European Monitoring Centre for Drugs and Drug Addiction

Malta

Malta Country Drug Report 2019

This report presents the top-level overview of the drug phenomenon in Malta, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2017 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

THE DRUG PROBLEM IN MALTA AT A GLANCE

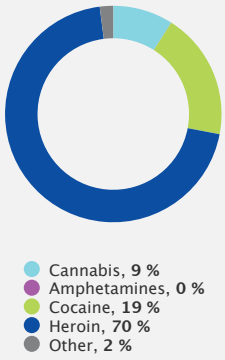
High-risk opioid users

1 425

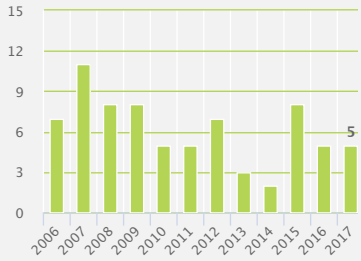
(1 332 - 1 544)

All treatment entrants

by primary drug



Overdose deaths



Drug law offences

739

Top 5 drugs seized

ranked according to quantities meas
kilograms

1. Cannabis resin
2. Heroin
3. Herbal cannabis
4. Cocaine
5. MDMA

Opioid substitution treatment clients

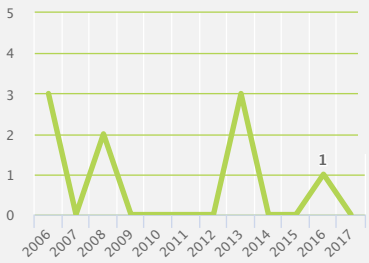
1 025

Syringes distributed

through specialised programmes

315 541

New HIV diagnoses attributed to injecting



Source: ECDC

Population

(15-64 years)

308 634

Source: Eurostat Extracted on: 18/03/2019

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or numbers reported through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnoses, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

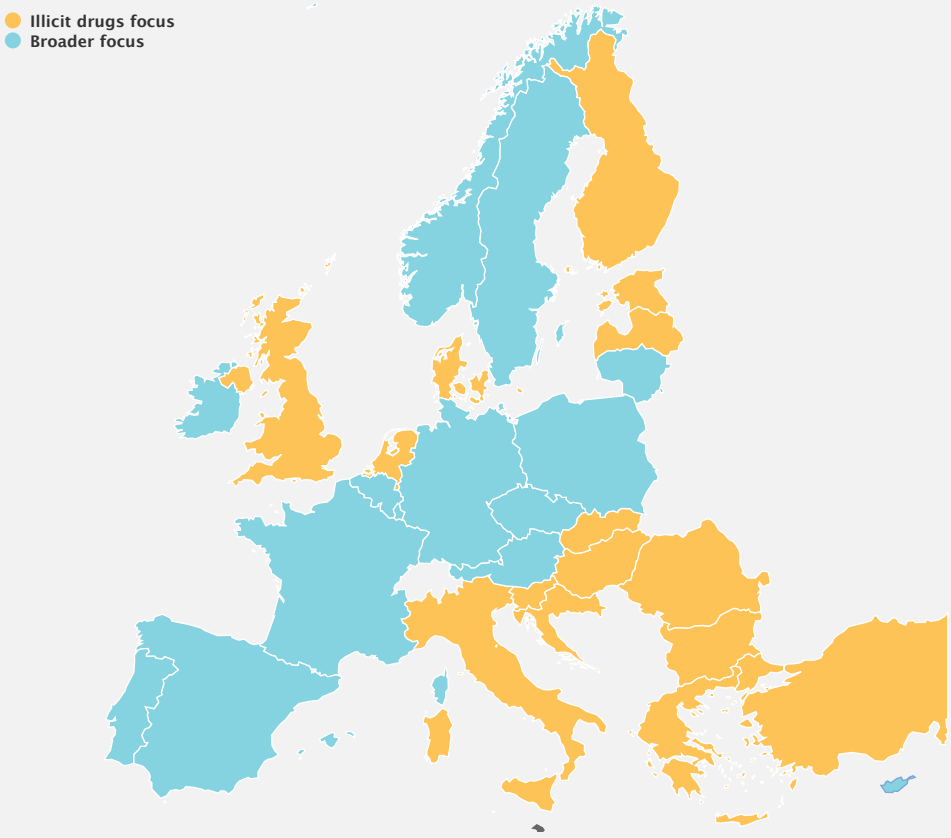
National drug strategy and coordination

National drug strategy

Launched in 2008, the Maltese National Drugs Policy document addresses illicit drug problems. The strategy aims to streamline the actions of the government and non-government bodies that are responsible for delivering services to drug users. It seeks to (i) improve the quality and provision of drug-related services; and (ii) provide a more coordinated mechanism to reduce the supply of and demand for drugs in society. The strategy's main objectives are to ensure a high level of security, health protection, well-being and social cohesion. It is primarily concerned with illicit drugs, but it also considers the abuse of prescription medications. The strategy is built around six main pillars: (i) coordination; (ii) legal and judicial framework; (iii) supply reduction; (iv) demand reduction, including harm reduction; (v) monitoring, evaluation, research, information and training; and (vi) international cooperation and funding. Forty-eight different actions are set out under these six pillars. A first progress review of the strategy was conducted in 2011.

As in other European countries, Malta evaluates its drug policy and strategy through ongoing indicator monitoring and specific research projects. A wide-ranging performance audit of problem drug use was undertaken by the National Audit Office in 2012. This mixed-methods assessment made a series of recommendations following a review of the structures and systems in place. Annual reports on the implementation of the 2008 strategy were compiled, and a progress review was undertaken in 2011.

Focus of national drug strategy documents: illicit drugs or broader



NB: Data from 2017. Strategies with a broader focus may include, for example, licit substances and other addictions.

National coordination mechanisms

The main body responsible for drug-related matters in Malta is the Advisory Board on Drugs and Addiction. The Board is part of the Ministry for the Family and Social Solidarity. The seven members of the advisory board are independent experts from fields such as law, youth studies, education, clinical psychology, psychiatry, epidemiology and neuroscience. The National Coordinating Unit for Drugs and Alcohol, which is also part of the Ministry for the Family and Social Solidarity, is responsible for the implementation of the National Drugs Policy, while the main remit of the national focal point for drugs and drug dependency is that of monitoring the situation and the responses, including the effectiveness of the actions put in place as a result of the National Drugs Policy.

Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments for expenditure on tasks related to drugs are identified as such in the budget (‘labelled’). Often, however, most drug-related expenditure is not identified (‘unlabelled’) and must be estimated using modelling approaches.

In Malta, the financing of drug-related activities is decided annually by the entities in charge of their implementation. The information available is limited and does not permit reporting on the size and trends of drug-related expenditure. Notwithstanding, the National Drugs Policy stresses the importance of identifying the funds required for implementing the planned actions. The government supplements funding for drug-related programmes from funds seized through the Prevention of Money Laundering Act.

The most recent estimate, for 2012, indicated that Malta spent an estimated EUR 5.5 million on drug reduction activities, and that drug-related expenditure amounted to approximately 0.08 % of gross domestic product (GDP). However, it is not known what proportion of all drug-related expenditure this represents.

Drug laws and drug law offences

National drug laws

The principal pieces of legislation dealing with substance use in Malta are the Medical and Kindred Professions Ordinance (Cap. 31), which relates to psychotropic drugs, and the Dangerous Drugs Ordinance (Cap. 101) and the Drug Dependence (Treatment not Imprisonment) Act 2014, which relate to narcotic drugs.

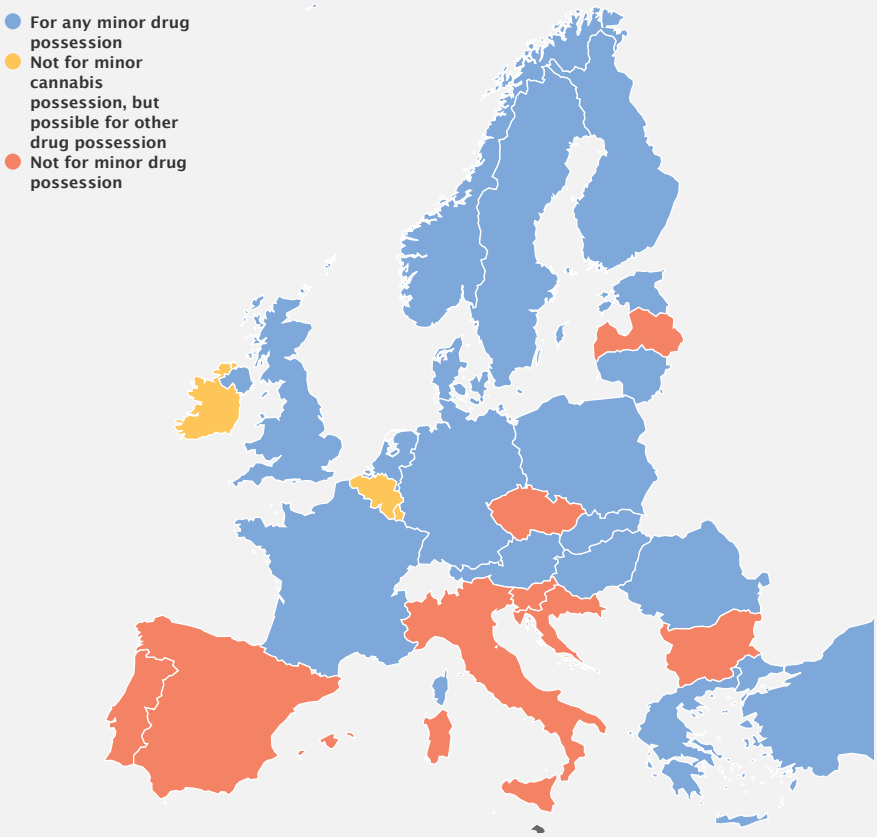
The illegal use of psychotropic and narcotic drugs is not, per se, recognised in Maltese law, although the use of these substances, if proven in court, leads to a conviction for possession or trafficking. Maltese law recognises two kinds of possession: simple possession, or possession for personal use; and aggravated possession, or possession of drugs not for the offender's exclusive use.

Under the Drug Dependence (Treatment not Imprisonment) Act 2014, a person found in possession of a small amount of drugs for personal use is tried in front of the Commissioner of Justice. If found guilty, a fine of EUR 50-100 will be imposed for possession of cannabis or of EUR 75-125 for possession of other drugs. Any offender who commits a second offence within a period of 2 years is required to attend the Drug Offenders Rehabilitation Board, where he or she is assessed for drug dependence and any necessary order may be issued; failure to comply with an order may be punished by a fine or 3 months in prison. A person found in possession of one cannabis plant for personal use will not liable to a mandatory prison term. In the case of an offender who commits a limited number of offences as a result of drug dependence, the Court may assume the function of a Drug Court and refer the offender to the Drug Offenders Rehabilitation Board.

The range of punishment for supply offences that may be imposed by the lower courts is 6 months' to 10 years' imprisonment, whereas the superior courts may impose a maximum punishment of life imprisonment. When certain offences take place within 100 metres of the perimeter of a school, youth club or centre, or any other place where young people habitually meet, the normal punishment is increased because these circumstances are deemed to be an aggravation of the offence. However, an amendment to the Dangerous Drugs Ordinance in 2006 allowed the court not to apply the mandatory prison term of 6 months if the offender intended to consume the drug on the spot with others. Since 2014, prosecution for trafficking may be guided towards a lower or superior court, depending on role of the offender and quantity guidelines for MDMA/ecstasy, lysergic acid diethylamide (LSD), amphetamine and ketamine. Courts may also opt for the lower punishment range if the higher range is considered disproportionate.

New psychoactive substances are addressed through the existing legal framework by amending the lists of proscribed substances in the Medical and Kindred Professions Ordinance and the Dangerous Drugs Ordinance.

Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



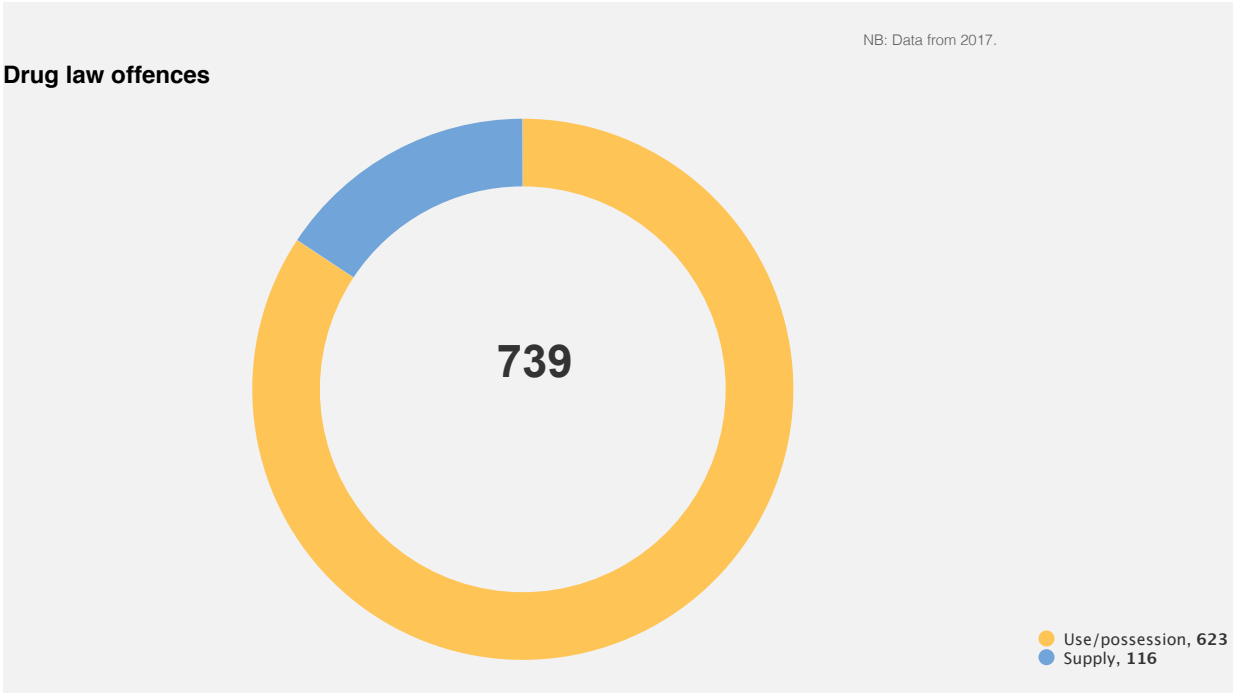
NB: Data from 2017.

Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

The statistical data provided by the Malta Police Force indicate that most DLOs in 2017 were related to possession, with the majority of these being related to cannabis.

Reported drug law offences and offenders in Malta



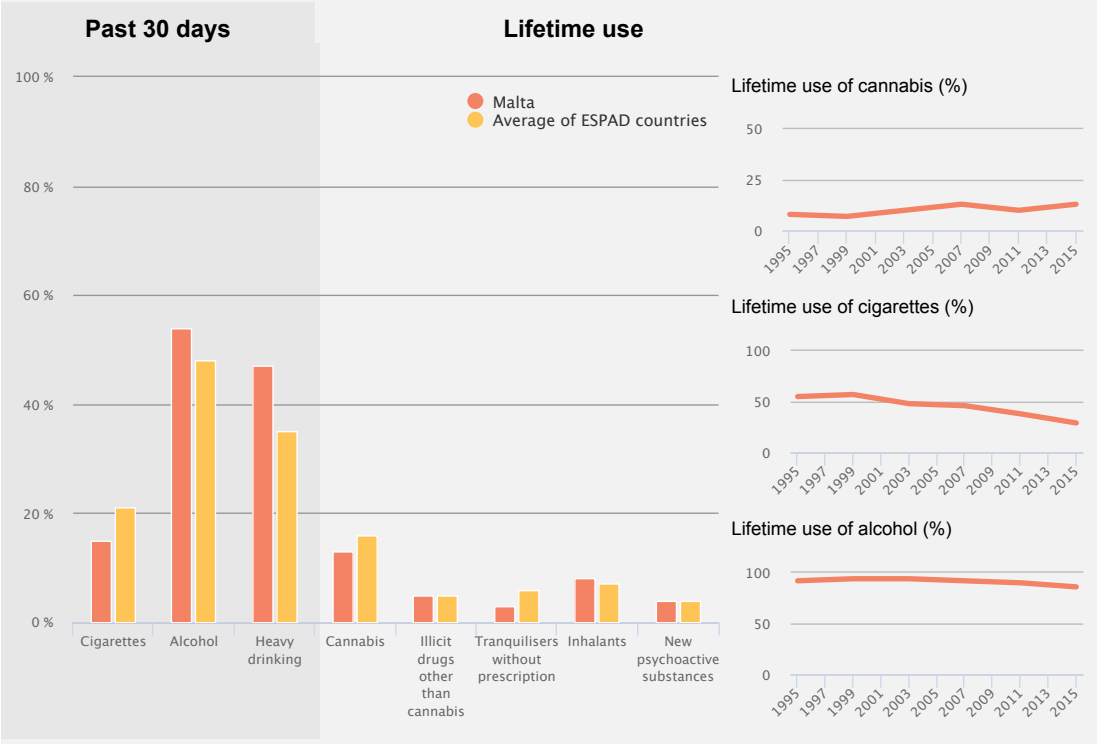
Drug use

Prevalence and trends

Cannabis is the most commonly used illicit drug among the Maltese adult population aged 18-65 years. According to the 2013 general population study, around 4.3 % of those aged 18-65 years reported having used cannabis during their lifetime. The level of lifetime use of illicit drugs other than cannabis (MDMA/ecstasy, amphetamines, cocaine, heroin, mephedrone, any of the new psychoactive substances (NPS) or lysergic acid diethylamide (LSD)) was 1.4 %; MDMA was the most popular among this group of substances. Drug use was more prevalent in younger adults, with the prevalence of lifetime use of cannabis at 5.1 % among 18- to 24-year-olds. In general, the use of illicit drugs was more common among males than females. In the 2013 study, among those who had used cannabis during their lifetime, the average age at first use was just under 19.

Drug use among 15- to 16-year-old students is reported in the 2015 European School Survey Project on Alcohol and Other Drugs (ESPAD). This survey has been conducted in Malta since 1995 and the latest data are from 2015. In 2015, Maltese students reported levels of lifetime cannabis use that were lower than the ESPAD average (based on data from 35 countries), while levels of lifetime use of illicit drugs other than cannabis and lifetime use of NPS were close to the ESPAD average. For two key variables studied, the Maltese students reported above average levels: alcohol use in the last 30 days and heavy episodic drinking in the last 30 days. Other than this, Maltese students reported substance use levels that were around or below the ESPAD averages.

Substance use among 15- to 16- year-old school students in Malta



Source: ESPAD study 2015.

High-risk drug use and trends

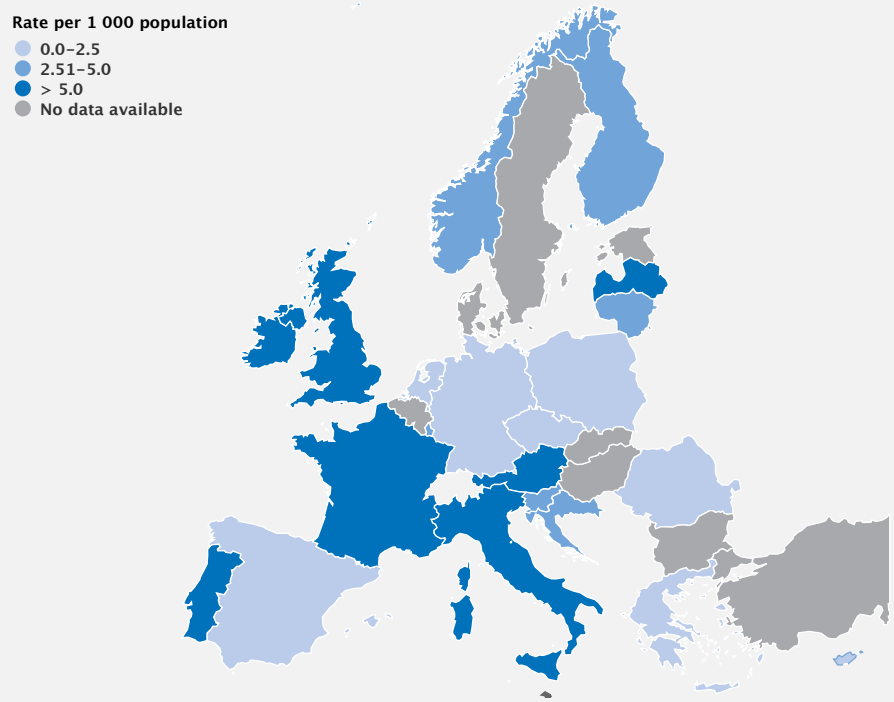
Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform an understanding of the nature of and trends in high-risk drug use.

In Malta, heroin remains the illicit drug that is linked to the most severe health and social consequences. In 2017, there were an estimated 1 425 high-risk opioid users (4.51 per 1 000 population aged 15-64 years).

Data from specialised treatment centres indicate that cocaine has become the most common substance among first-time

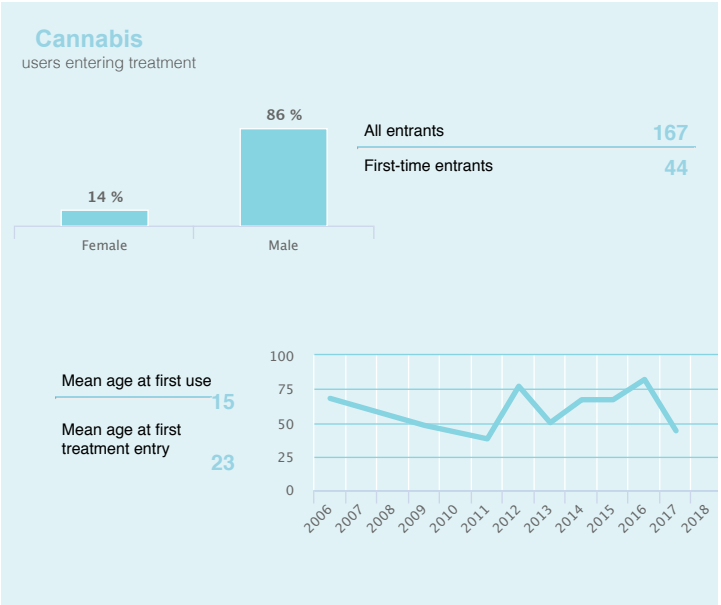
treatment demands in recent years, followed by heroin and cannabis. Yet, heroin remains the most common substance among all clients entering treatment. Sniffing is the main method of use for cocaine, and only a few treatment clients inject it. Almost half of first-time entrants with heroin as their primary drug report injecting. Fewer than one in five clients entering drug treatment are female.

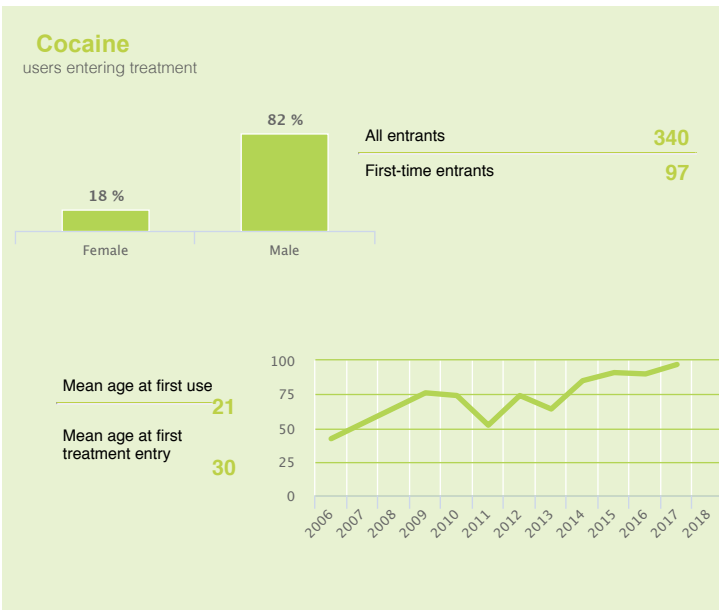
National estimates of last year prevalence of high-risk opioid use

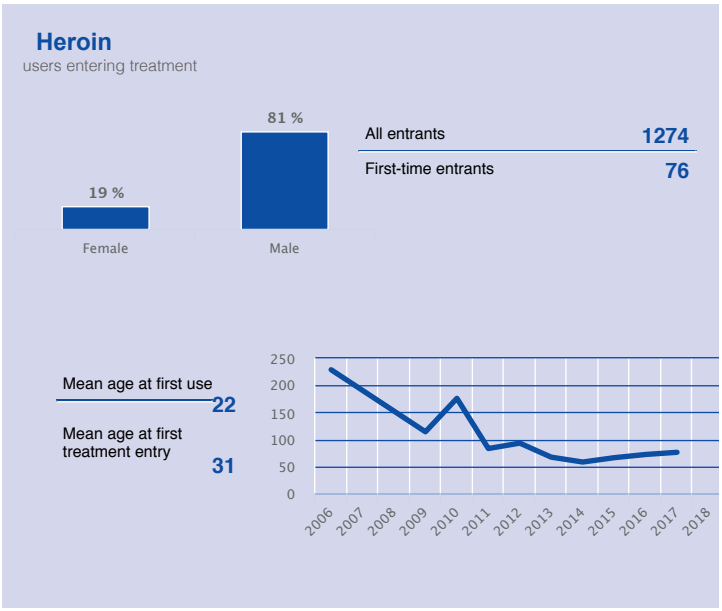


NB: Data from 2017, or the most recent year for which data are available.

Characteristics and trends of drug users entering specialised drug treatment in Malta







NB: Data from 2017. Data are for first-time entrants, except for the data on gender, which are for all treatment entrants.

Drug-related infectious diseases

In Malta, the National Infectious Disease Surveillance Unit in the Department of Health receives notifications of positive cases from virology departments and prisons. There were no reports of newly diagnosed cases of human immunodeficiency virus (HIV) infection linked to injecting drug use in 2017.

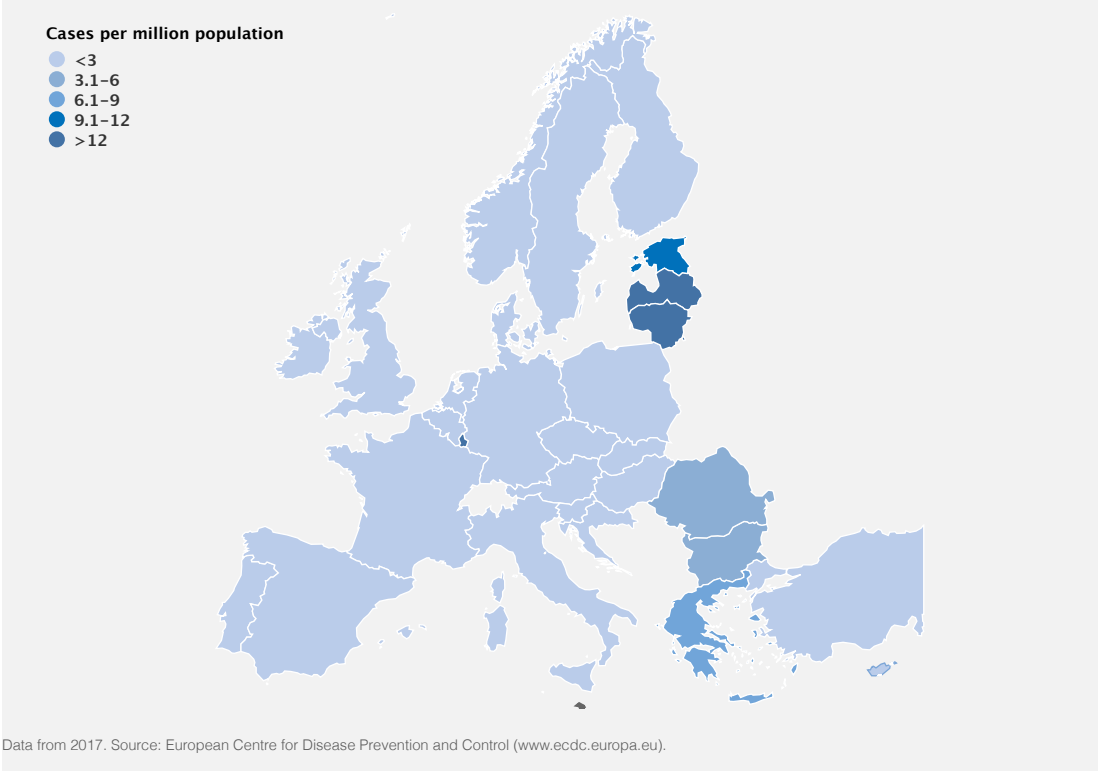
Prevalence of HIV and HCV antibodies among people who inject drugs in Malta (%)

	Region	HCV	HIV
	National	44.54	0.0 - 1.2
	Sub-national	:	:

Data from 2016/17 (HIV) and from 2017 (HCV).

Prevalence estimates of HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) come from diagnostic tests among people who inject drugs seeking treatment at the outpatient treatment unit run by Sedqa, the Maltese government's executive agency in the drugs field. In 2016, two clients out of 170 tested positive for HIV. In 2017, 53 out of 119 tested positive for hepatitis C antibodies and one out of 83 tested positive for hepatitis B antibodies.

Newly diagnosed HIV cases attributed to injecting drug use



Data from 2017. Source: European Centre for Disease Prevention and Control (www.ecdc.europa.eu).

Drug-related emergencies

The most recent data show that, in 2016, a total of 28 non-fatal overdoses were reported in Malta, slightly fewer than in 2015. Two thirds of non-fatal overdoses are attributed to the use of prescription medications.

A clinical toxicology unit from Valetta hospital participates in the European Drug Emergencies Network (Euro-DEN Plus) project, which was established in 2013 to monitor acute drug toxicity in sentinel centres across Europe.

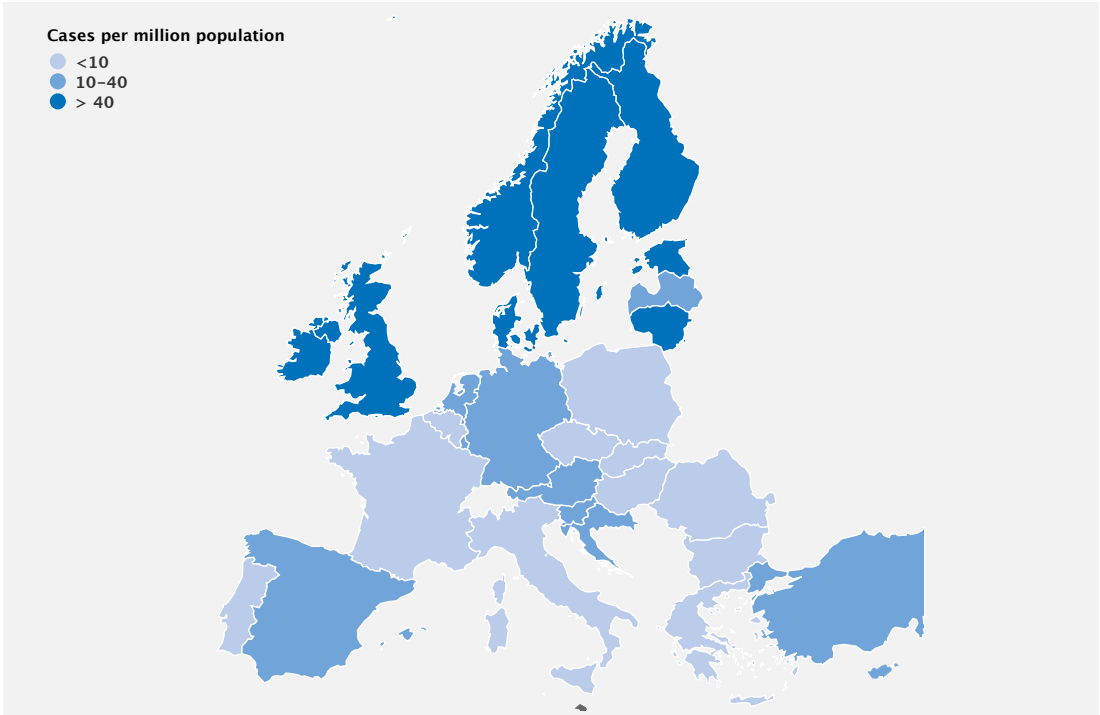
Drug-induced deaths and mortality

Drug-induced deaths are deaths that can be attributed directly to the use of illicit drugs (i.e. poisonings and overdoses).

In 2017, the Police Special Registry registered five drug-induced deaths. Toxicological analyses confirmed the presence of opioids in three of the five deaths, either alone or in combination with other illicit stimulants. In 2017, the mean age of the deceased was 34 years and all of them were male.

The estimated drug-induced mortality rate among adults (aged 15-64 years) was 16 deaths per million in 2017, which is slightly lower than the most recent European average of 22 deaths per million.

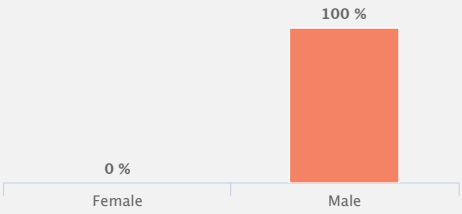
Drug-induced mortality rates among adults (15-64 years)



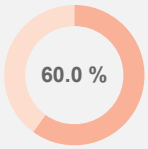
NB: Data from 2017, or the most recent year for which data are available. Comparisons between countries should be undertaken with caution. The reasons for this include systematic under-reporting in some countries, and different reporting systems, case definitions and registration processes. Data for Greece are for all ages.

Characteristics of and trends in drug-induced deaths in Malta

Gender distribution

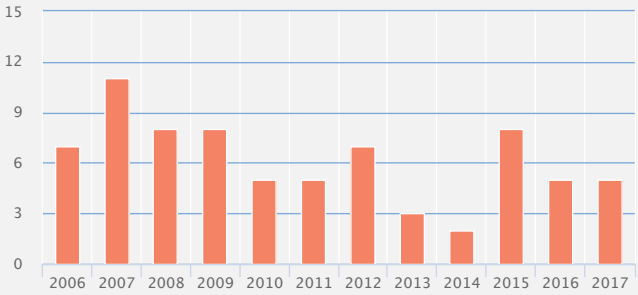


Toxicology



Deaths with opioids present among deaths with known toxicology

Trends in the number of drug-induced deaths



Age distribution of deaths in 2017

NB: Year of data 2017

Prevention

In Malta, the current National Drugs Policy defines a number of actions in the area of drug prevention and underlines the promotion of healthy lifestyles. The Foundation for Social Welfare Services and the Foundation for Medical Services implement prevention activities in close cooperation with non-governmental organisations (NGOs). Sedqa, the Maltese government's executive agency in the drugs field, has established a number of prevention interventions. The NGOs Caritas and the OASI Foundation run a range of prevention programmes targeting specific groups or settings, such as schoolchildren, peers, parents, the community and the workplace, while the Anti-Substance Abuse Unit within the Education Division carries out interventions in the school environment. Few interventions are evaluated.

Prevention interventions

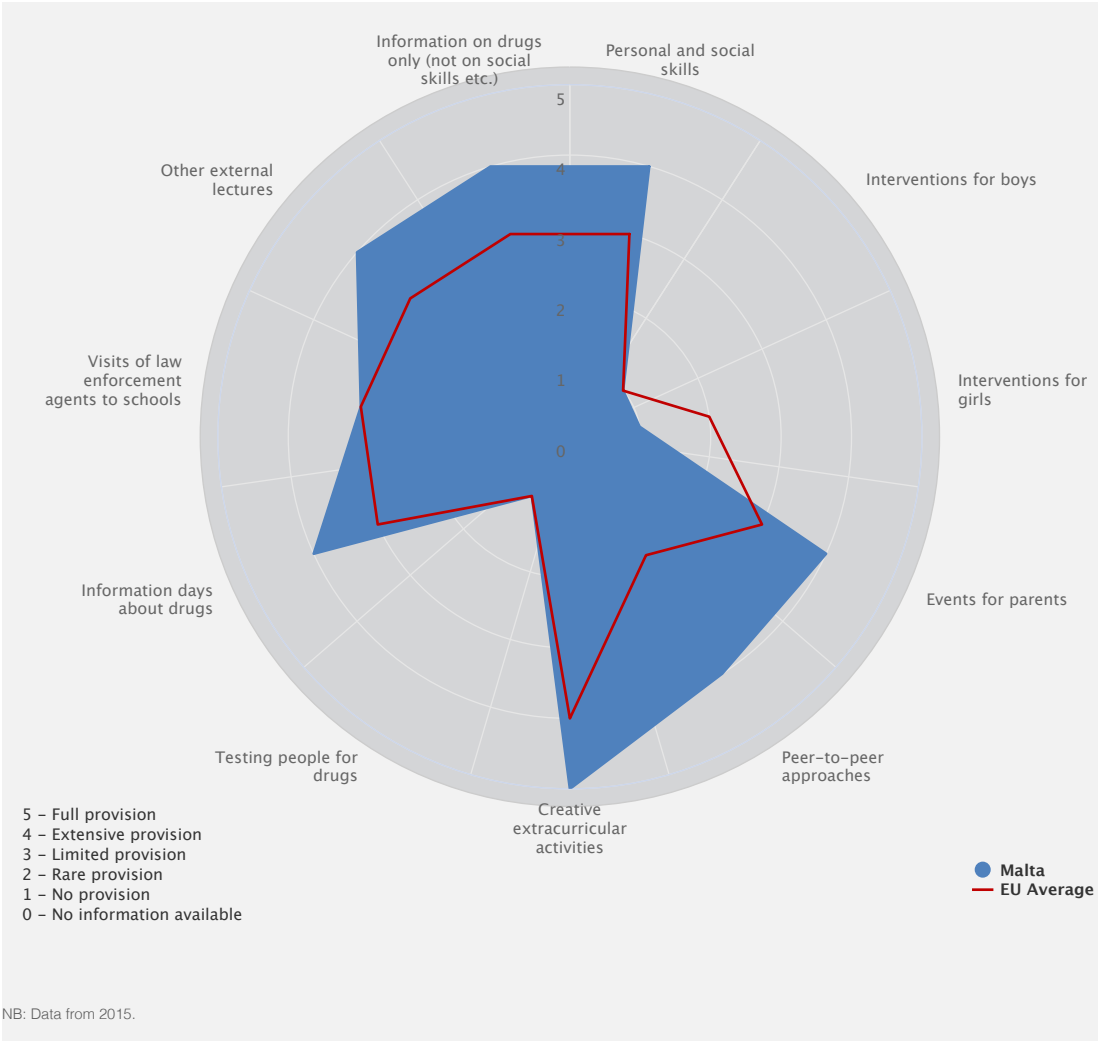
Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing substance use problems, and indicated prevention focuses on at-risk individuals.

Environment prevention approaches in Malta include the adoption of a complete ban on smoking in enclosed spaces and in playgrounds.

Universal prevention is primarily implemented in school settings. School-based programmes primarily focus on the development of life skills such as enhanced self-esteem, the ability to resist peer pressure and decision-making and on increasing young people's abilities to express their feelings and encouraging problem-solving skills. Universal family-based prevention programmes in an interactive environment generally tackle topics related to parenthood, such as leadership styles, communication and child development, and include discussions on drug and alcohol misuse. Community-based prevention programmes primarily target families and young people in local councils, youth organisations, religious societies and social and political clubs. Community and church activities, drug awareness talks, exhibitions, concerts and drug-free activities are organised at specific times of the year and are aimed at the general public.

Selective prevention interventions are mainly school based and focus on students with high levels of absenteeism and those who have dropped out of school. A nationwide initiative, the Leap Project, aims to consolidate community resources and networks to address social exclusion issues. Other target groups are young people in schools in deprived areas, juvenile prison inmates and young offenders. Appogg, the national agency for children, families and the community, and Sedqa have brought together professionals from several fields to develop a project that aims to offer individual guidance and counselling to adolescents who are referred for support as well as their parents and partners. The unit also offers crisis intervention when homelessness or abuse is involved.

Provision of interventions in schools in Malta (expert ratings)



NB: Data from 2015.

Harm reduction

One of the main objectives of the Maltese National Drugs Policy adopted in 2008 is to achieve a high level of health protection and social cohesion by preventing and reducing drug-related harm to health and society, ultimately promoting a culture that discourages the use of illicit drugs. The aim of this policy is to ensure that vulnerable groups receive adequate health and social services, including harm reduction services for those to whom abstinence is not immediately viable.

Harm reduction interventions

In Malta, harm reduction responses relate to the prevention of drug-related infectious diseases and include access to clean injecting equipment, testing and counselling for infectious diseases such as human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV), risk awareness and HBV vaccinations. Blood screening and counselling for infectious diseases are provided at the substance misuse outpatient unit, in prison and at the sexual health clinic in Malta.

Needles and syringes are distributed at seven fixed locations across the country. In 2017, around 316 000 syringes were distributed through these specialised facilities, a decrease for the second consecutive year. A special harm reduction centre for women who inject drugs is operated by Caritas and provides sheltered accommodation and intensive therapy to clients who cannot achieve abstinence in the short term. Protection from different forms of violence and from involvement in sex work is also provided.

Availablity of selected harm reduction responses in Europe

Country	Needle and syringe programmes	Take-home naloxone programmes	Drug consumption rooms	Heroin-assisted treatment
Austria	Yes	No	No	No
Belgium	Yes	No	Yes	No
Bulgaria	Yes	No	No	No
Croatia	Yes	No	No	No
Cyprus	Yes	No	No	No
Czechia	Yes	No	No	No
Denmark	Yes	Yes	Yes	Yes
Estonia	Yes	Yes	No	No
Finland	Yes	No	No	No
France	Yes	Yes	Yes	No
Germany	Yes	Yes	Yes	Yes
Greece	Yes	No	No	No
Hungary	Yes	No	No	No
Ireland	Yes	Yes	No	No
Italy	Yes	Yes	No	No
Latvia	Yes	No	No	No
Lithuania	Yes	Yes	No	No
Luxembourg	Yes	No	Yes	Yes
Malta	Yes	No	No	No
Netherlands	Yes	No	Yes	Yes
Norway	Yes	Yes	Yes	No
Poland	Yes	No	No	No
Portugal	Yes	No	No	No
Romania	Yes	No	No	No
Slovakia	Yes	No	No	No
Slovenia	Yes	No	No	No
Spain	Yes	Yes	Yes	No
Sweden	Yes	No	No	No
Turkey	No	No	No	No
United Kingdom	Yes	Yes	No	Yes

Treatment

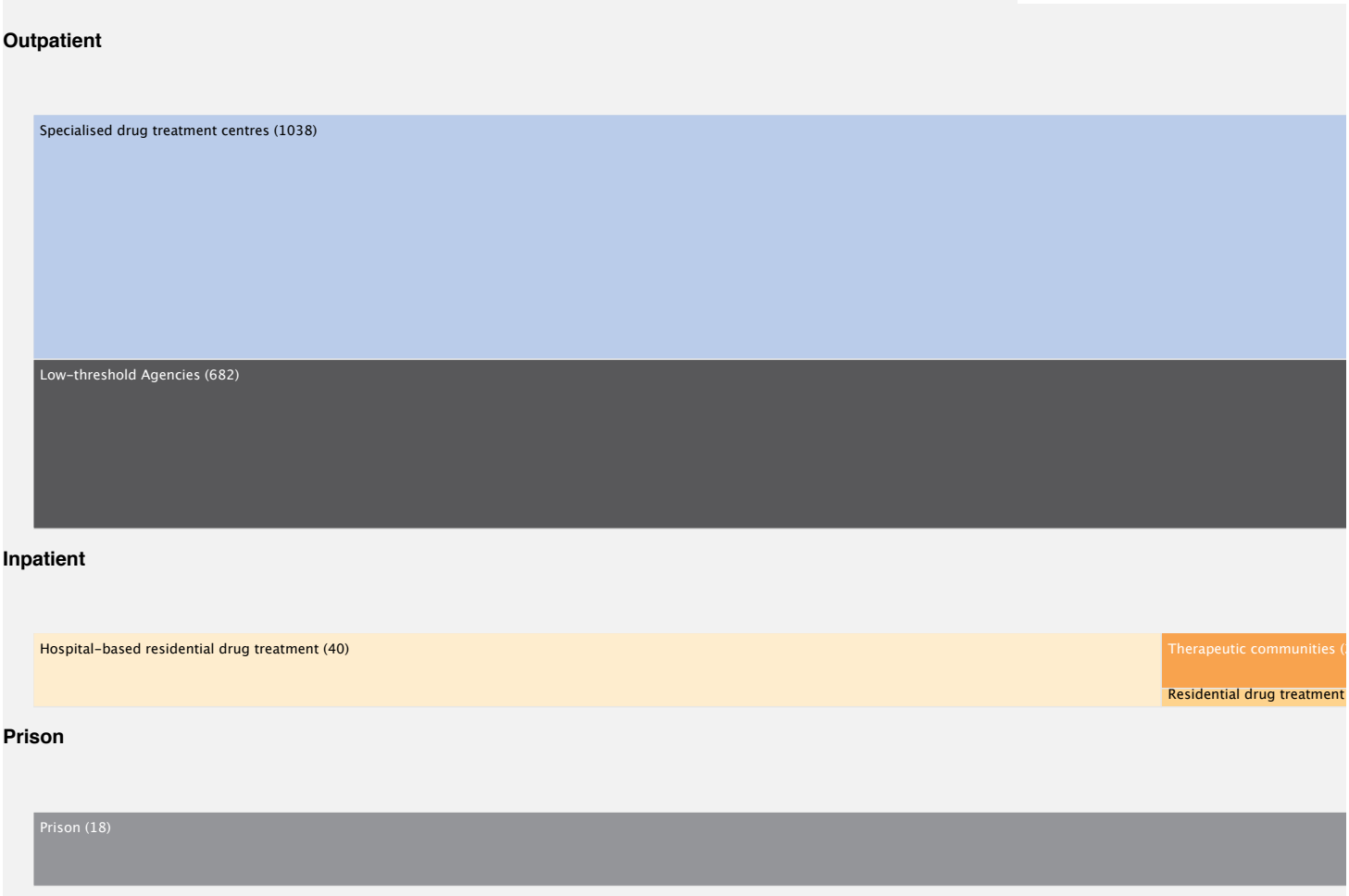
The treatment system

The National Drugs Policy puts an emphasis on synergies between service providers and other health and social professionals and institutions to ensure a multidisciplinary approach to treatment provision. There are five main drug treatment providers: three are funded by the government and two are non-governmental organisations (NGOs) partially funded by the government. These providers deliver different types of treatment, which can be classified into five main categories: (i) specialised outpatient services; (ii) low-threshold services; (iii) inpatient treatment programmes; (iv) detoxification treatment; and (v) opioid substitution treatment (OST). NGO-based outpatient services offer long- or short-term support through social work, counselling, group therapy and psychological interventions, while low-threshold programmes offer day-care services.

Five inpatient units are available in Malta, of which three are therapeutic communities. The residential programmes provide a holistic, multidisciplinary approach to therapy in a communal living environment, and aim to guide clients towards abstinence. One programme offers inpatient detoxification.

OST is provided by the Substance Misuse Outpatient Unit (SMOPU). Methadone maintenance treatment has been available in Malta since 1987, with take-home methadone prescriptions available since 2005. Buprenorphine was introduced in 2006. It is also available as a take-home treatment by prescription from either the SMOPU or a general practitioner. Dihydrocodeine is prescribed in rare instances.

Drug treatment in Malta: settings and number treated



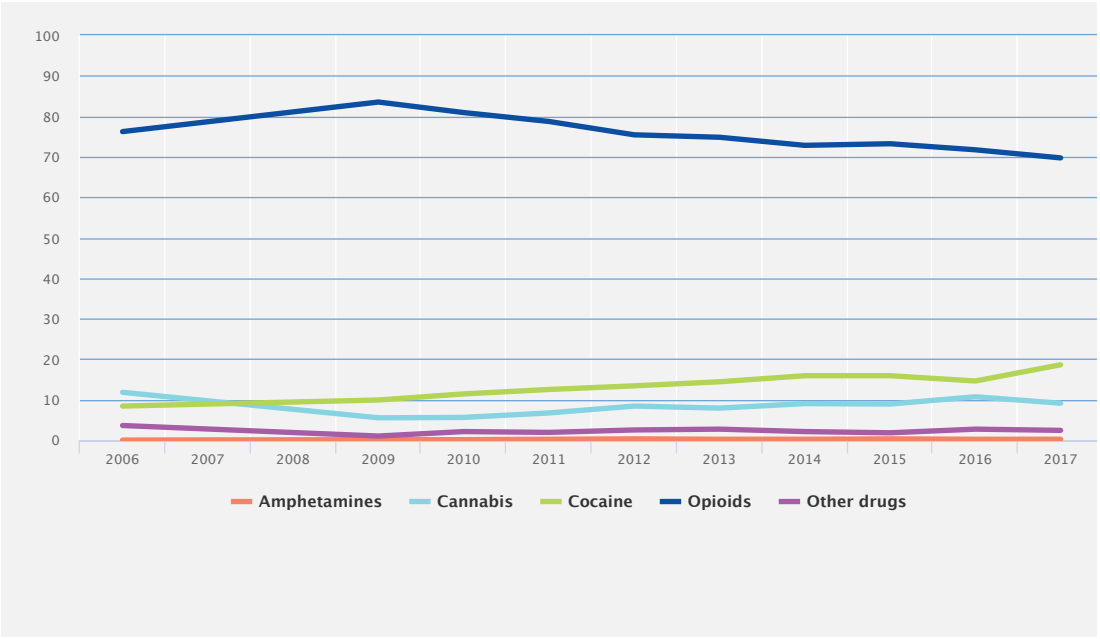
NB: Data from 2017.

Treatment provision

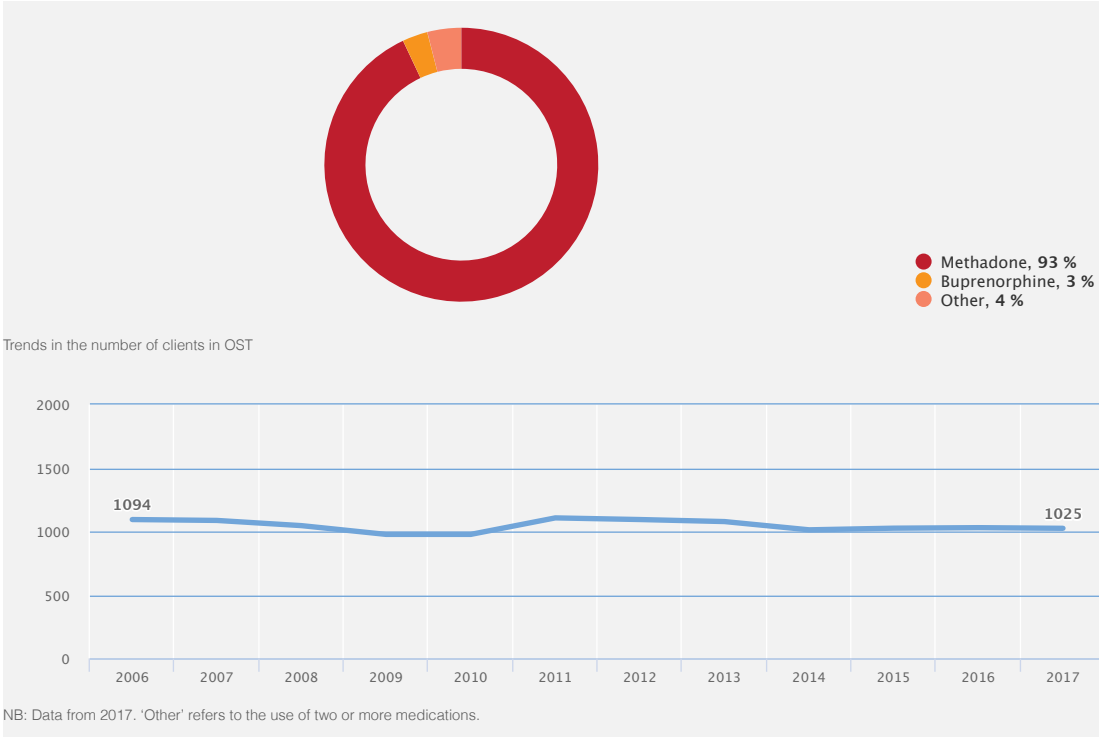
Most clients entering drug treatment in 2017 were treated in outpatient settings. The majority sought treatment as a result of primary use of opioids, mainly heroin, followed by primary cocaine use. Since 2004, a steady increase has been observed in the number and proportion of primary cocaine treatment demands.

Most clients in treatment because of primary heroin use received OST. In 2017, over 1 000 clients were prescribed OST in Malta, and around 9 out of 10 of those received methadone.

Trends in percentage of clients entering specialised drug treatment, by primary drug, in Malta



Opioid substitution treatment in Malta: proportions of clients in OST by medication and trends of the total number of clients



NB: Data from 2017. 'Other' refers to the use of two or more medications.

Drug use and responses in prison

According to the most recent data, in 2014 around 43 % of prisoners in Malta had a history of drug use prior to imprisonment and one quarter had been in drug treatment.

On entering prison, inmates undergo medical screening, which is followed by a consultation with the psychosocial team. Substance use problems are usually assessed with standardised tools. On admission, all prisoners are also tested for human immunodeficiency virus (HIV) and hepatitis B virus (HBV) infections.

Most prisoners undergoing drug treatment in prison receive opioid substitution treatment (OST). OST is initiated at a hospital's forensic unit and the inmates are transferred back to prison once they are stable. In addition, there are protocols for the transfer of inmates to selected drug rehabilitation units. Drug treatment agencies offer counselling and support services to inmates inside the prison, including assistance with social reintegration. Since 2007, a vaccination programme for HBV has been in place.

Activities are undertaken to prepare inmates for release, but it is not within the remit of the prison to provide continuity of care.

Quality assurance

The Research and Standards Development Unit within the Department for Social Welfare Standards is responsible for quality assurance and the development of standards in collaboration with service providers. In general, each service provider develops its own guidelines and standards, which should be in line with the National Drugs Policy. Common national standards in demand reduction areas have not yet been developed in Malta, although the national focal point provides training opportunities for professionals and other stakeholders at the national level. In addition, Malta is considering a recent report from the National Audit Office that suggests ways for the improvement of quality of services.

The national focal point to the European Monitoring Centre for Drugs and Drug Addiction promotes quality assurance and best practices among drug professionals in the country.

Drug-related research

In Malta, the National Drugs Policy recognises the need for adequate monitoring, collection and dissemination of information, as well as the periodical evaluation of policy interventions and ongoing research and training.

The Advisory Board on Drugs and Addiction is responsible for all drug-related issues. The national focal point for drugs and drug dependency is in charge of gathering the necessary information to support drug policy and of monitoring the drugs situation and responses. Both the government and university departments play an important role in undertaking research, which is mainly funded by the public sector. Drug-related research findings are disseminated by the national focal point through regular meetings with partners, direct mailing to interested parties, the media and on the national focal point website. Drug-related studies focus primarily on prevalence, incidence and patterns of drug use.

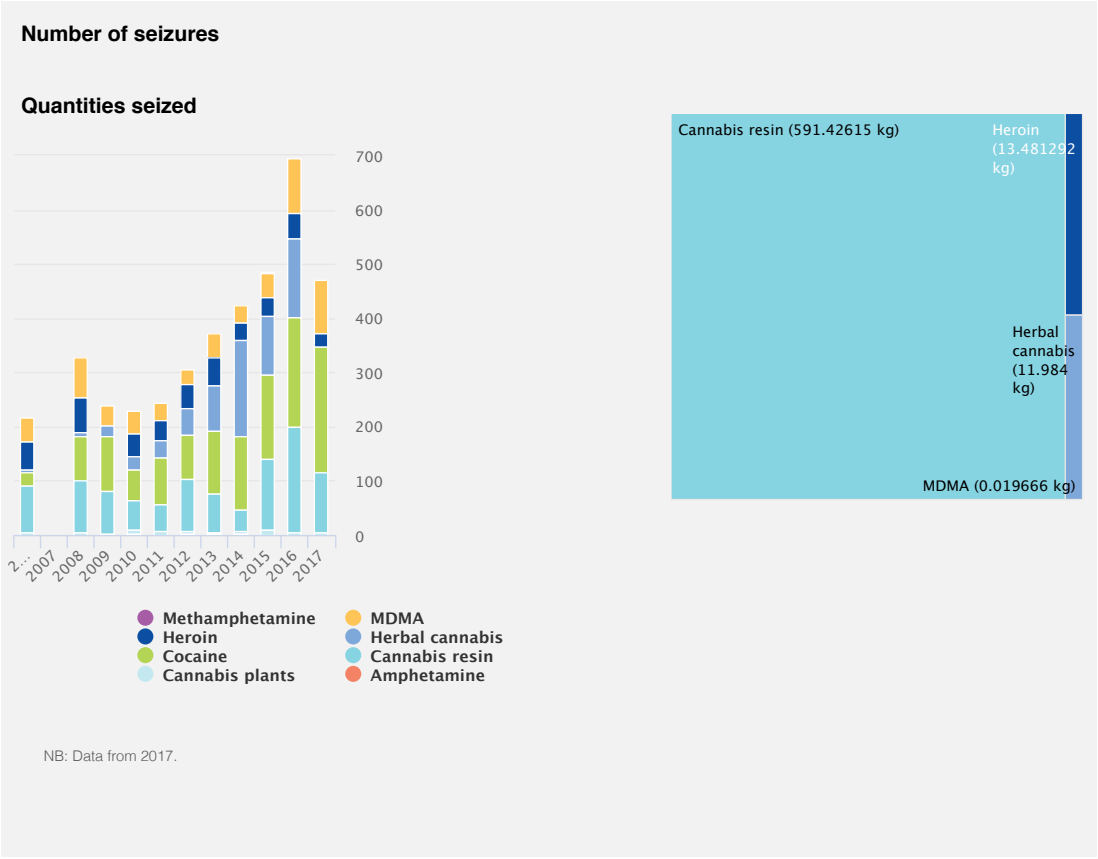
Drug markets

Cannabis is the most frequently seized drug in Malta, and it is the only illicit drug known to be produced in the country, mostly on a small scale. Cannabis resin from Morocco is imported via Tunisia and Libya. Heroin of Afghan origin is imported via Turkey, North Africa or Western European countries, and cocaine is smuggled to Malta mainly through Spain. Synthetic stimulant drugs such as MDMA/ecstasy and amphetamine are imported from other European countries, particularly Italy and the Netherlands. The availability of new psychoactive substances (NPS) is low, but it has grown in recent years.

The number of illicit drug seizures in Malta has increased in the last decade. In terms of quantities, in 2017, cannabis products, MDMA, heroin and, in particular, cocaine were seized in larger amounts than in previous years.

Data on the retail price and purity of the main illicit substances seized are shown in the 'Key statistics' section.

Drug seizures in Malta: trends in number of seizures (left) and quantities seized (right)



NB: Data from 2017.

Key statistics

Most recent estimates and data reported

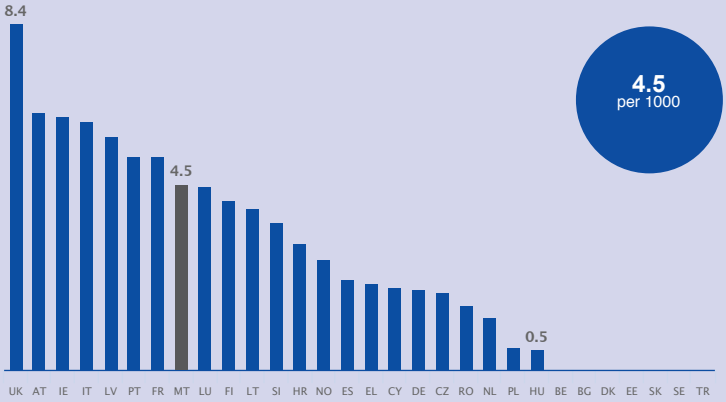
	Year	Country data	EU range Min.	EU range Max.
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	12.61	6.51	36.79
Last year prevalence of use — young adults (%)	n.a.	n.a.	1.8	21.8
Last year prevalence of drug use — all adults (%)	2013	0.9	0.9	11
All treatment entrants (%)	2017	9.1	1.03	62.98
First-time treatment entrants (%)	2017	19	2.3	74.36
Quantity of herbal cannabis seized (kg)	2016	12	11.98	94 378.74
Number of herbal cannabis seizures	2016	146	57	151 968
Quantity of cannabis resin seized (kg)	2017	591.4	0.16	334 919
Number of cannabis resin seizures	2017	109	8	157 346
Potency — herbal (% THC) (minimum and maximum values registered)	n.a.	n.a.	0	65.6
Potency — resin (% THC) (minimum and maximum values registered)	n.a.	n.a.	0	55
Price per gram — herbal (EUR) (minimum and maximum values registered)	n.a.	n.a.	0.58	64.52
Price per gram — resin (EUR) (minimum and maximum values registered)	n.a.	n.a.	0.15	35
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.76	0.85	4.85
Last year prevalence of use — young adults (%)	n.a.	n.a.	0.1	4.7
Last year prevalence of drug use — all adults (%)	n.a.	n.a.	0.1	2.7
All treatment entrants (%)	2017	18.6	0.14	39.2
First-time treatment entrants (%)	2017	41.8	0	41.81
Quantity of cocaine seized (kg)	2017	0.3	0.32	44 751.85
Number of cocaine seizures	2017	232	9	42 206
Purity (%) (minimum and maximum values registered)	n.a.	n.a.	0	100
Price per gram (EUR) (minimum and maximum values registered)	n.a.	n.a.	2.11	350
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.7	0.84	6.46
Last year prevalence of use — young adults (%)	n.a.	n.a.	0	3.9
Last year prevalence of drug use — all adults (%)	n.a.	n.a.	0	1.8
All treatment entrants (%)	2017	0.2	0	49.61
First-time treatment entrants (%)	2017	0.4	0	52.83
Quantity of amphetamine seized (kg)	2017	0	0	1 669.42
Number of amphetamine seizures	2017	1	1	5 391
Purity — amphetamine (%) (minimum and maximum values registered)	n.a.	n.a.	0.07	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	n.a.	n.a.	3	156.25
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.97	0.54	5.17
Last year prevalence of use — young adults (%)	n.a.	n.a.	0.2	7.1
Last year prevalence of drug use — all adults (%)	n.a.	n.a.	0.1	3.3
All treatment entrants (%)	2017	0.7	0	2.31
First-time treatment entrants (%)	2017	0.9	0	2.85
Quantity of MDMA seized (tablets)	2017	405	159	8 606 765
Number of MDMA seizures	2017	99	13	6 663
Purity (MDMA mg per tablet) (minimum and maximum values registered)	n.a.	n.a.	0	410
Purity (MDMA % per tablet) (minimum and maximum values registered)	n.a.	n.a.	2.14	87
Price per tablet (EUR) (minimum and maximum values registered)	n.a.	n.a.	1	40
Opioids				
High-risk opioid use (rate/1 000)	2017	4.51	0.48	8.42
All treatment entrants (%)	2017	69.7	3.99	93.45
First-time treatment entrants (%)	2017	32.8	1.8	87.36
Quantity of heroin seized (kg)	2017	13.5	0.01	17 385.18
Number of heroin seizures	2017	25	2	12 932
Purity — heroin (%) (minimum and maximum values registered)	n.a.	n.a.	0	91
Price per gram — heroin (EUR) (minimum and maximum values registered)	n.a.	n.a.	5	200
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2017	0	0	47.8
HIV prevalence among PWID* (%)	2016/2017	0.0 - 1.2	0	31.1
HCV prevalence among PWID* (%)	2017	44.54	14.7	81.5
Injecting drug use (cases rate/1 000 population)	n.a.	n.a.	0.08	10.02
Drug-induced deaths — all adults (cases/million population)	2017	16.2	2.44	129.79
Health and social responses				
Syringes distributed through specialised programmes	2017	315 541	245	11 907 416

Clients in substitution treatment	2017	1 025	209	178 665
Treatment demand				
All entrants	2017	1 845	179	118 342
First-time entrants	2017	245	48	37 577
All clients in treatment	2017	1 845	1 294	254 000
Drug law offences				
Number of reports of offences	2017	739	739	389 229
Offences for use/possession	2017	623	130	376 282

EU Dashboard

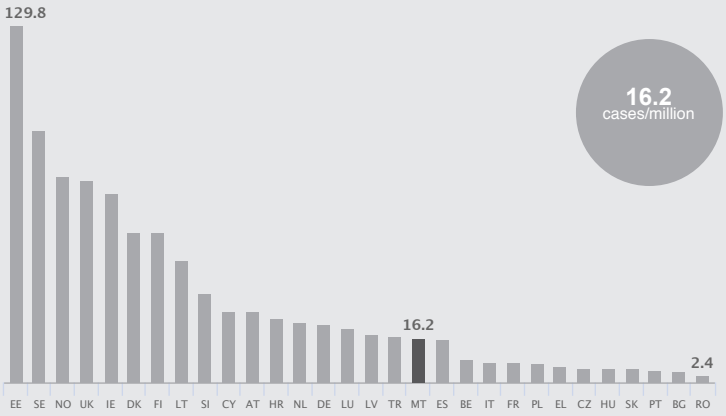
Opioids

High-risk opioid use (rate/1 000)



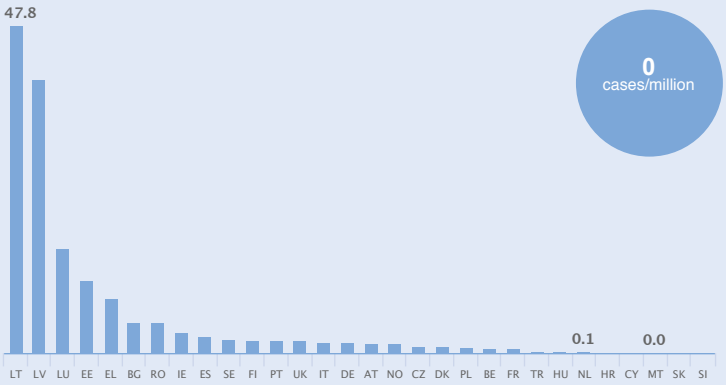
Drug-induced mortality rates

National estimates among adults (15-64 years)



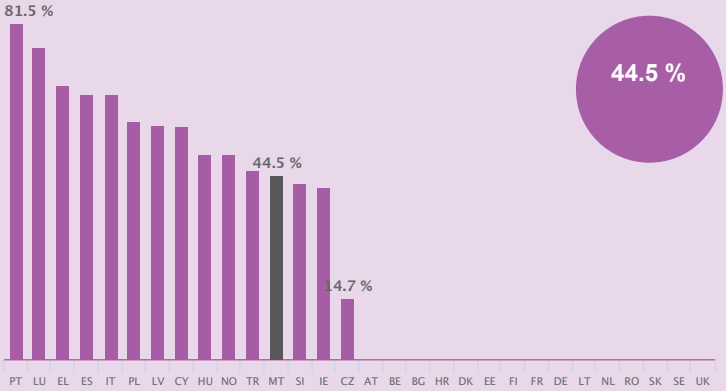
HIV infections

Newly diagnosed cases attributed to injecting drug use



HCV antibody prevalence

National estimates among injecting drug users



NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifcations on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Last year prevalence estimated among young adults aged 16-34 years in Denmark, Norway and the United Kingdom; 17-34 in Sweden; and 18-34 in France, Germany, Greece and Hungary. Drug-induced mortality rate for Greece are for all ages.

About our partner in Malta

The Maltese national focal point is based within the Ministry for the Family and Social Solidarity and is part of the National Coordinating Unit on Drugs and Alcohol. It started its operations in June 2004 as a result of a Twinning Light Project with the Netherlands.

Click here to learn more about our partner in Malta .

Maltese national focal point

Ministry for Justice, Dialogue and the Family

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Head of national focal point: Mr Carlo Olivari Demanuele

Methodological note: Analysis of trends is based only on those countries providing sufficient data to describe changes over the period specified. The reader should also be aware that monitoring patterns and trends in a hidden and stigmatised behaviour like drug use is both practically and methodologically challenging. For this reason, multiple sources of data are used for the purposes of analysis in this report. Caution is therefore required in interpretation, in particular when countries are compared on any single measure. Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin .