European Monitoring Centre for Drugs and Drug Addiction

MINISTRY FOR THE FAMILY AND SOCIAL SOLIDARITY

Malta

Country Drug Report 2017

THE DRUG PROBLEM IN MALTA AT A GLANCE

Drug use

in young adults (15-34 years) in the last year

Cannabis

No data

No data

Other drugs

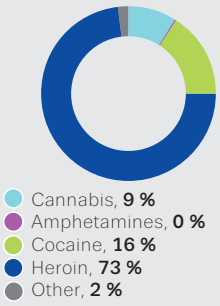
MDMA	No data
Amphetamines	No data
Cocaine	No data

High-risk opioid users

1 708
(1 584 - 1 863)

Treatment entrants

by primary drug



Opioid substitution treatment clients

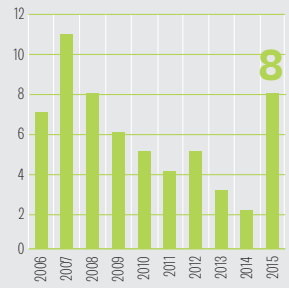
1 026

Syringes distributed

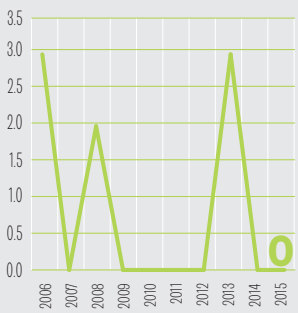
through specialised programmes

340 644

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

472

Top 5 drugs seized

ranked according to quantities measured in kilograms

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

Population

(15-64 years)

288 403

Source: EUROSTAT
Extracted on: 26/03/2017

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, 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.

About this report

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 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

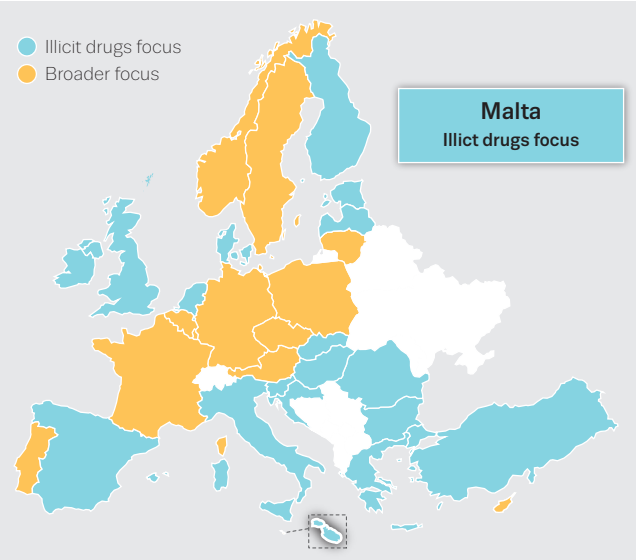
National drug strategy and coordination

National drug strategy

Launched in 2008, the Maltese national drug policy document addresses illicit drug problems (Figure 1). 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) the 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.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2015. Strategies with broader focus may include, for example, licit drugs and other addictions.

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.

National coordination mechanisms

The main body responsible for drug-related matters in Malta is the Advisory Board on Drugs and Addiction (part of the Ministry for the Family and Social Solidarity), which was set up when the National Commission on the Abuse of Drugs, Alcohol and other Dependencies became part of the Presidential Office. 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 drug policy, while the main remit of the national focal point for drugs and drug addiction to the EMCDDA is that of monitoring the situation and the responses, including the effectiveness of the actions put in place as a result of the national drug policy.

Launched in 2008, the Maltese national drug policy document addresses illicit drug problems

Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy.

In Malta, the financing of drug-related activities is decided annually by the entities in charge of their implementation. The available information is very limited and does not permit reporting on the size and trends of drug-related expenditure.

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

Drug laws and drug law offences

National drug laws

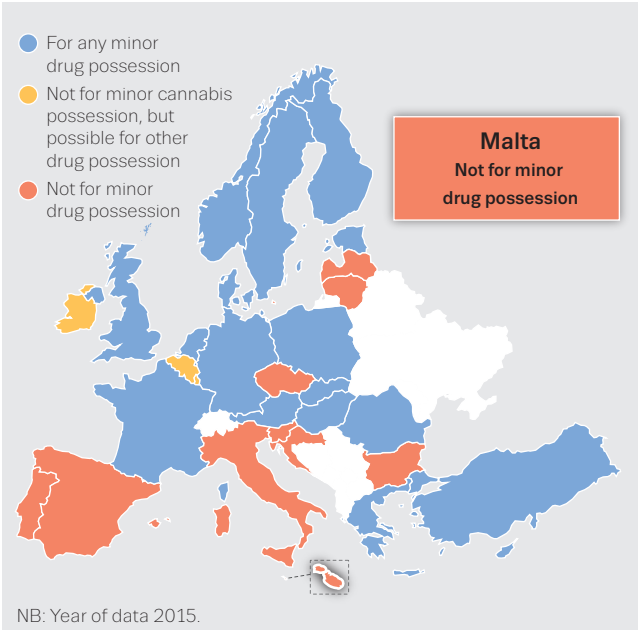
The principal pieces of legislation dealing with substance abuse in Malta are the Medical and Kindred Professions Ordinance (Cap. 31), which relates to psychotropic drugs, and the Dangerous Drugs Ordinance (Cap. 101), relating to narcotic drugs, combined with the new Drug Dependence (Treatment not Imprisonment)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

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.

In April 2015, the Drug Dependence (Treatment not Imprisonment) Act 2014 came into force. Under this Act, a person found in possession of a small amount of drugs for personal use will be tried in front of the Commissioner of Justice. If found guilty, a fine of EUR 50 to EUR 100 will be imposed for possession of cannabis or of EUR 75 to EUR 125 for possession of other drugs. Any offender who commits a second offence within a period of two years will be required to attend the Drug Offenders Rehabilitation Board, where he or she will be assessed for drug dependence and any necessary order may be issued; failure to comply with an order may be punished by a fine or three months in prison. A person found in possession of one cannabis plant for personal use will not

FIGURE 2

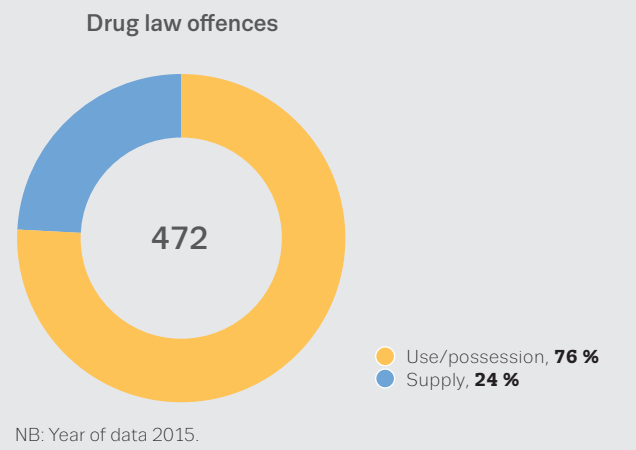
Legal penalties in laws: the possibility of incarceration for possession of drugs for personal use (minor offence)



NB: Year of data 2015.

FIGURE 3

Reported drug law offences in Malta



NB: Year of data 2015.

be liable to a mandatory prison term (Figure 2). 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 six 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 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 six months if the offender intended to consume the drug on the spot with others. In 2014, the laws were further amended to guide the choice of prosecution for trafficking in a lower or superior court, considering whether the offender was playing a leading role to a significant or lesser extent and defining quantity guidelines for MDMA/ecstasy, LSD, amphetamine and ketamine. Courts may also opt for the lower punishment range if the higher range is considered disproportionate.

New psychoactive substances (NPS) 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.

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 implementation of drug laws and to improve strategies.

The statistical data provided by the Malta Police Force indicate that most DLOs are related to possession (Figure 3). Most of the DLOs for possession are related to cannabis.

Drug use

Prevalence and trends

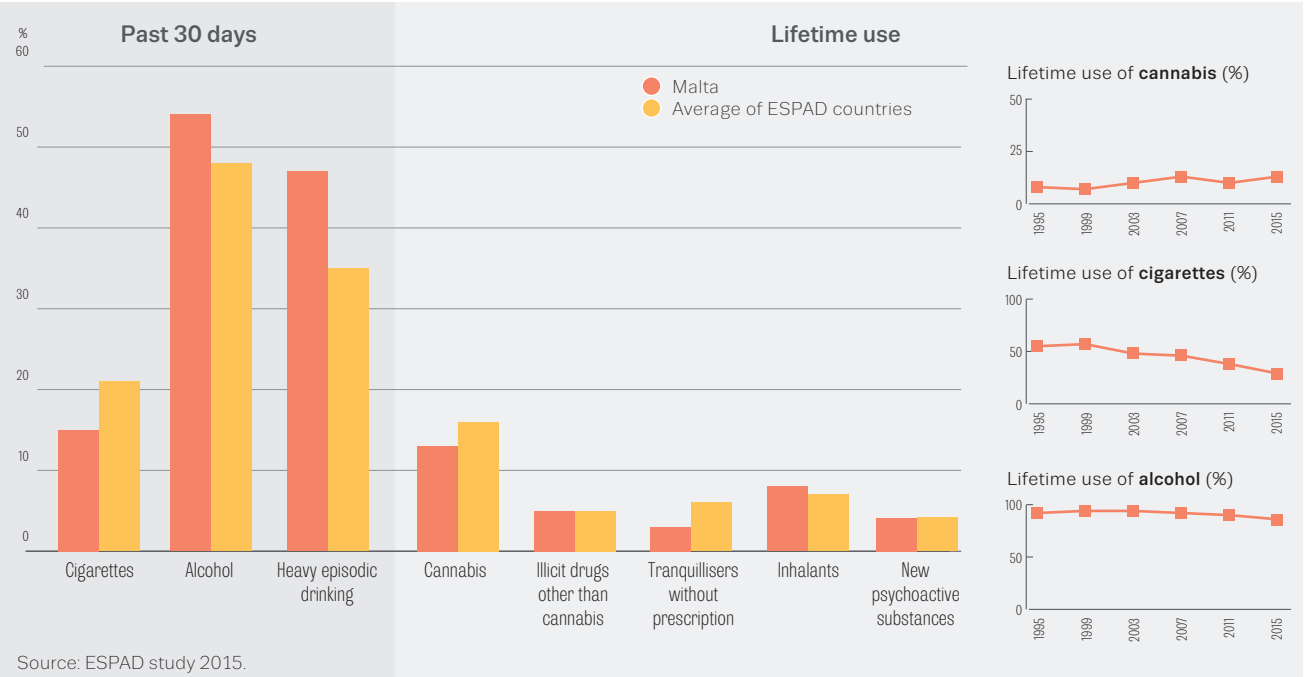
Cannabis is the most commonly used illicit drug among the Maltese adult population aged 18-65 years. According to the 2013 general population study, around 4.3 % of those aged 18-65 years reported having used cannabis during their lifetime. The level of lifetime use of illicit drugs other than cannabis was 1.4 % (MDMA, amphetamines, cocaine, heroin, mephedrone, any of the NPS or LSD); 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 (35 countries), while levels of lifetime use of illicit drugs other than cannabis and lifetime use of NPS were very 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 (Figure 4).

Cannabis is the most commonly used illicit drug among the Maltese adult population aged 18-65 years

FIGURE 4

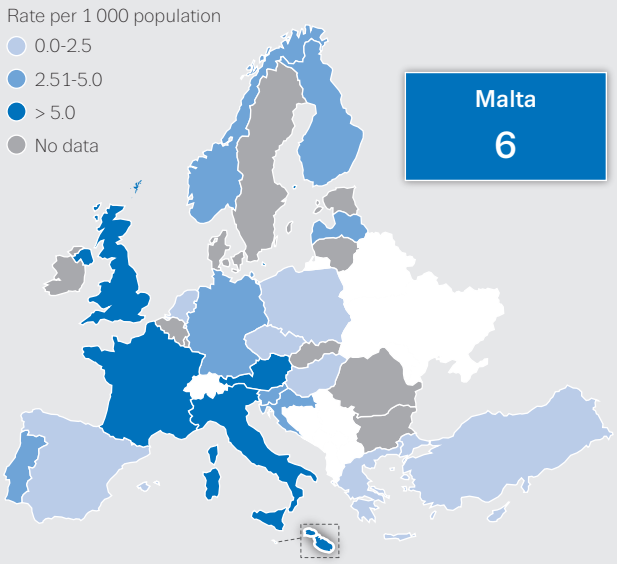
Substance use among 15- to 16- year-old school students in Malta



Source: ESPAD study 2015.

FIGURE 5

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



NB: Year of data 2015, or latest available year.

High-risk drug use and trends

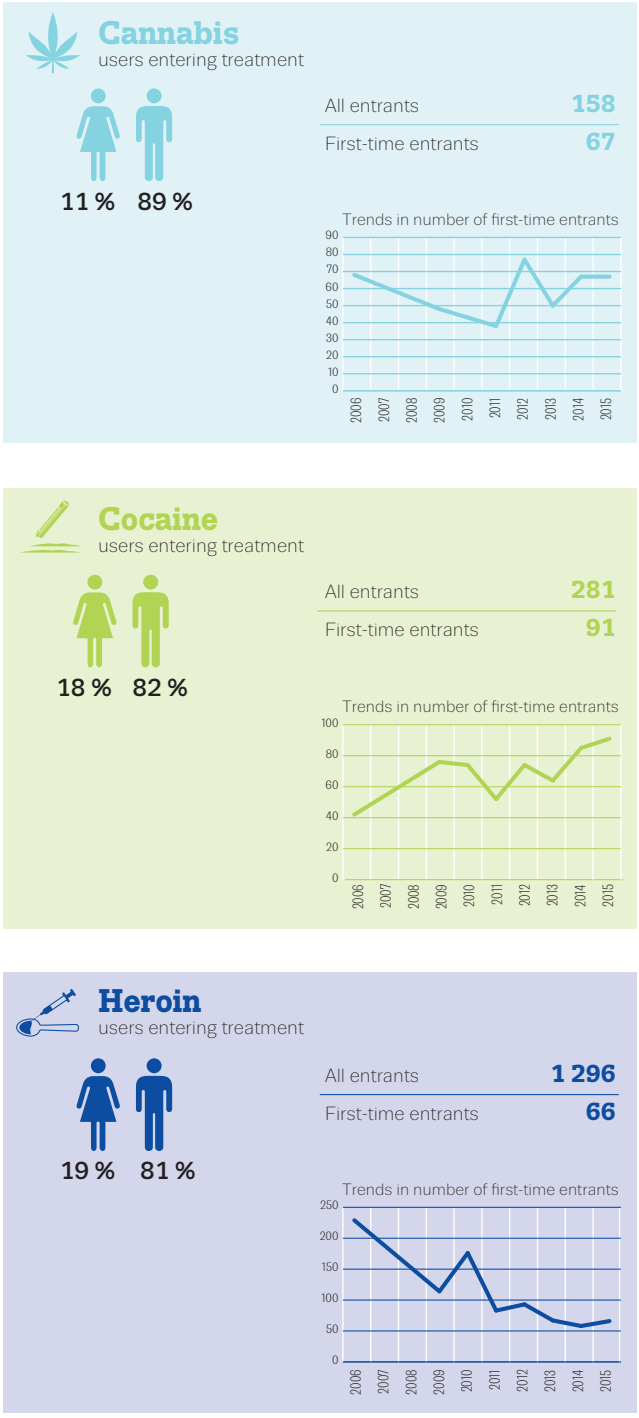
Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use (Figure 6).

In Malta, heroin remains the illicit drug that is linked with the more severe health, legal and social consequences (Figure 5).

Data from specialised treatment centres indicate that cocaine-related first treatment demands have increased in recent years, while heroin-related treatment demands have decreased. Sniffing is main method of use for cocaine, and only a few treatment clients inject it. Although 6 out of 10 primary heroin use clients reported injecting as a primary method of use, injecting is less common among first-time clients. Fewer than one fifth of clients in treatment are female (Figure 6).

FIGURE 6

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



NB: Year of data 2015. Data is for first-time entrants, except for gender which is for all treatment entrants.

Drug harms

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. A small number of newly detected human immunodeficiency virus (HIV) cases were linked to injecting drug use (Figure 7).

An additional information source is the results of testing 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 2015, one client was HIV positive, 65 out of 182 were positive for hepatitis C virus (HCV) infection and 1 out of 212 was positive for hepatitis B virus (HBV) (Figure 8). HCV infection is more common among heroin users than those who reported cocaine as their primary substance of use.

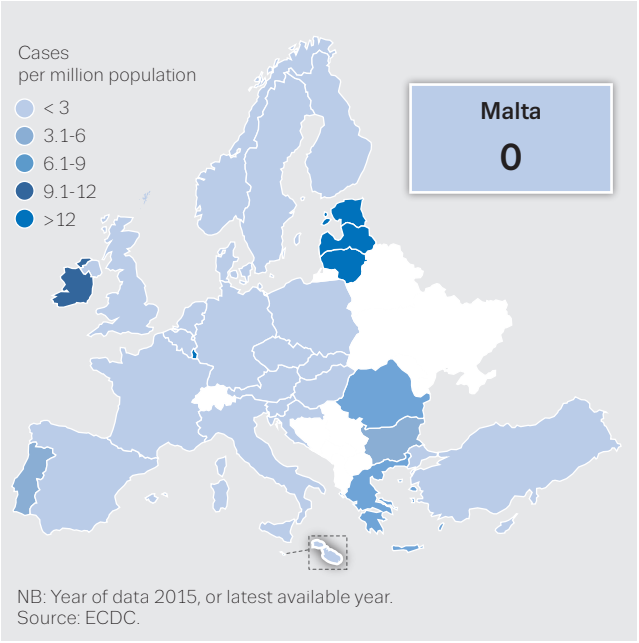
Drug-related emergencies

In 2015, a total of 33 non-fatal overdoses were reported in Malta, which indicates a declining trend in the last five years. The majority of non-fatal overdoses can be attributed to the use of prescription medications.

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

FIGURE 7

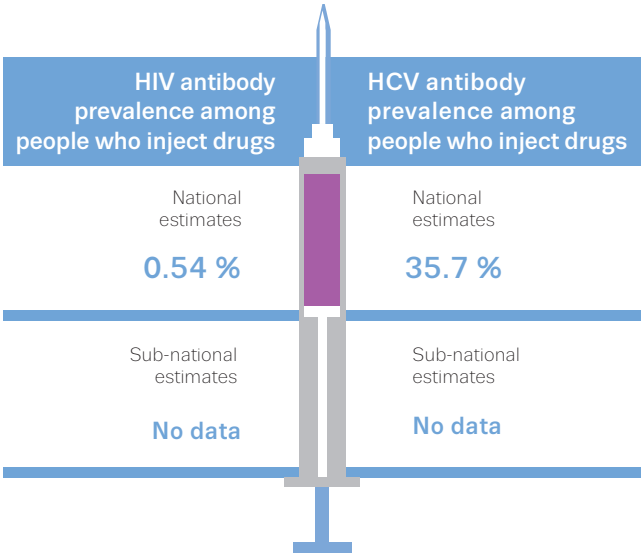
Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2015, or latest available year.
Source: ECDC.

FIGURE 8

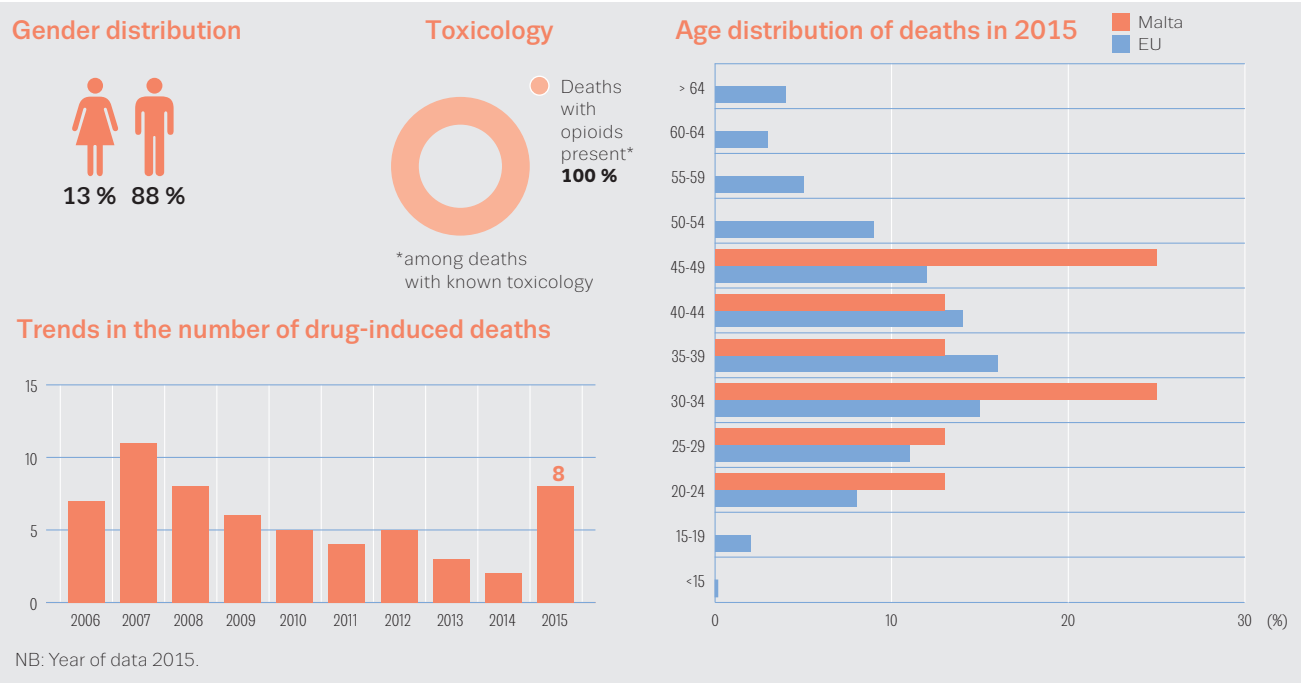
Prevalence of HIV and HCV antibodies among people who inject drugs in Malta



NB: Year of data 2015.

FIGURE 9

Characteristics of and trends in drug-induced deaths in Malta



NB: Year of data 2015.

Drug-induced deaths and mortality

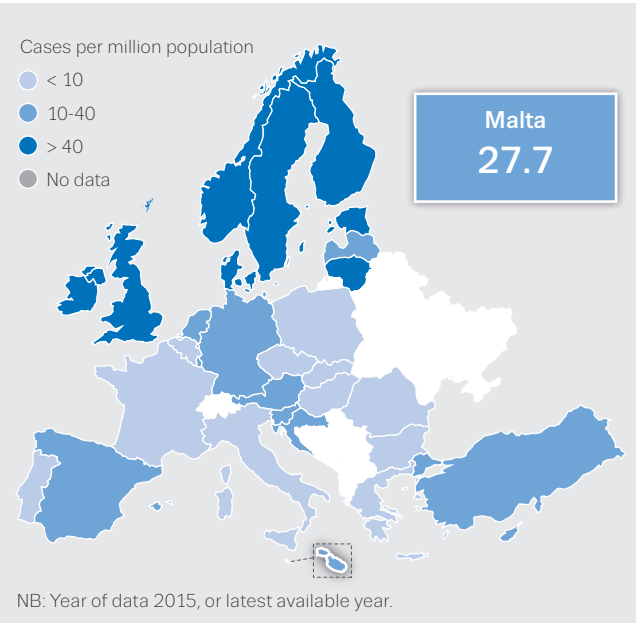
Drug-induced deaths are deaths directly attributable to the use of illicit drugs (i.e. poisonings and overdoses).

In 2015, the Police Special Registry registered a fourfold increase in drug-induced deaths compared with 2014, although the number remained within the range reported annually over the last decade (2-11). Toxicological analyses confirmed the presence of opioids in all deaths, either alone or in combination with other illicit stimulants. The mean age of the deceased was 36 years (Figure 9).

The drug-induced mortality rate among adults (aged 15-64 years) was 27.7 deaths per million in 2015 (Figure 10), which is slightly higher than the most recent European average of 20.3 deaths per million.

FIGURE 10

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



NB: Year of data 2015, or latest available year.

Prevention

The current national drug policy defines a number of actions in the area of drug prevention and puts an emphasis on the promotion of healthy lifestyle.

The Foundation for Social Welfare Services and the Foundation for Medical Services implement prevention activities in close cooperation with non-governmental organisations (NGOs). Sedqa has established a number of prevention interventions. The NGOs Caritas and the OASI Foundation run a range of prevention programmes that target specific groups or settings, such as schoolchildren, peers, parents, the community and the workplace, while the Anti-Substance Abuse Unit within the Education Division also 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 drug use problems, and indicated prevention focuses on at-risk individuals.

The environmental prevention activities in Malta are mainly limited to tobacco control policies and restrictions of smoking in public places.

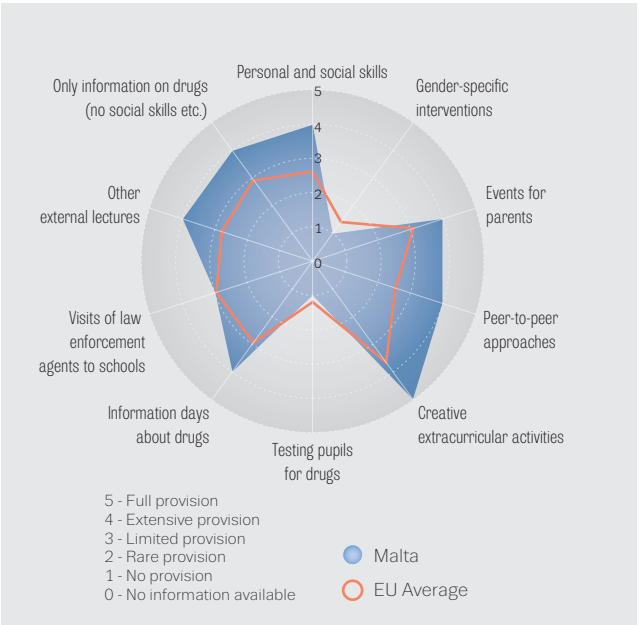
Universal prevention is primarily implemented in school settings, where interventions begin at primary school level and continue into secondary schools. Prevention activities in primary schools focus on friendship and peer pressure, with some introductory information on the possible problems that tobacco and alcohol use can cause. Interventions in secondary schools are designed to develop life skills, self-esteem, decision-making and problem-solving skills and resistance to peer pressure. The messages focus on encouraging abstinence from tobacco, alcohol and drugs, with the aim of preventing the development of any long-term harmful use of these substances (Figure 11).

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 abuse. Community-based prevention programmes primarily target families and young people in local councils, youth organisations, religious societies and social and political clubs.

Selective prevention interventions are mainly school based and focus on students with high levels of absenteeism and those who have dropped out of school. Other interventions include outreach work targeting young people from disadvantaged neighbourhoods. A new nationwide initiative, the Leap Project, which is funded through the European Social Fund, was launched in 2014 and has the aim of consolidating 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. Interventions for these groups occur mainly as a result of referrals to drug treatment agencies. Appogg and Sedqa have brought together professionals from several fields and have developed a project that aims to offer individual guidance and counselling to adolescents who are referred for support. The support offered by this project is also available to the parents and partners of the young people referred to the services. The unit also offers crisis intervention when homelessness or abuse is involved. The programme aims to build a network of support by joining forces with other institutions and professionals involved with the young person in question. Two online services that allow children and young people to ask for assistance and report any type of abuse have been created (kellimni.com and Be Smart Online).

FIGURE 11

Provision of interventions in schools in Malta (expert ratings)



NB: Year of data 2015.

Harm reduction

One of the main objectives of the Maltese National Drugs Policy is to achieve a high level of health protection and social cohesion by preventing and reducing drug-related harm to health and society. The policy's aim is to provide the general public with information on the harms of drug use and to promote ongoing public health campaigns.

Harm reduction interventions

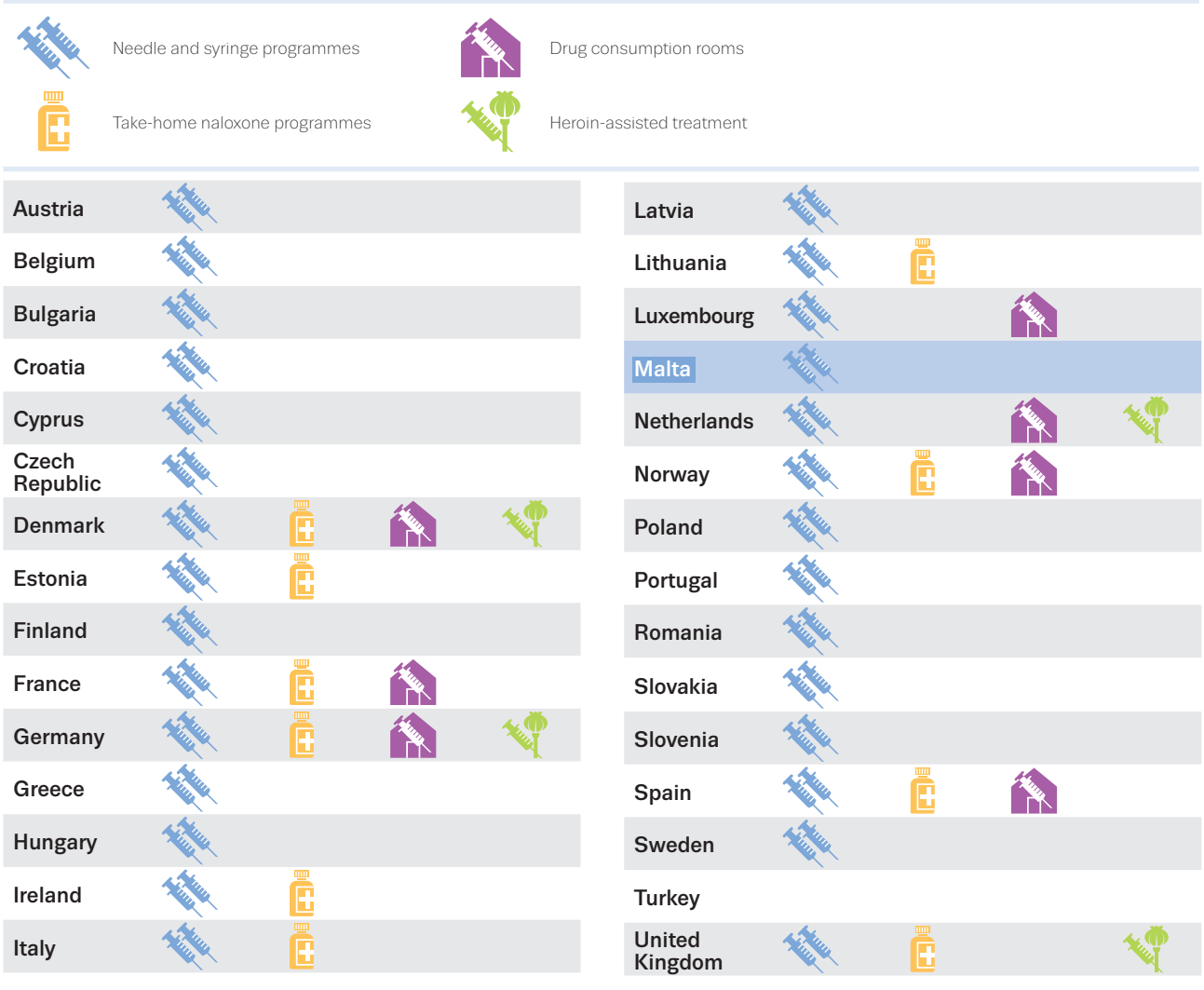
In Malta, harm reduction responses relate to the prevention of drug-related infectious diseases and include access to clean injecting equipment, testing and counselling for infectious diseases such as HIV, HBV and HCV, risk awareness and HBV vaccinations (Figure 12).

Needles and syringes are distributed at seven fixed locations across the country. In 2015, around 341 000 syringes were distributed through these specialised facilities, representing an increasing trend since 2013. A special harm reduction centre for females who inject drugs is operated by Caritas and provides intensive therapy to clients who cannot achieve abstinence in the short term; sheltered accommodation and protection from different forms of violence and from involvement in sex work is also provided.

In 2015, 341 000 syringes were distributed through the needle and syringe programmes

FIGURE 12

Availability of selected harm reduction responses



NB: Year of data 2016.

Treatment

The treatment system

The current national drug 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, of which three are funded by the government, while two NGOs are partially funded by the government.

These treatment providers deliver different types of treatment, which can be classified into several main categories: specialised outpatient services; low-threshold services; inpatient treatment programmes; detoxification treatment; and 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.

Three of the main drug treatment providers offer inpatient treatment. All inpatient 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 and buprenorphine was introduced in 2006. In 2005, take-home methadone prescriptions were introduced. Buprenorphine is also available as a take-home treatment and is available by prescription from either SMOPU or a general practitioner. Dihydrocodeine is prescribed in rare instances.

Treatment provision

The number of treatment clients in Malta has increased in the last 10 years; this can be attributed to an enhanced level of coordination between services, an increase in referrals to treatment from several agencies and also improvements in treatment data collection and reporting.

Most clients entering treatment in 2015 were treated in outpatient settings (Figure 13).

The majority of clients sought treatment as a result of the primary use of opioids, mainly heroin, followed by those seeking treatment for primary cocaine use; the proportion of primary cocaine users has increased in recent years (Figure 14).

Most clients who required treatment because of primary heroin use in 2015 were placed in the OST programme. Around 9 out of 10 people who received the OST were prescribed methadone (Figure 15).

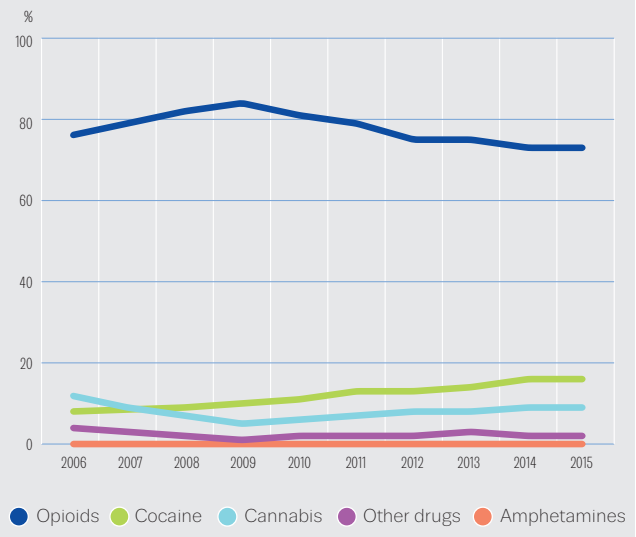
FIGURE 13

Drug treatment in Malta: settings and number treated

NB: Year of data 2015.

FIGURE 14

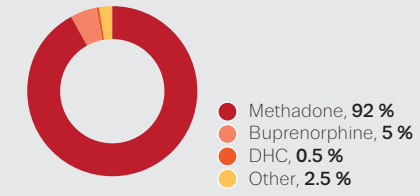
Trends in percentage of clients entering specialised drug treatment, by primary drug in Malta



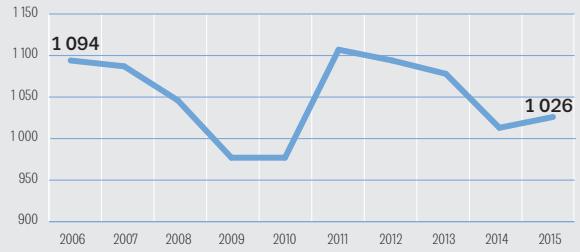
NB: Year of data 2015.

FIGURE 15

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



Trends in the number of clients in OST



NB: Year of data 2015. DHC: dihydrocodeine.

Drug use and responses in prison

According to the last available data from 2014, fewer than half of prisoners had a history of drug use prior to imprisonment and one quarter had received drug treatment. Among those receiving treatment whose primary drug of use was known, heroin was most commonly used drug, followed by cannabis and cocaine.

On entering prison, inmates are first seen by medical personnel, who carry out thorough medical screening. They are then seen by the psychosocial team. Substance use problems are usually assessed by applying standardised tools. All prisoners are also tested for HIV on admission and screened for HBV infection. A vaccination programme for HBV was initiated in 2007.

Most prisoners undergoing drug treatment in prison receive OST. Individuals start OST at a hospital's forensic unit and are sent back to the prison once they are stabilised, on the condition that they do not have any other psychiatric condition that requires monitoring.

Additionally, there are protocols for the transfer of inmates to selected drug rehabilitation units, if needed. Drug treatment agencies also offer counselling and support services to inmates inside the prison, including assistance with social reintegration. Activities are undertaken to prepare inmates for release, but it is not within the remit of the prison to provide for continuity of care.

According to 2014 data, fewer than half of prisoners had a history of drug use prior to imprisonment and one quarter had received drug treatment

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.

The national focal point to the EMCDDA promotes quality assurance and best practices among drugs professionals in the country.

Drug-related studies focus primarily on prevalence, incidence and patterns of drug use

Drug-related research

Research is one of the sections of the current national drug policy. The policy recognises the need for adequate monitoring, collection and dissemination of information, periodical evaluation of policy measures 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 addiction is responsible for gathering the necessary information to support the policy cycle and for monitoring the drug situation and the responses. Both government and university departments play an important role in undertaking research, which is mainly funded by the state budget. Drug-related research findings are then disseminated by the national focal point through regular meetings with its network of partners, direct mailing to interested parties, through the media and on the national focal point website. Drug-related studies focus primarily on prevalence, incidence and patterns of drug use.

Drug markets

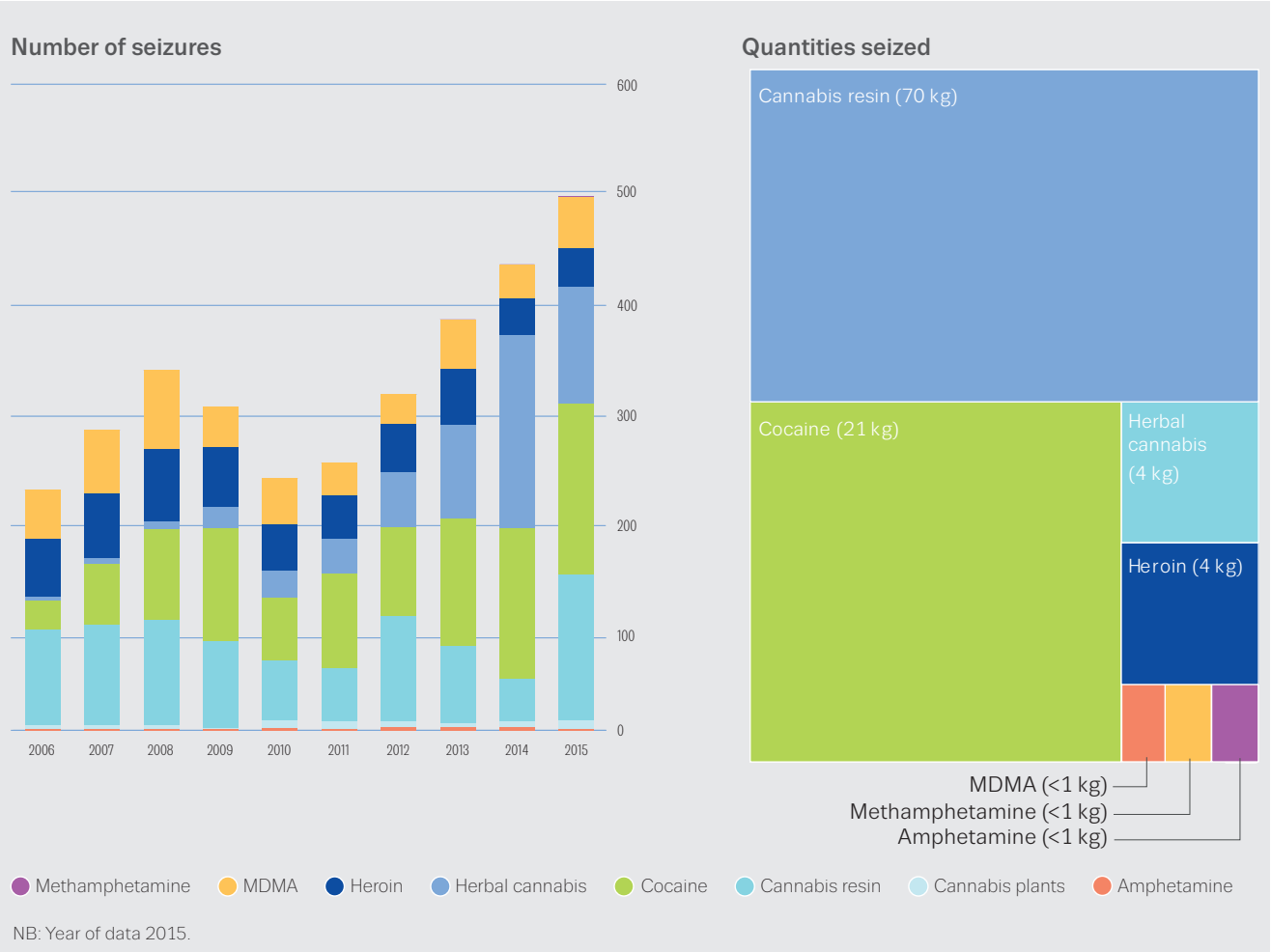
Cannabis is the most frequently seized drug in Malta, and it is the only illicit drug cultivated in the country, because of the favourable climatic conditions on the island. Cannabis is mainly cultivated by home growers, although commercial operations have been discovered occasionally. Cannabis resin is imported from Tunisia and Libya. Heroin arrives from Turkey, via North Africa or Western European countries, and cocaine is smuggled mainly through Spain. Synthetic stimulants, such as MDMA and amphetamines, are imported from other European countries, particularly from the Netherlands. The availability of NPS has grown in recent years.

The number of illicit drug seizures in Malta doubled between 2009 and 2015. In terms of quantities, in 2015, cannabis resin, cocaine, heroin and MDMA were seized in larger amounts than in 2014 (Figure 16).

The retail price and purity of the main illicit substances seized are shown in Figure 17.

FIGURE 16

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



NB: Year of data 2015.

FIGURE 17

Price and potency/purity ranges of illicit drugs reported in Malta

NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum.
Year of data 2015.

KEY DRUG STATISTICS FOR MALTA

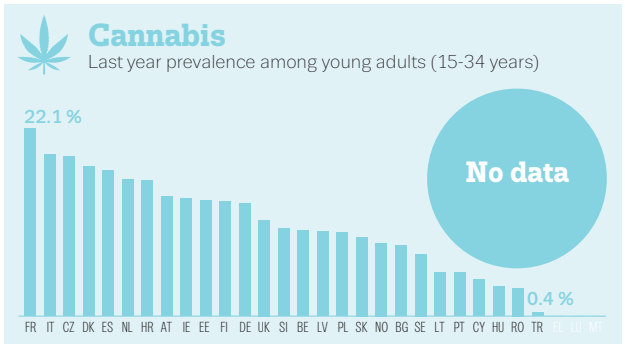
Most recent estimates and data reported

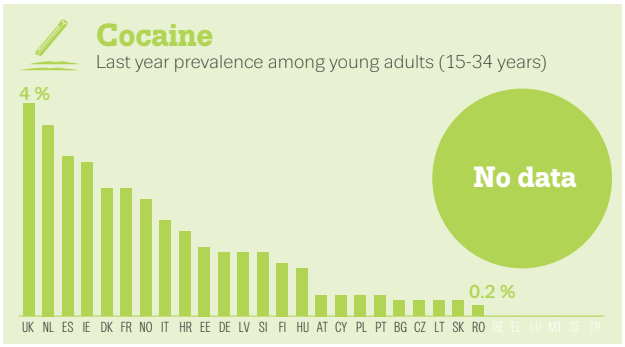
	Year	Country data	EU range	
			Minimum	Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	12.6	6.5	36.8
Last year prevalence of use — young adults (%)	No data	No data	0.4	22.1
Last year prevalence of drug use — all adults (%)	2013	0.9	0.3	11.1
All treatment entrants (%)	2015	9	3	71
First-time treatment entrants (%)	2015	29	8	79
Quantity of herbal cannabis seized (kg)	2015	4	4	45 816
Number of herbal cannabis seizures	2015	106	106	156 984
Quantity of cannabis resin seized (kg)	2015	69.9	1	380 361
Number of cannabis resin seizures	2015	132	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	2015	5.5-11	0	46
Potency — resin (% THC) (minimum and maximum values registered)	2015	3.5-11	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	2015	10-28	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	15-30	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.8	0.9	4.9
Last year prevalence of use — young adults (%)	No data	No data	0.2	4
Last year prevalence of drug use — all adults (%)	No data	No data	0.1	2.3
All treatment entrants (%)	2015	16	0	37
First-time treatment entrants (%)	2015	40	0	40
Quantity of cocaine seized (kg)	2015	21.2	2	21 621
Number of cocaine seizures	2015	156	16	38 273
Purity (%) (minimum and maximum values registered)	2015	10-22	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	18-80	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.7	0.8	6.5
Last year prevalence of use — young adults (%)	No data	No data	0.1	3.1
Last year prevalence of drug use — all adults (%)	No data	No data	0	1.6
All treatment entrants (%)	2015	0	0	70
First-time treatment entrants (%)	2015	0	0	75
Quantity of amphetamine seized (kg)	2015	0	0	3 796
Number of amphetamine seizures	2015	1	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	No data	No data	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	No data	No data	1	139.8

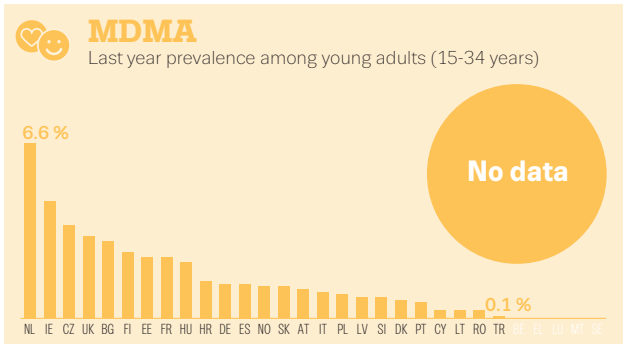
	Year	Country data	EU range Minimum	EU range Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2	0.5	5.2
Last year prevalence of use — young adults (%)	No data	No data	0.1	6.6
Last year prevalence of drug use — all adults (%)	No data	No data	0.1	3.4
All treatment entrants (%)	2015	1	0	2
First-time treatment entrants (%)	2015	2	0	2
Quantity of MDMA seized (tablets)	2015	1 404	54	5 673 901
Number of MDMA seizures	2015	46	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	No data	No data	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	7-10	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	2015	6	0.3	8.1
All treatment entrants (%)	2015	73	4	93
First-time treatment entrants (%)	2015	29	2	87
Quantity of heroin seized (kg)	2015	4	0	8 294
Number of heroin seizures	2015	35	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	15-30	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	60-78	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	0	0	44
HIV prevalence among PWID* (%)	2015	0.5	0	30.9
HCV prevalence among PWID* (%)	2015	35.7	15.7	83.5
Injecting drug use (cases rate/1 000 population)	No data	No data	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2015	27.7	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	2015	340 644	164	12 314 781
Clients in substitution treatment	2015	1 026	252	168 840
Treatment demand				
All clients	2015	1 829	282	124 234
First-time clients	2015	276	24	40 390
Drug law offences				
Number of reports of offences	2015	472	472	411 157
Offences for use/possession	2015	359	359	390 843

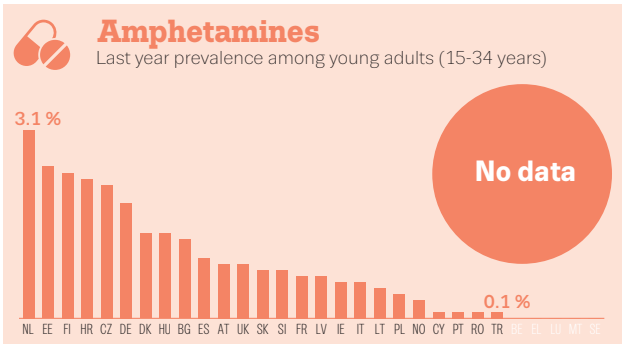
* PWID — People who inject drugs.

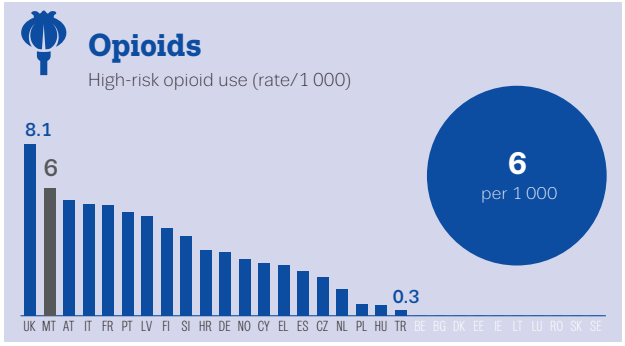
EU Dashboard

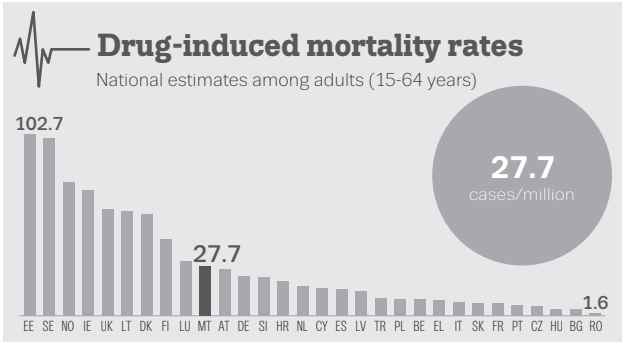


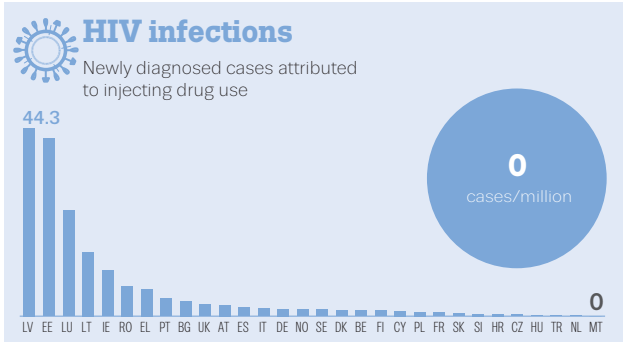


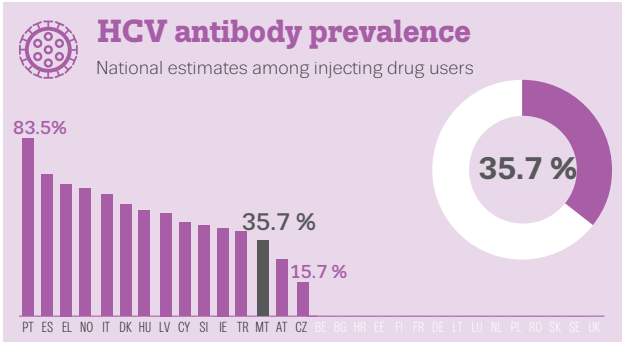












NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

Recommended citation

European Monitoring Centre for Drugs and Drug Addiction (2017), *Malta, Country Drug Report 2017,* Publications Office of the European Union, Luxembourg.

About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

MINISTRY FOR THE FAMILY AND SOCIAL SOLIDARITY

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.

National Anti-Drug Agency

Ministry for the Family and Social Solidarity
LEAP Community & Resource Centre
72, Melita Street
MT -Valletta, VLT 1120
Malta
Tel. +356 2590 3324/86/78
Head of national focal point: Mr Carlo Olivari Demanuele — nfp.msoc@gov.mt

Luxembourg: Publications Office of the European Union
doi:10.2810/663623 | ISBN 978-92-9168-997-2

This publication is available only in electronic format.

EMCDDA, Praça Europa 1, Cais do Sodré, 1249-289 Lisbon, Portugal
Tel. +351 211210200 | info@emcdda.europa.eu
www.emcdda.europa.eu | twitter.com/emcdda | facebook.com/emcdda

Publications Office