Young people & injecting drug use
in selected countries of Central and Eastern Europe
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Developed by

EHRN

In partnership with

Youth R.I.S.E.
Resource. Information. Support. Education
for reducing drug-related harm
About the Eurasian Harm Reduction Network

The Eurasian Harm Reduction Network (EHRN) – previously known as the Central and Eastern European Harm Reduction Network (CEEHRN) – is a regional network with a mission to support, develop, and advocate for harm reduction approaches in the field of drugs, HIV, public health, and social exclusion by adhering to the principles of humanism, tolerance, partnership and respect for human rights and freedoms.

Founded in 1997, EHRN today brings together more than 260 individuals and organizations from 25 countries in Central and Eastern Europe and Central Asia. The network’s members come from both the public and private sectors and include government agencies, drug treatment and HIV professionals, harm reduction organizations, researchers, activists, and community groups (especially those representing people living with HIV or drug users), as well as supporters and experts from outside the region. EHRN is governed by its members through a steering committee of elected representatives. The executive work is carried out by a secretariat based in Vilnius, Lithuania.

The main activities of the network include advocacy for better policies on HIV and drugs, informational support and exchange, and capacity building for members and other stakeholders involved in reducing drug-related harm in Central and Eastern Europe and Central Asia. EHRN members and their allies seek to reduce drug-related harm, including the transmission of HIV and other blood-borne diseases, by promoting less repressive and less discriminatory policies affecting drug users and other vulnerable populations.

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The picture shows Vitaliy Berestov, 14, watching his friends talk in the sewer where they live on the outskirts of Odessa, Ukraine, on Tuesday, 19 December 2006. According to The Way Home, a Ukrainian NGO, more than 3,000 homeless children live on the streets of Odessa. Almost all of these street children use drugs. The latest research by The Way Home found that practically all of them have STDs and many of them are HIV-positive.

Donors
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Young people's drug use is an emotive issue. As adults, our initial impulse can be to deny the choices that young people make, so that we don't have to deal with the underlying reasons. This response is all the more tempting because contemporary young people inhabit such a different cultural, social, and economic environment than the one we, the generation making many decisions that shape their lives, are familiar with.

We also feel a strong impulse to control their behavior. We are responsible for our children and we have the wisdom that comes with age. Surely we should compel them to do what is right and punish them when they don't?

Not only are denial and the urge to control and punish entirely understandable among parents grappling with the discovery of a child's decision to use drugs; they are also understandable in the responses of policymakers, legislators and others, who are – after all – often parents themselves.

Although this reaction is understandable, it is also wrong.

If we are to respond meaningfully and effectively to young people's drug use, we must first develop a clear understanding of what they do and what they think; their values, beliefs, aspirations, concerns, and behavior; the ways in which they expose themselves to risk; and the measures they take to protect themselves. This report – and especially Chapter 2 – represents an important contribution to this understanding, for not only does it synthesize a wide body of evidence about young people's lives and injecting drug use, but it also points out what we don't know, providing invaluable guidance for policymakers and researchers. In this way it helps us confront truths about young people's drug use, however uncomfortable.

Chapter 3 highlights how our instinct to control and punish has greatly influenced responses to young people's drug use across Central and Eastern Europe. Although national responses vary, it is striking how extensively they rely on criminal justice systems. Furthermore, these responses are often geared towards older people and fail to address the very different characteristics and needs of young people, which only a distinct juvenile justice system can. This chapter provides compelling arguments for shifting the weight of our responses away from the criminal justice system and, instead, developing a more enabling environment for effective action.

Questioning the over-reliance on the criminal justice system is not, however, an argument for indifference. On the contrary, we urgently need to act, and Chapters 4 and 5 provide valuable guidance on how to do so. They bring together important lessons about what effective action requires: a youth-friendly culture among service providers; the direct involvement of young people; an emphasis on working with young people rather than doing things to them; specific interventions that reduce overdose-related deaths and the transmission of HIV and hepatitis B and C; and interventions that target the growing problem of amphetamine-type stimulants.
Young people & injecting drug use provides vital information for several audiences: policy-makers and legislators, people providing young people with drug-related services (harm reduction services as well as services in areas such as youth justice and sexual health), researchers, non-government organizations, and international agencies. It will equip the reader with an excellent understanding of how injecting drug problems affect young people in Central and Eastern Europe – and how we can respond to them wisely. As such, it should be required reading for anyone concerned with the well-being of young people.

—Neil Hunt

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Acronyms

AIDS acquired immunodeficiency syndrome
AFEW AIDS Foundation East–West
ARAS Romanian Association Against AIDS
ATS amphetamine-type stimulants
CEE Central and Eastern Europe
CEEHRN Central and Eastern Europe Harm Reduction Network (now EHRN)
CPT European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CRC Convention on the Rights of the Child
EMCDDA European Monitoring Centre for Drugs and Drug Addiction
EHRN Eurasian Harm Reduction Network (formerly CEEHRN)
EU European Union
HCV hepatitis C virus
HIV human immunodeficiency virus
IDU injecting drug user
ICESCR International Covenant on Economic, Social and Cultural Rights
IHRA International Harm Reduction Association
IJPP United Nations Interagency Panel on Juvenile Justice
NGO nongovernmental organization
NSP needle and syringe exchange program
PDI peer-driven intervention
PPA phenylpropanolamine
Reitox European Information Network on Drugs and Drug Addiction
UN United Nations
UNAIDS Joint United Nations Programme on HIV/AIDS
UNICEF United Nations Children’s Fund
UNODC United Nations Office on Drugs and Crime
VCT voluntary counseling and testing
WHO World Health Organization
Youth RISE Youth Resources/Information/Support/Education
Injecting drug use is one of the gravest public health crises facing Central and Eastern Europe (CEE) today. Besides an obvious role in drug addiction (and its side effects), drug injecting is the driving force behind the explosive spread of HIV in Eastern Europe, where the number of infected people has grown 20-fold in the last decade (Lazarus et al., 2008), and behind the much larger epidemic of hepatitis C that affects the entire region. Though data are hard to come by, injecting drug use unfortunately appears to be on the rise in the region.

Young people – defined as 10 to 24 years old – represent both the greatest source of new injectors and the greatest hope for reversing the growth of injecting drug use. This report focuses on the situation among young people in nine CEE countries: the Czech Republic, Estonia, Georgia, Hungary, Romania, Russia, Serbia, Slovenia, and Ukraine. It analyzes the obstacles to reducing the drug-related harm for this group, and recommends concrete ways to address these obstacles.

Why focus on young injecting drug users (IDUs)?

Young people have several characteristics that make them more likely to take risks and more vulnerable to harm. In contrast to older people, young people:

- feel and respond to peer pressure more readily;
- are less likely to think about long-term consequences;
- have fewer financial resources;
- are more prone to mistrust institutions and service providers;
- have limited experience in navigating institutions and organizations;
- fear losing their independence;
- are less aware of their rights;
- are less informed about risks.

IDUs typically begin their injecting careers when young, establishing not only dependency but injecting behaviors that are likely to continue when older – including behaviors that put them at risk for HIV, the hepatitis C virus (HCV), and overdose. In contrast to older IDUs, young IDUs are also likelier to:

- use several kinds of drugs (polydrug use);
- share needles and other injecting equipment;
- practice unsafe sex; and
- inject amphetamine-type stimulants (ATS), use of which is characterized by different settings and usage patterns than use of opiates (see below).

Fortunately, young people also break habits more easily, and familiarity with their motivations can enable harm reduction providers to target them effectively. Taken together, these
tendencies argue for early, targeted efforts to prevent drug injecting – and mitigate its associated harms – among young people.

**Injecting drug use and associated harms among young people in CEE (Chapter 2)**

- **General characteristics.** Although data on injecting drug use in CEE are quite patchy, especially for minors, young people appear to comprise the majority of IDUs in the Czech Republic and Estonia, and a substantial minority in the other focus countries. Significantly higher injecting rates are found among certain ethnic groups, such as the Roma and Russian-speaking minorities in Estonia. While the most commonly injected drugs are heroin and homemade opiates, ATS are becoming quite popular among young people (see below).

- **Injecting initiation.** The initiation age for injecting appears to be decreasing in CEE and is now between 15 and 19 in most focus countries. A Ukrainian study of initiation into drug injecting (Balakireva et al., 2006) found that most first-time injectors had tried other administration routes before. Their first injection was usually a spontaneous decision. It was typically made in a familiar setting in the presence of friends, relying on their assistance for both obtaining and administering the drug. Young females were much likelier to be introduced to injecting by their sexual partners.

- **Blood-borne infections.** Factors contributing to the HIV and HCV epidemics in CEE include poverty, collective preparation of drugs, and poor understanding of transmission risks. While needle sharing has declined in many settings, the sharing of other injecting equipment – a major risk factor for HCV – continues to be widespread, helping explain why most CEE sample studies of young IDUs show HCV prevalences of 20% and over (see Table 4).

- **Sexually transmitted infections (STIs).** Most young IDUs are sexually active and practice unsafe sex. Young female IDUs are at particular risk for STIs (including HIV). The overlap between injecting drug use and sex work is especially significant among young people, who comprise 80% of the region’s sex workers. Female sex workers frequently sell sex to support their – and many times their partners’ – drug habits.

**Juvenile justice and drug use (Chapter 3)**

Minors – which all the focus countries define as people under 18 – have emotional and developmental needs that differ from adults'. UN agencies have accordingly called on countries to institute the following reforms to protect and support juvenile drug users.

- **Decriminalizing drug use and possession.** UN guidelines state that, even for adults, “drug use should be treated as a health care condition and drug users should be treated in the health care system rather than in the criminal justice system” (UNODC et al., 2008). Yet simple use and possession remain a crime for minors in six of the focus countries, thereby creating criminal records.

Overly broad definitions of “serious crime” can also subject minors with drug problems to the lower age of criminal responsibility for stealing in order to buy drugs. Such offenses should remain misdemeanors.
• **Implementing a juvenile justice system.** The central purpose of most adult justice systems is punishment. To protect the welfare of juvenile offenders and support their rehabilitation, the Convention on the Rights of the Child (*UN General Assembly, 1989*) obligates all CEE countries to establish a separate justice system for juveniles who break the laws, including drug laws. However, most of the study countries have persisted in using an adult criminal justice approach to juvenile drug use.

• **Providing alternatives to detention.** International guidelines state that imprisonment of minors should be a “last resort.” Czech, Estonian, and Serbian laws now prioritize alternatives to detention for minors, ranging from warnings to psychologist referrals to educational programs, though implementation is not yet optimal. At the other end of the scale, Georgia has no detention alternatives for juvenile offenders whatsoever.

• **Providing comprehensive support for juvenile users.** Whether in detention or not, young users have the right to appropriate health care and promotion services. Yet in most focus countries, such support – including the harm reduction services described below – remains inadequate in prisons and other places of detention. Instead, these places are often notorious for encouraging unsafe injecting and sex, spreading disease, and teaching criminal conduct.

See also the recommendations at the end of Chapter 3.

**Young IDUs’ access to drug treatment and other harm reduction services** (*Chapter 4*)

The good news is that a variety of interventions have been shown scientifically to reduce the various harms associated with injecting drug use. The most efficacious harm reduction services for IDUs include:

- **opioid substitution therapy (OST),** recognized by the UN as the most successful form of drug dependency treatment;
- **needle and syringe exchange programs (NSPs),** for preventing transmission of HIV and hepatitis C caused by sharing needles;
- **voluntary counseling and testing (VCT) for HIV and HCV;**
- **condom distribution,** the most effective, inexpensive way to reduce sexual transmission of HIV and other diseases;
- **injecting initiation prevention programs;** and
- **overdose prevention programs.**

See Appendix 2 for further information and implementation guidelines.

The bad news is that few young people in the focus countries are in contact with harm reduction services, except perhaps in the Czech Republic. Though research suggests that young IDUs in CEE are open to such services, survey respondents from all nine countries agreed that services specifically targeting young IDUs were largely absent from their countries. And while various HIV prevention programs do exist for young people, most of them do not address injecting drug use, though it drives the worst national HIV epidemics in the region. Why not?

• **Legal age limits.** Most of the study countries studied have age restrictions, especially for OST and NSPs, with minimum ages ranging from 15 to 25 years. In addition, many
health workers in CEE are personally reluctant to provide young people with harm reduction services, particularly OST.

- **Consent requirements and lack of confidentiality.** Many CEE harm reduction services do not protect young IDUs’ confidentiality. Clients of all ages face widespread data sharing between harm reduction and law enforcement services that expose them to police harassment, unemployment, etc. Furthermore, many programs require parental consent before serving young clients. Unfortunately, the mere suspicion of poor confidentiality or parental consent requirements makes many young IDUs avoid such services altogether.

- **Aiding and abetting laws.** Many countries have laws that criminalize the promotion of juvenile drug use. Yet by equating provision of drug information or paraphernalia with drug dealing, such statutes threaten harm reduction providers with prosecution, discouraging and even deliberately blocking education, outreach, and – notably in Russia – NSPs aimed at young people.

- **Untargeted offerings.** Regrettably, CEE services that are available to young people frequently ignore their particular needs and characteristics.

- **Other barriers.** For IDUs of all ages, common obstacles include geographically limited offerings, reliance on law enforcement to address drug dependency, endemic stigmatization and discrimination, and lack of funding. Moreover, government distrust of OST has made it practically unavailable where it is most needed, Russia and Ukraine. Similarly, Serbia has only two NSPs because it believes they promote drug use.

To facilitate young IDUs’ access to harm reduction services, they should be free, widely available, tailored to young people, non-judgmental, confidential, and low threshold (see Chapter 4 recommendations and Appendix 1).

**Stimulant injecting among young people (Chapter 5)**

The use of ATS, especially methamphetamine, is widespread in much of CEE, where they are the drugs of choice for an increasingly large number of young people. Surveys for this report and the small amount of ATS research done elsewhere suggest that opiate use and ATS use have several significant similarities and differences.

- **Same primary dangers.** ATS injectors and opiate injectors share many of the same risks and harms, including HIV, HCV, and overdose.

- **Different usage patterns.** Since ATS effects are typically shorter in duration than opiate effects, ATS users may inject as often as 10 times a day, compounding their opportunities for sharing infected paraphernalia. Studies have also shown that ATS lower sexual inhibitions and that young ATS users are less likely to use condoms than other young people, putting them at higher risk for STIs. ATS use is also associated with various other psychological and physical problems, including aggression and violence.

- **Different user profiles.** In CEE, ATS users differ substantially from opiate users. On one hand, because they energize users, ATS are popular party drugs at music clubs and festivals. The many occasional users do not see their use as problematic or see themselves as drug users. They tend to be well integrated socially, and their use on festive occasions readily leads to needle sharing.
On the other hand, low cost, ready availability, and easy synthesis have made use of homemade ATS widespread among marginalized young people, notably the homeless and the unemployed, e.g., in Georgia, Russia, and Ukraine. These drugs are traditionally prepared and injected in small groups of friends, where sharing of needles and other injecting equipment is common.

Regrettably, CEE harm reduction services have virtually ignored ATS. Not only are harm reduction services for young people quite rare, but except in the Czech Republic, such services invariably focus on opiate users. A few low-threshold services have started to develop sorely needed materials and approaches for users of homemade ATS, but they are decidedly the exception. ATS research and interventions are therefore critically needed (see Chapter 5 recommendations).
Young people & injecting drug use
1. Introduction

Globally, young people – defined as people younger than 25 – accounted for an estimated 45% of all new HIV infections in 2007 (UNAIDS, 2008). It is also estimated that of the 6000 new HIV infections that occur each day among people age 15–24, more than 3000 are related to injecting drug use (Dolan et al., 2005).

In Eastern Europe, the HIV epidemic is growing, and people who inject drugs and their sexual partners account for most cases. In Central Europe on the other hand, reported HIV incidence is stable and chiefly associated with behaviors other than injecting drug use, while HIV prevalence among injecting drug users (IDUs) is low (UNAIDS, 2008).

Despite these differences in HIV epidemiology, injecting drug use remains the principal risk factor for transmission of the hepatitis C virus (HCV) throughout both parts of the region (CEEHRN, 2007). Moreover, not only is injecting drug use not declining in most of the region’s countries, but Georgia, Hungary, Romania, Serbia, Slovenia, and Ukraine have reported that it is on the rise (IHRA, 2008).

It should be noted that in Central and Eastern Europe (CEE) as a whole, young people are not the age group most affected by HIV today. In Central Europe, 51% of cumulative HIV cases among males and 34% among females at the end of 2006 were first identified in people age 25–49. In Eastern Europe the corresponding figures were 51% for males and 41% for females (Lazarus, 2008a). Most of these cases were associated with drug injecting and accordingly represent aging cohorts of IDUs.

Nevertheless, a significant and in some countries growing number of IDUs are young, and few signs meanwhile indicate that the region’s epidemics of opiate and stimulant injection are under control. By the end of 2006 in Central Europe, 31% of cumulative HIV infections among males and 48% of those among females were first reported among young people.1 Similarly, in Eastern Europe, 40% of cumulative HIV infections among males and 51% of those among females were first identified in young people2 (Lazarus, 2008a). These figures represent new, younger cohorts of drug injectors.

UNAIDS data show that across Eastern Europe and Central Asia, as much as 25% of IDUs are younger than 20, with some starting to inject as early as 12 (UNAIDS, 2003). In the new EU member states from CEE (the 12 countries acceding in 2004 and 2007), the proportion of people seeking drug dependency treatment who are young is also increasing (EMCDDA, 2007a), while in some of these countries (including the Czech Republic, Estonia, Latvia, Lithuania, Romania, Slovakia, and Slovenia), from 30% to more than 50% of IDUs in various settings are younger than 25 (EMCDDA, 2008). These figures foreshadow an imminent explosion in injecting drug use as this population ages.

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2 Males: 0% younger than 15, 40% age 15–24. Females: 1% younger than 15, 50% age 15–24.
The vulnerability of young people is a complex phenomenon, determined by both individual and structural factors. In CEE, much of this vulnerability stems directly from the region’s continuing social and economic changes, including high unemployment and poverty. Paradoxically, the expansion of the new market economies in CEE has increased the vulnerability of young people across class and income lines, while the expanding nightlife culture and increasing mobility within and among countries has also heightened their exposure to drugs. As a result, it is not only socially and economically disadvantaged young people who are at high risk for injecting and its associated risks.

Studies suggest that when young people start injecting drugs, it is typically unplanned and often occurs after exposure to injecting among friends. The first injection commonly occurs at a friend’s apartment with help from peers or siblings (Balakireva et al., 2006; Gray, 2007), and it sets a pattern for future injecting behavior. Some initiates subsequently become regular injectors, while others – frequently young people who are less disadvantaged – inject occasionally (Balakireva et al., 2006). Recent and occasional injectors often do not identify themselves as problem drug users and are less likely to present at harm reduction or health care services.

The close association between risky injecting behaviors and risky sexual behaviors in young people can lead to the rapid spread of HIV, HCV, and other blood-borne and sexually transmitted diseases. Female drug users, most of whom are young in CEE, frequently engage in sex in exchange for housing, sustenance, protection, or drugs (CEEHRN, 2005). They may also rely on men to inject them with drugs or to acquire drugs and injecting equipment, increasing the likelihood of their using contaminated equipment (Pinkham et al., 2007).

These factors – combined with the illegal nature of drug injecting and the stigmatization of IDUs and sex workers – add up to an unhealthy risk environment for many young IDUs (Rhodes, 2002) and a reluctance to seek health, youth or drug services.

Unfortunately, especially in the eastern part of the region, harm reduction services are still limited, and where they do exist, they are seldom tailored to the complex needs of young people. Lack of information on drug-related risks and safer injecting behaviors, as well as the absence of evidence-based prevention and treatment interventions targeting minors, contribute to the spread of drug injecting, overdose, and HIV and HCV transmission among young people.

While underage and young adults may not comprise the majority of IDUs in CEE, there are several important reasons to focus harm reduction efforts on young IDUs.

Juvenile drug users face specific legal and practical barriers in accessing drug services, which means that basic drug services often do not cover this group.

Harm reduction can play a critical role in preventing the initiation of injecting behavior. It can also facilitate in a non-judgmental way the reverse transition to non-injecting drug use and even abstinence.

Drug behavior patterns develop at a young age, making early intervention crucial in preventing harmful injecting behaviors and related problems, e.g., through safer injecting and overdose prevention interventions and health and social services.

This report seeks to summarize the situation of young IDUs in CEE and the barriers to effective harm reduction efforts targeting them. The survey component investigates how well harm reduction services are tailored to the needs of young people. Since young IDUs do not always identify themselves as drug users, they do not access harm reduction services as often as
they otherwise would, and so the study explores alternative approaches that these services can use to reach them.

1.1 Geographical scope

For this report, we gathered data from nine focus countries: the Czech Republic, Estonia, Georgia, Hungary, Romania, the Russian Federation, Serbia, Slovenia, and Ukraine. We primarily targeted countries that joined the EU in 2004 and 2007. However, the dynamics of drug use, HIV transmission, and increasing mobility in the rest of CEE also affect the health of young people in the EU, especially the new member states. We therefore included four non-EU countries where drug use patterns are representative of those in the overall region. In selecting focus countries, we carefully evaluated national situations on issues such as differences in injecting opiates and amphetamine-type stimulants (ATS), the dynamics of HIV epidemics among IDUs and young people, and the availability of services. Finally, we aimed to present a geographically diverse picture by including at least one country from each major subregion (Central Europe, the Baltic states, South-Eastern Europe, and Eastern Europe).

1.2 Methodology

We conducted the study in four stages: (1) expert consultation, (2) literature review, (3) survey of country experts, and (4) expert follow-up.

In Stages 1 and 4, a group of researchers, youth activists, harm reduction service providers, human rights specialists, and representatives of international agencies contributed at both the beginning, in planning the study and developing the survey methodology, and at the end, in analyzing the data, drawing conclusions, and drafting recommendations.

In Stage 2, we reviewed secondary sources in English and Russian, including published research, country assessments, and reports on injecting drug use among young people.

We developed a standardized questionnaire and submitted it to country experts in Stage 3. It included questions on national legislative frameworks, harm reduction services and barriers to young IDUs accessing them, and ATS use among young people. The survey also asked these experts to identify key issues for young IDUs in their respective countries. These national respondents collected data in May and June 2008.

1.3 Risks and limitations

EHRN acknowledges that the problem of drug use among young people is a concern throughout the region and beyond. Although we are confident that the information presented here fairly represents drug use among young people and the barriers to their access of harm reduction services in CEE, it may not be representative for the situation in every country of the region. Moreover, we recognize that drug use patterns can change quickly and locally, as can related policy and services.

In addition, this report does not provide an in-depth legal analysis and overview of services for young IDUs. Rather, it focuses on the legal constraints in providing effective, evidence-
based, non-discriminatory services to IDUs, particularly juveniles and young adults, as well as the role of harm reduction services in addressing the needs of young people who inject or are at risk for injecting drugs. Space limitations have further restricted detailed discussions of complex issues such as the impact of environmental and individual factors on the initiation of drug use and drug injecting among young people, and restricted close examination of other services that are invaluable in helping young IDUs, including housing for homeless children, youth drop-in centers, and primary prevention of drug use.

Finally, as noted above, country respondents collected most of the report data. The depth and reliability of the data will thus vary by country and should be interpreted accordingly.

1.4 A note on terminology

International and national reports and studies use a variety of age ranges when discussing young people. The UN defines young people as age 10 to 24 years (UNODC, 2004), the range we employ in this report. For statistical purposes, the UN defines youth as age 15 to 24 and adolescents as 10 to 19 (UN Department of Economic and Social Affairs, 2005; Ross et al., 2006). Of course, the period of transition from childhood to adulthood varies among and within societies. “This critical stage in the life cycle may begin as early as age 10 … and may in some cases continue into the mid- to late 30s” (UN Department of Economic and Social Affairs, 2005). Another reason to use the lower age range is that injecting drug use sometimes begins in early puberty, as data in this report shows. In this report, results from studies based on age ranges other than 10–24 are indicated clearly.

1.5 Report structure

Chapter 1 presents the subject of this study and provides information about the study objectives, methodology, and limitations.

Chapter 2 provides an overview of drug injecting among young people in the nine focus countries, including the age and circumstances of initiation into injecting and regional patterns of drug use. It discusses the harms associated with injecting drug use, including HIV and HCV infection, sexual risk behaviors, and overdose.

This chapter also identifies some of the particular needs of young IDUs, providing background for the ensuing chapters.

Chapter 3 describes justice in CEE as it relates to drug use, focusing on minors. It discusses how well national legal frameworks provide a supportive and enabling environment for honoring countries’ international commitments to juvenile justice, especially by treating drug use as a health issue rather than a criminal issue.

Chapter 4 explores national and local environments for harm reduction services for young people, including HIV and HCV testing and treatment and drug treatment. It seeks to identify gaps in service provision, the role that harm reduction services can play in targeting young drug users, and concrete ways to improve civil society’s response.

The chapter discusses legislative barriers to service provision, again by comparing them to relevant international commitments. Since some legislative and practical barriers concern the age of consent, much of this section focuses on juvenile injectors.
Chapter 5 raises the topic of amphetamine-type stimulants (ATS) among young people. ATS have been associated with more frequent injecting and heightened sexual activity than heroin, putting users, especially young people, at increased risk for HIV and HCV (Kozlov et al., 2006), yet few harm reduction services address ATS directly.

Chapter 6 rounds out the body of the report with a series of closing observations.

Lists of recommendations for policymakers, researchers, service providers, and international organizations conclude Chapters 3, 4, and 5. Tables and references appear at the end of the report. Finally, Appendix 1 provides service planners and providers with key considerations when developing effective harm reduction services for young people.
2. Injecting drug use and risks among young people in Central and Eastern Europe

2.1 Introduction: drug use among young people

People have always used drugs, both licit and illicit. In the 1960s, however, young people in the United States, Australia, and Europe increasingly used substances that differed from what had been available to previous generations. Drug use emerged within a context of decreased parental control and emerging countercultures, such as the Beats and the hippies. In Central and Eastern Europe (CEE) before the fall of Communism, closed borders largely precluded access to drugs other than alcohol, tobacco, and psychotropic medications. In addition, the Pioneers, the All-Union Leninist Young Communist League (Komsomol), the Socialist Youth Union, and other Party youth movements helped keep young people within the bounds of Communist ideology – and away from drugs. Yet though illicit drug use was rare, small underground pockets of drug use started to develop throughout the region during the 1970s and 1980s.

One distinctive feature of drug use in CEE is that young people seem to have less trepidation of needles than their Western European counterparts. For most IDUs in Russia and other former Soviet republics, the first injection with an illicit drug was not their first injection ever, since many medications that are prescribed orally in Western Europe (such as penicillin) have been traditionally injected in CEE. In fact, according to former drug users who started injecting in Moscow during the 1980s, Soviet anti-drug propaganda linking Western drugs to needles only furthered their acceptance among young people who deviated from Party ideology (personal communication, former AFEW outreach worker in Moscow, 2008).

In the 1990s, the use of illicit drugs grew rapidly in all the emerging democracies of CEE. Largely obscured by the focus on economic transition, this explosive growth set the stage for a major regional public health crisis. Since 1995, HIV has spread rapidly among IDUs in Eastern Europe, while a HCV epidemic has been reported throughout both Central and Eastern Europe.

Most IDUs commence their injecting careers in their teens or early twenties. This chapter delineates the chief features of injecting drug use among people younger than 25. Drawing upon regional and international studies, it describes the prevalence of drug injecting, the drugs injected, the characteristics of their users, and the circumstances in which drugs are first injected. It then discusses the physical harms associated with drug injecting among young people, including HIV, HCV, overdose, and incarceration-related risks. Finally, it addresses the injecting and sexual behaviors that put young people at risk for these harms, including the role that gender plays.
2.1.1 Historical context of drug injecting in Central and Eastern Europe

The Iron Curtain separating Communist countries from the West prevented drugs such as heroin, cocaine, amphetamines, and LSD from being available in most Communist countries. Young people who wished to use drugs had to turn to alternatives that could be found or produced locally. Inspired by the regional tradition of самогон (or samagon, Russian for “home-distilled vodka”), young people turned to their chemistry textbooks during the 1970s and 1980s. To emulate the drugs of the West, they began concocting crude but powerful injectables in their kitchens and homes from poppy straw and ephedrine-based medications (Grund, 2001, 2005a). By mixing ground poppies or crude opium with household soda and a common solvent such as ethyl acetate and then heating the mixture on a kitchen stove, drug users in the Central Asian republics extracted opium alkaloids. Subsequent mixing with acidic water, evaporation, several cycles of re-suspension and filtering, and the addition of a few drops of acetic anhydride gave them a mixture of acetylated opiate alkaloids – including diacetylmorphine, or heroin. The end product, a dark injectable suspension known as cheornaya (“black”) or himia (“chemistry”), was generally shared among a few friends who prepared and used drugs together.

Likewise, young people in the former Czechoslovakia and most western parts of the former Soviet Union used ephedrine- or pseudoephedrine-based medications to produce methamphetamine and methcathinone in their kitchens and basements. Methamphetamine is produced by reduction, while methcathinone is produced by oxidation, a less complex chemical reaction. Ephedrine and pseudoephedrine are recovered from decongestants, cold medications (e.g., Solutan) or herbal preparations, and most of the chemicals involved are still relatively easy to come by. Methamphetamine is known in CEE under local names such as pervitin, piko, vint (“screw”), and bielie (“white”), while methcathinone is commonly referred to as jeff or boltushka (“chatterbox”), though the latter name has also recently come to cover home-produced cathinone as well (see Section 5.2). As with cheornaya, the production of vint and jeff usually results in a liquid, injectable substance.

Homemade drugs are mostly injected in small groups of drug-using friends. Users pool money and collaborate in organizing covert drug production and consumption, including acquiring the required precursors and chemicals. Regardless of what the others contribute, the process revolves around the cook.

Unless their equipment is particularly good, home producers manufacture drugs that are crude and often include a mixture of related alkaloids, not to mention plant or chemical residues and other pollutants that are often neurotoxic. Furthermore, these drugs – especially short-acting methcathinone – are injected at high frequencies and with large-bore needles, which may lead to serious venous damage.

The production of homemade drugs and the resulting liquid drugs are not in themselves associated with increased risk for disease transmission, although HCV and HIV may survive the production of boltushka (Abdala et al., 2006, 2008). Yet the social process of collectively preparing and injecting these drugs may well lead to increased rates of risk behaviors, such as needle sharing or syringe-mediated drug sharing (both frontloading and backloading) (Jose et al., 1993). Involvement in home production has reportedly resulted in increased rates of syringe sharing, front- and backloading, and using common containers in Ukraine (Booth et al., 2008).

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3 Front- and backloading both involve squirting part of a liquid drug dose from one syringe into another. Both practices are associated with HIV transmission.
Meanwhile, the recipes for homemade opiates and amphetamine-type stimulants (ATS) have spread throughout CEE, and the internet has become an important vehicle for disseminating them in the Russian-speaking world.

Home production continues to dominate drug injection patterns throughout the CEE region. The country respondents from Georgia, Russia, and Ukraine all commented that home production, of ATS in particular, may be growing among certain populations of young injectors. In Georgia, drug use usually takes place in groups. In addition to the pragmatic reasons for collaboration described above, drug users are also said to associate in small, closed groups of four to six people to avert social stigma, police harassment, and arrest. Recent increases in the availability of illegally imported Subutex (buprenorphine) and homemade ATS have reportedly increased the prevalence of group injection. The introduction of Subutex injecting has not weakened the strong social ties in these user/producer groups. On the contrary, as the average dose of Subutex needed for injecting is rather small and the price of black market Subutex very high (about 74 EUR per 8-mg tablet), four to eight injectors often share a single tablet. Transforming the solid tablet into an injectable solution is more difficult than commonly thought and takes time and the correct use of the proper equipment (Anonymous, 2007). Thus the price, use, and preparation of Subutex encourage the formation of small user collectives that revolve around drug preparation and consumption.

One Russian study indicated that IDUs who engaged in home preparation were younger than those who did not (24.9 vs. 28.4 years on average), had been injecting fewer years (7.4 vs. 10.2), and were more likely to have injected amphetamines in the previous 30 days (24.5% vs. 5.2%) (Platt et al., 2008). It has been observed in Ukraine that young IDUs sometimes lack the experience to prepare their own drugs and therefore buy prepared drugs in syringes on the streets, which may increase their risk of HIV infection. Sales of ready-to-inject heroin in syringes has also been reported in Romania (Operations Research et al., 2004). Preparing heroin for injecting under non-sterile conditions is also common among young IDUs in Serbia (Wong, 2002).

2.1.2 Prevalence of injecting drug use among young people

Collecting accurate data on criminalized or stigmatized behaviors is difficult by definition, and even more so when researching young IDUs, especially minors (whom all of the focus countries define as people younger than 18). Although monitoring of young IDUs has generally improved, data availability and quality vary considerably among regions and countries and remain poor in many places. Differences in data collection methods and definitions make comparisons between regions and countries difficult. Overall, there are few published studies on young drug users in CEE. The figures mentioned in this report come from the latest national studies, treatment data, and treatment demand data reported by country respondents, as well as from international studies. Estimates of young injectors result from disaggregated data on all IDUs applying for or participating in all drug services, including harm reduction and drug treatment programs. Since these data reflect the numbers of young people reached by services more than the extent of their drug use, they should be used with caution, especially the data summarized in Table 1. Where the data are weak, the report relies on best estimates of local and national experts. Their comments provide further context for the numbers cited.
The proportion of IDUs in contact with drug treatment and harm reduction services who are younger than 25 is relatively high in the Czech Republic (62.1%), Estonia (55.8%), and Romania (49.3%) (see Table 1). Treatment demand among young IDUs is increasing in Estonia, where it comprises 71% of all drug treatment demand (EMCCDA, 2006), and where around 75% of the country’s estimated 13,800 IDUs are men younger than 25 (Usuküla et al., 2005).

The proportion of young people among those receiving drug-related services is much lower in Georgia (16.8%) and Hungary (15%). According to recent estimates, the proportion of young people among Hungary’s 4000 IDUs is considerably higher, 33% (personal communication, Reitox National Focal Point for Hungary, 2008). A study among out-of-treatment IDUs in Budapest in 1999–2000 found that 16% of the participants were 15–19 and 45%, 20–24 (unpublished study, Márványkövi et al., 2008).

Not only injecting drug use, but drug use in general is reported to be spreading rapidly among young Russians. According to the country respondent, the age of first drug use is decreasing, with drugs being cheap⁴ and readily available in schools, at clubs, on the street, and from friends. Studies suggest a very high prevalence of drug injecting among young people in various Russian cities. A survey in Moscow among 15- to 18-year-olds showed that at least 12% of the males had injected drugs (UNAIDS, 2003). A recent study in Kazan reported that that the prevalence of injecting in young people age 20–29 is 3.5%, and that IDUs age 15–19 are under-represented in narcology services (Badrieva, 2006).

In 2002 in Kharkiv, Ukraine, an estimated 18% of all IDUs were age 10–24 (Balakireva et al., 2003a). Behavioral surveillance studies conducted in 2007 showed that in a sample of 4143 Ukrainian IDUs, 26% were 13 to 24 (Balakireva et al., 2007). Local and regional studies and experts’ opinions suggest that between 25% and 58% of IDUs in Ukraine may be younger than 25, and that this figure varies greatly among different cities and regions (Balakireva et al., 2003a, 2003b; International HIV/AIDS Alliance 2004, 2005). In summarizing these sources, Balakireva and others (2006) estimate that 43% of the IDUs in Kyiv city, 20% in Poltava oblast, 36% in Odessa oblast, and 47% in Dnipropetrovsk oblast are younger than 24.

### 2.1.3 Drugs injected

Opiates (heroin and homemade poppy extracts) are the most commonly injected drug in many places, but there is an increase in the injecting of stimulants, particularly methamphetamines, among young people in many of the countries studied, and ATS are among the primary drugs of choice in most of them (see Table 2).

In the Czech Republic, the number of people injecting methamphetamine (usually homemade) is higher than the number injecting opiates. Methamphetamine accounts for two thirds of the estimated 31,000 problem drug users⁵ in the Czech Republic. In 2006, pervitin users represented 58% of those seeking drug treatment in the country, 62% of first-time treatment applications, and 63% of drug injectors who used low-threshold services (Griffiths et al., 2008).

In Estonia, a study of young IDUs (average age 24) in two cities suggested that fentanyl (a strong synthetic opioid), heroin, and amphetamine injecting are on the rise, while outside the

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⁴ For comparison, a pack of cigarettes costs €1.50, an amphetamine tablet €2, and half a gram of heroin €10.

⁵ As defined by EMCDDA, problem drug use is “injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines” (2008).
major cities, the injecting of homemade opiates remains common, with the number of poppy extract users increasing since the previous year (Uuskiä et al., 2005).

In a study among clients of needle and syringe exchange programs (NSPs) and voluntary counseling and testing (VCT) services in four Georgian cities – Tbilisi, Zugdidi, Gori, and Batumi – 16.8% of the respondents were under 25 (Otiashvili et al., 2008b). Of them, 87.5% had injected Subutex, 70.3% heroin, 68.7% opium extract, 65.6% narcotic painkillers, 59.4% sedatives, and 57.8% methamphetamine. During the previous 30 days, homemade stimulants were the second most frequently injected kind of drugs (after opium extract) among young respondents. For 49.2% of these young injectors, heroin was their initial drug of dependence, compared to 38.4% for those age 25 and older. Only 17.4% of young injectors named opium extract as their initial drug of dependence, in contrast to 50.3% of older injectors. A total of 63.5% of young injectors named heroin as their main drug of choice, compared to 35.4% of the older injectors. The authors concluded that most of the older IDUs started their injecting careers with opium extract, which they still favor, while most younger injectors started their injecting careers with heroin and later switched to (illegally imported) Subutex. The injection of methamphetamine appears to be of more recent date.

Amphetamines do not play an important role among drug injectors in Serbia, where heroin is still the most commonly injected drug, or in Romania, where heroin and ketamine are.

In Ukraine, opiates (poppy extract and heroin) are the most commonly injected drugs, followed by homemade ATS based on ephedrine or pseudoephedrine. Yet there are important differences among Ukrainian cities in injecting patterns, which may be subject to rapid change. A 2004–2005 study among young IDUs in four Ukrainian cities found that, after homemade opiates (60%), stimulants (methamphetamine and methcathinone) are the drugs most frequently injected first in an injecting career (25%). In Poltava, 77% of young IDUs first injected homemade opiates and 11% stimulants, while in Pavlograd, 35% first injected homemade opiates, 55% stimulants, and only 5% heroin. In Kyiv, 23% first injected stimulants (Balakireva et al., 2006). A more recent study in four cities in Ukraine indicated that among IDUs aged 18–29, opiate use and sedative use were most common, followed by stimulant use (Booth et al., 2008).

As the discussion of the Georgian study above suggests, polydrug use is a common phenomenon, and opiates and stimulants are combined often. In both Estonia and Russia, the most-used drugs are opiates (heroin or poppy extract) and ATS (mostly home-produced methamphetamine or methcathinone; see Chapter 5). In Russia, a study among IDUs found that 74% of the participants had injected heroin, and 44% had injected it with other substances such as opium, homemade substances, or amphetamines (Gore-Felton, 2003). In Slovenia, data on clients in drug treatment suggest that heroin use often appears alongside the use of cocaine and cannabis, while in Hungary, an estimated 79% of all IDUs are using heroin and 35% amphetamines.

Taken together, these studies indicate that young people inject opiates, ATS, and, to a lesser extent, other drugs in most of the focus countries. Heroin is injected in all nine focus countries, particularly in countries on trafficking routes and in capital cities and major ports. Estonia, Georgia, Russia, and Ukraine report significant levels of home-produced opiate injecting, in particular during the summer poppy season. Home-produced amphetamines are injected in the Czech Republic, Georgia, Russia, and Ukraine. Estonia and Hungary both report ATS injecting but do not distinguish drug type (methamphetamine and methcathinone vs. amphetamine.
sulfate) or mode of production (home production vs. organized crime).Injecting patterns vary among countries and cities due to differences in drug availability and local injecting cultures. A single kind of drug – such as opiates, ATS, or something else (e.g., Subutex in Georgia) – may also dominate the local situation, or several may be equally available.

2.1.4 Age and ethnicity
The average age of IDUs varies by country and by kind of drugs injected (see Table 2). Older users seem to inject opiates more often, though some differences may also be due to variations in geographical diffusion, i.e., different drugs being (re)introduced in different regions at different times (Grund et al., 1993a). In the Czech Republic, the age of opiate users averages 26.4, while the average age of pervitin users is 24.5. Clients of needle exchange programs in Estonia in 2003–2005 were on average 23. The average age of clients entering drug dependency treatment was 26.7 in Hungary, 27.1 in Slovenia, and 32.3 in Romania (EMCDDA, 2008). In a 1999–2000 Hungarian study of 197 out-of-treatment IDUs, 16% were 15 to 19 years old and 45% 20 to 24 (Márványkövi et al., 2006). In a more recent study of 140 out-of-treatment injectors and needle exchange clients in Budapest, 32.9% were between 18 and 25 years old (unpublished study, Márványkövi et al., 2008). Ukrainian studies suggest that injecting homemade ATS has become popular among young, poor residents since the late 1990s (Chintalova-Dallas et al., 2006; Booth et al., 2008). But harm reduction service providers report that ATS use cuts across classes and that ATS are increasingly injected by socially integrated youth, such as students (see Chapter 5 for ATS use by country).

In Estonia, around 85% of all IDUs are from the Russian-speaking minority, while in the Czech Republic, many drug injectors are found among Russian-speaking immigrant laborers. Despite their different circumstances, both Russian-speaking minorities are described as difficult to reach. Some differences in which drugs are used have also been observed with respect to ethnicity. In Estonia, heroin injecting is more common among Russian-speaking and Roma IDUs, while ethnic Estonian IDUs inject ATS more often (Grund, 2005b; Uusküla et al., 2005).

Many Roma communities throughout CEE, including in Estonia, Hungary, Romania, and Serbia, have higher rates of injecting drug use than the ethnic majority population. One study conducted in 1999 estimated that rates of injecting drug use in Roma communities in 11 cities across CEE were 2 to 20 times higher than in the general population (Grund et al., 2007b).

2.2 Initiation into injecting drug use
Most drug users do not start by injecting but by sniffing, smoking, or inhaling. Some people use drugs for years before they start injecting, others switch to injecting after a few months, and still others never inject (Grund, 1993b; Howard et al., 2003).

2.2.1 The first hit
For young people, initiation into injecting drug use is a social process that typically occurs in networks of like-minded others (Crofts et al., 1996). Two studies – one of 808 IDUs under 24 and 802 of their non-injecting friends in Ukraine (Balakireva et al., 2006), and the other of 202 young IDUs in the Central Asian republics of Kyrgyzstan and Uzbekistan (Gray, 2007) – have explored the initiation of young IDUs in the region.
The Ukrainian study suggests that for 16% of male IDUs and 37% of female IDUs, their first drug experience was through a needle. The first injection was generally a spontaneous decision. Only 44% of men and 28% of women actually planned their first injection, while 60% of the men and 45% of the women planned their second injection. Meanwhile, 44% of the non-IDUs and 18% of the non-drug users in the study had considered injecting drugs. The drugs first injected were mostly homemade opiates or ATS. The first injection most often occurred in the presence of friends or good acquaintances (80%) or a sexual partner (17%), and at a friend’s or the initiate’s own apartment (45% and 17%, respectively). Only 5% injected alone the first time. The first injection was rarely self-administered (15% of males and 4% of females). Normally it was given by a friend or acquaintance (64%) or a sexual partner (17%). For 81% of the IDUs, their first injection was free or they bought the drugs together with friends, while 16% bought the drugs alone. In addition, 21% of the study’s young IDUs had introduced someone else to drug injecting, and the initiators were on average five years older than the initiates (Balakireva et al., 2006). In the Kyrgyzstan and Uzbekistan study, 89.9% of the young respondents had received help with their first injection – 53% from a sibling or cousin, and about 33% from friends. In addition, 23% of them had helped administer someone’s first injection in the previous month (Gray, 2007).

The country respondents for the present report enumerated several reasons why drug users switch from non-injecting to injecting. Curiosity, ignorance of the possible negative consequences of injecting, thrill seeking, boredom, and cost savings can all play a role. While the Ukraine study has explored these and many other possible psychosocial factors, the best-documented reasons for starting to inject are connected with the social context of young people’s drug use and the influence of peers. Although the study did not establish causality, it did find that among the drug users who did not inject, those who spent time with injecting friends and at injecting sessions wanted to try or considered trying injecting twice as often as those who did not spend such time (Balakireva et al., 2006). This finding suggests that young people start injecting because friends, sexual partners, or others in their networks do.

The Ukraine study also raised two important gender differences. First, while 32% of the young female IDUs it surveyed had been initiated into drug injecting by their sexual partners, only 3% of the young male IDUs had. In addition, the proportion of young female IDUs who had planned their first injection was substantially lower than the corresponding proportion of young male IDUs (Balakireva et al., 2006).

2.2.2 Age of initiation

Overall, the age of initiation for injecting seems to be decreasing in CEE, and several country respondents expressed their concern about young adolescents starting to inject drugs. For example, drug injecting among people younger than 15 is increasing in Romania. The outreach experience of the Romanian Association Against AIDS (ARAS) shows that some children start injecting at the age of 12–14 (personal communication, ARAS, 2008). According to ARAS, they are often the children of IDUs, or they are involved in drug dealing, which gives them easy access to drugs. Most of these young IDUs start by snorting or smoking heroin but switch to injecting after only 6 to 12 months.

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6 Injecting is cheaper than sniffing or smoking, at least in the short run, because it requires less of a drug to achieve the same effect.
Injecting drug use in **Russia** is also reported to start at a very young age, and the number of young adolescent IDUs may be growing sharply there. One Moscow study (*Должанская [Dolganskaya], 2005*) showed that most drug use commenced between the ages of 12 and 23, chiefly between 14 and 16, while most systematic drug use careers started between 15 and 20. Overall, the average age of injecting initiation was 16.3 years. The study also showed that young males initiate drug use earlier than young females (average age 14.0 and 17.6 years, respectively). Among the study participants, 51.9% of the young males and 77.4% of the young females reported that their first drug was injected.

Another study in the city of Kazan suggested that the number of IDUs who had injected for less than a year had doubled in 2005–2006 from 2003–2004 (*Бадриева [Badrieva], 2006*). It also suggested that local IDUs who are minors are under-represented in narcology services. The closeted nature of their drug use, which they usually hide from parents and peers, prevents them from contacting services, and they are considered to be especially vulnerable to HIV and other drug-related harms.

In most of the focus countries, the average initiation age for injecting lies between 15 and 19 years (see Table 2). In **Hungary**, the mean initiation age for all drug use is 15.7 and for injecting drug use, 17.7. The situation is similar in **Serbia**, where the corresponding ages are estimated to be 15.7 and 18.2. In contrast to **Romania** and **Russia**, where users quickly progress to injecting, it takes two years on average in both **Hungary** and **Serbia** to switch from snorting or smoking (“chasing the dragon”) to injecting heroin. Both the **Czech Republic** and **Estonia** estimate the age of injecting initiation to be between 15 and 19 years. In **Georgia**, it is estimated to be a little higher (20.1 years), almost exactly the same as in **Slovenia** (20), where the use of synthetic drugs starts at an earlier age, albeit not by injection.

In a **Ukrainian** study of young IDUs younger than 24, the average age of first injection was 17.7 (*Balakireva et al., 2006*).

### 2.2.3 Occasional injecting drug use

Occasional injecting drug use – which is often experimental or recreational in nature – has been the topic of very few studies in the region. Several country respondents reported that harm reduction services sometimes have contacts with occasional injectors, such as students. They said that these young people primarily inject stimulants, and that most of them do not identify themselves as IDUs and avoid harm reduction services. According to Public Health, an NGO in Poltava, 5–10 of every 1000 students in any **Ukrainian** university town experiment with injecting at some point. In Odessa, another NGO called The Way Home has suggested that occasional injecting drug use occurs in various groups of young people associated with certain lifestyles, music, or attitudes (such as hippies, emos, and punks). Street kids in larger Ukrainian cities mostly inhale solvents when they use drugs. Being willing to “use anything that comes their way,” however, many have injected drugs too. A survey of 44 minors in correctional settings in Poltava found that 34 (77%) had injected occasionally before incarceration (*personal communication, Public Health, 2007*).

**Slovenia** reports occasional drug use among students, but injecting is rather uncommon in this population. In **Hungary**, of the young people who requested treatment for the first time in 2006 and had a history of drug injecting, 28% said that they had not injected in the last month, suggesting that for them, injecting was not their chief route of drug administration (*personal communication, Reitox National Focal Point for Hungary, 2008*).
Young people are often involved in a variety of overlapping networks in which they may be exposed to occasional or recreational injecting. Studies from Ukraine (Balakireva et al., 2006) and Hungary (Gyarmathy et al., 2006) suggest that there are overlaps between networks of IDUs, drug users who do not inject, and non-users. A recent Russian ethnography of both occasional and regular methamphetamine and opiate users suggests that user networks are often diffuse, that young users make efforts to control their drug use, and that young users practice or are interested in practicing harm reduction (Sarang, unpublished master’s thesis, 2007).

2.3 Young people and drug-related harms

2.3.1 Risk behaviors, knowledge of risks

Risks for transmission of blood-borne viruses

Sharing injecting equipment is the main reason for the spread of HIV, hepatitis, and other blood-borne viruses in the CEE region. In many EU countries, particularly in the western part, concerns about these health risks have led to the establishment of NSPs and the relatively easy availability of sterile injecting equipment through them and other harm reduction programs, pharmacies, and syringe vending machines. These countries have also developed information campaigns and other programs targeting IDUs – such as safer use education, safer sex education, injection rooms, and overdose prevention programs – to reduce the risks of injecting drug use. By the end of 2005, the transmission of HIV among IDUs was low in the EU and hepatitis infections among IDUs had decreased too, while in many member states the living conditions of both infected groups had improved considerably (EMCDDA, 2007c).

However the same source (EMCDDA, 2007c) also showed that HIV transmission among IDUs remained disturbingly high in several EU countries, as well as in neighboring Eastern European countries, where people often have limited access to sterile injecting equipment, harm reduction information, and other social and medical services.

Among CEE residents, knowledge of transmission risks is often inadequate and the gravity of HIV and HCV infection underestimated. Poor living conditions and a lack of long-range perspective among young people, particular IDUs, contribute to risk taking. “Soviet-style” drug use also involves high transmission risks for blood-borne infections from the preparation process, from front- and backloading, from injecting in a group, and from certain drug-selling practices, such as the sales of already prepared solutions in potentially used syringes.

Age-disaggregated data on injecting risk behaviors are available for only a few countries in the region. However, using in groups, sharing injecting equipment, frontloading, and using the same needle repeatedly are still reported to be common practice in many of the focus countries, including among young people.

Needles and syringes are the last thing to worry about; you need to find money for pills – that’s what’s important. In most cases after having gone a long way to buy the pills and hurrying back home to make boltushka you don’t even remember to think about syringes. There’s at least one person in the group who will have the syringe if you don’t have yours.

—Young IDU, Ukraine
(Chintalova-Dallas et al., 2006)
A study in Serbia showed that 57% of young drug injectors had shared drug-injecting equipment and 29% had reused the same needle more than once (Wong, 2002). In “crisis” (withdrawal), people share and reuse injecting equipment more frequently, as respondents from several of the countries observed. In some areas, syringes are only available in a few pharmacies (for example, only 2% of the pharmacies in Belgrade sell syringes to drug injectors), and most of the time it is hard to obtain sterile injecting equipment.

IDUs in Russia are young, and a substantial proportion of them engage in using and sexual behaviors that put them at increased risk for HIV and HCV. In a study among young Russian IDUs (age 16–25, mean age 21.3) in low-threshold facilities, a significant subset (35%) of HIV-positive participants reported sharing needles in the previous month; in fact, almost one quarter of the sample (24%) reported they had not once used a clean needle during the previous month. The study found no significant gender differences in the respondents exchanging needles and those sharing works (Gore-Felton, 2003). New research also highlights the importance of social relations within networks of injecting drug users. In a study done in St Petersburg, for example, all the new IDUs reported that they had been recruited by older, long-term IDUs, many of whom were likely to be HIV-positive. Newcomers using non-sterile injecting equipment or having sex with their “mentors” faced very high risks of contracting HIV and HCV (Stormer, 2006).

What is also troubling is that while the sharing of needles and syringes may be decreasing due to preventive interventions in some countries and settings, the sharing of other injecting equipment (a risk factor in HCV transmission) has been less influenced by these efforts. For example, a study in Hungary shows that dividing drug solutions among injectors typically involves the shared use of cooking equipment, filters, and water containers (Rácz, 2005). In Georgia, behavioral surveillance studies show that the use of sterile needles and syringes is increasing, yet HCV testing results show that every fourth IDU under 25 is infected with HCV, indicating that sharing filters, spoons, and cookers is still the norm among young injectors there (Republic of Georgia, 2008).

Injecting homemade opiates or stimulants in groups is very common in most of the focus countries. HCV and HIV are not necessarily killed in the process of preparing boltushka (homemade methcathinone) and may be transmitted when drugs are shared by frontloading the syringes of injecting partners (Abdala et al., 2008).

Knowledge of risks

According to Elena Voskresenskaya, the director of AIDS Foundation East–West (AFEW), an important reason why 80% of all new HIV infections in Ukraine occur in the 14–29 age group is that years of information campaigns by AFEW and other organizations in cooperation with the Ukrainian ministry of education have not led to sufficient decreases in risk behaviors, while many young people remain poorly informed about the disease. Vaskriesjenska said, “In the Ukraine it is still believed that you can get infected with HIV by standing next to somebody, or by drinking from the same cup, or even through a mosquito bite” (de Jong, 2008).

A Ukrainian study among 808 IDUs younger than 24 (Balakireva et al., 2006) lends some support to her opinion. While 95% of the participants knew of HIV transmission through sharing needles and syringes, only 70% knew that HIV can also be transmitted by sharing other injecting equipment (spoons, cookers, filters) and by frontloading. While 90% of the respondents
were aware of sexual transmission, only 58% knew of mother-to-child transmission. Moreover, 20% thought HIV could be transmitted by sharing towels, soap, and other everyday items, while 40% believed it could be transmitted through mosquito bites.

A study on HIV knowledge among young non-IDUs in Romania had similar results: 37% of the respondents believed in HIV transmission through mosquito bites and 18% thought it could be transmitted by sharing eating utensils. At the same time, 97% knew that condoms prevent HIV infection and 98.5% that sharing syringes and needles could transmit HIV (unpublished assessment provided by country correspondent; Romanian National Agency Against Drugs, ARAS, and the Alliance for the Struggle Against Alcoholism and Drug Addiction (ALIAT); 2008). Thus, while young people seem rather well aware of the actual routes of disease transmission, they also seem to repeat transmission myths that may interfere with the adoption of effective harm reduction measures.

Other than the Ukrainian study just cited, few studies from the region have looked specifically at the HIV knowledge of young IDUs. Limited data suggest that young IDUs in some countries and settings are actually better informed about injecting-related risks than older IDUs. For example, in a Georgian study of IDUs recruited at needle exchange sites, young injectors scored better on an HIV knowledge test than IDUs over 25 (unpublished data, Kirtadze I, 2008). A study of nine needle exchange sites in the Czech Republic, Hungary, Macedonia, Poland, Russia, and Ukraine showed that although levels of risk behavior among IDUs under 25 were moderately higher than among older IDUs (both before and during participation in needle exchange), young injectors responded positively to such programs (Des Jarlais et al., 2001).

In sum, the available research suggests that young IDUs in CEE are susceptible to HIV prevention and harm reduction interventions, though they may not always feel they are in a position to actually turn prevention knowledge into actual behavior change. This discrepancy should be a focus of further research.

Unfortunately, there are few studies on young IDUs’ knowledge of transmission risks for hepatitis B and C in the nine focus countries for this report. It appears, however, that young IDUs tend to underestimate the risk of transmitting HCV through sharing injecting equipment other than syringes and needles. According to the country respondent from Serbia, young injectors have incomplete knowledge of HCV transmission and believe HCV is common among IDUs. Incomplete knowledge of HCV transmission was also evident in a survey of 29 young IDUs (average age 23 years) in Hungary. Participants indicated that they shared syringes and needles occasionally but other injecting equipment frequently, usually with friends, partners, or relatives. Their risk behaviors were influenced by their trust in their sexual and injecting partners’ self-reported infection status (Gyarmathy et al., 2006). While disclosure of one’s status is considered the norm when injecting with friends and family, the lack of free, confidential HIV and HCV testing and insufficient knowledge of safe behavior encourage young people to take unnecessary injecting and sexual risks, an issue that arises again in the next section.

### 2.3.2 Sexual risks and gender issues

Most young IDUs are sexually active. Studies of sexual risk behaviors among IDUs reveal clear differences between young IDUs and IDUs older than 25 and, more markedly, between male and female IDUs. Key HIV and HCV risk factors associated with gender issues include
Young people & injecting drug use frequently changing sex partners, sex under the influence of drugs, and engagement in sex work – and these factors are common among young people.

Young people in Russia are becoming sexually active at earlier ages and rarely use condoms. In one study, the average person 14–20 years old started having sex before the age of 16, whereas the average person 30–40 years old did not have sex before the age of 18. Almost two thirds (63%) of sexually active respondents aged 14–20 said they had not used a condom the last time they had sex (Vannappagari et al., 2004). A study of young IDUs in Ukraine reported similar findings. Respondents’ average age of sexual initiation was 16.5, and 65% of the participants had had sex during the previous week. Yet in a marked contrast to the young Russians from the general population, 62% of the young Ukrainians from the IDU population had used a condom. The reasons Ukrainians gave for not using a condom included being in a trusting relationship with a partner, not having a condom available, and being requested by the sexual partner (usually male) not to use one. A total of 55% of the young IDUs in the study also reported having been under the influence of drugs the last time they had sex (Artiuch, 2005).

A Georgian survey that compared the sexual risk behavior of young drug injectors and those older than 25 indicated that knowledge of safe sex practices was slightly higher among the young injectors – 92.5% of them knew that condom use reduces HIV risk, compared to 87% of the IDUs older than 25. The younger IDUs were also tested for HIV significantly less often than the older ones, a pattern that reflects the testing situation in the general population of Georgia (Republic of Georgia, 2008).

Overlaps between injecting drug use and sexual activity (especially sex work) increase the risk of transmitting HIV and other sexually transmitted infections, particularly among young IDUs and, most strikingly, those who are female. A San Francisco study (Evans et al., 2003) suggested that injecting transmission risks are greater in young female IDUs than young male IDUs, despite a comparable frequency of injecting (Evans et al., 2003). Overlapping sexual and injection partnerships were a key factor in explaining the increased HIV risk in females. Females were more likely to be injected by another IDU than males were (even after adjusting for length of injecting history) and to be in a relationship with another IDU.

A study of sexual risk behaviors among young IDUs in Russia showed that, on average, males began having sex at a younger age than females, while females were more likely to have sexual partners who also inject. Over half of the female injectors (58%) reported being in a steady relationship, versus only 35% of the males. For the young female IDUs who were in a steady relationship, 59% reported that their partner also injected drugs, compared with only 25% for the corresponding young male IDUs (Gore-Felton, 2003). The study underlined the importance of gender in predicting sexual risk behavior associated with multiple sex partners, as both an independent predictor and a moderating factor. The males were significantly more likely to report multiple sexual partners in the previous month, especially the males who were youngest at sexual initiation. Interestingly, though there was no association between frequency of drug use and the number of partners among the young male IDUs, the more frequently the females injected, the more likely they were to report multiple sex partners (Gore-Felton, 2003).

A significant overlap between injecting drug use and sex work exists in many of the focus countries. Reports from harm reduction projects indicate that a high proportion of sex workers use drugs, particularly those working the streets. A recent report estimates that approximately 80% of sex workers in the CEE region are under 25 (CEEHRN, 2005). Moreover, studies suggest
that sex workers who inject drugs are often younger than those who do not (CEEHRN, 2005). Female sex workers tend to sell sex to support their – and often their sexual partners’ – drug habits, as shown in a rapid assessment and response study from Serbia that revealed that young sex workers exchanged sex for drugs (Wong, 2002).

2.3.3 HIV and HCV among young IDUs

Globally, youth (people aged 15–24) accounted for an estimated 45% of all new HIV infections in 2007 in people over 15 (UNAIDS, 2008). More than 80% of those infected with HIV in Central and Eastern Europe are younger than 30, in contrast to Western Europe and the United States of America, where only 30% of the reported cases are (UNAIDS, 2003).

It is also estimated that out of 6000 new HIV infections that youth aged 15–24 contract every day, over half are related to injecting drug use (Dolan et al., 2005). In the CEE region, the majority of those infected through drug injecting are young men, but as heterosexual transmission rates rise, the proportion of infections among women does too. The proportion of females among new HIV infections reported in youth aged 15–24 in Russia was 27% in 1999–2002 and 53% in 2003–2005 (Matic et al., 2008).

A recent study from Russia also showed that many women who report heterosexual transmission had a history of injecting drug use (Eramova et al., 2007). A Ukrainian AIDS Center/UNAIDS review of all HIV+ cases in Ukraine reported similar findings, showing in addition that cases of sexual transmission between men were severely under-recorded (Grund et al., 2003), while behavioral studies of men who have sex with men suggested high levels of HIV risk behavior (Ukrainian AIDS Center et al., 2000). These studies highlight that young people do not feel confident about discussing their injecting and sexual behaviors, even when they get tested.

HCV surveillance across Europe shows that the highest hepatitis C infection rates are found in people who are 25–44 years old, followed by those who are 15–24 (Rantala et al., 2008).

The data on HIV and HCV among young people discussed in the rest of this subsection come mainly from drug treatment samples and HIV and HCV testing (whether voluntary or compulsory), and they do not accurately represent the actual epidemiological situation in the focus countries. Few studies have attempted to estimate HIV or HCV prevalence among out-of-treatment IDUs; moreover, there are almost no data disaggregated by age. As a result, the prevalence rates presented in Tables 3 and 4 do not for the most part distinguish between young IDUs and older IDUs and may well include people both under and over 25. It should be iterated, then, that any reported differences in disease prevalence between young IDUs and older IDUs may not reflect actual epidemiological variations by age, and that these data should be interpreted with appropriate caution.

HIV prevalence

The Czech Republic, Georgia, Hungary, Romania, and Slovenia reported that HIV prevalences among tested IDUs were less than 2%, with little difference between those under 25 and those who were older. (See Table 3 for details of the observations in the present discussion, including references). In Georgia, the majority of people diagnosed with HIV are over 24; as of 2006, IDUs represented 62% of all cases with a known route of transmission (Javakhishvili et al., 2006).
Estonia, Russia, and Ukraine are the three European countries with the highest HIV incidence rates in both IDUs and the general population. Estonia and Russia also report high HIV rates specifically among young IDUs. While the proportion of newly registered HIV cases that were among young people decreased from 68% in 2000 to 56.5% in 2005 (Estonian Ministry of Social Affairs, 2008), studies among IDUs in Tallinn suggest that HIV is becoming more prevalent among “new” IDUs, defined as those injecting for three years or less. HIV prevalence among these new injectors is between 34% and 50%, with 64–80% of them being 20 years or younger (Uusküla et al., 2008).

By the end of 2007, 82.4% of HIV cases in Russia were related to drug injecting, with the majority of cases registered among people under 30. The average age among IDUs infected with HIV was 24 (Kalichman et al., 2000). While national data are not available for Ukraine, a 2004 study of young IDUs in four cities found that teenagers aged 15–19 comprised 55.6% of the HIV cases among IDUs in Donetsk, 36.0% in Poltava, and 26.1% in Odessa (where overall HIV prevalence among IDUs was highest) (Balakireva et al., 2006).

HCV prevalence

Available data from the nine countries evaluated for this report show that, for both young and older IDUs, HCV prevalence is much higher than HIV prevalence, in low- and high-HIV-prevalence countries alike. For example, in Hungary a surveillance study in rural areas found that none of the respondents tested positive for HIV, but 25.7% tested positive for HCV antibodies, including 20.3% of the respondents younger than 25 (unpublished surveillance report, Hungarian National Epidemiological Centre, 2008).

There is no discernable pattern in the differences between national HCV transmission rates for young IDUs and the same rates for IDUs of all ages. Studies in Hungary and Romania show either similar or slightly higher HCV rates among younger IDUs, suggesting that HCV is transmitted quite early in drug injecting careers. Only in Georgia and Slovenia sample studies suggested lower HCV transmission rates among young IDUs than among IDUs generally. Yet the rates in these two countries remain unacceptably high, at about 25% and 15% respectively, indicating that HCV risk behaviors are still very widespread among young IDUs.

For the results of particular national studies, see Table 4.

2.3.4 Drug-related death and overdose

Overdose is a major cause of death among IDUs in the European Union, chiefly occurring in people age 20 to 40, according to EMCDDA (Hedrich et al., 2004). In the countries that were EU member states before 2004, rates of overdose death are high but decreasing in many countries. The decline may be due to increased access to treatment services, including OST and other harm reduction services, as well as to changes in drug use and administration patterns.

Drug-related death (a “drug overdose”) can be defined as death following the consumption of one or more psychoactive substances. Different methodologies regarding the factors and conditions of death determine whether a drug-related death is recorded as such in official statistics. In some countries, such as Germany, drug-related death is only registered as such if injecting equipment is found with the deceased. Some countries separate statistics for deaths related to so-called “hard drugs” (such as heroin, cocaine, and amphetamines) from those related to legal drugs or medications (such as benzodiazepine and alcohol), while others do not. Moreover, dif-
different institutions are responsible for the registration of drug-related deaths in different countries, such as the Federal Drug Control Service in Russia and the Clinical Toxicology Department in Hungary.

Cooperation on these statistics among government agencies and other organizations is problematic in many places. The country respondent from Serbia, for example, questioned the official number of drug-related deaths, due to “lack of communication between institutions” and because “cases of drug-related death are misclassified under other causes.” As a result, drug-related death data do not always reflect actual overdose mortality, making local and national comparisons difficult.

Data on drug-related death and overdose are limited in the nine focus countries of this report. The data reported suggest rather low overdose-related death rates among people under 25. It should, however, be noted that the low numbers may reflect underreporting, limited technical resources, poorly trained staff, and the absence of clear procedures for reporting overdose deaths (e.g., when to perform a psychological autopsy). In some CEE countries, for instance, HIV-positive IDUs die of unspecified causes which are not related to HIV but are, according to harm reduction experts, associated with overdoses, both intentional and unintentional.

The EMCDDA reports that the mean age of fatal overdose victims is comparatively low in Estonia, followed by Bulgaria, Romania, and Slovenia, while it is high in the Czech Republic. ATS-related deaths are reported infrequently, although in the Czech Republic, 16 deaths were attributed to methamphetamine in 2004 and 14 in 2005, corresponding to an increase in the estimated number of problem pervitin users in recent years (EMCDDA, 2007c).

The highest number of drug-related overdoses in the focus countries is reported by Russia. According to the Federal Drug Control Service, 100,000 deaths occurred following drug overdoses in 2005, although the figure seems an overestimate (Кошкина [Koshkina], 2008). In 2006, Russia recorded 9536 deaths as resulting from “illicit drug poisoning” (ibid.). Age breakdowns are not available, but around 80% of drug users in Russia are minors or young adults, suggesting that a large proportion of overdose victims are people under 25.

Data on non-fatal overdoses among young people indicate that young IDUs have little information on avoiding overdose and reducing the health harms associated with using drugs. A 2000 assessment in Poltava, Ukraine, among clients of a harm reduction program concluded that 65% of the IDUs questioned had experienced an overdose at some point in their drug career. These overdoses were attributed to a lack of experience and information and to mixing drugs (personal communication, Public Health (NGO), 2008). In Hungary, although no national data on non-fatal drug overdoses are available, the Clinical Toxicology Department in Budapest does analyze all drug intoxication cases from Budapest and the surrounding area. In 2007, it reported that among males, 59 of 194 non-fatal opiate overdoses (30.4%) and 28 of 98 non-fatal amphetamine overdoses (28.6%) concerned males under 25, while among females, 31 of 78 non-fatal opiate overdoses (39.7%) and 35 of 159 non-fatal amphetamine overdoses (22.0%) occurred in females under 25 (personal communication, Reitox National Focal Point for Hungary, 2008).

2.4 Drug use, young people and prisons

Prisons present an environment of increased risk for HIV and HCV transmission (Jürgens, 2007). Criminalization of drug users and an over-reliance on law enforcement strategies to ad-
Young people & injecting drug use has resulted in the systematic incarceration of people who inject drugs in countries around the world (Canadian HIV/AIDS Legal Network, 2006; MacDonald, 2005). Many studies indicate that incarceration of drug injectors increases the likelihood of drug injecting and unsafe injection practices in prisons (Stöver et al., 2006), and that a significant minority of prisoners start injecting drugs while in prison (Canadian HIV/AIDS Legal Network, 2006). Penitentiary institutions thus present an extremely high risk environment for inmates (Rhodes, 2002), particularly young inmates (Kikas et al., 2006).

2.4.1 Rates of incarceration

**Russia**, **Georgia**, **Ukraine**, and **Estonia** have, in descending order, the highest per capita incarceration rates among Council of Europe states. The lowest incarceration rate in the focus countries is in **Slovenia**. Data for 2006–2008 show that in most of these countries, minors under the age of 18 represented around 2% of the total prison population (Estonia, Georgia, Romania, Russia, and Ukraine). In the **Czech Republic** and **Serbia** this rate was around 1%, while in **Slovenia** it was only 0.4%. **Hungary** had the highest percentage of incarcerated minors at 3.1% (see Table 6). In the focus countries, drug law offenses committed by young people, including possession and trafficking, were relatively few. However, in **Ukraine**, drug law offenses comprised 20% of the crimes committed by young people, and the percentage has been increasing each year. It should be noted, however, that the data received were not sufficiently disaggregated to allow proper analysis of the incarceration rates for young drug users.

2.4.2 Imprisonment and drug-related harms

In **Estonia**, prisoners represented 21% of new HIV cases in 2004 (155 people); in the same year, 12–13% of Estonian prisoners were HIV positive, the vast majority of them male (Estonian Ministry of Social Affairs, 2008). Injecting drug use in prisons was also associated with an HIV outbreak in 2001 in the overcrowded Alytus prison in **Lithuania**, where, according to the prison doctor, most prisoners injected drugs out of boredom after entering the facility (Caplinskas et al., 2002; Grund, 2002). A survey of injecting drug users in **Russia** (all ages) showed that 77% had been arrested for drug offenses and 35% had been incarcerated at some point in their lives (Demoscope Weekly, 2007). Most imprisoned drug users inject in a hurry, fearing punishment if caught by guards. In **Ukraine**, according to the country respondent, harm reduction service providers who work in prisons report that injecting there occurs in extremely unhygienic environments and in large groups of up to 30 people. The lack of sterile injecting equipment results in sequential use of unsterile injecting equipment by an already unhealthy population.

Although numerous studies of drug injecting in prisons have been conducted (see for instance WHO et al., 2004; Jürgens, 2007; Canadian HIV/AIDS Legal Network, 2006; Stöver et al., 2006), injecting and initiation of injecting is largely unexamined among young prisoners. In a recent study in **Estonian prisons**, almost all respondents agreed that around 10% of drug-using inmates had started injecting drugs in prison. Most drug-using inmates were between 22 and 30, followed by those age 18 to 21 and 31 to 40. On the other hand, drug use was rare among inmates over 40 (Kikas et al., 2006).
2.5 Conclusions

Treatment data and behavioral surveillance studies suggest that there are large groups of juvenile and young adult drug injectors in the nine countries this report examines. In some of these focus countries, drug injecting among young people seems to be increasing, although national data and local studies often present discordant findings. Meanwhile, the age of initiation into injecting drug use appears to be decreasing, and several country respondents expressed their concerns about children starting to inject drugs early in puberty.

The average age of IDUs varies by country (see Table 2) and by drugs injected. Opiates are the most commonly injected drugs in the focus countries, but stimulant use is on the rise among young people. Injection of stimulants, particularly homemade methamphetamine and methcathinone, appears to be associated with youth. Collective, Soviet-style home production dominates drug injection patterns in most of the focus countries and throughout the CEE region. Unfortunately, collective preparation and injecting may lead to increased occurrence of HCV and HIV risk-taking.

Initiation into injecting drug use is a social process among networks of young people. Young IDUs usually initiate friends into drug injecting at their explicit request. Most male IDUs learn to inject from friends, while many females IDUs are first injected by a male sexual partner, a dependent behavior that may continue for years. Female IDUs often engage in sex work to support their own and their partners’ drug habits, suggesting that gender roles result in a different risk environment for female injectors, who often are not in a position to make independent decisions. Young females are among the most vulnerable IDUs due to multiple, often poorly understood dependencies such as these.

Young people often participate in various overlapping networks that may expose them to drug injecting. Occasional injecting is reported in several of the focus countries, often among middle-class youth such as students. Occasional injectors frequently use stimulants, but most of these young people avoid harm reduction services and do not identify themselves as IDUs.

Reported risk behaviors and HIV and HCV prevalence data suggest that while young IDUs engage in risky behaviors just as often as older IDUs, age-related barriers may restrict their access to harm reduction services and limit their options for safer use (see Chapter 4). The high prevalence of HCV indicates that though prevention messages about not sharing needles may be effective, particularly in Central Europe, IDUs and prevention workers still do not properly understand other risk factors associated with HCV, such as sharing other injecting equipment. Furthermore, though young people appear to be sufficiently aware of actual disease transmission routes, they also persist at the same time in believing transmission myths, which may contribute to discrimination against people living with HIV and hepatitis. Such misconceptions can also interfere with the adoption of effective harm reduction measures. Finally, the data suggest that young IDUs in CEE are responsive to HIV prevention and harm reduction interventions, but they may not always feel themselves to be in a position to turn preventive knowledge into actual behavior change.

Studies of sexual risk behaviors among IDUs shows clear differences between young injectors and older injectors and, especially, between male and female IDUs. Frequently changing sex partners, sex under the influence, and engagement in sex work – especially at a young or very young age – are all associated with gender inequalities and contribute to young females’ risk for HIV and HCV.
In combination with high levels of sexual risk-taking among young IDUs – whether in steady relations, casual encounters, or sex work – the overlaps between injecting drug use, sexual activity, and sex work argue for comprehensive interventions to decrease the risks of transmitting HIV, HCV, and other sexually transmitted and blood-borne infections.

Problem drug use and various infectious diseases (including tuberculosis) are often more prevalent among vulnerable segments of the population, in which they can merge with other serious social and health problems. Such “disease clustering” (Knox, 1989) or “syndemics” (Singer et al., 2003) can often lead to increased visibility and heightened public concern, which can quickly lead to stigmatization and discrimination. According to March and colleagues, personal, social, and economic conditions are all linked in a process of social exclusion that compounds the problem of drug misuse (2006).

The Czech Republic, Georgia, Hungary, Romania, and Slovenia reported HIV prevalence among tested IDUs of less than 2%, with little differences between users under 25 and older users. Together with Serbia, the same countries have reported HCV prevalence rates among IDUs many times higher than the corresponding HIV rates.

On the other hand, Estonia, Russia, and Ukraine are the three European countries with not only the highest HIV rates, but also the highest HCV infection rates, among both IDUs (who are mostly young) and the general population.

The observed differences in HIV prevalence between the Central and the Eastern European countries are striking, and researchers and service providers have discussed the reasons for the disparity at length. Yet, given that (1) coverage of HIV prevention and drug treatment programs remains below the UNAIDS norm of 60% in large areas of both subregions, and that (2) in the 1980s and 1990s, many IDUs acquired HIV in developed countries in Western Europe and North America, the current low prevalence in Central Europe offers no guarantee for the future. Perhaps the statistics of Estonia, Russia, and Ukraine reflect the end stage of an epidemic process that has been left unchecked – an out-of-control situation in which the extent of the HIV and HCV epidemics overlap each other more and more in large populations of coinfected drug injectors. HIV/HCV co-infection among IDUs seems to be yet another unanticipated consequence (Merton, 1936) of counterproductive drug and health policies.

This chapter has sought to describe the social epidemiological context of drug injecting among young people in CEE. Depending on the country, between a quarter and a half of the IDUs in this region are younger than 25. Drug injecting typically starts at a relatively young age and is mostly initiated among friends, whereby a novice receives assistance from an experienced friend or, especially if female, a sexual partner. Opiates and stimulants are the substances injected most often, and in many countries, users produce these drugs themselves in small groups. Home production of injectable drugs can result in increased occurrence of HIV and HCV risk behaviors, including not only well-known ones such as needle sharing, but also lesser-known ones such as collective use of drug preparation utensils and syringe-mediated sharing of drugs. The lesser-known behaviors are key risk factors for HCV infection among IDUs, whether they inject homemade drugs or drugs bought on the black market (such as heroin). Gender-related

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These discussions emphasize factors such as Central Europe’s early introduction of harm reduction services, better health care access, and rapid social reforms (especially reform of the Soviet narcology system). See for example Csémy et al., 2001; Grund et al., 2008.
inequalities particularly increase the risks for young female IDUs. Besides infectious diseases, young IDUs also risk overdose and incarceration.

These observations suggest the urgency of focusing more on the needs of young people who inject or are at risk for injecting. Policies and interventions must create an enabling and non-judgmental environment that provides young drug users equal access to drug treatment, prevention information, and harm reduction services. As the following chapters will discuss, doing so will require concerted attention from a variety of stakeholders, including policymakers, legislators, and service providers. In addition, this chapter identified several data gaps and weaknesses that are particularly critical in making good policy for young IDUs; researchers need to address these needs and strengthen the evidence base for relevant policy and interventions.
3. Juvenile justice and drug use

States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child’s sense of dignity and worth…
—Convention on the Rights of the Child, Article 40.1
(UN General Assembly, 1989)

3.1 Introduction: applicable international standards

This section focuses on minors – defined in most countries as those younger than 18 – who are in conflict with the law and therefore become the responsibility of “juvenile justice.” The UN Interagency Panel on Juvenile Justice (IPJJ) has defined juvenile justice as:

… legislation, norms and standards, procedures, mechanisms and provision, institutions and bodies specifically applicable to juvenile offenders…. It also includes efforts to address the root causes of offending behaviour and implement measures to prevent such behaviour (IPJJ, 2006).

One central concept in juvenile justice is that when addressing juvenile offenses, the main emphasis should be placed on constructive responses instead of the more punitive approach that is often adopted for adult offenders. Juvenile justice thereby recognizes the detrimental impact of imprisonment on juveniles and the need to ensure alternatives to imprisonment. When detention is used, juvenile justice ensures access to adequate health and psychosocial services, including drug treatment and rehabilitation, and it seeks to reintegrate detainees back into the community. In accordance with these principles, juvenile sentencing in many European countries focuses on education, rehabilitation, and, as may be appropriate, reparation.

The nine states examined in this report have all ratified the UN Convention on the Rights of the Child (CRC). The Committee on the Rights of the Child, which oversees implementation of the CRC, has determined that the Convention requires the ratifying states to “develop and implement a comprehensive juvenile justice policy… which takes into account the child’s age and the desirability of promoting the child’s reintegration and the child’s assuming a constructive role in society” (Committee on the Rights of the Child, 2007a). Several other important global and
regional instruments provide details and guidance as to how these principles are to be developed and implemented.8

3.2 Criminal responsibility

Legislation in all nine focus countries sets the minimum age of criminal responsibility suitably high (see Table 5) (UNICEF, 2008). Georgia, Romania, Russia, and Ukraine utilize two minimum ages – one for minor offenses and a lower age for the “most serious crimes.” In Romania, Russia, and Ukraine, the range of offenses considered to be “most serious” includes acquisitive crime (stealing and robbery), which is sometimes associated with drug dependence problems. For that reason, the Committee on the Rights of the Child recommended that Ukraine “review its classification of serious crimes in order to minimize the scope of criminal responsibility for 14 to 16-year-old children” (2002).

It is important to note that, in itself, the fact that a young offender is above or below the minimum age should not determine the nature of the response, only whether the response may be determined by a court (of the juvenile justice system) rather than an administrative body (of the child welfare system). The court should be in a position to review each case in order to identify the most appropriate and constructive disposition for the minor in question, taking into account drug use when appropriate as a factor in the commission of serious offenses. The court can thus propose drug treatment – to the extent that adequate treatment services exist – as part of the response, in the same way that a child welfare body might for a minor below the minimum age.

Whether younger offenders who use drugs are offered (or obliged to undergo) drug treatment and specific rehabilitation services within the child welfare system is beyond the scope of this chapter, which focuses on the justice system and therefore only on minors above the minimum age of criminal responsibility.

3.3 Criminal records for drug use, and for possession of drugs for personal use

Guidelines issued by UNODC and WHO state, “In general, drug use should be seen as a health care condition and drug users should be treated in the health care system rather than in the criminal justice system where possible” (UNODC et al., 2008, Principle 6). The Committee on the Rights of the Child has repeatedly stated that minors who use drugs should not be criminalized as such (2005a, paragraph 77b; 2004, paragraph 63). However, in all but three of the countries studied (Hungary, Russia, and Slovenia), a criminal record is created when a minor is arrested for drug use or for drug possession for personal use, indicating a criminal justice approach to juvenile drug use.

8 Key international instruments include:
- Recommendation Rec (2006)2 of the Committee of Ministers to Member States on the European Prison Rules (Council of Europe Committee of Ministers, 2006);
- Guidelines for Action on Children in the Criminal Justice System (ECOSOC, 1997);
- United Nations Rules for the Protection of Juveniles Deprived of their Liberty [the Havana Rules] (UN General Assembly, 1990);
- United Nations Standard Minimum Rules for the Administration of Juvenile Justice [the Beijing Rules] (UN General Assembly, 1985); and
There are differences in the types of drug-related offenses for which a criminal record may be created. In the Czech Republic, drug use is not a crime, but possession of an amount of drugs “greater than small” will result in the case being forwarded to court. In Estonia, not only are supplying drugs and possession with intent to supply criminal offenses, but drug use and possession for personal purposes create criminal records too. In Romania, while drug use is forbidden by law but carries no penalties, possession for personal use may be punished by a fine or imprisonment of 6 months to 2 years, or up to 5 years for “high risk” drugs. In Serbia, possession for personal use in small amounts is illegal but “tolerated.” However, the Serbian respondent for this report noted that there are no guidelines on amounts for personal use, and that in practice, charges are filed in most cases of possession for personal use, especially in the case of heroin.

It is important to understand the overall effect of imposing a criminal record on a minor with respect to the minor’s rights. The consequences of criminalization range from discrimination and stigmatization to diminished access to education and reduced prospects for future employment, as well as negative effects on family relationships. That is why criminal records should be reserved only for serious crimes. When a criminal record is imposed upon a minor, it should remain confidential. If, in accordance with UN policy, drug use is to be treated as a health problem and juvenile users are to be rehabilitated, neither drug use nor drug possession for personal use should result in a criminal record.

3.4 Diversion and alternative sentencing

3.4.1 Diversion from judicial proceedings

One effective way to avoid creating criminal records – and the unnecessary and counterproductive stigmatization associated with the judicial process – is to divert juvenile offenders away from the justice system. A variety of principles, mechanisms, and tools can be used by law enforcement and justice professionals to effect diversion, especially – though not exclusively – if the law provides for them (UNICEF, 2008). However, formal diversion remains underdeveloped in the countries covered by this study, and there is therefore a lack of cases and data available for examining how well diversion is adapted for and applied to juvenile offenders who use drugs. One hypothesis that needs to be tested is that law enforcement authorities are sometimes less inclined to use their discretionary powers to divert minors from judicial proceedings in the case of drug users. Some practices that can be used either as alternative sentences or in the context of diversionary measures, such as mediation and family conferencing, are just emerging in these countries, and they show great potential for benefiting juvenile offenders, their families, and any victims there may be.

3.4.2 Alternative sentencing

A holistic approach to the rights of minors is required when considering the risks and impact of detaining them. Aside from the danger of abuse and neglect, detention carries serious consequences for a minor’s development that can hamper his or her reintegration into society.

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9 Amounts considered “greater than small” are not set out in law but have been developed in practice, e.g., five 30-mg doses of heroin, five 30-mg doses of cocaine, ten 50-mg doses of ecstasy, and ten 30-mg doses/joints of cannabis.
including the risk of drug use and related health harms such as HIV and hepatitis C. To ensure a minor’s optimal development, it is therefore important to avoid detention whenever possible.

Common to all relevant international guidelines is the principle that detention or imprisonment of a minor be used only as a measure of “last resort.” With respect to drugs, Article 33 of the CRC requires countries to “take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances” (UN General Assembly, 1989). Appropriate is key. The UN Working Group on Arbitrary Detention has, on numerous occasions, raised concerns about the arbitrary detention and over-incarceration of vulnerable groups, including “drug addicts” (2004, 2005, 2006). As noted by UNICEF, placing harsh custodial penalties on minors for drug use is a deeply ineffective form of protection (Hodgkin et al., 2002).

The Georgian respondent was the only one to report that no alternative sentences were available for minors. Indeed, the Committee on the Rights of the Child very recently raised concerns about the “absence of efficient mechanisms to ensure that imprisonment is used as a last resort” in the country (2008a). It also noted the “increasing number of children entering the criminal justice system and receiving custodial measures and punishments” and the “often disproportionate length of sentences in relation to the seriousness of offences.” Nonetheless, only 10 of the 426 people under 18 who were incarcerated in Georgia in 2006 were there for drug-related offenses. More may have been drug dependent but incarcerated for other crimes.

Respondents for two countries, Romania and Hungary, also noted that alternatives to detention were available, although not specifically for minors. Nonetheless, the European Committee on Social Rights raised concerns that in Romania, 2874 of the 7005 minors sentenced in 2002 were imprisoned, and that imprisonment was still being imposed “more often than educational measures” (2005). The laws are currently being amended to allow for greater use of alternatives to incarceration.

A new Czech law adopted in 2008 prioritizes educational and protective measures over imprisonment for minors, stating that imprisonment should be a “last choice” (Government of Czech Republic, 2003). In Estonia, a range of alternatives to detention also exists, including warning, educational measures, referral to a psychologist, residential requirements, compensation, and participation in youth programs. In Serbia, a “social protective approach” has been adopted in the recently initiated juvenile justice system (Committee on the Rights of the Child, 2007b). Detention measures may be pronounced against a person who has attained the age of 14 years in exceptional cases only, “on the basis of the decision of a juvenile judge or juvenile panel.”

The Russian government argues that the general standard should be that “detention in custody is used when no other less severe restrictive measure can be applied,” and for juveniles, only in the case of serious offenses. Yet the Committee on the Rights of the Child has also noted in Russia a “lack of alternative measures of detention and forms of reintegration for children in conflict with the law” (Committee on the Rights of the Child, 2005c).

In general, alternative sentencing does exist in most of the focus countries’ legal systems, but the speed and conditions of its implementation are not optimal. Unfortunately, not enough disag-

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10 There are, however, some discretionary measures open to Georgian judges, including placing a minor on probation or suspending sentences less than three years. Fines are also possible in certain circumstances relating to drug offences, though judges largely ignore this option.

11 By law, there are six kinds of punishment for juveniles, four of which are non-custodial. See Article 108 in the Criminal Procedure Code of the Russian Federation (Russian Federation State Duma, 2001).
Aggregated data were received to allow for analysis of the incarceration rates of convicted juvenile offenders who use drugs versus the rates for those who do not.

### 3.4.3 Availability and imposition of treatment in the juvenile justice system

According to UNODC and WHO, “interventions for drug dependent people in the criminal justice system should address treatment as an alternative to incarceration” in order to “decrease the risk[s] of relapse in drug use, of HIV transmission and of re-incidence in crime” (UNODC et al., 2008, Principle 6). The Georgian respondent was the only one to report that treatment was unavailable as an alternative to detention. Though compulsory treatment may, by law, be ordered for offenders, Georgian judges do not use this measure because there is no infrastructure or financial support to implement it.

A juvenile justice system centered on juveniles should be based on juvenile-specific legislative measures and processes, and it should include drug dependence treatment as an alternative to detention when appropriate. Although the respondents for the other eight focus countries reported the availability of treatment as an alternative to detention, none reported specific legislation or treatment measures aimed at minors. Any drug user in these nations, regardless of age, may be sent to a drug treatment program. A juvenile user may request treatment too, or a prosecutor may recommend it. In some cases, parental consent is required for minors to be treated. The treatment may also involve referral to a psychologist, addictions specialist, or other specialist for consultation.

The Serbian respondent noted that placement in treatment may only take place if it is considered to be in the best interest of the minor. Such treatment takes place in open centers and clinics rather than closed treatment facilities, but these clinics are not specific to minors. Moreover, consent to such treatment is not required. This raises questions about the potential effectiveness of the measure, given the poor prognosis for drug treatment that is instituted against users’ wishes, which are critical in determining their best interests (CRC, Article 3) and showing due respect for their opinions (Article 12) (UN General Assembly, 1989).

The Hungary, Russia, and Ukraine respondents all reported no obligatory treatment for juvenile drug users; in their countries, a judge may only impose treatment with the consent of the person involved. Drug treatment must be recommended by the court and agreed to by the defendant. In Hungary, no differentiation is made for age or severity of drug dependence. In 2005, the government reported to the Committee on the Rights of the Child that “in the case of young people addicted to alcohol or drugs, the difficulty is that there are very few boarding institutions in the country that specialize in treating them” (Committee on the Rights of the Child, 2005b).

The Estonia and Romania respondents reported that treatment may be imposed with parental consent. In Estonia, treatment is actually compulsory for minors, though voluntary for people over 18. Under the Juvenile Sanctions Act, minors have to go through obligatory drug treatment if a juvenile committee decides to use this sanction. Paragraph 7.3 of the Act states, “Upon imposition of a sanction, a juvenile committee shall take into account the opinions of the representative of the minor, the social worker, representative of the educational institution and the police officer and the consent of the minor to accept obligations voluntarily” (Government of Estonia, 1998).

Compulsory treatment without the consent of either juvenile or parents is used in three countries: Georgia, the Czech Republic, and Slovenia. Compulsory treatment may be imposed on people of any age in Georgia under Article 96 of the criminal code. However, there is no funding or infrastructure to support such treatment, so judges do not use it in sentencing. In the Czech Republic, treatment may be imposed on minors without parental consent in criminal pro-
ceedings. And in Slovenia, compulsory treatment for drugs and alcohol is defined by Article 66 of the penal code. A person who commits a criminal act owing to their drug use may be sentenced to compulsory treatment, which can take place in either prison or a treatment institution.

If a juvenile justice system is to be child-centered, it follows that sanctions applied to children must also, as a key component of that system, be child-centered. For minors in conflict with the law, sanctions should accordingly respect their rights as enshrined in the CRC. In particular, honoring the health rights enumerated in Article 24 means ensuring that drug treatment services are accessible, acceptable, and appropriate (UN General Assembly, 1989). Not only should drug treatment be physically accessible to juveniles who need it, but any stigma and discrimination issues need to be confronted too. Furthermore, the treatment offered should be appropriate to their age and particular needs. Compulsory drug treatment without the consent of child or parent contradicts the principles of appropriate health care.

An important question that arises in this context is the nature of the treatment provided. In many countries around the world, abusive measures are adopted under the banner of drug “treatment” or “rehabilitation.” As a basic principle, human rights should never be restricted on the grounds of treatment and rehabilitation (UNODC et al., 2008, Principle 4). For the present report, qualitative data on the nature of treatment provided was not sought, and further research on this crucial topic is needed.

3.5 Protection: treatment in places of detention for juveniles

To deprive someone of his liberty entails a moral duty of care.
—Thomas Hammarberg, European Commissioner for Human Rights (2007)

3.5.1 Availability of medical and psychological assistance in places of detention (including pretrial detention)

A government is obligated to protect the human rights of the people it has deprived of liberty, subject to the restrictions that are unavoidable in closed environments (Human Rights Committee, 1992). In such situations, health-related rights are of central importance, including a child’s right to optimal development (CRC, Article 6.2 (UN General Assembly, 1989)). Specific provisions relating to juveniles’ health-related rights are contained in the Beijing and Havana Rules (UN General Assembly, 1985, 1990).

The European Prison Rules require prison authorities to “safeguard the health of all prisoners in their care” (Council of Europe Committee of Ministers, 2006, Rule 39). More specifically, “medical services in prison shall seek to detect and treat physical or mental illnesses or defects from which prisoners may suffer” (Rule 40.4), and all necessary medical, surgical, and psychiatric services, including those available in the community outside, shall be provided to the prisoner (Rule 40.5). The responsibilities of prison authorities thus include:

a. observing the normal rules of medical confidentiality;

12 See also the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12, and the revised European Social Charter, Articles 11 and 13 (UN General Assembly, 1966; Council of Europe, 1996).
b. diagnosing physical or mental illness and taking all measures necessary for its treatment and for the continuation of existing medical treatment;

...  
d. dealing with withdrawal symptoms resulting from use of drugs, medication or alcohol;

e. identifying any psychological or other stress brought on by the fact of deprivation of liberty;

f. isolating prisoners suspected of infectious or contagious conditions for the period of infection and providing them with proper treatment;

g. ensuring that prisoners carrying the HIV virus are not isolated for that reason alone;

h. noting physical or mental defects that might impede resettlement after release;

...

j. making arrangements with community agencies for the continuation of any necessary medical and psychiatric treatment after release, if prisoners give their consent to such arrangements.

(Council of Europe Committee of Ministers, 2006, Rule 42.3)

The European Court of Human Rights has recently connected the denial of medical assistance to people in prison – in the case of a drug user who was HIV positive – to cruel, inhuman, and degrading treatment and punishment, which is prohibited by Article 3 of the European Convention on Human Rights (Council of Europe, 1998).  

Few of the focus countries live up to these obligations, and pretrial detention is clearly the area of least compliance. In Serbia, no psychological or medical assistance is available for any age groups in pretrial detention. The Ukraine respondent reported that while consultations with medical and psychological staff were available during pretrial detention, they were operated by an NGO, the International HIV/AIDS Alliance, indicating that the service may not be sustainable. In Georgia, it was reported that no medical or psychological assistance was available to pretrial detainees of any age. The Russian respondent reported that the need for this type of assistance was not anticipated in the criminal code. While medical assistance is provided during pretrial detention, no psychological help is available.

Respondents from the remaining countries reported having medical and psychological assistance in places of detention. In Romania and Slovenia the laws require that medical and psychological assistance be provided to everyone in detention, regardless of age. However, no information was received on whether this requirement has been implemented for juveniles, nor on whether it is applied to pretrial detention. In Hungary, the law stipulates that medical care be provided to juveniles in police jails, penal institutions, and juvenile correction centers (Committee on the Rights of the Child, 2005b). However, it does not mention medical and psychological assistance during pretrial detention.

Incarceration has been repeatedly identified as a major risk factor for fatal overdoses, and such overdoses often occur shortly after release (McGregor et al., 1998; Coffin et al., 2007; Farrell, 2008). Nevertheless, preparing detained drug users for release appears to be a major gap in the services provided during detention. (For more on overdoses, see Appendix 1.)

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13 See Khudobin v. Russia (Application No. 59696/00), Judgment of 26 October 2006, which states “the State must ensure that the health and well-being of detainees are adequately secured by, among other things, providing them with the requisite medical assistance” (European Court of Human Rights, 2006).
3.5.2 Availability of drug treatment in places of detention

The Havana Rules specifically require drug dependence treatment for juveniles in places of detention. Rule 51 states that “the medical services provided to juveniles should seek to detect and should treat any physical or mental illness, substance abuse or other condition.” Rule 54 further states,

*Juvenile detention facilities should adopt specialized drug abuse prevention and rehabilitation programmes administered by qualified personnel. These programmes should be adapted to the age, sex and other requirements of the juveniles concerned, and detoxification facilities and services staffed by trained personnel should be available to drug- or alcohol-dependent juveniles (UN General Assembly, 1990).*

The only drug dependence treatment reported to be available in Georgia is a 12-step program run by an NGO in two prisons. The European Committee for the Prevention of Torture (CPT) highlighted the lack of treatment during its 2007 visit. Though the CPT report focused on adults, it is worth noting its concern that, though “the number of prisoners with drug-related problems was on the rise,” “the response to the growing problem of drug addiction seemed to consist primarily of putting drug addicts in prison, without any medical and psychological programs to assist them [to] avoid or overcome problems associated with the use of drugs.” The CPT recommended that the Georgian authorities develop a comprehensive strategy for providing assistance to persons with drug-related problems *(CPT, 2007).*

Estonian and Russian respondents reported that their countries provided no drug dependence treatment to juvenile prisoners. Their communications are cause for considerable concern because drug users are so often over-represented in prisons. While Romania and Slovenia respondents did report the availability of drug dependence treatment, it was not specific to minors. The Czech Republic and Serbia were the only focus countries reported to have drug dependence treatment available specifically for juveniles.

The respondents provided no data on the form that drug treatment in prisons takes (when it is available), and further research on this point is needed.

3.6 Conclusions and recommendations

Two main observations can serve to summarize the findings of this chapter.

The first is that most of the countries examined for this report have adopted a criminal justice approach to juvenile drug use. Most of them create criminal records for drug possession by minors. Drug-related offenses often fall under the heading of “most serious crimes,” subjecting the offenders to the lowest minimum age of criminal responsibility and the risk of severe punishment.

Second, analysis of the data obtained for this report highlights a lack of juvenile-specific legislation, legal processes, sanctions, drug treatment, and diversionary measures in many of the nine focus countries. Yet international legal instruments and guidelines stipulate separate, specific, child-centered juvenile justice systems. While the situation in Georgia, for example, is far different from that in Serbia, this chapter shows how adequate consent procedures do not

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sufficiently guarantee minors’ rights in either country. Where alternatives to detention, including drug treatment, are available for minors, they are often not juvenile-specific but simply general provisions for the entire population. In addition, detention is rarely a measure of “last resort,” as international guidelines stipulate, and in most countries, the availability of medical assistance and drug dependence treatment in places of detention is underdeveloped. Moreover, while it is not documented in this chapter, it is likely that, due to stigma and discrimination, juveniles from minority communities come in conflict with the law more often than other juveniles, and are therefore more susceptible to drug-related harm in detention.

An additional point concerns the nature of drug dependence treatment provided for minors. It is not enough to insist that treatment be available and accessible; it must also be of acceptable quality. This report did not examine data on the nature of drug treatment for minors, in either open or closed facilities. Qualitative research is needed on the nature and quality of existing drug treatment in juvenile justice settings.

Together, these observations highlight significant gaps in the implementation of the focus countries’ international legal obligations. Separate juvenile justice systems based on relevant international law would help bridge many of these gaps, with a significant positive impact on the juvenile drug users who come into contact with the criminal justice system.

This analysis points to a number of specific recommendations for legislative and policy action, as well as suggestions for service development and further research.

**General recommendations**

Simply depriving juvenile offenders of liberty in cases directly connected to their desire or need for drugs is not only an ineffective deterrent, but it can also have negative consequences (fatal overdoses, widespread infections due to injecting conditions in detention).

- Offer juveniles identified as drug users counseling and treatment in an appropriate health care setting, rather than letting the justice system deal with them. Allocate enough resources to make sure such services are widely available.
- Help minors who commit offenses related to drug dependence avoid turning again to drugs (and therefore to offending). Again, ensure that adequate treatment programs are in place so that the justice system can assign offenders to treatment rather than just punishing them.

**Recommendations for law- and policymakers**

- Pass specific legislation on juveniles and drugs that recognizes the relevant international commitments in this area.
- Create or improve existing juvenile justice systems in line with international standards. Such systems imply diversion from judicial proceedings, alternative sentencing, and rehabilitative approaches to facilitate the full reintegration of juvenile offenders into society.
- Provide judges, prosecutors, and public defenders with juvenile justice training that includes modules on drug dependence and drug treatment.
- Do not subject minors to criminal proceedings and criminal records simply because of drug use or possession for personal use.
- Where two minimum ages of criminal responsibility exist, ensure that the “most serious crime” category excludes minor acquisitive offenses based on need, such as shoplifting.
- In juvenile justice proceedings, employ drug treatment as a protective measure rather than a punishment.
• Seek consent in drug treatment and diversionary measures. Give minors the opportunity to express their views, and take them into consideration in all judicial and administrative proceedings that affect them.

• Seek the consent of parents or guardians whenever a juvenile is not mature enough to consent to drug treatment. While requiring parental consent for HIV counseling or other harm reduction efforts can impede access, requiring parental consent for externally imposed drug treatment provides an important protective buffer between the minor and judicial discretion (see Section 4.3.2).

• Implement specialized drug treatment for juvenile detainees consistent with (and connected to) services in the community outside.

• Ensure that community-based treatment is continued when clients are detained or imprisoned. Similarly, take steps to ensure cross-institutional and intersectoral cooperation to provide minors who are treated in detention with treatment upon release, and in open centers rather than closed institutions.

• Provide incarcerated juvenile drug users with access to HIV prevention and other harm reduction services, e.g., pre-release counseling on overdose prevention.

• Sensitize service providers to the rights of minors, and educate them on applying these rights to drug treatment and harm reduction interventions.

**Recommendations for researchers**

• Study the reasons for the gap between laws intended to protect juvenile drug users (including those providing detention alternatives) and their implementation.

• Research the length of pretrial detention for minors, or juvenile offenders’ exposure to violence, or the separation of minors and adults in detention, disaggregating in each case drug user data from non-user data. To understand which minors are coming into conflict with the law, which minors are being imprisoned, and which minors are accessing drug treatment, further disaggregate the data by (at a minimum) age, sex, ethnicity, and socioeconomic status.

• Research the nature and efficacy of drug treatment for juveniles in the community and in closed institutions.

**Recommendations for international organizations** (IPJJ and its members, WHO, etc.)

• Work on developing juvenile justice approaches that address drug dependence and drug treatment issues as fully as possible.
4. Access to drug treatment and other harm reduction services

4.1 Introduction: harm reduction and young people

Many programs for young people provide health-based interventions and programs for young drug users. However, abstinence-only policies, questionable treatment standards, and lack of training often limit the scope and effect of their services, especially those targeting young experimenters and injectors, who are likely to be put off by treatment that focuses on immediate abstinence (Burniston et al., 2002). The integration of a harm reduction approach into evidence-based drug education significantly improves its efficacy. However, programs with this philosophy may still not provide the targeted services and interventions that young IDUs need.

Harm reduction services provide a broader range of treatment, prevention, and care options for young users than primary prevention programs for drug use do. While the latter are often broadly based and unfocused, harm reduction services are focused by design. They target the immediate needs of the individual drug user and the specific risks associated with certain drugs or modes of drug administration, while at the same time they support changes in individual behavior and communal norms. Harm reduction programs have become a key component of efforts to protect minors from using narcotic drugs, as required by Article 33 of the Convention on the Rights of the Child (CRC), and vital in guaranteeing juvenile users’ right to health, as recognized in Article 24 (UN General Assembly, 1989).

Initiation into using a given drug and into injecting it does not necessarily happen at the same time. A delay between the two is common, more often in Western Europe and the United States than in Eastern Europe. Initiation patterns are closely connected with a variety of social, cultural, legal, and economic factors, including drug availability, legislation, law enforcement practices, and the availability of services (Grund, 1993b; Howard et al., 2003; Dolan et al., 2005; Burrows et al., 2006). Older IDUs respond fairly well to outreach, low-threshold drug treatment, and drop-in services, and they feel more comfortable seeking out services. These types of programs allow them to access lifesaving harm reduction information and supplies (e.g., clean needles) and otherwise maintain their health while keeping their substance use anonymous. Unfortunately, very few such services have been established for young people in Central and Eastern Europe and they are uncommon elsewhere, while those that do exist too often ignore the special needs that young people have.

Service providers often hesitate to work with young people because of legal age restrictions and the need for consent. As a result, young drug injectors remain isolated from health care systems, which increases their vulnerability to unsafe drug use and sexual behaviors, and conse-
Young people & injecting drug use

Quently, to infection with HIV, HCV, and other diseases. The stigma associated with substance use has helped render it more invisible, a situation that has exacerbated the lack of adequate harm reduction programming for young people. Many adolescents practice or experiment with substance use and sexual behaviors. Without access to comprehensive, evidence-based drug and sex education, young people share injecting equipment and engage in unsafe sex much more often, increasing their vulnerability to blood-borne and sexually transmitted diseases.

At the same time, many harm reduction providers assume that all IDUs will seek them out and utilize their services eagerly and easily. This assumption is especially untrue for young IDUs, who differ from older IDUs in a variety of key aspects.

- Early-age injecting drug use is associated with increased rates of HCV and HIV risk behaviors (Garfein, et al., 1996; Doherty et al., 2000; UNODC, 2004). Initiation into injecting drug use is most often a peer-based process that relies on learning by observation and imitation (Grund et al., 1993a; Balakireva et al., 2006). There is no phlebotomy manual available to young people intent on injecting drugs. Young IDUs are often poorly skilled injectors, and they pass on poor injecting practices (and the associated risks) to successive generations of novice injectors.

- Young IDUs typically have less economic security and access to resources than older ones, as they are often unemployed and, especially since many of them drop out of school, unskilled. Many resort to crime or sex work to pay for drugs. Financial constraints can hinder young IDUs from obtaining clean injecting equipment and increase their reuse and sharing of used equipment.

- That said, drug injecting has spread across class and education borders, and a sizable minority of IDUs comes from middle- and even upper-class families. A Hungarian study suggests that though these socially integrated young people are more in control of their drug use than their marginalized coevals, their levels of risk behavior are similar (Gyarmathy et al., 2006).

- Young people often feel strong and invulnerable. Moreover, young people have difficulty connecting current behaviors with long-term consequences (Smit, 2007; UNODC, 2004).

- A number of studies show that young IDUs are more inclined to borrow and to share injecting equipment than older IDUs (Fennema et al., 1997; Cassin et al., 1998).

- Many young people are insufficiently aware of their rights to health services and do not know how to access them (UNODC, 2004).

- Many young people experiment with drugs in adolescence and early adulthood. Where injecting is a common route for administering illicit drugs, they may also inject out of curiosity, through peer or partner pressure (Treloar et al., 2003; Hunt N et al., 2001), or for other, more personal reasons (Howard et al., 2003). It is likely that most young people who inject drugs do so only a few times. If addressed appropriately, drug experimentation can often be prevented from escalating into regular use or addiction.

- Novice or occasional injectors are often unaware of injection-related health risks and ways to minimize them. Moreover, they often resist calling themselves IDUs or “problem” drug users in need of services, avoiding harm reduction services even if injecting friends use them. They may also suspect that accessing such services will compromise their anonymity.
• Young IDUs often lack trust in institutions and service providers. They have limited experience in navigating institutions, and they fear losing their independence, being arrested for substance use, and being forced into treatment.

• The differences in traditional gender roles are often magnified in the drug scene. Female IDUs face distinct gender-related risks for the harms associated with injecting, particularly at the onset of their injecting careers.

• Lastly, because young injectors find stigma especially hard to deal with, the young IDU community is often smaller and more underground than the older IDU community, which reduces the visibility of issues that concern young people and injecting drug use.

Fortunately, while all these factors put young people at increased risk for HIV, HCV, overdosing, and other health problems, they also provide opportunities for harm reduction services to address these risks early in IDUs’ drug careers. Working with young people who are at risk for injecting or are already experimenting with it is, however, a relatively new terrain within the evolving practice of harm reduction. This terrain is fraught with major obstacles, and one of this report’s aims is to assess them.

It also seeks to develop practical recommendations for developing harm reduction services that encourage the participation of young people, empowering them to take responsibility for their health and social problems with practical, individual solutions that accommodate their lifestyles and circumstances.

4.2 Availability of drug treatment and harm reduction services for young people

As discussed in Section 4.3 below, most harm reduction programs in the focus countries must confront age restrictions in providing services to young drug users, for example OST and needle and syringe exchange. In some countries, the reluctance of these programs to provide safer injecting equipment and information to young people stems from the existence and enforcement of laws on supplying drugs (and paraphernalia) and on “encouraging” drug use, decreasing their ability to reach young IDUs, especially juveniles (see Section 4.3, Table 5, and Table 9).

The limited data available indicate that the proportion of young people in contact with harm reduction services is low in all of the focus countries. Around 14% to 16% of NSP and VCT clients in four Georgian cities are young people (Otiashvili et al., 2008b; unpublished data, Kirtadze I, 2008). In Ukraine, an estimated 9% of harm reduction clients are young people (Apmnox [Artiuch], 2005). The Hungarian country experts consulted for this report suggested that most clients of their country’s drug prevention services are over 20. One exception to the pattern may be the Czech Republic, where according to the country respondent, a study of low-threshold harm reduction clients suggests that around two thirds are younger than 24.

In Estonia, around 77% of NSP clients are close to 23 (Reitox National Focal Point for Estonia, 2006). Overall coverage of harm reduction services falls short of need – e.g., NSPs reached an estimated 37% of IDUs in 2005 – and a great part of the shortfall is among young injectors. Though the age of initiation for drug injecting is between 15 and 19 (see Table 2), services do not target young Estonians, who often take years to begin accessing assistance.

There are primary drug use prevention programs for young people in all of the focus countries, usually drop-in centers that offer them information on drug use and HIV (see Table 8).
Nonetheless, all of the survey respondents indicated that services specifically targeting young IDUs were largely absent in their countries.

One of the drawbacks of the prevention programs that are available to young people is that they are “broadcast,” targeting a general audience. They do not focus on the young people who are most at risk for HIV and other drug-related harm. For example, in Estonia, the Estonian Association of Sexual Health coordinates a service network to run points providing free HIV testing and counseling to people under 24. Though it is perhaps not surprising that most of their materials focus on the sexual transmission of HIV, the fact remains that HIV is primarily transmitted in Estonia by injecting drug use, and they have not arranged any activities for young people who use drugs. In addition, although transmission rates are higher among the Russian-speaking minority, their materials were available mainly in Estonian until recently. Nonetheless, the network has seen some positive results, and the Estonian Health Insurance Fund’s financing of it presents a useful model for other countries with social health insurance.

The effectiveness of narrowcasting in reaching risk groups has been demonstrated by a small number of programs for street children implemented in the Czech Republic, Estonia, and Romania, and by programs focusing on juvenile drug users in a few cities in Russia and Ukraine. Unfortunately, however, these programs cannot officially provide basic harm reduction services such as needle exchange. Another intervention that six of the focus countries have implemented (the exceptions being Estonia, Georgia, and Russia (see Table 8)) is outreach to young people, notably at music and dance party events. In Serbia, for example, information, condoms, and safer injection kits were distributed at the Dragon’s Kiss music festival in 2004. In Ukraine, a peer-driven intervention (PDI) recently targeted young IDUs (see Appendix 1). And in Hungary, workers at the Contact Cafe drop-in center engage young IDUs on the streets to inform them about the café’s services, including internet access.

Yet these examples are the exceptions, and very few harm reduction services in the region conduct outreach or peer interventions that specifically target young people. The majority of country experts reported that outreach services target all drug users, not distinguishing between young IDUs and older IDUs. Nor do most outreach programs, according to respondents, utilize specific methods or messages to reach juvenile injectors. Only a few of the country respondents (including those from Romania and Ukraine) indicated that their countries sought to adapt HIV prevention materials to the needs of young IDUs.

Even fewer respondents indicated the existence of outreach to drug users who do not inject. To a limited extent, the Czech Republic, Serbia, and Ukraine implement such services, which mainly involve motivating NSP clients to bring their friends in to get further information.

4.3 Barriers to access

Throughout the region, the availability of drug treatment and other harm reduction services to young people varies considerably. Access is better in the Czech Republic (where governmental funding has expanded services), Slovenia, and to a lesser extent Estonia, while in Serbia, Romania, and Russia, access remains poor. Limited geographical availability of services is one of the key problems. Law enforcement and confidentiality fears have also resulted in the widespread belief among IDUs that most services cannot operate without police “permission.” Whether or not such fears are justified in a particular situation, any harm reduction programs that target IDUs or other vulnerable populations (such as sex workers or young homosexuals) must overcome simi-
lar problems in achieving “street cred.” Furthermore, these programs need to confront stigma and discrimination, which, as the country respondents from Georgia, Russia, and Ukraine report, can also drastically reduce uptake of services.

The barriers to OST are especially pronounced. It remains illegal in Russia and is only slowly expanding in Ukraine, the two countries with the largest IDU populations and HIV epidemics in the entire European Region.

4.3.1 Age restrictions

While it is hard to estimate either how many juveniles need harm reduction services, or how many would be willing to employ them, it is clear that age restrictions are a major barrier to providing such services equitably. Governments have wide discretion as to how, precisely, to implement the CRC in their countries, yet decisions relating to drug policy must still be grounded in four principles contained in Articles 2, 3, 6, and 12 of the convention (UN General Assembly, 1989). Specifically, the principles describe how government actions are obligated to respect and ensure the rights of minors by:

1. not discriminating against them, in part by seeking out juvenile groups in need of special care and assistance and ensuring that their rights are protected;
2. acting in minors’ best interests;
3. promoting minors’ optimal physical, social, and psychological development; and
4. consulting minors and taking their views into account (Committee on the Rights of the Child, 2003).

These general principles can be equally applied to all young people. At a bare minimum, the process of determining an appropriate response to drug use among young people should revolve around young drug users and involve their participation. Age restrictions for services based on political expediency, discomfort with young people’s drug use, or a lack of national evidence on the efficacy of services for young people are arbitrary and do not honor these international legal obligations.

The CRC guarantees minors the right to health (Article 24) (UN General Assembly, 1989) – a right guaranteed also, inter alia, by the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12 (UN General Assembly, 1966), and the European Social Charter, Article 11 (with Article 13 specifying the right to medical assistance) (Council of Europe, 1996). In the context of the following sections, it is important to note that both the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health and the UN Committee on Economic, Social and Cultural Rights have confirmed that harm reduction is an essential component of drug users’ right to health. Denying young people harm reduction services – or permitting significant barriers to their access of such services – violates their internationally guaranteed right to health (Hunt P, 2005, 2007, 2008; Committee on Economic, Social and Cultural Rights, 2006, 2008).

Age limits for drug treatment and other harm reduction services represent clear violations of young IDUs’ right to health. An important element of the right to health is the right to protection from epidemic diseases, as specifically stated in the ICESCR and the European Social Charter. Harm reduction measures are lifesaving public health interventions aimed at preventing the transmission of HIV, HCV, and other blood-borne viruses. Restrictions that require clients to already be ill fail to guarantee this crucial aspect of the right to health.
Drug dependency treatment

Country respondents reported that six of the focus countries do not have minimum ages for accessing drug treatment. The other three countries do: Slovenia (minimum age 15 years), Romania (16), and Hungary (18, the highest minimum age reported). However, exceptions can be made for younger drug users in these countries (see Table 9).

Access to OST is subject to much stricter regulations. The minimum age for OST is 15 in both the Czech Republic and, for buprenorphine, Slovenia, followed by 16 in Romania and Slovenia (for methadone). In Ukraine the minimum age for OST is 16 as well, but access by young opiate injectors is also restricted by numerous additional requirements (see Table 9). In Hungary, the minimum age for participation in OST is 18, but exceptions are made for some 17-year-olds. In Serbia, minors (young people under 18) can access OST only when diagnosed with HIV/HCV coinfection, while admission criteria for adults vary among individual facilities. Most OST centers will reportedly accept clients who are 18 and older, but the country’s largest OST facilities, in Belgrade and Novi Sad, do not as a rule accept people under 25. The highest national age limit, of 25, was reported for Georgia, although exceptions can be made for young drug users there who are living with HIV. In practice, the age limits can be even higher; for example, between September 2006 and February 2007, a treatment program financed by the Global Fund enrolled 60 IDUs whose minimum age was 30.

The survey for this report also revealed that some health care specialists are reluctant to provide OST to young people. For example, in Estonia, there is an ongoing debate on whether it is right to provide OST to young people. Opponents emphasize the needs of the individual IDU, arguing that, in contrast to IDUs with long injecting careers, young injectors have greater potential to overcome their dependency through abstinence-based treatment methods. This perspective was officially endorsed by the National Strategy on the Prevention of Drug Dependence 2004–2012, which largely targets people age 25 and younger, stating, “the result of successful rehabilitation is full (re)integration of a former addict into everyday life” (Government of Estonia, 2004). Proponents of OST for young people have emphasized the broader health needs of young injectors, their peers, and the general population, pointing towards the HIV epidemic as an immediate public health concern that is more threatening than drug dependency.

For more on OST and guidelines for service providers, please see Appendix 1.

Needle and syringe exchange programs (NSPs)

Most respondents reported that their countries do not legally prohibit minors from accessing NSPs, but on looking closer, a more complex picture emerges. On one hand, only the Czech Republic has an age limit, allowing needle exchange only for IDUs who are at least 15, though legislation is also pending in Ukraine to set the minimum age there at 16. On the other hand, only the correspondents from Romania and Slovenia indicated that there were no restrictions on NSP participation.

In reality, NSP providers in most countries – including Estonia, Georgia, Hungary, and, for the present, Ukraine – do not accept drug users under 18. In Estonia, minors may be admitted to the programs, where they are provided with information and counseling but not needles and syringes. The respondents from the Czech Republic, Hungary, Serbia, and Slovenia stated that since NSP services are often anonymous and client ages unrecorded, it is hard to assess whether any clients are under 18.

For more on needle and syringe exchange and service provider guidelines, please see Appendix 1; for individual country information, see Table 9.
4.3.2 Confidentiality and anonymity

Another major obstacle to young people's utilizing drug services is a lack of anonymity and confidentiality, for instance by requiring parental consent for services such as voluntary drug treatment and HIV testing.

When applying for drug treatment, minors normally need the consent of their parents or guardians (such as social workers or a child protection agency). In Slovenia, parental consent is not mandatory, but prospective patients under 18 are encouraged to involve their parents in their treatment. In Romania, parents must be present at a minor's medical evaluation before he or she starts treatment. Treatment guidelines in Estonia require informing social services and police when minors enroll, and parents are supposed to be involved in determining treatment plans. If a juvenile has a supportive network – parents who are caretakers and ready to collaborate in the treatment process – outpatient treatment is more likely. In Russia, the consent of parents is needed for potential clients under 18, while for those between 14 and 18, consent is also needed from the clients themselves.

In every one of the focus countries where OST is available to minors, parental consent is required. In Slovenia, parental consent is also required before take-home opioid substitution doses can be dispensed (see Table 9).

Many countries in this region still maintain official “narcological” registries, dating back to the Soviet period, listing drug users known to law enforcement and drug treatment services (which are still known as narcology services in many former Soviet republics). In Ukraine, the names of OST clients are also included in the official register.

Inclusion in such registrations limits young people's choice of professions (ruling out, for example, anything involving driving or operating machinery) and chances on the labor market. As part of the Soviet legacy, information is often shared between medical and law enforcement institutions, putting otherwise anonymous drug users who seek treatment at risk for discrimination, police harassment, and arrest (IHRA, 2008; Grund et al., in press). Avoiding contact with law enforcement is therefore a top priority for drug users (Des Jarlais et al., 2002; Connors, 1992; Grund et al., 1995; IHRD, 2008). For most young drug users, the suspicion of a link between services and the police is enough reason to avoid those services. Concerns among young drug users about inclusion in the narcological registry were identified in Estonia, Georgia, and Russia and are a likely obstacle to service uptake in all countries with similar registries.

While voluntary anonymous testing for HIV and HCV is available in most countries, not all of them provide testing to minors. For example, in Georgia and Romania, a person needs to be over 15. For minors under this age, parental consent is normally required. In Ukraine, parental consent is required for testing any minors. And in Russia, medical examinations of children under 14, including HIV testing, can be conducted only if requested by the juvenile patient or the parents (who have the right to be present). Any HIV-positive results for minors are reported to their parents.

The country correspondents were not asked about the quality of counseling that accompanies HIV and HCV testing, but the responses suggest that it is not always appropriate for young drug users. In Estonia, for example, HIV testing is offered at young people's centers to people under 24 and is reported to be widely available throughout the country. However, counseling at these centers primarily addresses sexual behaviors, which, while important, are of secondary concern for IDUs.
4.3.3 Risk of criminal aiding and abetting charges

Chapter 3 focused on juvenile justice in discussing the legal position of juvenile drug users vis-à-vis UN conventions, guidelines, and other international standards. One important point that it did not discuss, however, was legislation that imposes harsh sanctions on those who “incline” or “induce” young people to use drugs or who supply them with drugs. Unfortunately, while such laws aim to protect young people from the bad intentions of others, they display an unrealistic sense of how young drug users and drug markets operate. They make both young drug users (particularly those who have reached the age of criminal responsibility) and drug service providers liable for criminal charges and act as a significant barrier to harm reduction services.

According to the respondents for all nine focus countries, the law regards providing drugs or drug paraphernalia to minors, or encouraging them to use drugs, as a serious aggravating factor in criminal proceedings, resulting in significantly increased penalties. In some countries, these offenses are severely punished. In Estonia, for example, the penalty is up to 5 years in prison for small amounts of drugs and up to 15 years for larger amounts, while encouraging minors to use drugs can result in 10 years’ imprisonment. In Georgia, it is a crime to provide space for minors to use drugs (e.g., an apartment where friends can gather to use together), punishable by 2 to 5 years in prison. Encouraging a person over 18 to use drugs carries a maximum sentence of 3 years in prison – a sentence that is more than tripled, up to 10 years, if the person is under 18. And in Ukraine, encouraging or forcing minors to use drugs carries a penalty of 5 to 12 years in prison.

The assumption behind these sanctions is that older, calculating pushers are otherwise luring presumably innocent juveniles into using drugs. This assumption is rooted more in the “moral panic” (Cohen S, 1972; Goode et al., 1994; Thompson, 1998) that surrounds the use of illicit drugs than any scientific studies of drug users or markets. However, initiation into injecting drug use primarily occurs in friendship networks, where young people who have started injecting drugs introduce novice friends to the practice, normally on their explicit request (see Section 2.2.1).

Studies from other regions (Crofts et al., 1996; Roy et al., 1998; Hunt N et al., 2001) also suggest that initiation into injecting drug use tends to be far removed from the stereotypical image of the playground pusher in action. Rather, the context is usually a group of young friends experimenting with drugs. The initiator is usually a friend who is within five years of the novice and started injecting only recently. Typically, the drug is shared without thought of financial gain (Balakireva et al., 2006). Nonetheless, in commercial powdered drug markets, young people may get drawn into dealing by friends, family members, or acquaintances involved in distribution. While young IDUs may start dealing to finance their own habits, the opposite can also be true; for example, according to the Romanian country respondent, ARAS has several young contacts who started injecting after getting involved in dealing. Usually, young people involved in drug trafficking occupy dangerous positions at the bottom of the distribution chain (e.g., as “hawkers,” “runners,” or street sellers) or transport drugs between “safe houses” and points of sale. They can experience high stress levels as a result, from both legal and direct “occupational” risks. For some, drug use can be a tempting stress reduction or survival strategy.

This composite portrait suggests that the ones who run the greatest risk of being charged for dealing or encouraging drug use are not unscrupulous older pushers but young users themselves, who frequently share or inject drugs with minors. The risk is greatly magnified in CEE, particularly the former Soviet republics, where young drug users often get together to cook up injectable opioid and amphetamine concoctions themselves, using plant materials (poppy heads) or ephedrine-based medications as precursors (Abdala et al., 2006; Otiashvili et al., 2008a; Grund
et al., in press; IHRA, 2008). This practice also exposes them to criminal charges of producing and distributing drugs.

Sometimes, accusations of supplying drugs or drug paraphernalia are made due to prejudice or in an attempt to blackmail arrested users. Studies suggest that such charges are more often aimed at injectors from minority populations, including Roma throughout the region and Russian speakers in countries like Latvia and Estonia (Grund et al., 2007b; Downes, 2003; Grund, 2005b; Barrett et al., 2008).

Box 1. Cultivating knowledge of safer injecting: a missed opportunity

Legal paragraphs on aiding and abetting often assign the same penalties to dealing drugs to minors and providing drug paraphernalia and drug information to them. Such legislation has been used both inside and outside the CEE region to obstruct needle exchange, outreach to young IDUs, and the distribution of harm reduction information to IDUs with explicit or graphic information on safer drug use. In 1997, shortly before the Russian HIV epidemic reached the “tipping point” (Gladwell, 2000), three Dutch organizations – the Trimbos Institute, Medecins Sans Frontieres–Holland (now AFEW), and Mainline Foundation – developed a visually attractive and well-designed informational flyer on safer injecting of illicit drugs. Using language that would be readily understood by IDUs and pictures of home drug production, the organizations wrote the flyer for UNAIDS based on ethnographic research in Kazakhstan, Russia, Ukraine, and the Baltic states. Focus groups of outreach workers and former injectors and field tests both showed that the target audience was very receptive to this narrowcast product. However, after the Narcology Department in the Russian Ministry of the Interior raised objections, citing aiding and abetting laws and a perceived clash with “Russian values,” UNAIDS withdrew its support and the flyer was shelved for several years. Although a few copies trickled into Russia via trainings and conferences, it was only after HIV infection among IDUs in Russia had become a full-blown epidemic that the flyer was released and distributed widely.

Aiding and abetting legislation has been used to undercut effective, proven interventions, for instance in blocking public information campaigns (see Box 1) or justifying the posting of police near needle exchange and methadone distribution points. In some countries, harm reduction programs have circumvented problems by obtaining local exemptions or reaching agreements with law enforcement authorities (IHRD, 2008). Other programs have resorted to distributing harm reduction supplies underground or while fighting in the courts. In some countries (such as the United States), harm reduction workers have been charged with aiding and abetting, though very few charges have resulted in lasting convictions, particularly in democratic countries (Burris et al., 1996; Cohen J, 2003).

While some programs have been closed down, either temporarily or permanently, the most disturbing result of aiding and abetting legislation has been its discouraging effect on harm reduction services for IDUs, particularly on those for young IDUs. In the focus countries, these laws can present serious obstacles to harm reduction services targeting those at greatest risk for
drug-related harm, and program staff may face criminal charges. In a field—young people and harm reduction—that needs new approaches, the prospect of potential arrest does not motivate workers to innovate, particularly in countries with limited legal protections.

Therefore, the survey for this report inquired about whether the focus countries regarded needle and syringe exchange efforts to be aiding and abetting drug use. Fortunately, most of them do not. In Serbia, however, NSPs are still viewed as “inducing” drug use. Even though the first HIV outbreaks among Serbian IDUs date back to the mid-1980s, the country respondent reported that there were still only two NSPs. One of them is a pilot program, with a government waiver allowing it to work with drug injectors under 18 (see Appendix 1, Box 4). In Russia, due to a broad definition of “imposing drug use upon another person” and aggravated penalties for violations, harm reduction services choose not to work with IDUs under 18, to avoid the risks of staff arrest, program closure, and other unwanted attention from the authorities. According to the Russian Penal Code, criminal responsibility in such cases arises from a person’s understanding of the damage and consequences of drug use. Punishments are severer in cases where clients die or suffer health damage, including drug addiction or HIV infection.

The 1988 Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances requires states to put in place measures to ensure that “production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation or exportation of any narcotic drug or any psychotropic substance” (UN General Assembly, 1988, Article 3.1) is considered “particularly serious” by the courts if any such action exploits or uses minors, or if it takes place in the vicinity of places to which “school children and students resort for educational, sports and social activities” (Article 3.5). The intention of the latter provision, as noted in the commentary to the convention, is to “give the maximum possible protection to children” (paragraph 3.122).

While these articles can be cited to support legislative measures requiring stricter penalties for adults who encourage children to use drugs, the issue is not as clear-cut as it may seem. Two very important points should be noted. First, the convention applies only to intentional conduct. Harm reduction programs intend in no way to promote drug use or entice people to use drugs. They intend only to protect people who use drugs from harm. Even if strict legislation is in place to protect children from drug use, it should not be applied to harm reduction services or materials. Second, the convention does not require any specific legislation for encouraging, enticing, or permitting minors to use drugs; it refers only to the involvement or use of minors in the offenses listed, and to the commission of offenses near facilities they use. Moreover, any measures that result in disproportionate punishment of young drug users would contradict the overriding “protective” intent of the provisions of the convention.

This overriding intent is also evident in the CRC. Article 33 requires states to take “all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances” (UN General Assembly, 1989). In the context of this article, the UN implicitly endorses legislation that imposes stricter penalties for adults who encourage minors to use drugs. It is not clear, however, whether the convention drafting committee fully thought through the consequences of such laws for the full range of children’s rights.

As noted in Chapter 3, appropriateness is a central criterion in interpreting Article 33 correctly. If strict criminal legislation has the effect of criminalizing young drug users and driving young people away from essential health services, as this section provides examples of, it cannot
be deemed appropriate. Nor can it be defended as “protecting” children if, in fact, it increases their vulnerability to harm. Moreover, in order to ensure that the full range of the rights enumerated in the CRC are guaranteed for minors who use drugs, the Committee has frequently stated that they should be treated as victims of drug use rather than criminals (see Chapter 3). The best interests of the minor must always be a primary consideration.

4.3.4 Other barriers

In addition to age restrictions, lack of confidentiality (whether actual or perceived), and the threat of aggravated legal charges for providing services to minors, there are other circumstances that can also impede young people's access to and uptake of harm reduction services. They include stigma and discrimination, an overemphasis on law enforcement in addressing drug problems, and a lack of funding.

Stigma and discrimination. Most of the country respondents acknowledged that stigma associated with drug use is an issue for young users. They reported that they fear not only discovery by parents and non-using peers, but also the condemnation of society at large, both of which make them reluctant to acknowledge their drug use and contact harm reduction services. Studies suggest that drug users from minority communities, such as the Roma (Grund et al., 2007b; Hoover, 2007) and Russian speakers in the Baltic states (Downes, 2003; Grund, 2005b), particularly avoid services for fear of further marginalization. Survey respondents from Hungary, Romania, and Serbia suggested that the segregation of the Roma contributes to their poor access to drug treatment and HIV prevention services. Likewise, young migrant drug users (such as Russian speakers in the Czech Republic) are not reached by services that are not adapted for their native language. This vulnerability should receive more attention as an important human rights concern, both in the EU and beyond.

A law enforcement approach to drug use. When a government addresses drug use primarily through law enforcement rather than social and health care services, it drives users underground and makes it difficult to address overdose and the injecting-related epidemics of HIV and HCV effectively. Several respondents from outside the EU identified an over-reliance on law enforcement as a barrier to service provision in their countries, which included Georgia, Russia, and Ukraine. (See also Section 3.3 for more on the UN principle of treating drug use as a health problem rather than a criminal issue, and Section 4.3.2 for more on confidentiality and law enforcement.)

Lack of funding. Lack of funds is a major obstacle to scaling up harm reduction services and in developing services that target young IDUs, as respondents from both inside and outside the EU recognized. The absence of special drug treatment units for young people in Hungary is associated with a lack of funding. In Romania, the absence of government funding for harm reduction services make scaling up to adequate levels a daunting task. One result is the under-capacity of OST programs and enrollment caps on new OST clients. In Georgia and Serbia, limited drug treatment is the only free IDU service available. Serbia, for instance, only provides juvenile drug users with detoxification services; other treatment can only be obtained in private centers at cost. Furthermore, most government drug use prevention funding for young people goes to primary prevention programs, with little available for targeted prevention.
4.4 Conclusions and recommendations

These findings illustrate how existing harm reduction services in the CEE region are insufficiently tailored to the needs of those aged 25 and younger. They do not work with the young people who are most at risk for HIV, HCV, and other drug-related harm. The capacity of health care providers, both governmental and nongovernmental, to adapt their services to the needs of young people is severely hampered by legal age restrictions, confidentiality issues, and the prospect of aggravated “aiding and abetting” charges for harm reduction workers and the adult friends of juvenile drug users. Social exclusion, an overall lack of government support for harm reduction, and inadequate funding further hamper the development of services for young people at risk.

Age restrictions hamper the protection of minors who have made the adult choice to use drugs. For every successive generation has been getting older faster – and not merely in the eyes of parents, since improved nutrition and health have led to the earlier onset of puberty. Yet on topics they would rather ignore, parents and religious authorities continue, as they always have, to object to providing children with information. At the same time, young people today have access to a tremendously greater amount of information – and misinformation – than their parents had. There are web sites and other sources available for every interest. They include not only the latest ring tones for cellular phones, but also recipes for cooking up methamphetamine from cough medications.

Whether picked up on the internet or on the streets, the enticements to “deviance” seem increasingly unrestricted, while those who work with young people and harm reduction must stand aside. Although age restrictions are well intended, aimed at protecting young people, they are better suited to help young people who are well adjusted and socially integrated than those most likely to engage in or experiment with drug injecting, sex work, and other “deviant” behaviors.

Young people have always shared “adult” information and commodities among themselves. Aiding and abetting statutes can result in the disproportionate punishment of young adult IDUs who get caught using with friends who are minors. It also complicates the development of juvenile-friendly harm reduction services, because it deters services for young people and harm reduction programs from investing in services that target minors who inject drugs or are at risk for injecting. Whether aiding and abetting articles are actually enforced or not, the uncertainty they confer on the status of these service providers is a key barrier to providing harm reduction services for young drug users. These unanticipated consequences (Merton, 1936) of aiding and abetting laws cannot have been intended by those who drafted the international drug conventions and the CRC.

One of the main determinants of an effective response to the HIV epidemic is a legal and political environment that is conducive to proven interventions. Laws and policies should encourage individuals to take personal responsibility for their health and participate in prevention programs. To facilitate such a response, Guidelines 3 and 4 of the International Guidelines on HIV/AIDS and Human Rights advise reviewing and reforming outdated health and other laws that hamper effective responses to the epidemic (UNOHCHR et al., 1998). Guideline 3 recommends:

States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.
And Guideline 4 proposes that:

States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.

The International Guidelines also place great emphasis on the “promotion of a supportive and enabling environment.” Thus, Guideline 8 states:

States should, in collaboration with and through the community, promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

Parnell and others provide clear guidance on what such an environment comprises when they state, “the most effective responses to the epidemic grow out of people's action within their own community and national context” (Parnell et al., 1996, cited in UNAIDS et al., 1999). Participation rights are strongly protected in the Convention on the Rights of the Child, which upholds the central importance of showing respect for minors’ views in all matters affecting them (UN General Assembly, 1989, Article 12; see also Committee on the Rights of The Child, 2008b). This principle accordingly applies to implementation of CRC Article 33 on drugs.

Taken together, these international guiding documents clearly outline the reasoning that a state has to apply to meet the needs of its young people and its international obligations. To provide services that benefit the health and social well-being of young people at risk, it must be willing to confront their grown-up choices and create an environment they find “supportive and enabling.” Harm reduction services that provide such an environment can empower young drug users and help them reduce chaotic drug use and its associated harms.

**Recommendations for policymakers**

- Remove legal barriers to the provision of harm reduction supplies and information to minors who inject or are at risk for injecting drugs, e.g., through the review of aiding and abetting legislation. Such barriers should be removed for health workers, harm reduction workers, and peers.
- Remove legal barriers to providing juvenile IDUs with drug treatment, including OST.
- Abolish age restrictions for harm reduction services.
- Exempt young drug users and those who provide them with health and prevention services from aiding and abetting legislation.
- Until such changes take effect, provide drug treatment and other harm reduction programs with health emergency waivers so they can serve young IDUs.

**Recommendations for researchers and the media**

- Study and publicly debate the impact of current laws on providing harm reduction services to the young people who are most at risk for drug-related harm. Include drug users and their families as key partners in such discussions.
Recommendations for international organizations

- Develop and provide guidance on harm reduction services for the young people of CEE and elsewhere.
- *(For the Committee on the Rights of the Child.)* In light of the unanticipated consequences of aiding and abetting laws on harm reduction service providers and young drug users, reexamine your position on such legislation.

Recommendations for harm reduction service providers

- Guarantee equal access to services for everyone in need, including minors where practicable.
- Regard the development of services for young people not as a liability, but an opportunity. Appendix 1 provides an overview of approaches that have proven effective for this target group.
- In considering extending services to drug users who are minors, seek legal advice, especially since (as respondents to this study have suggested) aiding and abetting articles are not entirely clear on age limits in some countries, including Russia. Contemplate legal action if it seems likely to change or clarify court opinion.
- Where there may be negative repercussions from providing services to young people and it is feasible, avoid recording clients’ ages.
access to drug treatment and other harm reduction services
Young people & injecting drug use
5. Focus issue: stimulant injecting among young people

5.1 Introduction: stimulant use among young people

The term “amphetamine-type stimulants” or ATS refers to a range of drugs related to amphetamine which share stimulant properties that increase the activity of the central nervous system and produce effects similar to adrenalin. Methamphetamine and amphetamine are now the major ATS available worldwide (Degenhardt et al., 2008).

ATS have become a focus of growing attention worldwide because of a substantial increase in the production and consumption of these drugs over the past decade – and in related harm. In 2006, about 35 million people around the world used ecstasy, methamphetamine, or amphetamine, making ATS the most widely used group of synthetic drugs (UNODC, 2007).

EMCDDA data suggest that in many European countries, the second most commonly used illicit substance, after heroin, is some type of synthetically produced stimulant. In Western and Northern Europe it is usually ecstasy or amphetamine, while in Central and Eastern Europe it is more often methamphetamine. The use of ATS among the general population is typically modest, but prevalence rates among younger age groups are substantial, and the use of these drugs is particularly common in certain social settings and cultural groups (EMCDDA, 2007b).

In the Czech Republic, methamphetamine users comprise the majority (58%) of those applying for drug treatment. In Slovakia, methamphetamine use is growing rapidly and it now accounts for 24% of treatment demand. In Latvia and the other countries on the Baltic Sea, including Finland and Sweden, one third of the applications for drug dependency treatment are associated with amphetamines (EMCDDA, 2007b).

Because of their energizing effects, ATS such as ecstasy, amphetamine sulfate, and (especially in CEE) methamphetamine have emerged as party drugs, making inroads at clubs, dance parties, and music festivals across Europe, which helps explain why ATS are so popular among young people. Surveys of young people in EU dance music settings find them to be 10 times more likely than those in the general population to have ever tried stimulant drugs. In some cases around two thirds of club-goers reported using these substances at least once in their lifetime (EMCDDA, 2006). Other studies suggest that users under 25 use ATS more often than older users. Data from the United States show that the use of amphetamines is more frequent among young men than older men (Durell et al., 2008). Studies from the CEE region also suggest that young people inject amphetamines more frequently (Kozlov et al., 2006; Chintalova-Dallas et al., 2006; Booth et al., 2008; Grund et al., in press).
There is a dearth of research on the behaviors of young ATS users in the CEE region. One American study suggests that about one in seven stimulant users will start injecting at some point in their lifetime (Wu et al., 2004). In a study of IDUs aged 16 to 25 in Queensland, Australia, 87.3% of the respondents noted that methamphetamine was the first drug they had injected (Davey et al., 2006). In a Ukrainian study of IDUs under 24 in four cities, ATS (vint or jeff) were the first drugs injected for 25% of the respondents, while 60% had injected home-produced opiates first. However, the figures differed significantly by city, and in Pavlograd, 55% of the respondents had injected homemade stimulants first (Balakireva et al., 2006).

The use of stimulants has been associated with an increased risk for both sexual and injection-related transmission of HIV and other blood-borne infections. Another American study among youth living with HIV showed that ATS use reduced their inhibitions, lowering emotional, psychological, and sexual barriers between them. Those who used amphetamines had had more sexual partners and sexual encounters in their lifetime and had engaged in more risky behaviors than those who had never used amphetamines. The amphetamine users were also less likely to use condoms during sexual activities (Rotheram-Borus et al., 1999). Other studies have identified an association between ATS use and increased sexual activity (Luna, 2001; Kozlov et al., 2006). An increased risk for HIV and HCV transmission among ATS injectors has been associated with their injecting more frequently (Kral et al., 2001; Gibson et al., 2002) and sharing needles more frequently (Rotheram-Borus et al., 1999) than heroin injectors.

Compared to heroin, amphetamine is more often used recreationally (Loxley, 1997), especially in social environments such as nightclubs and dance parties. Users are thus more likely to be around others when they administer the drug (Darke et al., 2000), which can lead to sharing injecting equipment.

In addition to HIV transmission, a variety of other adverse consequences have also been associated with ATS use. Among the acute physical effects are sweating, heart palpitations, headaches, tremors, and increases in body temperature. Adverse psychological side effects include restlessness, anxiety, dizziness, irritation, confusion, and psychosis, while ATS have also been linked to aggression and violence. It should, however, be noted that most of these symptoms are associated with the sleep deprivation that amphetamines induce. Cardiovascular or cerebrovascular toxicity have also been reported. Those who use the drug heavily over a period of time face the attendant risks of developing dependency (Degenhardt et al., 2008).

Beyond the physical and psychological harms of ATS abuse, several additional problems have arisen that are specific to the drug culture and markets in Central and Eastern Europe, which are often characterized by home production of injectable drugs.

Participation in home production itself poses an increased risk of long prison terms. UNODC has reported that most of the methamphetamine labs seized in Europe are small kitchen labs (UNODC, 2007). In most CEE countries, the charge of drug production does not differentiate between production for personal (or friends’) consumption without intent to profit, and large-scale production. This conflation does not do justice to the distinct socioeconomic context of illicit drug consumption in CEE. Furthermore, such strict interpretation of the UN drug conventions (UN General Assembly, 1961, 1988) does not serve the public health goals of preventing HIV, overdose, and other morbidity associated with problem drug use. Instead, incarceration puts drug users and their families at heightened risk for HIV, HCV, tuberculosis, and other health and psychological problems (unpublished paper, Irwin KS et al., 2008).
5.2 ATS situation in the focus countries

Data on ATS use among young people are limited, particularly on route of administration. However data obtained for this survey on the injecting drugs preferred by young people shows that in most of the focus countries – the Czech Republic, Estonia, Georgia, Hungary, Russia, and Ukraine – the drugs of choice include ATS (see Table 2). In the other three focus countries, the national respondents reported that ATS injecting is not a major problem – or at least it has not been judged to be one. For example, the Romanian respondent indicated that due to the magnitude of problematic heroin use, ATS use has been assessed poorly and does not receive enough attention.

In the Czech Republic, the use of methamphetamine (pervitin), usually homemade, has a long history. In 2006, 38% of the Czech applications for drug treatment came from males under 19. The average applicant age for treatment related to pervitin use was 24.2 years. In a Czech study of dance party patrons, 21% of the respondents had tried injecting pervitin. The respondents were young, with the average male being 21.8 and the average female 20.3 (Kubů et al., 2006).

Disaggregated data for young people were unavailable in Estonia, but studies suggest that ATS are the most commonly injected drugs after opiates. In one Estonian study, around 62% of IDUs had injected ATS in the previous four weeks (Uusküla et al., 2005). A similar trend was observed among regular needle-exchange clients in 2004; 73% of them reported using opiates, while 55% reported using stimulants (Estonian Ministry of Social Affairs, 2008). The Estonian country respondent also described the country’s drug injectors as young.

Georgia has seen a significant increase in the use of homemade stimulants in recent years. The 2005 report on the drug situation by the Southern Caucasus Anti-Drug Programme identifies ATS injecting as an emerging new trend on the country’s drug scene (Javakhishvili et al., 2006). The main preparations injected are vint, jeff, and boltushka. In Georgia, the extremely cheap cost of homemade stimulants is considered a major reason for the increasing popularity of ATS – in contrast to most developed countries, where the variety of groups associated with ATS use (including nightlife patrons, students, and workers) suggest a corresponding variety of non-economic reasons for the choice. In one study, 57.8% of young Georgian NSP and VCT clients had injected homemade stimulants, while 43% of young injectors had used ATS in the last month, with homemade stimulants ranking behind homemade opiates as the drugs they had injected most frequently in the previous 30 days (Otiaishvili et al., 2008a).

Between 2003 and 2006, the number of ATS users in Hungary remained stable. Treatment demand data suggest that most Hungarian IDUs use heroin, cocaine, and amphetamine as part of polydrug use patterns, and that the age of initiation for all three drugs is almost identical, hovering around 19–20 years (Reitox National Focal Point for Hungary, 2007).

The data provided by the Serbian country respondent indicate what may be another troubling trend. They show that ATS users switch from non-injecting administration routes to injecting more rapidly than heroin users do. According to Serbian service providers, young people usually start injecting heroin after a year of sniffing it, while ATS users start injecting after less than a year. The service providers cite the example and encouragement of injecting peers as key reasons for starting to inject ATS.

While data from Slovenia show that ATS injecting in the country is not widespread (EMCDDA, 2008), ATS use is high among young people, particularly in nightlife settings, where they tend to mix different stimulants. Similarly, a study among IDUs in St Petersburg, Russia
Young people & injecting drug use (mean age 24.3 years, range 17.2–42), found that young people who inject ATS primarily do it collectively (Kozlov et al., 2006).

In Ukraine, as in Georgia, homemade stimulants are growing in popularity, particularly among young people. In the 1980s, Ukrainian users started preparing and using vint (methamphetamine). During the 1990s they turned to cooking and using jeff and boltushka. Since the end of 1990s, when ephedrine, pseudoephedrine, and methamphetamine processing chemicals started being more tightly regulated, boltushka has often been made from cold medicines that contain phenylpropanolamine (PPA) (Chintalova-Dallas et al., 2006), resulting in cathinone or, when reduced, amphetamine. PPA has been associated with increased risk for hemorrhagic stroke (Horwitz et al., 2000), and most home-produced stimulants (and opiates) contain remnants of processing chemicals, such as permanganates, sulfur, and strong acids, which are all highly toxic. Boltushka is extremely cheap in Ukraine, one dose costing under 1 EUR. As the effect of methcathinone and cathanone lasts a short time, young injectors may inject these drugs 5–6 times a day, with some IDUs reporting injecting rates of up to 10 times a day (Chintalova-Dallas et al., 2006).

Low price and easy access have made homemade stimulants very popular among young, often poor Ukrainians. Most ATS injectors are age 15–25 and use homemade boltushka (Voloshina et al., 2000). Nonetheless, harm reduction service providers indicate that ATS injecting is also prevalent among less disenfranchised populations, such as students. A study by Booth and others (2008) also suggests that risky injecting and sexual behaviors prevail among Ukrainian stimulant users, who were younger than the opiate users studied.

5.3 Current services and best practices

There is a dearth of information on harm reduction programs that target ATS users, including drug prevention and treatment services, in both the focus countries and the greater CEE region. As discussed in the previous chapter, legal obstructions to service provision for minors have resulted in the almost complete absence of harm reduction services for them. In addition, except in the Czech Republic, most harm reduction programs in CEE countries are focused on opiate users.

Young people do not necessarily associate ATS use with drug problems or dependency, as they more typically would with opiate use. Those who use stimulants at dance parties or in other nightlife settings are for the most part well integrated socially. Most of those who inject occasionally would not label themselves problem drug users, and they are thus not inclined to seek out harm reduction services.

Although overall service provision for young IDUs, especially juvenile IDUs, in CEE seems to be stuck in the dark ages, some bright spots have emerged. Harm reduction workers in a number of Ukrainian cities have been trying to engage stimulant users through active outreach efforts. Low-threshold program workers in Georgia, Russia, and Ukraine are collaborating with national harm reduction networks to develop practical working methods and information materials that focus on homemade stimulant users, including young ones. Their efforts are based primarily on the practical experience of service providers and assessment of client needs.

5.4 Conclusion and recommendations

ATS are increasingly becoming the drugs of choice for young people, as observed in the Czech Republic, Estonia, and Slovenia, while homemade stimulants are becoming more popular throughout CEE, including countries such as Georgia and Ukraine. This phenomenon should be
Focus issue: stimulant injecting among young people is a cause for policymakers’ serious concern. The dangers of the rise in ATS injecting among young people include increasing group use in interconnected peer networks, the sharing of injecting equipment, syringe-mediated drug sharing, higher injecting frequencies, increased sexual activity, and a variety of neurological and psychological side-effects, including those caused by toxins used in preparing homemade stimulants.

Against this background, the almost complete absence of effective evidence-based prevention and treatment methods for ATS dependence may become an important factor contributing to the further spread of stimulant injecting, in and beyond the CEE region. In many countries, there is no access to any treatment for ATS dependency at all (UNODC, 2007). Service providers in some focus countries have indicated that drug treatment facilities can be especially reluctant to admit clients with a history of homemade stimulant use, as clinic staffs believe they have poor prognoses and are difficult to care for. The exception to the general lack of ATS treatment is the Czech Republic, where most drug treatment is geared towards methamphetamine users because of the country’s long history of methamphetamine injecting.

This study identified a significant lack of research on ATS use and a near absence of CEE services for ATS users, especially young ATS users. Analysis of the ATS situation in the focus countries suggests that it is difficult to identify the specific segments of young people at greatest risk for injecting or otherwise using ATS, as stimulants have gained popularity among both the disenfranchised and those better off. This survey does suggest that in almost all the focus countries, ATS are now among the drugs of choice for young users and drug injectors. Amphetamine-type drugs are part of the youth nightlife culture that has evolved since the late 1980s around electronic dance music. Over the years, clubbing has turned into a global industry and a “glocal” (Robertson, 1995) youth culture. In clubs and discotheques, at dance parties and music festivals, socially integrated young people use ecstasy, methamphetamine, amphetamine, and other drugs. Studies from Western Europe suggest that most of these users do so in a fairly controlled manner and on an occasional basis without experiencing substantial harm or problems. While the media and politicians tend to focus on excesses, young people’s ATS use while clubbing is largely constrained by the social control of peers who tolerate controlled intoxication but frown on excessive use (Varga, 2008; Grund, 1993a, 1993b). Nonetheless, the Czech finding that, among dance party patrons who had ever used pervitin, 31.5% had also tried injecting is particularly unsettling (Kubů et al., 2006). The punitive approaches to young people’s drug use and the absence of appropriate services for young people, both common in CEE, may result in different outcomes than those reported in Western Europe, where official responses tend to be different.

The use patterns tend to be different too. In Central and Eastern Europe, the relatively low price, relatively easy access, and simple preparation of homemade stimulants have contributed to their increased diffusion among marginalized young people, including homeless juveniles on the streets of major cities and unemployed youth in poor rural communities. These drugs are produced to be injected, and indeed, their principal route of administration throughout the region is injection.

This study does in fact point towards the predominance of home production among stimulant users in many Eastern European countries and some new EU member states. As discussed above, homemade stimulants have been associated with HIV and other health threats, as well as possible legal problems. All the CEE countries are affected by their shared social history, which has spawned a greatly idiosyncratic drug culture (Grund et al., in press; Heimer et al., 2007). Drug users throughout this region have brought their parents’ tradition of samagon (home-distilled vodka) to a new level by applying its logic to ephedrine-based medications (Grund, 2001). One
of the most troubling aspects of this development is that most recipes have resulted in drugs that were meant to be injected instead of being ingested by less risky and addictive routes. With the EU expansions in 2004 and 2007, this shared drug culture has become an increasing part of the European Union.

The magnitude of ATS use and injecting, as well as the future popularity of these drugs, remain questions for further research. Research targeting young stimulant users – and the development and implementation of specific services for them – should be a public health priority in many CEE countries, including some new EU members.

**Recommendations for law- and policymakers**
- Use legislation and policy to encourage the research and development of evidence-based harm reduction, prevention, and treatment options for young ATS users, particularly those who inject or are at risk for injecting.

**Recommendations for researchers**
- Seek to better understand ATS use among young people and its associations with infectious diseases and other harm.
- Study subregional patterns of ATS use among different young populations, routes of ATS administration, and how young people begin and stop injecting ATS.
- Develop and evaluate promising interventions to prevent or reverse injecting drug use.
- Research young people’s use of home-produced drugs – e.g., the diffusion of these drugs, the medical and legal complications of their use, and promising approaches to preventing and treating their use and reducing associated harms.

**Recommendations for international organizations** (including the EU)
- Support ATS research, interventions, training, and evidence-based policy in the countries inside and just across the EU border where young people are involved in ATS use.

**Recommendations for service providers**
- Make it a priority to target harm reduction programming to young ATS injectors to prevent the further spread of stimulant injecting and related harms, including HIV, HCV, and overdose. Suggested strategies include:
  - developing and scaling up peer prevention approaches for educating young people who may experiment with ATS and ATS injecting, including in nightlife and dance party settings;
  - developing materials on ATS use, risks, associated harms, and safer use, including information on drug interactions and overdose prevention;
  - building coalitions to reach ATS users, partnering with organizations that work with socially disadvantaged young people as well as with dance party promoters, nightclub owners, deejays, and emergency responders; and
  - adjusting interventions for preventing and stopping injecting drug use so they specifically address ATS users, especially since relatively small interventions in this area may significantly reduce injection-related health risks (Gray, 2007).
- Develop and implement prevention strategies to target the elevated levels of risk behavior around the production and use of homemade stimulants, particularly among young, disenfranchised IDUs.
• Develop training for harm reduction workers who work with young people, about effective approaches for reaching young ATS users, and encourage them to share their experiences.
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6. Closing observations

Unfortunately, one of this study’s inescapable conclusions is that most of the focus countries do not comply with the international conventions and standards on the rights of young people, particularly minors. Though there clearly are differences among these nine countries, in general they do not adequately protect young people who come in contact with the criminal justice system. At the same time, they have created significant obstacles that prevent juvenile drug users from accessing drug dependency treatment and other harm reduction services. And the situation is similar in the other transition economies of Central and Eastern Europe.

These circumstances lead to what initially appears to be contradictory recommendations in Chapters 3 and 4. Chapter 3’s main recommendations involve the establishment of a juvenile justice system that treats underage offenders as victims rather than criminals. Treating minors as adults, as described in this report, violates their basic human rights, particularly their right to health and well-being, since it puts them at high risk for HIV and other deadly diseases, overdose, violence, and abuse. While it can be argued that prison is unhealthy for all inmates, the absence of adequate juvenile justice systems leaves incarcerated minors especially vulnerable to these harms. For not only are they subjected to the standard prison regime, but they also find themselves at the bottom of the underground hierarchy found in any penal institution. For many young inmates, prison serves as a criminal boarding school, while criminal records further diminish their prospects for decent education and legal employment, thereby preventing them from achieving their full potential. The chapter thus calls for legislative reform to distinguish between minors and adults.

Chapter 4 demonstrates how legal age restrictions on access to harm reduction services, a lack of anonymity and confidentiality in providing such services, and the threat of aiding and abetting charges can all heighten young drug users’ risk for HIV. Therefore, Chapter 4 recommends abolishing these age distinctions and other barriers to access. It also suggests developing harm reduction services specifically for young people, including options such as needle exchange and OST that only older drug users can now access in many countries.

A key point to make here is that the barriers discussed in Chapter 4 have been established to protect all young people. Unfortunately, they have the unintended consequence of increasing the risks for health and social harms in the young people most at risk. Denying young drug users access to life-saving drug treatment and other harm reduction services contributes to the risk environment surrounding their use (Rhodes, 2002) and violates their right to health and well-being.

Developed in the 1980s, harm reduction is a pragmatic approach to the protection of vulnerable populations. Initially, it focused on HIV prevention among IDUs, e.g., by offering needle exchange or opioid substitution treatment. But harm reduction is not merely a methodology for working with IDUs; rather, it is a broad paradigm for dealing with the unanticipated and unin-
tended consequences of technical and social phenomena as diverse as motorized transportation, sports, and work.¹⁵ Harm reduction is being increasingly applied in providing services to other vulnerable populations, including sex workers, street children, men who have sex with men, and victims of domestic violence. For drug users, recent foci of harm reduction efforts include preventing the initiation of injecting drug use (e.g., Break the Cycle campaigns (Hunt N et al., 2001; Gray, 2007)), overdose (Coffin et al., 2007; Coffin, 2008), and non-injecting recreational drug use in nightlife settings. In providing services to IDUs, harm reduction has become a mainstream approach, endorsed system-wide by the United Nations.

Nonetheless, the mainstreaming of harm reduction services for adult drug users is fairly recent. For years, harm reduction workers have fought for legitimacy around the world – a struggle that continues today in many CEE countries. It should not be necessary to fight these battles again in developing harm reduction services for young people. This report suggests that specific interventions should be developed for novice, experimenting, and occasional injectors.

As discussed in Chapter 5, intravenous use of stimulants in most of the focus countries is high (Czech Republic) or on the rise (Georgia and Ukraine). As Booth and others have contended (2008), stimulant injectors may usher in the next wave of the HIV epidemic in the CEE region. This report, the study by Booth et al., and other studies from the region, such as Otiashvili, et al., 2008a, suggest that homemade stimulants are often the first drugs in an injecting career, especially among young injectors, and that young and novice IDUs are at increased risk for HIV and other drug-related harm. Furthermore, in mixed or overlapping drug markets, as reported for example in Hungary and the Czech Republic, young ATS injectors may easily move on to heroin and polydrug use, which are associated with longer drug-using careers. Both of these concerns underline the importance of getting young IDUs and young people at risk for injecting into harm reduction services that are specifically designed to support young people. States can help create an “enabling environment” for such services by undertaking appropriate legal reforms and providing proper funding.

While methamphetamine use remains limited in the 15 countries that were EU members before the 2004 expansion (Griffiths et al., 2008), many of the newer member states and their neighbors house significant populations of (homemade) methamphetamine injectors. This situation represents a major challenge to the European Union's social and public health objectives – and an obligation. The low level of use in most of the EU is not a reason to ignore methamphetamine, but an opportunity to address it before it explodes. After all, Western Europe and Latin America are the only parts of the world where methamphetamine does not yet have a good foothold.

The appetite for stimulants in Latin America is being met by regional cocaine dealers, who also supply most of the stimulant demand in Western Europe, cocaine being at present the most popular stimulant in the EU (Griffiths et al., 2008). Western Europe is also home to a major industry in illicit ATS (ecstasy and amphetamine sulfate). As the popularity of ecstasy dwindles in Western Europe, this unregulated industry may be ready for a new product line – such as methamphetamine. The EU should accordingly monitor the ATS situation and support ATS

¹⁵ Specific examples of harm reduction in these three areas include, respectively, traffic lights, seatbelts, airbags, and designated driver campaigns; protective equipment, official regulations, and sporting event licenses; and occupational safety standards and protective clothing.
research, interventions, and evidence-based policymaking, particularly in member states and neighboring countries where (homemade) stimulant use is widespread.

To decrease the prevalence of drug injecting and drug-related harm, it is essential to focus on the young people at risk. Although much remains to be said – and studied – about how to respond to injecting drug use among young people in Central and Eastern Europe, this report should provide a comprehensive overview of the obstacles and complications involved in providing services to prevent young people from injecting and reduce harm among young IDUs. We hope that it will also serve as a call to action.
Young people & injecting drug use


Young people & injecting drug use


Young people & injecting drug use


* All the annual reports from Reitox national focal points from 2000 to present are available online at http://www.emcdda.europa.eu/html.cfm/index34296EN.html.


Young people & injecting drug use
# Tables

## Table 1. IDU population, with percentage that is young

<table>
<thead>
<tr>
<th>Country</th>
<th>IDU population (estimated)</th>
<th>% of IDUs who are young (under 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>27,000(^1)</td>
<td>62.1% of IDUs in contact with harm reduction services(^2)</td>
</tr>
<tr>
<td>Estonia</td>
<td>13,800(^1)</td>
<td>55.8% of IDUs in contact with harm reduction services(^2) An estimated 75% of all IDUs are young males(^3)</td>
</tr>
<tr>
<td>Georgia</td>
<td>80,000(^4)(^5)</td>
<td>16.8% of IDUs in contact with harm reduction services(^4)</td>
</tr>
<tr>
<td>Hungary</td>
<td>~4,000(^7)</td>
<td>15% of IDUs in contact with harm reduction services(^2) An estimated 33% of all IDUs(^7)</td>
</tr>
<tr>
<td>Romania</td>
<td>24,000 IDUs (13,694–34,318 heroin injectors in Bucharest(^6)</td>
<td>49.3% of IDUs in contact with harm reduction services(^3) An estimated 80% of all IDUs are under 29(^9)</td>
</tr>
<tr>
<td>Russia</td>
<td>2,000,000(^8)</td>
<td>12% of male Muscovites aged 15–18 have injected drugs(^11)</td>
</tr>
<tr>
<td>Serbia</td>
<td>Registered 9,000 Estimated 30,000–100,000(^12)</td>
<td>—</td>
</tr>
<tr>
<td>Slovenia</td>
<td>5,000(^13)</td>
<td>33.2% of IDUs in contact with harm reduction services(^2)</td>
</tr>
<tr>
<td>Ukraine</td>
<td>325,000–425,000(^14)</td>
<td>25–58% of IDUs in Ukraine may be under 25. 43% of IDUs in Kyiv, 36% in Odessa region, 47% in Pavlohrad, and 20% in Poltava region are under 24(^15) 26% of 4143 IDUs tested in 2007 age 13–24(^16)</td>
</tr>
</tbody>
</table>

* Problem drug user estimates.

## Comments

**Czech Republic.** Young IDU percentage comes from 2002/2003 data from low-threshold facilities (n=757). According to the EMCDDA Statistical Bulletin (EMCDDA, 2007a), 53% of all drug users entering treatment in 2006 were under 25.

**Estonia.** According to the estimate, injectors make up about 2.4% of the population aged 15–44. The young IDU percentage comes from 450 IDUs at two low-threshold facilities in Tallinn and Kohtla-Jarve in 2005.

**Georgia.** Percentage of young IDUs comes from NSP clients in three cities (n=381).

**Hungary.** Percentage of young IDUs comes from 10 sites (drug treatment centers and NSPs) in 2006, n=300. According to the EMCDDA Statistical Bulletin (EMCDDA, 2007a), 42% of all drug users entering treatment in 2006 were under 25.

**Romania.** According to data submitted to the EMCDDA (Reitox National Focal Point for Romania, 2004), in 2003 there were an estimated 24,000 IDUs [range 13,694–34,318] in Bucharest alone, 90% using heroin. The percentage of young IDUs comes from Bucharest in 2006 (n=138). According to the EMCDDA Statistical Bulletin (EMCDDA, 2007a), 40% of all drug users entering treatment in 2006 were under 25. Additionally, according to the country respondent, ARAS reports that around 12% of its NSP clients are under 18, most of them with a history of drug use longer than two years.
Russia. The same report that provides the IDU population figure (Onishenko, 2006) estimates that they make up to 2.5% of the adult population.

Slovenia. Percentage of young IDUs comes from IDUs at 19 drug treatment sites in 2004 (n=476). According to EMCDDA Statistical Bulletin (EMCDDA, 2007a), 52% of drug total drug users entering treatment in 2004 were under 25.

Sources
1 Reitox National Focal Point for the Czech Republic, 2005.
2 EMCDDA, 2008.
3 Uusküla et al., 2005.
5 Republic of Georgia, 2008.
6 Otiaishvili et al., 2008b.
7 Unpublished data, Reitox National Focal Point for Hungary.
8 Reitox National Focal Point for Romania, 2005.
9 Iliuta et al., 2006.
10 Onishenko, 2006.
12 Unpublished data, Serbian country respondent.
13 Reitox National Focal Point for Slovenia, 2005.
14 Ukrainian AIDS Center, 2008.
16 Balakireva et al., 2007.
Table 2. **Drugs injected, age of injecting initiation, and other characteristics**

<table>
<thead>
<tr>
<th>Country</th>
<th>Drugs most commonly injected by young people</th>
<th>Age of injecting initiation, years</th>
<th>Other national characteristics of drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Czech Republic</strong></td>
<td>Amphetamines and opiates (according to treatment demand data)¹</td>
<td>15–19²</td>
<td>Reaching new groups of IDUs such as migrants and Russian speakers, many of them young, is an emerging problem according to country respondent</td>
</tr>
<tr>
<td><strong>Estonia</strong></td>
<td>A study among IDUs (average age 24) in two cities show increased injection of fentanyl, heroin, and amphetamines. Outside the capital, homemade opiates are also common³</td>
<td>15–19⁴</td>
<td>An estimated 85% of all IDUs are Russian speakers, including “new” IDUs. Overall, Estonian drug users are young</td>
</tr>
<tr>
<td><strong>Georgia</strong></td>
<td>Heroin, buprenorphine, and homemade stimulants⁴</td>
<td>20.1⁵</td>
<td></td>
</tr>
<tr>
<td><strong>Hungary</strong></td>
<td>Heroin (79%) and amphetamines (35%)⁶</td>
<td>17.7 for injecting use</td>
<td>A study of IDUs under 30 shows overlapping networks of drug users, including friendships between injectors and non-injectors that put the latter at risk for injecting⁶</td>
</tr>
<tr>
<td><strong>Romania</strong></td>
<td>Heroin, methadone, ketamine⁷</td>
<td>Initiation age is falling, starting as early as 12–14. Non-injecting users start injecting after 6 months to 1 year.⁷ 17–19.⁸</td>
<td>ARAS experience shows that very young people who are at increased risk — those who have IDU parents, those who are involved in drug dealing or trafficking (since they are too young to be punished) — are the ones who start injecting very early⁹</td>
</tr>
<tr>
<td><strong>Russia</strong></td>
<td>Heroin (74%); 44% also reported polydrug use, e.g., injecting heroin with opium, homemade substances, or amphetamine.⁵ Opium extract, pervitin, and hashish are also used¹⁰</td>
<td>Some IDUs are 14.⁹ Many begin injecting between 11 and 17.¹¹ Systematic drug use: 14.7 for boys, 18.0 for girls¹⁰</td>
<td>Injecting among young people is not decreasing. In Kazan in 2005–2006, the number of IDUs who had been injecting for less than a year was double the number in 2003–2004¹²</td>
</tr>
<tr>
<td><strong>Serbia</strong></td>
<td>Heroin¹³</td>
<td>13.0–18.2 for injecting use. 15.7 for all drug use¹³</td>
<td>Age of injecting initiation is decreasing due to low prices of drugs such as amphetamines or heroin. Lack of money is one of the reasons the young people start injecting¹⁴</td>
</tr>
<tr>
<td>Country</td>
<td>Drugs most commonly injected by young people</td>
<td>Age of injecting initiation, years</td>
<td>Other national characteristics of drug use</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Slovenia</td>
<td>Heroin Data from drug treatment show polydrug use, combining heroin with cannabis and cocaine(^{15})</td>
<td>20(^{16})</td>
<td>Use of synthetic drugs is most common among young people, especially students, though they are not necessarily injected. Drug use is beginning at an earlier age(^{15})</td>
</tr>
<tr>
<td>Ukraine</td>
<td>Heroin, ATS among socially integrated young people such as students(^{17})</td>
<td>17.7(^{18})</td>
<td>According to The Way Home (an NGO), members of various young groups and social networks inject occasionally. Occasional injecting also occurs among students. Street children may also inject though not on a regular basis; though their primary drugs of choice are inhalants, they will usually use anything they come across, including heroin(^{17})</td>
</tr>
</tbody>
</table>

Comments

**Czech Republic.** Opiate users were the oldest on average (26.4), and 70% of them were males. The average age (24.5) and percentage of males (67.5%) were somewhat lower among pervitin users (Reitox National Focal Point for the Czech Republic, 2006).

**Estonia.** A study among IDUs in two cities (average age 24) found that they began injecting on average at 17.2 years; 19% of the respondents reported starting injecting when they were younger than 15, and 63% between 15 and 19.

**Hungary.** Study on the drugs used by young people was conducted among IDUs under 30, average age 23.

Sources

1. EMCDDA, 2008.
2. Polanecký et al., 2008.
3. Uusküla et al., 2005.
8. Iliuta et al., 2006.
10. Должанская [Dolganskaya], 2006.
11. UNODC Regional Office for Russia and Belarus, 2006.
15. Reitox National Focal Point for Slovenia, 2005. The average age of people seeking treatment was 23.1.
17. Information provided by Ukrainian country respondent, 2008.
### Table 3. HIV prevalence among all IDUs and young IDUs

<table>
<thead>
<tr>
<th>Country</th>
<th>% of all IDUs</th>
<th>Year</th>
<th>Sample size, etc.</th>
<th>% of young IDUs with HIV</th>
<th>Year</th>
<th>Sample size, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>0.0–0.1%1</td>
<td>2006</td>
<td>2134</td>
<td>0.0–0.8%1</td>
<td>2002–2004</td>
<td>Three samples, ranging from 173 to 243</td>
</tr>
<tr>
<td>Estonia</td>
<td>54.3%–89.9%1</td>
<td>2005</td>
<td>449</td>
<td>63.3%1</td>
<td>2005</td>
<td>251</td>
</tr>
<tr>
<td>Georgia</td>
<td>0.4%2</td>
<td>2004</td>
<td>From Tbilisi</td>
<td>0%2</td>
<td>2006</td>
<td>82</td>
</tr>
<tr>
<td>Hungary</td>
<td>0%1</td>
<td>2006</td>
<td>369</td>
<td>0%1</td>
<td>2006</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0%3</td>
<td>2007</td>
<td>111</td>
</tr>
<tr>
<td>Romania</td>
<td>1.4%1</td>
<td>2006</td>
<td>138</td>
<td>1.5%1</td>
<td>2006</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Slight increase since 2004–2005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Russia</td>
<td>64%4</td>
<td>2007</td>
<td>300 from Yekaterinburg</td>
<td>55.2%5</td>
<td>2001</td>
<td>Recent initiators (injecting 3 years or less) in Togliatti city</td>
</tr>
<tr>
<td></td>
<td>14.7%4</td>
<td>2007</td>
<td>300 from Oryol</td>
<td>11.5% (among recently initiated IDUs only)5</td>
<td>2004</td>
<td>426, including: 96 recent initiators (mean age 19); and 138 who were recent initiators (mean age 20) in 2001 study. See comments for more</td>
</tr>
<tr>
<td></td>
<td>15.3%4</td>
<td>2007</td>
<td>335 from Chelyabinsk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serbia</td>
<td>3%6</td>
<td>2005</td>
<td>433 from Belgrade</td>
<td>No specified data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slovenia</td>
<td>0%1</td>
<td>2005–2006</td>
<td>350</td>
<td>0%1</td>
<td>2002–2004</td>
<td>Samples range from 158 to 288</td>
</tr>
<tr>
<td>Ukraine</td>
<td>61% in Kyiv sample; median 41.8% for other cities2</td>
<td>2006</td>
<td>From Kyiv and other cities</td>
<td>13% among IDUs under 253</td>
<td>2006</td>
<td>Among 7127 IDUs of all ages tested positive for HIV</td>
</tr>
</tbody>
</table>

**Comments**

**Georgia.** Most Georgians diagnosed with HIV are over 24. As of 2006, IDUs represented 62% of all cases with a known route of transmission (Republic of Georgia, 2008).

**Estonia.** A study among IDUs in Tallinn found HIV more prevalent among new IDUs (injecting for three years or less). According to two parts of the study carried out, HIV prevalence was 50% (Study 1) and 34% (Study 2) among "new" injectors, with around 80% (Study 1) and 64% (Study 2) being under 20 (Uusküla et al., 2008).

The proportion of new HIV cases registered among young people was 68% in 2000, 78% in 2002, 66% in 2003, 60.7% in 2004, and 56.5% in 2005 (Estonian Ministry of Social Affairs, 2008).

**Russia.** By the end of 2007, 82.4% of HIV cases were associated with drug injecting. Most HIV cases occur among people under 30 (Ministry of Health and Social Development of the Russian Federation, 2008).
A study in Togliatti found lower HIV prevalence among young IDUs than older IDUs. It also found that a history of drug treatment decreased the chances of contracting HIV. Another study (Stormer et al., 2006) identified the overlap of IDU networks as a risk factor when older IDUs recruited into treatment programs younger IDUs who admitted sharing injecting equipment or having sex with their “mentors.”

**Serbia.** Of the HIV cases with a known transmission source between 1985 and the end of 2007, 43% were associated with injecting (Republic of Serbia National AIDS Commission et al., 2008).

**Sources**

1 EMCDDA, 2008.
2 Republic of Georgia, 2008.
3 Unpublished data, Reitox National Focal Point for Hungary.
5 Platt et al., 2008.
8 Reitox National Focal Point for Ukraine (2007).
Table 4. 

<table>
<thead>
<tr>
<th>Country</th>
<th>% of IDUs with HCV</th>
<th>Year</th>
<th>Sample size, etc.</th>
<th>% of young IDUs with HCV</th>
<th>Year</th>
<th>Sample size, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>16%(^1)</td>
<td>2006</td>
<td>695</td>
<td>20.6%(^1)</td>
<td>2003</td>
<td>470 from twelve low-threshold sites</td>
</tr>
<tr>
<td>Estonia</td>
<td>90.5%(^2)</td>
<td>2002–2003</td>
<td>63 from Tallinn</td>
<td>No specific data, but hepatitis incidence is highest in people age 15–19 and 20–29</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>89.2%(^3)</td>
<td>2002–2004</td>
<td>37 from Ida Viruma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>64.6%;(^2) 81.8% among “older IDUs”;(^4)</td>
<td>2006</td>
<td>247</td>
<td>24.4%(^4)</td>
<td>2006</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hungary</td>
<td>14%(^5)</td>
<td>2004</td>
<td>93</td>
<td>7.7%(^3)</td>
<td>2006</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>6.4–28.9%(^1)</td>
<td>2006</td>
<td>334</td>
<td>28.9%(^1)</td>
<td>2006</td>
<td>45 drug treatment and NSP clients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22.4%(^5)</td>
</tr>
<tr>
<td>Romania</td>
<td>46.2%(^1)</td>
<td>2006</td>
<td>106</td>
<td>52.1%(^1)</td>
<td>2006</td>
<td>48 drug treatment clients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75%(^6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>63.7%(^6)</td>
</tr>
<tr>
<td>Russia</td>
<td>89.7%(^7)</td>
<td>2007</td>
<td>300 from Yekaterinburg</td>
<td>—</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>61%(^7)</td>
<td>2007</td>
<td>300 from Oryol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50.7%(^7)</td>
<td>2007</td>
<td>335 from Chelyabinsk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serbia</td>
<td>70%(^8)</td>
<td>2005</td>
<td>From Belgrade</td>
<td>—</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slovenia</td>
<td>40%(^1)</td>
<td></td>
<td>40 OST clients</td>
<td>14.1%(^1)</td>
<td>2002</td>
<td>269</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15.8%(^3)</td>
</tr>
<tr>
<td></td>
<td>22.5%(^1)</td>
<td>2004</td>
<td>467 drug treatment clients</td>
<td>14.2%(^1)</td>
<td>2004</td>
<td>155</td>
</tr>
<tr>
<td>Ukraine</td>
<td>78.8%(^2)</td>
<td>2002</td>
<td>Low-threshold facility clients in Odessa</td>
<td>—</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60.9%(^2)</td>
<td>2004</td>
<td>450 low-threshold facility clients in Kharkiv</td>
<td>—</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

Georgia. The prevalence of HCV among young IDUs is much lower than among older IDUs from the same sample – 24.4% vs. 81.8%. The overall prevalence rate for the study is relatively high (64.6%) because there were few young people in the sample (Dershem et al., 2007).
Sources
1 EMCDDA, 2008.
3 Republic of Georgia, 2008.
4 Dershem et al., 2007.
5 Unpublished data, Reitox National Focal Point for Hungary.
6 Unpublished information, Romanian country respondent, 2008, based on testing done for National Agency Against Drugs, ARAS, and Alliance for the Struggle against Alcoholism and Drug Addiction (ALIAT).
8 Republic of Serbia National AIDS Commission et al., 2008.
Table 5. **Framework of legal regulations relating to minors and drug use**

<table>
<thead>
<tr>
<th>Country</th>
<th>Minimum age of criminal responsibility</th>
<th>Do the courts automatically expunge minors’ criminal records?</th>
<th>Does charging a minor with drug use or possession create a record?</th>
<th>Does national law regard providing drugs to minors an aggravating circumstance?</th>
<th>Are less strict punishments or punishment alternatives available for minors convicted of drug-related offenses?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>15</td>
<td>Yes</td>
<td>Yes (for internal purposes)</td>
<td>Yes. All drug-related offenses (possession, dealing, production, etc.) involve stricter penalties when the victim is a child (0–14) or juvenile (15–18)</td>
<td>Yes. The New Juvenile Act prioritizes educational and protective measures over penal measures</td>
</tr>
<tr>
<td>Estonia</td>
<td>14</td>
<td>—</td>
<td>Yes (for internal purposes)</td>
<td>Yes: • providing minors with drugs, small amounts — up to 5 years; • providing large amounts — up to 15 years; and • inducing or encouraging minor to use drugs — up to 10 years</td>
<td>Yes, specifically for minors. The penal code also specifies that a person under 18 cannot be detained for 10 years</td>
</tr>
<tr>
<td>Georgia</td>
<td>14; 12 for “most serious” crimes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes. Aggravating circumstances include providing space (e.g., an apartment) for using drugs: up to 3 years prison (2–5 years for offending minors). Other forms of “imposing” drugs on a minor: up to 10 years, vs. up to 3 years for “encouraging” an adult</td>
<td>No</td>
</tr>
<tr>
<td>Hungary</td>
<td>14</td>
<td>Yes</td>
<td>Yes (for internal purposes)</td>
<td>Yes, for direct provision of drugs</td>
<td>Yes (but nothing specific to minors)</td>
</tr>
<tr>
<td>Romania</td>
<td>14</td>
<td>No</td>
<td>Yes</td>
<td>Yes, for providing drugs or encouraging use</td>
<td>Yes (but nothing specific to minors)</td>
</tr>
<tr>
<td>Russia</td>
<td>16; 14 for “most serious” crimes</td>
<td>Yes</td>
<td>No</td>
<td>Yes, for either: (1) encouragement (through motivation, suggestion, persuasion, description of positive effects, lying, etc.); or (2) threats or physical persuasion</td>
<td>Yes</td>
</tr>
<tr>
<td>Country</td>
<td>Minimum age of criminal responsibility</td>
<td>Do the courts automatically expunge minors' criminal records?</td>
<td>Does charging a minor with drug use or possession create a record?</td>
<td>Does national law regard providing drugs to minors an aggravating circumstance?</td>
<td>Are less strict punishments or punishment alternatives available for minors convicted of drug-related offenses?</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Serbia</td>
<td>14</td>
<td>Not as a rule</td>
<td>Yes</td>
<td>Yes. Penalties are doubled for offering a minor drugs, providing a minor space for drug use, or in any other manner enabling people under 18 to use drugs</td>
<td>Yes. Alternatives (not applicable for “most serious” crimes) include: judicial caution (judicial admonition), community service, special courses with knowledge testing and other measures of protective supervision, and compensating injured parties for damages</td>
</tr>
<tr>
<td>Slovenia</td>
<td>14</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ukraine</td>
<td>16, 14 for “most serious” crimes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*As defined in the Convention on the Rights of the Child (CRC).

**Comments**

**Georgia.** Article 100 of the penal code provides for expunging criminal records for minors 1 year after the end of a criminal term for less serious crimes (for adults it is 3 years), 3 years afterwards for serious crimes (for adults, 5 years), and 5 years afterwards for very grave crimes (for adults, 8 years).

**Romania.** Criminal records are not automatically removed; rather, a convicted offender has to make a special request at least 3 years after he or she has completed a sentence, and a judge will decide whether to grant the request.

**Russia.** For providing drugs to minors: in case (1), encouragement is considered a crime, even if the object of the efforts does not end up using the drug. The crime consists of understanding the consequences while intending to persuade a minor to use drugs. Anyone who is 16 or older can be charged with this crime. Penalties for (1) and (2) include, restriction of liberty for up to 3 years or detention for up to 6 months; the penalty rises to imprisonment from 3 to 8 years in case the aggrieved party is a minor. The third part of this article in the Penal Code identifies higher penalties, of 6–12 years’ prison, if encouragement or imposition of drug use on another person results in death or other serious health consequences, including drug addiction, HIV, or suicide.

**Serbia.** For minors age 14–18, records are not expunged but remain archived, where they are accessible only with permission from a court or by request of a public attorney. A criminal file can be removed if no new crimes are committed for a certain period after conviction, if a court recognizes the individual's good behavior, or if the offender has made recompense for material damage. The same conditions apply to the removal of adult records.

**Ukraine.** Minors and other young people can answer for their criminal responsibility in two ways: participating in educational programs or serving out their sentences.

**Sources**

All information was provided by the respective country respondents.
Table 6. Minors, drug law offenses, and detention

<table>
<thead>
<tr>
<th>Country</th>
<th>Drug law offenses committed by minors</th>
<th>Minors in detention for committing drug law offenses</th>
<th>Prison population, including pretrial detainees (date)</th>
<th>% of prison population who are minors (date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>In 2007: 65 offenses by minors (age 1–14); 139 offenses committed by minors (age 15–17); and 130 accused minors (age 15–17)</td>
<td>—</td>
<td>19,145 (11 Apr 2007)</td>
<td>1.0% (1 Apr 2007)</td>
</tr>
<tr>
<td>Estonia</td>
<td>51 (about 2% of all crimes committed by minors, and 4% of all drug offenses)</td>
<td>—</td>
<td>3,467 (1 Jan 2008)</td>
<td>2.0% (1 Jan 2008)</td>
</tr>
<tr>
<td>Georgia</td>
<td>10 cases (about 0.4% of all drug-related offenses in 2007)</td>
<td>In 2007, 426 minors were imprisoned, 10 for drug law offenses</td>
<td>19,441 (1 Oct 2007)</td>
<td>1.9% (1 Oct 2007)</td>
</tr>
<tr>
<td>Hungary</td>
<td>Drug law offenders in 2006: All ages: 5725 (100%); 0–14: 17 (0.3%); 14–18: 836 (14.6%); 19–24: 3166 (55.4%); 25–30: 1190 (20.8%)</td>
<td>—</td>
<td>14,821 (31 Dec 2006)</td>
<td>3.1% (1 Sep 2006)</td>
</tr>
<tr>
<td>Romania</td>
<td>Between 2001 and 2004, the proportion of drug-related offenders who were minors remained stable at 6.0–6.7%</td>
<td>121 (24 June 2008)</td>
<td>28,851 (1 Apr 2008)</td>
<td>1.8% (1 Apr 2008)</td>
</tr>
<tr>
<td>Russia</td>
<td>No disaggregated data, but the number of drug-related offenses is rising. By 2000, the number of crimes related to drug trafficking had increased 14-fold from 1990. Over 70% of drug-trafficking offenders are under 30</td>
<td>—</td>
<td>892,330 (1 Mar 2008)</td>
<td>1.8% (1 Jan 2007)</td>
</tr>
<tr>
<td>Serbia</td>
<td>—</td>
<td>—</td>
<td>8,600 (Mar 2007)</td>
<td>0.9% (1 Sep 2006)</td>
</tr>
<tr>
<td>Slovenia</td>
<td>Of all the offenses committed by minors in 2006, drug trafficking-related offenses comprised 2.4% and other drug offenses 0.9%</td>
<td>—</td>
<td>1,336 (1 Sep 2007)</td>
<td>0.4% (1 Sep 2007)</td>
</tr>
<tr>
<td>Ukraine</td>
<td>In 2006 there were 42,000 drug-related offenses (2.5 times as many as in 2005). About 20% were committed by young people</td>
<td>No specific data, but the number of imprisoned drug offenders under 18 is increasing</td>
<td>149,690 (1 Jan 2008)</td>
<td>1.8% (1 Sep 2006)</td>
</tr>
</tbody>
</table>

Comments

**Romania.** The proportion of drug-related offenders who were minors was 6.1% in 2001, 6.0% in 2002, 6.3% in 2003, and 6.7% in 2004. In 2005, four minors under 14 were involved in illicit drug trafficking, showing that the age of minors involved in such illegal activities is falling (Iliuta et al., 2006).
Russia. The proportion of drug-related crimes went from 1% in 1990 to 11% in 2002 and 8.5% in 2006 (as calculated from court decisions (Demoscope Weekly, 2007).

Sources
1 International Centre for Prison Studies, 2008.
4 Data of Georgian Department of Execution of Punishment, 2008.
5 Data of Supreme Court of Georgia, 2008.
7 Iliuta et al., 2006.
9 Unpublished data, Ukrainian country respondent, 2008.
Table 7. Juvenile justice and drug use

<table>
<thead>
<tr>
<th>Country</th>
<th>Is drug treatment available as an alternative to detention for minors using drugs?</th>
<th>Can juvenile offenders who use drugs be sentenced to compulsory treatment?</th>
<th>Is drug treatment available for minors in detention?</th>
<th>Are medical and psychological assistance available for drug-dependent minors in detention?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>Yes, though not specifically for minors. As noted in the Juvenile Justice Act: custody should be applied only in exceptional cases, and imprisonment as a last resort</td>
<td>Yes, in criminal proceedings ordered by a court (in special facilities for minors)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Estonia</td>
<td>Yes, though not specifically for minors</td>
<td>Courts may order it to be imposed on minors with parental consent. Such treatment is voluntary for people over 18</td>
<td>No</td>
<td>—</td>
</tr>
<tr>
<td>Georgia</td>
<td>No</td>
<td>Can be imposed on users of any age. Due to lack of treatment resources, however, it is rarely assigned</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Hungary</td>
<td>Yes, though not specifically for minors</td>
<td>No compulsory treatment</td>
<td>Yes</td>
<td>Yes, available to all minors and adults in special prison departments</td>
</tr>
<tr>
<td>Romania</td>
<td>Yes, by decision of a judge</td>
<td>May be imposed with parental consent</td>
<td>OST was recently launched on pilot basis (along with NSPs) in two prisons</td>
<td>Yes, though not specifically for minors</td>
</tr>
<tr>
<td>Russia</td>
<td>Yes, though not specifically for minors. Can be an alternative to short-term incarceration</td>
<td>No, it has been removed from the penal code, though it can be recommended by a court</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Serbia</td>
<td>Yes, though not specifically for minors</td>
<td>Yes, it can be imposed by a judge as an alternative to imprisonment</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Slovenia</td>
<td>Yes, though not specifically for minors; by decision of a judge</td>
<td>No obligatory treatment, except when a person commits a crime owing to drug use</td>
<td>Yes, though not age-specific</td>
<td>Yes, though not specifically for minors</td>
</tr>
<tr>
<td>Country</td>
<td>Is drug treatment available as an alternative to detention for minors using drugs?</td>
<td>Can juvenile offenders who use drugs be sentenced to compulsory treatment?</td>
<td>Is drug treatment available for minors in detention?</td>
<td>Are medical and psychological assistance available for drug-dependent minors in detention?</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ukraine</td>
<td>Yes, though not specifically for minors; by decision of a judge</td>
<td>Can be applied by court as an alternative to incarceration, in which case it becomes mandatory. Most often a person's desire to undergo treatment will be taken into account (not just for minors)</td>
<td>No</td>
<td>In 60 correctional facilities where the International HIV/AIDS Alliance in Ukraine works, minors can access the following services: instruction on HIV/AIDS, drug addiction, and tuberculosis; voluntary HIV testing and counseling; consultations with medical staff and psychologists; psychological support; and peer support</td>
</tr>
</tbody>
</table>

**Sources**

All information was provided by the respective country respondents.
Table 8. Availability of drug-related services for young IDUs

<table>
<thead>
<tr>
<th>Country</th>
<th>Young IDU outreach</th>
<th>Peer counseling</th>
<th>Outreach at party scenes</th>
<th>IDU support at youth drop-in services</th>
<th>Training on safer injecting practices</th>
<th>Materials for young people at harm reduction services</th>
<th>Outreach by harm reduction services to non-injectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>Outreach to either youth (street, leisure activities) or IDUs, but not specifically to young IDUs</td>
<td>No</td>
<td>Yes</td>
<td>Information, counseling, referrals to drug services</td>
<td>Yes, at all outreach and drop-in programs; for all IDUs</td>
<td>No</td>
<td>Limited</td>
</tr>
<tr>
<td>Estonia</td>
<td>To street children</td>
<td>No</td>
<td>No</td>
<td>Yes. Young people’s counseling centers offer free HIV testing (for people under 24), counseling, and information, which are mainly linked to sexual health. No specific services for drug users</td>
<td>Limited, provided by a few NGOs</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Georgia</td>
<td>Not specifically to young people</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Hungary</td>
<td>Not specifically to young people</td>
<td>Not specifically for young people, though some peer educators are young</td>
<td>Yes</td>
<td>Limited</td>
<td>No</td>
<td>No</td>
<td>Limited</td>
</tr>
<tr>
<td>Romania</td>
<td>To street children and other groups – not specifically to young people</td>
<td>Not specifically for young people, though some peer educators are young</td>
<td>Limited, special initiatives</td>
<td>No</td>
<td>Not on a regular basis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Russia</td>
<td>To street children in Moscow and St Petersburg</td>
<td>No</td>
<td>No</td>
<td>Only for projects targeting street children</td>
<td>Limited</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Country</td>
<td>Young IDU outreach</td>
<td>Peer counseling</td>
<td>Outreach at party scenes</td>
<td>IDU support at youth drop-in services</td>
<td>Training on safer injecting practices</td>
<td>Materials for young people at harm reduction services</td>
<td>Outreach by harm reduction services to non-injectors</td>
</tr>
<tr>
<td>---------</td>
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<td>-------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------</td>
<td>------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Serbia</td>
<td>Yes, in cities with harm reduction services</td>
<td>No, though some peer educators are young</td>
<td>Limited, special initiatives (in 2004 and planned for 2009)</td>
<td>Limited</td>
<td>Not on a regular basis</td>
<td>No</td>
<td>NSPs encourage IDUs to bring friends who do not necessarily inject</td>
</tr>
<tr>
<td>Slovenia</td>
<td>Not specifically to young people</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not specifically for young people</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Ukraine</td>
<td>To street children (limited)</td>
<td>No</td>
<td>Limited</td>
<td>Limited</td>
<td>Limited</td>
<td>Limited</td>
<td>Planned. Also, clients of The Way Home in Odessa, which targeting student users, are encouraged to bring their friends</td>
</tr>
</tbody>
</table>

**Sources**
All information was provided by the respective country respondents.
<table>
<thead>
<tr>
<th>Country</th>
<th>Drug treatment</th>
<th>OST</th>
<th>NSPs</th>
<th>Anonymous HIV and HCV testing</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Age criteria</td>
<td>Parental consent requirements</td>
<td>Age criteria</td>
<td>Parental consent requirements</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>No age restric-</td>
<td>Yes</td>
<td>Minimum age 15</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>tions. Special drug treatment units for minors are available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estonia</td>
<td>No age restric-</td>
<td>Yes, According to guidelines they should also be involved in treatment process</td>
<td>No age restrictions, though most health care providers are critical of providing OST to young people</td>
<td>Yes</td>
</tr>
<tr>
<td>Georgia</td>
<td>No age restric-</td>
<td>Required in practice for minors</td>
<td>Minimum age 25 (see comment below)</td>
<td>Minors are not accepted as a rule</td>
</tr>
<tr>
<td></td>
<td>tions</td>
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<tr>
<td>Hungary</td>
<td>Usually not allowed for those under 18. Exceptions can be made for those aged 15–17</td>
<td>Yes. In practice, required for inpatient treatment only</td>
<td>Minimum age 18, with some exceptions for 17-year-olds</td>
<td>Minors are not accepted as a rule</td>
</tr>
<tr>
<td>Country</td>
<td>Drug treatment</td>
<td>OST</td>
<td>NSPs</td>
<td>Anonymous HIV and HCV testing</td>
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<tr>
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<tr>
<td></td>
<td>Age criteria</td>
<td>Parental consent requirements</td>
<td>Age criteria</td>
<td>Parental consent requirements</td>
</tr>
<tr>
<td>Albania</td>
<td>Minimum age 16</td>
<td>Yes. Parents are also required to be present during medical evaluation prior to admission</td>
<td>Minimum age 16</td>
<td>Yes</td>
</tr>
<tr>
<td>Russia</td>
<td>No age restrictions</td>
<td>Yes, for clients 18 and under. Clients aged 14–18 must give their own consent too</td>
<td>Not applicable</td>
<td>No explicit restrictions, but due to the broad description of what can be considered to encourage drug use, NSPs usually work with people over 18</td>
</tr>
<tr>
<td>Serbia</td>
<td>No age restrictions yet, but some proposed guidelines are pending approval</td>
<td>Yes</td>
<td>No legal restrictions, but in practice the minimum age is 18 and 25 (see comments). Minors are admitted if coinfected with HIV/HCV</td>
<td>Yes</td>
</tr>
<tr>
<td>Country</td>
<td>Drug treatment</td>
<td>OST</td>
<td>NSPs</td>
<td>Anonymous HIV and HCV testing</td>
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<tr>
<td></td>
<td>Age criteria</td>
<td>Parental consent requirements</td>
<td>Age criteria</td>
<td>Parental consent requirements</td>
</tr>
<tr>
<td>Slovenia</td>
<td>Minimum age 15, with exceptions possible</td>
<td>Not mandatory, though efforts are made to motivate parental involvement</td>
<td>Minimum age 16 for methadone, 15 for buprenorphine</td>
<td>Not mandatory, though efforts are made to motivate parental involvement</td>
</tr>
<tr>
<td>Ukraine</td>
<td>No age restrictions</td>
<td>Yes</td>
<td>Minimum age 16, provided one of the admission criteria is satisfied (see more in comments below)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Comments**

**Georgia.** Criteria for admission to OST are (1) a minimum age of 25 years (the only exceptions are for HIV-positive clients); (2) at least three years of opioid dependence, including one year of injecting use; and (3) a history of at least two verifiable unsuccessful treatment attempts.

While there is agreement among NSP services not to accept clients under 18, country experts say that there have been only a few cases of minors contacting currently operating NSPs.

**Serbia.** The most common minimum age for admission to OST is 18. However, in the Belgrade and Novi Sad OST centers, the two with the most patients, the minimum age is 25.

**Slovenia.** OST clients under 18 are not allowed to take medication home without parental consent.

**Ukraine.** To be accepted into drug treatment, a potential client age 16–18 must satisfy at least one of the following criteria: a drug use career of at least three years; at least two confirmations from drug dependency treatment specialists about two previous unsuccessful attempts at treatment; a positive HIV test; tuberculosis requiring immediate treatment; pregnancy; hepatitis B or C; sepsis; and cancer.

NSPs currently make their own decisions about acceptance requirements. Most of the exceptions they make to their exclusion of minors are for street children. NSPs are the only harm reduction service in contact with this group of IDUs, and the only one providing them any kind of help and support.

**Sources**

All information has been provided by the respective country respondents.
Appendix 1.
Developing harm reduction services for young people: considerations for service planners and providers

The traditional model of service delivery has expected young people to come to services, but it is now recognized that services may need to reach out to young people, especially to prevent HIV infection in vulnerable populations. This requires a re-orientation on the part of health workers to adolescent health and development and the involvement of a broad range of professionals (health and social workers, psychologists, teachers, the police and peer educators) in community based approaches.


Existing harm reduction approaches do not always work with young IDUs. However, when governments provide an enabling environment and sufficient funding, young people’s services and harm reduction services can develop interventions that are effective in helping young populations avoid or mitigate the harms of injecting drugs. While these approaches may of course need to be adapted to address local circumstances, it is possible to identify some of the key features of interventions that have proven successful in reaching young people.

“Young-friendly” services
The provision of harm reduction services to young IDUs needs to be accessible, relevant, reliable – and grounded in the principles of “young-friendly” services, which are essentially the same as those of youth-friendly services. These principles include privacy, confidentiality, and respect for the young. Young-friendly services emphasize gender sensitivity and ensure that their service providers are appropriately trained. They also involve young people in service planning, implementation, and evaluation (Juntunen, 2004).

Harm reduction services for young people who inject or are at high risk for injecting should have low access thresholds, create an enabling and protective environment, and convey non-judgmental attitudes. Services should also be anonymous or confidential, with no legal and at
most few administrative hurdles. Harm reduction services aimed at young people often involve the provision of specific services, such as educational outreach, needle and syringe exchange, voluntary testing and treatment for HIV and other sexually transmitted infections, counseling, psychiatric services, and other medical and legal services. They address concrete problems while emphasizing flexibility in working with young people. Such services consider the diversity of young subcultures and where possible offer recreational and leisure activities that appeal to young people’s interests. Where appropriate, they also address basic needs such as poverty, hunger, secure housing, and hygiene.

Involvement of young people

Involving people from the target group that a service intends to reach will increase its effectiveness. Inviting them to focus groups and planning meetings that center on how to satisfy their needs, reduce drug-related harms, and improve health is a critical first step. However, an invitation to participate should always be clear about what may actually be possible, and it should affirm a commitment to implementing resulting proposals where practicable.

Outreach

Two systematic reviews of available studies strongly indicate that outreach can be an effective means to reach and educate drug users who are not in treatment, helping them to significantly reduce their levels of drug-related risk behaviors and drug-related morbidity (Coyle et al., 1998; Needle et al., 2004).

With young people, outreach represents an important means of providing harm reduction – and a serious challenge. Outreach is a tool for building trusting relationships with young people at risk before or during the initial stages of drug use, and for preventing the transition to more harmful drug behaviors. Outreach and mobile services aim to intervene where risk behaviors are occurring and increase service coverage (Ross et al., 2006).

Most outreach approaches were developed in response to the HIV epidemics among IDUs and crack smokers, as well as, to a lesser extent, those among sex workers and men who have sex with men.

Needle and others distinguish three basic models of outreach: the provider-client intervention, the peer leader intervention, and the peer-driven intervention (PDI) (Needle et al., 2004). The provider-client model dominates, relying on a small number of paid outreach workers (often ex-users) to educate drug users and reintegrate them into the community. However, several studies have revealed major shortcomings with the traditional provider-client model (Broadhead et al., 1990, 1993, 1995).

Peer approaches

The present study suggests that age restrictions, lack of confidentiality, and parental consent requirements are major barriers to the uptake of harm reduction services by the young people who are most at risk. Many of them have “good” reason to distrust older people, most of whom disapprove of drug users’ lifestyles. Young people therefore hide their use and avoid older people and institutions that might compromise their anonymity or otherwise complicate their lives.

Peer approaches become therefore an important way to deliver harm reduction services to young people. Young peer educators serve as an intermediary between these services and otherwise hard-to-reach young people.
Peer support in the field of harm reduction is based on several ideas derived from research. Studies have documented how peers can act responsibly, as key distributors of harm reduction supplies (Grund et al., 1992) and information (Broadhead et al., 1998; Aggleton et al., 2005) and as support mentors, even if they themselves use drugs or work in the sex industry (Malin et al., 2007). Ethnographic studies have documented a range of compassionate, generous behaviors among drug users, the homeless, street youth, and other disenfranchised populations (de Bruin et al., 2003; van Doorn, 2002; Grund, 1993b). Peer approaches capitalize on these naturally occurring altruistic impulses.

Harm reduction providers generally arrange team and individual support of peer workers. While peer approaches can often be empowering to individual participants, they can risk creating super peers who may become alienated from their communities.

A relatively new model of peer education is the peer-driven intervention (PDI). The PDI model engages many members of a targeted community by providing them with modest incentives for educating their peers and recruiting them into interventions. Each participant plays an important but modest role in the intervention, that of educating near friends (Broadhead et al., 1998). When PDIs are tied into other services, such as needle exchange, they can serve as the starting point for more permanent mechanisms of peer support, such as secondary distribution of harm reduction supplies (Grund et al., 1992; Irwin et al., 2006; Huo et al., 2005). In several needle exchange studies, about half of the participating IDUs engaged in secondary exchange, either as provider or recipient of sterile injecting equipment (Des Jarlais et al., 2002; Tyndall et al., 2002; De et al., 2007). Studies have also suggested that secondary exchange reaches IDUs who are less well informed about HIV and safer drug use, practice risk behaviors more often, and report a higher prevalence of HIV (Tyndall et al., 2002; De et al., 2007). Needle exchange peers should therefore be thoroughly and regularly educated about HIV risk behaviors and safer drug use, and they should be encouraged to disseminate prevention information in their peer networks and recruit more peers.

Box 2. PDIs among young IDUs in Odessa, Ukraine

In Odessa, young IDUs generally come from the middle class, use easy-to-access drugs such as boltushka, and gather at clubs, discos, and internet cafés. Since they tend to live with their parents and hide their use, they often reuse a single syringe and are reluctant to participate in prevention programs. As a result, young people have lower harm reduction coverage than any other age group in Odessa.

Unfortunately, differences between Odessa’s young IDUs and its harm reduction workers – in age, social status, drug use history, etc. – precludes the possibility of peer leader outreach. In 2007, the NGO The Way Home therefore decided to use the PDI model to reach female IDUs and IDUs under 24, especially the ones injecting stimulants.

First, three consultants were trained in PDI methodology and interviewing, as well as in HIV/hepatitis prevention and safer injecting practices. The Way Home assessed their suitability, including their commitment to HIV prevention and the non-judgmentality of their approach towards behaviors, choices, drug use, and sexuality. The consultants then established con-
tacts at various locations: the AIDS Center, a youth social support center, the agency of labor and social policy, the state university, and internet clubs. They essentially interviewed these contacts, providing them with basic guidance on how to communicate information to other people. Each contact received three coupons to convey to three other people.

In the last stage of the project, clients brought coupons to a consulting room established specifically for this program. There they each discussed two main issues: (1) how to prevent blood-borne infections, inject more safely, and practice overdose management; and (2) how to attract new peers into the program, for which they received more coupons. In addition, each IDU was counseled and referred to a low-threshold facility. Every one who brought a coupon to the program and agreed to being interviewed and receiving basic information on prevention and teaching other IDUs was paid a small fee. Additional money was paid if he or she successfully recruited other young IDUs for the project.

Over the course of five months, the organization established contact with 519 young IDUs and counseled 56.8% of them. However, it retained only 12.2% as permanent harm reduction clients, indicating a need to employ peer mechanisms that will engage prospective clients beyond the initial recruitment.

**Preventing the initiation of injecting**

Research has shown that those who socialize with IDUs or are exposed to injecting drug use are more likely to inject drugs themselves (Crofts et al., 1996; Balakireva et al., 2006; Gray, 2007). A study in the United Kingdom (Hunt N et al., 2001) found that fewer than 1 in 10 of IDUs interviewed felt that pressure from injectors had been important in their decision to try injecting. Many more had been actively seeking initiation. About 7 in 10 mentioned that seeing someone inject had been an important factor in their decision to inject for the first time, while more than half thought that talking about injecting with an IDU played an important role. Finally, more than 8 out of 10 had injected in front of a non-injecting drug user at some time, and well over half had done so in the three months before the first interview. Other studies confirm these findings (see for example Howard et al., 2003; Treloar et al., 2003). Curiosity has been found to be another important motivation for young people who start injecting drugs (Longfield et al., 2004; Balakireva et al., 2006).

It is important to not only target young non-injectors at risk for injecting, but to educate injectors about how to deal with non-injectors’ requests for assistance. One useful model for the latter is Break the Cycle. Originally developed in the United Kingdom (Hunt N et al., 1998), this intervention aims at changing IDU attitudes and norms around the initiation of non-IDUs, as well as supporting IDUs in developing acceptable strategies to refuse such requests. The methodology has recently been introduced in Central Asia (see Box 3).
Box 3. Preventing the initiation of injecting in Central Asia

A baseline study of 440 IDUs in Uzbekistan and Kyrgyzstan (Gray, 2007) found that 85.9% had received help with their first injection. Of them, the majority – 53% – received assistance from a sibling or a cousin, 33% from friends, 12% from other people, and 2% from dealers. In most cases, it was curiosity that drove them to seek assistance from existing IDUs.

Since 2005, Population Services International (PSI) has been establishing Youth Power Centers in Kyrgyzstan, Tajikistan, and Uzbekistan. Each center serves as a safe, drug-free place where youth at risk can socialize. Youth Power Centers employ peer educators recruited directly from this target group, training them to communicate about behavior change to prevent initiation of drug use and to reduce injecting and sexual risk behaviors. Peer education sessions are conducted at the centers, schools, and other places young people gather.

While the centers focus on potential injectors, the Break the Cycle concept concentrates on the role of IDUs in injecting initiation. Implemented in Tashkent (Uzbekistan) and Bishkek (Kyrgyzstan) in 2006–2008, the Break the Cycle program actively involved IDUs in its design. It uses motivational interviews to help build IDUs’ ability to field initiation requests. Peers, outreach workers, and needle exchange staff conduct motivational interviews with individual IDUs, typically in places where the IDU feels comfortable, be it an apartment, a drop-in center, or a café. To give IDUs something that benefits them more directly, interviewers are also trained to help IDUs develop overdose prevention and management skills.

Early results are promising. Pre-intervention assessments, as well as information from United Kingdom (Hunt N et al., 2001), indicate that many injectors have not considered how they will deal with an initiation request beforehand, and IDUs have responded warmly to this program that helps them resist unwelcome pressure from drug-curious youth.

Overdose prevention

Barriers to young people’s access to drug services are likely to aggravate their risk for overdose. Studies have demonstrated that the greatest risk factor for overdose is a history of overdose (Coffin et al., 2007), which emphasizes the importance of following up on overdose events – and preventing them in the first place.

While few overdose studies specifically address young people, several applicable interventions have been developed for service providers and drug users, including training in overdose prevention, overdose recognition, and overdose management. Specific interventions include various educational materials, training in rescue breathing and cardiopulmonary resuscitation (CPR), campaigns to encourage overdose witnesses to contact emergency medical services (EMS), and laws protecting witnesses from prosecution for low-level offenses. Another major component of overdose prevention efforts is the lay distribution of naloxone – a safe, highly effective antidote to opiate overdose listed on the WHO Model List of Essential Medicines – for witnesses to administer. Two other initiatives that could be described as overdose prevention are the expansion of drug treatment and the development of safer injecting facilities.
These interventions are all relatively novel and research on their efficacy limited. Nonetheless, data demonstrate a life-saving effect of training in rescue breathing (Seal et al., 2005; Piper et al., 2007); preliminary literature suggests an association between expanding naloxone distribution and reduced overdose mortality (Maxwell et al., 2006; Sporer et al., 2007); studies have demonstrated a similar association between expanded methadone and buprenorphine maintenance services and reduced overdose (Caplehorn et al., 1996; Niveau et al., 2002; Welsh et al., 2008); and research shows zero overdose fatalities at safer injection facilities in seven countries (Kerr et al., 2006).

The current EU drug strategy and drug action plan both address the issue of overdose. Yet a report recently released by the Eurasian Harm Reduction Network (Coffin, 2008) notes that some of the new member states, such as Latvia and Romania, have not taken adequate measures to deal with the problem, which will require significant improvements in data collection, service development, knowledge, education, and policy.

**Young people and OST**

Based on a systematic review of the scientific evidence, WHO, UNODC, and UNAIDS have concluded that substitution treatment is a valuable tool in treating and managing the epidemics of both drug injecting and HIV (WHO et al., 2004). The existing studies on providing substitution treatment to minors point largely in the same direction as the bulk of studies on adult populations. Methadone keeps young patients longer in treatment than other modalities and leads to improved psychosocial functioning (Hopfer et al., 2002; Crome et al., 2000). The literature does not describe any evidence-based contraindications for OST and minors, but neither does it present any evidence-based guidelines (Health Canada, 2002). A public health ethics analysis used in preparing the 2006–2015 Estonian HIV strategy weighed the available evidence on substitution treatment for opiate injectors under 18 (Grund, 2005). It suggested that, while OST effectiveness has not been established “beyond a doubt” for juvenile IDUs, the evidence for alternative, drug-free approaches to tackling both HIV transmission and heroin injecting in this group is much weaker – making substitution treatment a necessary and appropriate public health response to both problem opiate use and HIV infection among young IDUs.

**OST: some international cases**

It is quite difficult to prescribe substitution treatment to young drug users in CEE. As this study found, most focus countries impose age restrictions on OST (see Table 9), making it unavailable to most young IDUs in the region. OST age restrictions also exist elsewhere in Europe, e.g., the minimum ages in Finland and Sweden are 20 and 22, respectively.

Since there is little research on OST and young people, EHRN and Youth RISE used the framework of the present report to invite experts who work in this field elsewhere to share their experiences. Their responses have been used to provide the following examples of providing young people with OST.

In Dublin, Ireland, OST is available through the Young Persons Program on a separate floor of a regular drug treatment center. Run by a multidisciplinary team that seeks to address the medical, psychological, and social needs of their young clientele, the drug treatment clinic was established to serve IDUs under 19, who had previously been treated in the same setting as adult IDUs (Fagan et al., 2008).

In New York, Safe Horizon Streetwork Lower East Side is a drop-in center and counseling program for homeless people up to age 25. It provides them with concrete services (showers, donated clothing, and daily home-cooked meals) as well as counseling, case management, groups,
psychiatric services, medical services, and syringe exchange – all in a young-friendly, homey environment. Streetwork’s overall goal is to provide all its clients with a stable counseling relationship through which they can work towards whatever positive, stabilizing changes they desire and are ready for.

Streetwork is not authorized to dispense methadone, as methadone substitution therapy in the United States is only available in methadone clinics. However, Streetwork employs a part-time psychiatrist who is able to prescribe buprenorphine to clients on-site, which makes this treatment lower-threshold and more accessible than an off-site program. Most Streetwork clients have used it for brief detoxification or substance use management, since sustained buprenorphine maintenance is not financially possible for the majority of them. Many young people who use buprenorphine temporarily do not intend to discontinue long-term drug use, though it does provide them an opportunity to take a break from the chaotic street scene that heroin dependence involves them in. In general, buprenorphine has been a positive step for these young people to take in managing their drug use and reestablishing a sense of control. Streetwork Lower East Side also refers some of its clients to methadone programs, whose restrictive structures filter out those who are not committed to long-term substitution therapy.

While the prevention of HIV and HCV is one important goal for substitution treatment, OST must be looked at holistically to see how it provides young IDUs with a measure of stability in many areas of their lives. Many clients who opt for OST are polydrug users, and by providing some stability in their use, OST can often create a foundation for further stabilization and reduction of drug intake later in the course of treatment.

**Young people and needle exchange**

While few studies explicitly explore the provision of needle exchange services to young people, several demonstrate positive behavioral and attitudinal change in young people who access them. These studies show that young people using needle exchange services practiced safer injecting, for instance by sharing fewer syringes. A study among IDUs in the Czech Republic, Hungary, Macedonia, Poland, Russia and Ukraine (Des Jarlais et al., 2001) showed that while the levels of needle and syringe sharing was modestly higher among IDUs under 25 than among older IDUs, both before and during NSP participation, the young injectors did change their behavior.

Studies also show that among young IDUs, the younger ones were more likely to be injected by someone else, and to feel that they could not access sterile injecting equipment as easily as the older ones (Kipke et al., 1997). A Ukrainian study showed that IDUs who were younger at their first injection were likelier to have no clue whether their first syringe had been used by anyone else first (Balakireva et al., 2006). But young injectors’ risks can also increase after their first year of injecting (Mullen et al., 2001). This increased risk underscores the need for harm reduction services that target young people (Kipke et al., 1997). Harm reduction activities should be tailored to the individual’s drug use practices, addressing HIV and HCV transmission, bacterial infections and vein care, and substitution and maintenance therapy. After initial engagement with a needle exchange facility, young people can be encouraged to spend more time there, giving the program opportunity to introduce them to other harm reduction and health services, such as primary health care (Guydish et al., 2000).

These and other studies suggest that needle exchange, like OST, is a necessary and appropriate public health response to HIV among young IDUs. It should be a cornerstone of harm reduction services for young people, in CEE and elsewhere.
Box 4. Serbia: equal access to harm reduction for all

A harm reduction program in the Serbian capital, Belgrade, was established in 2002 after a year of active lobbying and cooperation building with authorities. It was established with the support of Médecins du Monde-France, and since 2005 it has been managed by the NGO Veza. The program offers services that now include needle and syringe exchange, individual counseling, educational materials, outreach, peer counseling, medical assistance with wounds, social services, and referrals to testing and treatment.

In the beginning, the primary client group averaged 40 in age, mainly IDUs who already had had contact with law enforcement, either through placement on the drug users’ registry or through a criminal or prison record. The program struggled to establish contact with younger people, whom the director described as distrustful and fearing exposure. Currently, the average client age is between 20 and 30, including a limited number of minors, many of them from Roma neighborhoods.

The program’s success in reaching young people has two sources. On the one hand, providing services anonymously increased its user friendliness, while its growing experience also helped it gain the trust of the younger IDUs, especially when some of them began working in the drop-in center. On the other hand, the program established a good relationship with the Ministry of Health when it began in 2001, and the two parties signed a memorandum of understanding. The relationship with the ministry allowed the program to develop services in a favorable political environment and explicitly prioritize equal provision of services for all IDUs, including minors. Although aiding and abetting laws expose the program to charges of facilitating drug use among minors, the memorandum has allowed it to implement services for all IDUs and focus on individual client needs first.

As a result, all services, including needle exchange, are accessible to anyone in need. “It helps that in our drop-in centers, staff members include drug users, who can assess the situation and behavior of the potential client,” explains Director Miodrag Atanasijevic. “If a person comes and there are marks of injecting on his/her hands, they will get needles, regardless of age.”

Due to the increasing number of young people using program services, as well as the increasing popularity of injecting among street children who used to sniff glue, the program is partnering with the Center for Youth Integration, which works with street children. Veza now refers young people who need lodging or specialized social support to the Center, and the Center refers young injectors to Veza’s harm reduction services.

Partnerships with sexual and reproductive health services for young people

As described in Section 2.3.2, injecting drug use and unsafe sex are connected. Drug use can mediate or facilitate sexual risk-taking, while the social networks of drug-using contacts and sexual contacts often overlap. Moreover, many young female IDUs engage in sex work. To effec-
tively prevent HIV, it is crucial to understand the transmission dangers of both sharing injecting equipment and practicing unsafe sex (Howard et al., 2003). Partnership and collaboration between harm reduction programs, young people's organizations, and sexual health programs can help address the problem of increased sexual risk behavior associated with substance use.

Such partnerships also allow for the development of more gender-sensitive programming in harm reduction services. Young female IDUs frequently rely on male partners to inject them with drugs, often exchange sex for drugs, and are more inclined to have sex partners who are IDUs – three things that increase their vulnerability to HIV.