amended and supplemented;

- **Methodological framework:** Standards of the medical, psychological and social care national system for drug users²⁶⁶.

As part of the secondary level of regulation, joint orders or dispositions were issued at the level of each institution that manages drug use to guide and make drug policy operational.

In relation to the development of response policy on drug use in prison settings the following should be mentioned:

- Joint order of the Minister of Health, Ministry of Justice, Ministry of administration and interior no. 1.216/C of May 18, 2006 on carrying out medical, psychological and social care integrated programmes for prison inmates, who use drugs (it explicitly mentions the principle of “equivalent services” of medical care for drug using prison inmates and those outside penitentiaries) and
- Joint order of the Minister of Health and Ministry of Justice, no. 898/2002 regarding medical and education measures applicable to drug-addicted people in penitentiaries.

It should be mentioned that the Joint order of the Minister of Health, Ministry of Justice, Ministry of administration and interior no. 1.216/C of May 18, 2006 enforces the provisions of the art. 28, indent 7 of the Law no. 143/2000 on countering the illicit drug trafficking and use (the Romanian special drug law) and art. 23, indent 1 of the Governmental Decision no. 860/2005 approving the Enforcement regulation of the provisions of the Law no. 143/2000, further amended and supplemented.

In addition, the internal documents issued by the National Administration of Penitentiaries should be mentioned. The most important is the Decision no. 452 of 04.07.2008 of the NAP's General director approving the Procedure book of the penitentiary system, which includes specific operational procedures of categories A003 – Education and psychological care, A00303 – Management of education and psychological care and A00601 – Preventive medical care and medicine, which includes **A00601025 – Prevention and fight against drug use in penitentiaries**.

Two other orders focusing on drug use in penitentiary settings were issued in 2011:

- Decision no. 324/18.02.2010 of the National Administration of Penitentiaries `s General director on carrying out education and psychological care programmes, that was distributed to NAP units;
- Decision no. 534/15.07.2011 of the National Administration of Penitentiaries `s General director on the setup of three therapeutic communities in penitentiaries in Jilava, Rahova and Târgșor as part of the Project RO-0034 "Setting up three therapeutic communities in Jilava, Rahova and Târgșor penitentiaries" funded by the Financial mechanism of the European Economic Area.

11.2. DRUG EPIDEMIOLOGIC DATA²⁶⁷

An analysis of the drug law crime²⁶⁸ in the last 10 years in Romania illustrates that a maximum of 1.5% of people with custodial sentences are convicted for offences under the Law no. 143/2000.

By contrast, although through a slower evolution, the number of self-declared drug using prison inmates doubled (1,065 in 2001 to 2,043 in 2010). The profile of the beneficiary of prison-based medical-psychological-social care services is: male, aged under 30, heroin user, intravenous route. Although many are self-declared injecting drug users, only a low number seeks syringe exchange services or substitution treatment based on opiates that are available in the penitentiary medical network.

11.2.1. DATA ON ILLICIT DRUG MARKET IN PRISONS

A study²⁶⁹ conducted by the National Administration of Penitentiaries in 2010 (data from the time period 2007-2009), related to drug law crime in prison settings reveal the following elements of this “market”:

²⁶⁶ See chapter 5.2 – national treatment system

²⁶⁷ See the most recent epidemiologic data described in Chapter 9

Methodology:

The study was conducted in 39 penitentiary units and two staff categories were interviewed: 42 penitentiary managers and 55 crime prevention workers. Documentation, self-administered questionnaire and content analysis were used in the process. The main goals were to estimate the scope of the phenomenon in the prison setting; identify the units where illicit trafficking is more likely to occur; identify the main means and routes to sending forbidden substances to inmates; establishing the main favouring factors leading to the maintenance and evolution of the illicit drug trafficking and use in penitentiary etc.

Findings:

- Most respondents estimate an increase of the number of prison inmates who participate in drug trafficking in the last 3 years;
- In the time period 2007-2009, most cases were detected in Bucharest-Giurgiu area (Bucharest - Rahova, Bucharest -Jilava and Giurgiu penitentiaries) and less in Mărgineni and Ploiești penitentiaries (mainly in 2009, when a large number of organised group members, specialised in drug trafficking, were imprisoned). In addition, there was an increase of the number of attempted introduction of forbidden substances in penitentiaries (Galați, Brăila, Craiova, Târgșor, Slobozia, Poarta Albă, Iași, Botoșani, Baia Mare, Aiud, Timișoara, Arad, Oradea and penitentiary hospitals Jilava and Poarta Albă).
- A working pattern was determined for the organised crime network operating in the field of drug trafficking in penitentiary, and roles/specialities of the network members were defined: dealer – provider, user – end user and carriers or “arrows” (selected by dealers among prison inmates in open or half-open penitentiaries, with a higher mobility, without a history of violence and no reasons to be suspected). Penitentiary networks are most often based on organised crime groups known outside the penitentiary.
- Prison inmates convicted/arrested for breaking the Law no. 143/2000 participated in almost 21% of the cases in which forbidden substances were detected,
- The various locations where forbidden substances were discovered show a good organisation of the network and a large influence in penitentiary setting. Over half of the cases were identified in the unit Packages, Visits, Correspondence (80% of the cases – packaged for inmates). The room/detention areas, inner/exterior yards and areas for daily activities (work points) were preferred for this kind of activities.
- Most respondents mentioned packages as the means to get forbidden substances into prison, while visits and prison staff are second and third on the list. Mentions were made to dropping forbidden substances from the outside in the detention area, sending drugs to inmates who benefited from penitentiary leave, who are transferred, taken to investigations or returning from exterior work points etc.
- The activity implies the link with exterior leaders and specialised roles for people inside: inmates who get substances during visits; people who keep substances in their rooms or storage areas temporarily; people who make “deliveries” or “reception” and who play the role of “carrier” or “arrow” (the most visible); inmates who provide protection to network leaders; inmates who collect debts etc.
- Drug users may come by drugs by: buying from relatives outside penitentiaries; swap of forbidden substances; “selfishness” method (trading drugs for nothing in return – the initial stage when the drug user is attracted); penitentiary “internal market” (in exchange for money, goods and services); “mediated internal market” (when a carrier is used and rewarded for that); “externally mediated internal market” (drugs are provided to a user based on agreements between third parties outside the penitentiary).
- The data show most inmates who participated in forbidden substance cases were from closed penitentiaries (50%), half-open (25%) and on remand in police custody (12%).
- The main risks of drug use and trafficking in penitentiary, as classified by respondents are: 1. forbidden substances may cause violence among prison inmates; 2. infectious disease (HIV, HBV and HCV);

²⁶⁸ see chapter 9.4 Problem drug use in prison

²⁶⁹ <http://www.scribd.com/doc/30563012/Studiu-Consumul-si-traficul-de-droguri-in-penitenciare>

- 9 main factors that favour this penitentiary phenomenon were identified: 1. lack of technical and logistical equipment to detect substances; 2. highly “specialised” inmates (repeat offenders, offenders involved in “penitentiary tourism” or in transfer etc); 3. Limited information and training of the staff; 4. Insufficient staff participation (negligence and corruption); 5. under-staffing and pressure on current staff; 6. crime spread – links between organised crime groups outside the penitentiary; 7. inability of users to quit drugs; 8. flexibility of legal regulation – numerous rights for inmates (especially the right to receive packages); 9. under-funding of measures to fight the phenomenon. These factors were classified in 4 categories: technological factors, human cause factors; regulation factors and macro-social cause factors (e.g. location of penitentiary in an area with a high crime rate).

11.3. INFORMATION ON THE PROVISION OF SPECIALISED SERVICES TO PRISON INMATES WHO USE DRUGS

Even if concern for the management of illicit drug use and trafficking existed in penitentiaries (prison inmates would declare themselves drug users in the time period 2001-2003 and measures of medical care would be taken for them), the public recognition and will to develop policy and responses delayed until after the National anti-drug strategy 2005-2012 was enacted and after the first study on the prevalence of drug use in prison settings was made public in 2007 (conducted by the NAA in cooperation with NAP)²⁷⁰. The *Study to estimate the prevalence of HIV, hepatitis B and C prevalence among prison population*²⁷¹, conducted by NAP in 2007 with the support of Romanian Angel Appeal Foundation and funded by NAP and Global Fund to fight HIV/AIDS, Tuberculosis and Malaria should also be mentioned.

These studies and the financial support provided by the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria²⁷² and UNODC underpinned for services and pilot-projects of prevention and integrated care (medical, psychological and social care) for drug using prison inmates, implemented by NAP, in cooperation with the NAA and a few NGO`s that manage activities to prevent infectious diseases and provide care to injecting drug users. Once the legal framework was completed, the national strategic regulation of the fight against drugs and financial mechanisms identified, it was possible for the *Standards of the medical, psychological and social care national system for drug users* to be applied in the prison system. Although some medical services have a long history, the development of pilot programmes of harm reduction, syringe exchange and opiate substitution treatment (OST) began in 2008 and is being extended at present.

Because the availability of these services in the penitentiary system is a prerequisite of the compliance with Romania`s obligations to fight drugs, with international and European principles of rights and fundamental liberties of the prison inmate, through the National Administration of Penitentiaries as key institution in the field, the process of policy and response development is expected to continue in the upcoming period of time. Therefore, an evaluation of the types of services in place in the penitentiary system in Romania could be useful in outlining an overview and setting priority future actions.

²⁷⁰ <http://www.ana.gov.ro/vechi/rom/upl/intreg.pdf>

²⁷¹ The aims of the research: knowing diseases transmitted by parenteral route, disease related risk factors, defining health strategies for the prison system in relation to such diseases. The survey sample was representative for the prison population (N=1391) and consisted in: blood tests to determine anti-bodies for HIV infection, C and B hepatitis; questionnaire applied to determine risk factors of HIV, HVC and HBV infections. Findings: 5.7% of the inmates declared using injecting drugs (13% of them declared knowing people who use injecting drugs) and 3.8% shared needles or syringes. The study showed the use of injecting drugs and sharing syringes is more common among female inmates aged 30 and less.

²⁷² In 2006, the Country coordinating committee for projects funded by the Global Fund, analysed the financial shortfall in the control of the two epidemics in Romania and decided to apply a new funding scheme under the Global Fund – Round 6. Both financial applications were made and approved and grants should be implemented by the Romanian Angel Appeal Foundation nominated by the Country Committee as main recipient. The Fund concluded with the Romanian Angel Appeal Foundation the grant agreement for the 1st phase (first 2 years) of the HIV/AIDS and Tuberculosis programme. Funding was approved for the 1st phase of the 6th Round to the amount of 9,338,352.00 USD for the HIV/AIDS components and 5,212,177.00 USD for tuberculosis.

11.3.1. DRUG USE EVALUATION

The Joint Order of the Ministry of Health and Ministry of Justice on providing medical care to prison inmates in custody of the National Administration of Penitentiaries no. 1016/2007, stipulates at art. 13 that “upon admission of prison inmates in a new unit, by transfer, re-admission by referral from judicial bodies, interruption of sentence, after prison escape or upon return from leave, the following steps should be taken:

- a) short clinical examination to detect possible cases of contagious and parasitic diseases or any other diseases that call for medical supervision;
- b) detection of obvious signs of aggression;
- c) detection of obvious signs of drug use;
- d) application of hygiene-health measures tailored to each case;
- e) bathing;
- f) full equipment in clean civilian clothing, personal or provided by the detention unit administration, including personal hygiene items.

The examination results are written down in a medical chart called selection chart upon penitentiary admission.

Epidemiologic selection is also mentioned in the procedure A00601025 – Prevention and fight against drug use in penitentiaries, of the Procedure book of the penitentiary system.

Considering the need to comply with the continuum of services established by national regulations²⁷³ for self-declared drug using prison inmates, several episodes of the initial assessment stage can be identified to ensure future case management by DPECC in the structure of the NAA. Therefore,

- If the penitentiary physician suspects a case of drug use during the compulsory medical examination upon admission in the custodial setting, he/she will inform the user of the possibility to contact DPECC, in order to be evaluated and included in a treatment integrated programme.
- Case evaluation is performed by a case manager (assigned in DPECC) together with the staff that provides medical and psychological care in penitentiaries. Evaluation is performed along domains provided for in art. 14²⁷⁴ of the Enforcement regulation of the provisions of the Law no. 143/2000, further amended and supplemented, approved by Governmental Decision no. 860/2005;
- After the report is completed and the individualised plan of care included, the case manager shows them to the user as a stage prior to signing the programme inclusion agreement. If the user signs the programme inclusion agreement, the staff that provides medical, psychological and social care in penitentiary will ensure programme implementation together with the case manager.

To conclude, it can be stated that this type of drug service for prison inmates that is being carried out in partnership with another public institution - National Anti-drug Agency -, follows a specific methodology and implies resource coordination towards the next stage of the actual provision of specific treatment services.

Of the 440 drug users that were treated by DPECC in 2008, 46.4% (210 people) were referred by the justice system or brought in by the police and 164 people by the justice system only (penitentiaries/re-education facilities). DPECC specialists made initial assessments and provided integrated care inside penitentiaries to 152 beneficiaries in 12 prison units in 2009.

11.3.2. PREVENTION SERVICES: INFORMATION-EDUCATION-COPUNSELLING ON DRUGS IN PENITENTIARIES

Information-education-counselling services fall in the category of specific services used generally by NAP to socially reinsert prison inmates after release. The information topics have been tailored and

²⁷³ Joint order of the Minister of Health, Ministry of Justice, Ministry of Administration and Interior no. 1.216/C of May 18

²⁷⁴ Assessment is performed on the following domains:

- a) Personal drug use history and record of intoxication and/or withdrawal;
- b) Biological-medical conditions and complications;
- c) Psychological or psychiatric conditions and complications: treatment retention/resistance, relapse potential, resumption of addiction, other problems;
- d) Social and family conditions;
- e) Legal situation.

completed with specific drug topics since 2003. Information, as a means to prevent drug use onset in penitentiary or increase awareness among users of the risks, is a useful tool in the initial phase of therapy, and a support mechanism to enhance progress throughout the treatment of prison inmates.

Generally, prevention measures depend on the specificity of the detention facility and are taken by the staff in cooperation with DPECC²⁷⁵, victim protection and offender social reinsertion services as well as other public services, NGO's, authorised legal and natural persons, as well as international bodies.

The Joint order of the Minister of Health, Ministry of Justice, Ministry of Administration and Interior no. 1.216/C of May 18, 2006 stipulates in art. 1, indent (3) the following: "emergency measures, treatment integrated programmes and prevention measures shall be taken for drug users".

In addition, art. 25 of the Joint Order on providing medical care to prison inmates in custody of the National Administration of Penitentiaries no. 1016/2007, stipulates that in the case of drug prevention, measures shall be taken to:

- a) Provide, upon penitentiary admission, brochures/fliers with general information of the risks of drug use, and available care;
- b) Organise information and education actions focusing on the risk of drug use, HIV, B and C hepatitis infection, by multi-disciplinary treatment teams;
- c) Organise specific activities, attended by NAA specialists, and other specialised public bodies as well as NGO,
- d) Organise special information, education, counselling and relapse prevention programmes for people with a drug use record.

From a historical perspective, the progress of this type of services began in 2003, when the Directorate General of Penitentiaries formulated a programme to prevent and fight drug use and abuse in penitentiaries. It approached in a multi-disciplinary manner the issue of drug use with the help of a team made up of doctors, educators, sociologists, psychologists and social workers. The PHARE twinning project fiche "Assistance to penitentiary reform" between Romania and Spain was formulated and approved in the same period of time, and was aimed at preventing and providing treatment to drug users in the penitentiary system.

The medical service of the Directorate general of penitentiaries was member of the Romanian Harm Reduction Network (RHRN) and implemented specific programmes in penitentiaries. The main programmes carried out from 2003 to 2005 were:

- "HIV infection prevention in penitentiaries", in partnership with ARAS, with a 44,000 euro PHARE funding and a 2,700 euro co-financing by ARAS and 4,600 euro funding by the Directorate general of penitentiaries.
- „HIV infection prevention among prison inmates", in partnership with ARAS and supported by "John Snow Institute" with 38,000 USD and by the Directorate general of penitentiaries with 26,000 USD. Information materials, posters, brochures and video tapes on HIV and the risk of HIV infection in penitentiaries were distributed within this programme.

NAP implemented the project **Initiative 38** in 2007 in partnership with Romanian Harm Reduction Network, three member organisations – ARAS, *Alături de Voi* Foundation, *Integration* association, and funded by the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria. The project implementers intended to increase access of prison inmates to HIV infection prevention programmes by information and education activities. An information campaign was launched sending messages adjusted to the target group (prison inmates). The campaign included direct information sessions delivered by health educators, peer education courses, information dissemination on printed, electronic and visual materials.

The DPECC and the penitentiary multi-disciplinary teams implemented 56 information and education activities on the drug risks, with 4,408 people as beneficiaries (of whom 3,890 male inmates, 39 women, 346 underage inmates, 83 institutional members, 50 volunteers) and 49 culture-education activities (competitions, exhibitions, theatre plays, documentary films, music and dance shows) in 44

²⁷⁵ See chapter 9.4.2

locations (penitentiaries, penitentiary hospitals, re-education centres) in 2008. 1639 prison inmates were included in education programmes focusing on the promotion of a healthy lifestyle in 2009.

Numerous activities of drug use prevention addressing prison inmates such as: distribution of fliers, brochures, playing card and posters informing about drug use, theme exhibitions, community outings, TV shows, articles in penitentiary magazines were carried out in all penitentiaries in 2010, as part of programmes carried out in partnership with NGO`s.

11.3.3.TREATMENT SERVICES

Once treatment integrated programme (TIP) is settled and the individualised plan of care (IPC) defined, the drug user is guided by the case manager to a unit that provides specialised care in penitentiary, in line with the user's individual needs.

11.3.3.1.Psyco-social care

Designed to continue the plan of care at liberty and prepare social reinsertion of prison inmates, the integrated services of psycho-social care work in several stages of the therapeutic process: as autonomous services, right after penitentiary admission, to enable adjustment to penitentiary settings, or as support services that complete and strengthen the effect of OTS or syringe exchange on medium and long term.

Initially developed with the external support of the NAA and partner NGO`s and later with institutional human resources, based on training, NAP has been implementing psycho-social care programmes since 2008.

Thus, NAP data shows 3,528 prison inmates with a drug use record were included in 2008 on psycho-therapeutic programmes carried out by specialised staff in psycho-social care penitentiary services (educators, psychologists, social workers) in partnership with medical unit staff, and local DPECC, but also with organisations and foundations. Performed activities include education-information, initial psychological and social assessment, individual and group psychological counselling, crisis intervention, psycho-therapy and social care. NAP report mentions that apart from former drug users (self-declared), inmates with a record of addictive behaviour also benefited from specialised care (alcohol, tobacco, medication), upon demand.

1,820 inmates, drug using or with a drug use record, benefited from the psycho-social care penitentiary programme in 2009, and 1,006 in 2010.

NAP formulated a psychological assessment tool of the needs and risks in 2010 that includes a separate unit dedicated to drug use. A specialised unit distributed in NAP subordinated units the *Handbooks of education, psychological and social care programmes*. The *Good practice guide of the psychologist working in the penitentiary system* was formulated and completed and it includes a unit destined to carrying out psychological activities among prison inmates with a drug addiction record.

11.3.3.2. Detoxification services

As defined by addiction medical staff, interviewed towards the aim of this analysis, as a specific medical service aiming to remove physical addiction, detoxification is performed in penitentiary based on symptomatic medication. The service is available throughout the entire penitentiary system because it can be demanded from any psychiatric hospital unit in the competence area of the penitentiary units and can be considered as the "oldest" medical service available for drug using prison inmates. In addition, Rahova penitentiary has its own detoxification facility with 5 beds, available since 2003.

11.3.3.3. Opiate substitution treatment

Substitution treatment has been available pursuant to the joint order of the Minister of Health, Ministry of Justice, Ministry of administration and interior no. 1.216/C of May 18, 2006. These services have been developed within the project *Prevention and treatment of HIV/AIDS among injecting drug users*

in community and penitentiaries in Romania, since 2008, with the technical and financial support of UNODC- Romania.

Project preparatory activities were carried out in 2007: needs assessment study and several training sessions of the medical staff. The procedure handbook/guide on OST in penitentiary was finalised in the first part of 2008, along with training sessions for security and monitoring staff, peer education for prison inmates and trainings for the medical staff in 5 prison units. The first methadone substitution pilot centre became functional in Rahova penitentiary hospital.

Three more similar units were opened in Rahova, Jilava penitentiaries and penitentiary-hospital Jilava in 2008, according to the report. Several monitoring visits were made by the funding party. 4 new units added to the first 4 in 2009 – two in Colibași penitentiary and Colibași penitentiary-hospital and two in Craiova penitentiary and Craiova penitentiary-hospital. One more methadone substitution treatment was opened in Braila penitentiary in 2009, within the same project. Another such facility became operational in 2011 in Braila penitentiary in 2011. 68 drug using prison inmates benefited from methadone substitution treatment services from 2008 to 2010. The average daily dose of methadone was 60 to 72 mg/day.

According to NAP, once the international financial assistance ends in 2012, methadone will be acquired from the budget of the Ministry of Justice, because in spite repeated efforts of the NAP, none of the penitentiary-hospitals was included in the schedule of health units that undergo the drug-addiction prevention and treatment secondary programme, within the Mental Health National Programme, funded by the Ministry of Health. This measure should have been implemented in 2011 but was deferred because UNODC funding allowed for the continuation of the HIV/AIDS prevention programme in prison settings for one more year.

Regarding the future of this type of services, NAP set a medium-term strategic goal to extend the range of drug treatment services for prison inmates by introducing along with methadone, other agonists from the suboxone category (buprenorphine and naloxone). Additionally, a new methodological substitution treatment guide²⁷⁶ was launched in 2010 and its recommendations will be promoted by RHRN towards application in the prison system.

11.3.3.4. Therapeutic communities/other residential services

The Project RO - 0034 "Setting up three therapeutic communities in Jilava, Rahova and Târgșor penitentiaries" aims to enable the social reinsertion of former heroin users after release in the time period 2009-2012. The project is implemented by a consortium made up of National Administration of Penitentiaries, Probation Directorate of the Ministry of Justice, National Anti-drug Agency and its territorial network, namely the DPECC, Phoenix Haga Foundation and the Ministry of Justice – Norway. The following activities were completed in 2010: development of the therapeutic communities, staff training (15 penitentiary specialists and 3 probation services specialists), formulation of a working methodology for the staff working with people included in therapeutic communities, and evaluation of 225 prison inmates which will result in the future beneficiaries of the therapeutic communities.

Based on the classical theoretical model of George de Leon²⁷⁷, the three therapeutic communities are functioned in 20100 with almost 25 beneficiaries each (Rahova and Jilava penitentiary), namely 7 beneficiaries (Târgșor penitentiary)²⁷⁸.

The setup of the three pilot services as therapeutic communities²⁷⁹ shows the commitment of the National Administration of Penitentiaries to develop and extend progressively the range of specialised services, destined for drug using prison inmates.

²⁷⁶ prof. dr. Dan Prelipceanu, dr. Gabriel Cicu (coord.) – *Ghid clinic de tratament substitutiv al dependenței de opiacee*, Editura Asociației Psihiatrice Române, Bucharest, 2010.

²⁷⁷ The Therapeutic Community, Theory, Model, and Method, George De Leon, PhD, Pub. Date: 4/2000, Springer Publishing Company, ISBN-13: 9780826113498

²⁷⁸ Data provided by NAP specialists in September 2011

²⁷⁹ Decision of NAP director general no. 534/15.07.2011 to set up three therapeutic communities in Jilava, Rahova and Târgșor penitentiaries as part of the Project RO-0034 "Setting up three therapeutic communities in Jilava, Rahova and Târgșor penitentiaries" funded by the Financial mechanism of the European Economic Area

11.3.3.5. Counselling and syringe exchange programmes (harm reduction services)

The aim of prison-based syringe exchange programmes is to prevent HIV infection and other infections among IDU as a result of injection equipment sharing and to increase access to medical-psychological and social care services. The main services provided in syringe exchange programmes focus on access to sterile syringes and needles and encourage the recovery of used equipment, reducing, in this manner, risks related to drug use.

The legal and methodological background for the implementation of syringe exchange services in penitentiaries consists of: Law no. 143/2000 on preventing and countering the illicit drug use and trafficking, Law. No. 487/2002, Law no. 487/2002 on the protection of mental health and people with psychiatric problems psihice; Law no. 522/24.11.2004 amending and supplementing the Law no. 143/2000 on countering the illicit drug trafficking and use; Enforcement regulation of the provisions of the Law no. 143/2000, further amended and supplemented approved by Governmental Decision no. 860/2005 and Joint order of the Minister of Health, Ministry of Justice, Ministry of Administration and Interior no. 1.216/C of May 18, 2006.

Other types of services started to be provided in 2008 at the same time with methadone substitution services as part of the project *Prevention and treatment of HIV/AIDS among injecting drug users in community and penitentiaries in Romania* implemented with the technical and financial support of UNODC- Romania.

Internal regulations referring to the creation and adoption of working protocols so as to allow for the implementation of syringe exchange programmes in the prison system were reviewed in 2008, and two syringe exchange programmes became available in Rahova and Jilava penitentiaries. In addition, the project of the first procedure book on providing syringe exchange services in penitentiaries was formulated. The syringe exchange services have started to become operational since 2009 along with opiate substitution treatment, so that it became available in 10 penitentiary units in 2011: Bucharest-Rahova Penitentiary and Bucharest-Rahova Penitentiary hospital, Bucharest -Jilava Penitentiary and Bucharest -Jilava Penitentiary hospital, Colibași Penitentiary and Colibași Penitentiary hospital, Penitentiary Craiova and Craiova Penitentiary hospital, Giurgiu Penitentiary and Brăila Penitentiary.

NAP data suggest 83 drug using prison inmates benefited from syringe exchange services and 18,383 syringes were distributed, of which 9,238 were returned. The project also contributed to training the medical-health, surveillance and psycho-social staff in order to prepare future similar projects and set up a *peer-to-peer* education network. In addition, the *Procedure books of penitentiary-based syringe exchange programmes in Romania* was formulated and published in 2010²⁸⁰. Intermediate evaluation of these services demonstrated they are a valid intervention that can be adjusted to the Romanian prison system, can bring about behavioural changes that can help reduce drug related harm, have not increased drug use in penitentiary, nor caused incidents related to syringe possession for personal use.

11.3.3.6. Drug testing among prison inmates who use drugs

It is performed in penitentiary hospitals that include detox units by quantitative and qualitative dosage of drug metabolites in blood and urine. Considering the costs needed for this type of analysis performed with the available drug testing equipment and the scarce resources, rapid tests are known to be more frequently used to identify traces of drug use in body fluids (saliva or urine). These are used for testing during methadone substitution treatment, upon programme admission and when there are suspicions of intake of forbidden substances. The costs related to testing have been covered from UNODC-funded methadone substitution treatment programmes. There are no available data on the evaluation of the risk of overdose upon prison release.

11.3.4. AFTER RELEASE SOCIAL REINSERTION SERVICES

A poll²⁸¹ conducted by NAP among prison inmates shows “over two thirds (67%) of the prison inmates stated they were not aware of an institution that could help prison inmates after prison release”. The

²⁸⁰ Procedure book of medical-psychological-social programmes of syringe exchange in penitentiaries in Romania, Bucharest, Speed promotion, 2010.

²⁸¹ <http://www.anp-just.ro/Studii/Cercetare%20detinuti.pdf>

authors consider this an indicator that “the potential of crime behaviour spread is very high”²⁸². The same inquiry states that only 33.8% of the respondents had contact with institutions or organisations that implement re-insertion actions or project inside prison, during detention. Probation services are equally unknown (only 8.8% of the respondents heard about them).

National Anti-drug Agency in partnership with Rahova Bucharest Penitentiary and Community Care Foundation implemented the project ANCORA, addressing drug using prison inmates and aiming at building social reinsertion skills by organising monthly information sessions and relapse prevention and pre-release training groups. The project had 200 direct beneficiaries who attended 32 weekly small-group meetings and 10 informative sessions. Due to the success of the project, the intervention model was transferred and continued thanks to internal resources.

The projects launched/implemented in 2010 are presented in Chapter 9.

11.4. TREATMENT ADMISSION AND PERCEPTION OF DRUG PREVENTION/TREATMENT PROGRAMMES IN PENITENTIARIES

According to the respondents included in the survey²⁸³ on the scope and trends of the use of illicit drug, alcohol and other substances among prison inmates, conducted by NAA in cooperation with NAP in 2011, 14.1% of the inmates self-reported as drug users upon penitentiary admission (more than in the 2006 survey: 9,1%)²⁸⁴.

4.6% of the respondents declared having been treated for drug addiction and drug related risks, and most interventions focused on psychiatric and neurological disorders and heroin use/addiction.

Table 11-3: Respondent distribution by type of treatment (medical record), 2011, (%)

Treatment for	%
Psychiatric disorders (depression, anxiety, delirium, attempted suicide, impulsiveness etc)	9.8
neurological disorders (head hits, trauma, etc)	9.4
Heroin use/addiction	7.4
Alcohol use/addiction	1.7
Other types (A, B and C hepatitis, HIV, epilepsy, scabies, syphilis, TBC, tumour etc)	1.4
Medication use/addiction (without medical prescription)	1.2
Use of/addiction to other types of drugs (cocaine, hashish, crack, SNPP, pain killers, ketamine)	1.2

Source: NAA

The type of programmes/measures that focus on drug use and harm reduction, and exist/are used and considered necessary by inmates as part of penitentiary programmes is quite low:

- Psychological care/counselling – the most familiar (32.3% of the respondents, more than in 2006: 28.4%), used (12% of the respondents) and deemed necessary (16.1% of the respondents),
- detox, methadone substitution and harm reduction are known by almost one in 10 inmates, accessed by 1.6% and deemed necessary by almost 5%,
- other types of programmes (anti-drug campaigns, drug prevention course, HIV, HBV, HCV testing, information, confinement of users, sports as re-education means, education programmes, labour) – more balanced situation: the share of those who are familiar with them (4.4%) deem them necessary (5.2%) is much closer to the share of those who seek them (4.9%).

²⁸² Idem 28, p. 15.

²⁸³ See chapter 9.4

²⁸⁴ Even the data reported by NAP indicate an increase of prison inmates who self reported drug users: 2006 – 6.3% (2268 people), and in 2010 – 7.6% (2043 people) – see chapter 9

Table no. 11-4: Anti-drug and harm reduction measures/programmes, existing/used and considered necessary by inmates as part of penitentiary activity (multiple-choice answer) - %

Type of programme	2006	2011		
	Know it exists	Know it exists	used	Consider necessary
Psychological care/counselling	28.4%	32.3%	12.0%	16.1%
detoxification	9.4%	12.9%	1.6%	4.9%
methadone substitution	-	11.6%	1.0%	4.3%
harm reduction	4.4%	9.0%	1.3%	4.9%
other types of programmes	1.5%	4.4%	4.9%	5.2%

Source: NAA

ENDIPP²⁸⁵ recommends the promotion and application of the principle of evenness (between the medical services provided to drug users in all settings they live in on a daily basis, and especially those with a restricted access to such services, and drug using prison inmates²⁸⁶). Only 27.7% of the respondents with a record of heroin use/addiction treatment are aware of methadone substitution treatment programmes, 18.1% of detoxification, 9.9% of psychological care/counselling and 20.7% of harm reduction programmes.

In this context, a strategic intervention model should be developed to improve these services, through three courses of action:

- including resources to promote systematically and efficiently existing services among potential beneficiaries and to evaluate their needs of new services (need assessment, surveys on service knowledge/accessibility etc);
- progressively develop a range of services and gradually extend existing services in more penitentiary units and guide them towards reaching long-term therapeutic goals (correlation with information and after-release social reinsertion services);
- coordination and integrated management of the two courses of action to increase access to services for the inmates who report having used these services prior to detention following heroin use. These people should be monitored in detention also so as to ensure continuity and efficiency of initial treatment measures.

As shown in policy and legal documents and in the actual steps taken, NAP proved openness and receptiveness towards all institutional partners, public or private, who started activities to know, evaluate and interpret drug use issues among prison inmates and, in addition, took further coherent and flexible steps, supported by national and international technical assistance to comply with the needs, requirement and limitations, that are specific for the penitentiary system.

²⁸⁵ European Network on Drugs and Infections Prevention in Prisons (ENDIPP)

²⁸⁶ Of the joint statement of the participants to the 9th edition of the European Conference on drug prevention monitoring and harm reduction in prison settings, organised by ENDIPP, October 5-8, 2006

Chapter 12 – Drugs users with children (addicted parents, parenting, child care and related issues)

As evidenced in studies, children with drug using parents tend to undergo more physical and psychological problems and are more likely to use drugs later, as compared to children whose parents never used drugs. Specialists state that school dropout and juvenile delinquency is higher among children with drug using parents than children whose parents never used drugs. On the other hand, parental styles of drug using parents are contradictory and lead to numerous education dysfunctions. To this aim, the studies indicate links between drug use among parents and their inefficiency in setting rules of conduct for their children. In addition, drug use among parents may lead to the lack of sustained and consistent affective family bonds, as these parents tend to take away from their children the necessary affection for a normal emotional development. These types of parental style may have consequences that will later bring about desadaptative behaviour in children, evidenced in emotional liability (anxiety, depression, and low self esteem), hostility, attention disorders, irritability and aggressiveness. At the same time, children of drug using parents are very likely to replicate the parental models they were subject to in childhood and become drug users themselves.

Another aspect of drug use among parents is present among drug using pregnant women, as the drug use affects both the mother and the new born.

Drug related infectious diseases are another component of drug use among parents. The higher intimacy is between infected and non-infected people, the higher is the probability of HBV, HCV and HIV infection transmission. Increased intimacy is more likely to occur between family members, which could enable disease transmission.

All the above emphasises the need for an approach of both the needs and problems of drug users who have children.

12.1 SCOPE OF PHENOMENON

12.1.1 Prevalence and epidemiologic characteristics of addicted parents

12.1.1.1 Research data

The general population survey²⁸⁷ also intended to capture the social-demographic features of drug users and among them the social risks in children following drug use among parents. The main findings will be presented in terms of prevalence and epidemiologic characteristics of drug using parents, as well as the consequences drug use among parents has on children.

Housing conditions

Over a third (34.8%) of the survey respondents have children under the age of 14 in their household:

- 13.9% have children of 6 year old and less;
- 15.3% have children in the age group 7-14;
- and 5.6% have children in both age groups.

Table no. 12-1: Respondent distribution by number of children in household (%), GPS 2010

No. of children	Of whom:		total
	6 year old and less	7 - 14 years of age	
1 child	13.4	15.7	20.9
2 children	3.1	4.5	9.7
3 children and more	0.5	1.0	4.2
Total	17.0	20.8	34.8
No children	83.0	79.2	65.2
Total	100	100	100

Source: NAA

²⁸⁷ See chapter 2

The results of the national survey in the general population (15-64 years) shows large rated of users:

- among subjects with children than no children for: lifetime tobacco use (58.8% vs. 56%) and use of solvents/sniffing glue/inhaling substances (0.3% vs. 0.1%) and current use (last 30 days) of alcohol up to drunkenness (10.8% vs. 9.7%).
- Among subjects with children of 6 years old and less than no children of 6 years old and less for the lifetime use of: tobacco, alcohol, cannabis, opiates, hallucinogens and solvents/sniffing glue/inhaling substances and the current use, abuse of alcohol up to drunkenness
- Among subjects with children aged 7 to 14 years than no children in primary education for lifetime use of: tobacco, amphetamines, solvents/sniffing glue/inhaling substances and the current abuse of alcohol.

Table no. 12-2: Respondent distribution by the use of psychoactive substances and children (parenthood), GPS 2010

prevalence	Subjects with children		Of whom			
	Yes	No	Subjects with children <=6 yrs		Subjects with children 7-14 yrs	
			Yes	No	Yes	No
smoking_lifetime	58.8%	56.0%	61.7%	55.9%	57.7%	56.7%
alcohol_lifetime	78.7%	80.0%	80.8%	79.4%	77.2%	80.3%
Alcohol abuse (drunkenness) _lifetime	30.3%	31.6%	30.3%	31.6%	30.7%	31.3%
Alcohol abuse (drunkenness) _last 30 days	10.8%	9.7%	10.5%	9.9%	12.0%	9.4%
total illicit drugs	4.0%	4.1%	5.2%	3.8%	2.9%	4.4%
total drugs (including medication)	6.8%	9.0%	7.2%	8.5%	6.2%	8.9%
Cannabis use_lifetime	1.6%	1.6%	1.9%	1.5%	1.1%	1.7%
Opiate use (heroin+methadone) _lifetime	.3%	.3%	.5%	.3%	.2%	.4%
Amphetamine use_lifetime	.1%	.1%	0	.1%	.2%	.1%
Ecstasy use _lifetime	.6%	.8%	.5%	.8%	.4%	.8%
Use of hallucinogens (LSD + mushrooms+ketamine) _lifetime	.1%	.1%	.3%	.2%	.2%	.2%
Cocaine use _lifetime	.1%	.3%	.3%	.3%	.0%	.4%
Use of sedatives, tranquillisers or anti-depressants without medical prescription_lifetime	3.1%	5.1%	2.5%	5.0%	3.5%	4.7%
Use of solvents/sniffing glue/inhaling substances _lifetime	.3%	.1%	.3%	.2%	.4%	.1%
Use of SNPP _lifetime	1.7%	2.1%	1.6%	2.0%	1.5%	2.0%

Source: NAA

Education level among children

Although for children aged 7 to 14 years, education is compulsory, 6.1% of the respondents have children aged 7 to 14 the respondents do not attend any form of education.

Table no. 12-3: Respondent distribution with children aged 7 to 14 by education level, GPS 2010

Children/young people in care aged 7 to 14	of which attend school		
	yes	no	Total
Yes	93.9%	6.1%	100.0%
No	.0%	100.0%	100.0%
Total	19.6%	80.4%	100.0%

Source: NAA

Psychoactive substance use among parents influences the education level of children. Thus, data show that the rate of children aged 7 to 14 and attend a form of education is lower in the case of children to parents who use tobacco and alcohol, both for lifetime and current use (in the last 30 days), as compared to parents that do not use tobacco nor alcohol.

Table no. 12-4: Respondent distribution by psychoactive substance use among parents and the rate of children aged 7 to 14 in care, who attend or not a form of education, GPS 2010

Psychoactive substance use among parents providing for children aged 7-14 years		Rate of children aged 7-14 years provided for, who attend a form of education or not		
		yes	no	Total
smoking_lifetime	Yes	92.9%	7.1%	100.0%
	No	95.2%	4.8%	100.0%
smoking _ in the last 30 days	Yes	92.2%	7.8%	100.0%
	No	94.8%	5.2%	100.0%
Alcohol use (beer, wine, vermouth, vodka, plum brandy or other spirit) _lifetime	Yes	93.3%	6.7%	100.0%
	No	96.0%	4.0%	100.0%
Alcohol use _ in the last 30 days	Yes	93.3%	6.7%	100.0%
	No	94.1%	5.9%	100.0%
Alcohol abuse (drunkenness) _lifetime	Yes	92.9%	7.1%	100.0%
	No	94.4%	5.6%	100.0%
Alcohol abuse (drunkenness) _ in the last 30 days	Yes	90.4%	9.6%	100.0%
	No	94.2%	5.8%	100.0%

Source: NAA

If the gender of parents is considered, there a higher share of children aged 7 to 14 provided for, that do not attend a form of education in case of:

- Mothers who smoked or used alcohol, illicit drugs, cocaine and sedatives, tranquillisers or anti-depressants without medical prescription at least once in lifetime, the rate reaching even 100% in the case of lifetime use of opiates and ecstasy;
- Fathers who have abused alcohol, smoked in the last 30 days, used alcohol and reached drunkenness;
- Parents of the young generation (15 to 34 years of age) who smoke and abuse alcohol (lifetime and current use) or have used alcohol, illicit drugs and amphetamines at least once (100%) and sedatives, tranquillisers or anti-depressants without medical prescription;
- Parents of the adult generation (35 to 64 years of age) with current alcohol use and lifetime cocaine use (100%).

Table no. 12-5: Respondent distribution by gender, age group and psychoactive substance use among parents and the rate of children aged 7 to 14 in care, who do not attend a form of education, GPS 2010

Psychoactive substance use among parents providing for children aged 7-14 years - YES		Rate of children aged 7-14 years provided for, who do not attend a form of education, by gender and age group of parents			
		male	female	15-34 years	35-64 years
smoking_lifetime	Yes	6.7%	7.8%	8.7%	6.2%
smoking _ in the last 30 days	Yes	8.0%	7.4%	8.9%	8.1%
Alcohol use (beer, wine, vermouth, vodka, plum brandy or other spirit) _lifetime	Yes	6.8%	7.1%	7.0%	6.5%
Alcohol use _ in the last 30 days	Yes	6.7%	6.6%	5.3%	6.7%
Alcohol abuse (drunkenness) _lifetime	Yes	7.3%	5.9%	8.7%	7.4%
Alcohol abuse (drunkenness) _ last 30 days	Yes	10.4%	0%	10.0%	9.4%
illicit drugs use (total) _ lifetime	Yes	0%	6.2%	8.3%	5.9%
Opiate use_ lifetime	Yes	0%	100%	0%	0%
Amphetamine use _ lifetime	Yes	100%	0%	100%	0%
Ecstasy use _ lifetime	Yes	0%	100%	0%	0%
Cocaine use_lifetime	Yes	0%	6.1%	0%	100%
Use of sedatives, tranquillisers or anti-depressants without medical prescription_lifetime	Yes	0%	8.3%	25.0%	7.7%

Source: NAA

In addition, by psychoactive substance use among parents connected with the education level and estimation of current household incomes, the share of children aged 7 to 14 provided for, that do not attend a form of education is higher in case of:

- Parents with a low education level and smokers (lifetime and current use) or use alcohol (lifetime and current use) or have used illicit drugs, amphetamines, sedatives, tranquillisers or anti-depressants without medical prescription once; parents with average education and abuse of alcohol (lifetime and current) or have use opiates at least once (100%);
- Parents who consider the level of household incomes is low and used illicit drugs, opiates (100%) and sedatives, tranquillisers or anti-depressants without medical prescription at least once; those who consider the level of household incomes is average and smoke or use alcohol as well as those who consider the level of household incomes is high and are currently using tobacco, abusing alcohol or have used amphetamines at least once.

Table no. 12-6: Distribution by education, estimation of household incomes and the psychoactive substance use among parents and the rate of children aged 7 to 14 in care, who do not attend a form of education, GPS 2010

Psychoactive substance use among parents providing for children aged 7-14 years - YES		Rate of children aged 7-14 years provided for, who do not attend a form of education, by education level of parents (respondents) and estimation of current household incomes					
		Education level of parents (respondents)*			estimation of current household incomes**		
		low	average	high	low	average	high
smoking_lifetime	Yes	7.9%	5.5%	6.1%	7.3%	8.0%	7.1%
smoking _ in the last 30 days	Yes	9.2%	6.2%	6.2%	8.2%	9.7%	20.0%
Alcohol use _ lifetime	Yes	7.5%	6.2%	4.8%	5.9%	9.4%	8.0%
Alcohol use _ in the last 30 days	Yes	6.7%	6.7%	3.4%	6.3%	9.8%	6.2%
Alcohol abuse (drunkenness) _lifetime	Yes	6.9%	8.2%	.0%	7.1%	4.3%	11.1%
Alcohol abuse (drunkenness) _ last 30 days	Yes	10.3%	13.3%	.0%	11.4%	.0%	25.0%
illicit drugs use (total) _ lifetime	Yes	9.1%	.0%	.0%	5.9%	.0%	.0%
Opiate use_ lifetime	Yes	6.8%	100.0%	.0%	100.0%	.0%	100.0%
Amphetamine use _ lifetime	Yes	6.8%	.0%	-	.0%	-	100.0%
Use of sedatives, tranquillisers or anti-depressants without medical prescription _lifetime	Yes	16.7%	.0%	.0%	10.0%	.0%	.0%

Note: * low level – no education+ primary ed. + secondary ed.+ vocational school + 1st stage of highschool, average level - highschool + pre-university or technical school, high level – short-term university/college + long-term university + post-university;** low level – not enough to cover basic needs + enough to cover basic needs, average level – enough for decent living, but we cannot afford expensive goods, high level - we can also afford expensive goods, with certain limitations + we can also afford expensive goods, without limitations.

Source: NAA

• Data resulted from the Drug treatment admission indicator

As shown by the data collected by Treatment admission indicator, some of the people admitted to drug treatment live with children, either together with partner and children or as single parents.

The situation of people admitted to drug treatment presented as follows live with children, but it should be mentioned that the analysis included only cases that “live alone with children” and those who live “with partner and children”, and besides them mothers/fathers with children in the category of those who live with their original family could also exist, especially for those who live only with children and no partner. In addition, the analysis makes reference to cases for which housing conditions are known. We should mentioned that case reporting for treatment admission has been made since 2009 only based on single codes, and double counting was as such avoided. The decrease of the number of people admitted to treatment in 2009 can be tracked back to the data collection system. Although, the number of people admitted to drug treatment from 2007 to 2008 does not generally follow a spectacular trend, the number of people living with partner and children increased drastically (almost 9 times more in 2008, as compared to 2007, with a rate of 7.9 of the total).

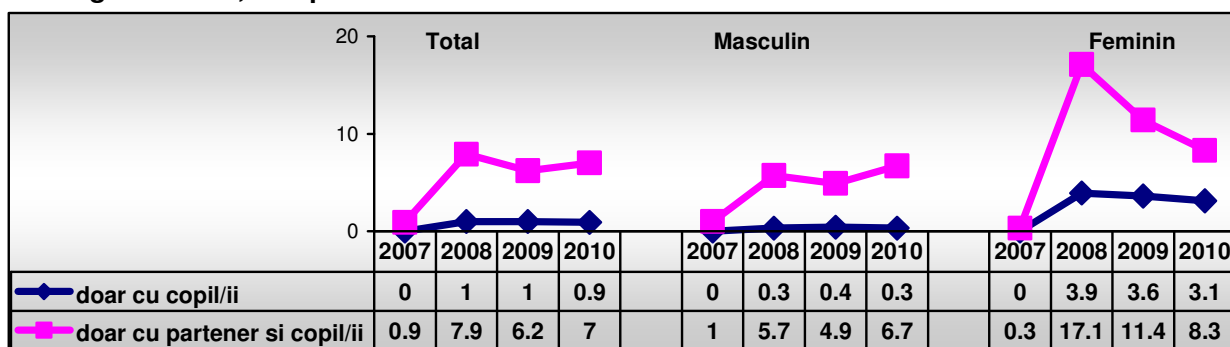
Table no. 12-7: Distribution of people admitted to drug treatment (illicit and licit) by housing conditions, comparison between 2007 and 2010

	Total				Male				Female			
	2007	2008	2009	2010	2007	2008	2009	2010	2007	2008	2009	2010
Single parents	0	20	17	20	0	5	5	5	0	15	12	15
With partner and children	17	156	104	151	16	90	66	111	1	66	38	40
Total	1891	1974	1689	2163	1539	1584	1354	1663	352	387	332	480

Source: NAA

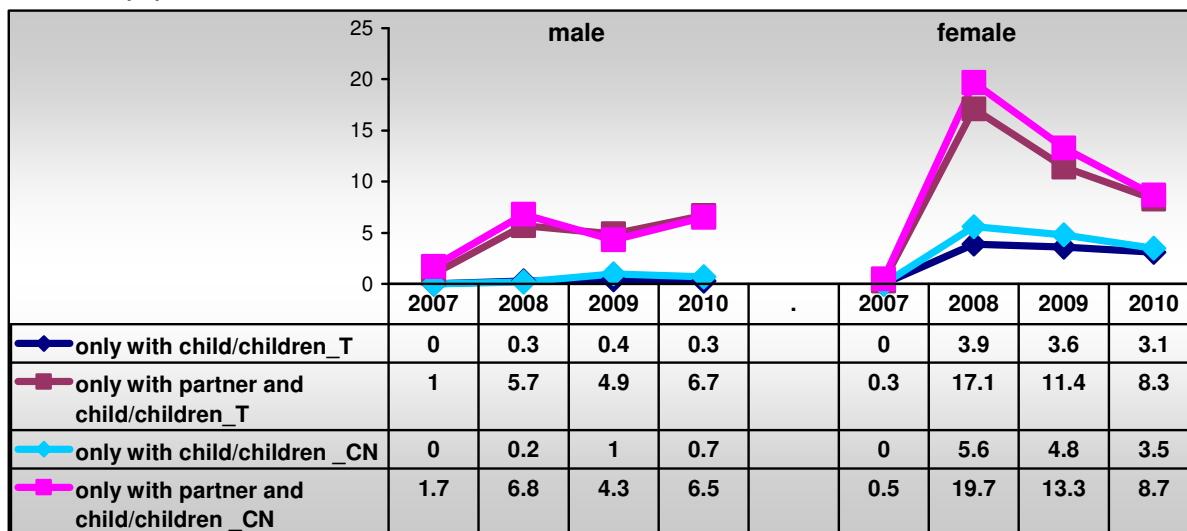
After a drop in the number of people admitted to drug treatment in 2009, the total number of people admitted to drug treatment and of those living with partner and children increased in 2010, although the share of latter are below the level recorded in 2008 (7.0% of the total number). Although most people admitted to drug treatment are male users, the share of those living as single parents, namely of those who live with children and partners, is generally lower than among female users.

Graph no 12-1: Trend of the rate of people admitted to drug use treatment (licit and illicit) by housing condition, compared data 2007-2010



Source: NAA

Graph no 12-2: Trend of the rate first drug treatment admission, by genders, compared data 2007-2010 (%)



Source: NAA

The gender distribution of the first drug treatment admissions shows people admitted to treatment for the first time live with children to a large extent (alone or with partner) and more female users who demanded treatment for the first time live with children (alone or with partner) than male users. After the increase in 2008 there is a decreasing trend of the share of people living with children (alone or with partner).

If the analysis is done only based on 2010 data, there are 88 people demanding treatment for psychoactive substances and living only with children, of whom half were alcohol users, a quarter sought drug treatment services (most of them for hypnotics and sedative use), while the rest demanded treatment for tobacco use. On the other hand, 1053 people demanded drug treatment in 2010 and are living with partner and children, of whom: almost half for alcohol use, more than a third for tobacco use and 14.3% for illicit drug use and SNPP (of whom half for opiate use).

Table no. 12-8: Distribution of people admitted to drug treatment (illicit and licit) by main drug of abuse and housing conditions, 2010

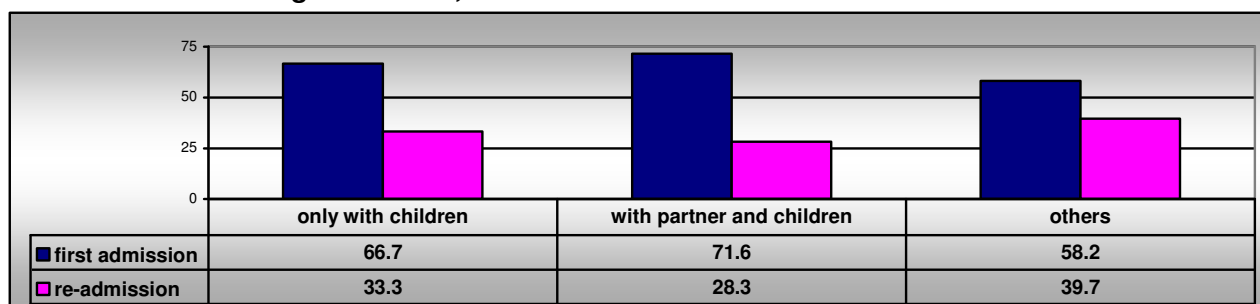
	Illicit drugs + SNPP				Tobacco and alcohol			
	Only with children	With partner and children	Other	Total	Only with children	With partner and children	other	Total
hypnotics and sedatives	8	30	84	122				
opiates	6	84	995	1085				
SNPP+other substances	6	32	549	636				
Other drugs (cannabis, cocaine, stimulants, hallucinogens, inhalants)	0	5	274	285				
alcohol					44	483	795	1322
tobacco					24	419	330	773
Total	20	151	1902	2073	68	902	1125	2095
%	1.0	7.3	91.8	100	3.2	43.1	53.7	100

Note: only for those for whom housing conditions are known

Source: NAA

The high rate of people admitted to treatment for alcohol use live only with children or with partner and children is a topic of concern given the social consequences of this type of use on children (e.g. violence, school dropout, financial problems etc) and it should underpin for treatment services for alcohol using parents. The extension of social care services provided to their children should also be considered.

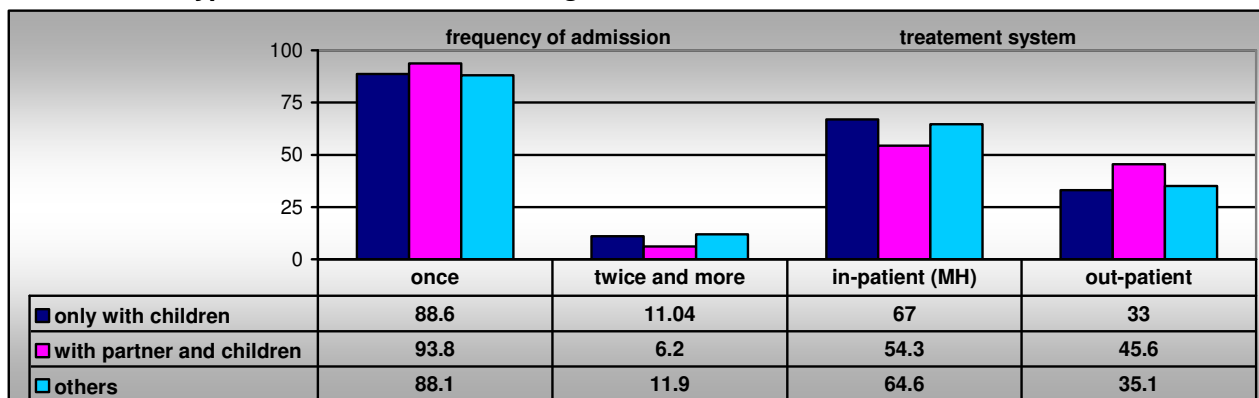
Graph no. 12-3: Distribution of people admitted to drug treatment (illicit and licit) by type of admission and housing conditions, 2010



Source: NAA

The distribution by type of admission – first admission and re-admission – shows of the total treatment admission in 2010 and are living only with children, 2/3 are first admissions, while for treatment admissions in 2010 and people who are living with partner and children, there is a 71.6% of first admission. As for the number of treatment admissions in 2010, although single admissions are much higher than re-admissions, both for people who live only with children and those who live with partner and children; however, there is a high rate of people who are living only with children and were admitted to treatment more than twice, as compared to those who are living with partner and children.

Graph no. 12-4: Distribution of people admitted to drug treatment (illicit and licit) by frequency of admission, type of treatment and housing conditions, 2010



Note: people in treatment in prison units make up for the rest to 100%

Source: NAA

In addition, more people admitted to treatment in 2010, who are living with partner and children, have demanded out-patient treatment as compared to people admitted to treatment who are not living with children (45.6% as compared to 35.1%).

Table no. 12-9: Distribution of people admitted to drug treatment (illicit and licit) by referral source and housing conditions, 2010

Referral source	Only with children	With partner and children	other	Total
Emergency services	39.8	29.4	27.2	28.0
Personal choice	35.2	50.0	37.5	40.6
Family practitioner. primary care	10.2	8.2	11.3	10.5
Psychiatry service +psychological care service + specialised drug service	6.8	3.5	5.8	5.3
Social work service		0.3	0.4	0.4
family/ friends	3.4	3.8	7.2	6.3
court/lawyer/prosecution office/police/probation service/legal medicine institute	3.4	3.7	8.3	7.1
others/not specified	1.1	1.0	2.1	1.8

Source: NAA

Most of the people admitted to treatment, who are living with children or partner and children, are referred by emergency medical services, come on their own choice, or by referral from family doctor, while referral from social care services is very low.

The gender distribution of people admitted to treatment in 2010 and who are living only with children or partner and children shows: there are more women than men among single parents admitted to treatment, and three times more women than those admitted to treatment against the total population admitted to treatment (65.9% as compared to 22.5%) while male users tend to prevail among people living with partner and children (76.4%).

Table no. 12-10: Distribution of people admitted to drug treatment (illicit and licit) by gender and housing conditions, 2010

gender	only with children	with partner and children	others	Total
male	34.1%	76.4%	79.1%	77.5%
female	65.9%	23.6%	20.9%	22.5%
Total	100.0%	100.0%	100.0%	100.0%

Source: NAA

The age distribution of people admitted to treatment and do not live with children shows:

- Average age is higher among people living with children and those who live with partner and children (51 years of age among those living only with children, 44 years of age among those living only with partner and children as compared to 35 years of age among those not living with children);
- By type of main drug of abuse, the average age of people living only with children and those living only with partner and children is higher for opiate, hypnotics and sedative users, as compared to those who have different housing conditions;
- As compared to the average age upon treatment admission, the average age of people in out-patient treatment is higher for people living only with children and those living only with partner and children as compared to the average age of all in-patient treatment admissions – 30.9 years, namely out-patient treatment – 26.4 years.²⁸⁸

Table no. 12-11: Distribution of people admitted to drug treatment (illicit and licit) by gender and housing conditions, 2010

age		Only with children	With partner and children	Other case
Hypnotics and sedatives	average	61.1	50.6	52.0
	minimal	46	34	20
opiates	average	35.8	32.2	27.9
	minimal	20	22	16
SNPP+other substances	average	55.3	45.3	28.6
	minimal	25	25	12
cannabis + cocaine+ stimulents +hallucinogens+inhalants	average		29.8	23.1
	minimal		25	11
alcohol	average	54.2	48.3	46.7
	minimal	22	20	13
tobacco	average	45.3	41.1	39.9
	minimal	29	18	16

Source: NAA

There is a low education level among people admitted to treatment in 2010 and who are living only with children, most of them (50.4%) having completed primary, secondary and vocational studies. 6.8% have never attended school or have not completed primary education, with higher rates than the total population admitted to treatment in 2010 (3%). Considering these people are living only with children, the low level of education may cause a reduction of education and social prospects among their children. 44.5% of the people living with partner and children have a better education level namely have completed primary, secondary or vocational studies, and over a third completed high-school and pre-university studies (37.1%).

Related to the route of administration of the main drug, 70% of people admitted to treatment following illicit drug use and SNPP live only with children and use drugs orally, while a fourth of them inject drugs.

52.7% of those living only with partner and children inject drugs while only 37.7% use illicit drugs and SNPP orally. These drug use practices evidenced among drug and SNPP users indicate high risk for their children.

The analysis of the drug related epidemiologic risks children to drug using parent may be exposed to, by serologic status to HIV, HBV and HCV, as illustrated by Treatment admission data in 2010, shows the following:

- None of the people admitted to treatment who are HIV positive, is living with children;

²⁸⁸ See chapter 5 – Treatment admission

- HCV prevalence among people admitted to treatment who are living with children or only with partner and children is higher among SNPP and illicit drug users than the total people admitted to treatment for this type of use: 44.4% HCV positive status among people living only with children, 31.9% HCV positive status among people living with partner and children, 31.7% HCV positive status of the total people admitted to treatment; similar situation is recorded for HBV among people living with partner and children: 4.8% HBV positive status as compared to 4.6% HBV positive status among people admitted for this type of treatment.

Table no. 12-12: Distribution of people admitted to drug treatment (illicit and licit), by serologic status of HIV, HBV and HCV infections and housing conditions, 2010

Type of drug	serologic status	Housing conditions			
		Only with children	With partner and children	Other case	Total
illicit drug and SNPP	status_HIV positive	0.0%	0.0%	1.7%	1.6%
	status_HVB positive	0.0%	4.8%	4.6%	4.6%
	status_HVC positive	44.4%	31.9%	31.6%	31.7%

Source: NAA

12.1.2 The risks of children of addicted parents

One of the most important drug related issues among parents is drug using mothers who often give birth to drug-addicted children. In addition, they account for the majority of the cases of medical-psychological-social pathology and are prone to development disorders, both cognitive and somatic, nourishing problems and excessive irritability.

On the other hand, specialists state that infant mortality is higher among new-born to mothers who use drugs. Expert opinions have shown drug use during pregnancy increases the risk of congenital malformation, premature birth, and underweight at birth or even miscarriage.

Drug use is also linked to high morbidity and mortality among new-born and exposes mothers and their unborn children to risks, especially in case of injected use, such as HIV, HCV and HBV transmission as well as other infectious diseases (syphilis). Children to drug using mothers usually present neonatal withdrawal that can last from one week to 1 month.

A phenomenon that was unheard of 15 years ago (the first chronic intoxications to opiates in Romania can be tracked back to 1995), drug use had direct consequences on the drug users but can also affect the health and social insertion of the new born. Thus, against the increasing drug use in Romania after the revolution the first cases of new-born to drug using mothers appeared and neonatology specialists started dealing with a new issue of diagnosing and selecting a therapeutic option adjusted to the situation. Apart from the medical issues, social issues appear, as many new-born are abandoned in hospital by their mothers.

The increasing frequency of new-born to drug using mothers and the impact of drug use on the new-born increased concern among specialists of the Neonatology Service of the Gynaecology - obstetrics Unit „Gheorghe Polizu” within the Institute for Mother and Child Care „Prof. Dr. Alfred Rusescu” – who have conducted several studies in the field since 2003.

Based on the data gathered from 2000 to 2002, the findings of the first retrospective study of this type were made public in Romania under the title “*The seduction of drugs and the medical-social impact on the new-born*”. Three years later, the second study “The new born at risk following a pregnancy dominated by drug addiction” was presented in the conference “Risks of drug use in mothers and children”²⁸⁹, with data gathered from 2000 to 2004.

Building on the conclusions of previous studies, a scientific communication “*Ethical aspects of the treatment of new born from pregnancy dominated by drug addiction – Parent responsibility*” was made

²⁸⁹ Organised by the National Anti-drug Agency and Administration of the 2nd district, Bucharest

in the National Neonatology Congress²⁹⁰ in 2011 in which the ethics of the approach to drug using mothers and their children is being tackled for the first time.

The findings of the research and the clinical experience prompted the specialists of the Neonatology Service²⁹¹ of the Gynaecology-obstetrics Unit „Gheorghe Polizu” within the Institute for Mother and Child Care „Prof. Dr. Alfred Rusescu” to make an inventory of the risks of psychoactive substance abuse on pregnancy and to disseminate among neonatology specialists in Romanian the clinical scale (FINNEGAN) used in assessing the severity of withdrawal and selecting the therapeutic option.

Table no. 12-13: Risks of the abuse of psychoactive substances during pregnancy

PRODUCTS	Pregnancy risks	Embrional risks	Foetal risks	Neonatal risks
Alcohol	fake spontaneous contractions	Foetal alcoholism syndrome with foetal disorders	Intrauterine growth retardation ²⁹²	Withdrawal Mental retard
Amphetamines Lsd	fake spontaneous contractions Premature birth reactions Retroplacental hematoma	Malformations: cardiovascular digestive	Intrauterine growth retardation Chronic foetal pain Intrauterine foetal death	Need of gavage
Benzodiazepines	No significant risk	Rare malformations	Foetal movement retardation	respiratory distress, apnia, hipothermia etc. Withdrawal
Cannabis		no malformations	Intrauterine growth retardation	Prematurity Underweight at birth hyperactivity (30 days)
Cocaine	fake spontaneous contractions Premature birth reactions	Malformations microcephaly cardiovascular of the urinary tract	Intrauterine growth retardation Chronic foetal pain	Prematurity Underweight at birth Intracranial haemorrhage
Heroin	fake spontaneous contractions Premature birth reactions	Malformations	Intrauterine growth retardation Chronic foetal pain	Prematurity Underweight at birth Withdrawal Intracranial haemorrhage
Methadone	The same as in the case of heroin but more seldom	The same as in the case of heroin	Intrauterine growth retardation	Prematurity Underweight at birth Withdrawal

Source: IOMC-POLIZU

A Data collection methodology on drug using mothers was formulated based on the collaboration protocols concluded between the National Anti-drug Agency, Institute for Mother and Child Care and Neonatology Association in Romania that should be applied in all 2nd and 3rd level neonatology and obstetrics-gynaecology as part of a national study called “Drug using parents” that will be conducted starting with 2010. Thanks to the pioneer work of the specialists of the Neonatology Service²⁹³ of the Gynaecology-obstetrics Unit „Gheorghe Polizu” within the Institute for Mother and Child Care „Prof. Dr. Alfred Rusescu” among the cases of drug using mothers that have been identified in this medical unit in time, several information on mothers and new born could be easily found due to this methodology.

²⁹⁰ September 15-16, 2011, Iasi

²⁹¹ univ. prof. dr. Silvia Maria Stoicescu and dr. Doina Broscăncianu

²⁹² Intrauterine growth retardation) - RCIU is the case in which the foetus cannot reach ideal growth potential

²⁹³ univ. prof. dr. Silvia Stoicescu and dr. Doina Broscăncianu

A summary of the pilot-study based on this methodology and data collected in the IOMC-POLIZU is presented below. We should mention retrospective data have been included, and some variables included in research were not available in the medical file. Although not recommended by methodology (because the two periods of time are not equal), the comparison of collected data from 2000 to 2004 was meant to guide towards confirmation or invalidation of certain theories. The analysis and interpretation of data, included in the pilot study, were performed in partnership by the specialists of the Neonatology Service (IOMC) and the Romanian Monitoring Centre for Drugs and Drug Addiction (NAA).

Research aim

- Reduce the medical social impact of illicit drug use on the new born

Study goals

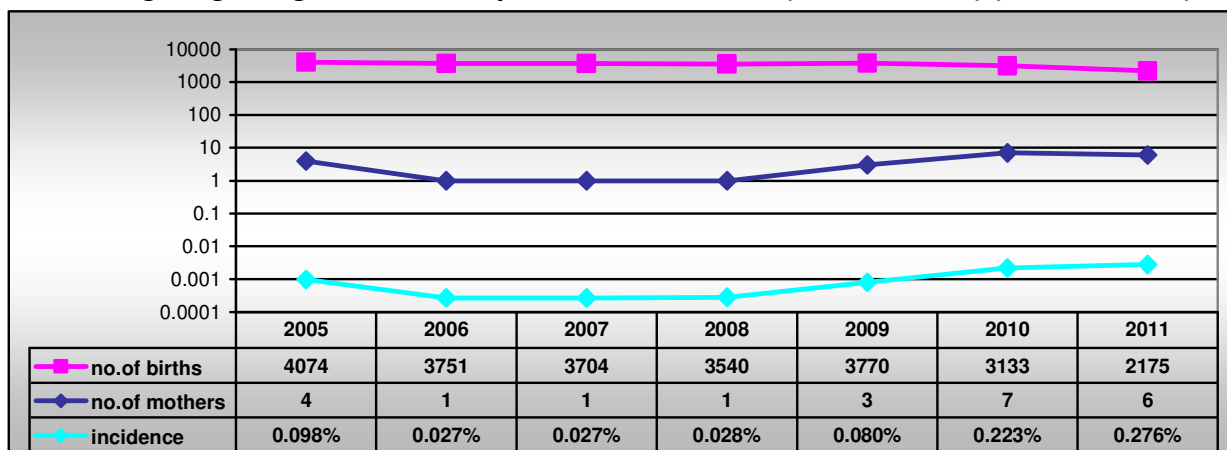
- Identification of foetal and neo-foetal risks of drug-addiction among mothers;
- Application of correct attitude during neo-natal period in line with European experience of countries dealing with the same problem;
- Support and creation of a professional team for a drug-addiction unit for the intake, evaluation (medical, psychological and social problems), referral (in the network), treatment, research, education

Methodology

- Retrospective study
- New born from 2005 to 2011 (first 8 months)
- Case investigation was performed based on:
 - *anamnesis* of pregnancy and birth;
 - *clinical examination* of new born – evaluation by “FINNEGAN” scale;
 - urine *toxicological* analysis of new born and mothers;
 - *analysis* of serologic, bacteriologic, biochemistry, and X-rays data
 - *psycho-social research* made by two social workers and maternity psychologist.

Outcomes

Graph no. 12-5: Progress of number of births, of drug using mothers and incidence of new born among drug using mothers, compared data 2005-2011 (first 8 months) (no.of cases %)



Source: IOMC-POLIZU

1. Scope of analysed problem:

23 cases of newborn children to drug using mothers were recorded by the Neonatology Service of the Gynecology-obstetrics Unit „Gheorghe Polizu” within the Institute for Mother and Child Care „Prof. Dr. Alfred Rusescu” from 2005 to 2011 (first 8 months).

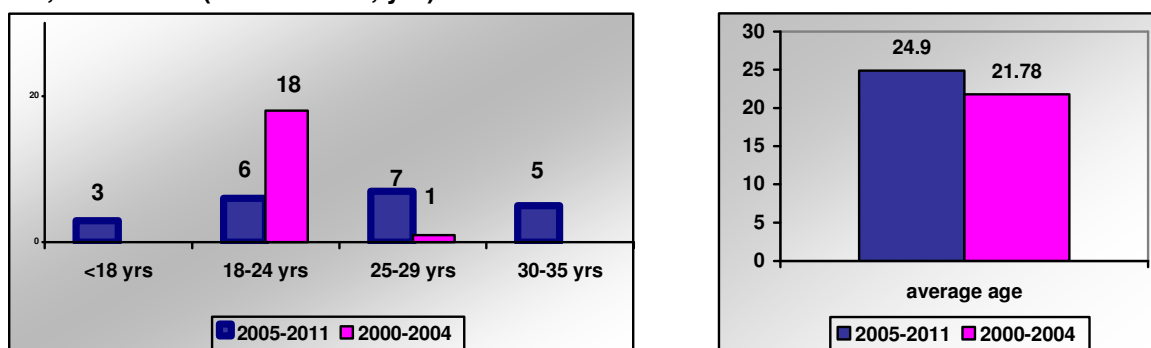
By comparing this number to the total number of births recorded in the same period of time by IOMC, there is a 0.11% average incidence, which also represents a significant increase for the last two years (0.223% in 2010 and 0.276% in the first 8 months of 2011).

2. Social-demographic and medical features of drug using mothers

Age:

- The age of drug using mothers included in the analysed sample ranges from 14 to 35, the most frequent age ranging from 18 to 29 (13 in 23 cases recorded from 2005 to 2011)
- 19 is the modal age value;
- 27 is the mean age;
- The average age of drug using mothers is 24.90 years, by 3.12 years higher as the age illustrated from previous research (21.78 in the time period 2000-2004).

Graph no. 12-6: Age distribution of drug using mothers and average age, compared data 2000-2004, 2005-2011 (no. of cases, yrs)

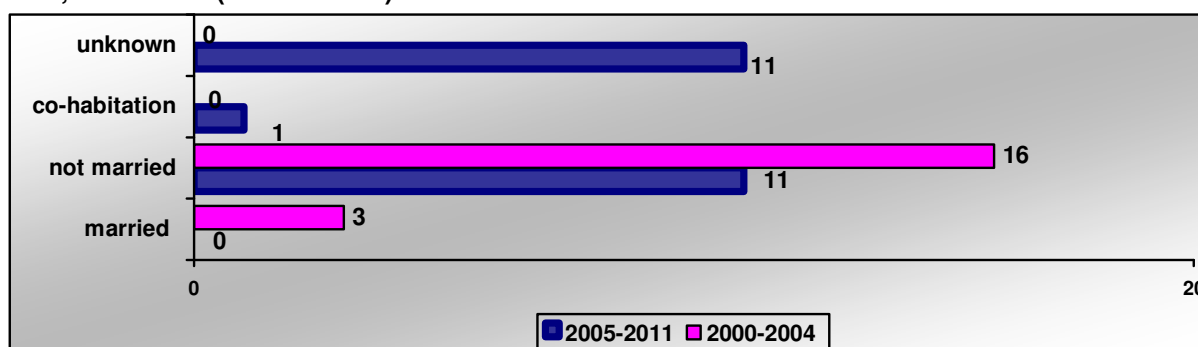


Source: IOMC-POLIZU

Marital status

Although marital status data was not available for all cases, most drug using mothers are not married (11 cases), and cohabitation was mentioned in one case only. As compared to 2000-2004 data, the not married women prevail among drug using mothers and there is an absence of married mothers (3 cases from 2000 to 2004).

Graph no. 12-7: Distribution of drug using mothers by marital status, compared data 2000-2004, 2005-2011 (no. of cases)

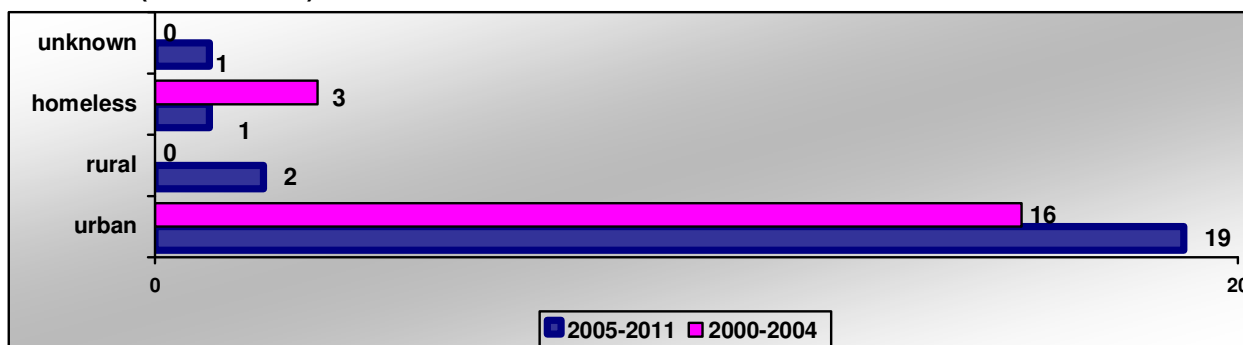


Source: IOMC-POLIZU

Residence

Most drug using mothers are from urban settings (19 cases), but unlike the period 2000-2004 there were also 2 cases of rural origin. At the same time, there is a decrease of drug using mothers without housing (so-called "homeless").

Graph no. 12-8: Distribution of drug using mothers by residence, compared data 2000-2004, 2005-2011 (no. of cases)

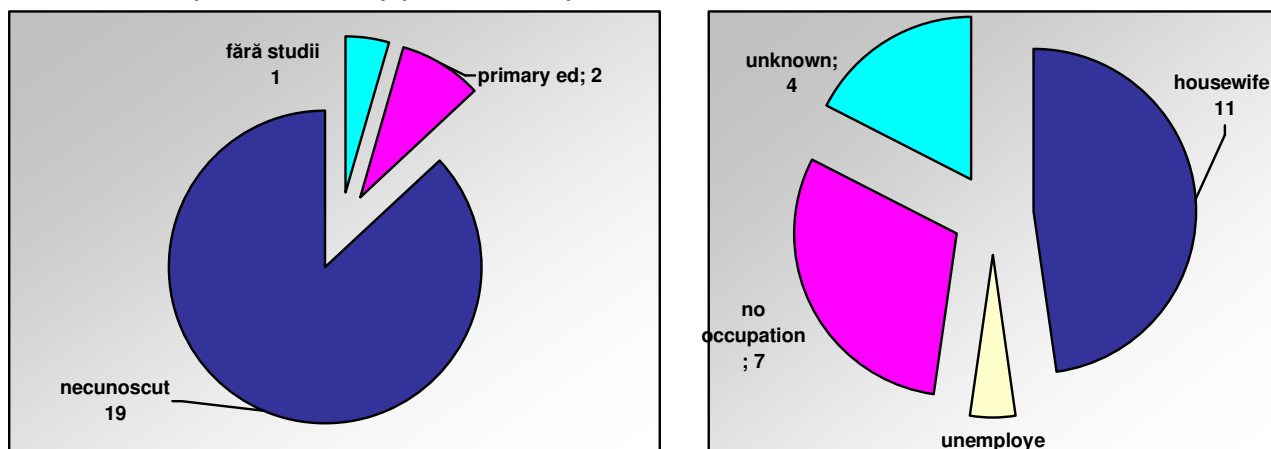


Source: IOMC-POLIZU

Education and professional status

Alike the marital status variable, there were several data missing for the education level among the cases included in the survey (19). Considering existing data, 2 of the drug using mothers completed primary education and one never attended school. The occupational status shows most drug using mothers do not have personal incomes: 11 are housewives, while 7 have no occupation and one is unemployed. Economic inactivity and low education (resulting most often in unstable economic status) linked to the other medical, psychological and social issues caused by drug use during pregnancy, increase the risks the new-born are exposed to. On the other hand, low education affects the access of the mother to information of the risks of drug use in general and on the unborn and newborn, which can lead to continued drug use during pregnancy and resumption of drug use during future pregnancies.

Graph no. 12-9: Distribution of drug using mothers by education and occupation, compared data 2005-2011 (first 8 months) (no. of cases)

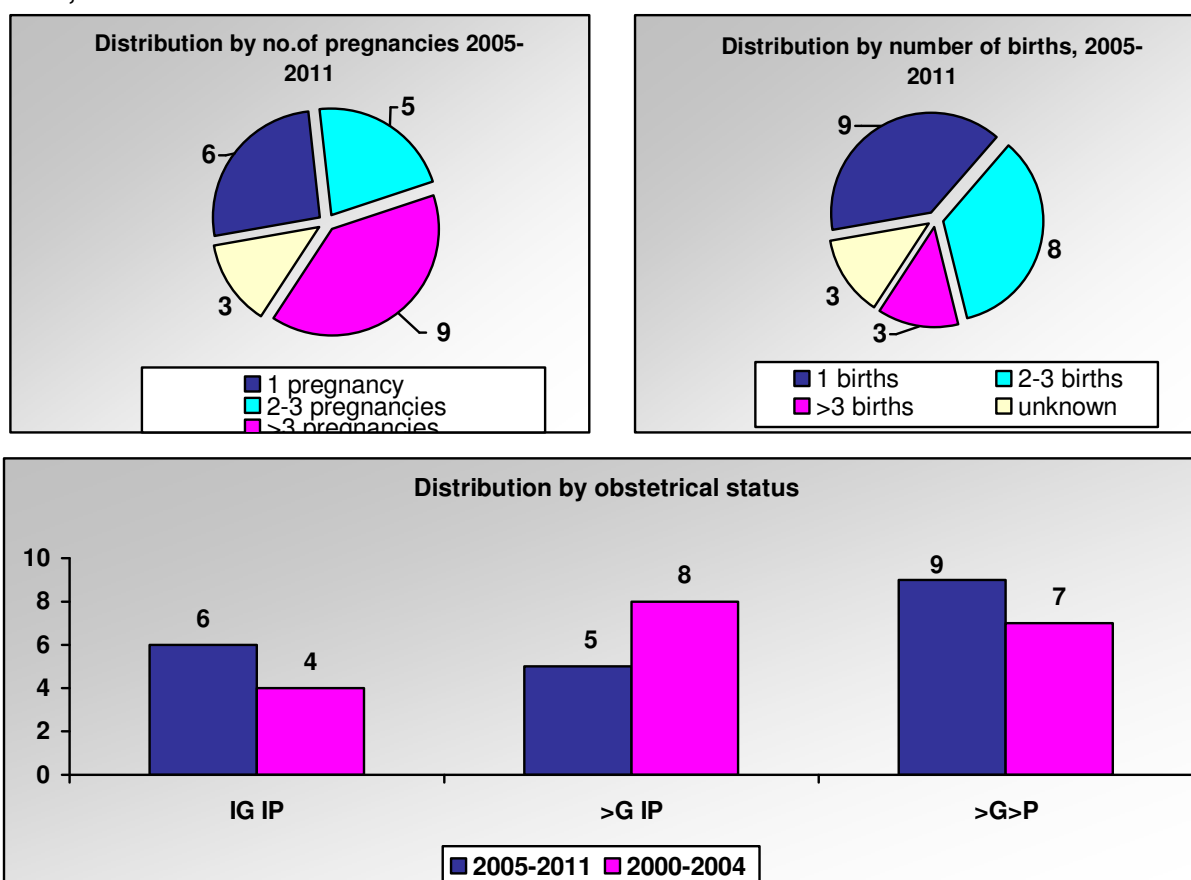


Source: IOMC-POLIZU

Obstetrical record

Case distribution by obstetrical record shows: over two thirds of drug using mothers has over three pregnancies (9 cases), almost a fifth had 2 to 3 pregnancies (5 cases) while a fourth experienced their first pregnancy (6 cases). The number of births shows that: the number of mothers giving birth for the first time prevails (9 cases), a third gave birth for the second or third time (8 cases) while the number of mothers giving birth more than 3 times is low (3 cases). A classification by obstetrical status, namely first pregnancy, first birth (*IG IP, primigesta-primipara*), several pregnancies, first birth (*>G IP, multigesta-primipara*), several pregnancies, several births (*>G >P, multigesta-multipara*) indicate a prevailing number of mothers with several pregnancies and several births (9 cases) followed by *primigesta-primipara* (6 cases) and *multigesta-multipara* (5 cases).

Graph no. 12-10: Distribution of drug using mothers by number of pregnancies, number of births, obstetrical status



Note: IG IP – primigesta, primipara, >G IP – multigesta, primipara, >G >P – multigesta, multipara

Source: IOMC-POLIZU

Drugs used, route and frequency of administration

For most mothers included in the study heroin is the main drug of abuse (in 21 cases), of which 13 single use and 8 cases are poly-drug use: methadone (6 cases), morphine (1 case), new psychoactive substances (1 case). There are 2 more cases of amphetamine use in combination with other substances (methadone, ketamine, lidocaine, petidine and metamizol). The available data show most mothers administer the main drug by injection (11 cases). Drug use was continued by most mothers during pregnancy, only three stopped using in the last trimester of pregnancy, while 3 of them administered the last drug dose at least 12 hours before giving birth.

Health of drug using mothers

Over three quarters of drug using mothers show medical-psycho-social pathology (19 cases), and among recorded disorders are: sexually transmissible infections (syphilis, 6 cases), HCV infections (4 cases), psychosis (2 cases), attempted suicide (2 cases), scabies (1 case), pediculosis (1 case).

3. Features of new-born to drug using mothers

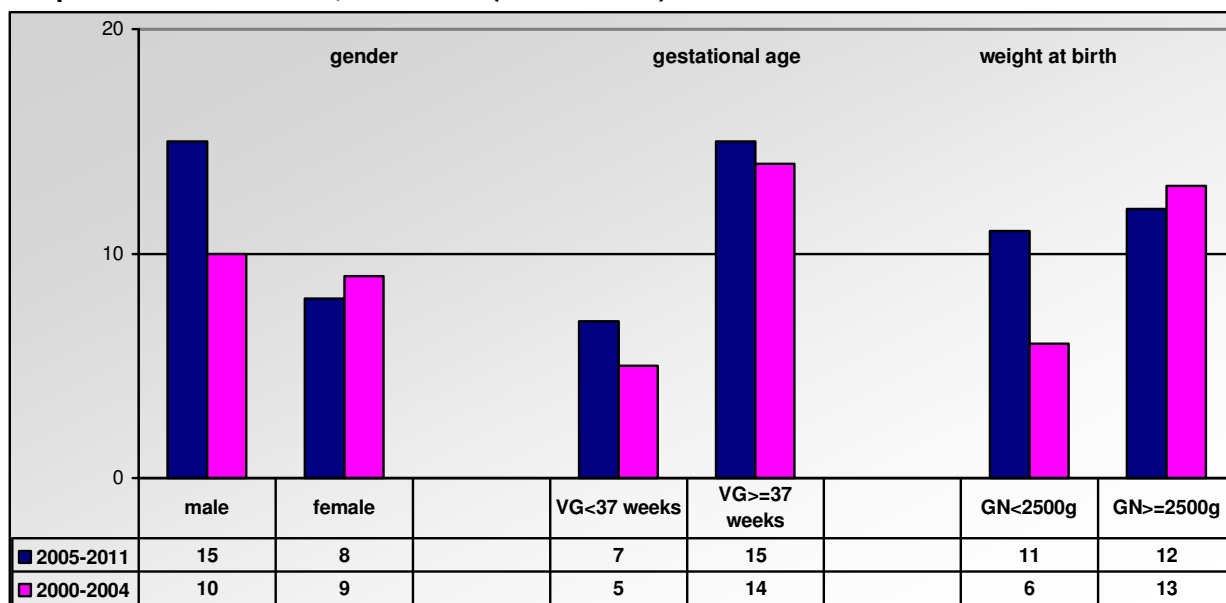
Gender

Most new born of drug using mothers are male (15 cases) similarly to the cases recorded from 2000 to 2004.

Gestational age

Two thirds (15 cases) of the new born were born prematurely, in this cases the pregnancy lasting over 37 weeks. The average gestational age was 36.9 weeks in the studied sample, a minimal age of 29 weeks and a maximum age of 42 weeks, which makes 38 the most frequent gestational age. As compared to the data collected from 2000 to 2004, there is an increase of the share of duly new born.

Graph no. 12-11: Newborn distribution by gender, gestational age, and weight at birth, compared data 2000-2004, 2005-2011 (no. of cases)



Source: IOMC-POLIZU

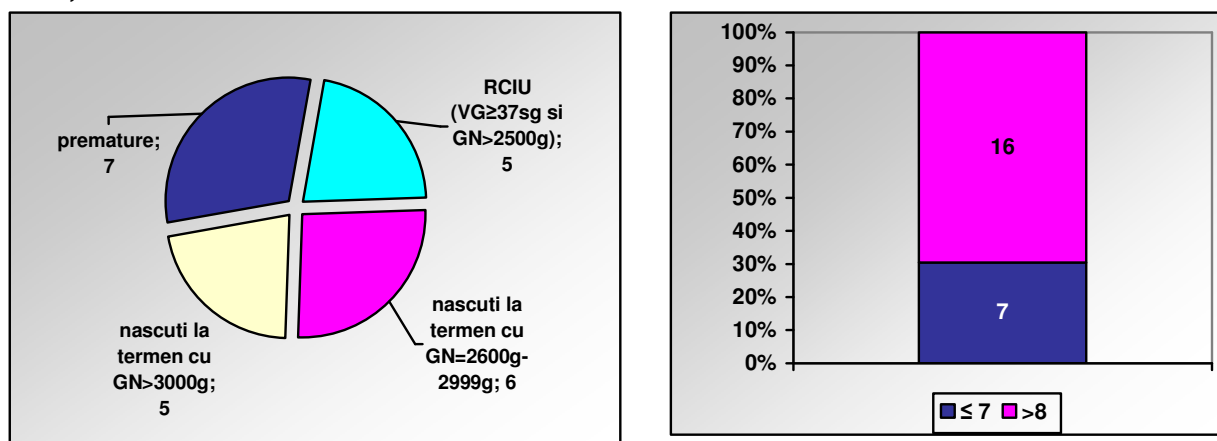
Weight at birth

Almost half of the new born weighted less than 2500 g (11 cases), the average weight was 2447.8 g, and the lowest was 900 g, the highest 3300 and the most frequent 1950 g.

APGAR scale²⁹⁴

Two thirds of the new born to drug using mothers recorded an APGAR scale over 8, the lowest scale was 4, and the highest 9.

Graph no 12-12: Newborn distribution by gestational age (VG) and weight at birth, by APGAR scale, 2005-2011



Source: IOMC-POLIZU

Morbidity and mortality

3 in 4 new born to drug using mothers experienced after birth at least one of the disorders: withdrawal, respiratory distress, haemorrhage, sexually transmissible infections, maternal-foetal infections, HIV and HCV infections. Most often (in 16 cases), withdrawal in new born was dominated by:

- *Neurological signs: tremor of member, sleeping disorders, agitation, screaming, hypertonia, hyperreflexia, convulsions in the first days of living;*

²⁹⁴ APGAR scale assesses the state of the new born right after birth, its capacity to adjust to extra uterine life

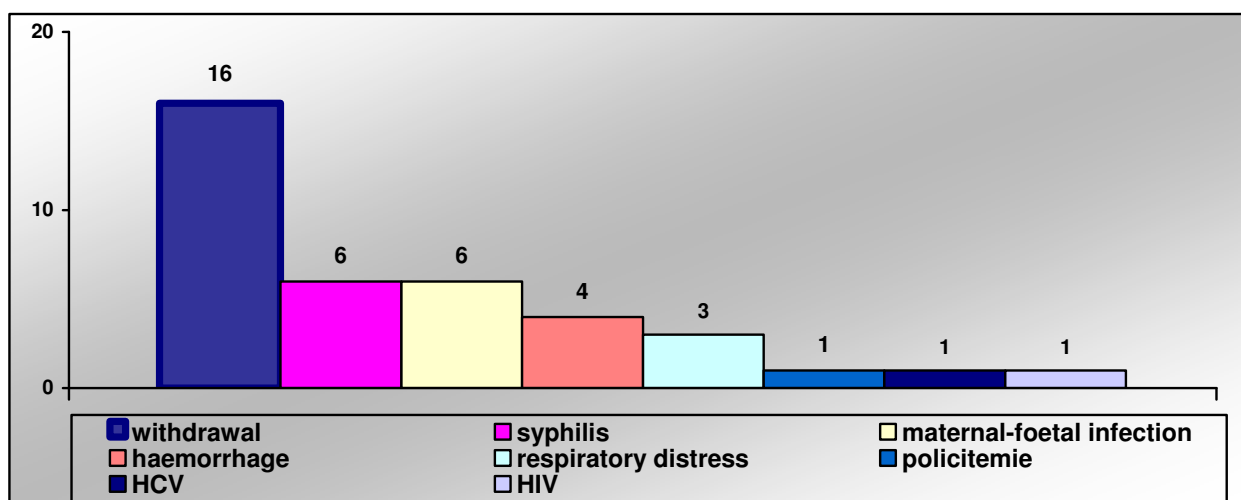
- *General signs* (fever), digestive disorders (vomit, diarrhoea), acute dehydration
- *Respiratory signs.*

Sexually transmissible diseases were also noticed (syphilis, 6 cases), maternal-foetal infections (6 cases, mainly E.coli), digestive haemorrhages (4 cases) and respiratory distress (3 cases).

Hospitalisation lasted on average 26.23 days, the shortest being 3 days and the longest 68 days. Nourishment of new born was done in only one case with human milk, in 2 cases with mixed sources and artificially in the rest of the cases.

In almost a fourth of the cases, the new born was abandoned in hospital, and was transferred to the social care services so it can be later integrated either in the origin family of the mothers or in a maternity centre. In one case, after escaping from hospital, one day after birth, the mother dies of an overdose.

Graph no. 12-13: Morbidity among new born to drug using mothers, 2005 - 2011



Source: IOMC-POLIZU

If morbidity data remains constant as compared to the time period 2000-2004, mortality data has shown improvements. If 3 deaths were recorded among new born to drug using mothers from 2000 to 2004 (premature death by pulmonary and intra-ventricular haemorrhage) no such case was recorded from 2005 to 2011. The experience gained by the neonatology experts within the Neonatology Service²⁹⁵ of the Gynaecology-obstetrics Unit „Gheorghe Polizu” within the Institute for Mother and Child Care „Prof. Dr. Alfred Rusescu” made a special contribution to the treatment and care of new born to drug using mothers.

Conclusions:

- There is a significant increasing incidence of new-born to drug using mothers in the last 2 years (0.223% in 2010 and 0.276% in the first 8 months of 2011), more than double the average incidence throughout the analysed period of time;
- Although there were cases of drug using mothers younger than 18 from 2000 to 2004, there is an overall increase of the average age of drug using mothers caused by the occurrence of mothers over 30. On the other hand, the number of drug using mothers under 18 should raise concern because of the high risk of social and health consequences among the population of very young women and their new born;
- The high rate of not married drug using mothers and absence of married ones may indicate high social risks for the new born, considering the integrating societal role of the family;
- Most drug using mothers have personal incomes or a low education level;
- Two in five mothers have had several pregnancies and births; one in four experienced her first pregnancy and birth; there is a change in the obstetrical status of drug using mothers from 2000 to 2004 among *multigesta-multipara* mothers and *primigesta-primipara* mothers that increase in numbers, while the number of *multigesta-primipara* mothers decreased;

²⁹⁵ univ.prof. dr. Silvia Stoicescu and dr. Doina Broscăuncianu

- Most mothers are opiate users (mainly heroin), use drugs by injection and continue using throughout pregnancy;
- Most newborn to drug using mothers are male; although most were duly born, almost half weighted less than 2500 g, a third were born prematurely (VG<37 sg and GN<2500g), and a fourth were cases of intrauterine growth retardation (VG≥37sg and GN>2500g);
- Over three quarters of the new born presented after-birth morbidity, and needed medical treatment over a hospitalisation term longer than normal;
- By contrast to the 15.7% of the gross rate of mortality recorded from 2000 to 2004 (3 deaths in 19 cases), there were no death cases from 2005 to 2011.

These results tend to confirm the theories related to the health risks posed by drug using mothers to newborn children. On the other hand, the need for prevention interventions is supported by the high hospitalisation costs for these children and the additional social risks they run after hospital discharge, which can be caused by a possible abandonment or the generally poor economic situation of mothers.

The authors of the study recommend multi-disciplinary teams be made (family doctor, obstetrician, neonatology specialist, paediatrician, anaesthesia specialist, infection disease specialist, dermatologist, immunologist, psychologist, psychiatrist, social worker) before, during and after the child is born, to ensure further normal development and social reinsertion of a child born after a drug use in pregnancy.

12.2 LEGAL CONTEXT AND POLICY

Prevention

The National anti-drug strategy²⁹⁶ for the period 2005-2012 includes specific targets in the field of family-based drug prevention, as follows:

- sensitizing and raising awareness and motivation of parents, for their active, objective involvement, correlated with the other areas of preventive intervention
- supplying drug prevention programmes allowing parents to become active in preventing drug use within the family;
- developing parent training programme in order to increase the influence of protection factors and decrease that of risk factors related to drug use.

In addition, the Action Plan to implement the National anti-drug strategy in the time period 2010-2012²⁹⁷, includes 6 activities out of the 84 activities of the demand reduction chapter that focus on reaching targets of family-based prevention:

- formulation and implementation of at least one local pilot-project of selective drug prevention (information or skill-building programmes) targeting families;
- implementation of a pilot-programme of basic addiction training of the professionals in the child care system that works with parents at risk (economically and socially disadvantaged families etc) of the abandonment prevention services, child abuse/neglect/exploitation prevention, residential services etc. in the directorates general for child social care and protection;
- implementation of a pilot-programme of basic addiction training and skills building for maternal assistants in the directorates general for child social care and protection;
- implementation of a national pilot-programme „Parent school“, through resource people;
- implementation of local prevention programmes for families with the aim of reducing risk factors and increasing family protection factors;
- implementation of a pilot-project of selective drug prevention, addressing parents who work in Spain, Italy, Germany, Great Britain, through a specialised chat service and provide information and family support in order to increase the influence of protection factors (mainly communication skills, decision making skills and emotional support etc).

²⁹⁶ Approved by GD no. 73 of January 27, 2005

²⁹⁷ Approved by Governmental Decision no. 1369 of 23.12.2010 approving the Action Plan for the implementation of the National Anti-drug Strategy 2010-2012

Medical care

The Order no. 1389/ 513/ 282 of August 4, 2008²⁹⁸ establishes the specific organisation and functioning criteria of a detoxification centre²⁹⁹ and the specific organisation and functioning criteria of opiate-based substitution treatment. This regulation mentions pregnancy as one of the criteria for substitution treatment inclusion. The order mentions that drug using pregnant women have priority in entering a substitution treatment.

Protection of children to drug using parents

The amendments of the Criminal procedure code through the Law no. 202 of October 25, 2010 on measures to speed up case settlement, for settling criminal cases involving underage people, in order for the psychiatric medical-legal expertise to be performed on the juvenile, a social investigation should be conducted by the liable authority for the area of the subject's residence³⁰⁰. The social investigation should cover the investigation of the family setting, the underage subject origin family, including data on substance use (alcohol, high risk drugs, psychotropic medication etc). In this manner, the evaluation of the circumstances leading to a criminal act by an underage offender also includes the negative influence of parent drug use on child behaviour.

12.3 SPECIFIC INTERVENTIONS FOR DRUG USING PARENTS

12.3.1 SPECIFIC SERVICES

Family-based tobacco, alcohol and drug use

A. National campaigns and projects

- ***Children do what they see*** – media campaign broadcast from November 12, 2003 to January 15, 2004, on national and local radio and TV stations, both public and private (but not necessarily market leaders in terms of national coverage). The social ad (audio and video) focused on the abuse of alcohol in the family and its effect on children and was intended to sensitise and increase responsibility among parents on the role they have in alcohol use prevention among children and young people. The campaign targeted a population aged 15 to 40, and the aim of the campaign was that 95% of the target population sees the ad at least three times. The campaign evaluation showed 1,990,000 (of 4,618,000 people-2003) of those aged 15 to 40, in the urban area, saw the ad at least once. Later, a new component was added to the programme which focused on: the participation of parents in alcohol prevention and information of young people of the risks of the use and abuse of alcohol. Posters were distributed in learning institutions, hospitals and public settings and 1,088 debates were conducted among pupils, students and teachers in 31 counties and 4 districts in Bucharest, while in 4 other counties competitions were organised on alcohol topics and involved mainly high-school students.
- In 2005, Save the Children Organization initiated a campaign for the prevention of drug use among young people. In 2006, the message of the ***Drugs Kill*** media campaign, which was implemented by the *Save the Children* Organization, was developed – *You can quit drugs if you allow yourself to be helped*, which was especially meant for parents.
- ***Alcohol and drug related risks among future mothers***– campaign implemented in the time interval 01.09.2006-15.03.2007 by the ANA. The project was addressed to a number of 800

²⁹⁸ Order no. 1389/ 513/ 282 of August 4, 2008 establishes the specific organisation and functioning criteria of a detoxification centre and the specific organisation and functioning criteria of opiate-based substitution treatment;

²⁹⁹ Detoxification centre – Minimum criteria regulating the staff structure and professional skills: the Centre has the following full-time staff: a psychiatrist, a psychologist, a social worker, nurses and medical aid. a) the physician has graduated a higher education institution and is licensed in medicine, psychiatry specialisation and a member of the Romanian College of Physicians b) the psychologist has graduated a higher education institution and is licensed in psychology or equivalent, has an individual practice certification for one of the professional specialisations: psychology, psychological and psychotherapy counselling, in line with current regulations. One psychologist is ensured for 6 to 8 beneficiaries. c) the social worker has graduated a higher education institution and is licensed in social work, is a member of the Social Workers' National College in Romania. There should be one social worker for 10 to 12 beneficiaries. d) the medical assistant is a member of the Medical assistants' College and has an individual practice certification. There should be one nurse for 6 beneficiaries. Nurses should be continuously present, and continuance should be ensured in shifts, according to the law. e) medium education nurse; there should be one nurse for 20 beneficiaries.

³⁰⁰ Law no. 202 of October 2010 on measures to enhance case settlement, art. XVIII, paragraph 15

mothers or future mothers in the records of the family planning medical units, of the family physicians, and of the gynaecology departments of the county hospitals. Throughout the development of the campaign at the national level, 921 doctors from the medical network were involved. There have been distributed 2933 brochures containing the summary of the National Convention from Bucharest, between June 2 – June 3 2006, and 18937 fliers on the effects of drug, tobacco and alcohol use on the foetus. The campaign was implemented by 40 Drug Prevention, Evaluation and Counselling Centres and it benefited from 108 appearances in the local media.

- The National Anti-Drug Agency in partnership with the ITSY BITZY radio station has developed from March 1 to June 30 2007 a campaign for the prevention of drug tobacco, alcohol and drug use, meant for the parents. The campaign consisted in promoting healthy lifestyle attitudes by the Agency psychologists and by the CPECA psychologists from Bucharest and Ilfov, within the show *Grown-Ups*.

B. Local projects and campaigns

DPECC implemented independent activities and selective prevention projects for parents at local level, of which we mention:

- **PROTEGO** - *Family training for building education skills for alcohol and tobacco abuse prevention* – launched October 2005 – July 2006 (pilot programme in Bucharest, Constanța and Brașov in 24 schools, continued in the school year 2006-2007, and Ilfov, Bihor, Constanța and Brașov in 2009-2010), by the NAA, Ministry of Education, Research, Youth and Sport, ICAA regional office and the Directorate for Child Care and Protection – 1st district, Bucharest. The project was implemented in 64 schools and addressed families with pre-adolescent children (aged from 9 to 13), with children/parents at risk for drug use. The project was aimed at developing education and family management skills (communication skills, skills to respond to the child needs) as protection factors against drug use in parents of pre-adolescent children at risk for drug use, as opposed to the population of the same age. The specific targets of the project were to: train monitors of the DPECC in implementing the PROTEGO programme, train auxiliary monitors among teachers; build parent education skills as protection factors against drug use. The evaluation methodology included attitude and behaviour evaluation questionnaires for the children and parents in the project (pre-test, post-test) and the impact of the intervention was evaluated.
- **For a healthy child** – project implemented by DPECC Botoșani, in partnership with MYOSOTIS Association in Bârlad – Myosotis health centre. The project aimed at raising the awareness of young mothers of the risks of substance use and their effects on the child. 60 young mothers benefited from the project directly along with their families and the local community. The young mothers aged 16 to 35 and were included in the records of the Myosotis health centre.
- **Learn so you can teach your child!** – implemented by DPECC Braila, addressing parents and pupils in the 5th and 8th grade and aiming at informing on the family risk and protection factors that can be used in alcohol, tobacco or drug use, as well as efficient communication skill building among parents and children by developing efficient education strategies and making parents responsible for alcohol, tobacco and drug use among children and teenagers.
- **Mother, I am addicted to you!** – implemented from March to December 2008 by DPECC Călărași in partnership with DGASPC and intended to prevent tobacco, alcohol and drug use among mothers and future mothers attended to by the Maternity Centre within the Community Services Compound of the DGASPC. An anti-drug information point was organised and functioned throughout project implementation. 8 information sessions of the 12 resident mothers, in two series of 6 with the help of the centre staff (5 specialists/session: 2 medical assistants, 2 social workers, and psychologist). Four project topics were presented to each series. 48 evaluation questionnaires were applied at the end of each information sessions and 92 information fliers were distributed.
- **Together for a better family** – a project implemented by DPECC Galați, aiming to reduce risk factors and increase family protection factors among primary school students in Negrea, county of Galați, by improving family education skills, strengthening family bonds and making the attitude of the family towards drug use clear, as well as by strengthening the relation between family, school and community. The project addressed 24 parents in Negrea, in the county of Galați, with children aged 7 to 11 years. Seven 80-minute activities were organised in which parents received information materials on substance use. The working methods included: role play, energisers, heuristic conversation, presentation, group activities, documentary films, interactive discussions, evaluation based on observation of the participation of project team members.

- **Parent school** – implemented by DPECC Mehedinți in partnership with «Bambi» Foundation, was intended to prevent the birth of children with health problems, educate parents to raise healthy children from the psychological point of view.
- **The health of your child and For a healthy child** – implemented by DPECC Vaslui in partnership with Myosotis Association in Bârlad from September 2006 to October 2007 in order to raise the awareness of young mothers of the risks of substance use and their effects on the child.
- **Drug – deficiency (handicap) of our days**, implemented by DPPDC Vrancea and DPECC Vrancea in the Emergency intervention services (Day-running centres, maternity centre) from April 2007 to December 2007 and **Informed mothers have healthy children** – an information activity of young mothers of the risks of substance use and their effects on the child, attended by 19 future mothers.
- **It is up to me to have a healthy child** – implemented by DPECC Galati and aiming to raise awareness of risk and protection family factors that can play a role in the onset of alcohol and tobacco use. Beneficiaries: a group of mothers aged 14 to 30, included in assistance care services provide by NOVA 2002 Association in Galati. Twenty two 2-hour sessions were implemented throughout the project for residents of NOVA 2002 Association. The methods included in workshops: role play, energisers, heuristic conversation, presentation, small group activities, documentary films, interactive discussions. Applied methods focused on debates, modelling, and identification of personal resources that might determine unfavourable behaviour towards alcohol, tobacco and drug use.

12.3.2 SPECIFIC TREATMENT/INTERVENTION STANDARDS/RECOMMENDATIONS

12.3.2.1 Treatment of pregnant women

In order to provide specialists with accessible tools adjusted to the needs, opiate addiction experts in treatment centres formulated a good practice guide within an UNODC-funded project in 2010: *Clinical guide on substitution treatment for opiate addiction*³⁰¹, as part of a UNODC-funded project. The guide is approved by the Ministry of Health, the Medical Board in Romania, Romanian Psychiatry and Psychotherapy Association and certified by the National Administration of Penitentiaries and is based on the guidelines and good practices in place in other countries experienced in the treatment of drug addiction such as: USA, UK or Ireland or international bodies: OEDT, NIDA, NIAAA, WHO, UNAIDS, UNODC.³⁰²

Pregnant women are one of the target groups of the guide. The guide mentions that the start of substitution treatment should not delay for patients with indications and if delays cannot be avoided, pregnant women are one of the category that have priority in entering treatment programmes based on substitution medication. As mentioned in the guide, “detoxification is the ideal case for pregnant women who are addicted to heroin but that is virtually impossible because it is shortly followed by relapse”. This is the reason why the guide recommends the transfer and maintenance of pregnant women addicted to heroin under substitution treatment based on a synthetic opioid, preferably methadone.

The substitution treatment goals for drug using pregnant women are the same of any kind of substitution treatment. In addition, it reduced the likelihood of complications, safer and more stable conditions for pregnancy progress, pre and post-natal care. The guide emphasizes the importance of early stabilisation through methadone programme in case a pregnant woman is evaluated as suitable for methadone programme.

Some of the recommendations related to methadone substitution programme are:

- Avoidance of withdrawal symptoms, because they cause major harm to the foetus;
- adjustment of the dosage quantity and the frequency of administration should be flexible;

³⁰¹ prof. dr. Dan Prelipceanu, dr. Gabriel Cicu – Bucharest : publishing of the Romanian Psychiatric Association, 2010

³⁰² ex: Northern Ireland – Guidelines on Opiate Substitution Treatment for Opiate Dependence (http://www.who.int/hiv/topics/ idu/drug_dependence/ en/index.html) și National Treatment Agency for Substance Misuse (Marea Britanie) – Treating drug misuse problems: evidence of effectiveness (http://www.nta.nhs.uk/publications/documents/nta_treat_drug_misuse_evidence_effectiveness_2006_rb5.pdf)

- because physiologic changes occur in the later stages of pregnancy (large plasmatic volume, increase of plasmatic proteins level that stabilises methadone) an increase of dosage is necessary or the split of the dose in two in order to maintain an optimal plasmatic level, avoid withdrawal and parallel drug use;
- methadone use shall not be interrupted before birth (high risk of premature birth).

The authors of the guide are reserved in the efficiency of substitution treatment in drug using pregnant women as follows:

- *substitution treatment based on naloxone* – recommended only after overdose, because it might endanger pregnancy;
- *substitution treatment based on buprenorphine* – recommended that pregnant women be transferred under medical supervision based on methadone because there are contradictory studies about the safety of buprenorphine administration during pregnancy; the use of a combined preparations (*buprenorphine + naloxone*) is *not* recommended during pregnancy.

12.3.2.2 Treatment of new born to drug using mothers

As mentioned in chapter 12.1.2., specialists of the Neonatology Service of the Gynaecology - obstetrics Unit „Gheorghe Polizu” (Institute for Mother and Child Care) disseminated in 2003 a methodological recommendation referring to the FINNEGAN clinical scale with the aim of improving withdrawal syndrome and approach specific therapeutic conduct based on the grades resulted by applying this scale.

In addition, the *Clinical guide on substitution treatment for opiate addiction*, mentioned above, makes a few recommendations referring to their treatment and medical approach, of which we mention:

- monitoring for at least a week after child birth of the women on methadone treatment, to prevent neo-natal abstinence syndrome;
- the severity of neo-natal abstinence syndrome is evaluated based on Finnegan scale, and treatment is tailored according to Finnegan scale;
- naloxone shall not be provided to the child of a opiate-addicted women because it can cause serious complications (e.g. apoplexy seizures).

In addition, the guide also includes indications on feeding new born to drug using mothers.

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LEGISLATION

1	Decision no. 534/15.07.2011 of the National Administration of Penitentiaries's director general on the setup of three therapeutic communities in penitentiaries in Jilava, Rahova and Târgșor as part of the Project RO-0034 "Setting up three therapeutic communities in Jilava, Rahova and Târgșor penitentiaries" funded by the Financial mechanism of the European Economic Area.
2	Governmental decision no. 461/ 11.05.2011 laying down the groundwork for the organisation and functioning of the National Anti-drug Agency (issued by the Government of Romania published in Official Gazette of Romania, Part 1, no. 331 of 12.05.2011)
3	Law no. 38/ 28.03.2011 approving the Emergency Governmental Ordinance no. 20/2009 amending the art. 13 indent (2) and (3) of the Emergency Governmental Ordinance no. 30 laying down the groundwork for the organisation and functioning of the Ministry of Administration and Interior and for the reorganisation of several units subordinated to the Ministry of Administration and Interior (issued by the Romanian Parliament, published in the Official Gazette of Romania, Part 1, no. 215 of 29.03.2011)
4	Joint order of the minister of health no. 121 of 16.02.2011, of the minister of agriculture and rural development no. 43 of 16.02.2011, of the minister of administration and interior no. 43 of 17.02.2011, of the minister of public finance no. 1.647 of February 16, 2011, the president of the National Authority for Food Safety no. 8 of February 16, 2011, of the president of the National Authority for Consumer Protection no.1/239 of February 16, 2011 for the setup of joint team that will perform controls, according to competences, in locations and/or settings where new psychoactive substances and/or products that are health threatening are manufactures, traded, used, other than the ones regulated by law (issued by the Ministry of health, Ministry of Agriculture and Rural Development, Ministry of Administration and Interior, Ministry of Public Finance, National Authority for Food Safety and National Authority for Consumer Protection, published in the Official Gazette, Part 1, no.123 of February 17, 2011)
5	Decision no. 324/18.02.2010 of the National Administration of Penitentiaries `s General director on carrying out education and psychological care programmes, that was distributed to NAP units
6	Governmental Decision no. 261 of March 31, 2010 approving the Health national programmes in 2010 (issued by the Government of Romania, published in the Official Gazette, Part 1, no.205 of 01.04.2010)
7	Governmental Decision no. 575 of June 16, 2010 which amended and supplemented the Law no. 339/2005 on the legal status of narcotic and psychotropic plants, substances and preparations and the Law no. 143/2000 on preventing and countering the illicit drug use and trafficking (issued by the Government of Romania, published in the Official Gazette, Part 1, no.509 of 22.07.2010)
8	Governmental Decision no. 87 of 05.02.2010 supplementing the appendix to the Governmental Decision no. 1102/ 2008 approving the National programme of medical, psychological and social care of drug users – 2009-2012 (issued by the Government of Romania published in Official Gazette of Romania no. 672 of 30.09.2008)
9	Governmental Decision no. 1040 of 13.10.2010 approving the National Strategy for Public Order – 2010 – 2013 (issued by the Government of Romania, published in the Official Gazette, Part 1, no.721 of 28.10.2010)
10	Governmental Decision no. 1369 of 23.12.2010 approving the Action plan for the implementation of the National Anti-drug strategy (issued by Romanian Government, published in the Official Gazette, Part 1, no.38 / 17.01.2011)
11	Governmental Decision no. 1388 of 21.12.2010 approving Health National Programmes for 2011 and 2012 (issued by the Government of Romania, published in the Official Gazette, Part 1, no.893 of 31.01.2011)
12	Decision no. 1286 of December 18, 2010 – M.OF. no.853/20.12.2010 amending the appendix to the GD no. 261 of March 31, 2010 approving the Health national programmes in 2010
13	Decision no. 1331 of December 23, 2010 amending the appendix to the GD no. 261 of March 31, 2010 approving the Health national programmes in 2010 (M.Of. no. 871/27.12.2010)

14	Law no. 135 of July 1st, 2010 on the Criminal Procedure Code (Issued by the Parliament of Romania, Romania, published in the Official Gazette, Part 1, No. 486 of 15/07/2010)
15	Law no. 202 of October 2010 on measures to enhance case settlement
16	Joint order of the minister of public health no. 264/2010 and of the president of the Health Insurance National House no. /407 din April 1, 2010 approving the Technical regulations for the formulation of health national programmes in 2010
17	Joint order of the minister of public health and of the president of the Health Insurance National House no. 1277 of 07.10. 2010, approving the Technical regulations for the formulation of health national programmes in 2010
18	Joint order of the minister of public health and of the president of the Health Insurance National House 1445 / 24.11.2010 approving the Technical regulations for the formulation of health national programmes in 2010
19	Joint order of the minister of public health and of the president of the Health Insurance National House 390 / 29.04.2010 approving the Technical regulations for the formulation of health national programmes in 2010
20	Joint order of the minister of public health and of the president of the Health Insurance National House 881 / 03 june 2010 approving the Technical regulations for the formulation of health national programmes in 2010
21	Joint order of the minister of public health and of the president of the Health Insurance National House 937 / 16.06.2010 approving the Technical regulations for the formulation of health national programmes in 2010
22	Joint order of the minister of public health and of the president of the Health Insurance National House 1532 / 22.12.2010 approving the Technical regulations for the formulation of health national programmes in 2010
23	Joint order of the minister of public health and of the president of the Health Insurance National House 1585 / 29.12.2010 approving the Technical regulations for the formulation of health national programmes in 2010
24	Emergency governmental ordinance no. 6 of February 10, 2010 amending and supplementing the Law no. 143/2000 on countering the illicit drug trafficking and use and supplementing the Law no. 339/ 2005 on the juridical regime of plants, substances and preparations with narcotic and psychotropic contents (issued by the Romanian Government, published in the Official Gazette no. February 15, 2010)
25	Governmental decision no. 1424 of November 18, 2009 on the setup, organisation and operation of the National Centre for Mental Health and Fight against Drugs (issued by the Government of Romania, published in the Official Gazette, Part I no. 842 of December 07, 2009)
26	GD no. 939/2009 amending the appendix of the GD no.1102/2008 approving the <i>National programme of medical, psychological and social care of drug users – 2009-2012</i> ,
27	Decision no.1054 of October 23, 2009 - M.Of. no.76/26.10.2010
28	Law no. 286 of July 17, 2009 on the Criminal Code (Issued by the Parliament of Romania, published in the Official Gazette no. 510 of July 24, 2009)
29	Governmental Emergency Ordinance no. 20 of March 2009 amending art. 13 paragraphs (2) and (3) of the Governmental Emergency Directive no. 30/2007 laying down rules for the organisation and operation of the Ministry of Administration and Interior and for the re-organisation of some units subordinated to the Ministry of Administration and Interior (issued by the Government of Romania, published in the Official Gazette no. 156 of March 12, 2009)
30	Decision no. 452 of 04.07.2008 of the NAP General director approving the Procedure book of the penitentiary system
31	Governmental decision no. 1101/September 18, 2008 approving the National interest programme to prevent tobacco, alcohol and drug prevention 2009 - 2012 (issued by the Government, published in the Official Gazette no. 672 of September 30, 2008)
32	Governmental Decision no. 1102 of 18.10.2008 approving the National programme of medical, psychological and social care of drug users – 2009-2012. (emitent Guvernul, publicată în Monitorul Oficial nr. 675 din 1 octombrie 2008)

33	Governmental Decision no. 358/26.03.2008 approving the Enforcement regulation of the Emergency ordinance of the Government no. 121/2006 on the juridical regime of drug precursors, and amending the Governmental Decision no. 1.489/2002 on the setup of the National Anti-drug Agency, issued by Government, Official Gazette no. 269/04.04.2008
34	Order no. 1389/ 513/ 282 of August 4, 2008 establishes the specific organisation and functioning criteria of a detoxification centre and the specific organisation and functioning criteria of opiate-based substitution treatment. Issued by: MPH (No. 1.389 of August 4, 2008), Ministry of labour, social solidarity and family (no. 513 of August 15, 2008) and Ministry of Interior and Administrative Reform (No. 282 of August 24, 2007), published in the OG no. 830 of December 10, 2008
35	Decision no. 11/2007 approving the operation of CAIA Obregia
36	Decision of the NAA president no. 4/2007 approving the operation of CAIA Pantelimon
37	NAA President's decision no. 13/2007 – laying down the legal framework for the setup and management of the waiting list within the treatment centres of the NAA
38	Decision no. 9/2007 approving the operation of CAIA Pericle
39	Law no. 186/13.06.2007 on the approval of the Emergency ordinance of the Government no. 121/2006 on the juridical regime of drug precursors, issued by the Parliament, Official Gazette no. 425/26.06.2007
40	Joint order MPH and MIAR no. 770 and 192 of 2007 approving the Methodology regarding the completion of the standard records and the transmission of data to be included in the personal emergency chart for drug use, personal chart for drug treatment admission, recorded HCV and HBV cases among injecting drug users and the prevalence of HIV, HBV and HCV infections among injecting drug users issued by the Ministry of Interior and Administrative Reform and Ministry of Public Health, Official Gazette no. 344/21.05.2007
41	Order on providing medical care to prison inmates in custody of the National Administration of Penitentiaries no. 1016/2007
42	Decision no.16 of October 2, 2006 approving the <i>Compulsory minimal standards of the organisation and operation of the centres that provide services for drug users and the authorisation methodology for these centres</i> (ANA, MO 899/06.11.2006)
43	Decision no. 17 of October 2, 2006 approving the Methodology for the formulation, amendment and implementation of the customised care plan for the drug users (NAA, OG no. 899/06.11.2006)
44	Decision of the Supreme Defence Council no. 62 of 17.04.2006 aproving the National Security Strategy of Romania
45	Governmental Decision no. 1873/21.12.2006 amending and supplementing the GD no. 1489/2002 on the setup of the National Anti-drug Agency, issued by Government, Official Gazette no. 8/05.01.2007
46	Governmental decision no. 1915 of 22.12.2006 approving Normelor metodologice de aplicare a Law no. 339/2005 on the on the legal status of narcotic and psychotropic plants, substances and preparations; Emitent Guvernul, MO nr. 18/11.01.2007
47	Governmental decision no. 196 of 17.05.2006 approving the Strategy of the Ministry of Administration and the Interior for ensuring public order and safety, for increasing citizens' safety and for preventing street crimes (published in the Official Gazette no. 243 of 23.05.2006)
48	Joint order no. 1216/C / 18.05.2006 on providing integrated programmes of medical, psychological and social care to prison inmates, who use drugs
49	The Ministry of Public Health (MPH) issued the Order no. 372/2006 which lays down measures for the promotion and protection of mental health and for the prevention of psychiatric diseases.
50	Order no. 374/10.04.2006 approving the Mental health strategy, issued by the Ministry of Public Health, OG no. 373/02.05.2006
51	Emergency ordinance no. 121/21.12.2006, regarding the legal regime of the drug precursors, which repeals the Law no. 300/2002, issued by Government, Official Gazette no. 1039/28.12.2006
52	Emergency Governmental Ordinance no. 34 of 19.04.2006 on awarding public procurement contracts, public works lease, service lease, as amended and supplemented (published in the Official Gazette no. 418 of 15.05.2006)
53	EU Council decision no. 11 (art. 5.1, Decision 2005-387-JHA)

54	Governmental Decision no. 73 of January 27, 2005 on the approval of the National Anti-drug Strategy 2005-2012 (published in the Official Gazette no. 112 of February 3, 2005)
55	Decision no. 860/2005 approving the Enforcement regulation of the Law no. 143/2000 on preventing and countering the illicit drug use, further amended and supplemented, (MO no. 749 / 17.08.2005)
56	Law no. 339/2005 on the legal status of narcotic and psychotropic plants, substances and preparations
57	Commission Regulation (CE) no. 1.277/2005 of July 27, 2005 on the enforcement of the Regulation 273/2004 and Regulation 111/2005 (published in the Official Journal of the European Union no. L 202 of August 3, 2005)
58	Council Regulation no. 111/2005 of December 22, 2004 on the monitoring of the trade in drug precursors between Community and third states (published in the Official Journal of the European Union no. L 22 of January 26, 2005)
59	Governmental Decision no. 1342/22.09.2004 approving the National strategy for the monitoring, control and prevention of HIV/AIDS infection cases in the period 2004-2007, issued by Government, Official Gazette no. 865/22.09.2004
60	.D. no. 1434/2004 laying down the tasks and the Framework regulation for the organisation and operation of Directorate General of Child Social Care and Protection, issued by the Government, OG no. 869/23.09.2004
61	Law no. 239 on the status of public servants in the National Administration of Penitentiaries, June 28, 2004.
62	Law no. 522 of November 24, 2004 amending and supplementing the Law no. 143/ 2000 on preventing and countering the illicit drug use and trafficking (Issued by the Parliament of Romania, published in the Official Gazette no. 1155 of December 7, 2004)
63	Regulation (CE) no. 273/2004 of the European Parliament and Council of February 11, 2004 on drug precursors (published in the Official Journal of the European Union no. L 47 of February 18, 2004),
64	GD no. 68/2003 on social services, issued by the Government of Romania, OG no. 619/30.08.2003
65	European Council recommendation of June 18, 2003 on the prevention and reduction and drug addiction harm and on the priorities in the EU Action plan on drugs 2009-2012.
66	Order of the Minister of Health and Family no. 187/2002 defining the types of medical units that can be authorised to provide medical care for drug-addicted people, as well as for non-governmental organisations that can be authorised to carry out prevention activities related to blood communicable diseases among injecting drug users
67	Joint order of the Minister of Health and Ministry of Justice, no. 898/2002 regarding medical and education measures applicable to drug-addicted people in penitentiaries
68	Law no. 350/2005 on public funding for not-for-profit activities of general interest based on non-reimbursable financial support (published in the Official Gazette no. 1128 of 14.12.2005)
69	Emergency Governmental Ordinance no. 60 of 25.04.2001 on public procurement (published in the Official Gazette no. 241 of 11.05.2001)
70	Governmental ordinance no. 92/29.08.2000 on the organisation and operation of social reinsertion services for offenders and monitoring the prison sanctions, issued by Government, OG no. 423/01.09.2000
71	Order of the Minister of Health no. 963/1998 approving the methodological rules for the organisation and provision of medical care, treatment and services to addicted people
72	Recommendation no. R (89) 12 Committee of Ministers of the Council of Europe, October 13, 1989, on education in prisons
73	Recommendation no. R (87) 3 adopted by the Committee of Ministers of the Council of Europe, 12 February 1987 ON European Prison Rules
74	UN resolution 35/177 of December 15, 1980- Body of principles for all persons under any form of detention or imprisonment

75	Resolution no.663 C (XXIV) of July 31, 1957, by which the Social and Economic Council adopted a the Standard minimal rules for the treatment of prisoners
76	the joint statement of the participants to the 9 th edition of the European Conference on drug prevention monitoring and harm reduction in prison settings, organised by ENDIPP

RELEVANT SITE CONSULTED

- ✓ <http://www.afladec.ro>, website addressing Viral Hepatitis C
- ✓ <http://www.aliatong.ro>, website of ALIAT Association
- ✓ <http://www.ana.gov.ro>, National Anti-drug Agency's website
- ✓ <http://www.anit.ro/>, website of the Drug Addition Intervention National Association
- ✓ <http://www.ccmromania-gfatm.com>, website of the Coordination Council of the Global Fund
- ✓ <http://www.cdep.ro>, website of the Representatives` Chamber
- ✓ <http://www.cnlas.ro>, website of the National Commission to Fight Against AIDS
- ✓ <http://www.educatiepentrusanatate.ro>
- ✓ <http://www.emcdda.europa.eu>, website of the European Monitoring Centre for Drugs and Drug Addiction
- ✓ <http://europa.eu.int/servlet/>, EurLex: European legislative news
- ✓ <http://www.incb.org/> - website of the International Office for Narcotic Control
- ✓ www.just.ro, site of the Ministry of Justice
- ✓ <http://www.legmed.ro>, website of the National Forensic Network in Romania
- ✓ <http://www.mtc.ro>, web page of the Ministry of Education and Research
- ✓ www.mfinante.ro, website of the Ministry of Finances
- ✓ <http://www.ms.ro>, web page of the Ministry of Health and Family
- ✓ <http://www.pmu-wb-gf.ro>, site of the Programme of the Global Fund for Romania
- ✓ <http://www.presspro-medic.ro/> Online magazine Medic.ro
- ✓ <http://www.psymotion.ro>
- ✓ <http://www.raa.ro>, web page of the Romanian Angel Appeal NGO
- ✓ <http://www.reitox.emcdda.eu.int>, extranet of the European Information Network on Drugs and Drug Addiction of the National Focal Points
- ✓ www.rhrn.ro, website of the Romanian Harm Reduction Network
- ✓ <http://www.salvaticopiii.ro>, website of Save the Children Romania
- ✓ <http://www.un.ro/un aids.html>, website of the United Nations Office Romania
- ✓ <http://www.unaids.org>, website of the Joint United Nations Programme on HIV/AIDS
- ✓ http://www.who.int/hiv/topics/idu/drug_dependence/en/index.html
- ✓ <http://www.en.wikipedia.org> - on-line encyclopaedia
- ✓ www.alcoholhelp.ro
- ✓ www.state.gov – US State Department website - Bureau of international narcotics and law enforcement affairs
- ✓ www.presidency.ro, Romanian Presidency website
- ✓ www.mai.gov.ro, Ministry of Administration and Interior website
- ✓ <http://www.rosaac.ro/index.php>, Romanian Substance Abuse and Addiction Coalition
- ✓ <http://www.scribd.com>, on-line library
- ✓ <http://www.nta.nhs.uk>, National Treatment Agency for Substance Misuse website

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LIST OF ABBREVIATIONS USED IN THE TEXT

AICC	Addiction Integrated Care Centres
AIDS	Acquired immune deficiency syndrome
ALIAT	Association for the Fight against Alcohol and Drugs
ANP	National Administration of Penitentiaries
ANIT	Drug Addition Intervention National Association
ARAS	Romanian Association against AIDS
BSS	Behavioral Surveillance Survey
CNOASIIDS	National Centre for the Organisation and Provision of the IT and Information System in the Health Field
COFOG	Classification of The Functions of Government
CC	Criminal Code
CSOP	Centre for Market and Opinion Polls
DIICOT	Directorate for Investigation of Organized Crime and Terrorism
DGPMB	Directorate General of Police of the Municipality of Bucharest
DPPDC	Directorate for Child Care and Protection
ELDD	European Legal Database on Drugs
ENDIPP	European Network on Drugs and Infections Prevention in Prison
EGO	Emergency Governmental Ordinance
FESU	European forum for Urban Security
FOC	Fundația Familia și Ocrotirea Copilului (Child and Family Care Foundation)
GPS	General Population Survey
GRADO	Romanian Group for Human Rights Protection
HIV	Human Immune deficiency Virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
ICCA	Regional Office of the International Council for Alcohol and Addiction for Eastern Europe and Central Asia
ICD	International Classification of Diseases
IDU	Injecting Drug Users
IGRP	Inspectorate General of the Romanian Police
INML (LMNI)	Legal-medicine National Institute
IPC	Individualised plan of care
CPI	County Police Inspectorate
IREFREA	European Institute of Studies on Prevention
LSD	Lysergic acid diethylamide
MECTS	Ministry of Education, Research, Youth and Sports
MDMA	Methylenedioxymethamphetamine
MDPV	Metilendioxipirovalerona
MAI	Ministry of Administration and Interior
MIRA	Ministry of Interior and Administration Reform
MMSSF	Ministry of Labour, Social Solidarity and Family
MSP (MH)	Ministry of Public Health
MSM	Men who have sex with men
NAA	National Anti-drug Agency
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NAP	National Administration of Penitentiaries
NGO	Non-governmental Organization
NUP	Prosecution not pursued
OG	Official Gazette
OEDT/EMCDDA	European Monitoring Centre for Drugs and Addiction

OSI	Open Society Institute
OST	Opiate substitution treatment
RDS	Respondent Driven Sampling
PHEA	Public Health Executive Agency
PNESSR	Health Education in the Romanian School National Programme
RAA	Romanian Angel Appeal
REITOX	European Information Network on Drugs and Drug Addiction
ROP	regional operational programme
RHRN	Romanian Harm Reduction Network
RMCDDA	Romanian Monitoring Centre for Drugs and Drug Addiction
SEP	Syringes Exchange Program
SOP HRD	Sectoral Operational Programme Human Resources Development
SNA (NAS)	National Anti-drug Agency
SNPP	new psychoactive substances (sold as “ethno-botanical plants”)
SSF	Sociology and Social Work Faculty
STD	Sexual Transmitted Diseases
SUP	Suspended prosecution
SW/CMS	Sex workers/commercial sex workers
SJML	legal medicine county services
TDI	Treatment Demand Indicator
THC	Tetrahydrocannabinol
TIP	Treatment integrated programme
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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