



Annual Report

The Czech Republic

2008 Drug Situation



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This Annual Report summarises information about the situation in the field of drug use and its consequences, in the fields of legislation, strategies, and drug policy coordination, and about interventions, especially in the areas of drug demand reduction, drug crime, and drug markets in the Czech Republic in 2008, as well as trends in the above-mentioned fields. When the latest data are available, it also refers to the current period in 2009. In the parts where the latest up-to-date or more detailed data were published in recent years, references have been made to the Annual Reports on the Drug Situation for the years 2002-2007 (Mravčík et al. 2003; Mravčík et al. 2004; Mravčík et al. 2005a; Mravčík et al. 2006; Mravčík et al. 2007; Mravčík et al. 2008).

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SUMMARY

The preparation and enforcement of the national drug policy is the responsibility of the Government of the Czech Republic. Its main counselling body for drug-related issues is the Government Council for Drug Policy Coordination, which met four times in 2008. The National Drug Policy Strategy for the Period 2005 to 2009 and the Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2007 to 2009 are in force. All regions drew up their documents on regional drug policy strategies in 2008. In the first half of 2009, the Czech Republic held the presidency of the Council of the European Union. In relation to that, the Government Council for Drug Policy Coordination considered a number of documents pertaining to the preparation and the course of the presidency and its Secretariat was responsible for the leadership of the Horizontal Drugs Group, a working group of the EU Council.

In early 2009, Act No. 40/2009, Coll. Penal Code, effective from 1 January 2010, was adopted and included in the Collection of Laws. The new Penal Code includes significant changes in how to address illegal drugs. In comparison to the previous sentencing guidelines, a lower punishment range will apply to people who possess cannabis in a quantity greater than small. A significant change was also introduced by the new provision concerning the illegal cultivation of plants containing a narcotic or psychotropic substance: the growing of designated plants or mushrooms for personal use will be covered by less strict sentencing guidelines than was the case under the previous legal regulations and the cultivation of a small quantity of plants or mushrooms for personal use will be punished under the Misdemeanour Act rather than the criminal law. In relation to the act on pharmaceuticals, restrictions on the over-the-counter supply of medicinal products containing up to 30 mg of pseudoephedrine per tablet were imposed. This measure involves a ban on mail order sales, the setting of a maximum monthly dose of 1,800 mg of pseudoephedrine (i.e. 60 tablets of 30 mg) per person, and the control of supply by means of the central database of electronic prescriptions.

Labelled public expenditure on drug policy reached a level of CZK 597.3 million (€ 23,947 thousand) in 2008. This amount included CZK 371.9 million (€ 14,912 thousand) provided from the state budget, and the regions and municipalities contributed amounts of CZK 162.9 million (€ 6,530 thousand) and CZK 62.5 million (€ 2,505 thousand), respectively. In comparison to 2007, total expenses showed a nominal increase on all three levels by 7%; on the central level, there was a decrease in expenditure on the part of all the ministries and central agencies under scrutiny, with the exception of the Ministries of Defence and of Labour and Social Affairs and the National Drug Headquarters of the Police of the Czech Republic. On the regional level, there was a nominal increase in aggregate year-on-year expenditure of approximately one third. An increase was recorded in almost all the regions; only the Zlín and Vysočina regions reported a year-on-year decline. Approximately one third of labelled regional expenditures was earmarked to finance sobering-up stations and the treatment of people intoxicated with alcohol or other drugs. The aggregate of funds expended by municipalities remained almost on the same levels as in 2007. Out of a total of CZK 597.3 million (€ 23,947 thousand), CZK 152.1 million (€ 6,100 thousand; 25.5%) was spent on law enforcement, CZK 184.5 million (€ 7,399 thousand; 30.9%) on treatment, CZK 159.4 million (€ 6,389 thousand; 26.7%) on harm reduction, CZK 58.4 million (€ 2,340 thousand; 9.8%) on primary prevention, and CZK 24.9 million (€ 999 thousand; 4.2%) on aftercare.

Two surveys covering the adult population were carried out in the Czech Republic in 2008: a general population survey specifically addressing the use of illicit drugs and a survey focusing on the health of the population in general. Both studies differed significantly in the methodology used and also provided different results. The former study (using a sample of respondents aged 15-64) showed that 37% of the population have had at least one experience with any of the illicit drugs under study; 34% have used cannabis and 17% of the population has had experience with a drug other than cannabis. In the past year and the past month, cannabis had been used by 15% and 9% of the respondents respectively. According to the latter study (working with a sample of respondents over 15 years of age), 15% had used an illicit drug at least once; cannabis had also been used by 15%, while any other drug than cannabis had been used by 4% of the respondents. Despite the above-mentioned differences, the results of both studies indicate that the proportion of people in the population who have experience of addictive substances is on the rise, with cannabis use showing the greatest increase. While in 2002 and 2004 at least one experience with cannabis was reported by one fifth of adult respondents, the 2008 study on illicit drug use recorded positive answers to this question from one third of the respondents. An increase over time has also been recorded in the surveys studying the population's health in general, although the prevalence rates reported by them are lower.

Out of the respondents included in the survey on the use of illicit drugs who reported having used cannabis in the past month, 9% used cannabis daily or almost daily. After extrapolation to the Czech population in the 15-64 age group, the number of daily, or almost daily, cannabis users may be estimated to amount to approximately 57 thousand (0.8% of the population aged 15-64). The survey also sought to identify the level of risky cannabis use. The use of cannabis poses a moderate risk for 26% and a high risk for 12% of the respondents who had used the drug in the past year. Men and people aged 25-34 comprise the most vulnerable group. After extrapolation to the Czech population in its entirety, the number of cannabis users at significant risk of dependency may be estimated to amount to 150 thousand, with people in the 15-29 age group accounting for approximately two thirds of them.

The international comparison of the results of the ESPAD school survey indicates that, within the European context, the Czech Republic ranks among the countries with the highest prevalence rates concerning the use of most of the drugs under study, with the exception of inhalants. As far as cannabis use is concerned, the Czech Republic's prevalence rates are by far the highest in Europe; at least one experience with cannabis use has been reported by 45% of 16-year-old Czechs.

Cannabis and ecstasy remain the most popular non-alcohol drugs in the nightlife setting, although experience with pervitin and cocaine has shown a rising trend recently.

In 2008 the estimated number of problem drug users rose to approximately 32.5 thousand, including approximately 21.2 thousand pervitin users and approximately 11.3 thousand opiate users. Approximately 31.2 thousand people, i.e. most of the users of opiates and pervitin, use drugs by injecting. In comparison to 2007, the number of problem users of all types of drugs increased in 2008. It is estimated that the highest numbers of problem drug users are in Prague (11.5 thousand) and in the Ústí nad Labem region (4.2 thousand); these regions also show the highest estimates of problem opiate users.

The relatively favourable situation concerning the occurrence of infections among (injecting) drug users continued in 2008; HIV seroprevalence remains far below 1%. The prevalence of hepatitis C virus among clients tested in low-threshold programmes was approximately 12%. However, such a low level of HCV seroprevalence may result from the fact that the testing is mostly sought by young users with a shorter history of injecting drugs. In 2008 HIV was newly diagnosed in 13 people, who may have contracted it through injecting drug use. While it is less than in 2007, it is a relatively high number when compared to the period prior to 2006. An HAV epidemic developed in the Czech Republic in 2008. In Prague, particularly at the beginning, it was associated with injecting drug users.

The number of overdoses on street drugs (illicit drugs and inhalants) remained very low in 2008; a total of 44 cases (15, 19, and 10 fatal overdoses on opiates, pervitin, and inhalants, respectively) were reported, which is 4 more than in 2007. There was a slight increase in opiates, pervitin overdoses recorded a significant increase, and the number of fatal overdoses caused by inhalants declined. No deaths by overdose on cocaine, ecstasy, hallucinogens, or THC were registered. One fatal overdose with the presence of methadone occurred in 2008, but none with the presence of buprenorphine. As regards causes of death other than fatal overdoses (especially accidents/injuries and suicides), the involvement of pervitin and THC has been detected with a rising frequency since 2004; 49 and 37 cases, respectively, were reported in 2008. Opiates/opioids accounted for 12 cases, including 5 cases of an active substance from a substitution product being detected. In addition, there was a significant year-on-year increase in the rate of positive findings for pervitin and cannabis in people who died in traffic accidents, or in consequence thereof, and were subjected to an autopsy at forensic medicine departments; 9.2% and 6.2% respectively of the drivers killed in accidents tested positive for these substances. However, the police have only registered sporadic cases. The increase concerning pervitin-related cases is also apparent in admissions to hospital for non-fatal overdoses. On the other hand, the number of non-fatal overdoses on heroin shows a declining tendency.

In the Czech Republic, drug users and addicts may seek help from a variety of easy-to-access services providing a wide range of interventions. The network of helping organisations experienced no major changes in 2008. The profession of an addictologist (addiction specialist) was incorporated in the law on non-medical health professions and the professional competencies required for the performance of this profession were defined.

Men outnumber women in all the types of treatment facilities; they account for approximately two thirds of the clients. The proportion of women tends to be higher in younger age groups. The average age of drug users in treatment continues to rise in the long term; this tendency is apparent across various sources of data. In the Czech Republic, the largest group of drug users in treatment comprises pervitin (methamphetamine) users, followed by the users of opiates/opioids (heroin and Subutex[®]) and cannabis. Polydrug use (the concurrent use of more than one drug) is commonplace. Injecting is the most frequent route of pervitin and opiate administration among users in treatment. The regions with the highest numbers of drug users in treatment include the Capital City, Prague, and the Ústí nad Labem region, where, as in the other regions of the Bohemian part of the country, high numbers and rates of opiate users are reported.

There has been a long-term decline in the number of psychiatric outpatient facilities reporting the provision of care for drug users; the number of their patients in 2008 remained approximately the same as in 2007. The numbers and regional availability of AT clinics, i.e. outpatient healthcare facilities specialising in addiction treatment, and their utilisation by drug users are not known accurately; 124 outpatient facilities have declared that they provide specialised addiction treatment services. In 2008 there was a decline in the number of individuals in inpatient psychiatric facilities, which especially resulted from a drop in the number of admissions to the psychiatric departments of hospitals. On the contrary, the number of admissions to psychiatric hospitals rose slightly. The number of patients registered for substitution treatment has increased. This applies to both specialised centres and individual physicians who prescribe products containing buprenorphine (Subutex[®] and Suboxone[®]). Nevertheless, treatment with buprenorphine has not been fully included in the substitution register.

Drug-related harm reduction activities in the Czech Republic are pursued by the dense network of low-threshold programmes, which have undergone no major changes in recent years. The number of needles and syringes

distributed as part of exchange programmes saw a slight increase again (from 4.5 million in 2007 to 4.6 million in 2008). In 2008, for the first time after a long period, the number of tests for HIV and HCV performed on drug users in low-threshold facilities almost doubled.

The number of people arrested or prosecuted for drug-related offences has remained relatively stable in recent years; in 2008 it ranged from 2,296 to 2,322 people, depending on the source. 2,100 people were charged with drug offences, which represents a slight year-on-year increase. Final sentences were passed on 1,360 individuals convicted of drug offences. Traditionally, the highest numbers of people prosecuted for drug-related criminal offences have been reported in the Ústí nad Labem region, followed by the Capital City, Prague, the Moravian-Silesian region, and the South Moravia region. As in the previous years, most of the drug offences were committed in relation to pervitin. The structure of the sentences for drug offences has not changed significantly in the past four years: a suspended prison sentence has been the type most frequently imposed.

Cannabis is the most widely available illegal drug in the Czech Republic. The availability of pervitin is also high in the long term. Traditionally, the highest numbers of seizures were associated with both of these drugs. The domestic production of marijuana with a higher THC content has been on the rise. It is grown in artificial conditions and, with increasing frequency, on a large scale. The volume of the marijuana seized more than tripled in comparison to the previous years, and there was also a significant increase in the number of growing sites detected and cannabis plants seized. The amount of pervitin seized was lower than in the previous years, but the number of pervitin-cooking laboratories detected was the highest in the past six years and the seizures of precursors used to manufacture pervitin also increased in quantity. Since May 2009 restrictions have been imposed on the sale of medicines containing pseudoephedrine by pharmacies. In relation to this measure, an increase in individual imports of these pharmaceutical products from the neighbouring countries has been observed recently. The prices of most drugs continue to be stable, according to the available data. There was a year-on-year increase in the average potency of the cannabis seized and the average purity of the heroin seized.

The Report concludes with three chapters on selected issues, including Cannabis Markets and Production, page 96, Problem Amphetamine and Methamphetamine Use, Related Consequences and Responses, page 102, and Treatment and Care for Older Drug Users, page 115.

In the Czech Republic, as in the rest of the world, cannabis is the most common illicit drug used. In the second half of the 20th century, cannabis was mostly grown and used among closed groups of people in the Czech Republic. A commercial market in cannabis (marijuana and hashish) opened up in the 1990s. At present, the Czech Republic ranks among the European countries with the highest prevalence of cannabis use. According to the majority of the adult population, it is difficult to obtain cannabis, but three quarters of respondents in the 15-24 age group find it easy. The places where cannabis is most frequently obtained in the Czech Republic include bars, restaurants, and clubs. Almost three quarters of the respondents reported that they had last obtained cannabis free of charge. Cannabis was most likely to be obtained from a friend, a relative, or a partner. The dealers tend to consume it themselves and do not usually sell any other drugs. The retail prices of marijuana and hashish remain stable; they are sold at approximately CZK 200 (€ 8) and CZK 250 (€ 10) per gram, respectively. On the occasion of their last sales transaction, three out of four respondents had bought cannabis in a quantity up to 2 grams. The average potency of marijuana shows a slight increase, while that of hashish is in decline. In the Czech Republic, the greatest proportion of cannabis, including that found on the commercial market, comprises indoor-grown marijuana, followed by outdoor-grown marijuana. Most of the cannabis users identified the Czech Republic as the country of origin of the marijuana they had last obtained. In the Czech Republic there are several "grow shops" selling equipment needed for the cultivation of marijuana; seeds for the growing of cannabis plants may be obtained through social networks or via the internet, both from within the country and abroad. The annual number of marijuana seizures ranges from 550 to 600 and there has been an increase in the overall amount of marijuana seized; in 2008 the number of cannabis plants seized rose fourfold on a year-on-year basis. In the past three years, approximately 5% of marijuana seizures and only one hashish seizure involved an amount exceeding 1 kg. Since 2005 the number of large-scale indoor growing sites detected has increased; 79 such facilities were detected in the Czech Republic in 2008.

The objective of the second chapter on a selected issue is to describe the situation concerning the use of amphetamines, i.e. amphetamine and methamphetamine, and the related measures. In the past thirty years, methamphetamine has had a dominant position among problem drug users in the Czech Republic, which makes the Czech situation exceptional within the European context. Therefore, this chapter deals almost exclusively with methamphetamine, which has been traditionally referred to as pervitin in the Czech Republic. It is estimated that there are approximately 20 thousand problem pervitin users in the Czech Republic, which amounts to two thirds of all the problem drug users in this country; 80-90% of those are injecting users. The level of pervitin use in the general population has remained very low over the years, although it has a rising tendency in nightlife settings. Pervitin users comprise the largest group of all the drug users in treatment; from the long-term perspective, they account for approximately 60% of all the cases. Pervitin is often used in combination with other drugs, mostly cannabis, opiates, and alcohol. Long-term pervitin use is associated with psychiatric co-morbidity, involving toxic psychoses especially. The incidence of infections is mainly related to pervitin use by injecting. However, it does not seem to differ significantly from that in (injecting) opiate users, as far as the level of risk is concerned. In the Czech Republic, there

are approximately 10-20 cases of fatal pervitin overdoses annually, which accounts for about one third of fatal overdoses on street drugs (i.e. illicit drugs and inhalants). Pervitin use treatment has long been integrated into the system of drug services. With few exceptions, no pervitin use-specific programmes are provided. There are differences in the provision of certain services: harm reduction organisations have recently conducted programmes featuring the distribution of gelatine capsules intended almost exclusively for pervitin users and, as far as treatment is concerned, variations can be found in its pharmacotherapy. These are determined by a different course of withdrawal and detoxification, different psychological complications, and, in particular, the development of psychotic symptomatology and toxic psychosis. There is sporadic, although long-term, experience with the substitution therapy of pervitin addicts using various psychostimulants, presently mainly methylphenidate. Pervitin is manufactured using ephedrine, pseudoephedrine in particular, which is extracted from over-the-counter medicines. The availability of these medicinal products from pharmacies has been reduced significantly since May 2009 as a result of legal and administrative measures. The number of illegal pervitin manufacturing sites detected by the police rose from 188 in 2003 to 434 in 2008. The estimated annual pervitin consumption in the Czech Republic has maintained a level of about 4 tonnes in recent years; every year, law enforcement agencies seize approximately 5 kg of pervitin in total. The price of pervitin remains stable at CZK 1,000 (€ 40) per 1 g and its purity has been approximately 60% for a long time.

The third selected issue concerns older drug users (for the purpose of this selected issue, an older drug user means any user over 40 years old), both in treatment and outside it, as well as specific services designed for older users. The prognosis announced by the Czech Statistical Office indicates that in 2050 people aged 65 and above will account for 31% of the Czech population. The demographic aging of the population results from the declining birth rate and the rising life expectancy, which are associated with better health care and a higher quality of life. The available data show that the population of drug users is also aging in the Czech Republic. There has been an increase in the average age of people in contact with low-threshold facilities for drug users and the number of older drug users in treatment is also on the rise, although their proportion is still low. In comparison to those of a younger age, drug users aged 40 and above are more likely to be unemployed and homeless, and they also include more individuals with higher education. Nevertheless, the Czech drug policy seems neither to articulate specific measures nor implement them in order to address the issue of the aging of the population of drug users. In the Czech Republic there is only one establishment specialising in services for older users of non-alcohol drugs. The vast majority of the existing programmes deals with older clients' specific problems, encountered in treatment or during the provision of low-threshold or outreach services, on the basis of individual demands and needs.

PART A: NEW DEVELOPMENTS AND TRENDS

1 Drug Policy: legislation, strategies, and economic analysis

In 2008 the Chamber of Deputies of the Czech Parliament passed the bill for a new Penal Code. In early 2009 the bill was adopted by the Senate and included in the Collection of Laws as Act No. 40/2009, Coll. Penal Code, effective from 1 January 2010. The new Penal Code includes significant changes in how to address illegal drugs. In particular, the changes concern the stipulation providing for drug possession for personal use, which is to distinguish drugs according to their social and health risks. In comparison to the previous sentencing guidelines, a lower punishment range will apply to people who possess cannabis in a quantity greater than small; other types of drugs will be covered by stricter sentences. A significant change was also introduced by the new provision concerning the illegal cultivation of plants containing a narcotic or psychotropic substance. The growing of designated plants or mushrooms for personal use will be covered by less strict sentencing guidelines than was the case under the previous legal regulations. In addition, the cultivation of a small quantity of plants or mushrooms for personal use will not be governed by criminal statutes but will be punished under the Misdemeanour Act.

In relation to the act on pharmaceuticals, the National Institute for Drug Control has imposed restrictions on the supply of medicinal products containing up to 30 mg of pseudoephedrine per tablet. This measure involves a ban on mail order sales, the setting of a maximum monthly dose of 60 tablets per patient, and the control of supply by means of the central database of electronic prescriptions.

In 2008, the profession of an addictologist (addiction specialist) was incorporated in the law on non-medical health professions and the professional competencies required for the performance of this profession were defined.

The preparation and enforcement of the national drug policy is the responsibility of the Government of the Czech Republic. Its main initiating, counselling, and coordinating body for drug-related issues is the Government Council for Drug Policy Coordination; the activities of the Council are managed by the Secretariat, an organisational unit of the Office of the Government of the Czech Republic. The Council met four times in 2008.

The National Drug Policy Strategy for the Period 2005 to 2009 and the Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2007 to 2009 are in force.

A draft of the Vision of Outpatient Drug Services was developed and submitted to the professional community for discussion in 2008. The document proposes structural changes in the network of facilities providing outpatient services for substance users.

In 2008, there were regional drug coordinators working in 13 regions (the Moravian-Silesian Region has not established this office). They make use of a network of drug coordinators in individual municipalities with extended competencies in their region. With the exception of the Pilsen region, all regions had drawn up their regional drug policy strategies.

Public expenditure on drug policy reached a level of CZK 597.3 million (€ 23,947 thousand) in 2008. This amount included CZK 371.9 million (€ 14,912 thousand) provided from the state budget, and the regions and municipalities contributed amounts of CZK 162.9 million (€ 6,530 thousand) and CZK 62.5 million (€ 2,505 thousand), respectively. In comparison to 2007, total expenses increased on all three levels by 7%; on the central level, there was a decrease in expenditure on the part of all the ministries and central agencies under scrutiny, with the exception of the Ministries of Defence and of Labour and Social Affairs and the National Drug Headquarters of the Police of the Czech Republic. On the regional level, there was an aggregate year-on-year expenditure increase of approximately one third. An increase was recorded in almost all the regions; only the Zlín and Vysočina regions reported a year-on-year decline. Approximately one third of regional expenditures was used to finance sobering-up stations and the treatment of intoxicated people. The aggregate of funds expended by municipalities was almost the same as in 2007. Out of a total of CZK 597.3 million (€ 23,947 thousand), CZK 152.1 million (€ 6,100 thousand; 25.5%) was spent on law enforcement, CZK 184.5 million (€ 7,399 thousand; 30.9%) on treatment, CZK 159.4 million (€ 6,389 thousand; 26.7%) on harm reduction, CZK 58.4 million (€ 2,340 thousand; 9.8%) on primary prevention, and CZK 24.9 million (€ 999 thousand; 4.2%) on aftercare.

1.1 Legal Framework

1.1.1 Laws, Regulations, Directives, or Guidelines in the Field of Drug Issues

1.1.1.1 Penal Code

Following a protracted procedure¹, a new Penal Code was adopted in 2008. On 11 November 2008, the bill for a new Penal Code was approved by the Chamber of Deputies of the Czech Parliament². Subsequently, it was

¹ The bill for a new penal code was (after spending many years in preparation and being subjected to parliamentary debate for almost two years) rejected by the Parliament of the Czech Republic in February 2006. In December 2007, after being reconsidered by the Government, it was presented to the Parliament again, almost unaltered.

debated and passed, on 8 January 2009, by the Senate³. The new Penal Code was included in the Collection of Laws, under Title 11, on 9 February 2009 as Act. No. 40/2009, Coll., Penal Code. It becomes effective on 1 January 2010.

The drug-related criminal offences, currently provided for by the stipulations of Sections 187 to 188a of Act No. 140/1961 Coll., the Penal Code, as amended, are newly covered by Sections 283 to 287 of the new Penal Code. Definitions of the relevant offences fall under a heading of their own now: Section 283 – Unauthorised production and other handling of narcotic and psychotropic substances and poisons; Section 284 – Possession of a narcotic and psychotropic substance or poison; Section 285 – Unauthorised cultivation of plants containing a narcotic or psychotropic substance; Section 286 – Manufacturing and possession of equipment for the unauthorised production of a narcotic and psychotropic substance or poison, and Section 287 – Promotion of drug use. There is an innovation, the introduction of the definition of an offence under Section 285 – Unauthorised cultivation of plants containing a narcotic or psychotropic substance – which encompasses cannabis, as well as psychotropic mushrooms and other plants, as applicable.

The growing of designated plants or mushrooms for personal use will be covered by less strict sentencing guidelines than was the case under the previous legal regulations. In addition, the cultivation of a small quantity of plants or mushrooms for personal use will not be governed by criminal statutes but will be punished under the Misdemeanour Act. Criminal sanctions for the possession of cannabis for personal use were also mitigated. Furthermore, other drug-related offences are specified in more detail or redefined in the new Penal Code (for more details refer to the 2007 Annual Report⁴).

The stipulations of Section 290 (2) and (3) of the new Penal Code authorise the Government to issue a regulation specifying (1) what substances should be considered poisons in terms of Sections 283, 284, and 286 and what quantities are to be considered greater than small as regards narcotics, psychotropic substances, including products containing them, and poisons, as well as to issue a regulation setting out (2) what plants and mushrooms contain a narcotic or psychotropic substance according to Section 285 and what quantities thereof are to be considered greater than small pursuant to Section 285. As of the closing date of this annual report, drafts of both regulations had been submitted by the Ministry of Justice and included in the Government's agenda. At the moment they are at the stage of an amendment procedure.

1.1.1.2 Changes in the Handling of Medicinal Products Containing Pseudoephedrine

In relation to the new law on pharmaceuticals, i.e. Act No. 378/2007, Coll., effective from 1 January 2008 (for more details see the 2007 Annual Report), changes were made in the handling of medicinal products containing pseudoephedrine. As of 1 May 2009 restrictions were imposed on the supply of medicines containing up to 30 mg of pseudoephedrine per tablet (the sale of which was completely unlimited until the above date). This measure was introduced on the basis of a decision rendered by the State Institute for Drug Control (SUKL) which, according to the stipulations of Section 39 (3) of the Act on Pharmaceuticals, made a change to the marketing authorisation for these medicines and introduced the following measures: (1) a ban on mail order sales; (2) the setting of a maximum monthly dose per patient available without prescription (1,800 mg, i.e. 60 tbl. of 30 mg), and (3) the registration of supplies in the central database of electronic prescriptions. In practice, this implies that, in consideration of the restrictions mentioned above, medicinal products containing pseudoephedrine can only be supplied by pharmacies connected to the central database of electronic prescriptions. If not connected to this database, a pharmacy is allowed to provide medicinal products containing pseudoephedrine on prescription only.

Another change in the approach to pseudoephedrine took place in the first half of 2009. With effect from 1 June 2009, Act No. 167/1998, Coll.,⁵ on addictive substances, was amended. The legal conditions for the handling of products containing ephedrine and pseudoephedrine were tightened up. The restrictive measures prescribed by the law on addictive substances now apply to all products containing pseudoephedrine, not only those containing pseudoephedrine in an amount exceeding 30 mg per drug form unit, as was the case before.

The aforementioned changes are expected to ensure better control of the illicit handling of pseudoephedrine, which is used as a precursor in the production of pervitin in the Czech Republic; see also the chapter on Drug Markets (p. 92) and the chapter on a selected issue, Cannabis Markets and Production (p. 96).

² For more details see the website of the Chamber of Deputies of the Czech Parliament, where you can follow the history of the discussion on Chamber Print No. 410/0 http://www.psp.cz/sqw/historie_sqw?o=5&T=410.

³ For more details about the history of the discussion on Senate Print No. 11 refer to the website of the Senate of the Czech Republic http://www.senat.cz/xqw/xervlet/pssenat/historie?ke_dni=08.01.2009&O=7&action=detail&value=2401.

⁴ In comparison to the original text, changes were made to the numbers identifying the drug-related offences in the newly adopted wording of the Penal Code – in the wording submitted to the Chamber of Deputies, they were numbered as Sections 281-285 and Section 289. The newly adopted Penal Code refers to the relevant stipulations as Sections 283-287 and Section 290. These changes had no impact on the content of the provisions under consideration.

⁵ The amendment was implemented by virtue of Act No. 141/2009, Coll.

1.1.1.3 Incorporation of the Profession of an Addictologist in Legislation

Act No. 96/2004, Coll., (the Act on Non-medical Health Professions) laying down the conditions for the acquisition and recognition of qualifications for the performance of non-medical health professions and the performance of activities associated with the provision of health care, and revising certain related laws, was amended in 2008. By virtue of an amendment, implemented by Act No. 189/2008, Coll., a stipulation under Section 21a, setting out the professional competences required for the performance of the profession of an addictologist, was added to the law on non-medical health professions, together with some other new provisions. According to the above-mentioned stipulation, an addictologist performs activities within the framework of prevention, treatment, and rehabilitation provided as part of the discipline of addictology, i.e. a field of study concerned with the prevention and treatment of drug dependency and other types of addiction. This change provided the legal basis for the profession of an addictologist in relation to the accreditation of a new bachelor's study programme in addictology, which has been provided by the Centre for Addictology of the Psychiatric Clinic, 1st Faculty of Medicine, and General University Hospital, Charles University in Prague (the Centre for Addictology) since the academic year 2005/2006.

1.1.1.4 Changes in Providing Evidence of People Being under the Influence of Alcohol

Act No. 379/2005 Coll., on the measures for protection against harm caused by tobacco products, alcohol, and other addictive substances, was amended in 2008⁶. With effect from 1 January 2009, the stipulations of Section 16 (2) of Act No. 379/2005, Coll., provides that no additional special medical examination (i.e. blood alcohol testing carried out as a standard procedure prior to the amendment) should be conducted after a screening test for alcohol using a breathalyser has been performed. The amended stipulation provides that a specialised medical examination should only be carried out if a person refuses to undergo a screening test (for more details about the current application of this provision see the following chapter Implementation of Laws).

1.1.2 Implementation of Laws

In relation to the amendment to the law governing the process of proving that a person is under the influence of alcohol (see above), judicial practice shows certain differences in the application of this regulation in cases when a person under the influence of alcohol commits a crime (mostly traffic-related offences in this respect). Information provided by the Czech News Agency suggests that many courts find evidence based on a screening test for alcohol insufficient for the purpose of criminal proceedings. (Criminal court proceedings follow the principle of discretionary consideration of evidence and are conducted in accordance with the criminal code and the criminal procedure rules. Thus, it is up to a specific judge to determine what degree of significance is attributed to the individual items of evidence for the purpose of their decision). In this respect, it is necessary to wait until judicial practice becomes consistent in relation to such cases, which could be facilitated by the Supreme Court's analysis of this issue on the basis of cases that have already been decided.

No case law decisions which would significantly change the respective judicial decision making have been made in relation to the issue of drug-related criminal offences.

Criminal activities associated with drug use are covered in more detail in the chapter on Drug-related Crime, page 81.

1.2 National Action Plan, Strategy, Evaluation, and Coordination

1.2.1 National Action Plan and/or Strategy

The year 2008 was the fourth year of the implementation of the National Drug Policy Strategy for the Period 2005 to 2009 (the 2005-2009 National Strategy). The implementation of the strategy is facilitated by two action plans developed for the periods 2005-2006 and 2007-2009; for more information see the 2004 and 2007 annual reports.

1.2.2 Implementation and Evaluation of National Action Plan and/or Strategy

At its meetings in 2008, the Government Council for Drug Policy Coordination (GCDPC) discussed, on two occasions (in April and June), the interim evaluation of the application of the Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2007 to 2009 (the 2007-2009 Action Plan) in order to review the fulfilment of tasks. Out of the total number of 171 tasks, 15 (9%) were found to have been completed by the set deadline, 18 (11%) had been partly completed, 9 (5%) had not been accomplished, and 59 tasks (35%) were in process or still being worked on. No information was provided on the remaining 70 tasks (41%).

In view of the fact that the effective period of the 2005-2009 National Strategy is to expire soon, at its meeting held in June 2009, the GCDPC approved a plan for the evaluation of the Strategy and the related 2007-2009 Action Plan (Resolution No. 03/0609). The evaluation should cover the following areas:

- the interrelationship between the Action Plan and the Strategy and the Action Plan's internal structure;
- the implementation and fulfilment status of the activities set out in the action plans and outcomes resulting from their application;

⁶ The amendment was implemented by virtue of Act No. 274/2008, Coll.

- the implementation process and identification of the causes of both successes and shortcomings, as well as the factors limiting the implementation of the 2007-2009 Action Plan, and
- the degree of accomplishment of the objectives set in the Strategy on the basis of the relationship between the Strategy and the drug situation, i.e. the assessment of trends shown by measurable indicators according to the individual objectives of the 2005-2009 National Strategy.

The evaluation process will have been completed by the end of 2009. First and foremost, it will involve an internal evaluation which will be carried out by the entities responsible for the implementation of the Strategy and the Action Plans. The evaluation will also serve as the basis for the development of a new strategy for the period starting in 2010.

1.2.3 Other Drug Policy Developments

An interim evaluation of the Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2007-2009 was carried out in 2008; see also the chapter on Responses to Drug-related Health Issues in Prisons, page 89. It features 26 main tasks which determine other sub-tasks. The sub-tasks include 57 tasks from the 2005-2006 and 2007-2009 national action plans and an additional 45 tasks set out by the Prison Service. The evaluation concerned the 2008 tasks. Out of 102 sub-tasks, 32 were accomplished, 2 were completed in part, 3 were not completed, and 65 tasks were in process or still being worked on (Vězeňská služba České republiky, 2009).

A draft of the Vision of Outpatient Drug Services was developed and submitted to the professional community for discussion in 2008; for more details see the chapter Legislative Framework of Services for Drug Users, page 32, which also provides additional information on the scope of the treatment system.

1.2.4 Coordination Arrangements

1.2.4.1 Coordination at the National Level

The Government Council for Drug Policy Coordination (GCDPC) is the main coordinating body of the Government for issues related to drug policy. The Council met four times in 2008.

A working group on Drug Use Prevention and Harm Reduction at Dance Parties was established in January 2008; for more details see the 2007 Annual Report.

In October 2008, by virtue of its Resolution No. 06/1008, the GCDPC approved the establishment of the Methamphetamine Working Group, an inter-agency multidisciplinary body which, building on the operation and outcomes of the working group concerned with a reduction in the availability of medicinal products used for the illicit production of methamphetamine, working from 2007 to 2008 under the Ministry of Health, will address the issue of methamphetamine in the Czech Republic comprehensively and on a long-term basis. The working group's major areas of interest will include the availability of precursors for the production of pervitin, the assessment of the impact and efficiency of measures adopted so as to reduce access to precursors for the illicit production of pervitin (see also the chapter on Legal Framework, p. 5), the monitoring of trends in the availability of medicinal products containing pseudoephedrine, the monitoring of the availability of other precursors of drugs and substances used for the illicit production of pervitin (such as ephedrine, toluene, iodine, red phosphorus, phosphoric acid, and hydroiodic acid), the study of the effectiveness of harm reduction and treatment interventions of various types in relation to pervitin users, and the assessment of the risks which the illegal production of pervitin may pose for the health of the people inside the houses where such activities are pursued and in terms of the contamination of the environment in general.

As of June 2009, the GCDPC can use the expertise of a total of 5 committees and 4 working groups⁷ – see Table 1-1.

Table 1-1: GCDPC's advisory bodies as of June 2009

GCDPC's committees	GCDPC's working groups
GCDPC's Committee of Departmental and Institutional Representatives	Working Group on EU Collaboration – Ministerial Coordination Group
Certification Committee	GCDPC's Working Group for Non-Substance Addiction
GCDPC's Funding Committee for the Provision of Special-Purpose Subsidies from the National Budget	Working Group for Drug Use Prevention and Harm Reduction at Dance Parties
Committee of Regional Representatives	Methamphetamine Working Group
GCDPC Advisory Committee for Drug-related Data Collection	

⁷ In addition, the National Focal Point coordinates the activities of 7 working groups operating in various areas involving drug data collection.

1.2.4.2 Coordination at the Local Level

As far as the coordination of drug policy at the local level is concerned, no major changes have occurred in comparison to the previous year. As in 2007, all 14 regions, with the exception of Moravia-Silesia, have established the office of regional drug coordinator and all the regions have developed strategic documents providing for their regional drug policies (including strategies, strategic plans, and action plans setting specific tasks and deadlines for their completion). Almost all the regions have established drug commissions, often as advisory bodies to the mayor/governor, or their deputies, or the regional council; in some regions, drug policy is in the remit of advisory bodies covering a wider range of issues (such as social and health affairs and negative social phenomena, including crime prevention). The commissions are complemented by a varying number of working groups in most of the regions; for more details see the 2007 Annual Report.

The authorities of the municipalities with extended competencies provide drug policy coordination through local drug coordinators. They have been appointed in 196 out of a total of 205 municipalities with extended competencies and in all twenty-two Prague city districts.

The list of regional and local coordinators, including contacts, can be accessed via the Help Map application at drogy-info.cz.

1.2.4.3 Czech Presidency of the EU Council

In the first half of 2009, the Czech Republic held the presidency of the European Union (EU). In relation to that, the GCDPC considered a number of documents pertaining to the preparation and the course of the presidency of the Horizontal Drugs Group (HDG), a working group of the Council of the European Union. In 2008, the GCDPC adopted the EU Council Presidency Drug Policy Framework Document (Resolution No. 06/0408) and the priorities of the presidency in terms of drug policy (Resolution No. 05/0408), including:

- further development of the process of discussion, approval, and implementation of the EU Drugs Action Plan for 2009-2012;
- an integrated standpoint of the EU countries in the UN Commission on Narcotic Drugs, including a ministerial conference on the fulfilment of the conclusions of the 20th UN General Assembly Special Session (UNGASS) held in 1998;
- the topic of migration, integration, and drugs;
- the issue of methamphetamine production and use, and
- the effective coordination of liaison with third countries.

A session of the High-Level Segment of the UN Commission on Narcotic Drugs (CND) took place in Vienna in March 2009. The event adopted significant documents concerning the international coordination of drug policy, including the Political Declaration and the Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. A 10-year review of the conclusions of the 1998 UNGASS was also on the agenda. The EU's standpoint and the standpoints of the individual member states were coordinated by the Czech Republic as the presiding country.

Another significant outcome of the Czech presidency was a proposal made for the Council Conclusions concerning illicit drug supply reduction indicators, which was approved by the Justice and Home Affairs Council of the EU in June 2009.

1.3 Economic Analysis

1.3.1 Public Expenditures

In 2008, drug policy was funded in a method similar to that used in the previous years. This chapter summarises data on special-purpose, labelled, expenditures from the state and local (regional and municipal) budgets which were earmarked for the funding of drug policy (i.e. the direct cost of drug policy incurred by the state and local budgets). These are actual 2008 expenditures, stripped of transfers to the reserve fund and the amounts which were not utilised but returned by service providers to public budgets. The capital (investment) expenditures are indicated separately.

On the central level, the data were obtained from the national final accounts of selected ministries whose budgets include a drug policy programme. Additional information was obtained directly from the representatives or contact persons of individual ministries and public institutions, as well as from regional drug coordinators.

2008 expenditures from the state budget amounted to a total of CZK 371.9 million (€ 14,912 thousand)⁸; the trends of ministries and institutions from 2002 to 2008 are summarised in Table 1-2.

The subsidies approved by the GCDPC are provided by the Office of the Government of the Czech Republic. In 2008 such subsidies were used to support 154 projects to the tune of a total amount of CZK 95.3 million (€ 3,821

⁸ 2008 average exchange rate was used (1€ = CZK 24.942).

thousand). The resources were utilised for projects delivering prevention, harm reduction, treatment, and aftercare. The expenditure designated for the activities developed by the Secretariat of the GCDPC, including the National Focal Point, amounted to CZK 4.7 million (€ 188 thousand) and was predominantly allocated to monitoring and research, publication and information activities, the administration of the GCDPC's subsidy proceedings, and the implementation of the system of the certification of the professional competence of drug services.

According to the final national accounts, the Ministry of Education, Youth, and Physical Education (the Ministry of Education) spent a total of CZK 12.4 million (€ 499 thousand) on drug policy in 2008. The resources provided by the Ministry of Education concerned prevention. Subsidy proceedings involved three programmes: Programme I covered schools and educational facilities by means of subsidies to regions (CZK 7.4 million (€ 297 thousand) was distributed in this way in 2008), Programme II was intended for national and regional projects implemented mostly by NGOs, and Programme III addressed educational facilities for young people in institutional care and educational establishments for preventive care.

The resources from the budget of the Ministry of Defence spent on drug policy in 2008 amounted to CZK 5.3 million (€ 212 thousand). This money was mainly used to purchase diagnostic equipment for the detection of drugs and professional literature and to organise lectures and seminars.

Since 2007 the budget of the Ministry of Labour and Social Affairs has not included any expenses earmarked for the Drug Policy Programme. However, it provides financial support for social services for people at risk from drugs or dependent on them. In 2008 subsidies to the tune of CZK 79.5 million (€ 3,186 thousand) were spent on the operation of outreach centres (CZK 28.9 million; € 1,161 thousand) and therapeutic communities (CZK 23.1 million; € 926 thousand), the operation of streetwork programmes (CZK 16.2 million; € 648 thousand), social counselling (CZK 5.3 million; € 212 thousand), social rehabilitation (CZK 4.9 million; € 197 thousand), and other programmes⁹.

In 2008 the Ministry of Health provided a total amount of CZK 18.9 million (€ 757 thousand) for drug policy, including capital expenditure of CZK 3.9 million (€ 155 thousand). Priority was given to the funding of projects ensuring both outpatient and inpatient addiction treatment, substitution treatment, detoxification, and the operation of outreach centres and streetwork programmes (in particular, to cover the cost of medical supplies).

In 2008 the Ministry of Justice provided CZK 7.4 million (€ 296 thousand) for the drug policy. Subsidies amounting to a total of CZK 0.6 million (€ 24 thousand) were granted to NGOs working with drug users in prison. The Judicial Academy used CZK 0.2 million (€ 8 thousand) to host seminars and the Institute for Criminology spent CZK 49.9 thousand (€ 2,000 thousand) on participation in conferences. The largest sum (CZK 6.5 million; € 261 thousand) was earmarked for the Prison Service. These resources were used to train prison staff in dealing with drug-dependent inmates, to detect and monitor drugs in prisons, and to operate prison-based counselling and treatment programmes.

The budget of the General Customs Headquarters allows for the Drug Policy Programme. These funds, accounting for CZK 10.7 million (€ 427 thousand) in 2008, were primarily used for the refurbishment of stock (purchase of means of transport and special investigative equipment and technology).

The budget of the Ministry of the Interior does not account for any expenditure on the Drug Policy Programme¹⁰. However, this ministry is responsible for the National Drug Headquarters of the Criminal Police and Investigation Service of the Police of the Czech Republic (National Drug Headquarters), whose expenses reached a total of CZK 137.8 million (€ 5,527 thousand) in 2008, including (investment) capital expenditure of CZK 9.5 million (€ 380 thousand).

⁹ The expenditures on the part of the Ministry of Labour and Social Affairs do not include subsidies for special-regimen homes providing services for older clients dependent on alcohol.

¹⁰ The Ministry of the Interior coordinates and funds crime prevention activities which are not specifically targeted at drug issues; for more details see the chapter on Prevention of Drug-Related Crime, page 86.

Table 1-2: Drug policy expenditures from Czech state budget in 2002–2008 by ministries/departments (€ thousand)

Allocation	2002	2003	2004	2005	2006	2007	2008
GCDPC	2,886	3,261	3,153	3,547	3,838	3,762	4,008
Ministry of Education	299	293	316	315	381	452	499
Ministry of Defence	125	147	109	133	172	129	212
Ministry of Labour and Social Affairs	1,104	1,391	1,323	1,546	1,753	2,054	3,186
Ministry of Health	808	692	829	1,124	635	801	757
Ministry of Justice	302	442	427	1,233	1,455	454	296
General Customs Headquarters	863	708	292	487	829	963	427
National Drug Headquarters	n.a.	3,022	2,711	3,189	3,757	4,601	5,527
Total	6,387	9,957	9,161	11,574	12,821	13,217	14,912

NB: Average exchange rates in respective years were used for re-calculation of expenses from CZK to €.

In addition to the state budget, the drug policy in the Czech Republic is also funded by local budgets, i.e. those of regions and municipalities¹¹. In 2008 regions and municipalities provided CZK 162.9 million (€ 6,530 thousand) and CZK 62.5 million (€ 2,505 thousand) respectively for this field. The funds provided by regions and municipalities in 2008 and the trends since 2002 are indicated in Table 1-3 to Table 1-7.

Table 1-3: Drug policy expenditures from Czech regional budgets in 2002-2008 (€ thousand)

Regions	2002	2003	2004	2005	2006	2007	2008
Prague	399	391	820	1,029	1,147	1,463	2,006
Central Bohemia	114	251	432	495	505	625	713
South Bohemia	95	88	181	175	212	223	408
Pilsen	0	31	47	113	82	65	256
Karlovy Vary	3	16	16	35	29	41	53
Ústí nad Labem	47	237	248	232	242	174	203
Liberec	0	86	181	271	285	233	459
Hradec Králové	24	30	63	69	102	244	277
Pardubice	49	47	56	185	58	198	224
Vysočina	0	57	129	233	109	285	157
South Moravia	97	63	157	249	300	306	341
Olomouc	3	10	41	67	72	90	334
Zlín	36	110	75	71	49	170	178
Moravia-Silesia	74	94	112	147	157	505	921
Total	952	1,510	2,558	3,369	3,349	4,624	6,530

A summary of 2008 drug policy expenditures from the state, regional, and municipal budgets is provided in Table 1-6; the data are divided into regions according to the locations where subsidies were utilised by the providers of the projects and programmes. The total sum of labelled expenditures in 2008 amounted to CZK 597.3 million (€ 23,947 thousand), which is a 7% year-on-year increase¹². The 2008 drug policy expenditures from the state and local budgets designated for use on regional levels are depicted by regions in Map 1-1.

The developments in drug policy expenditure on drug demand reduction (i.e. prevention, harm reduction, treatment, aftercare, coordination, and research) and drug supply reduction (law enforcement) in the Czech Republic in 2002-2008 are summarised in Table 1-4. Until 2006 the expenditure on demand reduction included resources expended by: the GCDPC; the Ministry of Education, Youth, and Physical Education; the Ministry of Defence; the Ministry of

¹¹ The data on regional and municipal expenditure are based on the annual reports of drug policy implementation in regions and/or the specifying information requested from regional drug coordinators.

¹² All expenditures and its variations are indicated in nominal values.

Labour and Social Affairs, and the Ministry of Health, while expenditure on supply reduction included resources consumed by the Ministry of Justice, the General Customs Headquarters, and the National Drug Headquarters. Since 2007 the data have been more accurate, and the Ministry of Justice's expenditures have been divided into the two areas to reflect their actual purpose. As a result, the consistency of the data over time is impaired.

An overview of expenditures from state and local budgets in 2008 by service category is provided in Table 1-7. The first category is "primary prevention". The "harm reduction" category includes outreach centres, low-threshold day centres, and streetwork programmes. The "treatment" category encompasses medical care (substitution programmes, detoxification, outpatient and inpatient alcohol/drug treatment services, and social services provided in institutional care), non-medical outpatient care (crisis intervention, social counselling, and outpatient treatment provided by NGOs), and therapeutic communities, and a new separate category has been created for sobering-up stations. Other categories include "aftercare", "law enforcement", "coordination" (covering coordination, as well as monitoring and research, the evaluation of services, information, and training), and "others". Out of labelled 2008 drug policy expenditures amounting to a total of CZK 597.3 million (€ 23,947 thousand), CZK 184.5 million (€ 7,399 thousand) was earmarked for treatment (20% more than in 2007, although one third of the sum was dedicated to the operation of sobering-up stations), CZK 152.1 million (€ 6,100 thousand) was reserved for law enforcement (5% less than in 2007), CZK 159.4 million (€ 6,389 thousand) was allocated to harm reduction services (13% more), CZK 58.4 million (€ 2,340 thousand) to primary prevention (20% more), and CZK 24.9 million (€ 999 thousand) to aftercare (an increase by 21%). A comparison of expenditures from public budgets in 2007 and 2008, by service category, is provided in Table 1-5.

Map 1-1: 2008 drug policy expenditures from state and local budgets in regions of the Czech Republic (€ per 100,000 inhabitants)

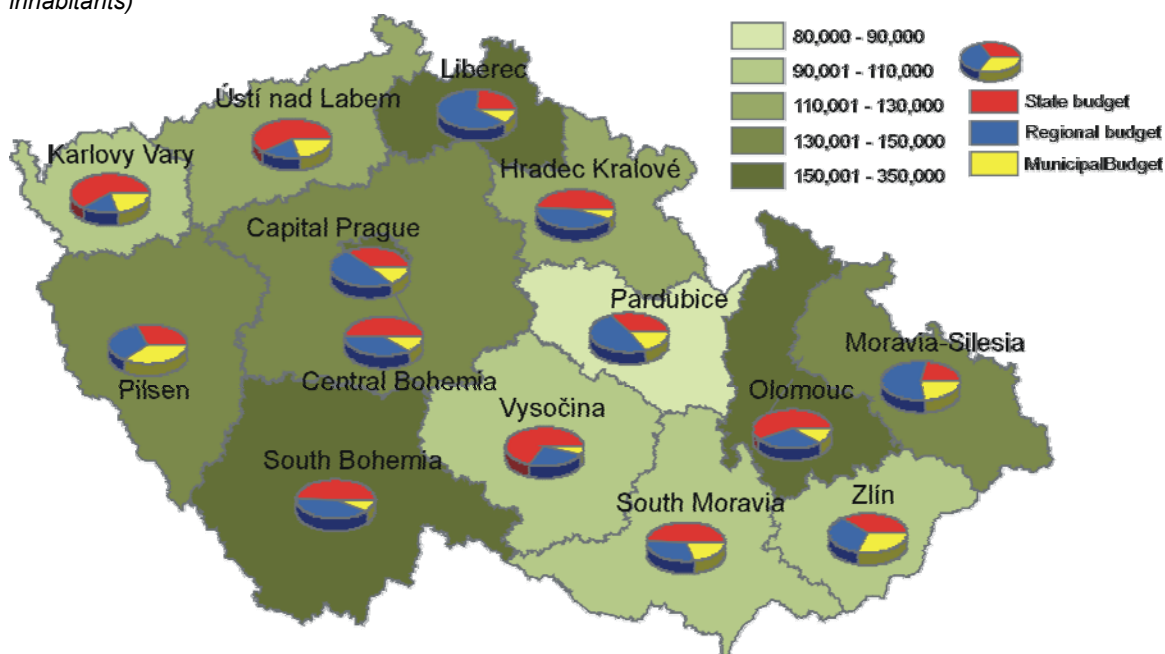


Table 1-4: Drug policy expenditures from state and local budgets in 2002-2008 (€ thousand)

Year	Demand reduction*				Supply reduction**		Total
	State budget	Regional budgets	Municipal budgets	Total	State budget		
2002***	5,397	952	n.a.	6,349	1,204		7,553
2003	5,785	1,510	n.a.	7,295	4,172		11,467
2004	5,731	2,558	1,972	10,261	3,430		13,691
2005	6,666	3,369	1,699	11,733	4,909		16,642
2006	6,780	3,349	1,699	11,828	6,041		17,869
2007	7,425	4,624	2,243	14,292	5,792		20,084
2008	8,812	6,530	2,505	17,847	6,100		23,947

NB: * Expenditures indicated for the period 2002-2006 are those of the GCDPC, the Ministry of Health, the Ministry of Labour and Social Affairs, the Ministry of Education, and the Ministry of Defence; since 2007 a part of the Ministry of Justice's expenditures has also been included; ** The amounts indicated for the period 2002-2006 represent the expenditures for the operation of the National Drug Headquarters and the General Customs Headquarters and those from the budget of the Ministry of Justice; since 2007 the expenditures on the part of the Ministry of Justice have been divided into those intended for demand reduction and those intended for supply reduction in order to reflect their actual purposes; *** Expenditures of the National Drug Headquarters are not included.

Table 1-5: Comparison of expenditures provided from public budgets by service category in 2007 and 2008

Category	2007		2008	
	€ thousand	%	€ thousand	%
Primary prevention	1,753	8.7	2,340	9.8
Harm reduction	5,078	25.3	6,389	26.7
Treatment	5,496	27.4	7,399	30.9
Aftercare	739	3.7	999	4.2
Coordination, research, evaluation	605	3.0	504	2.1
Law enforcement	5,792	28.8	6,100	25.5
Others, unspecified	620	3.1	217	0.9
Total	20,084	100.0	23,947	100.0

The selected issue of Drug-Related Public Expenditures included in the 2006 Annual Report provided estimates of both labelled (specifically earmarked) and non-labelled expenditures spent on the reduction of both drug supply (law enforcement) and demand (prevention and treatment, including expenses incurred by health insurers).

1.3.2 Social Costs

The most recent data regarding the social costs of drug use (including indirect costs) in the Czech Republic (Zábranský et al., 2001) were published in the 2002 Annual Report.

Supported by the internal grant agency of the Ministry of Health, in 2009 the Centre for Addictology began carrying out a study of the 2007 social costs of the use of alcohol, tobacco, and illicit drugs in the Czech Republic; the results will be available in 2012.

Table 1-6: 2008 drug policy expenditures from state and local budgets by location (region) of use (€ thousand)

Regions	GCDPC	Ministry of Education	Ministry of Defence	Ministry of Labour and Social Affairs	Ministry of Health	Ministry of Justice	General Customs Head-quarters	National Drug Head-quarters	Total state budget	Regions	Municipalities	Total local budgets	Total	Total (%)
Prague	929	72	–	316	260	–	–	–	1,577	2,006	557	2,563	4,140	17.3
Central Bohemia	124	47	–	620	114	–	–	–	906	713	196	909	1,815	7.6
South Bohemia	190	35	–	168	87	–	–	–	480	408	78	486	966	4.0
Pilsen	177	16	–	65	6	–	–	–	264	256	310	566	830	3.5
Karlovy Vary	102	19	–	37	14	–	–	–	171	53	57	110	282	1.2
Ústí nad Labem	292	21	–	189	79	–	–	–	581	203	208	411	992	4.1
Liberec	57	13	–	96	0	–	–	–	166	459	66	525	692	2.9
Hradec Králové	85	16	–	144	62	–	–	–	307	277	42	320	626	2.6
Pardubice	68	15	–	66	10	–	–	–	159	224	73	296	455	1.9
Vysočina	103	16	–	231	13	–	–	–	363	157	26	183	546	2.3
South Moravia	259	66	–	200	39	–	–	–	564	341	231	572	1,136	4.7
Olomouc	263	36	–	245	20	–	–	–	563	334	98	433	996	4.2
Zlín	103	19	–	104	6	–	–	–	232	178	179	356	589	2.5
Moravia-Silesia	160	37	–	162	2	–	–	–	361	921	383	1,304	1,665	7.0
Expenditure with regional designation	2,911	428	–	2,643	712	–	–	–	6,695	6,530	2,505	9,035	15,730	65.7
Expenditure with central designation	1,097	71	212	543	45	296	427	5,527	8,217	–	–	–	8,217	34.3
Total	4,008	499	212	3,186	757	296	427	5,527	14,912	6,530	2,505	9,035	23,947	100.0
– including investment expenditure	0	0	0	0	155	0	427	380	962	0	0	0	962	4.0
Total (%)	16.7	2.1	0.9	13.3	3.2	1.2	1.8	23.1	62.3	27.3	10.5	37.7	100.0	–

NB: For explanation of acronyms used in the table refer to the Abbreviations section below.

Table 1-7: 2008 drug policy expenditures in the Czech Republic by service categories (€ thousand)

Service category	GCDPC	Ministry of Education	Ministry of Defence	Ministry of Labour and Social Affairs	Ministry of Health	Ministry of Justice	General Customs Headquarters	National Drug Headquarters	Total state budget	Regions	Municipalities	Total local budgets	Total	Total (%)
Primary prevention	217	471	212	–	–	–	–	–	900	658	782	1,440	2,340	9.8
Harm Reduction	Low-threshold centres	1,103	–	–	1,161	106	–	–	2,370	859	564	1,423	3,793	15.8
	Outreach programmes	621	–	–	648	53	–	–	1,322	564	378	941	2,263	9.5
	Unspecified*	228	–	–	–	–	–	–	228	69	36	105	333	1.4
	Total	1,952	–	–	1,808	159	–	–	3,920	1,491	978	2,469	6,389	26.7
Treatment	Medical care**	81	–	–	43	554	15	–	693	482	177	658	1,352	5.6
	Non-medical outpatient care***	265	–	–	212	–	72	–	549	280	148	428	977	4.1
	Communities	865	–	–	926	–	–	–	1,791	555	215	770	2,561	10.7
	Sobering-up stations	–	–	–	–	–	–	–	0	2,509	0	2,509	2,509	10.5
	Unspecified	–	–	–	–	–	–	–	0	0	0	0	0	0.0
	Total	1,211	–	–	1,181	554	87	–	–	3,033	3,826	539	4,366	7,399
Aftercare	374	–	–	197	–	–	–	–	571	308	120	428	999	4.2
Coordination, research, evaluation	253	–	–	–	22	63	–	–	338	158	7	166	504	2.1
Law enforcement	–	–	–	–	–	146	427	5,527	6,100	0	0	0	6,100	25.5
Others, unspecified	–	28	–	–	22	–	–	–	50	88	79	167	217	0.9
Total	4,008	499	212	3,186	757	296	427	5,527	14,912	6,530	2,505	9,035	23,947	100.0

NB: * These projects include the activities of both low-threshold facilities and outreach work (streetwork). ** i.e., for example, outpatient and inpatient drug treatment, including substitution therapy, detox, and social services provided as part of institutional health care. *** i.e., for example, outpatient and intensive outpatient non-medical programmes, crisis intervention, social counselling, social rehabilitation, and prison-based programmes delivered by NGOs.

2 Drug Use in the General Population and Specific Targeted Groups

Two surveys covering the population over 15 years of age were conducted in the Czech Republic in 2008: a general population survey on psychotropic substance use and the European Core Health Interview Survey. Both studies show dramatic differences in the methodology used, as well as in the prevalence rates found. According to the survey focusing specifically on drugs (working with a sample of people aged 15-64), 37% of the population have had at least one experience with the use of any of the illicit drugs under study; 34% have used cannabis and 17% of the population has had experience with other drugs than cannabis. In the past year and the past month, cannabis had been used by 15% and 9% of the respondents respectively. The survey focusing on the health of the population (using a sample of people over 15 years of age) showed that 15% had used an illicit drug at least once; cannabis had also been used by 15%, while any other drug than cannabis had been used by 4% of the respondents. Both surveys suggest, however, that the proportion of people in the population who have experience of the use of illicit drugs is on the rise, with cannabis use showing the greatest increase. While in 2002 and 2004 at least one experience with cannabis was reported by one fifth of adult respondents, the 2008 study on illicit drug use recorded positive answers to this question from one third of the respondents. A rising trend in cannabis consumption is also supported by surveys studying the population's health in general, although the prevalence rates reported by them are lower.

The general population survey on the use of psychotropic substances focused on the degree of risky cannabis use. Out of the respondents who had used cannabis in the past year, 26% were identified as moderate-risk users and 12% were assigned to the high-risk category. Men and people aged 25-34 comprise the most vulnerable group. After extrapolation to the Czech population in its entirety, the number of heavy cannabis users at significant risk may be estimated to amount to 150 thousand, with people in the 15-29 age group accounting for approximately two thirds of them.

An international report from the ESPAD school survey was published in 2008. It indicates that, within the European context, the Czech Republic ranks among the countries with the highest prevalence of use of most of the drugs under scrutiny, excluding inhalants. As far as cannabis use is concerned, the Czech Republic's prevalence rates are by far the highest in Europe; lifetime cannabis use has been reported by 45% of 16-year-old Czechs.

Cannabis and ecstasy remain the most popular non-alcohol drugs in the nightlife setting.

2.1 Drug Use in the General Population

Two general population studies were carried out in 2008. A monothematic general population survey on the use of psychotropic substances in the Czech Republic (CS 2008) was conducted by the National Focal Point in association with INRES-SONES and the Centre for Addictology. A set of items concerning experience with alcohol, cigarettes, and illegal drugs was also included in the questionnaire used for the European Core Health Interview Survey, carried out by the Institute of Health Information and Statistics in the Czech Republic.

2.1.1 General Population Survey on the Use of Psychotropic Substances

The principal objective of the general population survey focusing on the use of psychotropic substances was to describe the current situation and trends in drug use and compare them to the data generated by the previous general population survey conducted in 2004. The questionnaire included a set of items from the European Model Questionnaire (EMQ) enquiring about the prevalence and frequency of illicit drug use within three time spans (lifetime, the past 12 months, and the past 30 days), the CAST (Cannabis Abuse Screening Test) module addressing heavy cannabis consumption, and modules measuring the availability of illicit drugs and involvement in the cannabis market. The data were collected in October 2008 using a representative sample of 4,200 respondents aged 15-64, enlarged with 300 individuals in the 15-29 age range. The data were weighted to account for the gender, age, and regional structure of the Czech Republic's population.

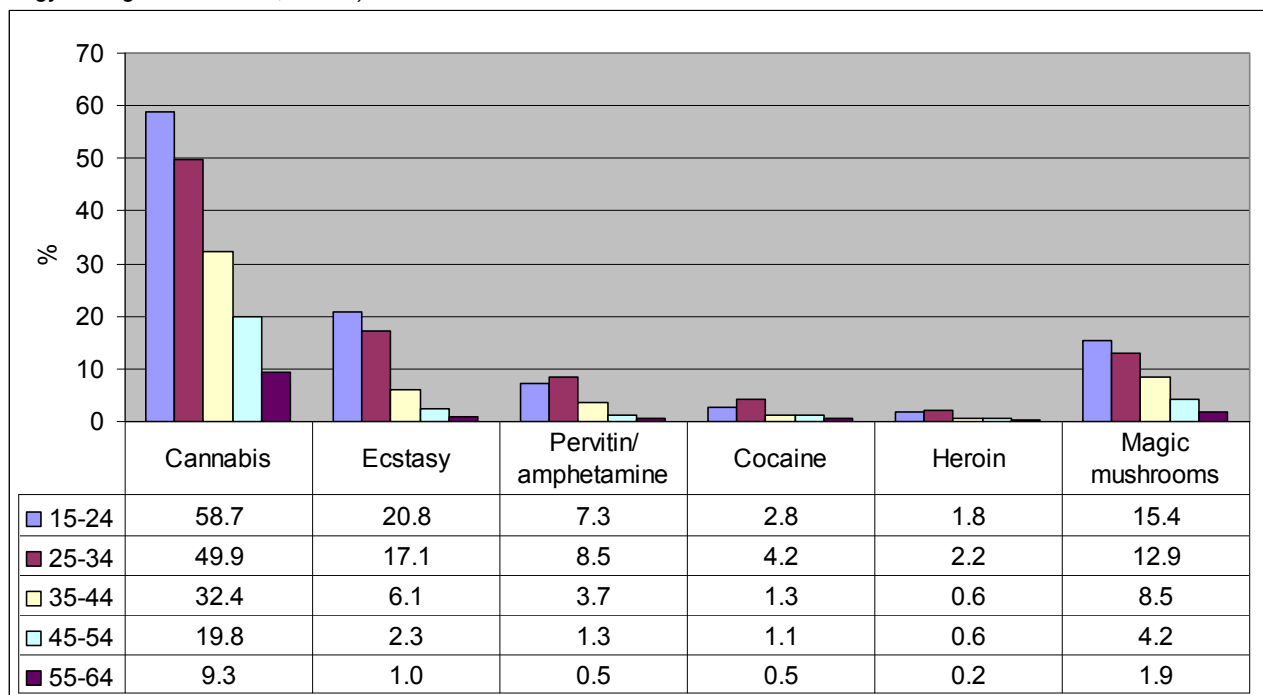
The results of the survey show that 37% (45% of men and 28% of women) of the population have had at least one experience with the use of any of the illegal drugs under study; see Table 2-1. Cannabis was represented to the greatest degree (34%), while other drugs had been used by 17% of the population over 15 years of age. One out of ten Czechs reported the lifetime use of ecstasy; magic mushrooms (psilocybin), LSD, pervitin, cocaine, and heroin had been used by 9%, 6%, 4%, 2%, and 1% of the population respectively. During the past year an illicit drug had been used by 17% of the respondents (15% accounted for by cannabis, 4% ecstasy). Cannabis was also the most frequently used drug within the past month; 9% of the respondents reported having used the drug.

Table 2-1: Prevalence of substance use among the population aged 15-64 (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d)

Drug	Lifetime (%)			12 months (%)			30 days (%)		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Any illicit drug	45.0	27.8	36.5	22.2	11.6	17.0	13.5	5.1	9.3
Any illicit drug other than cannabis	21.3	11.6	16.5	9.8	4.7	7.3	4.1	1.7	2.9
Cannabis (marijuana and hashish)	42.5	26.0	34.3	20.1	10.1	15.2	12.4	4.6	8.5
Ecstasy	11.9	7.3	9.6	4.8	2.6	3.6	1.5	0.9	1.2
Pervitin (or amphetamine)	5.7	3.0	4.3	2.3	1.0	1.7	0.9	0.5	0.7
Cocaine	2.8	1.2	2.0	1.2	0.3	0.7	0.6	0.1	0.4
Heroin	1.7	0.5	1.1	0.7	0.2	0.4	0.3	0.0	0.1
LSD	7.8	3.4	5.6	2.8	1.4	2.1	0.9	0.6	0.7
Magic mushrooms	12.4	5.0	8.7	4.4	1.7	3.1	1.8	0.4	1.1

The use of illicit drugs – with the exception of the use of pervitin, cocaine, and heroin - is the most common among the youngest age group, 15-24 years old. With increasing age, the proportion of people who had tried illicit drugs decreases; see Figure 2-1. In the age group up to 24 years, experience with cannabis, ecstasy, hallucinogenic mushrooms, LSD, and pervitin was reported by 59%, 21%, 15%, 11%, and 7% of the respondents respectively. The highest lifetime prevalence rates of cocaine, heroin, and pervitin were recorded among the 25-34 age group; experience with pervitin, cocaine, and heroin was reported by 9%, 4%, and 2% of the respondents respectively.

Figure 2-1: Lifetime prevalence of use of selected illicit drugs by age groups (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d)



The level of risk cannabis use in the population was measured by means of the CAST scale, consisting of six items enquiring whether a respondent had ever: (1) used cannabis alone or (2) before midday; (3) had memory problems as a result of cannabis use; (4) been told by friends or family members to stop or reduce their consumption of cannabis; (5) tried to stop or reduce their cannabis use without success, and (6) had problems (at school, for example) because of their use of cannabis. When transformed and added up, all six variables constitute the CAST scale with values ranging from 0 to 6, where one point or none means a low risk, 2 to 3 points imply a moderate risk, and 4 or more points suggest high-risk cannabis use requiring professional intervention (Beck and Legleye, 2008). In the 2008 study, cannabis consumption posed a moderate risk for 26% and a high risk for 12% of the respondents who had used it in the past year. Males and people in the age range from 25 to 34 years old comprise a particularly vulnerable group in this sense; for more details see Table 2-2. The results for the 55+ age group may be affected by the very small number of users belonging to this category.

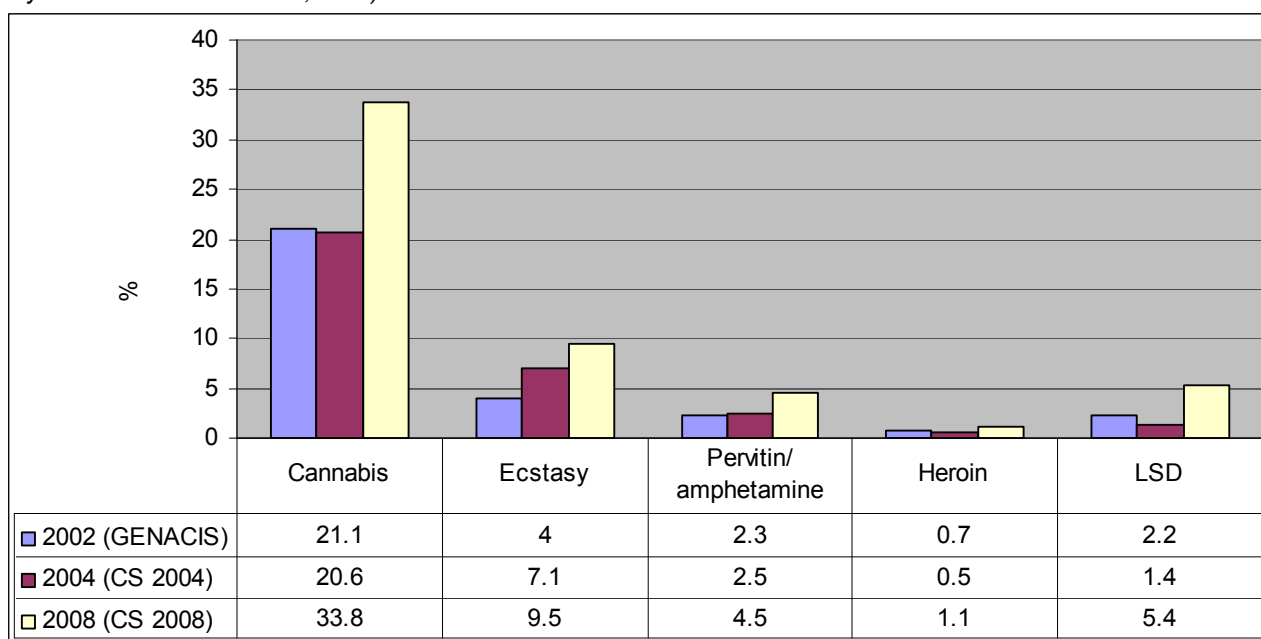
It is estimated that 1.9% of people aged 15-64 are exposed to high-risk cannabis use. When extrapolated to the entire population of the Czech Republic, the number of “problematic” cannabis users may be estimated at approximately 150 thousand, with people in the 15-29 age group accounting for two thirds of this figure.

Table 2-2: CAST scale results, by gender and age, for people who had used cannabis during the past 12 months (%)

Level of risk	Gender (%)		Age (%)						Total (%)
	Males	Females	15-17	18-24	25-34	35-44	45-54	55-64	
No or low risk	56.4	73.5	71.8	59.3	55.1	67.1	82.5	68.4	62.1
Moderate risk	30.0	17.1	24.4	27.3	30.6	19.7	12.5	10.5	25.7
High risk	13.6	9.5	3.8	13.4	14.4	13.2	5.0	21.1	12.2

The results of the previous studies indicate that the proportion of people in the population who have experience with addictive substances is growing, with cannabis use showing the greatest increase. In 2002 the Prague Psychiatric Centre conducted the GENACIS study, focusing on differences in the use of addictive substances between the genders. It employed a set of standard questions about people's experience with drugs in their lifetime and during the past 12 months. In 2004 the Institute of Health Information and Statistics carried out a general population survey (CS 2004), using, for the first time in the Czech Republic, the European Model Questionnaire (EMQ) comprising standard questions about the use of, and attitudes to, drugs. While in 2002 and 2004 at least one experience with cannabis was reported by one fifth of adult respondents¹³, in 2008 lifetime cannabis users accounted for one third of the population. In addition, the 2002 prevalence rates of lifetime experience with ecstasy, pervitin, and LSD had doubled by 2008; see Figure 2-2.

Figure 2-2: 2002-2008 drug use trends in the population aged 18-64: lifetime prevalence of selected drugs (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d; Ústav zdravotnických informací a statistiky, 2006; Psychiatrické centrum Praha, 2002)



2.1.2 European Health Interview Survey

In 2008 the Institute of Health Information and Statistics collected data for the Czech segment of the European Health Interview Survey (EHIS). Coordinated on the international level by Eurostat, the survey follows up on a series of sample surveys of the health status of the Czech population (HIS) carried out by the Institute of Health Information and Statistics in 1993, 1996, 1999, and 2002. The survey employs a unified methodology throughout Europe. All EU member states should carry out the EHIS in the period 2007-2010. The main purpose of the study was to assess the health of the population. In relation to healthy lifestyles, the questionnaire includes items concerning smoking, alcohol consumption, and illicit drug use. Data from 1,955 respondents aged 15 and over were collected in the summer and autumn of 2008.

For all the drugs and time periods under study, the EHIS results indicated significantly lower prevalence rates than those of CS 2008. Lifetime cannabis use was reported by 15% of the respondents, and 5% and 2% of the people had used cannabis during the past year and past month respectively. Ecstasy and magic mushrooms had been tried at some point by 2% of the population; see Table 2-3.

¹³ All three studies used subsamples of people aged 18-64 to allow comparisons.

Table 2-3: Prevalence of substance use among the population aged 15 and over (lifetime, past 12 months, and past 30 days) (%) (Ústav zdravotnických informací a statistiky, 2009a)

Drug	Lifetime (%)			12 months (%)			30 days (%)		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Any illicit drug	19.0	12.0	15.4	6.0	4.1	5.0	3.4	1.5	2.4
Any illicit drug other than cannabis	5.1	2.5	3.7	1.9	0.6	1.3	1.3	0.4	0.8
Cannabis (marijuana and hashish)	18.9	12.0	15.3	5.3	4.0	4.6	2.9	1.4	2.1
Ecstasy	2.9	1.3	2.1	0.9	0.6	0.7	0.3	0.3	0.3
Pervitin (or amphetamine)	1.4	1.3	1.3	0.7	0.3	0.6	0.4	0.1	0.3
Cocaine	1.5	0.8	1.1	0.9	0.8	0.5	0.2	0.2	0.5
Heroin	1.1	0.2	0.6	0.6	0.2	0.4	0.5	0.1	0.3
LSD	1.5	0.9	1.2	0.9	0.3	0.6	0.5	0.1	0.3
Magic mushrooms	3.2	1.4	2.2	1.4	0.5	0.9	0.7	0.1	0.4

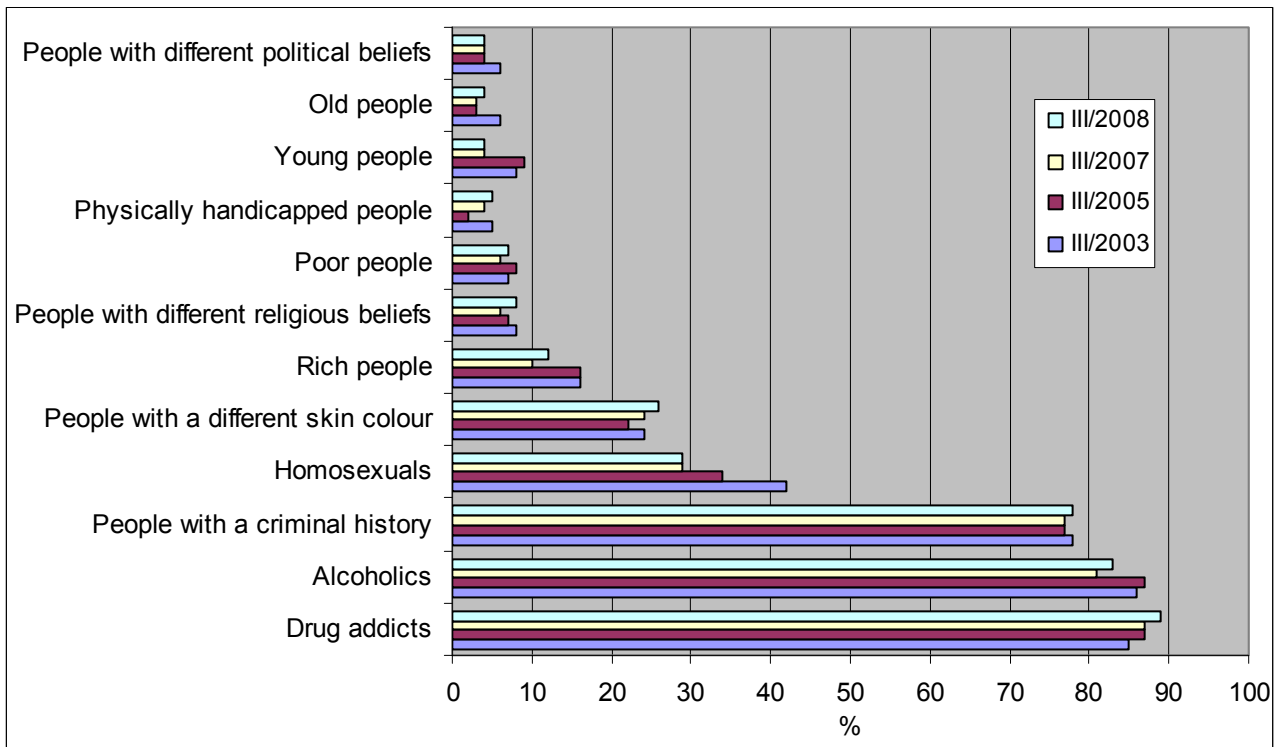
Similarly to general population surveys on drug use, surveys on the population's health status also suggest an increase in the use of drugs. In the 2002 HIS survey, at least one experience with cannabis was reported by 6.7% of respondents aged 18-64, while the last year's EHIS survey recorded lifetime cannabis use among the same age group at a level of 17.7% (Ústav zdravotnických informací a statistiky, 2003; Ústav zdravotnických informací a statistiky, 2009a).

The variations in prevalence levels found by both surveys conducted in 2008 (CS 2008 and EHIS) are likely to result mainly from their different methodologies; the questionnaires used differed in their content and the formulation of the questions and there were also differences in the data collection methods and the construction of the sample. Foreign experience shows that surveys working with questionnaires which start with items on health status and healthy lifestyles tend to show lower levels of illicit drug use than those focusing on illicit drugs only (Decorte et al. 2009). Furthermore, the data from both studies reflect different populations in terms of age: while the respondents included in the CS 2008 survey were 15-64 years old, the EHIS survey focused on a population of people over 15 years old, with no upper age limit. The reasons for the differences in drug use prevalence levels indicated by both surveys will be subjected to further thorough analysis.

2.1.3 Attitudes to Substance Use

As part of the Czech Society project, the Public Opinion Poll Centre conducts an annual survey of the attitudes and opinions of the population of the Czech Republic in relation to substance use and the level of tolerance towards the users of addictive substances. A survey project, Czechs and Toleration (Centrum pro výzkum veřejného mínění, 2008), was carried out in March 2008. The investigators presented the respondents with a battery of questions pertaining to 12 groups of people, out of whom the respondents were asked to choose those they would not like to have as their neighbours. Of the participants, 89%, 83%, and 78% would not like to have drug users, heavy drinkers, and people with a criminal history, respectively, as their neighbours. In 2008 people showed the least tolerance towards drug addicts since 2003; see Figure 2-3.

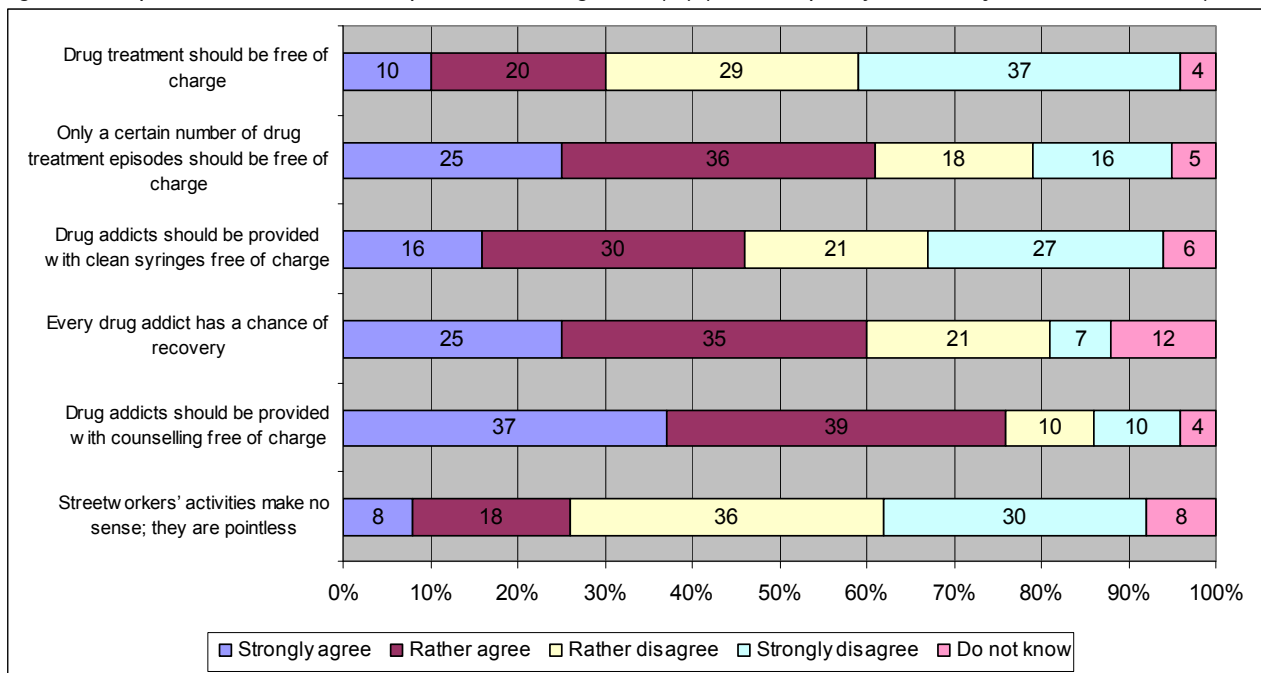
Figure 2-3: Year-to-year comparison of responses to the question “Who would you like not to have as your neighbours?” (%) (Centrum pro výzkum veřejného mínění, 2008)



In May 2009 the Public Opinion Poll Centre conducted a survey in which respondents were asked about their attitudes towards the consumption of selected addictive substances (Centrum pro výzkum veřejného mínění, 2009b) and opinions about drug addiction (Centrum pro výzkum veřejného mínění, 2009a). The questionnaire included items enquiring about the moral acceptability of drug use and the perceived level of health risks. The respondents had the fewest reservations about coffee, the use of which (on a regular or occasional basis) was acceptable for 96% of those interviewed. Alcohol consumption is tolerated by 93% of the respondents, while cigarette smoking was found acceptable by no more than 72%. As far as illegal drugs are concerned, marijuana is the most acceptable substance (18%), followed by ecstasy (6%), pervitin (3%), and heroin (2%). Undoubtedly, these results were also influenced by the perceived degree of risk associated with the substances under consideration. Heroin was identified as the most dangerous drug by the respondents (74% of them find even its first use risky), followed by pervitin (63%), ecstasy (55%), and marijuana (31%). In terms of criminal prosecution, the respondents were the most critical about the sale of “hard drugs”; 96% of them support criminal sanctions. 91% of those interviewed agree to the prosecution of dealing in cannabis. In addition, most of the respondents would be in favour of the criminal prosecution of the use itself; this was stated by 83% and 65% of the respondents as regards “hard drugs” and cannabis respectively (Centrum pro výzkum veřejného mínění, 2009b).

The five most common factors believed by the population of the Czech Republic to contribute to the development of addiction include friends (this factor was identified by 94% of the respondents), knowing people using drugs (83%), individual personality (83%), parenting (80%), and the community where a person lives (70%) (Centrum pro výzkum veřejného mínění, 2009a). Opinions on other aspects of the drug issue are summarised in Figure 2-4.

Figure 2-4: Opinions about selected aspects of the drug issue (%) (Centrum pro výzkum veřejného mínění, 2009a)

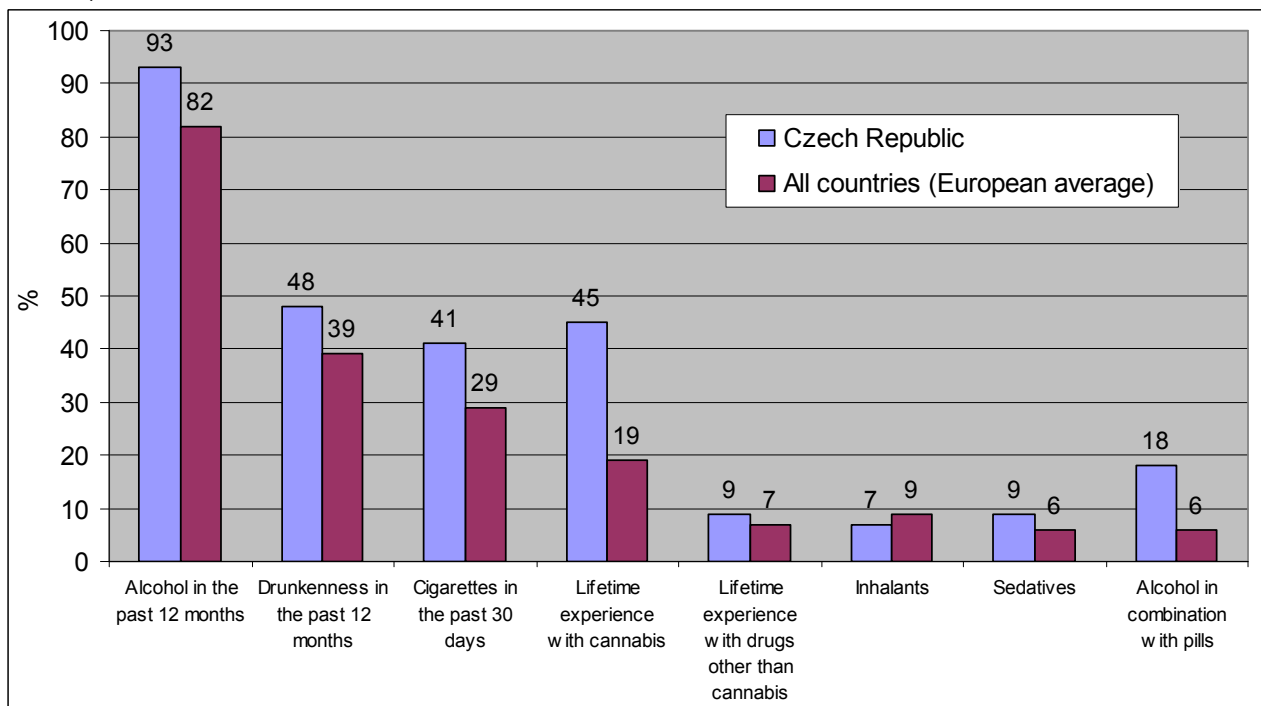


2.2 Drug Use in the School Population and among Young People

2.2.1 ESPAD Study in the International Context

An international report from the European School Survey on Alcohol and Other Drugs (ESPAD), which the Czech Republic participated in for the fourth time in 2007, was published in March 2009 (Hibell et al. 2009). The results for the Czech Republic were summarised in the 2007 Annual Report. The data on 3,901 Czech students born in 1991 (i.e. mostly 16 years old) were included in the international comparison. A comparison of the Czech and European levels of the eight key indicators of the 2007 ESPAD is provided in Figure 2-5.

Figure 2-5: Comparison of selected indicators for the Czech Republic with 2007 ESPAD European average (%) (Hibell et al. 2009)



The Czech Republic ranks among the countries which show the highest proportions of students having experience with most of the substances under study. As far as illicit drugs are concerned, in 2007 the respondents were most likely to report experience with cannabis use (45.1%). Further positions were taken by experience with sedatives (9.1%), the use of hallucinogenic mushrooms (7.4%), and the inhalation of solvents (7.0%). Experience with LSD (5.0%), ecstasy (4.6%), and amphetamines (3.5%) is less frequent, and experience with drugs such as heroin and

cocaine is only sporadic among the population of 16-year-olds (2.0% and 1.1% respectively). Within the European context, the Czech Republic scored the highest prevalence rates in relation to the consumption of alcohol, cigarettes, and cannabis. On the other hand, it showed the lowest prevalence of experience with inhalants. While cannabis use in the Czech Republic remained at the same level when compared to 2003, the proportion of people reporting experience with ecstasy declined.

2.2.2 HBSC Survey in the International Context

A summary international report from the 2006 Health Behaviour in School-aged Children (HBSC) survey was also published in 2008. The HBSC study primarily focuses on the healthy lifestyle of 15-year-old students (mostly ninth-graders in the Czech Republic), but it also addresses the use of alcohol and illegal drugs. For a summary of the results for the Czech Republic, refer to the 2006 Annual Report. Out of the illicit drugs, the international report only covers cannabis use. In the Czech Republic, at least one experience with the use of cannabis was reported by 25% of students, while 19% of students stated that they had used cannabis in the past year. It is noteworthy that the global lifetime prevalence average was 18% (World Health Organization, Regional Office for Europe, 2008).

2.2.3 Local School Surveys

In the spring of 2008 a survey among basic school pupils in the Prague 14 District was carried out using the ESPAD questionnaire (Skalský, 2009). The study included six basic schools, and the questionnaire was completed by 303 ninth-graders. The survey showed that 35% of those interviewed had lifetime experience with marijuana or hashish, and 28% and 15% of the respondents had used cannabis in the past year and the past month, respectively.

2.3 Drug Use among Targeted Groups/Settings at National and Local Level

The 2008 data about drug use in the nightlife setting (see below), as well as limited information on the issue of drug use among members of national and ethnic minorities, are available; for more information see the chapter on Drug Use among Socially Excluded Groups, page 77.

2.3.1 Drug Use in the Nightlife Setting

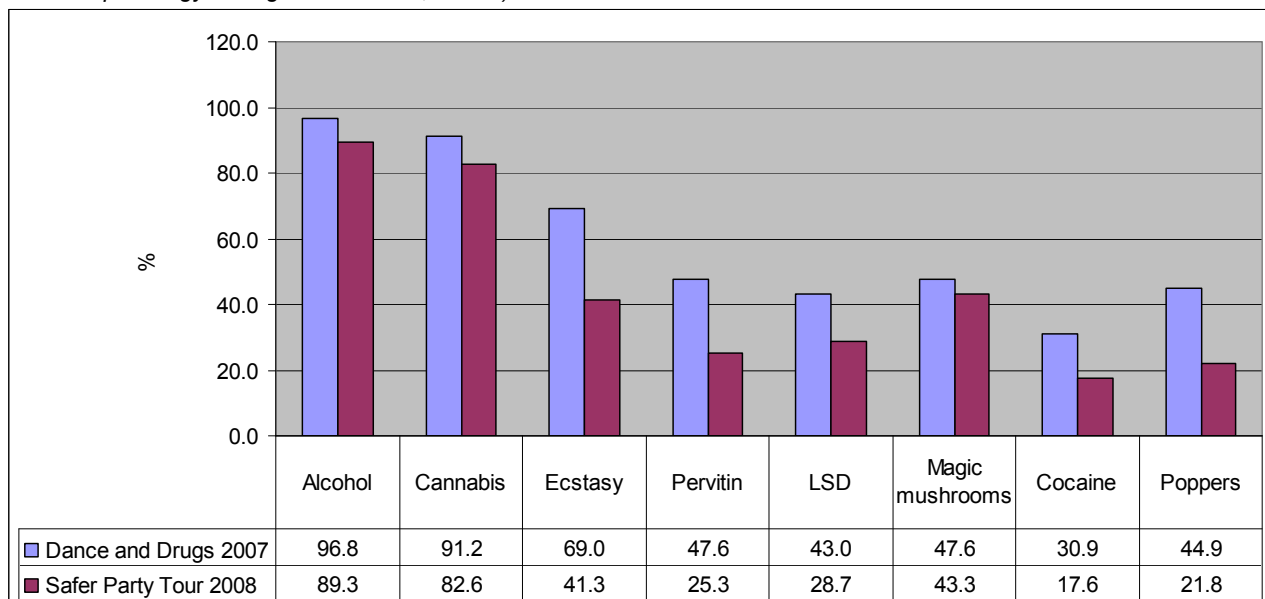
Evaluation of the 2008 Safer Party Tour project, implemented at eight music festivals with the intention of preventing substance abuse (see also the chapter on Selective Prevention, page 26), involved a questionnaire survey among clients of the services provided. The questionnaire was completed by 363 individuals from 15 to 63 years old; males comprised two thirds (67.2%), and the average ages of the male and female respondents were 23.1 and 21.4 years respectively. People with secondary education accounted for over half of the sample; the vast majority (93%) of the sample comprised either students or people in employment.

The most frequently consumed substances included alcohol and cannabis, followed by ecstasy and magic mushrooms. Alcohol, cannabis, and ecstasy were also the most likely to be reported by the respondents as the drugs which they had used, or planned to use, at the festival where they completed the questionnaire; in the case of alcohol and ecstasy, the proportion of such people was even larger than that of the people who had used drugs in the past thirty days (Národní monitorovací středisko pro drogy a drogové závislosti, 2008a). As regards the drugs used the most frequently, the clients of the 2008 Safer Party Tour services represented a group of recreational users as described in the 2007 Dance and Drugs study (Národní monitorovací středisko pro drogy a drogové závislosti, 2008d). A comparison of the degree of experience with drugs between both samples is provided in Figure 2-6.

Table 2-4: Proportions of 2008 Safer Party Tour clients who reported experience with drugs in their lifetime, in the past 12 months, and the past 30 days, and/or planned to use them at the event where they completed the questionnaire (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2008a)

Drug	Lifetime (%)	12 months (%)	30 days (%)	This event (%)
Alcohol	89.3	50.4	43.3	51.2
Cannabis	82.6	56.7	32.2	28.4
Magic mushrooms	43.3	23.4	4.4	1.9
Ecstasy	41.3	24.5	8.3	11.0
LSD	28.7	13.8	5.2	2.2
Pervitin/amphetamine	25.3	14.0	4.4	2.2
Poppers	21.8	9.6	0.8	0.8
Cocaine	17.6	9.9	3.9	1.4
Opiates/heroin	5.5	0.8	0.3	0
Ketamine	3.6	1.4	0.6	0
GHB	2.5	0.8	0.3	0

Figure 2-6: Lifetime prevalence of use of selected drugs among 2008 Safer Party Tour clients and 2007 Dance and Drugs survey respondents (Národní monitorovací středisko pro drogy a drogové závislosti, 2008d; Národní monitorovací středisko pro drogy a drogové závislosti, 2008a)



The 2008 Safer Party Tour clients were also asked about any health problems ensuing from their presence at a dance party and drug use, if any. A total of 78.9% of the clients reported that they had sometimes experienced health problems at a party or festival. It is noteworthy that 57% of them stated that they had had multiple health problems. They were most likely to have suffered from nausea, vomiting, and headaches; approximately a quarter of the sample reported overheating and dehydration, inexplicable tiredness, and/or disorientation. The most frequently reported causes of such problems included the excessive consumption of drugs and/or alcohol. However, only 4.3% of the respondents had sought professional assistance (Národní monitorovací středisko pro drogy a drogové závislosti, 2008a).

3 Prevention

Primary prevention, including the primary prevention of drug use, is co-ordinated by the Ministry of Education. The main goals and activities in the field of prevention are laid down in the Strategy for the Prevention of Risk Behaviour in Children and Young People in Education in the Period 2009-2012. In 2008 the Ministry of Education updated the standards and rules for the certification of professional competency for providers of primary prevention against the use of addictive substances; a total of 36 providers with 48 programmes had been certified by the end of 2008, mostly NGOs. In 2009, amendments were proposed to the methodological guidelines on the primary prevention of socially pathological phenomena in children, pupils, and students in schools and educational facilities.

The minimum preventive programme is the fundamental tool for school-based primary prevention in the Czech Republic. The programme focuses on promoting healthy lifestyles and preventing all forms of risk behaviour and is implemented in all basic and secondary schools.

Selective and indicated prevention programmes are provided by non-governmental organisations or specialist institutions; these programmes are primarily oriented at working with groups, individuals, and families at risk. The Safer Party Tour 2008, focused on drug use in night recreational settings, is an example of applied selective prevention.

Besides the "Pay Attention or Pay the Price!" safe driving campaign, which was partly targeted at driving under the influence of drugs, no other national campaign focused on drug use was launched in 2008. A number of events labelled as anti-drug events were organised at the regional and local levels, but their effect often remained unproven.

3.1 Drug Prevention System and Framework

Primary prevention is coordinated by the Ministry of Education. The main policy document in this field is the Strategy for the Prevention of Risk Behaviour in Children and Young People in Education in the Period 2009–2012. The long-term goals of this strategy, which also aims at preventing the use of drugs (tobacco, alcohol, and narcotic and psychotropic substances), include placing emphasis on specific universal, selective, indicated primary prevention, support for education, and evaluation of the certification process. The goals of the strategy will be detailed in the Ministry of Education's action plan (Ministerstvo školství, mládeže a tělovýchovy, 2009a).

In January 2009, the Government Council for Drug Policy Coordination imposed on the Minister of Education the task of adjusting and amending the methodological guidelines on the primary prevention of socially pathological phenomena in children, pupils, and students in schools and school facilities (Ref. No. 20 006/2007-51). The updated guidelines should already be applicable in the 2009/2010 school year. The proposed amendments concern:

- The implementation of prevention programmes in schools and school facilities – giving preference to certified external programmes is recommended; as regards indicated prevention activities, counselling interventions should be preferred over disciplinary, administrative, or criminal law measures.
- The implementation of screening drug tests in school settings – it is recommended to emphasise that across-the-board or random drug testing is not an effective prevention method, and nor is the use of drug-sniffing dogs to screen the surfaces of benches and other objects in schools for traces of drugs. If a school decides to conduct drug tests, it is recommended that it should have a list of sanctions in place, developed and published prior to the testing. Drug testing should only be conducted if there are reasonable grounds to believe that drugs have been used and only subject to informed consent. It is recommended that the term "reasonable grounds" be defined more accurately.
- Terminological improvements – some obsolete terms, such as "socially pathological phenomenon", should be replaced by more modern ones.

The Standards of Professional Competency for providers of primary prevention against the use of addictive substances were developed in 2005, to facilitate the evaluation of the quality of specific primary prevention measures (Ministerstvo školství, mládeže a tělovýchovy, 2005) and the certification system in the field of prevention was launched in 2006; for details see the 2006 and 2007 annual reports. In 2008 the primary prevention standards development working group, comprised of representatives of the ministries and institutions who have a professional stake in this field, met regularly; in December 2008 the Ministry of Education approved the updated version of the standards and the certification rules. In total, 40 facilities and 54 programmes applied for certification between December 2006 and the end of 2008. Out of this number, 36 facilities and 48 programmes complied with the certification requirements. 8 local audits in 9 programmes took place in 2008 (Agentura pro certifikace, 2009).

Since 2007, the Prev-Centrum civic association, with the support of the GCDPC and the Prague Municipal Authority, has been developing the PrevData application to unify reporting in the field of specific primary prevention. 2008 saw the pilot testing of the application and training of its users – primary prevention providers; see also the chapter Systems for Collection of Data on Drug Users in Treatment (p. 42).

In the second half of 2008 preparations started for the launch of the Prague Centre for Primary Prevention, in collaboration with the Prague Municipal Authority and the Centre for Addictology. The purpose of the centre is to create and coordinate a comprehensive system of primary prevention of risk behaviour in Prague by 2013.

3.2 Universal Prevention

3.2.1 Preventive Programmes in Schools and School Facilities

The Minimum Preventive Programme (MPP), which was defined by the Ministry of Education, is the basic tool for the implementation of prevention in schools; its implementation is binding and subject to supervision by the Czech Schools Inspectorate. The MPP focuses on promoting healthy lifestyles and the prevention of all forms of risk behaviour, including the prevention of the use of addictive substances. The school prevention worker (methodologist) is responsible for the implementation of the programme, together with other teachers at the school. The MPP also includes work with parents and teacher training. Schools implement the programme on their own or complement it with programmes arranged by external bodies, including NGOs.

The types of programme implemented in the framework of the Minimum Preventive Programme are illustrated by the structure of projects supported in 2008 by the Ministry of Education as part of Subsidy Programme I¹⁴. In total, 234 projects with over 500 programmes were supported. The most frequently supported types of programme were adaptation courses (48%), experiential programmes (10%), and one-off lectures, debates, and seminars (4%). 43% of them were programmes implemented as part of the curriculum, and 45% were those implemented outside the school curriculum; a total of 12,300 individuals were reached by the programmes, of whom 92% were students and 8% adults, mostly teaching staff, school prevention workers, and school counsellors. Parents and the public also played a part in the programmes (Ministerstvo školství, mládeže a tělovýchovy, 2009b).

School-based prevention programmes are often implemented or co-implemented by NGOs. Out of the 154 anti-drug projects to which the GCDPC provided a subsidy in 2008, 35 projects developed activities in the field of prevention; 25 of them mentioned the outcomes achieved in their final reports. For the most part, preventive programmes were delivered by the so-called prevention centres (17 programmes). In 11 cases, low-threshold programmes, i.e. low-threshold centres and outreach programmes, were involved in such activities. A total of 17,030 interventions (themed training segments, debates, interactive seminars, consultations, interventions, residential programmes etc.) were implemented and 120,673 persons were contacted within the framework of school curricula. As concerns extracurricular prevention within the framework of indicated prevention, educational activities, and the information service, a total of 9,755 interventions were carried out and 6,422 adults were reached (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j).

The Czech component of the EU-DAP 2 international project (EUropean Drug Addiction Prevention Trial) included the evaluation of the programme entitled "Unplugged", which is focused on preventing the use of addictive substances in selected basic schools through improving the psychosocial skills of 6th-grade pupils, i.e. children aged 12–14 (for information on the implementation of EU-DAP in the Czech Republic see also the 2006 and 2007 annual reports). The research project is implemented in 70 schools (an experimental group of 966 pupils from 37 schools; a control group of 888 pupils from 33 schools). Preliminary results after 6 months following the implementation of the project indicate that the programme is effective; achievements included a statistically significant reduction of tobacco use, the occurrence of insobriety, and the prevalence of cannabis and inhalants. Further testing is planned for June 2009 (Miovská et al. 2009; Jurystová et al. 2009). An analysis was also conducted in 2008, aimed at describing the framework of primary prevention activities in the schools involved in the project. The results indicate that the prevention activities most frequently implemented are one-off events – debates, which the schools or school prevention workers mostly organise themselves; only 20% of schools in the control group implemented a long-term programme comprising multiple sessions (Adámková et al. 2009).

Following amendments and additions to the methodological guidelines on the primary prevention of socially pathological phenomena in children, pupils, and students in schools and school facilities, the National Focal Point, in collaboration with the Ministry of Education, conducted a national questionnaire survey in 2009 to collect information about testing for alcohol and other drugs in Czech basic and secondary schools in 2008. Complete results are not available as yet but there are preliminary results, which describe the state of affairs in five regions of the Czech Republic (Prague and the Central Bohemia, Hradec Králové, Liberec, and Ústí nad Labem regions), see Table 3-1 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d).

In 2008 a school questionnaire survey was conducted in the school population of Pilsen. Among other things, the survey monitored the procedures that schools apply or intend to apply if a pupil is caught with a cigarette or shows signs of insobriety in school for the first time. These mostly include a notification to parents (59%), a written reprimand (55%), and an oral warning (50%). Approximately one school in four (27%) sends a drunk student a

¹⁴ For more information about drug policy expenditure and subsidies in 2008 see also the chapter Economic Analysis, page 9. Subsidy Programme I is a funding instrument for preventive programmes implemented by schools themselves. The Ministry of Education provides funding in the form of subsidies to individual regions, which further distribute them to schools and school facilities; school-based programmes may also be co-funded by regions and municipalities.

written reprimand and approximately one school in four reports sanctions such as a reprimand from the principal, a counselling session with the parents, a poorer grade for discipline in the school report, or referral to a physician; approximately one school in five makes an entry in the student's personal file (Vacek et al. 2009).

Table 3-1: Programmes of testing for alcohol and other drugs in basic and secondary schools in 5 regions of the Czech Republic in 2008 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d)

Indicator	Basic school	Secondary school	Total
Total number of schools in the sample	1,264	517	1,781
Schools that implemented alcohol testing	50	68	118
– positive alcohol test (number of cases)	136	125	261
Schools that implemented non-alcohol drug tests	32	53	85
– positive cannabis test (number of cases)	72	46	118
– positive pervitin test (number of cases)	6	5	11
– positive test for other drugs (number of cases)	16	14	30
Pupils/students punished*	63	115	178
Schools with serious drug problems**	52	39	91
Pupils/students with serious drug problems**	104	129	233
Schools where across-the-board drug tests were applied	3	0	3
Schools where furniture surfaces were tested for traces of drugs	4	4	8
Schools where screening was conducted using drug-sniffing dogs	7	3	10

NB: * In connection with their positive testing for alcohol and/or other drugs, ** in connection with the use of alcohol and/or other drugs.

3.3 Selective Prevention in At-risk Groups and Settings

Selective prevention programmes focus on groups of children and young people who are reasonably likely to have an increased probability of risk behaviour. These may include children living in families that are socially disadvantaged or come from a different cultural background (e.g. members of ethnic minorities, children raised outside their own family, children living in the families of drug and alcohol users, or children with non-specific or specific behavioural disorders such as ADHD). Effective selective prevention programmes include programmes based on working with the family, counselling, psychotherapy, and social skills training; evidence shows that approaches based on offering positive alternatives (e.g. low-threshold youth clubs) or peer programmes are also effective (Černý and Lejčková, 2007).

Examples of good practice in the field of selective (and indicated) prevention in the Czech Republic include the work of the Prev-Centrum civic association, which delivers a selective prevention early intervention programme for at-risk groups of basic school pupils in the 5th to 9th grades. This is a continuous targeted programme, which comprises 3–5 sessions with the class at intervals of 2–3 weeks. The programme aims to contribute, in collaboration with the school, to the improvement of relations between pupils in the class, focusing on those who are at risk because of bullying, experimenting with addictive substances, and other forms of risk behaviour that occur in the class. In its early intervention programme for children and adolescents, the Prev-Centrum civic association offers a counselling service for children, parents, and teachers where there are cases of a child having a difficult position in the class, problematic peer relations, and behavioural disorders such as stealing, truancy, experimenting with addictive substances, lying etc. (o.s. Prev-Centrum, 2008). Fifty-two selective-prevention training segments were provided in 2008, involving 19 classes; 6 experts made 1,120 contacts during them. Sixty-nine consultations with 19 class teachers and prevention workers at schools were conducted (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j).

Examples of selective prevention programme include the 2008 Safer Party Tour project, which was implemented by the Chilli.org civic association, in collaboration with other NGOs. The project focused on preventing drug use at dance events during the summer season. At the eight largest music festivals chill-out zones were established and 1,529 individuals were reached and provided with alcohol tests, crisis interventions, and other examinations and treatments (e.g. blood pressure measurements). Clients received leaflets with information about drugs and the associated risks, ear plugs, condoms, and other medical material. The project also continued during the summer festivals in 2009 (Národní monitorovací středisko pro drogy a drogové závislosti, 2008a). Information about the project for the general public, as well as experts, is available at www.saferparty.cz. Other outreach programmes at dance events are discussed in the section on Low-Threshold Harm Reduction Programmes, page 68.

Drug information and counselling is provided by a number of facilities on the internet or by phone; for more details see the Help Map application at drogy-info.cz.

3.4 Indicated Prevention

Indicated primary prevention programmes are focused directly on at-risk individuals showing signs of risk behaviour in combination with the use of addictive substances. The purpose of indicated prevention is to reduce the frequency, risks, and consequences of drug use. Indicated prevention is implemented by specialist governmental and non-governmental institutions; a list of them is provided in one of the chapters on selected issues included in the 2006 Annual Report. Indicated primary prevention programmes focus primarily on working with individuals and their families.

In 2008, the Prevent civic association monitored the situation and needs in the field of drug services designed for at-risk children and young people under imminent threat of using addictive substances in the South Bohemia region (Pešek et al. 2008). The results indicate that the target group in question comprises relatively well-established clients of various counselling services. These people most frequently show drug problems associated with the use of cannabis and experimental or weekend use of pervitin. The relative distribution of outpatient counselling services in the various districts of this region is satisfactorily even and the quality of care and level of liaison between them is good. Key facilities primarily include low-threshold centres or specialised facilities, such as the *Drug Counselling Service Prevent*. The availability of inpatient treatment is relatively good, both within the South Bohemia region and outside it. The main challenges include inaccurate referrals of clients from "non-drug" facilities (e.g. from pedagogical-psychological counselling services or educational care centres) and the lack of availability of collaboration with psychologists and psychiatrists or its often problematic nature. At-risk schools and locations were mapped, including the occurrence of drug-related problems in the Roma population in some locations. The needs repeatedly mentioned by the informants recruited from amongst professionals included, among other things, the development of targeted training programmes for experts primarily from "non-drug" services (Pešek et al. 2008).

3.5 National and Local Media Campaigns

The 2008 Safer Party Tour project (see above) was accompanied by a media campaign with a limited scope, supported by xPublishing, www.techno.cz, and Radio 1. The campaign was endorsed by the Czech Minister of Education, Ondřej Liška, who personally participated in the Creamfields festival (ČT24.cz, 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2008b).

A national safe driving campaign, "Pay Attention or Pay the Price!", was launched in October 2008. The campaign was commissioned by the Czech Ministry of Transport. It runs on the TV and radio, in cinemas, and on the internet (<http://www.nemyslis-zaplatis.cz/>); printed information leaflets are also available. The goals of the campaign, which is planned to run until 2010, include discouraging drivers from using alcohol and other addictive substances. The campaign, with total costs of some CZK 150 million (€ 6,014 thousand), is intended to reduce the traffic accident rate by 5–7%, saving approximately 60–75 lives a year (Aktuálně.cz, 2008; ČT24, 2009).

Numerous short-term or one-off events labelled as anti-drug are held in the Czech Republic each year; these usually include various leisure-time activities with an unproven preventive effect. For instance, in the town of Vsetín in the Zlín region the Cyrillos civic association organised a twelve-hour volleyball match between supporters and opponents of the legalisation of cannabis, with an accompanying programme (films, debates, simulations of court hearings, and counselling). A month-long campaign entitled "Can you tell if your child is on drugs?" was held in the town of Chomutov. It featured posters making parents aware of the signs of potential drug use by their children (Sláma, 2008; Chomutovský deník, 2009).

4 Problem Drug Use

The EMCDDA defines problem drug use as injecting drug use and/or long-term/regular use of opioids/opiates and/or amphetamine-type drugs and/or cocaine. Cocaine use in the Czech Republic is at a very low level and the prevalence of problem cocaine use has not been estimated. As a result, problem drug use in the Czech Republic is associated primarily with pervitin (methamphetamine) and opiates/opioids (heroin and Subutex[®], with the seasonal use of opium).

The estimated number of problem drug users grew in 2008 and reached approximately 32.5 thousand, of which number approximately 21.2 thousand are pervitin users and approximately 11.3 thousand are opiate users. It is estimated that approximately 31.2 thousand persons inject drugs, i.e. the majority of opiate and pervitin users. Compared to 2007, the estimated number of problem users of all types of drug increased in 2008; however, the increase is not statistically significant. The number of estimated problem drug users is highest in Prague (11.5 thousand) and the Ústí nad Labem region (4.2 thousand); at the same time, these two regions also have the highest estimated number of problem users of opiates.

4.1 Estimates of Prevalence and Incidence of Problem Drug Use

As in the previous years, in 2008 too the estimate of the prevalence of problem drug users was made using the multiplication method, which relies on data from low-threshold facilities. The data on the number of problem drug users in contact with low-threshold services were extrapolated to the total number of all such facilities in the Czech Republic and multiplied by the proportion of problem drug users in contact with such facilities (in-treatment rate), which was last updated in 2008 (for details of this method see the 2007 Annual Report).

The estimate of problem drug users in 2008 was again constructed as a sum of the estimates for individual regions. The national average multiplier without Prague was 68% (95% CI¹⁵: 66-72%), and the value of the multiplier for the capital city was 76% (95% CI: 63-90%). The total number of problem drug users in the Czech Republic was thus estimated at 32,500 (95% CI: 30,400-34,700), of which number 21,200 (20,700-21,800) were pervitin users, 6,400 (5,800-7,000) were heroin users, and 4,900 (4,500-5,200) were Subutex[®] users. Opiate users therefore form a group of approximately 11,300 (10,600-12,000) persons. The number of injecting drug users (IDUs) was estimated at 31,200 (30,000-32,400).

The trend of mean values of the estimated number of problem drug users between 2002 and 2008 is shown in Table 4-1. Compared to 2007, there was an increase in the total number of problem drug users; given the range of the confidence intervals, however, the differential is not statistically significant. The highest number of problem drug users was traditionally in the Capital City, Prague, and the Ústí nad Labem region. Prevalence estimates of problem drug use by region are shown in Table 4-2 and Map 4-1, and the trend of the estimated number of drug users in each region is provided in Table 4-2.

The incidence of problem drug users in the Czech Republic has not been estimated as yet.

Table 4-1: Mean values of prevalence estimates of problem drug use carried out using a multiplication method with the use of data from low-threshold programmes in 2002-2008 (Mravčík et al. 2008; Mravčík et al. 2007)

Year	Total number of problem drug users		Problem users of opiates/opioids				Problem users of pervitin		Injecting drug users	
	Number	Per 1,000 persons aged 15-64	Heroin users	Subutex [®] users	Total	Total per 1,000 persons aged 15-64	Number	Per 1,000 persons aged 15-64	Number	Per 1,000 persons aged 15-64
2002	35,100	4,89	n.a.	n.a.	13,300	1,85	21,800	3,04	31,700	4,41
2003	29,000	4,02	n.a.	n.a.	10,200	1,41	18,800	2,61	27,800	3,86
2004	30,000	4,14	n.a.	n.a.	9,700	1,34	20,300	2,8	27,000	3,73
2005	31,800	4,37	n.a.	n.a.	11,300	1,55	20,500	2,82	29,800	4,1
2006	30,200	4,13	6,200	4,300	10,500	1,44	19,700	2,69	29,000	3,97
2007	30,900	4,2	5,750	4,250	10,000	1,36	20,900	2,84	29,500	4,01
2008	32,500	4,39	6,400	4,900	11,300	1,52	21,200	2,87	31,200	4,21

¹⁵ 95% confidence interval – i.e. the interval in which the value occurs with a 95% probability.

Table 4-2: Prevalence estimates of problem drug users in the Czech Republic in 2008 by region (Mravčík et al. 2007)

Region	Total number of problem drug users	Opiate users			Pervitin users	IDUs
		Heroin	Subutex®	Total		
Prague	11,500	3,250	3,950	7,200	4,300	11,400
Central Bohemia	1,750	200	300	500	1,250	1,700
South Bohemia	1,550	50	150	200	1,350	1,550
Pilsen	1,650	750	< 50	750	1,000	1,550
Karlovy Vary	1,000	50	< 50	50	950	1,000
Ústí nad Labem	4,150	1,000	300	1,300	2,850	4,000
Liberec	1,500	< 50	< 50	< 50	1,500	1,500
Hradec Králové	1,100	< 50	< 50	50	1,050	1,100
Pardubice	450	< 50	< 50	< 50	400	450
Vysočina	500	< 50	< 50	< 50	500	450
South Moravia	3,250	900	< 50	950	2,300	3,100
Olomouc	1,600	50	< 50	50	1,550	1,400
Zlín	1,350	< 50	< 50	< 50	1,350	1,100
Morava-Silesia	1,150	100	< 50	150	1,000	950
Total	32,500	6,400	4,900	11,300	21,200	31,200

Map 4-1: Number of problem drug users per 1,000 inhabitants aged 15-64 and the number of problem users of opiates and pervitin in regions of the Czech Republic in 2008 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009c)

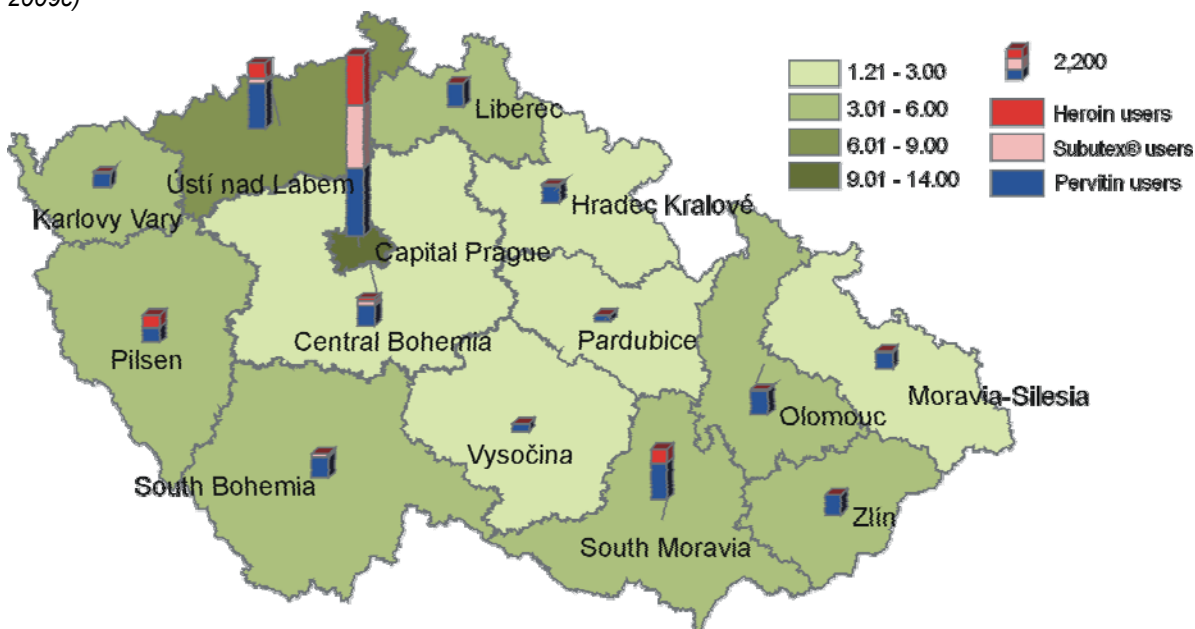


Table 4-3: Prevalence estimates of problem drug users obtained by means of questionnaire surveys among general practitioners in 2005-2008 (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009c)

Region	2005	2006	2007	2008
Prague	9,800	8,400	10,000	11,500
Central Bohemia	2,500	2,450	1,700	1,750
South Bohemia	1,700	1,750	1,500	1,550
Pilsen	1,450	1,350	1 300	1,650
Karlovy Vary	1,450	1,250	900	1,000
Ústí nad Labem	4,450	4,450	4,100	4,150
Liberec	750	500	500	1,500
Hradec Králové	1,150	1,050	1,750	1,100
Pardubice	600	350	450	450
Vysočina	600	350	700	500
South Moravia	2,800	3,150	3,400	3,250
Olomouc	1,900	2,350	1,650	1,600
Zlín	1,150	1,300	1,850	1,350
Morava-Silesia	1,500	1,450	1,100	1,150
Total	31,800	30,200	30,900	32,500

4.2 Data on Problem Drug Use from Non-treatment Sources

Data were collected between September 2008 and January 2009 in a study entitled New Trends on the Drug Scene (Radimecký et al. 2009). Data were collected from three focus groups comprising the staff of low-threshold programmes (one with representatives of the services in Prague and Central Bohemia, a second with participants from the Ústí nad Labem, South Bohemia, Karlovy Vary, Hradec Králové, and Pilsen regions, and a third with the staff of the services from the Olomouc, South Moravia, and Moravia-Silesia regions). The study was commissioned by the National Focal Point and undertaken by the Centre for Addictology. Its outcomes include a description of the clients of the low-threshold programmes.

According to the participants, the average age of the clients varies according to the region and type of facility. Older clients usually come to low-threshold centres, while outreach programmes report a lower average age. The age structure of the clients also depends on whether the facility has contacted a specific target group (e.g. recreational drug users, commercial sex workers, or the newly approached group of older, long-term drug users). The proportion of men to women among the clients of low-threshold facilities is estimated to be 2:1 in the long term. Survey participants from Prague report an increasing number of women, pregnant drug users, and whole families, including children, on the drug scene (Radimecký et al. 2009).

As regards the type of drugs used, the number of heroin users is decreasing in all regions except Prague and the Ústí nad Labem region, according to the respondents. Most low-threshold programmes in the Czech Republic work with a clientele using primarily pervitin, usually in combination with other substances. Using only one type of drug is less frequent; most clients are those with polydrug use. The abuse of medicaments (primarily benzodiazepines) reportedly occurs often in clients using opiates (heroin or substitution substances), to potentiate the effects of the drug. Clients using pervitin use benzodiazepines concurrently to dampen the unpleasant mental states associated with the use of stimulants. Among the reasons for abusing medicaments that were cited by the respondents was self-medication in clients with a dual psychiatric diagnosis. An increased use of pervitin was reported at dance events (Radimecký et al. 2009).

As regards the abuse of Subutex[®], the situation is specific. Suboxone[®], a composite preparation that is not abused by injecting, has been on the Czech market since February 2008. If Suboxone[®] only, not Subutex[®], is offered in substitution treatment, the demand for substitution treatment decreases¹⁶. Suboxone[®] is not sought on the black market and the occurrence of Subutex[®] on the black market also diminishes. In the opinion of low-threshold programmes, this makes some users turn (again) to heroin (Radimecký et al. 2009).

The respondents' experience suggests that the use of toluene and other inhalants shows a decreasing tendency and does not occur widely in (young) people from ethnic minorities either. Cocaine users are not among the clients of low-threshold centres at all or very rarely; there are no long-term and regular users, and the use of cocaine is primarily occasional. In the summer, the use of raw opium in poppy fields occurs as a seasonal phenomenon. The use of opium is associated with the occurrence of more serious health problems (Radimecký et al. 2009).

Most clients of low-threshold services use drugs by injecting. The risky use of injecting occurs primarily in older, long-term drug users, who are more difficult to persuade by messages concerning safer application. There is a demand for new equipment for drug administration and preparation among the clients (capsules and spoons for drug

¹⁶ The price of Suboxone[®] is higher than that of Subutex[®] and neither product is covered by public health insurance.

preparation¹⁷). Younger clients, particularly pervitin users, often also take the drug by sniffing it. This target group did not use to be much in contact with outreach programmes because it did not use their main service – the needle exchange programme. Since 2008 some outreach programmes have started to distribute gelatine capsules for oral drug application, which may be part of the outreach strategy towards non-injectors. Capsules are also used by older clients who experience trouble with injecting drugs because of damaged veins. The respondents also mention the distribution of aluminium foil as a method to reduce the injecting of heroin (Radimecký et al. 2009).

In 2008, a survey was conducted among the clients of all the Prague-based low-threshold programmes for drug users (Šejvl, 2008). The participants were 783 clients from 7 facilities (the SANANIM civic association's low-threshold centre and outreach programmes; the low-threshold centre and outreach programme run by DROP IN o.p.s.; the ESET HELP outreach programme, and the low-threshold centre and outreach programme run by the Progressive civic association). 79 clients refused to fill in the questionnaire (response rate 89.9%). The proportion of men to all clients was 70%, and the average age of the clients was 28.7. The clients' drug of choice was pervitin (34%), followed by Subutex[®] (24%), heroin (20%), marijuana (5%), Suboxone[®] (3%), psychotropic medications (5%), and alcohol (3%).

Information from both surveys concerning the clients' attitudes towards using low-threshold services, information about the prevention of infectious diseases, including testing, and information about collaboration with other services is mentioned in the chapter on Responses to Health Correlates and Consequences, page 67, data concerning work with clients from ethnic minorities are provided in the chapter on Social Correlates and Social Reintegration, page 76, and data about the clients' criminal activity in the chapter on Drug-related Crime, Prevention of Drug-related Crime, and Prison, page 81.

In the spring of 2007, a survey was conducted among the clients of the low-threshold centre and outreach programmes of the SANANIM civic association in Prague, with the participation of 400 clients. The purpose of the survey was to compare the clients of the two low-threshold services (Větrovec and Porubský, 2008). At the turn of 2007 and 2008, a qualitative survey focused on opium use was undertaken among the clients of the SANANIM low-threshold centre in Prague (Zeithammerová, 2008); for more details see the 2007 Annual Report.

More information about the characteristics and numbers of problem drug users who are in contact with various helping programmes is given in the chapters on Drug-related Treatment: treatment demand and treatment availability, page 32, Responses to Health Correlates and Consequences, page 67, and Social Correlates and Social Reintegration, page 76, and in the special chapter on Cannabis Markets and Production, page 96.

4.3 Intensive, Frequent, Long-Term, and Other Problematic Forms of Use

No study has been conducted in the Czech Republic so far that focused specifically on intensive or problematic forms of drug use which do not fall under the definition of problem use according to the EMCDDA. The studies in the general population and other sources of data (e.g. data about the treatment of drug users – see the chapter on Drug-related Treatment: treatment demand and treatment availability on page 32 – or data about drug crime – see the chapter on Drug-related Crime, Prevention of Drug-related Crime, and Prison on page 81) indicate that the relatively high prevalence of health or social problems in the Czech Republic is primarily associated with the use of psychoactive medications or cannabis, besides being associated with the problem use of opiates/opioids and pervitin. For detailed data about the risk consumption of cannabis see the section on General Population Survey on the Use of Psychotropic Substances, page 16 and the selected issue on Cannabis Markets and Production, page 96.

The heavy use of cannabis and how cannabis users end their drug career were the topics of a diploma thesis by T. Nechutný in 2008 (Nechutný, 2009). Using the grounded theory method, the author analysed 17 former heavy cannabis smokers, focusing primarily on what in their biographies preceded or inspired the decision to quit consumption. According to the author, cannabis careers are typically characterised by a loss of the entertaining character of intoxication in the long term and an increasing number of experiences felt by the respondents as unpleasant. The way users quit smoking cannabis is different in so-called passive users of cannabis, i.e. users who in the past did not seek the drug and whose consumption depended primarily on whether cannabis was available in their social environment, as opposed to the cannabis smokers that are considered by the author to be active. The results of the study indicate that passive users quit their cannabis career at a moment when the opportunity has disappeared or their social networks have disintegrated. By contrast, active users make more conscious decisions and the end of their cannabis career results from: (a) longer-term considerations; (b) some unpleasant breakthrough experience, e.g. a paranoid-hallucinatory state or a flashback, or (c) a potentially breakthrough event, which in the current context makes the user decide to quit using cannabis (e.g. sickness). The end of a cannabis career, however, can also be motivated by breakthrough events and experiences that are not directly related to intoxication (e.g. miscarriage). The author also demonstrates that the end of a cannabis career often does not mean complete abstinence but a transition to the controlled use of cannabis, which is rather limited in terms of frequency and intensity.

¹⁷ The pilot distribution of spoons only took place in research projects. They are not made in the Czech Republic and their import and distribution would be rather expensive.

5 Drug-related Treatment: treatment demand and treatment availability

The treatment of drug users and addicts in the Czech Republic takes the form of a network of various services with a relatively broad spectrum and generally good availability. In terms of the legislation, the treatment of drug users is regulated both by social and health care laws. The goals and measures in the area of treatment are laid out in national drug strategies; the first such strategy was adopted in 1993 and at present the 2005-2009 National Strategy and the related action plans are being implemented. A system of certification of the professional competency of services for drug users was implemented in 2005.

The year 2008 saw a decline in the number of outpatient health care facilities providing treatment to drug users, and of the number of live cases registered in the databases of outpatient facilities in connection with drug use disorders; the number of opiate and stimulant users, however, rose slightly.

In 2008, the number of patients hospitalised in inpatient psychiatric facilities declined for the first time in five years as a result of a drop in the number of admissions to psychiatric departments in hospitals, whereas the number of hospitalisations in psychiatric hospitals increased. Psychiatric hospitals recorded an increase in the three strongest patient groups (opiate/opioid, stimulant/pervitin, and polydrug users); the increase is most evident among patients hospitalised with disorders caused by polydrug use.

The number of patients in substitution treatment continues to rise both in specialised centres and, evidently, in medical practices prescribing buprenorphine preparations (Subutex® and Suboxone®). Note that treatment using these preparations is not captured in the substitution register in its full scope.

Men predominate over women in all types of treatment facilities, accounting for approximately two thirds of their clients. The proportion of women is higher in younger age groups. The average age of drug users in treatment continues to rise and the trend is evident across the various data sources. Pervitin (methamphetamine) is the drug most frequently connected with the treatment of drug users in the Czech Republic, followed by opiates/opioids (heroin and Subutex®) and cannabis. Polydrug use (the concurrent use of more than one drug) is commonplace. The Capital City, Prague, and the Ústí nad Labem region rank the highest in terms of the number of users in treatment, with a high number and proportion of opiate users in treatment, which is common to all Bohemian regions.

5.1 Strategy/Policy

The treatment of drug users and addicts in the Czech Republic takes the form of a network of various services with a relatively broad spectrum and generally good availability. Its present structure, including the legislative framework and current treatment strategies and policies, has a particular foundation in theory and historical developments (Skála, 2003; Kalina, 2007). The bio-psycho-socio-spiritual model of addiction and its treatment is presently the dominant concept in the Czech Republic (Kalina, 2003a; Kudrle, 2003b; Kudrle, 2003a); it is a model which assumes a multidisciplinary approach to drug users, integrating various biomedical and psychosocial interventions (Miovský, 2003).

Until 1989, the treatment of addictions and its legal basis were understood to be medical and health care issues. Since the first half of the 1990s there has been a boom in psychosocial services targeting drug users and existing outside the health care sector; the boom was driven, among other things, by the support given to these structures and by their integration into the official national drug strategies and policies of the Czech Republic as early as in 1993 (Bém, 2003). In recent years we have been seeing the increasingly tight regulation of the area of the treatment of and care for drug users on the part of policy and legislation in the area of social welfare and services.

5.1.1 Legislative Framework of Services for Drug Users

In terms of the legislation, the treatment of addictions is framed by a number of laws and by-laws in the department of health care. The pivotal law in this context is Act No. 20/1966 Coll. on public health care, which was adopted in the period of socialism, survived without change until 1990, and was subsequently amended on numerous occasions; its replacement by another health care law has failed, as the bill did not pass the legislative process. Health care legislation comprises a great number of other norms providing, among other things, for health insurance, medical professions, non-public health care facilities, the control of infectious diseases and public health protection, etc.

In terms of drug treatment, Act No. 379/2005 Coll. on the measures for protection from harm caused by tobacco products, alcohol, and other addictive substances, is the essential legal regulation. The law codifies key tenets and principles which were incorporated into all national drug strategies from the 1990s to date. The law recognises the term “drug policy” as one covering not only illegal drugs, but also tobacco products and alcohol. For the first time in the history of the Czech Republic, Section 20 of this law defined the types of services intended for drug users as follows:

- acute inpatient treatment, consisting of diagnosis and treatment, provided to patients who have, through the ingestion of alcohol or other addictive substances, induced themselves into a condition which presents a risk for their health, themselves, or their environment¹⁸;
- detoxification, which is treatment provided by outpatient and institutional health care facilities in the event of a withdrawal syndrome;
- outreach programmes, which are programmes of social services and health promotion, targeting users of addictive substances and addicted persons;
- low-threshold and counselling services;
- outpatient treatment of dependency on tobacco products, alcohol, and other addictive substances;
- day care programmes offering outpatient day care to problem users dependent on alcohol and other addictive substances, whose condition requires regular care without the need to extract them from their environment;
- short- and medium-term institutional (inpatient) treatment of problem users addicted to alcohol and other substances in inpatient health care facilities, with the usual duration being from 5 to 14 weeks;
- inpatient treatment in therapeutic communities, which takes the form of a treatment and social rehabilitation programme in inpatient health care facilities and in non-health care facilities, with the usual duration being from 6 to 15 months;
- after-care programmes provided by health care and other facilities; these programmes comprise a host of services provided after the basic treatment is concluded which are aimed at creating conditions for sustained abstinence;
- substitution treatment, which is a short- or long-term addiction treatment consisting of the administration or prescription of substances which act as substitutes for the original addictive substance and is provided in outpatient health care facilities under the supervision of a physician.

In 2006, the Act No. 108/2006 Coll. on social services, which had been in preparation since the early 1990s¹⁹, was adopted. The law defines the various types of social services and the system for their financing, provision, availability, and quality. Social services are defined as residential, outpatient, or field services. The law recognises 31 types of social services, which it divides into (1) social welfare services, (2) social prevention services, and (3) social counselling, which is the basic activity in the provision of all types of social services. Drug users are recognised by the law as a target group for some social prevention services; the following types of social services in particular are relevant in terms of the treatment of and care for drug users:

- outreach programmes;
- low-threshold/contact centres;
- low-threshold facilities for children and adolescents;
- social counselling and telephone intervention helplines;
- social rehabilitation;
- therapeutic communities;
- after-care services and sheltered housing;
- homes with a special regime (including, in particular, residential treatment for older clients dependent on alcohol).

The above lists of types of services defined by the law show overlaps between health care and social services for drug users, and the resulting conflict which often materialises in the practice of providing these services.

5.1.2 Treatment Strategies

The goals and actions in the area of treatment are laid out in national drug strategies; the first such strategy was adopted in 1993 and the present government drug policy is the fourth in the line: the 2005-2009 National Strategy and the related action plans (Bém et al. 2003; Kiššová, 2009). The 2007-2009 Action Plan defines 25 tasks in the area of treatment; the previous 2005-2006 Action Plan defined 27 tasks in the same area, of which – according to the Evaluation Report approved by the Government Resolution No. 442/2007 – 12 tasks (44.4%) were fulfilled, 3 were partially fulfilled (11.1%), and 12 tasks (44.4%) remained outstanding; see the 2006 and 2007 annual reports.

A Vision of Outpatient Drug Services was presented to the professional community for discussion in 2008. The document proposes systematic changes with a view to optimising and strengthening the existing network of outpatient facilities providing services to drug users, and to change the ways in which it is funded. The final version of the paper had not been published when this Report was prepared (Radimecký et al. 2008).

5.1.3 Professional Competency of Staff in the Area of Drug Services

A medical specialisation of “treatment of alcoholism and other addictions” has existed since 1980. According to Decree No. 185/2009 Coll., on specialisation areas in the education of physicians, dentists, and pharmacists, and on the study areas of certified courses, it currently takes the form of an extension specialisation course of “addiction

¹⁸ This provision principally relates to sobering-up stations – see further below.

¹⁹ The social services legislation to date has been wholly insufficient – only institutional care and nursing care had an adequate basis in the law; the other services were neglected.

disorders” that a physician may attend only if they have passed an examination in the basic specialisation course in psychiatry (this system of medical specialisations has also been referred to as “attestation”). An attestation specialisation may be conditional on professional competency for the provision of a certain type of treatment (e.g. pharmacotherapy), for instance, or the execution of a contract with a health insurer regarding reimbursement for medical interventions from public health insurance funds. Today, there are only two types of intervention defined in the area of addictology, which are tied in with the specialisation in the field of “addiction disorders”; they do not, however, relate to the treatment of non-alcohol drug users. The two types are an alcohol test diagnosis and a disulfiram (Antabus/e) reaction performed on a patient addicted to alcohol upon the commencement of desensitisation treatment; other interventions reimbursed from the system of public health insurance are either tied in with a specialisation in psychiatry or they are universal, across-the-board interventions for different medical specialists. The administration of a substitution preparation in treatment with opioid agonists, for instance, is not defined as an intervention reimbursed from the public health insurance system, and the prescription of substitution preparations is not tied in with the medical specialisation in addictology. These factors negatively affect the motivation and necessity to acquire the extension specialisation. In 2007 (the year of the last available statistics), the Institute of Health Information and Statistics of the Czech Republic kept a record of 1,411 psychiatrists (of these, 32 had the extension specialisation in “addiction disorders”) out of the total of 36,815 practitioners of medicine in the Czech Republic (Ústav zdravotnických informací a statistiky, 2008).

In 2005, the Centre for Addictology²⁰ was founded as a multidisciplinary research and training facility in the field of addiction treatment. Its foundation also marked the formal recognition of the discipline of addictology as an interdisciplinary field of study. A bachelor’s academic programme in addictology was introduced; the first 15 bachelors in addictology graduated in 2008. At the beginning of the 2008-2009 academic year, the three years of full-time study had enrolled 75 students, 53 students were in their first year of the combined form of study. A master’s degree programme is currently being developed. The profession of an addictologist was established in 2008 (along with the professions such as a general nurse or midwife) in connection with these study programmes; it was made possible by the amendment to Act No. 96/2004 Coll. on non-medical health professions, as subsequently amended²¹. In addition, the professional competencies required for the performance of this profession were defined (see also the chapter on Legal Framework on page 5).

At the time of publication of this Annual Report, the curriculum of an accredited qualification course, entitled Addictologist (with over 900 hours of instruction), was in the final stage of the approval process. The course is intended to train participants for the work of health professionals who will provide preventive, treatment and rehabilitation care in the field of addictology without professional supervision. The training course covers theoretical knowledge (about two thirds of the sessions) as well as practical skills in addictology services through practice-oriented subjects and internships (about one third of the sessions).

The professional competency of staff in the area of social services is defined in the Act No. 108/2006 Coll. on social services (see above), and, in principle, makes a higher vocational education or, if required, also an academic degree in study programmes such as social work, social policy, social pedagogy, social care, social pathology, law, or special pedagogy a prerequisite for the practice of the profession of a social worker; in all other cases, the practice requires completion of an accredited course of at least 200 hours and 5-10 years of experience in the field.

The majority of professionals working in the area of services for drug users provided outside health care facilities hold the status of a social worker. In addition to the statutory qualification requirements, other competency criteria for working with drug users are also set out in the Standards of Professional Competences for Drug Services (Kalina, 2003b), regulations and standards issued by professional bodies, for instance the Czech Psychotherapy Society²² or the Czech Medical Association of Jan Evangelista Purkyně (ČLS JEP), or in the methodological publication List and Definitions of Interventions of Drug Services (Národní monitorovací středisko pro drogy a drogové závislosti, 2006b).

5.1.4 Professional Competency of Services and Quality Assurance

In 2005, Government Resolution No. 300/2005, dated 16 March 2005, approved the system for the certification of the professional competency of drug services, which is an instrument of quality assurance for harm reduction, treatment, and after-care services. The certification system was implemented in 2006 and certification has been compulsory for NGOs applying for subsidies from the state budget since 2007; this requirement does not extend to new projects. Nine types of services are defined, and their quality is assured using the Standards of Professional Competency of Drug Services, which have a general part and a special part for each type of service (Kalina, 2003b); the certificate is good for a maximum of 3 years. 177 programmes were certified as of 30 June 2009; see Table 5-1.

²⁰ The full name of the Centre for Addictology is the Centre for Addictology at the Psychiatric Clinic of the 1st Medical Faculty and General Teaching Hospital in Prague.

²¹ The changes to the law were implemented by Act No. 125/2005 Coll., Act No. 11/2007 Coll., Act No. 124/2008 Coll. And Act No. 189/2008 Coll. The aforementioned amendment was implemented by the Act No. 339/2008 Coll.

²² See <http://www.psychoterapeuti.cz/>.

Table 5-1: Overview of certified programmes by type as of 30 June 2009 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009a)

Type of service	Number of programmes
Detoxification	4
Outreach programmes	58
Low-threshold and counselling programmes	59
Outpatient treatment	16
Day care programmes	1
Short- and medium-term residential treatment	3
Inpatient treatment in therapeutic communities	12
Outpatient after-care programmes	17
Substitution treatment	7
Total	177

The above overview clearly indicates that the requirement of professional competence for the financing of services from the state budget is now the primary motive for applying for a review of professional competence; it is an option used mainly by NGOs. Health care facilities, on the other hand, were not bound by this requirement in 2008 as they are financed largely from the public health insurance system.– only three programmes are certified for residential treatment, four for detoxification, and seven programmes for substitution treatment.

The Act No. 108/2006 Coll. on social services (see above) introduced the requirement of the registration of social services; the relevant regional authority approves registration applications submitted in writing by service providers (in the case of service providers operated by the regions themselves, the decision lies with the Ministry of Labour and Social Affairs). The regional authority, or the ministry, as the case may be, inspects the services for which registration is sought. The quality of social services is inspected on the basis of the quality standards for social services.

The system of inspection of social services and the certification system of the Government Council for Drug Policy Coordination overlap in terms of their requirements for professional competency. In June 2008, the Government Council for Drug Policy Coordination discussed a report concluding a questionnaire campaign carried out as part of the evaluation study concerning the system and processes of the certification of professional competency of drug policy programmes. The report draws attention, among other things, to the conflict between the two processes of quality assurance, to duplication in the systems of quality inspection by government authorities, and to the fact that health care facilities do not need a certificate to be eligible for subsidies from the Ministry of Health. The Government Council for Drug Policy Coordination had already approved a plan to harmonise the different quality assurance systems in the area of drug treatment and services in December 2005, but the two systems had not been harmonised when this Report was prepared.

A paper comparing the system of social services inspection and the certification system of the Government Council for Drug Policy Coordination was submitted to the professional community for discussion in May 2009 (Šedivá et al. 2009). The paper explains the differences in the philosophy and focus between the two quality assurance systems, and the procedural differences between the process of inspection and of certification which arise from the legislation and the related methodologies; it also highlights specific issues of drug services' practice as seen from the point of the Social Services Act, and it concludes with a glossary of terms, which codifies the interpretation of expressions used in both systems. The target audience is both drug service providers and social services inspectors.

Procedures in the treatment of addictions are defined by the Psychiatric Society of the Czech Medical Association of Jan Evangelista Purkyně (ČLS JEP) (Raboch et al., 2006). The procedures include instructions for the treatment of withdrawal symptoms, psychotherapeutic and psychosocial methods for the treatment of addictions, and pharmacological procedures, including substitution treatment and harm reduction. The importance of psychiatric care, in particular when dealing with acute psychiatric conditions (intoxication and withdrawal, toxic psychosis) and psychiatric co-morbidities (e.g. depression, eating disorders, and pathological gambling) is underlined.

5.2 Treatment System

Treatment programmes for drug users and addicts and their capacity and occupancy in 2008, subject to the availability of data, are summarised in Table 5-2.

Table 5-2: Treatment programmes catering to drug users in 2008

Type of programme	Number	Capacity (persons, beds)	Occupancy (number of persons)
Outpatient health care facilities	357	n.a.	15,711*
Outpatient (non-health care) facilities operated by NGOs	12	n.a.	1 923
Day care centres	1	10	38
Registered substitution centres	40	n.a.	1,375
Sobering-up stations	15	n.a.	n.a.
Detoxification units	19	n.a.	n.a.
Psychiatric hospitals	16	9,240**	3 389
Psychiatric departments in hospitals	32	1,396**	1,247
Psychiatric hospitals for children	3	300**	25
Therapeutic communities	15–20	138***	427***
Specialised schooling facilities for children at risk of drug addiction	5	46	76
After-care programmes	18	283****	1,041
Detoxification units in prisons	4	n.a.	208
Substitution treatment in prisons	7	n.a.	76
Departments for differentiated serving of sentence (voluntary treatment)	6	262	422
Departments for serving of compulsory drug/alcohol treatment in prisons	3	120	206

NB: * it involves the number of persons in the so-called live files, i.e. persons who have visited the facility at least once in that year, number of all psychiatric beds, *** data only from 10 communities, **** data involve the capacity of 15 intensive care programmes with sheltered housing.

The services available in prisons are covered in the chapter on Responses to Drug-related Health Issues in Prisons, page 89; harm reduction services are described in detail in the chapter on Responses to Health Correlates and Consequences, page 67; after-care programmes are set out in the chapter on Social Correlates and Social Reintegration, page 76.

The subsections below give more details on the outpatient and inpatient programmes of a health care and social nature.

5.2.1 Outpatient Treatment

Outpatient medical treatment is provided primarily through facilities in the field of psychiatry and other fields (in particular by general practitioners of adult medicine, also in connection with the more prevalent substitution treatment; see further below). The so-called AT clinics have historically played a special role in the treatment of addictions to alcohol and other drugs among psychiatric facilities.

AT clinics are the successors to the alcohol addiction counselling services that have existed on the territory of what is today the Czech Republic since 1910. After 1956, alcohol addiction counselling services were made a part of psychiatric outpatient clinics, and in the sixties, their role also encompassed non-alcohol drugs (Skála, 2003); they existed under the name AT ("Alcohol – Toxicomania") counselling centres since 1983 (Brožová and Šťastná, 2009). In the 1980s, there were approximately 180 AT counselling centres in the country (Brožová and Šťastná, 2009); the network was disbanded in 1989 and the formal role of AT counselling centres within the health care system has since been lacking. In the 1990s, the number of health care facilities which reported at least one user of illegal drugs grew to 350-400 in the latter years, but these were all outpatient psychiatric facilities that had drug users on record and that completed the A-013 psychiatry report sheet for AT facilities distributed by the Institute of Health Information and Statistics of the Czech Republic; they were not specialised AT counselling centres.

Between July 2008 and April 2009, the National Focal Point carried out a questionnaire campaign aimed at treatment programmes available to drug users in the network of outpatient psychiatric facilities (Národní monitorovací středisko pro drogy a drogové závislosti, 2009f); its purpose was to map the outpatient psychiatric care provided to drug users (AT treatment). 274 facilities in total were invited to respond, and 161 (58.8%) actually did respond; of the total number of respondents, 124 stated they provided AT treatment (i.e. they treat people dependent on alcohol and/or non-alcohol drugs). Out of the total of 124 respondent centres, 53 were registered as AT outpatient clinics and 71 had a contract for AT treatment services with a health insurer (48 subscribed to both options); 42 were neither registered nor contracted to a health insurer; 6 centres did not respond to the questions related to registration and a contract with a health insurance company.

In 2008, the provision of outpatient treatment of users of both legal and illegal drugs was claimed by 357 outpatient medical facilities in the field of psychiatry, which is down from 2007 by 4% (Ústav zdravotnických informací a statistiky, 2009c). Since 2005, there has been a decline in the number of outpatient clinics, as well as of their clients

in treatment, save for alcohol and tobacco users (in the so-called live cases records, i.e. clients in treatment in the given year); see Table 5-3. Outpatient clinics treating 1-10 patients per year – see Table 5-4 – comprised the largest group. The highest number of outpatient clinics and the highest number of patients have historically been reported by specialist clinics, i.e. largely private psychiatric/AT clinics; see Table 5-5.

Table 5-3: Number of outpatient clinics providing services to drug users in 2000-2008 (Ústav zdravotnických informací a statistiky, 2009c)

Year	Number of clinics	Number of drug-using patients in treatment
2000	320	11,423
2001	330	13,050
2002	342	14,203
2003	368	15,786
2004	382	14,040
2005	401	16,394
2006	388	16,392
2007	372	15,684
2008	357	15,711

Table 5-4: Number of outpatient facilities by number of drug users treated in 2003-2008 (Ústav zdravotnických informací a statistiky, 2009c)

Number of patients	Number of facilities					
	2003	2004	2005	2006	2007	2008
1–10	139	144	156	161	140	122
11–50	106	109	107	110	107	115
51–100	27	32	37	31	28	25
101–150	11	12	9	13	11	9
151–200	7	7	9	4	7	7
201–300	10	8	10	13	8	6
301–400	5	3	4	2	6	6
401 or more	8	7	8	9	6	10
Total*	313	322	340	343	313	300

NB: * The facilities are identified by their company identification number; one such identifier may represent several clinics. This is to explain why the number of facilities is lower than the number of clinics as shown in Table 5-3.

Table 5-5: Number of drug users (including tobacco users) treated in outpatient medical facilities in 2003–2008 (Ústav zdravotnických informací a statistiky, 2009c)

Type of facility	2004		2005		2006		2007		2008	
	Number of facilities	Number of persons	Number of facilities	Number of persons	Number of facilities	Number of persons	Number of facilities	Number of persons	Number of facilities	Number of persons b
Inpatient facilities with outpatient services	49	3,896	49	4,131	51	5,130	45	4,918	42	4,118
Integrated outpatient facilities	23	1,458	26	1,877	25	2,760	23	2,794	21	3,280
General practice	1	5	1	7	1	12	1	14	1	16
Specialist practice	243	8,611	257	8,890	260	8,480	237	7,216	229	8,558
Addiction treatment facility	n.a.	n.a.	6	2,584	5	1,495	5	1,513	5	1,322
Other outpatient facilities	6	1,420	1	42	1	44	2	64	2	25
Total	322	15,390	340	17,531	343	17,921	313	16,519	300	17,319

NB.: * The "Drug addiction treatment facility" reporting category was introduced by the Institute of Health Information and Statistics of the Czech Republic in 2005.

Outpatient treatment in the Czech Republic is also available through NGOs; some of these programmes are accredited as a medical facility, some also provide substitution treatment (these facilities and their clients may also be included in other reporting systems; see further below); the common denominator is that the NGOs apply for grants from the state budget to provide their services. The NGOs were founded after 1989, some of them by AT

treatment professionals, or they were transformed from state facilities that already existed²³. In 2008, 12 outpatient programmes subsidised by the Government Council for Drug Policy Coordination were in existence and treating 1,923 drug-using clients in total (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j); see Table 5-6.

Table 5-6: Outpatient treatment facilities operated by NGOs and their clients in 2003-2008 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)

Year	Number of subsidised facilities	Number of drug users
2003	19	1,590
2004	20	1,493
2005	18	1,743
2006	15	2,428
2007	13	1,642
2008	12	1,923

An intensive three-month outpatient programme in a day care centre is an option offered as a standard by only one facility in the Czech Republic: the Prague-based SANANIM civic association, in existence since 1996. The capacity of the programme is approximately 10 persons; in 2008, the service was provided to 38 clients.

5.2.1.1 Opiate Substitution Treatment

Three products for the substitution treatment of opiate/opioid addiction are available in the Czech Republic: (1) methadone, prepared from an imported generic substance (available in specialised substitution centres), (2) Subutex[®], with buprenorphine as the active substance, available since 2000, and Suboxone[®], a composite preparation containing buprenorphine and naloxone as the active ingredients, available since February 2008. Buprenorphine-based medication can be prescribed by any medical doctor, regardless of specialisation. Substitution preparations are only administered orally in treatment settings in the Czech Republic. Methadone in the form of syrup as a proprietary medical preparation has not yet been introduced in the Czech Republic.

The methodology for substitution treatment is defined in the Standard of Substitution Treatment; the previous version, drafted in the late 1990s, was amended in 2008 (Ministerstvo zdravotnictví ČR, 2008). For more information about the standard see the 2007 Annual Report.

All physicians administering a substitution preparation are obliged by law to report the patient data to the National Register of Users of Medically Indicated Substitution Substances (NRULISL) operated by the Institute of Health Information and Statistics of the Czech Republic. An electronic web-based application NRULISL²⁴ was implemented in November 2007. Until 2007, the register was maintained as a simple database, and the reports were collated only from specialised substitution treatment centres accredited by the Ministry of Health and forwarded by way of paper forms and reports taken by telephone. With new substitution treatment facilities emerging outside the network of specialised centres, the number of reporting facilities has increased since 2008, as has the number of patients receiving treatment and the number of treatment episodes, which also complicates the monitoring of trend data provided by the NRULISL.

Substitution treatment was introduced as a standard option in 2000, and the first substitution treatment centre was opened in the General University Hospital ("U Apolináře")²⁵ in Prague. In 2007, the Czech Republic had 15 specialised (accredited by the Ministry of Health) centres registered (two of which were in prison facilities at Prague-Pankrác and Příbram). In December 2008, the National Register of Users of Medically Indicated Substitution Substances kept a record of 40 facilities (Ústav zdravotnických informací a statistiky, 2009d), of which 21 reported patients to the NRULISL register in 2008 (of that number, 4 were prison medical facilities – in Brno, Kuřim, Opava, and Prague-Pankrác)²⁶; see Table 5-7.

In 2008, the NRULISL register received reports of 1,375 persons in substitution treatment (Ústav zdravotnických informací a statistiky, 2009e); the trend since 2000 is shown in Table 5-7. In 2008, a total of 887 persons were

²³ Drop-In, for instance, was founded by the transformation of the Centre for Drug Addictions, which was established in 1971 at "U Apolináře", as a project of the doyen of Czech alcoholology and addictology, Prof. J. Skála (Kalina et al., 2008). As late as in 1993-1994, there were only a few NGOs. In 1994 Kalina and Bém (Kalina and Bém, 1994) refer to only four NGOs active in the area of drug services (Drop-In, SANANIM, Domus, and Harmonie); of these, 2 are still among the largest providers of drug services in the Czech Republic today. In 2008, there are several dozen NGOs providing prevention, harm reduction, treatment, and after-care services in the Czech Republic, operating approximately 200 programmes which meet the standards of professional competency.

²⁴ See <https://snzr.uzis.cz/nrulisl/>.

²⁵ The first unofficial substitution treatment with ethylmorphine in the Czech Republic was started in 1987, also at "U Apolináře" (Kalina, 2007), at the then existing Centre for Drug Addictions; a one-year experimental methadone programme was provided in 1992-1993 by Drop-In (the successor organisation to the "U Apolináře" Centre for Drug Addictions); from 1997, a pilot methadone programme was implemented at the Centre for the Treatment of Drug Addictions at "U Apolináře", which was rolled out into a standard regime in 2000 (Zábranský et al., 2002).

²⁶ In 2008 substitution treatment was available in 10 prison facilities in the Czech Republic; for more information see the chapter on Interventions in the Criminal Justice System, page 86.

admitted for substitution; the highest number (28%) was reported by the Prague-based Remedis, s.r.o., a facility newly registered in the National Register of Users of Medically Indicated Substitution Substances (Remedis is a specialist facility for the treatment of physical complications connected with drug use, viral hepatitis in particular), followed by Drop-In Prague (22%) and the substitution centre in Ústí nad Labem (18%).

Methadone is used for treatment by 13 specialised centres – the so-called methadone centres; the Pilsen, Liberec, Pardubice, Zlín, and Vysočina regions do not have their own methadone centres. The Pilsen region announced that it would open a methadone centre in 2009 – to be operated by the civic association *Ulice – Agentura sociální práce*; in August 2009, the centre was not yet operational²⁷.

Table 5-7: Number of registered facilities providing substitution treatment and the number of patients receiving substitution treatment in 2000-2008 (Mravčík et al. 2008; Ústav zdravotnických informací a statistiky, 2009e)

Year	Number of facilities registered in the NRULISL	Number of clients
2000	7	245
2001	8	483
2002	9	422
2003	9	657
2004	9	729
2005	10	716
2006	14	837
2007	15	959
2008	40	1,375

The number of patients using buprenorphine preparations has been rising since 2000 (until 2000, only methadone was available): in 2001, Subutex[®] was prescribed in 6% of cases, in 2004 already in 34% of cases, in 2007 in 42% of cases, and in 2008 Subutex[®] and Suboxone[®] were the treatment option for 52% of patients (i.e. 503 and 78, 581 in total) reported to the NRULISL as of 31 December (Mravčík et al. 2008; Ústav zdravotnických informací a statistiky, 2009e).

The NRULISL does not keep a record of all medical facilities prescribing buprenorphine products (Subutex[®] and Suboxone[®]); their total number, as well as the total number of patients using buprenorphine preparations, is not known. According to research among general practitioners of adult medicine who prescribed Subutex[®], which was undertaken in 2007 (described in more detail in the 2007 Annual Report), their number was estimated at 150-240, and the number of patients receiving Subutex[®] was estimated at 4,300, of which number approximately 3,000 were the patients of psychiatrists, and approximately 1,400 were the patients of general practitioners (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2008). The estimated number of patients treated with Subutex[®] in 2007 outside specialised centres was 3,500-3,800 (Mravčík et al. 2008).

Between July 2008 and April 2009, the National Focal Point ran a questionnaire campaign focused on treatment programmes available to drug users in the network of outpatient psychiatric facilities (Národní monitorovací středisko pro drogy a drogové závislosti, 2009f); see also above. Out of the 161 facilities that responded, 42 (26.1%) stated they offered substitution treatment using buprenorphine preparations, and reported 1,109 patients receiving these preparations (the average was 32, the minimum was 0, the maximum was 275). Table 5-8 shows the number of facilities and persons receiving treatment by region. Ten facilities with 872 patients (78.6% of the whole data set of patients in substitution treatment) reported 20 or more patients; of this number, only 4 were physicians registered in the NRULISL, and together they treated 182 patients. The data only confirm the fact that there are still significant numbers (tens to hundreds) of medical practitioners and (hundreds to thousands) of patients outside the NRULISL reporting system.

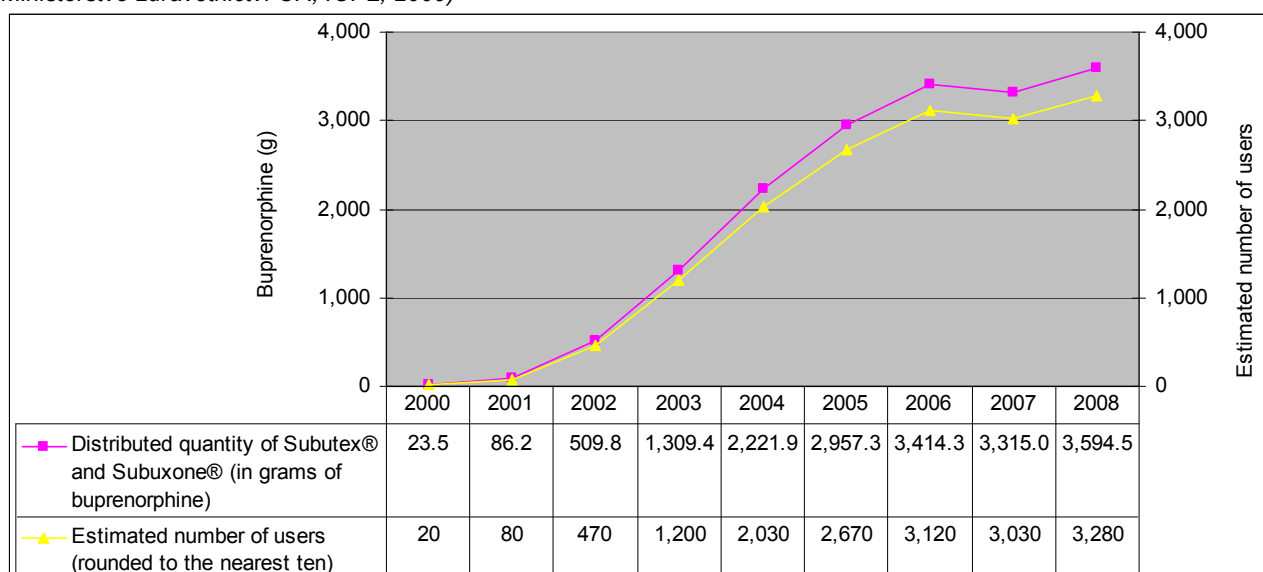
²⁷ Section "Services" on the website of the civil association *Ulice – Agentura sociální práce*, <http://www.ulice-plzen.com>, data from 6 August 2009.

Table 5-8: Outpatient psychiatric facilities offering substitution treatment using buprenorphine preparations and the number of patients receiving substitution treatment in 2008 by region (Národní monitorovací středisko pro drogy a drogové závislosti, 2009f)

Region	Number of completed and returned questionnaires	Facilities prescribing substitution by buprenorphine		Patients in substitution treatment	
		Number	Share in %	Number	%
Prague	16	10	62.5	686	61.9
Central Bohemia	17	7	41.2	122	11.0
South Bohemia	13	2	15.4	26	2.3
Pilsen	11	3	27.3	18	1.6
Karlovy Vary	6	3	50.0	32	2.9
Ústí nad Labem	7	1	14.3	70	6.3
Liberec	4	2	50.0	0	0.0
Hradec Králové	7	2	28.6	90	8.1
Pardubice	6	0	0.0	0	0.0
Vysočina	19	2	10.5	2	0.2
South Moravia	12	5	41.7	22	2.0
Olomouc	9	1	11.1	0	0.0
Zlín	22	2	9.1	1	0.1
Moravia-Silesia	12	2	16.7	40	3.6
Total	161	42	26.1	1,109	100.0

In 2008, a quantity of Subutex® and Suboxone® equivalent to 3,595 g buprenorphine was distributed on the Czech market (Ministerstvo zdravotnictví ČR, IOPL, 2009), which is a slight increase on the years 2007 and 2006. The number of Subutex® users in 2008 is estimated – on the basis of the same premise as in the previous years (i.e. an average daily dose of 6 mg of buprenorphine and a bi-daily average frequency of administration²⁸) – at 3,280 persons; see Figure 5-1.

Figure 5-1: Quantities of Subutex® and Suboxone® (in grams of buprenorphine) distributed and the estimated number of users of the preparations in 2000-2008 (Národní monitorovací středisko pro drogy a drogové závislosti, 2004; Ministerstvo zdravotnictví ČR, IOPL, 2009)



In 2008 and 2009, the outreach and counselling programmes for drug users which are operated by NGOs continued to cooperate with physicians prescribing buprenorphine in the area of the psycho-social component of substitution treatment; for more information see the 2007 Annual Report.

The selected issue on Problem Amphetamine and Methamphetamine Use, Related Consequences and Responses (p. 102) recapitulates the experience with the oral substitution of pervitin (methamphetamine) by other stimulants.

²⁸ The information on the average length of treatment (approximately 6 months) was obtained by way of a survey among outpatient psychiatrists in 2004 (Národní monitorovací středisko pro drogy a drogové závislosti, 2004), and was recalculated using the average of 1 application in two days.

5.2.2 Inpatient Treatment

The so-called sobering-up stations – special medical establishments for short-term stays (in the range of several hours) and for detoxification in the case of acute intoxication, of the alcohol kind in particular – are a special type of inpatient facility in the Czech Republic which is unique in Europe and in the wider world. The first facility of this type was opened in 1951 at “U Apolináře”, and in the mid-1970s there were already 50 sobering-up stations in the Czech Republic (Skála, 2003). At present, there are 15 sobering-up stations in existence in the country; they are established and operated by regions, and some regions which do not have such a facility of their own contribute towards the treatment of patients intoxicated by alcohol or other drugs in other health care facilities (e.g. the Liberec region).

The detoxification units, of which there are presently 19 in the Czech Republic, are inpatient health care facilities (departments) affiliated to addiction treatment departments or to other departments of hospitals; they usually provide short-term (typically under 3 weeks in duration) inpatient treatment aimed mainly at managing the withdrawal syndrome in the early days of abstinence, prior to referral to another (typically also residential) treatment facility. Prague now has a Detoxification Centre for Children and Adolescents at the Hospital of Sisters of Mercy of St Charles Borromeo, which offers a comprehensive treatment package for children and adolescents under 18 years of age. The centre also has an outpatient psychiatric clinic and a related inpatient facility with 14 beds; in addition to detoxification, it also offers a psychotherapeutic motivational programme and after-care. The facility admits patients regardless of the region of their domicile.

Psychiatric hospitals and the psychiatric departments of general hospitals provide inpatient medical treatment of addicted patients. Psychiatric hospitals in particular organise the treatment by departments specialising in various types of addiction. The first facility of this type was the men’s department for alcohol addiction treatment founded by J. Skála at the psychiatric clinic of the General University Hospital, “U Apolináře”, in Prague in 1948; gradually, over time, a whole range of services was developed, including an outpatient clinic, sobering-up station, therapeutic community, centre for children, adolescents, and family, self-help activities, regime activities, group psychotherapy, etc. (Skála, 2003; Kalina, 2007). This facility became the model for other departments and the whole system of inpatient and outpatient AT medical treatment of drug users in the Czech Republic as we know it today.

In recent years, the network of psychiatric hospitals and departments has not undergone many changes, except for a general reduction in the number of beds (Ústav zdravotnických informací a statistiky, 2009c).

The inpatient psychiatric facilities in 2008 admitted 14,228 patients for the treatment of disorders induced by the use of addictive substances, of which number 9,563 were disorders caused by alcohol dependency (there has been a marked decrease since 2005), and 4,665 were patients with disorders caused by the use of other psychoactive substances.

Court-imposed compulsory treatment, including its institutional form, is described in the chapter on Interventions in the Criminal Justice System, page 87.

Table 5-9: Number of inpatient psychiatric facilities, their total bed capacity, and occupancy by users of non-alcohol drugs (except tobacco) in 2000-2008 (Brožová and Šťastná, 2009; Ústav zdravotnických informací a statistiky, 2009c)

Year	Psychiatric hospitals for children			Psychiatric hospitals for adults			Psychiatric departments in hospitals		
	Number	Capacity	Number of patients	Number	Capacity	Number of patients	Number	Capacity	Number of patients
2000	4	358	28	17	9,717	3,181	32	1,534	1,868
2001	4	368	32	17	9,771	3,221	33	1,554	1,523
2002	4	368	13	17	9,677	2,494	33	1,546	1,200
2003	4	368	17	17	9,609	2,536	33	1,517	1,480
2004	4	368	27	17	9,583	2,880	33	1,501	1,762
2005	3	320	27	17	9,538	3,104	32	1,439	1,582
2006	3	320	29	17	9,442	3,200	31	1,420	1,629
2007	3	320	16	16	9,307	3,423	32	1,419	1,299
2008	3	300	25	16	9,240	3,389	32	1,396	1,247

A therapeutic community (TC) is another type of residential treatment programme. The first such programme developed on TC principles in the Czech Republic was the department at “U Apolináře” in 1948. After 1989, therapeutic community programmes were started mainly by NGOs. In the public sector, TCs are operated either as social services facilities or as separate departments of inpatient health care facilities – it is not common for a therapeutic community to be accredited as a health care facility itself. TCs provide medium-to-long-term treatment with a duration of 6-18 months. Enrolment in a TC is systemically preceded by detoxification and short-to-medium-

term institutionalised treatment, and it is followed by after-care programmes (Kooyman et al. 2004; Nevšimal et al., 2007).

The TC Němčice (SANANIM civil association) founded in 1991 was the first therapeutic community in the Czech Republic. The following therapeutic communities for drug users have been gradually established and accredited: TC Mukařov (operated by White Light I.), TC Podcestrný mlýn (Sdružení Podané ruce), TC Čeladná (Renarkon), TC Nová Ves (ADVAITA), TC Mníšek pod Brdy (Magdaléna), TC Karlov (SANANIM), TC Vršiček and TC Šluknov (Teen Challenge), TC o.s. Krok, TC Sejřek (Kolpingovo dílo CR). Some of the communities target specific groups (e.g. addicted mothers with children, adolescents, and clients with dual psychiatric diagnoses). The 11 programmes listed above and the Klíčov Rehabilitation Institute and Care Centre were fully accredited in 2008 for residential treatment in the form of a therapeutic community; 10 programmes drew grants from the Government Council for Drug Policy Coordination, which means they report the numbers of clients and services provided to them by means of project final reports; see Table 5-12 (p. 52). Therapeutic communities in the Czech Republic are associated in the section of therapeutic communities of the Association of Non-governmental Organisations (A.N.O.), which presently has 10 members (9 of the 12 programmes listed above and TC Fides at the Bílá Voda Psychiatric Hospital). In the Register of Social Services Providers maintained by the Ministry of Labour and Social Affairs²⁹, there are 15 programmes registered as therapeutic communities in the Czech Republic that target primarily people who are at risk of addiction or who are already addicted to substances; of this number, four are not accredited with the Government Council for Drug Policy Coordination and they are not members of the relevant professional section of A.N.O.

In 2008, five educational establishments had departments specialising in the treatment of children at risk of drug addiction. The total capacity was 46 persons, and the average duration of the treatment was approximately 7 months (the longest treatment was 40 months in the case of one boy). Seventy-six children were placed into their care in 2008³⁰.

5.2.3 Systems for Collection of Data on Drug Users in Treatment

Data on drug users using the services of low-threshold and treatment facilities are available from several data sources.

Data about drug users who use the services of low-threshold and treatment facilities are available mainly thanks to the national system of reporting into the Register of Treatment Demands, which has existed since 1995 and is a database of the Public Health Service and is maintained by the Public Health Office in Prague. Drug users who – in any given year – sought treatment, counselling, or social services in designated facilities for drug users, either of the health care or non-health care type (e.g. therapeutic communities, low-threshold centres), are included in the database. A special record of first treatment demands is kept. The data set and its structure and the definitions in use comply with the treatment demands collection standard issued by the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA). The register does not effectively cover the treatment provided through general practices, substitution treatment, and in-prison treatment. (Studničková, 2009c).

Other sources of data about drug users in treatment include databases of health care facilities maintained by the Institute of Health Information and Statistics (IHIS). The data are obligatorily reported by inpatient and outpatient (psychiatric) facilities and the NRULISL database of substitution treatment (see above). A greater number of facilities report to the IHIS system, compared to the system of the Public Health Service; however, the system only accounts for health care facilities.

The data on clients of and services provided by NGOs, or programmes delivered with financial support from the state budget, are mainly available from final reports of projects implemented as part of the subsidy proceedings administered by the Government Council for Drug Policy Coordination. This information is processed annually by the National Focal Point. In particular, the data cover low-threshold harm reduction, as well as other types of services provided by NGOs (outpatient treatment, after-care, and inpatient treatment in therapeutic communities)³¹.

The above data collection systems have overlaps, which leads, for instance, to a situation in which an NGO-operated outpatient health care facility providing substitution treatment and reporting to the Register of Treatment Demands completes datasheets for the Institute of Health Information and Statistics, reports data to the NRULISL register, and submits a report to the grant authority as part of the subsidy proceedings. Information originating from different sources therefore needs to be handled with knowledge of the overlaps.

²⁹ See <http://ireqipagempsv.cz/>.

³⁰ The information was disclosed by a representative of the Ministry of Education, Youth, and Sport at the meeting of the advisory committee for drug data collection of the Government Council for Drug Policy Coordination held on 22 September 2009.

³¹ Since 2003 the NMC has operated FreeBase, a software application of the consolidated system for data collection in low-threshold facilities, and from 2008 also UniData, an application for all types of services. A similar application – PrevData – was implemented in the area of primary prevention in 2008. All these applications are principally intended for capturing data about clients and the services provided to them. They contain a number of other tools, for instance the processing of reports which are compatible with the Register of Treatment Demands and with the requirements from the running and final reports in the subsidy proceedings of the Government Council for Drug Policy Coordination. The applications can be downloaded for free from <http://www.drogovesluzby.cz>.

5.3 Characteristics of Clients in Treatment

5.3.1 Treatment Demand Register

In 2008, the Register of Treatment Demands received data from 223 centres (67 low-threshold centres, 104 outpatient facilities, and 52 inpatient facilities). The most sought-after type of facility has traditionally been the low-threshold centre; as in the previous years, the clients of these facilities accounted for more than a half of the treatment demands – 48.2% of first treatment demands and 51.8% of all treatment demands. Outpatient facilities were the most widely represented type among the centres; however, their share of the total volume of the reported incidence and of the prevalence of drug users in treatment was only 25.2% and 25.1%, respectively (Studničková and Petrášová, 2009). The proportions of different types of facilities and their clients in the register have been stable in recent years (Studničková, 2009c).

A total of 8,279 drug users sought treatment services in facilities in 2008, i.e. 280 persons fewer than in 2007. Of these, 3,981 individuals sought treatment for the first time, i.e. 365 persons fewer than in 2007. Women made up approximately one third of treatment demands. The proportion of men was lowest in the 15-19 category (Studničková and Petrášová, 2009).

The order of drugs which were the cause of all and first-time treatment demands continued to be the same as in 2007. Users of stimulants³² were the most commonly represented among all treatment demands (61.3%) and even among first treatment demands (62.9%); this was especially the case for pervitin (61.0% and 62.6%, respectively), followed by opiate users among all treatment demands (24.9%) and cannabis users among first treatment demands (18.9%). Figure 5-2 and Figure 5-3 illustrate the development in the number of (first) treatment demands by drug type.

The prevalence and incidence of treatment demands and the representation of treatment demands by drug type is different in each region. The highest relative prevalence and incidence was recorded in the Ústí nad Labem region and in Prague. Stimulant users predominated in 2008 in all regions (from 52.3% in Prague and in Moravia-Silesia to 85% in South Bohemia). Opiate users were more significantly represented in Hradec Králové (37.6%), Prague (36.7%), Ústí nad Labem (29.9%), and South Moravia (29.9%); cannabis users sought treatment most frequently in the Vysočina (29.8%) and Moravia-Silesia (27.6%) regions; see Map 5-1.

The average age of persons seeking treatment has been increasing³³. The most commonly represented age group in 2008 among all treatment demands and among first treatment demands was 20-24-year-olds, who accounted for 32.2% and 28.1%, respectively. The average age of first treatment demands and all treatment demands is 24.3 years and 25.9 years, respectively (Studničková and Petrášová, 2009).

Among all treatment demands in 2008, the oldest group represented were opiate and cocaine users (the average age of a cocaine user was 29.6 years and that of a heroin user 28.7 years). The average age of a pervitin user was 25.4 years, of an inhalant user 25.7 years, and of a cannabis user 21.3 years. The order was also the same among first treatment demands; cocaine and heroin users were the oldest (29.5 and 27.3, respectively), followed by pervitin users (24), inhalant users (22.4), and cannabis users (20.5); see Figure 5-4 and Figure 5-5. 715 (18%) of first treatment demands and 1,290 (15.6%) of all the clients treated in 2008 began to use the primary drug before reaching 15 years of age; 70% of first treatment demands and 69% of all drug users treated began to use the primary drug before reaching 19 years of age.

³² The Public Health Service ranks amphetamine-type drugs, including MDMA, phenmetrazine, and ephedrine, as stimulants; cocaine is not included in this group.

³³ The number of cocaine users was very low.

Figure 5-2: First treatment demands by type of drug in 1997-2008 (Studničková and Petrášová, 2009)

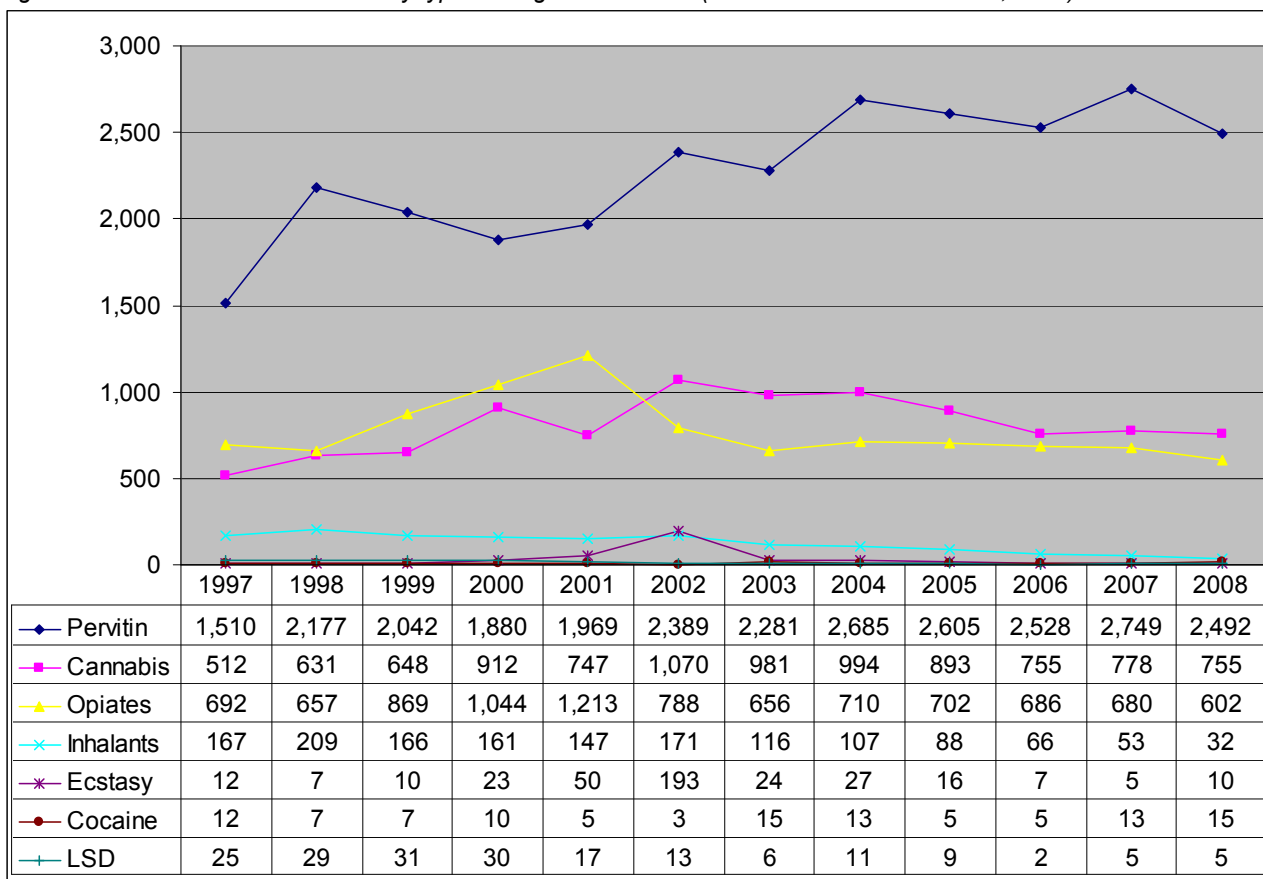
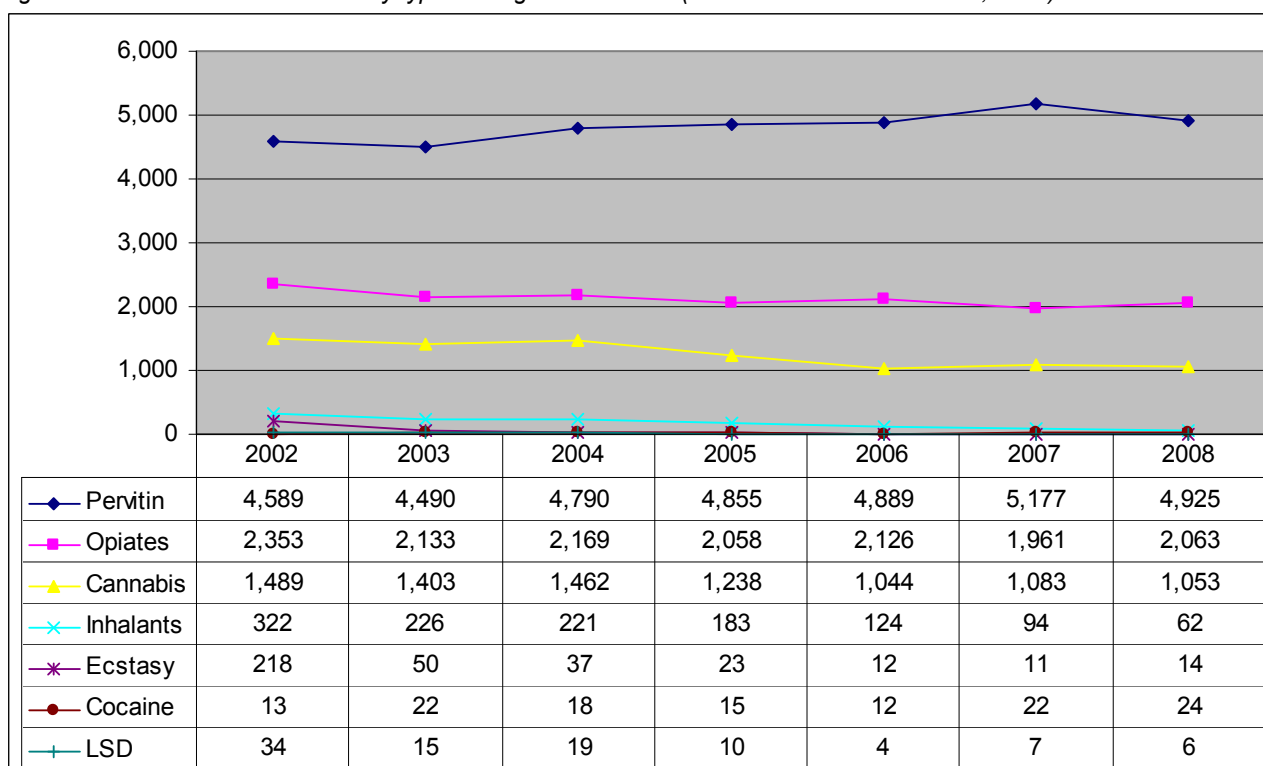
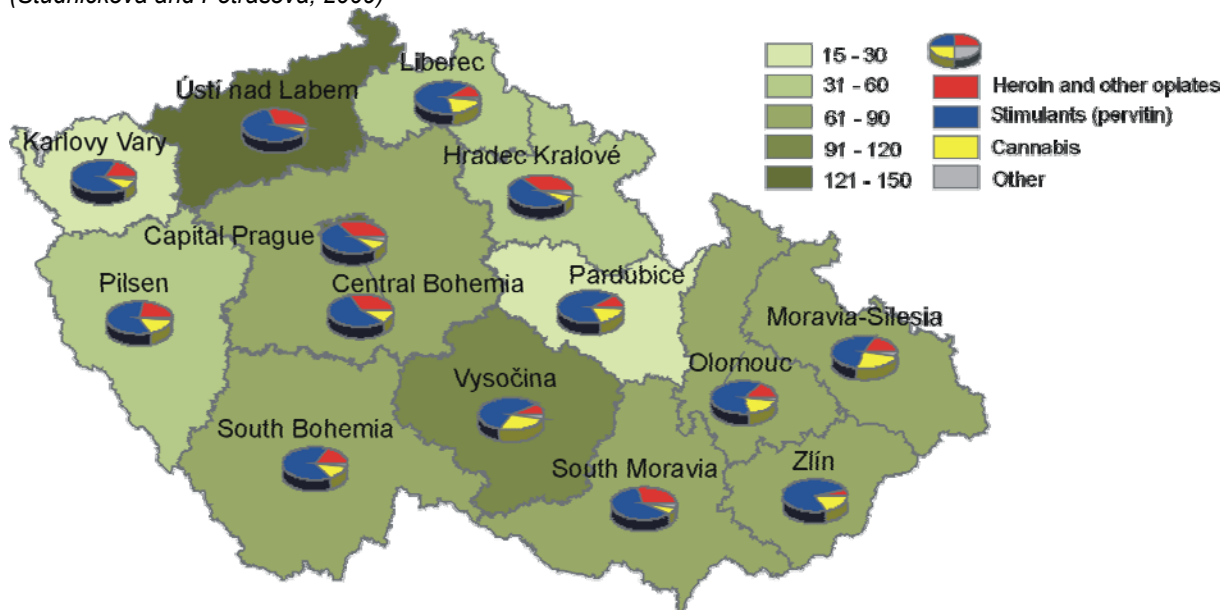


Figure 5-3: All treatment demands by type of drug in 2002-2008 (Studničková and Petrášová, 2009)

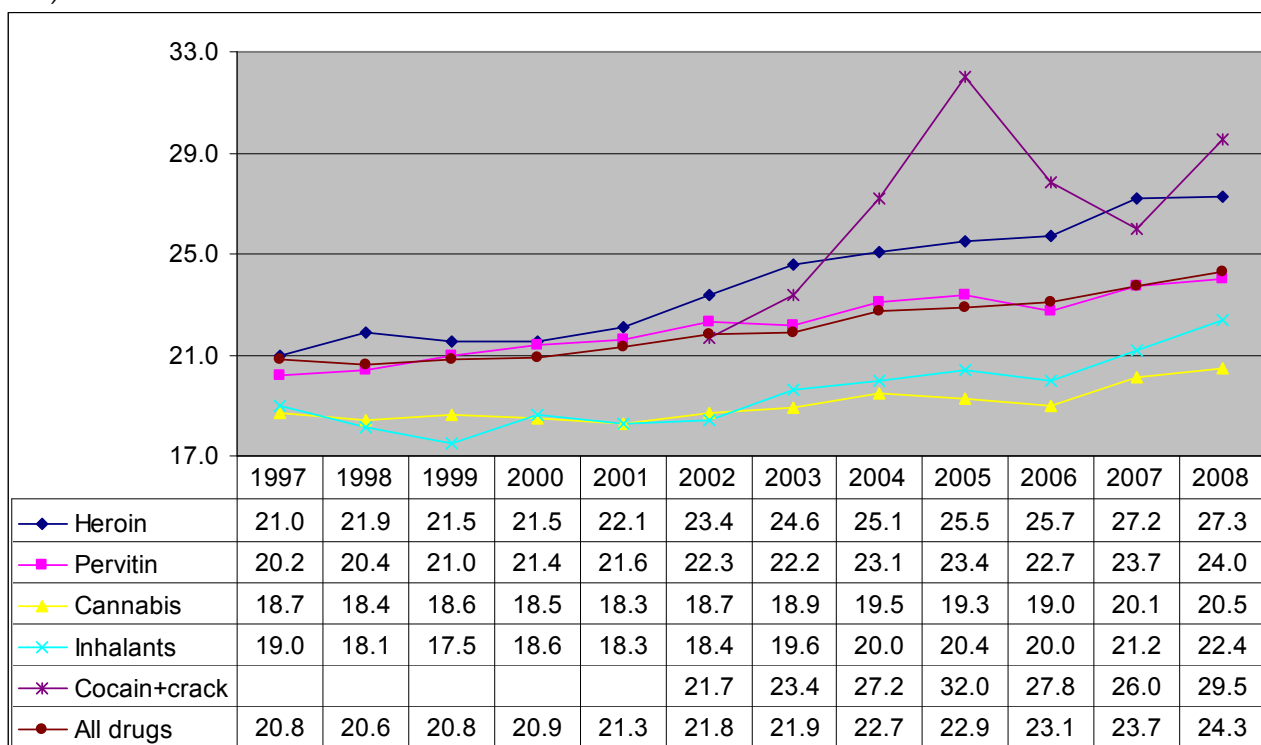


Map 5-1: All treatment demands by type of drug in regions of the Czech Republic in 2008 per 1,000 inhabitants (Studničková and Petrášová, 2009)



In 2008, the total of treatment demands involved 7,490 problem drug users (90.5%) and that of first treatment demands involved 3,428 problem drug users (86.1%)³⁴. The intravenous application of drugs (including secondary ones) was noted in 5,986 (72.3%) of all treatment demands and in 3,981 (62.0%) of first treatment demands (Studničková and Petrášová, 2009). The trends of selected characteristics of treatment demands are shown in Figure 5-6 and Figure 5-7; additional information about the injecting use of drugs among treatment demands is given in the chapter on Risk Behaviour of Drug Users (p. 58).

Figure 5-4: Average age of first treatment demands by selected drug type in 1997-2008 (Studničková and Petrášová, 2009)



³⁴ i.e. injecting drug users and/or opiate users and/or amphetamine users and/or cocaine users.

Figure 5-5: Average age of all treatment demands by selected drug type in 2002-2008 (Studničková and Petrášová, 2009)

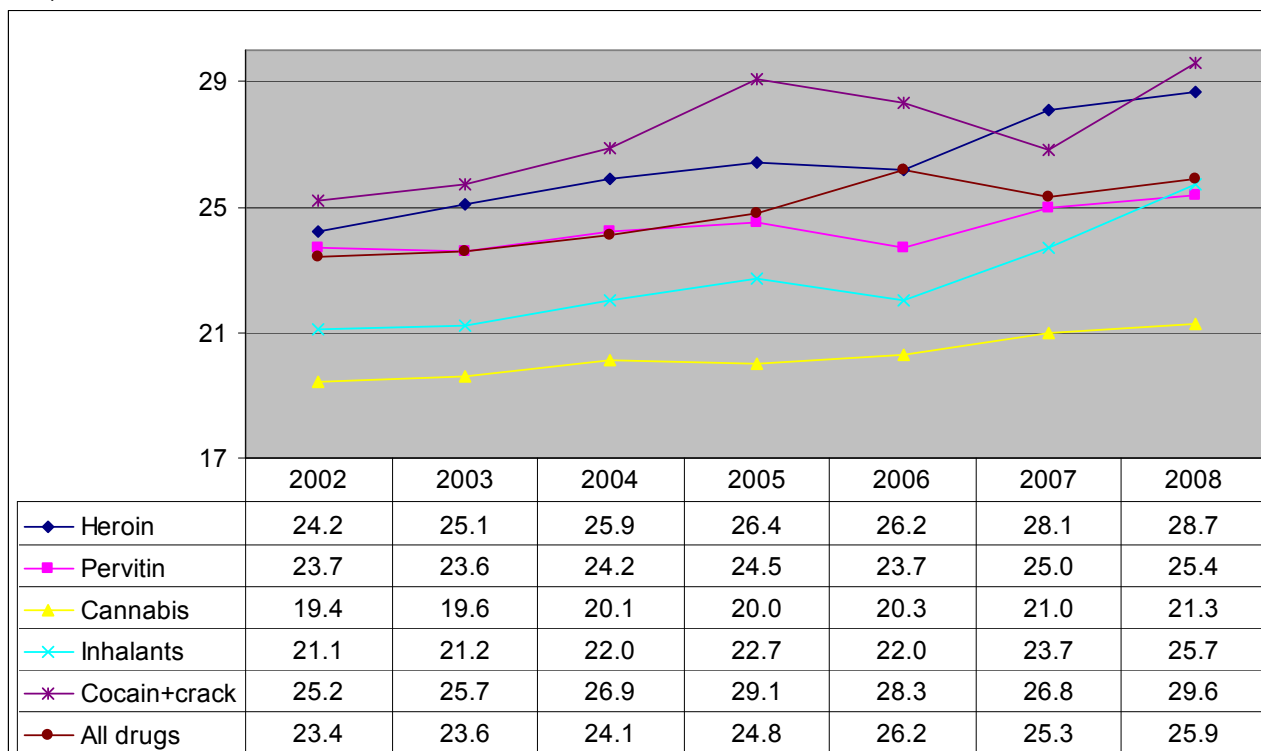


Figure 5-6: Selected characteristics of first treatment demands in 1997-2008 (Studničková and Petrášová, 2009)

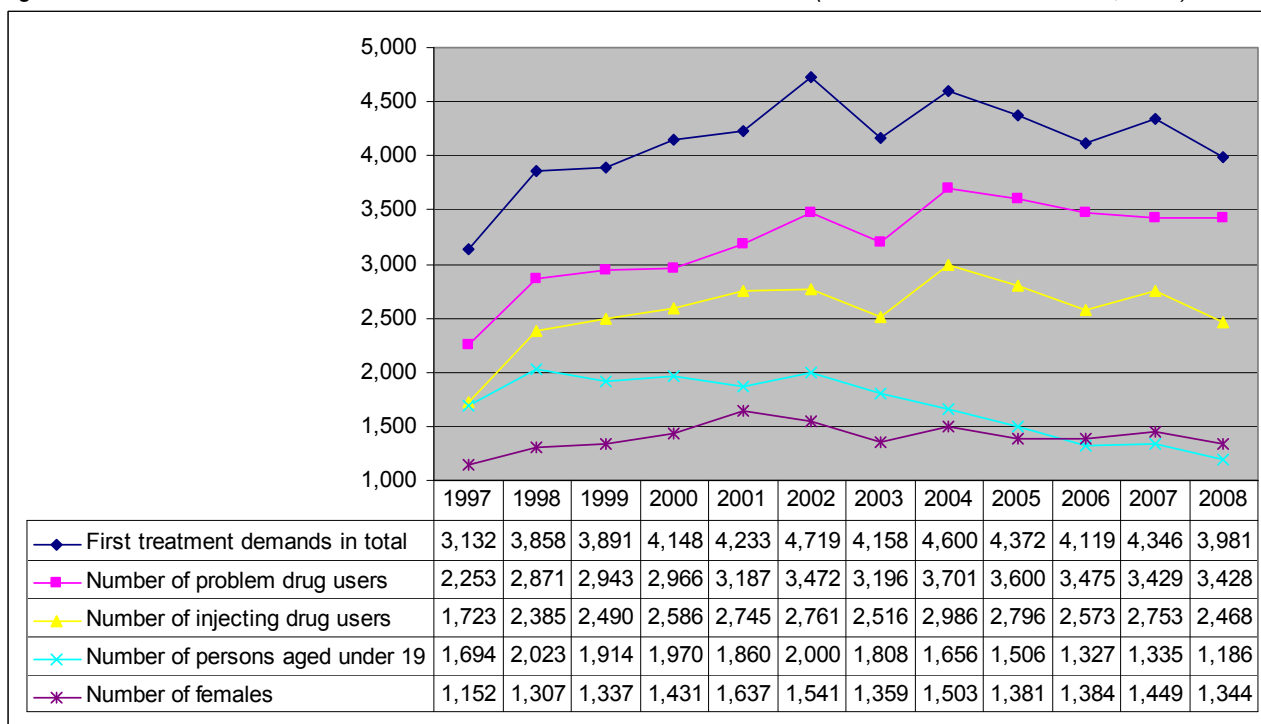
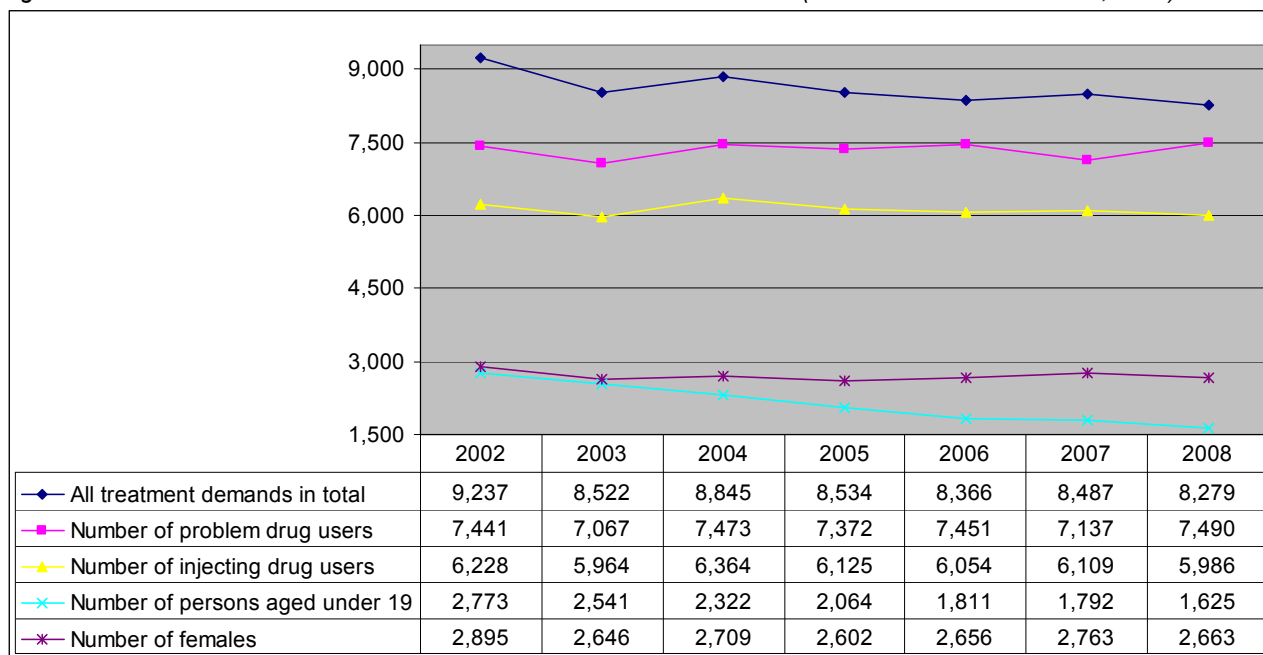


Figure 5-7: Selected characteristics of all treatment demands in 2002-2008 (Studničková and Petrášová, 2009)



In 2008, first treatment demands reported the daily use of drugs in 1,274 cases (32.0%); an additional 1,002 users (25.2%) used the drug 2-6 times per week. Among new treatment demands, heroin was the drug most frequently used on a daily basis (58.6% of heroin users); pervitin was the daily drug for 25.5% of its users. The most widely reported frequency of use of pervitin was 2-6 times per week.

All treatment demands in 2008 reported the daily use of drugs in 2,772 cases (33.5%); an additional 1,888 users (22.8%) used the drug 2-6 times per week. Among all treatment demands, heroin was the drug most frequently used on a daily basis by a half of its users; pervitin was used daily in one quarter of cases, and among all treatment demands, pervitin was most frequently used 2-6 times per week (28.8%). Subutex® users also reported a relatively high frequency of use: 79.8% of Subutex® users used it on a daily basis (Studničková and Petrášová, 2009).

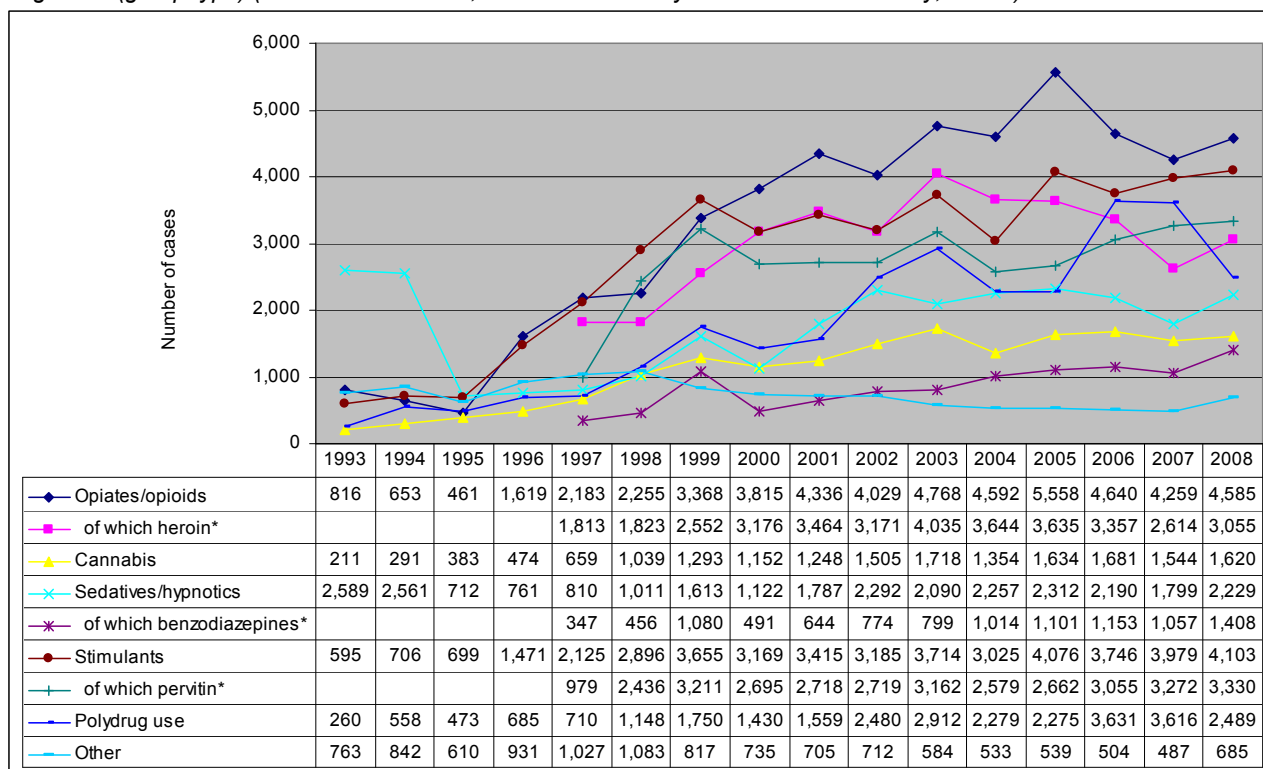
The socioeconomic aspects of treatment demands' characteristics have not changed since 2002. Out of the total of 8,487 treatment demands in 2008, 11.1% were from homeless people, and another 6.8% were from people resident in institutions (e.g. in prisons, institutional care, hostels, or in sheltered housing); only 52.3% gave a permanent address of residence. Less than a half of both all and first treatment demands were from drug users who lived with their parents, and 20.6% of all clients in treatment stated they lived alone – men (21.8%) more frequently than women (12.6%); 18.2% of newly registered clients stated that they lived alone. A total of 522 clients (6.2%) receiving treatment indicated they lived in a household with children (Studničková and Petrášová, 2009).

More than a half of treatment demands were from unemployed people or people in temporary jobs. 20.8% of first treatment demands and 22.2% of all treatment demands were from people who stated they were in regular employment. There was a higher proportion of unemployed or temporarily employed people among men. Almost 50% of treatment demands were from people educated to elementary level. 6.0% of first treatment demands and 4.1% of all treatment demands were from people who had not completed their basic education (Studničková and Petrášová, 2009).

5.3.2 Clients in Outpatient Treatment

In 2008, 17,319 users of various drugs with the exception of alcohol (dg. F11-F19) were treated in outpatient psychiatric facilities; of these, 15,711 were users of drugs with the exception of tobacco (dg. F11-F16, F18-F19). There were 10,707 men (68%), and 5,004 were women (32%). The 20-39 age group was the most numerous (71.4%), and 12.1% of the patients were in the under-20 age group. Table 5-3 and Table 5-4 show the trend in the total number of patients. Disorders caused by the use of opiates (F11), of stimulants (F15) and by polydrug use (F19) are traditionally the most frequent diagnoses of patients in treatment; see Figure 5-8.

Figure 5-8: Development in the number of drug users treated in outpatient health care facilities in 1993-2008 by diagnoses (group type) (Mravčík et al. 2008; Ústav zdravotnických informací a statistiky, 2009c)



NB: Separate statistics for heroin, benzodiazepines, and pervitin are not available prior to 1996.

In 2008, outpatient treatment was also available from 12 NGOs funded by the Government Council for Drug Policy Coordination. Services were provided to a total of 1,923 users of illegal drugs (1,088 men and 835 women), and the average age of the clients was 28.9 years. 724 clients (37.6%) injected drugs, 456 (23.7%) used pervitin, 317 (16.5%) heroin, 118 (6.1%) cannabis, and 186 (9.7%) other opiates, mainly buprenorphine obtained without prescription. Compared to 2007, there was a significant increase in the number of clients, in particular heroin users, and a slight decline in the number of pervitin users. Table 5-10 gives a comparison over the period 2003-2008 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j).

Table 5-10: Outpatient treatment facilities operated by NGOs and selected characteristics of their clients in 2003-2008 (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)

Indicator	2003	2004	2005	2006	2007	2008
Number of subsidised facilities	19	20	18	15	13	12
Number of clients	2,820	2,506	3,127	4,301	3,044	3,278
Number of drug users	1,590	1,493	1,743	2,428	1,642	1,923
– injecting drug users	848	697	1,034	1,024	708	724
– pervitin users	547	540	540	771	511	456
– cannabis users	246	339	158	405	101	118
– heroin users	310	223	391	240	256	317
– Subutex® users	n.a.	n.a.	126	110	116	186
Average age of drug user	23.6	25.9	26.8	29.6	26.3	28.9

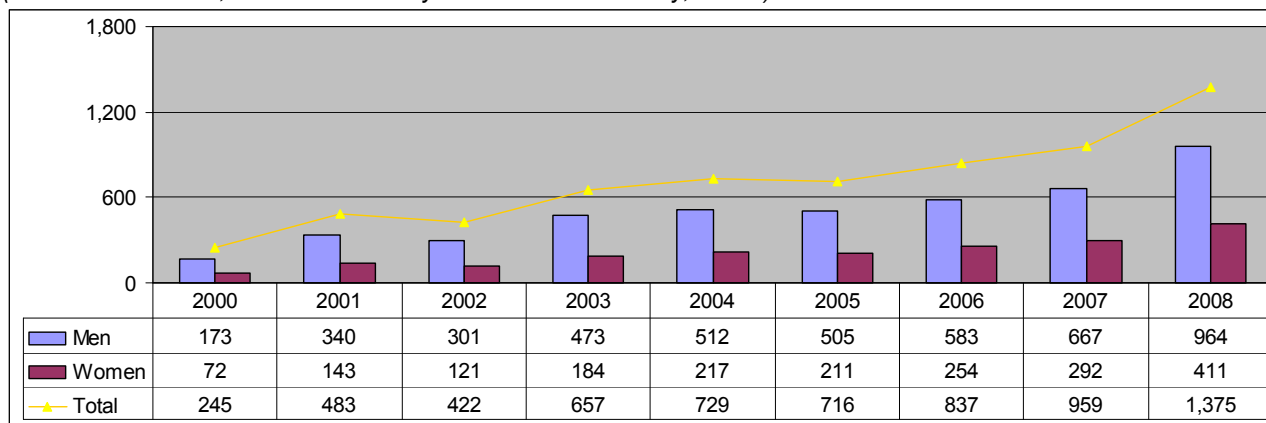
Only one facility in Prague, which is run by the SANANIM civic association, supplied intensive outpatient treatment in the form of a three-month course of treatment in a day care centre in 2008. The programme capacity was 10 persons and services were provided to 38 clients (11 men, 27 women), whose average age was 26.5 years. Altogether, 24 clients (63%) were injecting drug users before the treatment; 6 (15.8%) were heroin users and 24 (63%) used pervitin. 52.6% of the clients completed the treatment successfully. The average duration of the treatment per client was two months (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j).

5.3.3 Clients in Substitution Treatment

In 2008, the NRULISL register kept a record of 1,375 persons who underwent substitution treatment (Ústav zdravotnických informací a statistiky, 2009e); Figure 5-9 shows the trend from 2000. In 2008, a total of 887 persons were admitted for substitution treatment, of which number 422 were first-time substitution clients.³⁵

Clients from Prague, the Capital City, (45%), and the Ústí nad Labem region (20%) make up the largest groups among newly admitted substitution clients, whereas clients from the Pilsen, Liberec, Pardubice, Olomouc, Zlín, and Vysočina regions are relatively under-represented. With the exception of the Pilsen region, it is a reflection of the regional distribution of the problem use of opiates; for more information see chapter Problem Drug Use (p. 28).

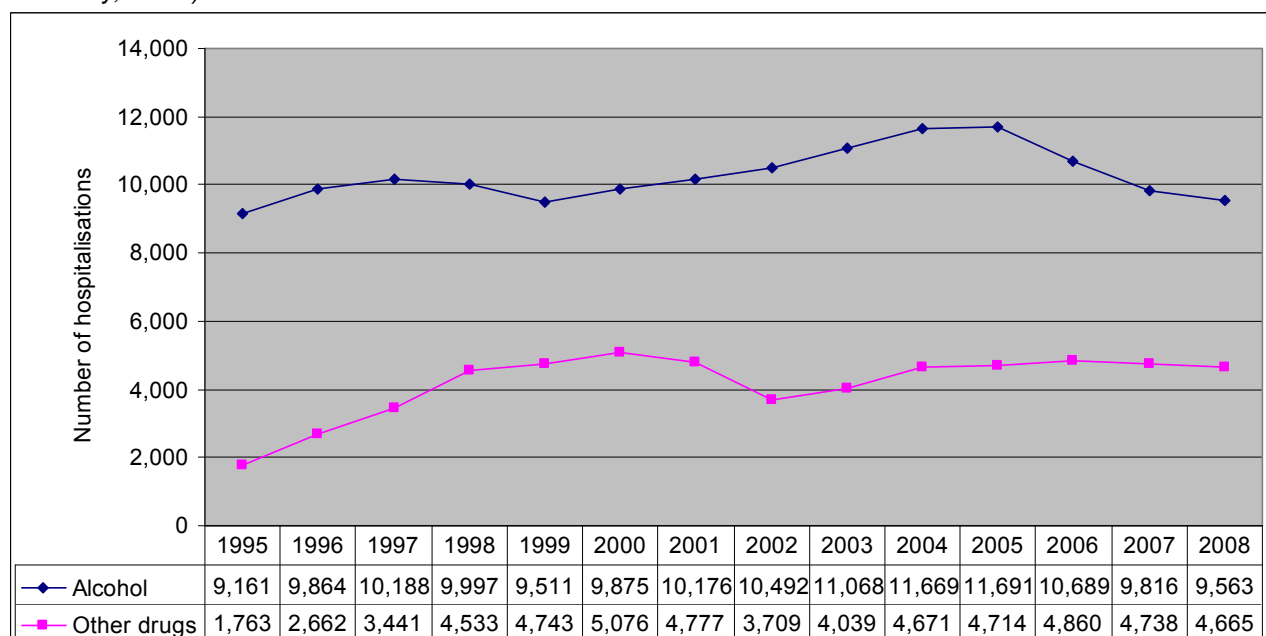
Figure 5-9: Number of patients in substitution treatment reported to the NRULISL database in 2000-2008 by gender (Mravčík et al. 2008; Ústav zdravotnických informací a statistiky, 2009e)



5.3.4 Clients in Inpatient Treatment

The trend in the number of hospitalisations resulting from disorders caused by the use of alcohol and other psychoactive substances in inpatient psychiatric facilities since 1995 is shown in Figure 5-10 (Ústav zdravotnických informací a statistiky, 2009c), and the numbers of patients by primary diagnosis and type of psychiatric department are given in Table 5-11.

Figure 5-10: Number of hospitalisations resulting from disorders caused by the use of alcohol and other psychoactive substances in inpatient psychiatric facilities for adults in 1995-2008 (Mravčík et al. 2008; Ústav zdravotnických informací a statistiky, 2009c)



³⁵ It is not uncommon for a person to be admitted and re-admitted within a calendar year. Out of the persons who were admitted for treatment in 2008, 8.5% were attempting for the second time, 2.8% for the third time, and the maximum number of attempts for treatment by one person was six. The highest number of re-admissions was reported by the South Bohemia Substitution Centre in České Budějovice, Drop-In in Prague, and the substitution centre at the University Hospital in Ostrava. The re-admissions, or more specifically the terminations of the previous treatment episode, were most frequently caused by a violation of the treatment regime on the part of the patient; in the long term, repeated violation of the therapeutic agreement is the reason behind 70% of all treatment terminations (Ústav zdravotnických informací a statistiky, 2009e).

Table 5-11: Number of hospitalisations resulting from disorders caused by the use of alcohol and other psychoactive substances in inpatient psychiatric facilities in 2008 by type of health care facility, gender, and diagnosis (Ústav zdravotníckých informáci a štatistiky, 2009c)

Diagnosis	Psychiatric hospitals for children			Psychiatric hospitals for adults			Psychiatric departments in hospitals		
	Men	Women	Total	Men	Women	Total	Men	Women	Total
F11-19 in total, excluding F17	23	2	25	2,389	1,000	3,389	793	454	1,247
– of which F11 (opioids)	0	0	0	233	97	330	216	113	329
– of which F12 (cannabis)	5	0	5	69	14	83	41	5	46
– of which F13 (sedatives/hypnotics)	0	0	0	49	101	150	37	63	100
– of which F14 (cocaine)	0	0	0	2	0	2	1	0	1
– of which F15 (stimulants)	0	0	0	672	312	984	229	118	347
– of which F16 (hallucinogens)	0	0	0	7	0	7	5	0	5
– of which F18 (inhalants)	7	0	7	30	0	30	7	1	8
– of which F19 (polydrug use)	11	2	13	1,327	476	1,803	257	154	411
F10 (alcohol)	0	0	0	5,317	2,263	7,580	1,301	682	1,983
F17 (tobacco)	0	0	0	0	0	0	4	0	4
Total F10-F19	23	2	25	7,706	3,263	10,969	2,098	1 136	3,234

Polydrug use (dg. F19) was also the most common cause of the hospitalisation of users of illegal drugs in inpatient psychiatric facilities in 2008 (47.7% of admissions). Other causes included stimulant use (28.7%) and opioid use (14.2%). The most common cause of hospitalisation in inpatient facilities for children was polydrug use or the use of inhalants and cannabis. The 20-29 age group (53.8%) was the most numerous, followed by the 30-39 age group (21.9%). 12.3% of hospitalised drug users were under 19 years of age (Ústav zdravotníckých informáci a štatistiky, 2009c).

The trend in the number of hospitalised patients by drug or by drug group varies. Since 2000, there has been a steady decline in the number of hospitalisations resulting from disorders caused by opioids (F11). In 2008, the number of hospitalisations resulting from disorders caused by polydrug use recorded a slight year-on-year increase, whereas the number of hospitalisations resulting from disorders caused by stimulant and opioid use declined marginally; see Figure 5-11. The number of hospitalisations resulting from disorders induced by other drugs is much lower by comparison; there was a slight decline in the number of hospitalisations resulting from disorders caused by inhalant use and an increase for cannabis and sedatives; see Figure 5-12.

Figure 5-11: Number of hospitalisations resulting from disorders caused by the use of opioids and stimulants and by polydrug use in inpatient psychiatric facilities in 2000-2008 (Mravčík et al. 2008; Ústav zdravotnických informací a statistiky, 2009c)

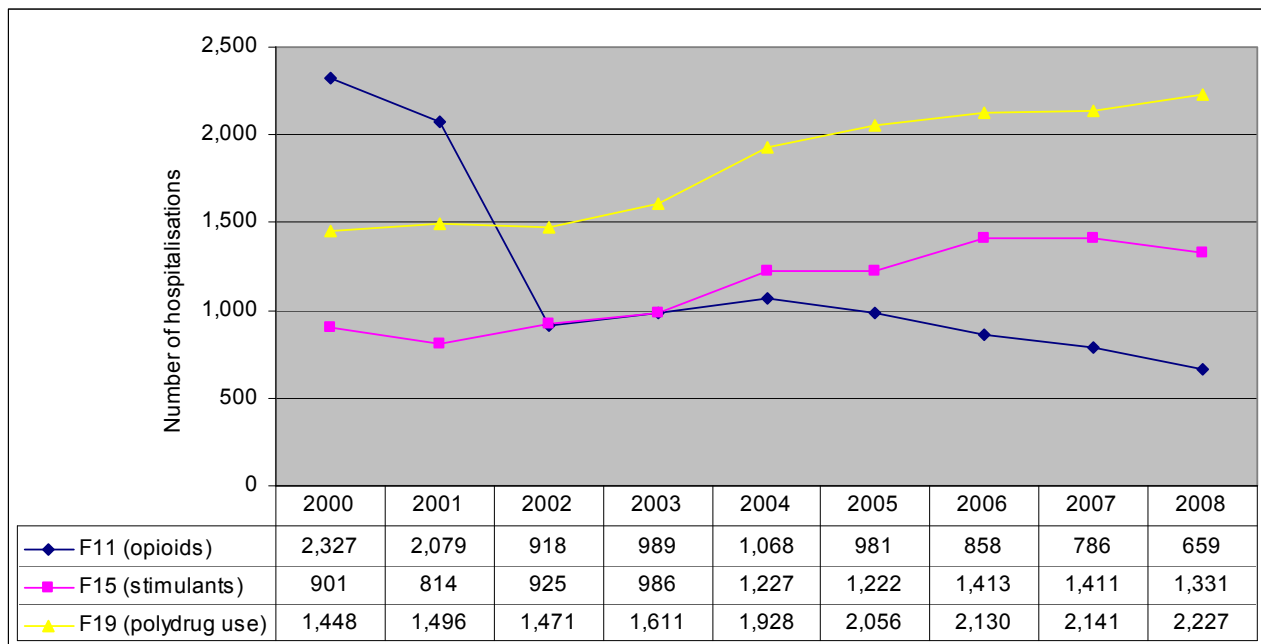
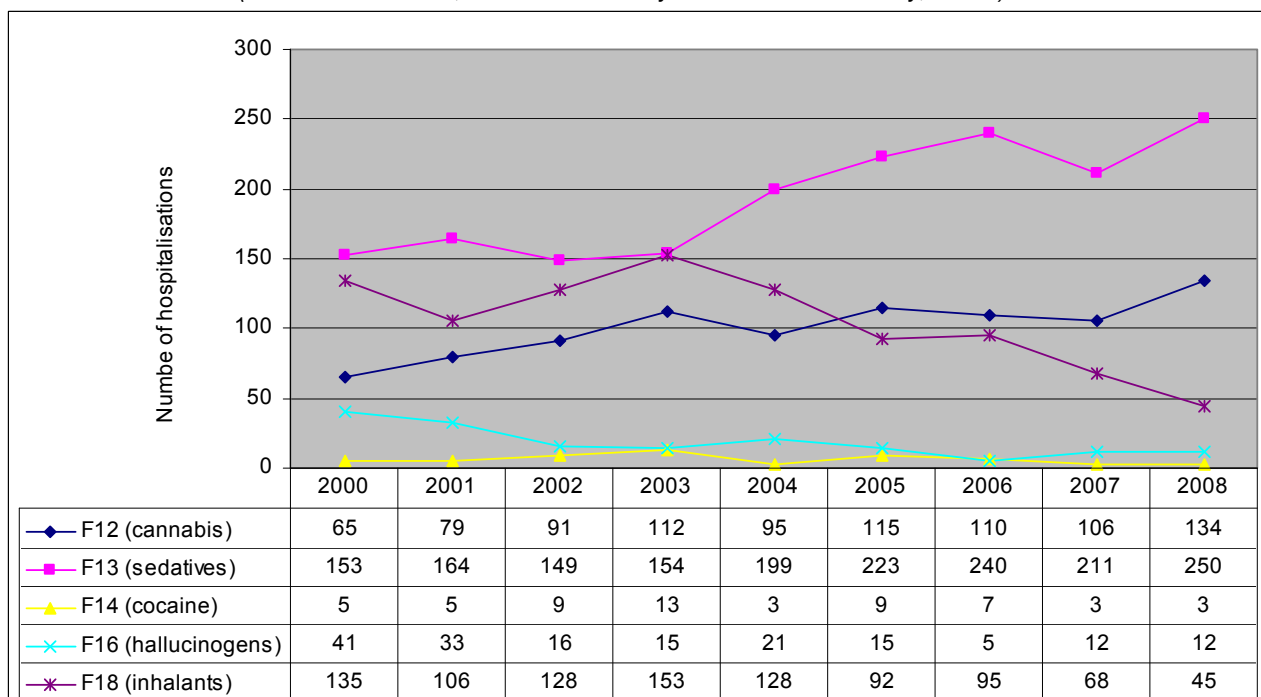


Figure 5-12: Number of hospitalisations resulting from disorders caused by the use of other drugs in inpatient psychiatric facilities in 2000-2008 (Mravčík et al. 2008; Ústav zdravotnických informací a statistiky, 2009c)



The data relating to the clients of therapeutic communities in 2008 were submitted by 10 therapeutic communities subsidised by the Government Council for Drug Policy Coordination. Their joint capacity was 138 beds (of these, 42 were reserved for juveniles and 9 for mothers with children); a total of 427 drug users (of these, 20 were mothers with children), whose average age was 23.8 years, were enrolled in a programme. A total of 326 clients (76.3%) injected drugs prior to treatment, 283 (66.3%) used pervitin, and 73 (17.1%) used opiates (67 used heroin, 4 used illegally procured buprenorphine). 123 clients (28.8%) successfully completed a programme; the average duration of a successful (completed) treatment was 308 days (approximately 10 months). 153 clients (35.8%) dropped out, 12% within 3 months of the commencement of treatment. The average duration of the treatment of all patients was 188 days (approximately 6 months). The trend in the period 2003-2008 is shown in Table 5-12 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j).

Table 5-12: Therapeutic communities and their clients in 2003-2008 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)

Indicator	2003	2004	2005	2006	2007	2008
Number of communities	17	14	12	12	11	10
Capacity of the facility	238	218	183	185	169	138
Number of clients	510	546	491	451	472	427
– of which injecting drug users	428	429	400	375	347	326
– of which pervitin users	270	306	287	281	291	283
– of which heroin users	187	151	132	93	66	67
Average age of client	23.4	24.2	24.9	25.1	24.2	23.8

A study entitled Treatment Outcome Evaluation of Therapeutic Communities for Drug Users, covering five therapeutic communities associated in the Therapeutic Communities Section of the Association of NGOs, was commenced in early 2007. Its purpose is to monitor the clients of the five therapeutic communities for drug users in the period from beginning treatment until one year after the completion of treatment, with a view to establishing which changes occur in five key areas: (1) drug and alcohol use; (2) mental and physical health; (3) degree of socialisation; (4) criminal behaviour, and (5) quality of life. The recruitment of new clients from partner communities was completed in 2008. The study cohort comprises 214 clients who enrolled for treatment in a therapeutic community either in 2007 or in 2008. The group represents 77.0% of all the clients who commenced treatment in the partner therapeutic communities in those years. The cohort comprises 137 men (64.0%) and 77 women (36.0%). The average age is 25.5 years (age range: 16-45 years). 145 clients (67.8%) stated pervitin had been their drug of choice at the time of their enrolment in treatment; for 61 clients (27.4%) it was heroin or other opiates, and 196 clients (91.6%) were injecting drug users with an average history of intravenous application of 6.2 years. The cohort includes a sizeable group of clients who had already begun injecting drugs at the age of 11-15 years (46 clients, 21.4%). The cohort also includes a sizeable group of clients with a history of the intravenous application of drugs 10 or more years long (44 clients, 20.5%). The number of clients who had shared needles and syringes in the 30 days preceding their treatment (47 clients, 29.5%) is also relatively high. In the area of physical health, 53 clients (24.8%) were infected with type C hepatitis. In the area of mental health, 72 clients (33.6%) reported severe symptoms of depression; the number of clients who reported serious anxiety symptoms is almost as high (78 clients, 36.4%). As for criminal behaviour, it was established that 55 clients (25.7%) had been detained or imprisoned. A total of 152 clients (71.0%) reported they had committed a crime in the period of 30 days prior to entering treatment (Šefránek, 2009).

6 Health Correlates and Consequences

The state of affairs in terms of infections among (injecting) drug users remained relatively favourable in 2008 – the HIV infection rate was still far below 1% and the prevalence of HCV among clients examined in low-threshold programmes was approximately 12%. In 2008, 13 new HIV-positive persons were identified, who may have become infected through injecting drug use. This is less than in 2007; compared to 2006, however, the number is relatively high. There was an HAV epidemic in the Czech Republic in 2008. At its outset, it was spreading among injecting drug users in Prague.

In the long term, the number of hospitalisations for non-fatal intoxication by pervitin appears to be growing. In contrast, the number of cases related to heroin appears to be declining.

In 2008, the number of fatal overdoses on the main groups of street drugs traditionally reported in the Czech Republic has remained low. In total, 44 cases were reported (15 cases of fatal overdoses on opiates, 19 on pervitin, and 10 on inhalants), which means four cases more compared to 2007; there was a slight increase in the number of overdoses on opiates, a more pronounced increase in that of overdoses on pervitin, and fatal overdoses on inhalants decreased. No fatal overdose on cocaine, ecstasy, hallucinogens, or THC was reported. One death with the presence of methadone occurred in 2008, but none with the presence of buprenorphine. As regards causes of death other than overdoses (particularly accidents/injuries and suicides), the number of cases with pervitin and THC has been growing since 2004. In 2008, 49 and 37 cases were identified, respectively. In 12 cases an opiate/opioid was detected, of which number five cases involved substitution substances.

As for deaths in traffic accidents or as a result of traffic accidents in 2008, the rate of positive findings increased for pervitin and cannabis – of the drivers killed in accidents, 9.2% and 6.2% respectively tested positive for these substances. However, the police records only contain one-digit numbers of these deaths.

6.1 Drug-Related Infectious Diseases

6.1.1 Reported Incidence of HIV/AIDS and Viral Hepatitis

The number of new cases of HIV infection reported each year in the Czech Republic up to 2006 had long ranged between two and six cases among injecting drug users and another one or two cases in the mixed category of injecting drug users and homo-/bisexuals. In 2007, 16 cases were reported of HIV-positive persons who may have become infected through injecting drug use. A relatively high incidence of HIV-positive injecting drug users (IDUs) continued in 2008, with 13 new cases reported. Altogether, 1,190 HIV-positive persons with a permanent place of residence in the Czech Republic were registered as of December 31, 2008; 62 of them are injecting drug users and another 21 are in the mixed category of injecting drug users and homo-/bisexuals at the same time (Státní zdravotní ústav Praha, 2009); see Table 6-1.

Table 6-1: Incidence of HIV in the Czech Republic in the period 1985-2008 by route of transmission (Státní zdravotní ústav Praha, 2009)

Route of transmission (risk group)	1985-2003	2004	2005	2006	2007	2008	Total	
							Number	%
Homo-/bisexual intercourse	356	30	52	54	72	88	652	54.8
Heterosexual intercourse	208	31	29	27	30	44	369	31.0
IDU	27	6	4	4	12	9	62	5.2
IDU and homo-/bisexual intercourse	9	1	1	2	4	4	21	1.8
Other	37	0	0	0	0	0	37	3.1
Not ascertained	28	4	4	6	4	3	49	4.1
Total	665	72	90	93	122	148	1,190	100

The year 2008 saw a decrease in the number of newly reported cases of acute HBV in injecting drug users, which has been declining in the long term. The number of newly reported cases of HCV in IDUs also decreased (Beneš, 2009); see Figure 6-1 and Figure 6-2.

Figure 6-1: Reported incidence of HBV among all patients and injecting drug users in the Czech Republic in 1996-2008 (Beneš, 2009)

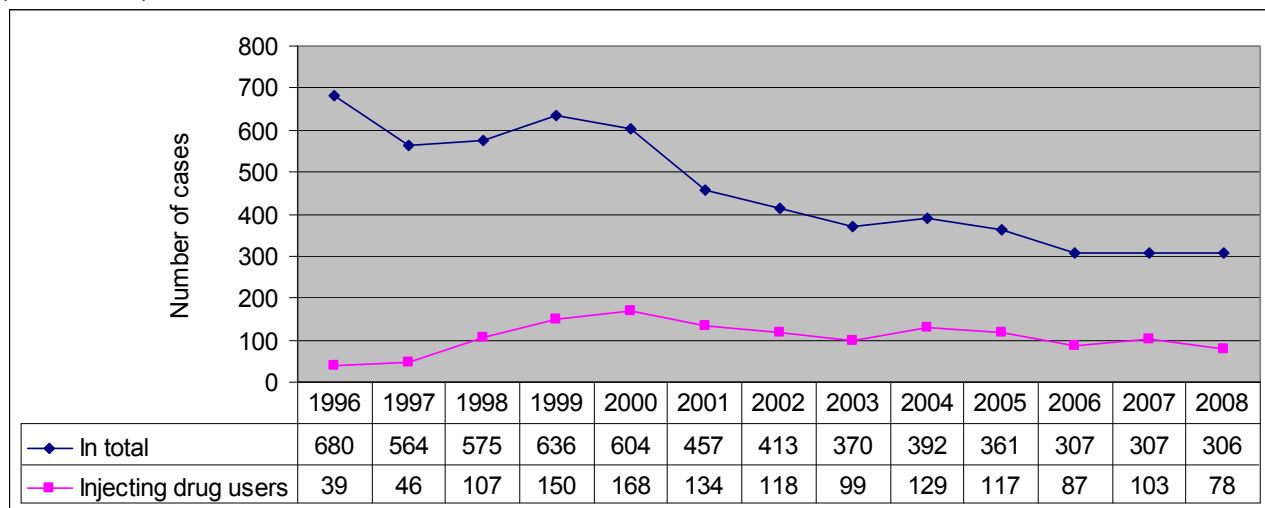
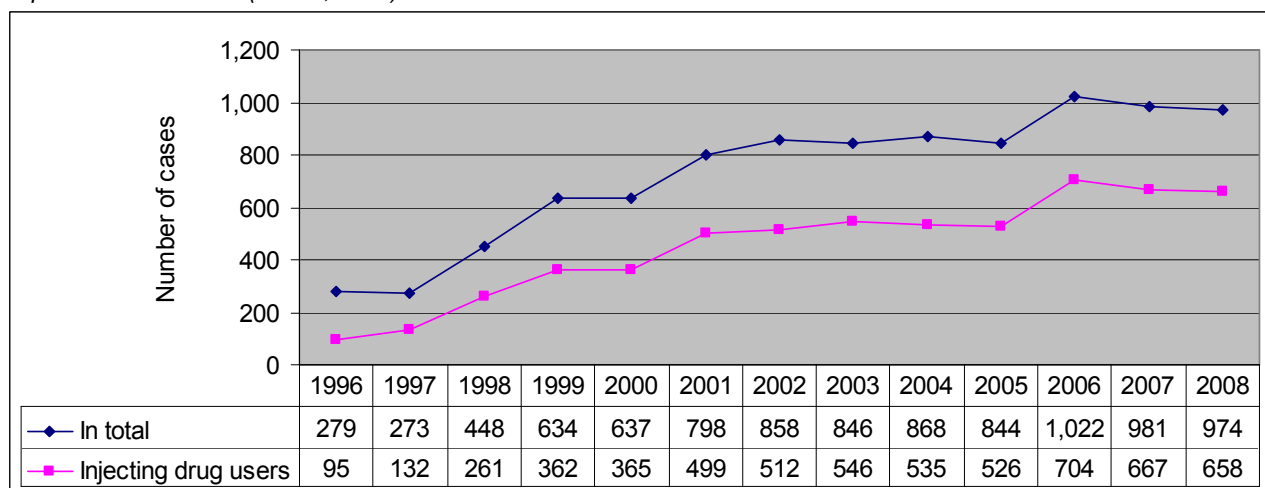
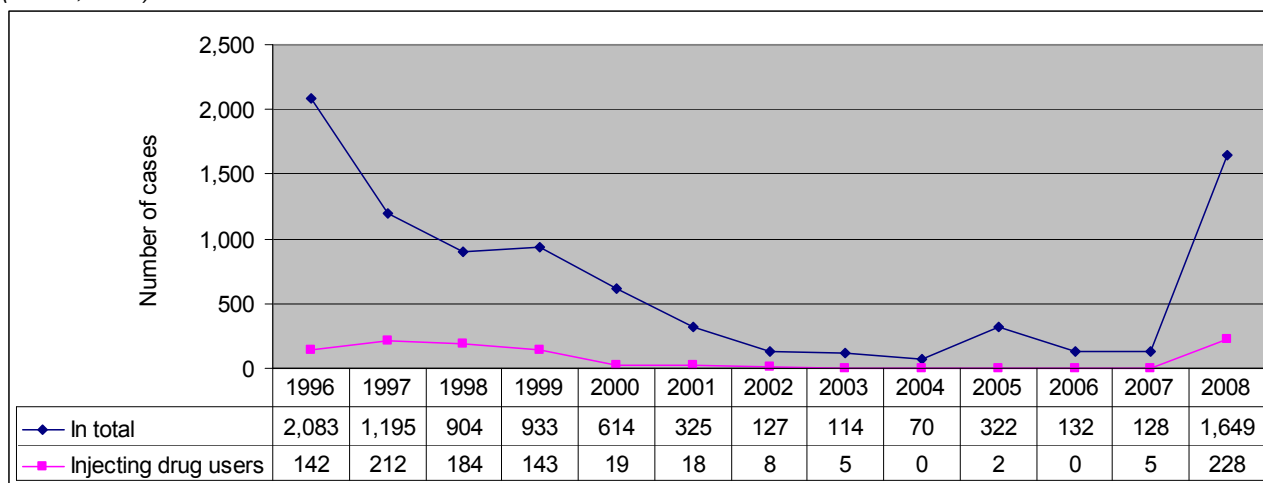


Figure 6-2: Reported incidence of acute and chronic HCV among all patients and injecting drug users in the Czech Republic in 1996-2008 (Beneš, 2009)



Since May 2008 there has been an epidemic of HAV in the Czech Republic, which in its initial period in May and June was associated with injecting drug use – IDUs accounted for two thirds of cases in this period. In the second half of 2008 the epidemic spread among other risk groups (homeless people, alcoholics, persons with risky sexual behaviour) and in the general population. Its proliferation through the alimentary route (water or food) was ruled out with a very high probability; direct contact or injecting were the likely routes of transmission among IDUs. Most cases were reported from Prague (54%), where the epidemic started, and from the Central Bohemia (13%) and Olomouc (9%) regions. Altogether, two persons died, of whom one case was an injecting drug user infected with HBV and HCV at the same time. One of the measures taken to counter the epidemic was the vaccination of drug users against HAV, which was introduced in Prague in July – in total, 2,002 drug users and homeless people were vaccinated in this campaign in 2008 (Beneš, 2009; Částková and Beneš, 2009). The trend of HAV incidence is shown in Figure 6-3.

Figure 6-3: Reported incidence of HAV among all patients and injecting drug users in the Czech Republic in 1996-2008 (Beneš, 2009)



In early 2009, an increased incidence of syphilis was reported among the clients of the Prague contact centre of the SANANIM civic association, with 11 positive cases identified in the period March-April 2009. These cases were clients with promiscuous or commercial sexual behaviour (Národní monitorovací středisko pro drogy a drogové závislosti, 2009k).

6.1.2 Prevalence of Infections Among Drug Users

According to the National Reference Laboratory for AIDS at the National Institute of Public Health in Prague, a total of 887,443 laboratory tests were conducted in the Czech Republic in 2008, of which 147 were positive (0.17‰); 1,363 tests were conducted among IDUs³⁶, with one positive result (0.7‰); the number of tests carried out among IDUs decreased again in 2008, and reached its lowest value in the period in question (Vandasová and Malý, 2009); see Table 6-2.

Table 6-2: Tests of injecting drug users for HIV antibodies in 1994-2008 (Vandasová and Malý, 2009)

Year	Blood tests		Saliva tests		Total	
	Number of tests	Number of positive results	Number of tests	Number of positive results	Number of tests	Number of positive results
1994-1997	1,206	1	895	0	2,101	1
1998	1,034	0	1,124	0	2,158	0
1999	1,101	0	1,219	0	2,320	0
2000	1,090	0	1,001	0	2,091	0
2001	1,208	1	961	0	2,169	1
2002	801	0	735	1	1,536	1
2003	985	1	652	0	1,637	1
2004	1,382	0	227	0	1,609	0
2005	925	1	449	1	1,374	1*
2006	994	1	412	0	1,406	1
2007	845	1	531	1	1,376	2
2008	886	1	477	0	1,363	1
Total	12,457	7	8,683	3	19,734	9

NB: * This involves one new case detected by a saliva test and subsequently confirmed by a blood test.

The monitoring of testing for infections among IDUs has been ongoing since 2004 in low-threshold programmes; the 2008 results were collected using an internet questionnaire at drogy-info.cz in the period January-February 2009. A total of 52 low-threshold programmes responded, of which 23 were low-threshold centres, 13 outreach programmes, and 16 were services concurrently operating a low-threshold and an outreach programme (Národní monitorovací středisko pro drogy a drogové závislosti, 2009i). The results are provided in Table 6-3.

³⁶ These are cases when information about drug use is known prior to the test or is reported as the reason for testing.

Table 6-3: Results of testing among injecting drug users in low-threshold facilities in 2008 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009i)

Infection	Type of test*	Number of testing programmes	Number of tests		Number of persons		
			Total	Positive tests	Total	Positive tests	Proportion of positive tests (%)
HIV	Saliva test	12	241	0	155	0	0.0
	Quick capillary blood test	15	311	1	281	1	0.4
	Quick capillary blood serum test	5	65	0	52	0	0.0
	Laboratory vein blood serum test	8	272	0	237	0	0.0
	Total	34	889	1	725	1	0.1
HCV	Quick capillary blood test	4	78	4	76	4	5.3
	Quick capillary blood serum test	15	340	26	314	24	7.6
	Laboratory vein blood serum test	11	269	52	232	45	19.4
	Total	26	687	82	622	73	11.7
HBV	Laboratory vein blood serum test	8	263	4	227	2	0.9
Syphilis	Quick capillary blood test	3	162	0	119	0	0.0
	Laboratory vein blood serum test	5	177	3	147	3	2.0
	Total	8	339	3	266	3	1.1

NB: * The monitoring of infections in low-threshold programmes finds the results of tests for long-term antibodies against various infections.

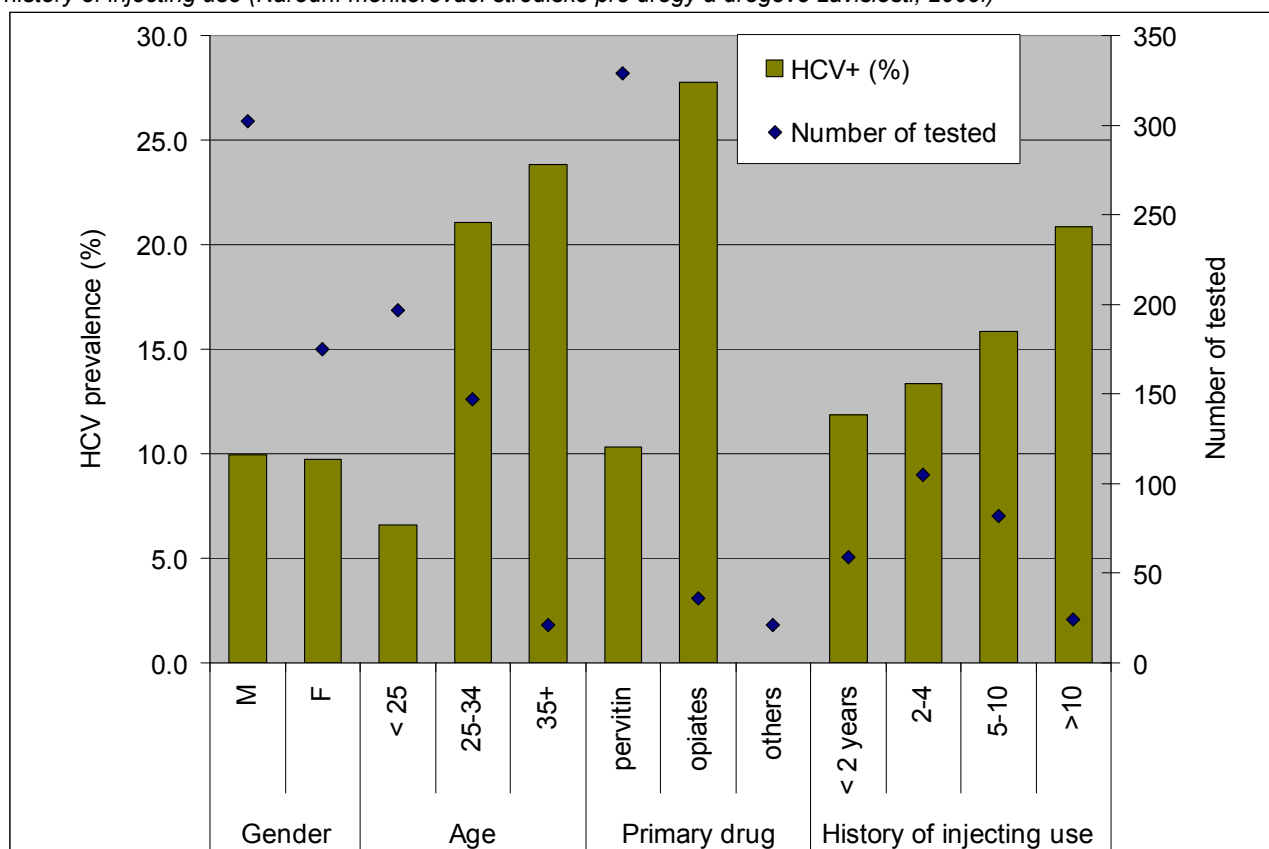
The prevalence of HCV determined on the basis of monitoring in low-threshold programmes is lower than that identified through the seroprevalence studies undertaken earlier (Trmal et al. 1999; Mravčík et al. 2000; Zábranský et al. 2006); one possible explanation is due to the fact that the opportunity for testing is used primarily by new clients with lower levels of infection and the results of monitoring are not available from all low-threshold programmes, particularly from localities with a higher prevalence of HCV (e.g. from Prague, where in 2008 low-threshold programmes did not examine clients for HCV). The results acquired by quick tests indicate a lower prevalence than the results of laboratory tests of vein blood serum; however, this may also be influenced by regional differences in the application of the various tests – high prevalence levels of HCV were identified even if the quick tests were applied, e.g. in the Ústí nad Labem region (20%) and the Moravia-Silesia region (33%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2009i). The results of the (sero)prevalence of HCV by region are given in Table 6-4.

Table 6-4: Results of HCV testing among IDUs in low-threshold facilities in 2008 by region (Národní monitorovací středisko pro drogy a drogové závislosti, 2009i)

Region	Number of centres		Number of persons tested		
	Number of questionnaires returned	Tested for HCV	Total	HCV+	HCV+ (%)
Prague	5	0	–	–	–
Central Bohemia	5	0	–	–	–
South Bohemia	7	6	58	3	5.2
Pilsen	2	2	113	3	2.7
Karlovy Vary	1	1	25	6	24.0
Ústí nad Labem	7	6	198	43	21.7
Liberec	1	1	22	1	4.5
Hradec Králové	3	1	41	1	2.4
Pardubice	2	0	–	–	–
Vysočina	2	1	25	1	4.0
South Moravia	5	1	13	0	0.0
Olomouc	5	3	36	5	13.9
Zlín	2	2	50	2	4.0
Moravia-Silesia	5	2	41	8	19.5
Total	52	26	622	73	11.7

The dependence of HCV seroprevalence on the demographic and user characteristics of the clients of low-threshold facilities is shown in Figure 6-4.

Figure 6-4: The results of HCV testing among IDUs in low-threshold facilities in 2008 by gender, age, primary drug, and a history of injecting use (Národní monitorovací středisko pro drogy a drogové závislosti, 2009i)



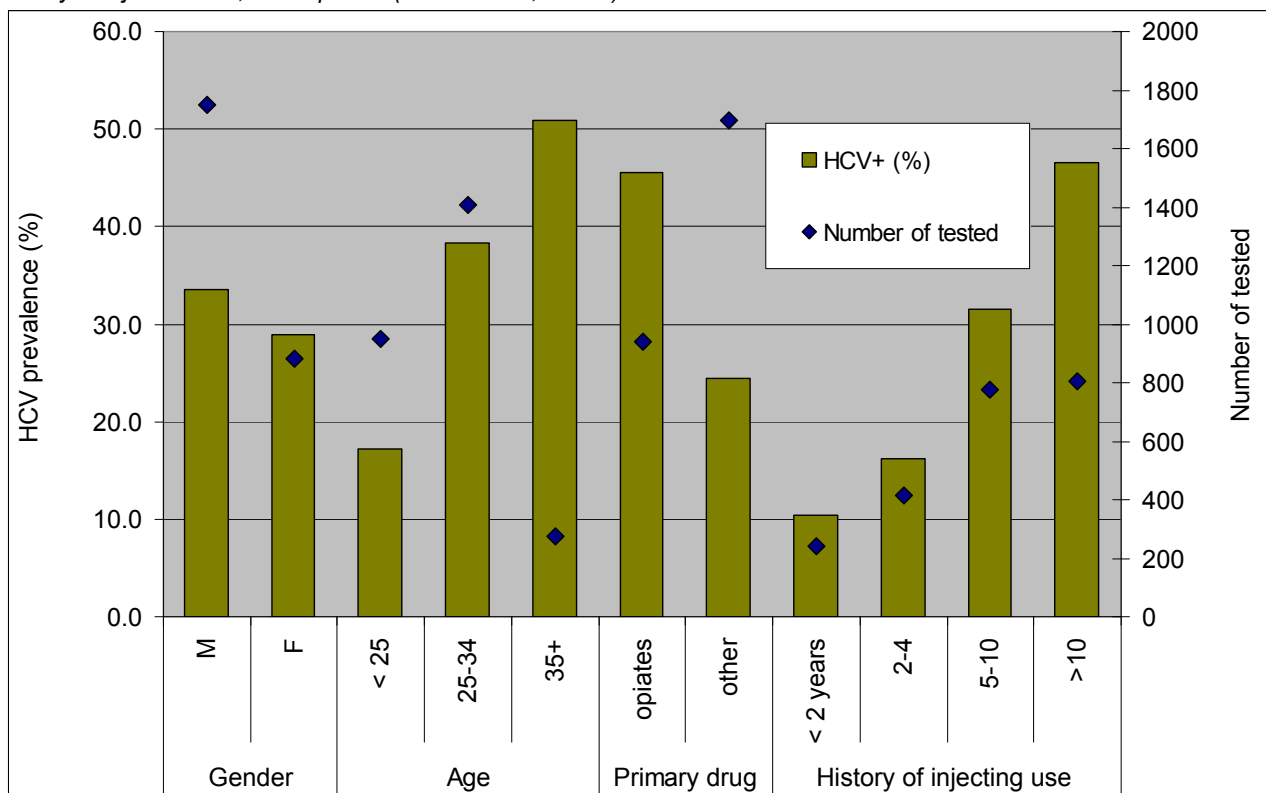
The trend in the number of low-threshold facilities performing tests for these infections and the numbers of tests conducted according to the information provided in the final reports of the projects supported in the GCDPC subsidy programme is given in Table 7-6 (p. 73) in the chapter on Prevention and Treatment of Drug-Related Infectious Diseases.

The data about testing for infections and the results of the tests may also be retrieved from the Register of Treatment Demands maintained by the Public Health Service (Studničková and Petrášová, 2009; Studničková, 2009b). This information is provided by the clients themselves; only tests with known results are included; see Table 6-5. The data, although their information value is limited, indicate a stable prevalence of infections among drug users. As regards the prevalence of HCV, it is about 50% higher than the prevalence according to the monitoring of clients in low-threshold programmes, although dependability of the characteristics monitored is similar; see Figure 6-5.

Table 6-5: The results of testing for HIV, HAV, HBV, and HCV among users demanding treatment, self-reported in 2003-2008 (Studničková, 2009b)

Infection		2003	2004	2005	2006	2007	2008
HIV	Total tested	2,471	2,483	2,253	2,196	1,905	2,332
	Positive tests (%)	0.8	0.4	0.2	0.5	0.3	0.6
HAV	Total tested	2,132	2,059	1,931	1,997	1,774	2,271
	Positive tests (%)	7.1	5.5	4.5	3.3	3.3	8.4
HBV	Total tested	2,504	2,581	2,332	2,290	2,004	2,463
	Positive tests (%)	11.2	9.9	10.1	10.0	8.4	8.9
HCV	Total tested	2,884	2,913	2,577	2,497	2,168	2,636
	Positive tests (%)	31.5	33.6	35.0	32.6	31.0	32.0

Figure 6-5 : The results of HCV testing among users demanding treatment in 2008 by gender, age, primary drug, and a history of injection use, self-reported (Studničková, 2009b)

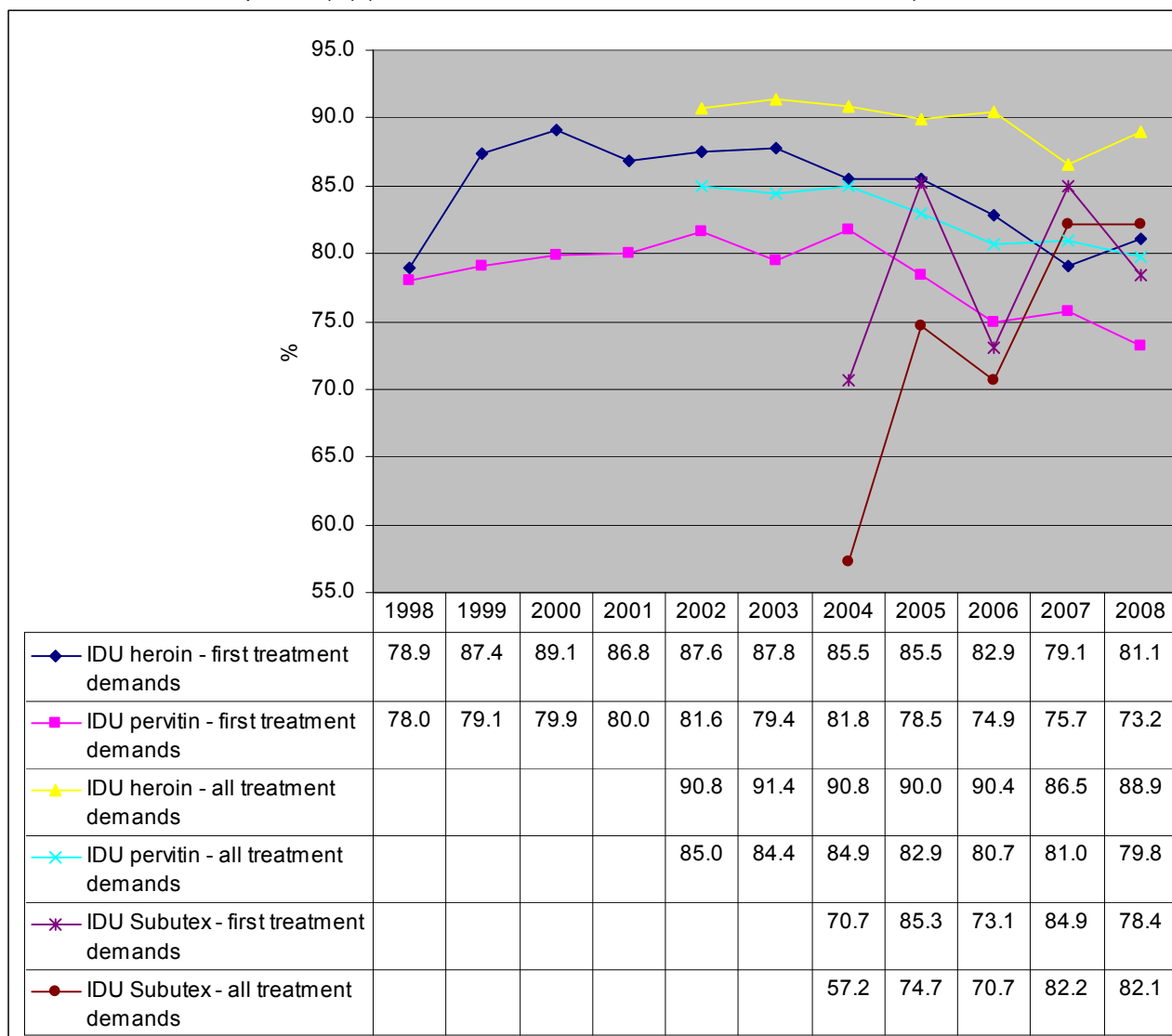


The Centre for Addictology undertook a study of the seroprevalence of HIV, HBV, and HCV in 2007-2008; the study focused on injecting drug users from the countries of the former Soviet Union living in Prague. The results indicated a significantly higher prevalence of HIV and other blood-borne and sexually transmitted infections; for further details see the 2007 Annual Report.

6.1.3 Risk Behaviour of Drug Users

In 2008, the proportion of injecting drug users in first treatment demands in relation to heroin use increased again, and that of pervitin users decreased slightly; injecting is also the most frequent route of administration of Subutex® in treatment demands, as far as the use of this drug is concerned; the developments in the period from 1998 to 2008 are shown in Figure 6-6. In the Czech Republic, cocaine is used almost exclusively by snorting (one out of the total of 23 treatment demands reported injecting); only one treatment demand in relation to the use of crack was registered in 2008 (Studničková and Petrášová, 2009).

Figure 6-6: Proportion of injecting drug use in first treatment demands and in all treatment demands in relation to the use of heroin, Subutex®, and pervitin (%) (Mravčík et al. 2008; Studničková and Petrášová, 2009)



The trend in the proportion of treatment demands among injecting drug users reporting having shared needles and syringes at any time in the past is given in Table 6-6.

Table 6-6: Sharing of needles and syringes in the lifetime reported by IDUs demanding treatment in 2002-2008 (Studničková, 2009b)

Year	Number of IDUs	Number of those sharing	Sharing (%)
2002	6,437	2,590	40.2
2003	5,901	2,356	39.9
2004	6,314	2,725	43.2
2005	5,769	2,421	42.0
2006	5,860	2,313	39.5
2007	5,338	2,139	40.1
2008	5,766	2,057	35.7

6.2 Other Drug-related Health Correlates and Consequences

6.2.1 Non-Fatal Drug Intoxications

The collection of data about non-fatal intoxications³⁷ is based on the system operated by the Public Health Service and the data are collected centrally by the Public Health Office in Prague. There are still major differences between the regions in the system of collecting data generated by various health facilities, primarily emergency units. 1,146

³⁷ This system reports cases of overdoses, as well as other health complications that require emergency hospitalisation.

cases of non-fatal intoxication by drugs were reported in 2008³⁸. The trend is shown in Table 6-7. In the long term, there appears to be an increase in the number of cases related to pervitin and, on the contrary, a decrease in the number of cases related to heroin and inhalants.

Table 6-7: Non-fatal drug intoxications in the Czech Republic in 2001-2008 (Mravčík et al. 2008; Studničková and Petrášová, 2009)

Drug	2001	2002	2003	2004	2005	2006	2007	2008
Pervitin	163	191	149	180	222	231	343	364
Heroin	285	176	152	179	244	149	190	166
Methadone	2	6	3	2	10	7	2	1
Subutex [®]			2	12	14	18	32	7
Other opiates	16	23	22	20	19	21	40	17
Benzodiazepines	137	89	157	126	153	124	139	113
Other sedatives, hypnotics	195	137	82	103	88	107	125	135
Other drugs and pills	182	179	100	92	111	89	124	140
Cannabis	63	101	90	84	73	72	127	108
Inhalants	75	58	69	64	48	28	31	9
Psilocybin	15	7	4	10	6	5	10	9
Cocaine, crack	4	2	6	5	7	8	1	7
Datura stramonium	4	0	0	0	1	0	1	5
LSD	3	2	3	7	3	5	7	4
MDMA	15	4	8	3	8	12	12	3
Other, unknown	24	25	34	65	186	78	71	58
Total	1,183	1,000	881	952	1,193	954	1,255	1,146

6.2.2 Psychiatric and Somatic Comorbidity of Drug Users

The results of a survey of psychiatric comorbidity of the clients of the CADAS outpatient psychiatric facility operated by the SANANIM civic association were published in the 2007 Annual Report.

In the first half of 2008, a survey was carried out among the clients of seven low-threshold programmes in Prague, focused on an analysis of the sociodemographic and user characteristics of the clients and their use of services (Šejvl, 2008), see also the chapter on Data on Problem Drug Use from Non-treatment Sources, page 30. The survey included a question about health problems related to drug use. Out of 783 clients, 396 (50.6%) reported health problems; their structure is given in Table 6-8. The prevalence of viral hepatitis or overdoses is relatively low.

Table 6-8: Health problems reported by clients of low-threshold programmes in Prague (Šejvl, 2008)

Problems reported	Number	%
Abscess at the injection site	266	34.0
Other inflammations around the injection site	49	6.3
HCV	34	4.3
HBV	15	1.9
Vein system disorders	14	1.8
Overdose	4	0.5
Other, unspecified	14	1.8
No problems	387	49.4
Total	783	100.0

Other information originally published in the 2005 Annual Report concerning somatic and psychiatric comorbidity and new information about the prevalence of toxic psychoses in a sample of hospitalised drug users in 2001-2005 are given in the special chapter on Problem Amphetamine and Methamphetamine Use, Related Consequences and Responses, page 102.

6.2.3 Drugs and Road Accidents

Since 2003, cases where ethanol and other drugs were detected³⁹ have been analysed in the victims of traffic accidents autopsied in forensic medicine laboratories and forensic toxicology departments in the Czech Republic; for

³⁸ The trends of the cases reported are also significantly influenced by changes in the network of the reporting facility – starting from 2007, for instance, data are available from the emergency medical service of the Central Bohemia region, while there was no case reported from the South Moravia and Hradec Králové regions in 2007 and 2008.

³⁹ A test is considered to be positive for ethanol if the level of ethanol is higher than 0.2 g/kg (Společnost soudního lékařství a soudní toxikologie, 1999), positive for cannabis if THC or its active metabolite is proven (i.e. not THC-COOH, for instance), and positive for

details see the chapter on Drug-Related Deaths and Mortality of Drug Users (p. 63). The data set is divided into 4 categories: pedestrians, cyclists, drivers of motor vehicles, and others. The category of other victims comprises mainly passengers in vehicles and the fatalities that could not be assigned to any of the three previous categories (i.e. victims of other than road accidents, e.g. aircraft accidents, construction site accidents, and public transport accidents).

According to the data reported by forensic medicine departments, 1,040 persons died in traffic accidents or as a result of traffic accidents in 2008, of whom 582 (56%) were subject to toxicological examination⁴⁰, which is a similar proportion as in the previous years. The highest proportion of positive tests was detected in the case of ethanol, where there was a year-on-year increase, particularly in drivers. As far as the three most common non-alcohol drugs are concerned, there was also an increase in the number of positive tests for pervitin and cannabis – 9.2% and 6.2% of drivers, respectively, tested positive for these substances; on the contrary, there was a decline in benzodiazepines; see Table 6-9. There were no cases where cocaine was detected in 2003-2008; cases with the presence of inhalants and opiates did not exceed 1% (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2009).

inhalants if the autopsy detects substances which do not develop post mortem or are not indicated in some physiological or pathological conditions (e.g. acetone, acetaldehyde, n-propanol, n-butanol).

⁴⁰ i.e. tested for ethanol or any drug from the following groups: inhalants, opiates, stimulants, cannabis, cocaine, benzodiazepines, barbiturates.

Table 6-9: Detection of ethanol and other drugs in the bodies of active road users who died in traffic accidents in 2003-2008 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2009)

Drug	Year	Category of active road users who died in traffic accidents							
		Pedestrians		Cyclists		Drivers		Total	
		Examined	Positive (%)	Examined	Positive (%)	Examined	Positive (%)	Examined	Positive (%)
Ethanol	2003	141	51.8	50	40.0	203	32.0	394	40.1
	2004	150	48.7	44	29.5	209	23.9	403	33.7
	2005	148	45.3	35	34.3	198	18.7	381	30.4
	2006	102	55.9	35	37.1	164	26.2	301	37.5
	2007	130	50.8	44	40.9	215	20.9	389	33.2
	2008	139	51.8	40	37.5	202	29.2	381	38.3
Stimulants (incl. pervitin and ecstasy)	2003	91	1.1	27	0.0	152	3.3	270	2.2
	2004	109	1.8	23	0.0	170	1.8	302	1.7
	2005	103	1.9	17	0.0	148	0.7	268	1.1
	2006	79	1.3	15	0.0	125	7.2	219	4.6
	2007	107	0.9	27	0.0	223	5.8	357	3.9
	2008	121	3.3	21	0.0	195	9.2	337	6.5
Cannabis (active metabolites of THC)	2003	70	2.9	21	0.0	101	4.0	192	3.1
	2004	44	2.3	14	0.0	100	0.0	158	0.6
	2005	54	1.9	11	0.0	94	3.2	159	2.5
	2006	53	11.3	8	12.5	91	4.4	152	7.2
	2007	61	3.3	11	0.0	154	4.5	226	4.0
	2008	60	6.7	13	0.0	130	6.2	203	5.9
Benzodiazepines	2003	89	3.4	28	7.1	150	2.0	267	3.0
	2004	109	5.5	23	4.3	172	2.9	304	3.9
	2005	103	2.9	17	5.9	147	4.1	267	3.7
	2006	81	2.5	15	0.0	127	3.9	223	3.1
	2007	114	7.0	30	3.3	223	5.8	367	6.0
	2008	135	5.2	24	12.5	204	2.0	363	3.9
Barbiturates	2003	88	0.0	28	3.6	149	0.0	265	0.4
	2004	109	1.8	23	0.0	169	1.2	301	1.3
	2005	101	2.0	15	0.0	131	0.8	247	1.2
	2006	77	0.0	14	0.0	111	0.9	202	0.5
	2007	109	0.0	29	3.4	195	1.5	333	1.2
	2008	134	1.5	23	0.0	191	1.6	348	1.4
Any drug besides ethanol	2003	108	7.4	35	11.4	171	6.4	314	7.3
	2004	117	9.4	26	7.7	181	5.5	324	7.1
	2005	110	8.2	19	5.3	158	7.0	287	7.3
	2006	84	9.5	18	5.6	133	12.8	235	11.1
	2007	122	9.0	30	6.7	233	13.7	385	11.7
	2008	142	10.6	29	10.3	213	12.7	384	11.7

Information about the influence of alcohol and other drugs on the rate of road traffic accidents registered by the police is given in Table 6-10. This information also indicates that in 2008 the number and proportion of accidents occurring under the influence of alcohol and other drugs and the number and proportion of those killed in the accidents occurring under the influence of alcohol increased; sporadic cases of accidents under the influence of drugs were registered by the police.

Table 6-10: Road traffic accident statistics in the Czech Republic in 2003-2008 – influence of alcohol and other drugs (Ředitelství služby dopravní policie Policejního prezidia ČR, 2009)

Year	Accidents					Deaths				
	Total	Under the influence of alcohol		Under the influence of medication and other drugs		Total	Under the influence of alcohol		Under the influence of medication and other drugs	
	Number	Number	%	Number	%	Number	Number	%	Number	%
2003	195,851	9,076	4.9	39	0.02	1,319	111	8.5	0	0.0
2004	196,484	8,445	4.5	53	0.03	1,215	59	4.9	1	0.1
2005	199,262	8,192	4.3	60	0.03	1,127	59	5.2	0	0.0
2006	187,965	6,807	3.8	64	0.03	956	42	4.3	1	0.1
2007	182,736	7,266	4.3	78	0.04	1,123	36	3.2	2	0.2
2008	160,376	7,252	4.8	109	0.07	992	80	8.1	1	0.1

Data about deaths due to other causes (including accidents and trauma *in toto*) under the influence of drugs are provided below in the chapter on Deaths with the Presence of Drugs (p. 65).

6.3 Drug-Related Deaths and Mortality of Drug Users

In the Czech Republic, a forensic surgeon carries out a mandatory autopsy in all cases of sudden death in which the examining practitioner could not determine the cause of death and in all cases of violent deaths. Since 1998 drug-related deaths (fatal overdoses), and since 2003 also indirect fatalities (with the presence of drugs), have been monitored on a routine basis by means of a special register kept by all thirteen departments of forensic medicine and forensic toxicology departments, with close collaboration between the National Focal Point and the Professional Association of Forensic Medicine and Toxicology of the Czech Medical Association of J. E. Purkyně. Since 2007, aggregated reports have also been provided by three departments of pathology where irregular autopsies are carried out mandatorily under law by forensic surgeons (none of the three departments reported any drug-related deaths in 2008).

6.3.1 Drug Overdoses

238 fatal overdoses on illicit drugs, inhalants, and psychotropic medicaments were identified in 2008 (213 in 2007). Out of this number, 44 were overdoses on street drugs, i.e. illicit drugs and inhalants (40 in 2007), and 194 on psychotropic medicaments (173 in 2007). The substances which caused the fatal overdose were successfully identified in all the cases in 2008.

In total, 15 cases were identified of fatal overdoses on (illicit) opiates (in 2007 there were 14 cases), primarily heroin (12 confirmed or very probable cases), out of which the opiate itself was identified in seven cases, in two cases in combination with pervitin, and in six cases in combination with ethanol or psychotropic medicaments (out of which one case involved methadone in combination with ethanol and barbiturates). Pervitin was the cause of the overdose in 19 cases (11 cases in 2007), out of which one case was in combination with THC and three cases in combination with psychotropic medicaments. Ten cases involved an overdose on inhalants (14 cases in 2007), out of which one case can be attributed to the inhalation of lighter gas. In 2008, as has been the case so far, no overdose with the presence of buprenorphine was identified (although a fatality due to other causes with the presence of buprenorphine has been reported for the first time ever) and there was no report of any overdoses on cocaine, MDMA, hallucinogens, or (as has been the case so far) THC or another cannabinoid (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2009); see Table 6-11.

Overdoses on psychotropic medicaments constitute a very heterogeneous category, which it would be difficult to evaluate accurately. This is because this category comprises suicidal overdoses, accidental overdoses, and overdoses without any established intention, both on medicaments prescribed *lege artis* and on diverted medicaments. In total, 194 cases of overdoses on psychotropic medicaments were identified in 2008⁴¹ (173 cases in 2007), out of which 77 cases involved overdoses on benzodiazepines (58 in 2007) and 37 involved overdoses on medicaments containing opiates (24 in 2007).

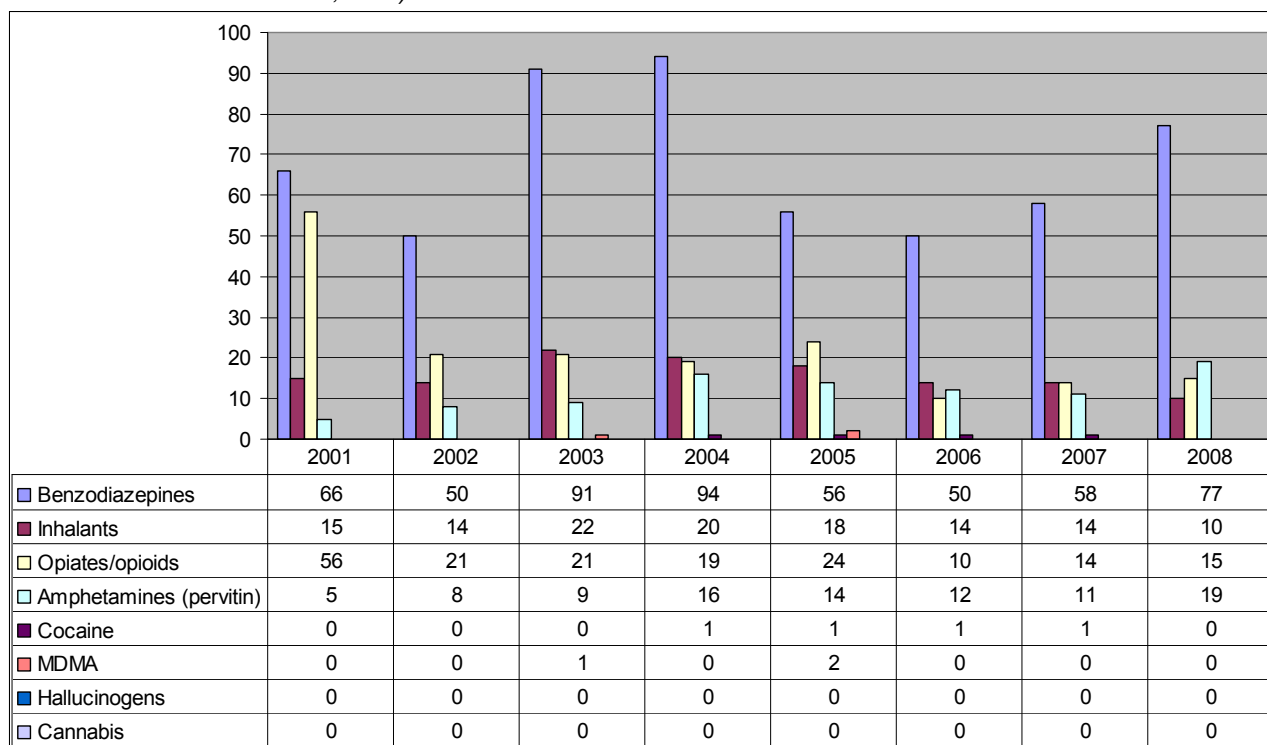
In the past three years, the number of fatal overdoses on street drugs (inhalants and illegal narcotic and psychotropic substances) has been approximately 40 cases. The year 2008 saw a slight year-on-year increase in the number of cases related to opiates and a more pronounced increase in those related to pervitin (these are the highest numbers in the past 8 years), while there was a decrease in the number related to inhalants; the long-term trend is shown in Figure 6-7.

⁴¹ Most overdoses on medications are suicidal in nature, most often involving a combination of (several) medicaments with alcohol.

Table 6-11 Fatal drug overdoses in the Czech Republic in 2008 by groups of drugs, age groups, and gender (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2009)

Drug/Age group	<15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>64	Unknown	Total		
														Men	Women	Total
Only opiates/opioids (except methadone)	0	0	1	5	1	5	0	0	0	0	0	0	0	11	1	12
Only methadone	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
More substances, including opiates/opioids	0	0	0	1	0	2	0	0	0	0	0	0	0	3	0	3
– of which methadone	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1
Total opiates/opioids	0	0	1	6	1	7	0	0	0	0	0	0	0	14	1	15
One or more substances, excluding opiates/opioids	0	3	5	6	5	5	2	2	0	1	0	0	0	22	7	29
– of which inhalants	0	1	1	1	2	4	0	0	0	1	0	0	0	8	2	10
– of which pervitin	0	2	4	5	3	1	2	2	0	0	0	0	0	14	5	19
– of which cocaine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
– of which dance drugs (e.g. MDMA)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
– of which hallucinogens	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Psychotropic medicaments	1	4	6	10	20	16	25	21	28	22	9	32	0	102	92	194
– of which benzodiazepines	0	2	2	6	6	6	13	10	11	7	4	10	0	42	35	77
Unspecified/unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total excluding pills	0	3	6	12	6	12	2	2	0	1	0	0	0	36	8	44
Total	1	7	12	22	26	28	27	23	28	23	9	32	0	138	100	238

Figure 6-7: Fatal overdoses on selected drugs in 2001-2008 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2009)



6.3.2 Deaths with the Presence of Drugs

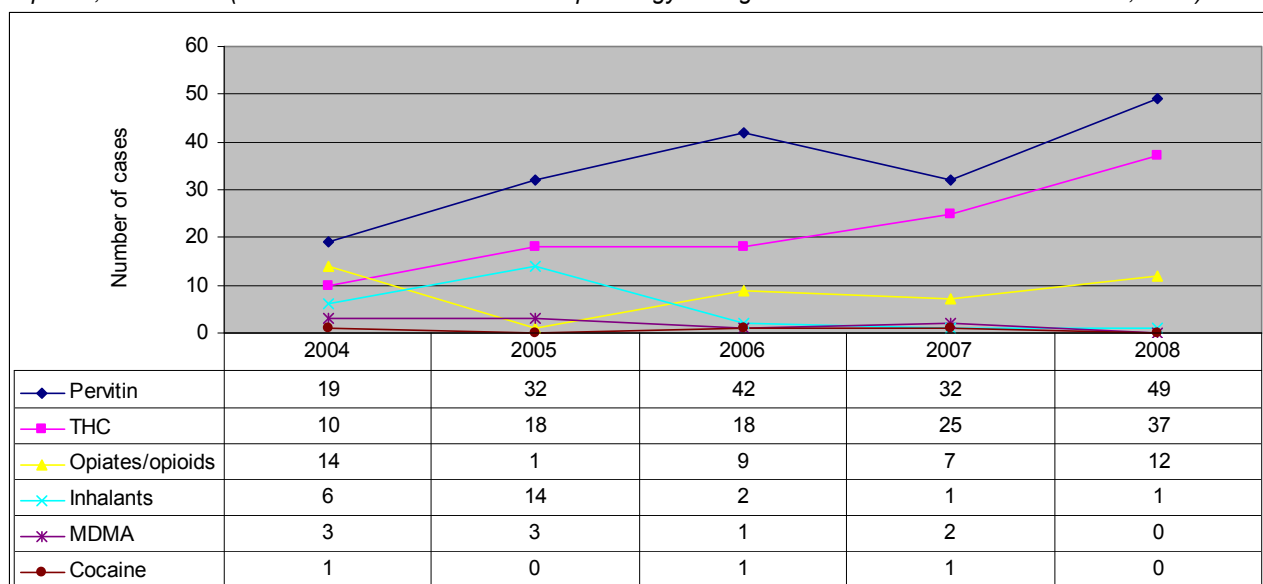
Altogether, 209 deaths with the presence of a drug were identified in 2008 (against 163 in 2007), of which eight cases involved an illness (one in 2007), 89 cases involved accidents (74 in 2007), 108 involved suicides (80 in 2007), and four were cases of manslaughter or murder (six in 2006). A summary of the numbers and proportions of selected groups of drugs in the individual groups of deaths with the presence of drugs is given in Table 6-12, and the trend since 2004 is shown in Figure 6-8. In particular, the number of indirect drug-related deaths involving the detection of pervitin and THC is increasing in the long term (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2009).

As regards opiates, three cases involved heroin (one accident and two suicides), each time in combination with pervitin and in one case also with methadone. Substitution opioids were identified in five cases (two cases involved illness and three accidents) in various combinations (buprenorphine + methadone, methadone + morphine, buprenorphine + a metabolite of THC, buprenorphine + methadone + psilocybin, methadone + heroin + pervitin). Buprenorphine was identified in the special register of drug-related deaths for the very first time.

Table 6-12: Deaths with the presence of drugs detected by forensic medicine departments in the Czech Republic in 2008 by selected groups of drugs and causes of death (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2009)

Drug	Illness (n = 8)	Accident (n = 89)	Suicide (n = 108)	Manslaughter/ murder (n = 4)	Other (n = 0)	Total (n = 209)	Proportion (%)
Benzodiazepines	1	27	50	1	0	79	37.8
Pervitin	2	24	21	2	0	49	23.4
THC	1	19	15	2	0	37	17.7
Opiates/opioids	2	4	6	0	0	12	5.7
MDMA	0	0	0	0	0	0	0.0
Inhalants	0	1	0	0	0	1	0.5
Cocaine	0	0	0	0	0	0	0.0

Figure 6-8: Deaths with the presence of selected drugs detected by forensic medicine departments in the Czech Republic, 2004-2008 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2009)



For information on the detection of drugs in the corpses of road accident victims see the chapter on Other Drug-related Health Correlates and Consequences (p. 59).

6.3.3 Mortality of Drug Users

The results of a retrospective cohort study of the mortality of drug users in the Czech Republic in 1997-2002 (Lejčková and Mravčík, 2005) were published in detail in the 2004 Annual Report.

In 2008, a retrospective cohort study of the mortality of drug users in the Czech Republic was conducted as a follow up to the aforementioned study, on a combined cohort of people hospitalised for conditions related to drug use in the period 1997-2007 (primary or secondary diagnosis F11-F19 according to ICD-10) and persons in opiate substitution treatment in 2000-2007. The study evaluated overall mortality and its trends, structure, and population fractions of mortality attributable to drug use (Drug-Attributable Fraction, DAF). The preliminary results are available and are provided below (Zábranský et al. 2009).

An analysis was carried out on a subgroup comprising opiate users (dg. F11 in hospitalisation or participation in opiate substitution treatment), stimulants (dg. F15), and polydrug users (dg. F19 or a combination of diagnoses in repeated hospitalisations with the condition of dg. F11 or F15 in previous hospitalisations). This subgroup included 15,799 subjects in total (of whom 10,581 were men), of whom 517 (of which number 420 were men), i.e. 3.3%, had died by the end of the period in question (as of 31 December 2007). In total, 92,390 man-days of monitoring were recorded. Overall mortality reached 5.6 (95% CI: 5.1-6.1) cases per 1,000 persons and year (6.8 in men; 3.2 in women; 6.5 in opiate users; 5.0 in users of stimulants). In contrast with a comparable cohort in the general population, mortality is approximately five times higher and the results show that drug use accounted for approximately 81% of the deaths in the group of problem drug users. The estimated number of problem drug users who died in the Czech Republic in the period under consideration was approximately 174 (95% CI: 160-190) and 141 of these can be attributed to drug use (95% CI: 127-160), i.e. 81%. As regards the structure of the deaths attributable to drugs, 82% were due to external causes (17% involved intoxication, 26% accidents and/or injuries, 27% suicide, and 2% assault), 18% were caused by illness (1% HCV, 2% endocarditis, 2% liver disease and liver carcinoma, 13% by other causes). Approximately 3% of the mortality (DAF) in the general population aged 15-45 was attributable to drugs (Zábranský et al. 2009).

Concurrently with the study mentioned above, another study was undertaken as part of a survey to determine the multiplier for estimates of problem drug use; the study focused on the structure of mortality in the clients of low-threshold facilities in 2007; for details see the chapter on Problem Drug Use, page 28. Low-threshold facilities were surveyed as to the numbers and causes of deaths among their clients. The purpose of this part of the study was to examine whether a cross-section design can be used to determine the structure of the mortality of drug users and potentially to determine a multiplier for the reported cases of drug overdoses on the basis of this structure. In total, 92 low-threshold programmes were approached, of which 16 programmes from 9 regions reported at least one death among their clients. Overall, 41 deaths were reported, of which 37 were among problem drug users (of whom 29, i.e. 78%, were men). As regards the structure of mortality, 54% of the deaths were due to external causes (16% involved intoxication, 24% accidents and trauma, 14% suicide), 19% were caused by illness (3% viral hepatitis, 8% sepsis, 3% liver failure, 5% by other causes), and in 27% of cases the cause of death was not reported. After multiplication of the number of drug overdoses reported from the special mortality register (see above), the number of deaths among problem drug users in the Czech Republic in 2007 can be estimated at 135-180 in total, which is virtually the same estimate as in the aforementioned cohort study (Mravčík et al. 2009).

The outcomes of the cohort study of the health and social status and mortality of problem drug users who participated in the study entitled Young People and Addictive Substances (Zábranský et al. 2008) in 1994 are not available as yet; see also the 2007 Annual Report.

7 Responses to Health Correlates and Consequences

The measures targeted at the reduction of drug-related health risks are implemented mainly by low-threshold facilities for drug users. Their availability is stable and the number of clients has been increasing in the past three years. Approximately 70% of problem drug users are estimated to be in contact with these facilities. A further increase in the number of needles and syringes distributed in exchange programmes in 2008 was observed, although the year-on-year increase was not as significant as in previous years. On the contrary, the availability of testing for infectious diseases can still be described as a weak point. Low-threshold facilities obtained the equipment to perform a certified blood serum test for HCV. HIV tests were available in 2008. Specifically, they were the capillary blood and saliva tests. However, the saliva tests which were formerly conducted in low-threshold facilities and evaluated by the National Institute of Public Health in Prague have not been available since the beginning of 2009. The Standard for the Treatment of Viral Hepatitis in Drug Users was published in the December issue of the Journal of the Czech Ministry of Health to establish the procedures for the prevention, diagnosis, and treatment of viral hepatitis in drug users. In connection with the HAV epidemic, drug users were vaccinated against HAV free of charge in co-operation with low-threshold facilities for drug users.

In January 2008, the Government Council for Drug Policy Coordination appointed a working group on Drug Use Prevention and Harm Reduction at Dance Parties. The outcome of the group's work was the Safer Party initiative and the implementation of a pilot project called Safer Party Tour 2008, which focused on the prevention and reduction of health risks and other consequences of drug use in the nightlife setting, and specifically at music festivals drawing large audiences. A number of low-threshold programmes were involved in the project. The project was evaluated in late 2008 and continues to run in 2009.

A survey conducted in 2008 included, among other topics, the use of gelatine capsules in harm reduction, and its outcomes were followed up on in 2009 with a questionnaire study, a focus group involving representatives of the facilities, and a group interview with the clients of the outreach programmes of the SANANIM civic association in Prague. The analysis shows that capsules are currently distributed as harm reduction material by 17 facilities, and another 20 facilities are considering capsule distribution as an option. Capsules are a suitable alternative for injecting perving users, and the client demand for capsules is increasing.

In May 2008, the PROGRESSIVE civic association launched the NON STOP 24 project concerning vending machines for harm reduction medical supplies. The project was suspended by the Prague 5 District Authority in October 2008, with the evaluation of the impact of the project on the city district being stated as the reason for the suspension. The project had not been resumed by August 2009 despite the fact that the evaluation had showed a continuous increase in the number of kits vended and positive feedback from the clients, and found that approximately one third of the clients had no contact with any other harm reduction programme, which means that the programme managed to address a group of injecting drug users in Prague who had not been previously contacted or were difficult to reach. Another harm reduction project running in Prague is the FIX POINT project conducted by the PROGRESSIVE civic association and involving the installation of special safe disposal containers for used injecting equipment.

In 2007 and 2008 the Centre for Addictology conducted a two-year research study into the role of pharmacies in health care and counselling for (injecting) drug users in the Czech Republic. It was confirmed that pharmacies are a potential place for the systematic provision of harm reduction interventions for drug users.

7.1 Prevention of Drug-Related Emergencies and Reduction of Drug-Related Deaths

In the Czech Republic, the prevention of overdoses is conducted through drug user counselling and as part of the services provided by low-threshold and treatment facilities. For low-threshold programmes see below; treatment is discussed in the chapter on Drug-related Treatment: treatment demand and treatment availability, page 32. The main educational topics include first aid in the event of an overdose, the risks of polydrug use, and the principles of safer drug use. Most low-threshold facilities also provide anonymous counselling in this area via email and telephone. The facilities have prepared and have available a number of reference materials⁴², some of which are also in other language versions⁴³. *Sdružení Podané ruce*, a civic association, has prepared a manual for safer (injecting) drug use⁴⁴ and made it available on the internet. Low-threshold facility staff, and especially outreach programme staff, are trained to respond in case of a client overdose.

⁴² Research concerning the reference materials intended for the clients of low-threshold facilities was conducted in 2008. It evaluated the content and form of the information leaflets and brochures focused on the health consequences of drug use and published by the individual drug services and other institutions, and subsequently provided recommendations for the preparation of such materials (Svobodová, 2009).

⁴³ Mainly in the Roma and Russian languages. Dozens of Russian-speaking nationals of post-Soviet countries (mainly of Ukraine) can be found on the drug scene in Prague. The outreach programme of the SANANIM civic association therefore employs (native) Russian-speaking streetworkers to approach such clients. Materials in English are also distributed, e.g. as part of the Safer Party Tour initiative; for details see the chapter Selective Prevention in At-risk Groups and Settings, page 26.

⁴⁴ <http://www.extc.cz/>

The *Dekontaminace* (Decontamination) magazine published by the SANANIM civic association is one of the sources of information for the clients of low-threshold programmes; for more information see the 2006 Annual Report.

In the early warning system (EWS) for new psychoactive substances, all low-threshold facilities are notified if new drugs or dangerous drugs involving higher health and overdose risks are detected in the Czech Republic. For example, the facilities were notified in 2009 about the possible penetration of fentanyl⁴⁵ into the Czech drug market and also received information regarding suspicious heroin-related deaths in Prague.

No other specific activities are being pursued in the Czech Republic with a view to the prevention of overdoses (e.g. the preventive distribution of opiate antagonists to drug users or safe application rooms for injecting drug users). Information about counselling and other services provided to drug users upon their release from prison is included in the chapter on Post-Penitentiary Care, page 91.

7.2 Prevention and Treatment of Drug-Related Infectious Diseases

7.2.1 Low-Threshold Harm Reduction Programmes

Activities in the field of the prevention of infection are among the basic services supplied by low-threshold facilities (dissemination of information, distribution of leaflets on the risks of infectious diseases and other health problems, education and motivation towards safer drug use and safe sex, exchange programmes for needles and syringes, the distribution of condoms, the provision of/referral to testing for infections and other medical care as needed). The target population of the low-threshold facilities includes problem drug users, experimenters, and their families and friends; some facilities deliver programmes aimed at drug users in the nightlife setting. The type and volume of the services vary from one low-threshold programme to another.

The network of low-threshold facilities comprises low-threshold centres and outreach (streetwork) programmes. In 2008, there were 100 of them in total; see Map 7-1. Information about the services provided in the low-threshold facilities and about the recipients of such services is mainly available from the final reports drawn up by the facilities for the purposes of the grant procedures of the Government Council for Drug Policy Coordination⁴⁶.

The number of drug users who receive the services of the facilities has been growing in the past three years; the ratio of male and female clients has been stable in the long term. However, there has been a noticeable increase in the number of problem drug users (injecting drug users, opiate and pervitin users), and a decline in the number of cannabis users since 2003. A decrease has also been observed in the number of inhalant users; however, that figure is of a lower order compared to the number of other drug users. In the long term, the average age of the users increased from 22.0 years in 2002 to 26.1 years in 2007, and reached 25.9 years of age in 2008; see Table 7-1.

The number of visitors to low-threshold facilities and the volume of services provided have remained stable in the past three years; see Table 7-2. A year-on-year increase was again marked in the number of injection kits exchanged (see below).

Similar to the previous year, the low-threshold programmes in Prague, followed by those in the Ústí nad Labem, South Moravia, and Olomouc regions, reported the highest numbers of contacts in 2008. The highest number of individual exchanges in exchange programmes was reported from Prague (app. 120,000), followed by the Ústí nad Labem (app. 31,000), South Moravia (app. 13,000), South Bohemia (app. 11,000), and Central Bohemia (app. 9,000) regions. A detailed account of the services reported by the low-threshold programmes in 2008 by region is provided in Table 7-3.

⁴⁵ Fentanyl is a high-potency opioid. It was first seized in Slovakia in 2009, which was the immediate reason for notifying the services.

⁴⁶ The number of programmes is influenced by the projects submitted by low-threshold facilities for their activities for grant procedures, and by the formal differentiation of the individual activities. A low-threshold centre or outreach programme may be both operated and conducted by a single entity within a single project and, in other cases or in other years, they can form two or more separate projects. Despite these influences, the offer and availability of low-threshold services in the Czech Republic have been stable in recent years.

Map 7-1: Low-threshold facilities in the Czech Republic in 2008 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j; Studničková and Petrášová, 2009)

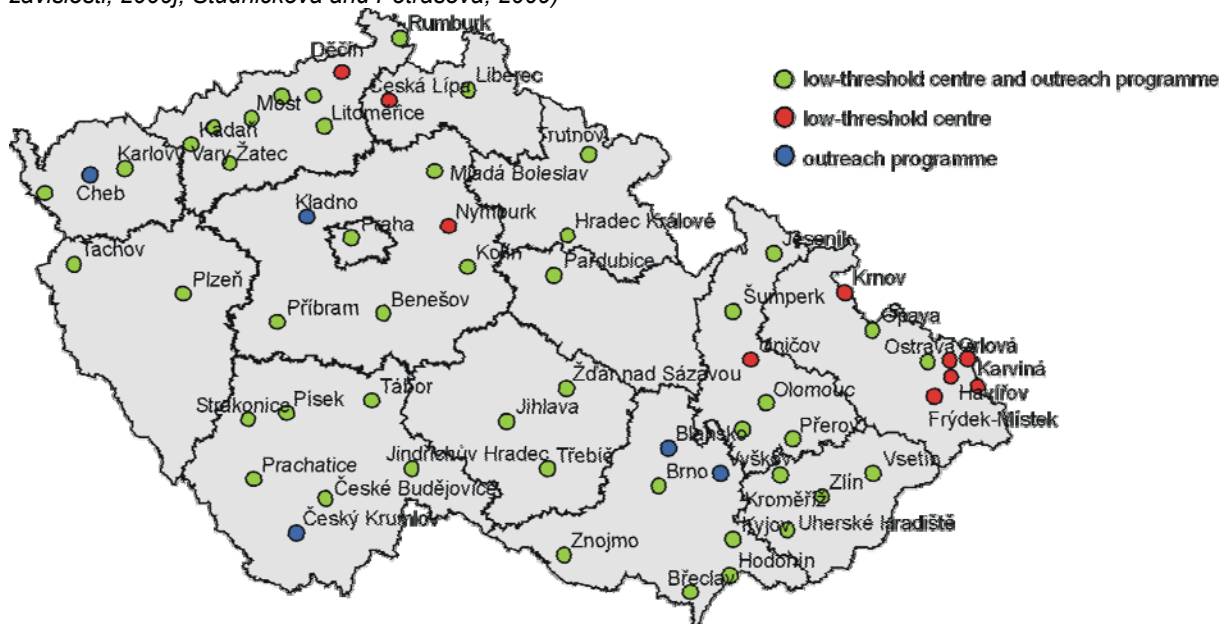


Table 7-1: Clients of Czech low-threshold facilities in the years 2002-2008, extrapolated to the total number of programmes (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)

Indicator	2002	2003	2004	2005	2006	2007	2008
Number of low-threshold facilities/programmes	92	93	92	92	90	109	100
Number of drug users	n.a.	25,200	24,200	27,800	25,900	27,200	28,300
– injecting drug users	19,000	16,700	16,200	17,900	18,300	20,900	22,300
– pervitin users	12,900	11,300	12,200	12,300	12,100	14,600	14,900
– opiate users	8,000	6,100	6,000	6,800	6,900	7,300	8,300
– Subutex® users among opiate users	n.a.	n.a.	n.a.	n.a.	2,900	3,200	3,700
– cannabis users	3,400	5,500	4,100	3,600	2,700	2,000	1,700
– inhalant users	n.a.	705	560	470	450	390	300
Average age of drug user (years)	22.0	23.2	23.4	25.0	25.3	26.1	25.9
Total contacts/visits	290,000	315,000	317,900	403,900	322,900	338,100	329,466

Table 7-2: Selected services of low-threshold facilities in the years 2004-2008, extrapolated to the total number of programmes (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)

Indicator	2004	2005	2006	2007	2008
Number of exchanges in exchange programmes	139,800	249,000	191,000	215,800	217,200
Food service	94,700	99,500	97,600	94,100	87,800
Hygiene service	34,500	40,900	41,100	40,000	34,800
Individual counselling	27,300	25,800	21,900	24,100	21,000
Medical attendance	13,500	12,500	10,500	9,400	7,700
Crisis intervention	3,000	2,500	1,800	1,600	1,100
Group therapy	1,800	1,500	1,500	1,000	1,100

Table 7-3: Selected services provided by low-threshold facilities in the individual regions in 2008, extrapolated to the total number of programmes (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)

Region	Contact	First contact	Exchange	Food service	Hygiene service	Individual counselling	Referral*	Medical attendance	Crisis intervention	Group therapy
Prague	137,594	347	119,551	16,054	3,489	3,057	2,612	1,382	214	212
Central Bohemia	12,478	653	8,913	5,108	1,481	1,222	2,191	,225	47	0
South Bohemia	18,973	743	11,156	8,084	2,567	2,363	1,156	165	144	150
Pilsen	10,636	776	5,324	3,053	1,594	1,925	1,801	472	87	43
Karlovy Vary	8,055	315	5,069	3,963	2,567	,342	1,113	3,149	34	67
Ústí nad Labem	44,341	1,595	30,675	10,617	5,157	1,525	1,463	600	181	258
Liberec	7,975	620	2,789	4,164	2,676	375	973	43	46	19
Hradec Králové	6,102	247	2,955	,526	425	256	120	54	17	0
Pardubice	3,392	205	1,147	1,368	960	64	134	59	8	6
Vysočina	6,561	152	1,303	3,726	1,815	774	707	130	26	0
South Moravia	23,147	856	12,788	6,161	3,330	3,093	724	521	47	117
Olomouc	20,683	851	5,444	10,521	3,109	3,705	1,018	575	108	23
Zlín	10,663	435	2,857	3,141	1,568	684	1,497	221	43	82
Moravia-Silesia	18,865	325	7,250	11,313	4,094	1,574	328	139	144	109
Total – Czech Rep.	329,466	8,120	217,221	87,799	34,831	20,960	15,838	7,735	1,147	1,086

NB:* Referrals to a low-threshold centre or a treatment facility, including substitution treatment.

Data on the clients of low-threshold facilities from other sources are also provided in the chapter on Data on Problem Drug Use from Non-treatment Sources, page 30. According to a survey conducted among the clients of all the low-threshold programmes in Prague in May 2008 (Šejvl, 2008), the greatest proportion of the clients used the exchange programme (48%), followed by counselling and interviews (25%), the services of the contact room (12%), medical attendance, and the hygiene service (7%). 26% of the clients stated they used the services on a daily or almost-daily basis, 33% several times per week, 24% several times per month, 13% less often, and 4% of the clients did not state the frequency with which they used the services. As for HIV testing, 51% of the clients stated they had been tested in the past 12 months, 31% earlier, and 18% stated they had never been tested. Two thirds (66%) of the clients were tested for HIV in a low-threshold centre, 19% upon admission to custody or prison, and 15% upon commencing addiction treatment. As far as HCV is concerned, 53% of the clients had been tested in the past 12 months, 33% earlier than in the past 12 months, and 14% had never been tested. 53% of the clients were tested for HCV in a low-threshold centre, 26% upon admission to custody or prison, and 17% upon commencing addiction treatment.

The low-threshold programmes in Prague co-operated in 2008 in the examination and vaccination efforts undertaken as a part of the anti-epidemic measures taken in response to the increased incidence of HAV; for additional information see the chapter on Drug-Related Infectious Diseases, page 53.

7.2.1.1 Needle and Syringe Exchange Programmes

A needle and syringe exchange component was included in 98 out of 100 low-threshold programmes. A comparison of the number of programmes and the number of needles and syringes distributed in the individual years 1998-2008 is provided in Table 7-4; the number of needles and syringes distributed in the individual regions is shown in

Table 7-5. According to information obtained from the final reports, each injecting drug user who visited a low-threshold facility made an average of 9.7 exchanges in 2008 (compared to 10.3 exchanges in 2007) and received a total of 208 sterile needles and syringes (214 in 2007). The number of injecting kits distributed in the individual regions corresponds with the relative number of injecting (problem) drug users; see Map 7-1 below and Map 4-1 (page 29).

Table 7-4: Exchange programmes in the Czech Republic in 1998-2008 (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009j; Studničková and Petrášová, 2009)

Year	Number of exchange programmes	Number of needles and syringes distributed
1998	42	486,600
1999	64	850,285
2000	80	1,152,334
2001	77	1,567,059
2002	88	1,469,224
2003	87	1,777,957
2004	86	2,355,536
2005	88	3,271,624
2006	93	3,868,880
2007	107	4,457,008
2008	98	4,644,314

Table 7-5: Number of needles and syringes distributed in the exchange programmes in 2002-2008, by region (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009j; Studničková and Petrášová, 2009)

Region/year	2002	2003	2004	2005	2006	2007	2008
Prague	858,507	979,560	1,210,704	1,697,554	1,850,330	2,071,788	2,060,588
Central Bohemia	12,561	31,682	66,600	110,325	168,220	215,640	309,590
South Bohemia	14,883	69,004	102,621	124,454	141,825	212,791	228,872
Pilsen	23,221	44,670	88,450	116,611	157,317	189,894	207,938
Karlovy Vary	16,608	29,299	35,756	58,680	66,382	83,462	79,834
Ústí nad Labem	256,071	262,418	351,561	479,383	612,259	655,882	637,887
Liberec	12,273	21,108	33,467	32,800	47,756	63,967	129,903
Hradec Králové	22,250	45,089	41,021	86,221	98,269	139,075	173,417
Pardubice	23,622	23,330	36,081	38,725	48,144	29,908	52,690
Vysočina	11,254	29,363	39,348	61,425	68,682	99,447	65,343
South Moravia	134,285	122,137	165,846	173,090	227,833	269,236	264,872
Olomouc	21,809	33,832	85,872	96,416	150,024	134,433	137,321
Zlín	19,973	11,362	41,977	52,169	69,005	115,744	89,913
Moravia-Silesia	41,907	75,103	56,232	143,771	162,834	175,741	206,146
Total	1,469,224	1,777,957	2,355,536	3,271,624	3,868,880	4,457,008	4,644,314

Map 7-1: Number of needles and syringes distributed in Czech regions in 2008 per 1,000 inhabitants (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j; Studničková and Petrášová, 2009)



Needle and syringe exchange programmes are complemented by the distribution of aluminium foil for smoking heroin and the distribution of gelatine capsules intended mainly for pervitin users.

7.2.1.2 Distribution of Gelatine Capsules as Harm Reduction Material

The first information about the gelatine capsule distribution programmes as a service provided with a view to reducing injecting drug use is provided in the 2007 Annual Report. An online questionnaire survey was conducted in 2009 in order to obtain a more detailed picture of capsule distribution. All the low-threshold facilities in the Czech Republic were approached. In addition, a focus group with the representatives of the facilities and a group interview with the clients of the Outreach Programmes of the SANANIM civic association in Prague were held.

The online questionnaire was filled in by 52 low-threshold facilities. The questionnaires returned show that capsules as harm reduction material are currently distributed by 17 facilities, and another 20 facilities are considering capsule distribution as an option. The demand for capsules has been on the rise among drug users. According to the members of the focus groups, the primary target group consists of injecting perversin users with damaged veins looking for an alternative to injecting drug use. Other target groups include mainly recreational perversin users who have no injecting experience, and socially stabilised drug users who are afraid of using drugs by injecting under certain circumstances (e.g. at work). Opiate users were not specified as a target group, which is probably attributable to the lower metabolic availability of opiates from the digestive tract. Damaged veins and the motivation to reduce the frequency of injecting use are the main reasons specified for the use of the capsules. In comparison with simple oral application, the capsules help eliminate the typical bitter taste of the drug and do not prevent the onset of the effect of the drug. The advantage of the capsules is in the ease of preparation and safety of application that they offer. Nevertheless, the health risks associated with the oral use of perversin were also mentioned, in particular those connected with damage to the mucous membranes in the gastro-intestinal tract. Capsule distribution appears to be a suitable and efficient approach to harm reduction, especially in the group of perversin and/or amphetamine-type drug users. The potential risks and advantages of the use of capsules in harm reduction should be subject to further research (Škařupová et al. 2009).

7.2.1.3 Syringe and Other Harm Reduction Material Vending Machines

In May 2008, the PROGRESSIVE civic association launched the NON STOP 24 project concerning vending machines for harm reduction material. The objective of the project is to increase the availability of harm reduction supplies and address a specific group of injecting drug users. The pilot stage of the project commenced with the installation of two machines in the Prague 5 District. The vending machines provided non-stop access to clean injecting equipment, disinfectants, clean water, etc. One vending machine was provided with a safe disposal container for used needles and syringes. The project was suspended by the Prague 5 District Authority in October 2008, with the evaluation of the impact of the project on the city district being stated as the reason for the suspension. The project had not been resumed by August 2009, despite the fact that the evaluation showed a continuous increase in the number of kits vended and positive feedback from the clients, and found that approximately one third of the clients had no contact with any other harm reduction programme, which means that the programme managed to address a group of injecting drug users in Prague who had not been previously contacted or were difficult to contact.

7.2.1.4 Safe Disposal Containers

Another harm reduction project is the FIX POINT project implemented by the PROGRESSIVE civic association. The project concerns the installation of special safe containers for the disposal of used injecting paraphernalia. The containers are placed in selected locations with a view to maximising their accessibility for injecting drug users. The objective of the FIX POINT project is to improve the opportunity to safely dispose of used injecting equipment in places exposed to a high level of injecting drug use. In preparation since 2008, the project was officially launched in June 2009. The containers are currently situated at 9 locations across the Prague 5 District (o.s. Progressive, 2009).

7.2.1.5 Testing for Infectious Diseases

Some low-threshold facilities conduct saliva HIV tests in co-operation with the National Reference Laboratory for AIDS, National Institute of Public Health, in Prague. However, HIV testing from saliva was suspended in late 2008 because of an interruption to the deliveries of the laboratory materials by the manufacturer. The National Reference Laboratory for AIDS is currently making efforts to validate and introduce a new method of testing saliva for HIV antibodies. In 2006-2007, there was a persistent problem with the availability of HCV testing in low-threshold facilities, mainly as a result of the absence of a quick test for HCV antibodies from whole blood. In June 2008 a range of quick tests and the related equipment for HCV antibody tests from capillary blood serum were successfully obtained for selected low-threshold facilities, some of which started to conduct the tests during July and August 2008. Seminars focused on using the tests were held for the staff of the low-threshold facilities in 2008 and 2009.

The National Focal Point is informed about the extent of testing for infections in low-threshold facilities from the final reports concerning projects supported within the framework of the grant procedure of the Government Council for Drug Policy Coordination. The test results are available from the monitoring of the tests in low-threshold programmes; for detailed information see the chapter on Drug-Related Infectious Diseases, page 53. In 2008, 50 facilities offered HIV testing, 40 HCV testing, and 18 HBV testing, and three low-threshold facilities offered syphilis testing. The number of tests conducted is still very low compared to the pre-2006 figures. Nevertheless, there was a

significant year-on-year increase in HIV and HCV tests (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j). See Table 7-6.

Table 7-6: Number of tests for infectious diseases and the number of low-threshold facilities providing tests in 2002-2008 (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)

Year	HIV		HBV		HCV		Syphilis	
	Tests	Facilities	Tests	Facilities	Tests	Facilities	Tests	Facilities
2002	1,158	35	515	26	1,202	33	176	2
2003	2,629	64	739	21	2,499	60	209	4
2004	2,178	58	932	25	2,582	53	84	1
2005	2,425	54	1,370	28	2,664	55	54	2
2006	1,253	46	693	56	1,133	62	209	3
2007	609	53	370	19	401	24	62	4
2008	1,120	50	399	18	862	40	124	3

In the past, a number of low-threshold and other providers of services to drug users co-operated with public health protection authorities in the field of prevention and testing for infections. Such authorities included regional public health offices or health institutes and, especially, the HIV counselling services of the health institutes. The monitoring of the tests for infectious diseases in low-threshold facilities in 2008 showed that only 4 out of 14 health institutes systematically co-operated with the drug services in the tests; to be specific, they were the health institutes in České Budějovice, Pilsen, Ústí nad Labem, and Pardubice (Národní monitorovací středisko pro drogy a drogové závislosti, 2009i).

7.2.1.6 Programmes Aimed at Drug Use in Nightlife Settings

The 2008 final reports of the total of 6 outreach programmes (Drop-In Prague, the CPPT Pilsen outreach programme, the Dance8 outreach programme of CPPT Pilsen, the Olomouc outreach programme of *Sdružení Podané ruce*, the *Jihočeský* sreetwork programme of the Prevent České Budějovice civic association, and the outreach programme of the Kappa-Help Přerov civic association) specified harm reduction activities among drug users in dance party settings (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j). The programmes reached a total of 1,839 clients, and 132 qualitative screening tests for synthetic drugs were performed. In comparison with 2007, this was the first year-on-year increase after a period of a decline in services provided in nightlife settings following 2004, when funding restrictions regarding the programmes significantly curbed these activities (in 2003 there were 18 active programmes in this area, reaching almost 5,000 clients); for additional information see the 2006 and 2007 annual reports and the issue of the “*Zaostřeno na drogy*” bulletin dedicated to this topic (Mravčík et al. 2008).

2008 saw a revival of services focusing on the nightlife settings: the “Drug Use Prevention and Harm Reduction at Dance Parties” working group was established by the Government Council for Drug Policy Coordination, and the Safer Party project was launched (for additional information on the project see the chapter on Selective Prevention (page 26). Among other aspects, the project included the evaluation of the environment at the event with regard to factors with a potential impact on the visitors’ health and safety. The common negative factors included the absence of return transport from the festival, the mandatory disposal of non-alcoholic beverages prior to entry (even where the festival area offered no free drinking water), and the poor hygienic standard of the sanitary facilities. On the contrary, the positives included the presence of emergency medical services at all festivals and, for the most part, easy orientation around the festival area (Národní monitorovací středisko pro drogy a drogové závislosti, 2008a).

7.2.2 Distribution of Needles and Syringes in Pharmacies

In 2007 and 2008 the Centre for Addictology conducted a two-year research study into the role of pharmacies in health care and counselling for (injecting) drug users in the Czech Republic (see also the 2007 Annual Report). The study consisted of a quantitative and a qualitative part. In the quantitative part, 310 out of the 373 pharmacies contacted participated in a questionnaire survey (response rate of 83.1%), while the qualitative part consisted of a semi-structured in-depth interview with representatives of 40 out of the 58 pharmacies addressed. According to the questionnaire survey, drug users (or clients considered by the pharmacy staff as drug users) visit most of the respondent pharmacies (87.7%), with the estimated ratio of men and women being 2.5:1 and the 20-30 age category being the one most represented (54%). Almost one third (31%) of the pharmacies do not sell needles and syringes, and 24.6% of the pharmacies will not sell them to a drug user. The price of one kit consisting of a needle and syringe (intended for insulin application) does not exceed CZK 10.00 (€ 0,4). Only 38% of the pharmacies included in the sample collect used needles and syringes. 41.6% of the pharmacists in the group are in favour of more intensive forms of work with drug users in pharmacies. Only 17.1% of the pharmacies in the group work with low-threshold services in their region. Only 3.2% of the pharmacies offer printed materials on the prevention of infectious diseases (Gabrhelík et al. 2008a; Gabrhelík et al. 2008b).

The qualitative study suggested that the pharmacy staff almost exclusively considered a drug user to be an injecting pervitin or opiate user. The most important distinctive way to identify a drug user was the goods requested (injection

supplies and medicinal products containing pseudoephedrine), followed by the person's behaviour (with the typical signs including nervousness, agitation, and eagerness to close the transaction quickly) and other signs of drug use (neglected appearance, needle marks, and skin rash). The typical contact was no different from ordinary contact with any other customer. Despite problems with drug users being rare, pharmacists are afraid of losing non-user customers. Most pharmacies have no restrictions on the sale of needles and syringes and sell them to users in the quantities requested. Some pharmacies only sell multiple injecting kits. The drug-using customers often ask for larger quantities of preparations containing pseudoephedrine, in response to which the pharmacy staff apply various strategies to prevent the dispensation of larger quantities of such medicinal products. In turn, drug users use different strategies to gather the highest quantity of such preparations possible (multiple sources, multiple shoppers, shopping with multiple pharmacists in a single pharmacy)⁴⁷. Conflicts, which were only rarely encountered in interacting with drug-using customers, mostly involved verbal aggression after the drug user's request was declined. Physical aggression only occurs as an exception (about a quarter of the pharmacies reported experience with a physically aggressive client), while theft is more common and was described by the staff of nearly one half of the pharmacies, most usually in the form of the customer running away without payment). Issues seen by the pharmacists as problematic included the sale of medicines containing pseudoephedrine, the abuse of prescription substitution products, and dependency on prescription drugs (Vacek et al. 2008; Gabrhelík et al. 2008b).

Proposals and recommendations were published in 2009 as part of the above-mentioned project in order to support the implementation of other services for injecting drug users in Czech pharmacies. Specifically, they included the potential involvement of the pharmacists in the prevention of drug use in terms of public health. In addition, the target groups for addictological interventions in pharmacies were identified, the potential of pharmacies in collecting drug user data was emphasised, etc. (Gabrhelík et al. 2008b; Gabrhelík and Miovský, 2009).

Approximately 1.5 million injecting kits a year are sold to drug users in pharmacies; for additional information see the 2007 Annual Report.

7.2.3 Treatment of Drug-Related Infections

There are 7 AIDS treatment centres in the Czech Republic, of which the AIDS Centre of the Na Bulovce University Hospital covers the area of Prague and the region of Central Bohemia and is the methodology and management centre for the other facilities. It is the only centre in the Czech Republic to provide obstetric care for HIV-positive mothers and paediatric care for newborn babies exposed to HIV. The treatment procedures include HAART (highly active antiretroviral therapy), which is also provided to indicated HIV-positive drug users. The treatment is funded partially from the health insurance budget and partially from government subsidies.

The Standard for the Treatment of Viral Hepatitis in Drug Users was published in the December issue of the Journal of the Czech Ministry of Health (Issue 7/2008, ref. no. 28629/2008) to establish the procedures for the prevention, diagnosis, and treatment of viral hepatitis in drug users. Among other provisions, it specifies that, within the framework of the preventive measures, drug users should be included in the injecting equipment exchange programme and vaccinated against HAV and HBV. The standard emphasises that the therapeutic procedure for viral hepatitis C in addicted patients, including those with an active addiction to drugs and patients undergoing substitution therapy (i.e. stabilised patients), is identical to the recommended procedure for non-addicted patients but that the fundamental precondition for the commencement of the therapy is the patients' motivation and co-operation. The standard points out the need for a multidisciplinary approach to the patients. The treatment follows the recommended procedures of the Czech Hepatological Society and of the Society for Infectious Medicine of the Czech Medical Association of J.E. Purkyně⁴⁸.

The Czech Republic currently has 63 centres providing the treatment of chronic viral hepatitis and certified by the Czech Hepatological Society and the Society for Infectious Medicine. The centres operate in all the regions, thus ensuring a high level of treatment availability. Virtually all the certified centres treat patients with a history of drug use, patients actively using drugs with lower health and social risks, and co-operating and motivated patients undergoing substitution therapy. Active problem users of illicit drugs, especially of pervitin, remain an issue, as there is no substitution available for them, and there is usually a low level of stabilisation, co-operation, and motivation for treatment on the part of such patients. Another problem is the payment for the antivirals used in the therapy from the public health insurance budget⁴⁹ (Urbánek et al. 2009).

The Motol University Hospital in Prague operates a specialised centre for the treatment and prevention of infection-related complications in drug users⁵⁰. The network of services for drug users in Prague also includes an internal

⁴⁷ The study was conducted prior to the restriction on the supply of medicines containing pseudoephedrine, which has been in effect since 1 May 2009; for additional information see the chapter on the Legal Framework, page 5.

⁴⁸ See also <http://www.infekce.cz/> and <http://www.ceska-hepatologie.cz/>.

⁴⁹ Virostatic treatment is currently covered from fees whose amount is determined on the basis of prior reference periods, thus potentially failing to consider the current needs. The professional societies of the JEP Czech Medical Associations request that treatment be covered from health insurance on an individual basis in specific clients.

⁵⁰ See <http://www.fnmotol.cz/infekce/>.

medicine outpatient centre and the Remedis⁵¹ counselling centre for hepatic diseases, which specialises in the treatment of somatic diseases of drug users.

Also employed in the Czech Republic are websites and free helplines aimed at counselling in the area of infections. For additional information see the 2007 Annual Report.

7.3 Responses to Other Health Correlates Among Drug Users

The treatment of drug users with dual diagnoses is carried out in an integrated manner, i.e. within the existing treatment system for drug users, and the specific needs of the patients are taken into consideration; see the chapter on Drug-related Treatment: treatment demand and treatment availability, page 32.

Other somatic disorders of drug users in the Czech Republic are treated using the public medical and preventive care system. The potential problems on the part of the clients include unclear medical health insurance status (e.g. following the loss of their insurance card or, in the case of health insurance payments, that these are owed) or, in some cases, the total absence of health insurance (as regards foreigners, for example).

⁵¹ See <http://www.remedis.cz/>.

8 Social Correlates and Social Reintegration

Social problems mainly accumulate among drug users who are members of ethnic minorities, among immigrants (in the Czech Republic, this mainly applies to Roma and people of Vietnamese descent and to users from the post-Soviet states) and older drug users.

Homelessness is likely to be associated with the use of mainly legal drugs (alcohol, tobacco). Nevertheless, the frequency of contact between illicit drug users among the homeless and the relevant institutions is lower. For that reason, their use of illicit drugs may be underestimated.

It appears that the prevalence of drug use among Roma in the Czech Republic has been stable in recent years, involving mainly legal drugs such as alcohol and tobacco, with marijuana and pervitin representing the most widespread illicit drugs. The available data indicate a declining trend in the use of toluene among Roma.

No major change in the number of aftercare facilities occurred in 2008. However, there was a significant increase in their capacity (which doubled in the case of sheltered housing, for example) and in the number of clients.

A Narcotics Anonymous-type of self-help group was set up in Brno in May 2009, representing a unique initiative in the Czech Republic after a long period of time.

8.1 Social Exclusion and Drug Use

8.1.1 Social Exclusion among Drug Users

The most significant social problems of drug users include family and work problems, unemployment, lower education, and poor housing, which sometimes even lead to homelessness. The specified problems mainly accumulate among drug users who are members of ethnic minorities and immigrants, as well as among older drug users, who show higher homelessness and unemployment figures (for more information see the chapter on Treatment and Care for Older Drug Users, page 115).

For information on the nature of housing and on the education and unemployment levels of the treatment demands see Drug-related Treatment: treatment demand and treatment availability, page 32.

In a survey conducted among 783 clients of Prague's low-threshold programmes in May 2008 (Šejvl, 2008); see also the chapter on Data on Problem Drug Use from Non-treatment Sources, page 30 – 674 clients (86.1%) stated they were Czech, 59 (7.3%) were Roma, and 29 (3.7%) were Slovak. Clients from Ukraine (6 persons), Russia (4), and Georgia (4) and 5 clients from other countries were also represented in the sample. As for employment and source of income, 145 clients (20.1%) had a steady job with a proper employment contract, 93 (11.9%) had occasional legal work, 185 (18.5%) had occasional undeclared work, 140 (17.9%) were on welfare, and 182 (23.2%) reported having another source of income. These other sources of income included, in the first place, theft (42 persons), dealing drugs (8) and other criminal activities (8), prostitution (14), and begging (15), as well as support from the client's parents, disability benefits, collecting scrap metal, and street performance. In terms of housing, 498 persons (63.6%) lived in a housing unit equipped with sanitary facilities (their own or a rented flat, living with parents or a partner), 165 (21.1%) lived without sanitary facilities available (squat, cottage), and 120 (15.3%) were shelterless.

The qualitative study into the new trends on the drug scene (for more information see the chapter on Data on Problem Drug Use from Non-treatment Sources, page 30) analysed responses from the staff of low-threshold programmes in the Czech Republic regarding their experience with clients who were members of ethnic minorities (Radimecký et al. 2009). The reported experience was mainly with Roma clients, who even represented the majority of the clients of the relevant programmes in certain areas (Pilsen, Ústí nad Labem, Brno, Ostrava, Uherský Brod, Teplice, Pečky). Other groups included clients from the post-Soviet states, Vietnamese, and Slovaks. The Roma clients are characterised by strong family bonds; whole families become clients, services are provided to family members with a different age profile, and drug procurement and use is under the strong influence of family rules. The Roma in certain areas participate in the trafficking of drugs, especially heroin, which is typically used by Roma. Some of the Roma clients consider pervitin a low-risk drug. The Russian-speaking clients are mainly concentrated in large cities (Prague, Brno) and only rarely appear elsewhere. They form a very tight group with little contact with the domestic drug scene. Both the language barrier and the clients' fear of losing their anonymity hinder the contacts of outreach staff with these clients. The use of pervitin and Subutex[®] and a near-100% representation of men are typical of this group. According to the workers of low-threshold programmes, the current problems on the labour market in connection with the global economic crisis may result in an influx of unemployed migrant clients to the drug services. Vietnamese clients are the most difficult to access for the outreach workers. Because of its entirely different language and cultural background, this community is hard to contact. In some regions, people of Vietnamese descent are involved in drug production and trafficking (cannabis growing and marijuana sales, heroin sales). Some programmes also include clients from Slovakia – mainly blue-collar workers in the Czech Republic.

For qualitative research into problem drug use among migrants in and around Brno, see the 2007 Annual Report.

8.1.2 Drug Use among Socially Excluded Groups

8.1.2.1 The Homeless

There is a close connection between addiction and/or mental disorders on the one hand and homelessness on the other hand; it is, however, often difficult to determine whether the addiction and/or a mental disorder is the cause or the consequence of the social status of the homeless. Combined with social and economic difficulties, a mental disorder may trigger homelessness, but, on the other hand, homelessness may result in mental problems, depression, and substance abuse (Šupková, 2008).

The Institute for Criminology and Social Prevention conducted a study aimed at homelessness and the homeless in 2006 (Štěchová et al. 2008). The research was conducted in 6 sheltered living homes in Prague (Salvation Army, *Emmauzy*, *Charita*, *Městské centrum*, *Naděje*, and *Dům Agapé*). The social worker filled in an answer sheet about each client staying in the facility for over 14 days (or long enough to answer the questions regarding their behaviour in the sheltered living home). 157 answer sheets were completed. It was found that the clients of the shelters most typically smoked cigarettes and/or drank alcohol. Illicit drug use was not found. The explanation given by the authors of the study was that homeless illicit drug users have difficulty finding accommodation in the facilities and are therefore not their clients.

8.1.2.2 Roma Communities

In the Czech Republic, social exclusion also concerns certain Roma communities, where it is the product of the accumulation of social problems. The primary factors of the social exclusion of Roma include long-term unemployment, low incomes, and either the unavailability or poor quality of housing (Kancelář Rady vlády pro záležitosti romské komunity, 2007).

Long-term monitoring and evaluation of the situation in Roma communities is provided by the Office of the Government Council for Roma Community Affairs as part of the Field Social Workers Support Programme. Altogether, 46 municipalities with 86 outreach workers were involved in the programme in 2008 (Kancelář Rady vlády pro záležitosti romské komunity, 2009).

Field social workers supplied services to 13,144 clients in 2008 and made 59,687 contacts. Individual work (48%) and work with families (29%) were the most common approaches. The topics addressed most often included debt, housing, and unemployment. Drug use-related interventions were provided to 3% of the clients; see Table 8-1. The number and percentage of problems related to illicit drug use and gambling has been stable and relatively low in the long term (Kancelář Rady vlády pro záležitosti romské komunity, 2009).

Table 8-1: Number of clients provided with the services of Roma field social workers in 2006-2008, by problem type (Kancelář Rady vlády pro záležitosti romské komunity, 2007; Kancelář Rady vlády pro záležitosti romské komunity, 2008; Kancelář Rady vlády pro záležitosti romské komunity, 2009)

Problem type	2006		2007		2008	
	Number	%	Number	%	Number	%
Debt	4,477	34.1	5,314	31.9	3,779	28.7
Unemployment	2,672	20.4	2,916	17.5	2,598	19.8
Housing quality	3,362	25.6	3,364	20.2	2,432	18.5
Problematic tenant/landlord relations	1,847	14.1	1,522	9.1	1,285	9.8
Insufficient sanitation	1,300	9.9	1,204	7.2	1,282	9.7
Truancy	907	6.9	716	4.3	1,000	7.6
Usury	277	2.1	320	1.9	696	5.3
Crime	620	4.7	574	3.4	636	4.8
Drug use	457	3.5	391	2.3	344	2.6
Gambling	268	2.0	302	1.8	323	2.5
Prostitution	63	0.5	39	0.2	51	0.4
Total*	13,116	100.0	16,662	100.0	13,144	100.0

NB: * The aggregate number of clients classified by problem type exceeds the total number of clients because of the accumulation of problems in individual clients.

In 2007, the government established the Agency for the Elimination of Social Exclusion in Roma Localities. The Agency's main objective is the transformation of Roma ghettos, with a view to an improvement in the quality of life in such problematic areas; for details see the 2007 Annual Report. In 2008, the Agency participated in the Long-term Monitoring of Roma Community Status – Locations in Moravia project (Kašparová et al. 2008). As a part of the project, ethnographic and anthropological research was conducted in the regions of Brno, Břeclav, Holešov, Jeseník, Přerov, and Silesian Ostrava in order to identify the context and dynamics of the social exclusion mechanisms. Among other factors, the research also focused on the health condition of the inhabitants of socially excluded communities, including drug use. All the sites reported tobacco and alcohol use and gambling. The most typical drug

in the past was toluene, whereas now pervitin users prevail. In addition, the use of cannabis (Břeclav, Holešov, Přešov), dance drugs (Břeclav), and opium (Holešov) was reported.

The Agency also participated in the project of the World Bank and the Government Council for Roma Community Affairs named "Czech Republic: Improving the Employment Chances of the Roma", and in the Roma Population and Health research conducted under the SASTIPEN project. The projects seek to describe the health and social status of Roma and their access to social and health resources.

In the course of 2008 the staff of the Agency prepared a number of case studies concerning housing in locations inhabited predominantly by Roma in Brno, Kladno, Ostrava, Pardubice, and Prague. A situation analysis of the socially excluded areas in Litvínov was also prepared, focusing particularly on the Janov housing estate. Three areas were identified in Litvínov whose geographical location, social segregation, (un)availability of services, and the nature of the settlement, or a combination of these factors, corresponded with the characteristics of social exclusion. Next to marijuana, which is used by children from as early as 13 years of age, pervitin was the most commonly used illicit drug in those areas. Other drugs used include illegally procured Subutex[®], magic mushrooms, and cocaine; the use of heroin is almost non-existent. As in other socially excluded communities in the Czech Republic, tobacco and alcohol use and gambling are widespread in those areas (Agentura pro sociální začleňování v romských lokalitách, 2009).

8.2 Social Reintegration

Aftercare for drug users and their social inclusion in the Czech Republic are provided through outpatient aftercare programmes and structured intensive outpatient programmes, which may include sheltered housing programmes and sheltered work programmes (sheltered workshops, sheltered employment, supported employment). Their target population consists of abstaining people with a history of substance addiction and a recommended minimum abstinence period of three months.

Aftercare was provided by 18 facilities using 27 programmes subsidised by the Government Council for Drug Policy Coordination in 2008; see Map 8-1. A total of 13 facilities offered sheltered housing and four also provided sheltered employment.

Map 8-1: Aftercare facilities in the Czech Republic in 2008 (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)



A total of 1,041 clients (65% of them male) used the aftercare services; 725 (70%) of them used to inject drugs before they entered treatment; 576 (55.3%) used to use pervitin and 176 (16.9%) heroin. The total capacity of the facilities offering sheltered housing was 126 places, and 25 clients worked in sheltered workshops (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j); the comparison for 2005-2008 is provided by Table 8-2.

Table 8-2: Aftercare programmes subsidised by the Government Council for Drug Policy Coordination in the period 2005-2008 (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)

Indicator	2005	2006	2007	2008
Number of facilities	20	18	18	18
Number of aftercare clients	865	904	883	1,041
Sheltered housing places	118	126	126	283
Number of clients in sheltered housing	244	235	261	298
Number of clients in sheltered workshops	59	40	44	25

Outpatient aftercare was offered by 12 facilities, whose services were used by 487 clients (335 of whom were men), which represents a marked increase compared to 2007. The average age of the clients has been rising in the long term and reached 30.3 years in 2008. A total of 306 clients (62.8%) had been injecting drug users prior to the treatment; 259 (53.2%) had used pervitin and 71 (14.6%) heroin or Subutex® (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j). The comparison for the period 2003-2008 is provided in Table 8-3.

Table 8-3: Outpatient aftercare programmes subsidised by the Government Council for Drug Policy Coordination, and their clients in the period 2003-2008 (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)

Indicator	2003	2004	2005	2006	2007	2008
Number of facilities	8	14	13	10	12	12
Number of clients	460	444	336	380	389	487
– injecting drug users	320	307	218	230	236	306
– pervitin users	210	187	182	216	209	259
– opiate users	120	115	58	78	69	71
Average age of clients	26.0	26.6	27.4	26.4	29.3	30.3

Fifteen facilities provided intensive aftercare (within a long-term structured programme, typically involving sheltered housing and employment); their total capacity of 283 beds was used by 554 clients (342 of whom were men). The average age of the clients was 28.7 years. A total of 422 clients (76.2%) had been injecting drug users prior to the treatment; 317 (57.2%) had used pervitin and 105 (18.9%) opiates (heroin or Subutex®). The average length of the programme per client was six months. 164 clients (29.6%) completed the programme, 121 (21.8%) dropped out, and 61 (11%) were expelled (Národní monitorovací středisko pro drogy a drogové závislosti, 2009j); see Table 8-4.

Table 8-4: Intensive aftercare programmes subsidised by the Government Council for Drug Policy Coordination, and their clients in the period 2003-2008 (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2009j)

Indicator	2003	2004	2005	2006	2007	2008
Number of facilities	14	14	15	16	15	15
Capacity	321	342	385	365	325	283
Number of clients	585	562	526	524	494	554
– injecting drug users	463	404	399	364	360	422
– pervitin users	245	260	276	304	284	317
– opiate users	224	184	143	105	104	105
Average age of clients	24.5	27.0	26.4	27.1	26.6	28.7

In addition to the facilities specified above, aftercare services may be provided to drug users by other inpatient or outpatient facilities. Their use by drug users, however, is difficult to determine. Alcoholics Anonymous (AA) groups operate on a self-help basis. There are currently 36 AA groups in 25 towns and cities in the Czech Republic (Anonymní alkoholici - Česká republika, 2009). A Narcotics Anonymous (NA) group named “Fatima” started to operate in Brno in May 2009. According to available data, there is no other self-help group which focuses on non-alcohol drugs in the Czech Republic.

Four work and social agencies (run by the SANANIM civic association in Prague, the Christian Help Centre in Pilsen, the White Light I. civic association in Ústí nad Labem, and the PASÁŽ agency of Sdružení Podané ruce in Brno) focused on improving the situation of former drug users through assistance on the labour market in 2008. The clients of these agencies can make use of a wide portfolio of services, ranging from the provision of resources for working individually (e.g. internet access) to direct intermediation of employment. The Restart project of the Prev-Centrum civic association was launched in 2009 with a view to placing the clients of the substitution programme on the labour market.

The Ministry of Labour and Social Affairs pursues a social protection and social inclusion policy, which specifies drug users as one of the target groups. The National Action Plan on Social Inclusion 2008-2010 currently applies. The National Report on Strategies for Social Protection and Social Inclusion 2008-2010 mentions drug addiction as a negative factor in the effort to reinforce social skills with a view to increasing employment and employability, and also

refers to the issue of drug addiction in the section dealing with projects in Roma communities (Ministerstvo práce a sociálních věcí ČR, 2008).

The Ministry of Labour and Social Affairs also operates several databases that can help drug users or helping professionals obtain information about the social assistance available. The databases also provide statistical information about social services:

- Information portal and database of social prevention services for persons facing social exclusion. As of the end of August 2009, the database included 113 out of 495 facilities (22.8%) for persons addicted to drugs; drug users were also the second-largest primary target group monitored in the database of social prevention services for people facing social exclusion⁵².
- The Register of Social Service Providers in the Czech Republic – the register enables services to be sought according to the target group; as of late 2009, it included a total of 418 services for “persons facing or with a history of substance addiction”⁵³.
- Integrated portal of the Ministry of Labour and Social Affairs, which summarises all the information related to social issues and employment services⁵⁴.

⁵² See <https://www.sluzbyprevence.mpsv.cz/>.

⁵³ See <http://registr.mpsv.cz/>.

⁵⁴ See <http://portal.mpsv.cz/>.

9 Drug-related Crime, Prevention of Drug-related Crime, and Prison

The number of persons arrested, prosecuted, charged, and sentenced for drug-related offences has been stable in the Czech Republic in recent years. 70-80% of such individuals are arrested, prosecuted, charged, and sentenced for violating Section 187 (illicit drug production and trafficking) of the Penal Code, most often in connection with pervitin. 2,296-2,322 individuals were arrested or prosecuted for drug-related offences. The percentage of persons arrested or prosecuted for the possession of drugs for personal use according to Section 187a of the Penal Code, most typically in connection with cannabis and pervitin, remained stable (approximately 12%). The largest numbers of people prosecuted for drug-related offences were reported from the Ústí nad Labem region, both in absolute and in relative terms per 100,000 inhabitants. 2,100 persons were charged and 1,360 persons were sentenced. The number and composition of the sentences for drug-related offences has been stable in recent years; 450 unsuspended and 688 suspended sentences were imposed in 2008. Institutional or outpatient compulsory (protective) treatment was imposed by the courts upon 162 persons; 91 of the cases involved the outpatient form and 71 the institutional form of treatment.

According to expert estimates, drug users account for 29% of the property crimes and violent crime (mostly involving various types of theft) that were investigated, which represents approx. 110,000 offences detected, mostly those against property, in a period of 1.5 years.

There were 35 prisons in the Czech Republic in 2008. In recent years, the daily headcount of prisoners in the Czech Republic has been around 19,000. However, an increase to 20,502 persons was reported at the end of 2008. A total of 9,390 inmates with a substance addiction, including individuals addicted to non-alcohol drugs, were reported in the prisons in 2008. Over 9,000 drug tests were performed in prisons, 13% of which returned a positive result, most frequently for pervitin. A total of 205 drug seizures, mostly involving cannabis, were reported in the prisons.

The Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2007-2009 is the main document governing the approach to drug users in prisons. Drug prevention counselling centres operated in all the prisons, and their services were used by 6,892 persons. Detoxification was carried out in the outpatient or inpatient form in four prisons and was used by 208 individuals. Thirty-three prisons have drug-free zones available, in which 3,646 inmates served their sentences. Two types of dedicated departments aimed at drug users were made available to prisoners: voluntary treatment departments were operated in six prisons and three prisons had dedicated departments for court-ordered institutional treatment. Substitution therapy was pursued in seven prisons, in which methadone was distributed to 76 persons. Eleven NGOs complemented the services in the area of care for imprisoned drug users, operating in 27 prisons, making a total of 744 visits and contacting 3,389 inmates.

9.1 Drug-related Crime

There are several data sources available in the Czech Republic regarding the so-called "drug offences", i.e. offences under the provisions of Sections 187, 187a, 188, and 188a of the Penal Code. They mainly include the statistics of the Police of the Czech Republic, especially the Criminal Statistics Record System and the statistics of the dedicated police unit – the National Drug Headquarters of the Criminal Investigation Service of the Police of the Czech Republic (the National Drug Headquarters) – as well as the statistics of the public prosecutors' offices and court statistics prepared by the Ministry of Justice. Additional data in this area are collected by the Probation and Mediation Service (PMS) and the Prison Service of the Czech Republic.

The data from the above-mentioned sources differ slightly. For example, persons arrested or prosecuted for drug-related offences are recorded in the system of the National Drug Headquarters, which only focuses on drug-related crime, and in the police and Ministry of Justice systems, which cover general, i.e. not only drug-related, crime. The differences in certain details result from the different reporting practices and discipline, as well as from the methodological differences between the individual reporting systems. For example, such differences include the recording of offences and offenders at different stages of the criminal proceedings⁵⁵, different definitions of the cases reported, and different statistical units (individuals, cases, or offences), duplications in the recorded data (e.g. if a single person has violated multiple drug-related sections of the Penal Code or in connection with multiple drug types). However, the non-existence of a uniform record-keeping system for all the institutions involved in the criminal proceedings (i.e. the police, PMS, public prosecutors' offices, and courts) is a major disadvantage in this context.

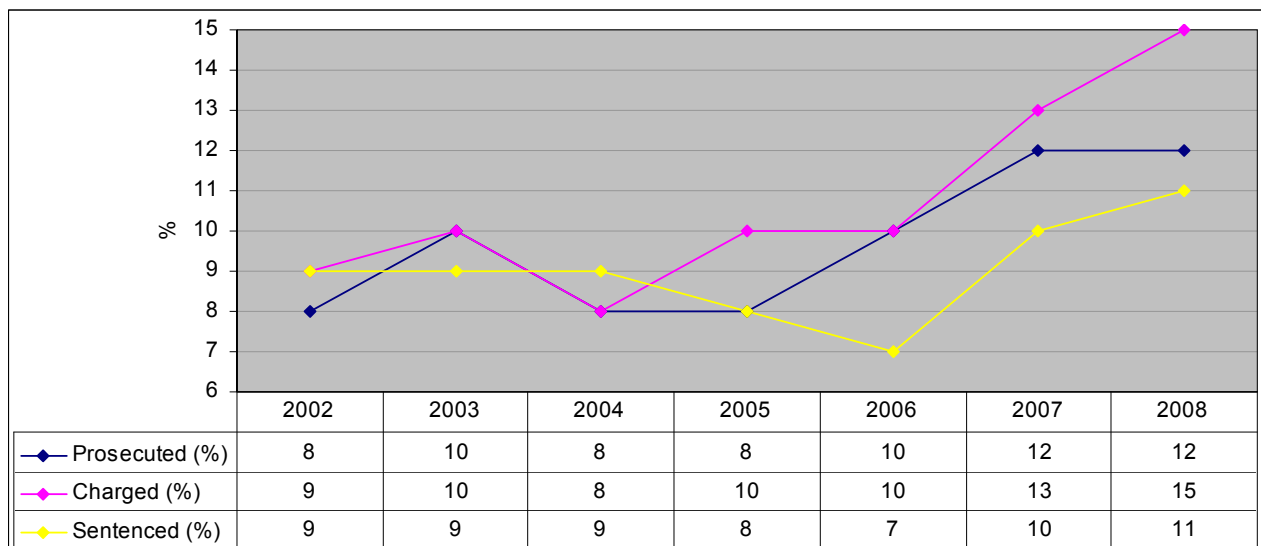
9.1.1 Drug Law Offences

The police data (Criminal Statistics Record System, National Drug Headquarters), as well as Ministry of Justice information regarding drug-related offences, confirm the relatively stable situation in recent years as far as the number of individuals arrested, prosecuted, charged, and sentenced is concerned, whether classified by drug-related Penal Code section, drug type, or region.

⁵⁵ The police statistics (the National Drug Headquarters database and the Criminal Statistics Record System) register a case as early as when prosecution starts. The individual cases enter the statistics of the Ministry of Justice with a certain delay – after the preliminary stage of the criminal proceedings is concluded (following a decision to indict the offender, suspend the criminal proceedings, etc.).

2,322 and 2,296 persons were arrested in 2008 according to the National Drug Headquarters and the Criminal Statistics Record System, respectively, and 2,304 persons were prosecuted for drug-related offences according to the Ministry of Justice; see Table 9-1. The percentage of persons arrested or prosecuted for drug-related offences is shown in Table 9-2 to Table 9-4, broken down by Penal Code section and main drug type. The number of individuals prosecuted in connection with drug-related offences has been stable in recent years. However, the percentage of people charged under Section 187a has been rising since 2004, and so has the percentage of persons sentenced according to that Penal Code section; see Figure 9-1.

Figure 9-1: Trends in the percentage of persons prosecuted, charged, and sentenced under Section 187a of the Penal Code in the period 2002-2008 (Ministerstvo spravedlnosti ČR, 2009b; Ministerstvo spravedlnosti ČR, 2009a; Mravčík et al. 2008)



According to the statistics of the National Drug Headquarters, 2,013 drug-related offenders (87%) were arrested for illicit drug production and trafficking (Section 187) and/or for possessing equipment for the unauthorised production of drugs (Section 188 of the Penal Code), most typically in connection with pervitin. 284 persons (12%) were arrested for the possession of drugs for personal use (Section 187a), mostly in connection with cannabis. Twenty-five persons (1%) were arrested for promotion of drug use (Section 188a of the Penal Code); see Table 9-2 and Table 9-3.

According to the Ministry of Justice statistics, 1,896 persons (83%) were prosecuted under Sections 187 and 188 of the Penal Code, mostly in relation to pervitin; 377 (16%) were prosecuted under Section 187a of the Penal Code, mostly in connection with pervitin and cannabis. The number of persons prosecuted under Section 188a of the Penal Code was 31 (1%) and the cases mostly involved cannabis; see Table 9-4.

In terms of regions, the highest absolute numbers of people prosecuted for drug-related offences in 2006-2008 were reported from the Ústí nad Labem region (299 persons in 2008), the Capital City, Prague (226), Moravia-Silesia (242), and South Moravia (240). The lowest numbers were prosecuted in the regions of Pardubice (60) and Hradec Králové (60). The highest numbers of persons prosecuted in the last 3 years per 100,000 inhabitants were reported from the Ústí nad Labem (36.3 persons in 2008) and Karlovy Vary (33.2) regions, while the regions of Hradec Králové (10.9), Zlín (11.2), and Pardubice (11.8) posted the lowest relative figures.

Table 9-1: Number of persons arrested and prosecuted for drug-related offences in 2003-2008 according to the individual information sources (Národní protidrogová centrála, 2009d; Ministerstvo vnitra ČR, 2009; Ministerstvo spravedlnosti ČR, 2009b).

Source	2003	2004	2005	2006	2007	2008
National Drug Headquarters	2,357	2,157	2,168	2,198	2,031	2,322
Police statistics	2,295	2,149	2,209	2,344	2,023	2,296
Ministry of Justice	3,088	2,944	2,429	2,630	2,282	2,304

Table 9-2: Number of persons arrested and prosecuted for drug-related offences in 2008, classified by Penal Code section (Národní protidrogová centrála, 2009d; Ministerstvo vnitra ČR, 2009; Ministerstvo spravedlnosti ČR, 2009b)

Source	Sections 187+188		Section 187a		Section 188a		Total
	Number	%	Number	%	Number	%	
National Drug Headquarters	2,013	87	284	12	25	1	2,322
Police statistics	1,990	87	278	12	28	1	2,296
Ministry Of Justice	1,896	83	377	16	31	1	2,304

Table 9-3: Number of persons arrested in 2008, classified by main drug type and Penal Code section, according to the National Drug Headquarters (Národní protidrogová centrála, 2009d)

Drug type	Sections 187+188		Section 187a		Total	
	Number	%	Number	%	Number	%
Cannabis	608	30	138	49	746	32
Pervitin	1,212	60	108	38	1,320	57
Cocaine	20	1	3	1	23	1
Heroin	124	6	27	10	151	7
Other drugs	49	2	8	3	57	2
Total number of people*	2,013	100	284	100	2,297	100

NB: *The "total number of people" row does not include 25 individuals arrested under Section 188a because information about the drug type involved is missing. The total number of persons arrested in 2008 according to the National Drug Headquarters is thus 2,322.

Table 9-4: Number of persons prosecuted in 2008, classified by main drug type and Penal Code section, according to the Ministry of Justice (Ministerstvo spravedlnosti ČR, 2009c)

Drug type	Section 187		Section 187a		Section 188		Section 188a		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Cannabis	460	28	158	42	20	8	17	55	655	28
Pervitin	1,052	63	170	45	205	87	10	32	1,437	62
Cocaine	43	3	11	3	0	0	0	0	54	2
Heroin	108	7	34	9	1	0	0	0	143	6
Other drugs	97	6	37	10	20	8	4	13	158	7
Total number of people*	1,660	100	377	100	236	100	31	100	2,304	100

NB: *The data provided in the "total number of people" row are not the aggregate number and percentage of drug-related offences by drug type because certain persons were prosecuted for the violation of multiple drug-related sections of the Penal Code or in connection with multiple drug types; a single person can therefore be included in the statistics several times. The Ministry of Justice provides two statistical reports, i.e. those by drug type and those by drug-related Penal Code section.

In comparison with the previous years, the situation is also stable as far as the persons charged are concerned. According to the Ministry of Justice statistics (Ministerstvo spravedlnosti ČR, 2009b; Ministerstvo spravedlnosti ČR, 2009c), 2,100 persons were charged with drug-related offences (compared to 2,042 in 2007), of whom 1,534 (73%) were charged under Section 187 (mostly in connection with pervitin), 318 (15%) under Section 187a (mostly in connection with pervitin), 221 (11%) under Section 188 (mostly in connection with pervitin), and 24 (1%) under Section 188a of the Penal Code in 2008 (mostly in connection with cannabis); see Table 9-5.

Table 9-5: Number of persons charged in 2008, classified by main drug type and drug-related Penal Code section (Ministerstvo spravedlnosti ČR, 2009c)

Drug type	Section 187		Section 187a		Section 188		Section 188a		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Cannabis	375	24	121	38	17	8	11	46	524	25
Pervitin	1,016	66	158	50	197	88	9	38	1,380	66
Cocaine	43	3	9	3	0	0	0	0	52	2
Heroin	107	7	33	10	1	0	0	0	141	7
Other drugs	88	6	30	9	19	8	4	17	141	7
Total number of people*	1,534	100	318	100	224	100	24	100	2,100	100

NB: *The data provided in the "total number of people" row are not the aggregate number and percentage of offences by drug type because certain persons are charged under multiple drug-related sections of the Penal Code or in connection with multiple drug types; a single person can therefore be included in the statistics several times. The Ministry of Justice provides two statistical reports, i.e. those by drug type and those by drug-related Penal Code section.

In comparison with the previous years, the situation also remains stable as far as the sentences are concerned. According to the Ministry of Justice statistics (Ministerstvo spravedlnosti ČR, 2009a; Ministerstvo spravedlnosti ČR, 2009c), 1,360 persons were sentenced for drug-related offences (compared to 1,382 persons in 2007), of whom 1,125 (83%) were sentenced under Section 187 (mostly in connection with pervitin – 572 persons), 150 (11%) under Section 187a (mostly in connection with cannabis – 44), 72 (5%) under Section 188 (mostly in connection with pervitin – 33), and 13 (1%) under Section 188a (mostly in connection with cannabis – 5 persons) in 2008; see Table 9-6.

Table 9-6: Number of persons sentenced in 2008, classified by main drug type and drug-related Penal Code section (Ministerstvo spravdnosti ČR, 2009c)

Drug type	Section 187		Section 187a		Section 188		Section 188a		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Cannabis	176	16	44	29	6	8	5	38	231	17
Pervitin	572	51	31	21	33	46	1	8	637	47
Cocaine	26	2	4	3	0	0	0	0	30	2
Heroin	51	5	15	10	0	0	0	0	66	5
Other drugs	174	15	23	15	21	29	4	31	222	16
Total number of people*	1,125	100	150	100	72	100	13	100	1 360	100

NB: *The data provided in the "total number of people" row are not the aggregate of the number and percentage of drug-related offences by drug type because the type of drug was apparently not determined for all the persons sentenced for drug-related offences.

9.1.1.1 Sentences for Drug-Related Offences

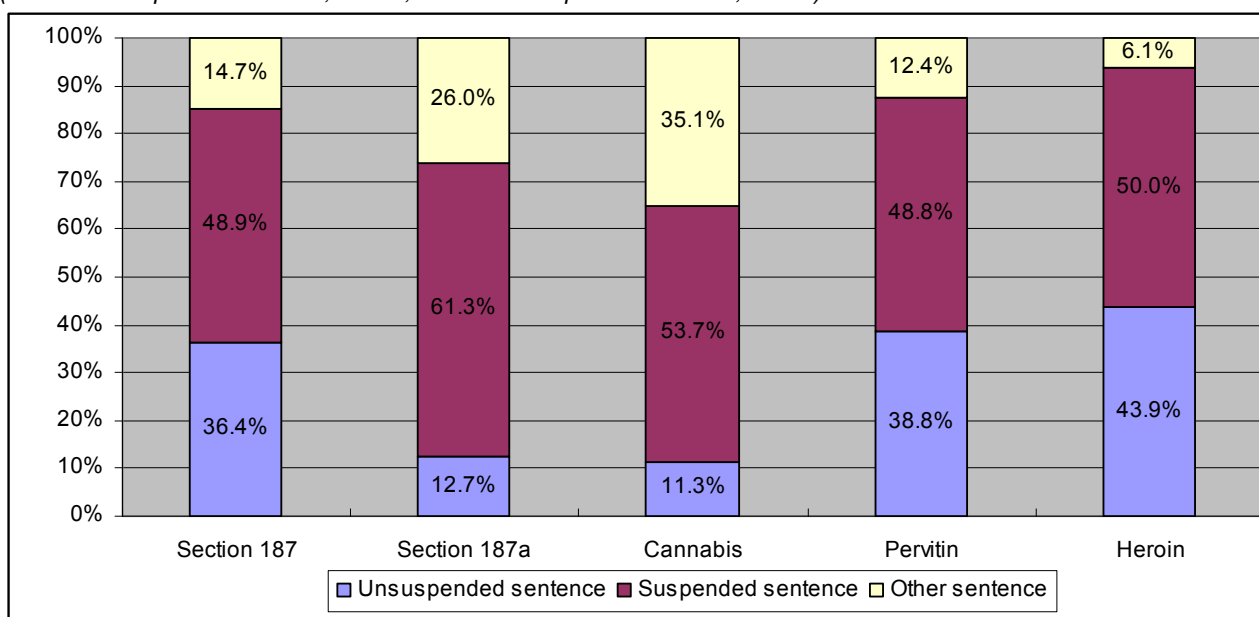
According to the Ministry of Justice statistics (Ministerstvo spravdnosti ČR, 2009a; Ministerstvo spravdnosti ČR, 2009c), a total of 1,360 persons were sentenced for 1,607 drug-related offences in 2008 (compared to 1,382 persons in 2007). A total of 450 unsuspended sentences (415 sentences in 2007) and 688 suspended sentences (734 in 2007) were imposed. The year 2008 saw an increase in the number and percentage of unsuspended prison sentences, with the courts imposing 335 unsuspended prison sentences ranging from one to five years – the highest number in the last 5 years. The composition of the sentences imposed in 2008 according to Sections 187 and 187a of the Penal Code is shown in Table 9-7 and Figure 9-2.

Table 9-7: Number of sentences imposed for drug-related offences under selected Penal Code sections in 2008, by selected drug type (Ministerstvo spravdnosti ČR, 2009a)

Sentence type	Section 187	Section 187a	Cannabis	Pervitin	Heroin
Unsuspended sentences	410	19	26	247	29
– up to 1 year's imprisonment	41	12	3	29	5
– imprisonment for 1-5 years	313	7	22	196	17
– imprisonment for 5-15 years	56	0	0	22	7
Suspended sentences	550	92	124	311	33
Other sentences	165	39	81	79	4
– community service	56	23	24	41	0
– penal measure*	56	2	43	8	0
– sentence waived	43	10	10	28	1
– other sentences	10	4	4	2	3
Total persons sentenced	1,125	150	231	637	66

NB: * The penal measure is a summary term for various types of sentences imposed on juvenile offenders under Act No. 218/2003 Coll. on the judiciary in juvenile affairs.

Figure 9-2: Composition of sentences imposed under selected Penal Code sections in 2008, by selected drug type (Ministerstvo spravdnosti ČR, 2009a; Ministerstvo spravdnosti ČR, 2009c)



9.1.2 Misdemeanours Involving Drug Possession for Personal Use

An amendment⁵⁶ to Act No. 200/1990 Coll. on misdemeanours changed the competence for the resolution of misdemeanours under Section 30(1)(j), i.e. the possession of a small quantity of a drug for personal use. Effective from 1 January 2009, the competence no longer rests with the Police of the Czech Republic but instead lies with the municipal authorities or special municipal bodies that have jurisdiction.

A total of 970 misdemeanours involving drug possession for personal use were reported in 2006, and 966 misdemeanours were reported in 2007. The incomplete data available for 2008⁵⁷ show 450 cases, which concerned 473 persons, 90% of whom were men, 26% were underage, and 98% were Czech. A total of 3 kg of marijuana, 10.6 g of hashish, 57.1 g of pervitin, 2 g of amphetamine, 1.5 g of cocaine, 10 g of heroin, 69 ecstasy tablets, and 28.3 g of magic mushrooms were seized in connection with all the cases reported above. Most cases (255) concerned marijuana (with 100 cases involving quantities of 1-5 g), 102 cases concerned pervitin (all under 1 g), 20 cases concerned heroin (with 17 cases involving less than 1 g), 3 cases were cocaine-related (all involving less than 1 g), and 5 were ecstasy-related (4 of which involved under 5 tablets). No misdemeanour was reported in connection with cannabis plants in 2008; however, the reports for 2008 are incomplete) (Národní protidrogová centrála, 2009c; Národní protidrogová centrála, 2009a).

9.1.3 Secondary Drug-Related Crime

In mid-2008, the National Drug Headquarters collected data to estimate the level of secondary drug-related crime for 2007 and the first half of 2008 (i.e. for 18 months), using a similar methodology to that applied in 2007 (for details see the 2006 Annual Report). The study was conducted as an expert retrospective estimate made by the district police headquarters, which estimated the proportion of criminal offences committed by drug users (mainly for the purpose of acquiring the wherewithal for purchasing drugs for personal use) in the above-mentioned period of 18 months. This was done for each of the 42 selected⁵⁸ offences defined in the Criminal Statistics Record System. The estimates were provided by 81 out of the total of 82 district police headquarters. In the course of the data processing, which was performed by the National Focal Point, the estimated percentages were weighted using the actual number of cleared-up criminal offences in the individual districts.

In the 18-month period, a total of 374,248 selected criminal offences (see above) were committed, with drug users estimated to have participated in 109,038 of those offences (29.1%). The 10 most common criminal offences in which drug users participated mainly included various types of theft, burglary, unauthorised possession of a payment card, and illicit drug production and trafficking according to Section 187 of the Penal Code; see Table 9-8 (Národní protidrogová centrála a Národní monitorovací středisko pro drogy a drogové závislosti, 2009).

Table 9-8: Estimated number of selected criminal offences committed by drug users, and their proportion in the total number of criminal offences, by type (Národní protidrogová centrála a Národní monitorovací středisko pro drogy a drogové závislosti, 2009).

Criminal offence type	Number	Proportion (%)
Vehicle burglary	46,838	62.7
Theft - pickpocketing	9,500	34.2
Other types of burglary	8,991	19.4
Vehicle theft	6,323	21.9
Theft on other premises	5,284	13.6
Other types of theft	3,416	19.5
Unauthorised possession of a payment card	3,227	27.4
Production and trafficking of a narcotic and/or psychotropic substance	2,445	70.7
Theft of bicycles	2,377	31.0
Other theft committed against persons	2,319	17.0
Others	18,318	17.7
Total	109,038	29.1

Criminal offences committed by drug users were also the topic of research conducted among the clients of all the low-threshold programmes for drug users in Prague in May 2008 (Šejvl, 2008); see also the chapters on Data on Problem Drug Use from Non-treatment Sources, page 30, and Social Correlates and Social Reintegration, page 76. As far as conflict with the law is concerned, the most common types of criminal activities mentioned by the clients included theft and the sale of drugs (with prostitution also being rather common). 73% of the clients stated that they

⁵⁶ The amendment was implemented by virtue of Act No. 274/2008 Coll. revising certain acts in connection with the Police Force Act.

⁵⁷ On average, they include 60% of all the required monthly reports the relevant district police headquarters were able to provide to the National Drug Headquarters in 2008.

⁵⁸ They especially included crimes against property (e.g. theft, fraud), crime with violence (e.g. robbery, bodily harm, arbitrary interference with the home) and others (neglect of compulsory maintenance, extortion, etc.). The selection also included the criminal offences of illicit drug production and trafficking under Section 187 of the Penal Code.

had had final sentences imposed upon them in the past in relation to criminal activities they had committed in connection with drug use (21% of the clients had been sentenced to community service, and 21% received suspended and 31% unsuspended prison sentences).

9.1.4 Clients of the Probation and Mediation Service

Details from the Probation and Mediation Service of the Czech Republic (PMS) regarding its clients who are drug users are available again. In 2008, the PMS recorded a total of 25,465 persons, 659 (2.6%) of whom were the perpetrators of drug-related criminal offences (Probační a mediační služba ČR, 2009). According to the PMS, “drug-related crime” includes both offences committed in connection with Sections 187, 187a, 188, and 188a of the Penal Code (i.e. primary drug-related crime) and property crimes committed for the purpose of acquiring the wherewithal for purchasing drugs (i.e. secondary drug-related crime). The proportion of all the drug-related cases⁵⁹ in all the cases handled by the PMS was around 3.5% in 2006-2008 (see Table 9-9). The competent PMS workers consider this figure significantly underestimated.

Table 9-9: Persons registered by the PMS in connection with drug-related crime in 2006-2008 (Probační a mediační služba ČR, 2009)

Cases registered by PMS	2006		2007		2008	
	Number	%	Number	%	Number	%
All cases	24,885	100.0	27,648	100.0	25,465	100.0
– primary drug-related crime	712	2.9	692	2.5	659	2.6
– offences under Section 187 of the Penal Code	506	2.0	566	2.0	501	1.9
– offences under Section 247 of the Penal Code*	86	0.3	101	0.4	75	0.3
– others**	69	0.3	138	0.5	134	0.5

NB: * Theft committed by a drug user. ** Other criminal offences committed by a drug user.

9.2 Prevention of Drug-Related Crime

In the Czech Republic, crime prevention is in the remit of the Ministry of the Interior, which addresses the issue without distinguishing the prevention of drug-related crime from other types of criminal activities. The information is concentrated on the website of the Ministry of the Interior⁶⁰. The issue also falls within the competence of the Ministry of Education, which is in charge of the prevention of risk behaviour among children and young people; for details see the chapter on Prevention, page 24.

The Ministry of the Interior regularly prepares strategic documents on crime prevention and administers a grant programme to support crime prevention projects at the local level (e.g. the drawing-up of municipal crime prevention plans or lighting or camera systems in dangerous or risky locations in urban settings). The list of the projects supported is available on the website of the Ministry of the Interior⁶¹. The funds expended from the budget of the Ministry of the Interior on the crime prevention programme in the period 2008-2011 should reach a total amount of CZK 400 million (€ 16,038 thousand) (Government Resolution No. 1150 of 15 October 2007).

The 2008-2011 crime prevention strategy mainly focuses on reducing acquisitive and violent crime and eliminating socially negative phenomena involving criminal risk (Ministerstvo vnitra ČR, 2007). The target groups include individuals dependent on alcohol and narcotic or psychotropic substances, at-risk children and young people, families with children showing behavioural disorders, and socially excluded individuals and groups, all as vulnerable individuals in the position of potential offenders or victims. Drug-related offences are present among the offences that are listed in terms of both acquisitive and violent crime. Crime prevention policies are also prepared at the regional level and are all published on the website of the Ministry of the Interior⁶².

9.3 Interventions in the Criminal Justice System

The instrument of (“protective”) compulsory treatment is mainly governed by Section 72 of the Penal Code, while Sections 351 et seq. of the Criminal Procedure Rules apply to its service; it is a protective measure rather than punishment. The compulsory treatment types include drug addiction, alcoholism, sexual, psychiatric, and combined therapies. It is mostly the drug addiction form that applies to drug users but the compulsory treatment of alcohol use, psychiatric, or combined disorders may also be imposed. Treatment may be in either the institutional or outpatient form. Compulsory treatment may also be undergone as a part of serving a prison sentence.

According to Section 72(2)(b) of the Penal Code, the court may also impose compulsory drug treatment on drug-using offenders who committed an offence under the influence or in connection with the substances they misuse.

⁵⁹ According to the reporting methodology employed by the Probation and Mediation Service, an unknown number of persons violated more than one provision of the Penal Code, i.e. a single person may have committed multiple offences. This implies that the total number of people may be lower than the quoted sum of the cases reported under the individual sections.

⁶⁰ See <http://www.mvcr.cz/clanek/programy-prevence-kriminality.aspx>

⁶¹ See <http://aplikace.mvcr.cz/archiv2008/prevence/ksp/dotace08.xls>

⁶² See <http://www.mvcr.cz/clanek/programy-prevence-kriminality.aspx?q=Y2hudW09Nw%3d%3d>

The court will not impose compulsory drug treatment if it is obvious that the purpose of such treatment cannot be achieved (e.g. in offenders with a negative attitude to treatment, in those who have a history of repeated unsuccessful treatment, etc.). The adequacy of compulsory drug treatment is assessed by a court-appointed expert; the court may, however, rule otherwise, in consideration of additional evidence (although it usually respects the recommendation of the expert). In cases which also involve another psychiatric disorder in addition to drug use, the court may impose multiple types of compulsory treatment at the same time. According to Section 72(6) of the Penal Code, compulsory drug addiction treatment lasts as long as warranted by its purpose, but no longer than two years. However, the court may, even repeatedly, extend the period of compulsory treatment by up to two additional years. The protective compulsory treatment of drug-using offenders may be terminated if it is found in the course of the treatment that the treatment cannot achieve the intended purpose. If there is a risk of the sentenced individual potentially committing another offence, the court may rule, in its decision on release from compulsory drug treatment, that the prisoner will be subject to supervision for a period of up to 5 years. This amendment was included in the Penal Code in connection with Act No. 129/2008 Coll. on security detention and amendments to certain related acts, effective from 1 January 2009. Before that date, there was no legal limit specifying the duration of court-ordered treatment (although it was common practice that the duration of institutional compulsory drug treatment was approximately 6 months).

The decision on the release from compulsory drug treatment is made by the court, usually upon a proposal from the sentenced individual or the health care facility in charge of the relevant person's treatment. If the offender does not start the compulsory drug treatment or violates the rules for its service, they may be liable to prosecution for obstructing justice (Section 171 of the Penal Code).

Compulsory treatment may also be imposed by the court in addition to a sentence or when a sentence is waived. The waiver of a sentence together with court-ordered compulsory treatment is generally possible in the case of offenders who committed an offence while of impaired mental capacity, and the court is of the opinion that compulsory treatment is a better way of correcting the offender than a sentence would be. However, this option cannot be used in the case of patients whose impaired mental capacity was due to their having used an addictive substance (Section 25 of the Penal Code).

If imposed together with an unsuspended prison sentence, institutional compulsory drug treatment can be served in the specialised departments in the Opava, Rýnovice, and Znojmo prisons or in the court-ordered compulsory treatment departments of psychiatric hospitals. In 2008, this concerned 10 psychiatric hospitals: Prague-Bohnice, Kosmonosy, Dobřany, Horní Beřkovice, Havlíčkův Brod, Brno-Černovice, Opava, Šternberk, Bílá Voda, and Červený Dvůr. The outpatient form of compulsory drug addiction treatment can be served in alcohol/drug treatment outpatient centres or in private psychiatric clinics, where the physician must be able to provide the expertise required for the field of addiction treatment. The court may change the form of compulsory treatment in the course of the therapy.

Courts impose compulsory drug treatment on approximately 150 persons annually. Institutional or outpatient compulsory treatment was imposed by courts upon 162 persons; 91 of the cases involved the outpatient form and 71 the institutional form of treatment in 2008; see Table 9-10. Out of the total number of 162 compulsory drug treatment orders, 53 concerned offenders sentenced for drug-related offences, 50 of whom violated Section 187 of the Penal Code. Another 37 persons were sentenced to compulsory drug addiction treatment for violating Section 247 of the Penal Code (theft) (Ministerstvo spravedlnosti ČR, 2009a). The 2008 data provided by the Probation and Mediation Service indicate that the outpatient form of compulsory drug treatment was imposed on 33 of the 142 PMS clients referred to as persons addicted to non-alcohol substances, mostly (19 cases) in connection with offences under Section 187 of the Penal Code (Probační a mediační služba ČR, 2009).

Table 9-10: Number of individuals ordered compulsory treatment by court in the period 2003-2008 (Ministerstvo spravedlnosti ČR, 2009a)

Compulsory treatment type	2003	2004	2005	2006	2007	2008
Drug use	143	161	141	164	139	162
Alcohol use	195	190	193	220	232	217
Others	222	199	239	221	221	201
Total	560	550	573	605	592	580

In addition to compulsory treatment, other options may also be applied in the case of drug users within the framework of procedural or criminal law diversions or alternative sentences. This mostly involves the imposition of the reasonable obligation to undergo treatment. For example, this may apply to decisions on suspended imprisonment with supervision (Section 60a of the Penal Code) or to cases of release on parole with supervision (Section 63 of the Penal Code). The key factor in these cases is the personal motivation to undergo treatment, which significantly affects the decision of the court or (in the course of preliminary proceedings) of the public prosecutor. Although this is not compulsory treatment, the failure to fulfil the obligation to undergo treatment or abstain from substance use may affect the decision of the court on meeting the conditions of the probationary period pertaining to a suspended sentence or release on parole. However, unlike in the case of compulsory treatment, the offender cannot face prosecution for obstructing justice.

9.4 Drug Use and Problem Drug Use in Prisons

There were 35 prisons, ten of which were remand prisons and five combined the serving of prison sentences with the functions of a remand prison in the Czech Republic in 2008. In recent years, the daily headcount of prisoners in the country has been around 19,000. However, a total of 20,502 persons (with 18,100 individuals serving prison sentences and 2,402 in custody) were reported as of 31 December 2008. The average age of the persons awaiting trial was 33 years and that of the persons sentenced was 36 years. 95% of them were men. 6,334 persons were admitted to custody and 10,475 persons were admitted to prison from civil life (i.e. not from custody) in 2008, compared to 6,085 and 9,468 persons, respectively, in 2007 (Generální ředitelství Vězeňské služby ČR (Odbor zdravotní služby), 2009; Generální ředitelství Vězeňské služby ČR, 2009).

As of 31 December 2008, a total of 1,662 prisoners were individuals sentenced or awaiting trial for drug-related offences according to Section 187-188a of the Penal Code; see Table 9-11 (Generální ředitelství Vězeňské služby ČR (Odbor zdravotní služby), 2009).

The level of drug use among the inmates of Czech prisons can only be generally estimated on the basis of information from several information sources:

- the data of the Health Service Department of the General Directorate of the Prison Service, which include persons addicted to habit-forming substances, including alcohol;
- the results of the urine toxicology screening of prisoners awaiting trial and serving a prison sentence;
- drug seizures in prisons.

There are no results available from any representative (cross-section) studies conducted among prisoners which could be used as the basis for the qualified determination of drug use among prisoners.

Table 9-11: Number of drug offenders sentenced to imprisonment under Sections 187-188 of the Penal Code, as of the end of the years 2007 and 2008 (Generální ředitelství Vězeňské služby ČR, 2008; Generální ředitelství Vězeňské služby ČR (Odbor zdravotní služby), 2009)

Drug-related offences	31 Dec 2007	31 Dec 2008
Section 187	1,314	1,257
Section 187a	101	127
Section 188	144	185
Section 188a	69	93
Total persons	1,628	1,662

As part of the medical and preventive care of inmates awaiting trial or serving a prison sentence, the staff of the Health Service Department conducted 312,479 examinations or treatment interventions in 2008. In this context, 9,390 persons dependent on habit-forming substances, including alcohol, were registered (compared to 8,338 in 2007).

Toxicology screening tests are conducted in Czech prisons on the grounds of a reasonable suspicion and randomly both upon admission to custody or prison and during the term of imprisonment, and as a part of substitution therapy (see below). A total of 9,165 tests capable of detecting multiple drug types at the same time were conducted in all the 35 prisons in 2008 (compared to 10,257 tests in 2007). 1,177 tests (12.8%) were positive (21.4% in 2007). The most common drug detected was pervitin (approximately 50% of all the positive tests), followed by THC (approximately one in three tests), benzodiazepines⁶³ (approximately one in three tests), and opiates (approximately one in ten tests). Scheduled and random searches using drug-sniffing dogs were performed in 24 prisons. They involved searches of the living quarters, common areas, and working places, and checks on correspondence, including packages etc. The dogs indicated 115 seizures (107 in 2007). In most (47) instances, it was a case of "positive indication without a find" (i.e. the dog reliably indicated the spot but a physical search was not able to reveal any drugs); marijuana was found in 21 cases, pervitin in 17 cases, and an unknown substance or syringe in 16 cases. Other seizures were made in various hiding places by the personnel of the Prison Service, who reported 90 seizures of various drug types with a total quantity of 143 g, mostly involving THC (39 seizures) and pervitin (25 cases) (Generální ředitelství Vězeňské služby ČR, 2009).

9.5 Responses to Drug-related Health Issues in Prisons

Information about counselling and therapeutic interventions for drug users in prisons is provided by the General Directorate of the Prison Service on an annual basis. Adopted in November 2007, Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2007–2009 is the key document in this context. This plan, which is compatible with the Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2007 to 2009, focuses on the following seven basic areas: (1) primary prevention; (2) treatment and aftercare; (3) harm reduction; (4) supply reduction and law enforcement; (5) information, research, and evaluation; (6) coordination and funding, and (7) international co-operation.

⁶³ Benzodiazepines may be a part of the medication prescribed by a physician.

9.5.1 Drug Prevention Counselling Centres

Drug counselling centres exist in all the prisons and provide drug users with professional drug counselling and other types of care in order to minimise the medical and social risks arising from drug use and motivate drug users to undergo treatment while serving their prison sentence. 6,892 inmates used these services in 2008, with the highest number (1,295) reported from the Prague-Pankrác Remand Prison. Four prisons did not report the number of persons who used the services of the counselling centres (Generální ředitelství Vězeňské služby ČR, 2009).

9.5.2 Detoxification

Rather detailed data on drug user detoxification are available for 2008. It was conducted either in the outpatient form in the health centre of the relevant prison, utilising mostly psychiatric medication and letting the inmates remain in their cells, or (in the more serious cases and based on a physician's decision), the persons were admitted to specialised departments (e.g. the Psychiatric Department of the Brno Remand Prison). If pharmacotherapy is applied in detoxification, the substances used mainly include opioids (e.g. buprenorphine), benzodiazepines, or neuroleptics (especially in the case of psychotic symptomatology). The detoxification period was between 5 and 10 days. Detoxification was performed in four prisons in 2008 (the Prague-Pankrác, Prague-Ruzyně, Brno, and Ostrava prisons), three of which (all except the Prague-Ruzyně Prison) reported the number of persons who had used the detoxification programme – 208 in total. Of that number, 171 were men, 191 were injecting users, 151 were opiate users, and 82 were pervitin users (Generální ředitelství Vězeňské služby ČR, 2009).

9.5.3 Drug-Free Zones

Drug-free zones are available in prisons in order to restrict the contact of the prisoners with drugs and lead them to abstinence and a healthy style of living, both during and after imprisonment. Inmates are accepted in drug-free zones on the basis of the decision of the relevant attending physician or at their own request, reviewed by a committee of prison service professionals. Prisoners may be disqualified from the drug-free zone on the grounds of violating the set rules and monitoring measures (which include, for example, a higher intensity of specific anti-drug programmes and more frequent urine testing for drugs). On the contrary, adherence to the rules brings certain advantages to the prisoners. The structure of the individual drug-free zones follows the criteria of gender, age, and drug problem type. Drug-free zones were in operation in 33 remand prisons and prison facilities (a decrease by two drug-free zones compared to 2007), but the capacity increased by another 121 places in 2008 to reach a total of 1,998 (1,877 places in 2007); see Table 9-12. Prison sentences were served in drug-free zones by 3,646 inmates in 2008, i.e. 122 prisoners more than in 2007 (Generální ředitelství Vězeňské služby ČR, 2009).

9.5.4 Special Treatment Departments

There were two types of special departments dealing with drug users in operation in prisons in 2008. The first type includes departments for prisoners with personality and behavioural disorders caused by the use of psychotropic substances; the treatment is voluntary and the prisoners enter the therapy at their own request, which is assessed by a committee of prison service professionals. Such departments operated in six prisons in 2008 (Bělušice, Nové Sedlo, Ostrov, Pilsen, Příbram, and Všehrady), were all only intended for men, and offered a total capacity of 262 places, with 422 men serving their prison sentences in these departments in 2008.

The other special department type is used for serving court-ordered compulsory treatment sentences. They can be found in the Opava, Rýnovice, and Znojmo prisons. They employ group therapy-based regime activities with the features of a therapeutic community. The treatment programme is designed for 6-12 months, but the length of the stay is determined on an individual basis. The total capacity in 2008 was 120 places, which were used by 206 persons; see Table 9-12 (Generální ředitelství Vězeňské služby ČR, 2009).

Table 9-12: Number, capacity and use of drug-free zones and two types of specialised departments in Czech prisons in 2006-2008 (Generální ředitelství Vězeňské služby ČR, 2009)

Year	Drug-free zones			Voluntary treatment departments			Departments for court-ordered treatment		
	Number of departments/prisons	Capacity	Persons	Number of departments/prisons	Capacity	Persons	Number of departments/prisons	Capacity	Persons
2006	31	1,665	3,201	6	286	625	3	105	162
2007	35	1,877	3,524	6	258	419	3	114	200
2008	33	1,998	3,646	6	262	422	3	120	206

9.5.5 Substitution Therapy

Methadone substitution therapy was available in seven out of the ten prisons planned for substitution therapy in 2008. Persons awaiting trial or serving a prison sentence may be included in substitution therapy at their own request (accompanied by a confirmation of the health facility in which the person underwent therapy prior to being admitted to the prison) or on the basis of a recommendation from the attending physician who performed the initial

medical examination of the inmate upon admission. Seventy-six persons were included in substitution therapy in prisons (compared to 12 prisoners in 2007); see Table 9-13. Six persons left the treatment early – two for breaching the therapy agreement, three at their own request, and one person for intolerance of the substitution substance administered (Generální ředitelství Vězeňské služby ČR, 2009).

Table 9-13: Number of persons receiving substitution therapy in prisons with substitution therapy planned in 2008 (Generální ředitelství Vězeňské služby ČR, 2009)

Prison	Programme implemented	Total number of persons in 2008	Number of persons as of 31 December 2008	Early termination
Brno	Yes	17	1	2
Břeclav	No	0	0	0
Kuřim	Yes	6	0	1
Litoměřice	No	0	0	0
Opava	Yes	3	3	0
Ostrava	No	0	0	0
Prague-Pankrác	Yes	34	9	2
Prague-Ruzyně	Yes	2	–	–
Příbram	Yes	11	7	1
Rýnovice	Yes	3	1	0
Total	–	76	21	6

9.5.6 Prevention and Treatment of Infectious Diseases

As of 7 August 2009, the Health Service Department of the General Directorate of the Prison Service registered 1,125 persons with chronic hepatitis type B, 874 (78%) of whom were drug users. As of the same date, five persons had received virostatic treatment with interferon. There were also 2,890 persons with hepatitis type C, 2,345 (81%) of whom were drug users. Virostatic treatment with interferon had been received by 51 persons as of the date indicated above. As of 20 August, Czech prisons had registered 17 HIV-positive inmates. Twelve of them had received antiretroviral therapy. The number of HIV-positive drug users serving their sentences in Czech prisons was unknown (Generální ředitelství Vězeňské služby ČR (Odbor zdravotní služby), 2009).

9.5.7 Services Provided to Drug Users in Prisons by Non-Governmental Organisations

Care for imprisoned drug users is complemented by the services provided by 11 NGOs. Six of the organisations are members of the Section for Drug Services in Prison of the Association of Non-Governmental Organisations (A.N.O.). These six NGOs provided various types of drug services, usually of a regular and comprehensive nature, in 15 prisons in the Czech Republic in 2008. All the programmes paid particular attention to the pre-release stage in order to prepare the clients for their release from prison and living independently, and to establish the clients' connection with other outpatient and residential treatment services in the community. These six programmes contacted 1,118 persons, including those recently released from prison. The services were offered to 997 prisoners in custody or serving a prison sentence, predominantly pervitin drug users aged 29 on average; see Table 9-14 (Generální ředitelství Vězeňské služby ČR, 2009; Ženíšková, 2009).

Table 9-14: Drug service providers associated in the A.N.O. Section for Drug Services in Prison, and prisons and remand centres in which their services were provided in 2008 (Generální ředitelství Vězeňské služby ČR, 2009)

A.N.O. Section for Drug Services in Prison	Prisons and remand centres
SANANIM Prague	Prague-Pankrác, Prague-Ruzyně
Semiramis Nymburk	Jiřice
Podané ruce Brno	Brno, Břeclav, Kuřim
Podané ruce Walhalla Olomouc	Olomouc, Mírov
Laxus – Hradec Králové	Hradec Králové, Hradec Králové – Pouchov, Pardubice, Světlá nad Sázavou, Valdice, Odolov
CPPT Pilsen	Pilsen

Other NGOs also offered various types of drug services. Their provision, however, was mostly irregular and non-systematic and often only concerned single occasions and events (e.g. speeches and discussions on drugs). These NGOs included the White Light I. civic association (for the Bělušice and Litoměřice prison and remand centre), Renarkon, a public service company (Heřmanice, Ostrava, Karviná, Opava), the *Rodiče* civic association (Ostrov, Příbram), *Magdaléna*, a public service company (Příbram), and *K centrum* Karlovy Vary (Horní Slavkov). These NGOs operated in ten Czech prisons and remand centres, to which they made 22 visits and where they contacted 251 clients (Generální ředitelství Vězeňské služby ČR, 2009).

9.5.8 Post-Penitentiary Care

Overdose prevention programmes are only pursued in the form of providing information to the relevant person being released from prison. Post-penitentiary care and the reintegration of drug users released from prison are a part of the services provided in the prisons by non-governmental organisations; see above. There were two programmes focusing specifically on post-release care in 2008 (those of SANANIM Prague and *Podané ruce* Brno). The problem in post-penitentiary care is the lack of services for drug users released from prison, especially in North and West Bohemia, and the generally insufficient co-operation between drug and non-drug social services (Ženíšková, 2009).

10 Drug Markets

While marijuana is the most widely available drug in the Czech Republic, the availability of plevitin also remains high. Typically, these two drugs top the statistics for seizures. There is an increasing trend in the domestic production of cannabis with a higher THC content, which is grown in artificial conditions. The volume of marijuana seized more than tripled against the previous years, and the number of growing sites detected and cannabis plants seized also increased considerably. The number and volume of hashish seizures is stable. The volume of plevitin seized was lower than in previous years, but the number of plevitin cooking labs detected exceeded that reported in the previous years. There was also an increase in the quantity of the plevitin precursors seized.

The decision restricting the availability of medicines containing pseudoephedrine in pharmacies has been in effect since May 2009. Increased individual imports of such medicines from Germany, Poland, and Slovakia are currently being observed. A lower amount of cocaine was seized in 2008. The street distribution of the drug is characterised by a decrease in price and quality. The availability of heroin, which predominantly comes to the country from Afghanistan via the so-called Balkan Route, has not changed; the volume of heroin seized showed an increase. First and foremost, ecstasy is commonly available in nightlife settings; the number of seizures of this drug was the lowest in the past 4 years.

The prices of most drugs continue to be stable. There was an increase in the average purity of the marijuana and heroin seized.

10.1 Availability and Supply

Information provided by the National Drug Headquarters and the General Customs Headquarters represents the basic source of data regarding the availability, production, smuggling, and distribution of drugs on Czech territory (Národní protidrogová centrála, 2009b; Celní správa ČR, 2009). Especially according to these sources, drugs are available in all the larger towns and cities of the Czech Republic, and their availability in small towns and rural areas has been on the rise in recent years. Cannabis is the most widely available drug and an increasing trend has been noted in the availability of cannabis with a higher THC content. Plevitin is available in larger towns but its availability is also rather high in small towns and in rural areas. Cocaine and heroin are most widely available mainly in large cities, in particular in Prague.

There has been an increase in the hydroponic growing of cannabis with a high THC content (up to 20%). Most of the large-scale plantations detected were run by offenders of Vietnamese descent, who have also been confirmed to be connected to Vietnamese groups in the Netherlands and in Canada. The production of cannabis from high-volume growing sites is intended both for the domestic market and for export to European countries (mainly to Germany, the Netherlands, Belgium, and Poland). Over 70 criminal cases related to indoor cannabis growing were instigated in 2008, with most of the cases involving Vietnamese offenders. The imported hashish mostly originates in North Africa (Morocco) and is smuggled into the Czech Republic mainly from the Netherlands and Spain (for detailed information on the cannabis market see Cannabis Markets and Production on page 96).

Plevitin is predominantly made by domestic producers (who are often also the users) using two precursors: ephedrine and the more widely available pseudoephedrine, which can be extracted from over-the-counter medicines such as Modafen[®], Nurofen Stop Grip[®], Paralen Plus[®], and Panadol Plus Grip[®]. An improvement in the quality of the technologies used for the production of plevitin from medicines containing pseudoephedrine has been observed. Plevitin trafficking is also pursued by Roma, e.g. in the Central Bohemia, Hradec Králové, and Pardubice regions. An increase was noted in 2008 in the number of German nationals participating in the trafficking of plevitin to Germany. The shipments in question were mostly of small volumes of up to 200 grams.

The decisions of the State Institute for Drug Control regarding the change in the marketing authorisation for medicines containing up to 30 mg of pseudoephedrine and used for plevitin production came into effect on 1 May 2009. The decisions limit the dispensation of such medicines to a maximum pseudoephedrine content of 1,800 mg (i.e. 60 tablets containing 30 mg of pseudoephedrine) per person and month. In addition, these medicinal products must not be sold by mail order or via the internet. The pharmacist must verify the identity of the customer to ensure that the limit has not been exceeded, and enter the dispensation details in the central database of electronic prescriptions; see also the chapter on Laws, Regulations, Directives, or Guidelines in the Field of Drug Issues, page 5. The sales of these products in pharmacies dropped by 75% in the second quarter compared with the first quarter (ČT1, 2009). In this context, an increase in the level of imports of medicines containing pseudoephedrine has been observed (mainly by the Customs Administration of the Czech Republic) since 2009.

Information about plevitin production and the market in it has been obtained through focus groups with the staff of low-threshold programmes (Radimecký et al. 2009). The participants indicate that plevitin is mainly produced in small cooking labs situated in private homes or in squats. The cooking labs are frequently relocated in order to reduce the probability of detection. If a cooking lab is detected in a smaller town, the availability and quality of the plevitin on the market decrease for a temporary period of time, whereas the situation is more stable in larger towns in this regard. The produced drug is primarily intended to supply the local communities of plevitin users. One of the

ways for a user to obtain cheaper or free pervitin is to procure chemicals and medicines containing pseudoephedrine for the producer. In order to gain access to medicines containing pseudoephedrine, the producers and users also make use of persons with a credible appearance, such as young people and pensioners, and/or the homeless in order to obtain small quantities of these medicines in exchange for payment. Larger amounts of the drug that are produced may be intended for anonymous sale in larger towns. Pervitin is also exported abroad using postal consignments; pervitin cooks sometimes travel to other countries to produce pervitin in order to meet local demand.

According to the National Drug Headquarters, lower price and quality were typical of the street distribution of cocaine in 2008. Its import and distribution are mainly pursued by West Africans (predominantly Nigerians), Albanian-speaking groups, and both Polish and Czech nationals, who are often used as couriers to transport cocaine from South America. Cocaine is mostly hidden in specially modified luggage or smuggled by the so-called "swallowers" inside their body.

Ethnic Albanians from Kosovo and Macedonia continue to participate in heroin importing and trafficking, mostly using the Balkan Route. At a lower level, Roma and Vietnamese groups are also involved in heroin trafficking, while the drug is also distributed by drug users in Prague in order for them to procure the wherewithal for drugs for their personal use (Radimecký et al. 2009). Heroin is most commonly transported in passenger vehicles in batches of under 10 kg. Trucks are mainly used by Turkish nationals for transporting heroin; the Czech Republic is usually only a transit country en route to Western Europe.

Subutex[®] continues to be sold on the black market and competes with heroin. The estimated number of problem users of Subutex[®] in the Czech Republic was 4,900 in 2008. According to data from the National Drug Headquarters, the price of 8 mg of Subutex[®] on the black market ranged from CZK 300 (€ 12) to CZK 800 (€ 32). Subutex[®] prescriptions are also sold (Národní protidrogová centrála, 2009b). Another substitution preparation, Suboxone[®], was introduced onto the Czech market in 2008. No interest was shown in the product on the black market. According to the staff of low-threshold programmes, the lower level of availability of Subutex[®] on the black market may result in some users (re)transitioning to heroin (Radimecký et al. 2009).

Ecstasy is mainly imported from Poland and the Netherlands. Lower quantities of tablets are mostly imported on an individual basis, concealed in luggage transported in vehicles, most typically in buses. In 2008, 100 ecstasy tablets containing mCPP (1-(3-chlorophenyl)piperazine) were seized in the Czech Republic.

10.2 Seizures

The data on drug seizures represent seizures made by the Police of the Czech Republic and the Customs Administration of the Czech Republic, which also include cases treated as misdemeanours (possession of a small amount for personal use). Seizures which involved multiple types of drugs are always included separately in the individual drug types; the total number of seizures was therefore lower than the sum of all the seizures by drug type.

Marijuana was the most commonly seized drug (602 seizures). In the last four years, the number of marijuana seizures remained in the range of 550-600 per year. The volume, however, more than tripled against previous years. Sixty-nine cannabis plant seizures were made in 2008. This represents a slight increase compared to previous years but the number of cannabis plants seized increased significantly and reached 25,223 in 2008, i.e. over fourteen times the number of plants seized in 2005. In this context, there is also a marked increase in the number of growing sites detected, from 17 in 2005 to 79 in 2008. The number of hashish seizures and the volume of the drug seized were relatively stable in 2006-2008. There are approximately 30-40 seizures per year, involving a total annual quantity of approximately 0.5 kg; see Table 10-2.

With 405 seizures, pervitin is the second most commonly seized drug. 370-400 seizures annually were reported in the last three years. The volume of pervitin seized was lower compared with the previous years (with 3.8 kg in 2008) but the number of cooking labs detected was the highest in the last 6 years (434 sites). An increase is also apparent in the amount of medicines containing pseudoephedrine seized in 2006-2008; see Table 10-1.

Table 10-1: Quantity of the precursors and medicines containing pseudoephedrine and intended for pervitin production seized, cooking labs detected, and pervitin seized in 2006-2008 (Národní protidrogová centrála, 2009b)

Seizures	2006	2007	2008
Ephedrine (g)	1,201	1,185	1,677
Pseudoephedrine (g)	0.7	218	–
Modafen [®] (tablets)	2,406	3,480	7,876
Nurofen Stop Grip [®] (tablets)	4,631	11,948	21,785
Panadol Plus Grip [®] (tablets)	–	72	17,021
Cooking labs	426	388	434
Pervitin (g)	5,249	5,978	3,799

In comparison with 2007, there was a relatively significant decrease in the number of cocaine seizures (24) and in the amount of the drug seized (7.6 kg) in 2008. The number and quantity of ecstasy seizures also decreased, with 18 seizures of 16,610 tablets in total. As far as heroin is concerned, the number of seizures remained rather stable (105) but there was an increase in the volume of heroin seized (from 20.3 kg in 2007 to 46.3 kg in 2008). The number of LSD doses seized reached 246, i.e. double the figure for 2007. No crack was seized in the Czech Republic in 2008. The other substances seized in 2008 included 20 tablets of Subutex[®] (310 in 2007) and 2 g of amphetamine (29 g in 2007); see Table 10-2.

Table 10-2: Number and quantity of seizures of main drug types in 2005-2008 (Národní protidrogová centrála, 2009d)

Drug/Year	2005		2006		2007		2008	
	Number	Quantity	Number	Quantity	Number	Quantity	Number	Quantity
Marijuana (g)	602	103,337	556	108,352	563	122,124	602	392,527
Pervitin (g)	316	5,310	406	5,249	374	5,978	405	3,799
Heroin (g)	107	36,340	86	27,877	96	20,332	105	46,302
Cannabis plants (pcs)	53	1,780	44	2,276	46	6,992	69	25,223
Hashish (g)	123	4,625	42	466	25	387	30	696
Ecstasy (tablets)	41	19,010	29	26,259	30	62,226	18	16,610
Cocaine (g)	16	10,169	11	4,708	38	37,587	24	7,631
LSD (doses)	5	3,067	7	1,748	5	117	5	246

The breakdown of the 2008 seizures by amount shows that almost two thirds of the marijuana seizures involved quantities of less than 20 g, and 6% of seizures concerned amounts of over 1 kg of the drug. In the case of cannabis plants, almost 60% of the seizures were of over 100 plants each. 75% of the pervitin seizures involved less than 5 g of the drug, 3% over 100 g, and no seizure of a quantity exceeding 1 kg was reported in 2008. As for cocaine, 63% of the seizures were of quantities up to 20 g, and one seizure of over 1 kg of the drug was noted. A quantity of 20 g of heroin was seized in 77% of the seizures, while approximately 8% of the seizures were of a quantity of over 1 kg. Less than 20 tablets were seized in two thirds of the ecstasy seizures; one seizure of over 1,000 tablets was reported. Forty-four seizures of marijuana, pervitin, cocaine or heroin involved a quantity exceeding 1 kg each, representing 4% of all the drug seizures by weight (Národní protidrogová centrála, 2009c).

10.3 Price/Purity

Information about the prices of the basic types of drugs in the Czech Republic is determined on an annual basis according to data and estimates provided by the district police headquarters (56 headquarters in 2008) to the National Drug Headquarters. The prices of the basic drugs in 2008 remain stable; see Table 10-3. Drug purity data are only available for a part of the drugs seized and are mostly obtained from regional forensic laboratories and from the Forensic Science Institute in Prague. In comparison with 2007, the average purity of the marijuana and heroin seized increased slightly in 2008. A reduced concentration was noted in hashish and cocaine (Národní protidrogová centrála, 2009f); see Table 10-4.

Table 10-3: Average and most common (modus) prices of drugs in 2006-2008 (€) (Mravčík et al. 2008; Národní protidrogová centrála, 2009d)

Drug type	2006		2007			2008		
	Average	Modus	Average	Modus	Wholesale	Average	Modus	Wholesale
Marijuana (g)	7.6	6.0	7.2	4.0	0.8-10.0	7.2	8.0	2.0-12.0
Hashish (g)	10.8	8.0	10.4	8.0	2.0-12.0	9.6	10.0	4.0-10.0
Ecstasy (tablets)	8.8	6.0	8.4	8.0	1.2-8.0	8.8	8.0	1.2-10.0
Pervitin (g)	42.5	40.1	45.3	40.1	20.0-60.1	45.3	40.1	16.0-60.1
Heroin (g)	43.7	32.1	44.1	40.1	16.0-60.1	43.3	40.1	16.0-42.1
Cocaine (g)	89.0	80.2	82.6	80.2	48.2-80.2	80.2	80.2	32.1-72.2
LSD (doses)	6.4	6.0	7.2	8.0	0.8-8.0	7.2	4.0	2.0-12.0

NB: Prices rounded to tenth of €.

Table 10-4: Average drug purity percentage in 2005-2008 (Mravčík et al. 2008; Národní protidrogová centrála SKPV Policie ČR, 2008)

Drug type	2005		2006		2007		2008	
	Number of samples	Average purity (%)	Number of samples	Average purity (%)	Number of samples	Average purity (%)	Number of samples	Average purity (%)
Marijuana	108	3.8	151	4.5	177	4.7	404	5.5
Hashish	10	7.4	1	11.0	2	8.1	5	5.2
Ecstasy*	135	27.2	54	22.6	31	27.4	20	17.5
Pervitin	65	62.9	58	52.3	123	66.4	145	64.3
Heroin	19	41.5**	35	7.9	31	17.4	47	22.6
Cocaine	25	55.9	12	40.2	48	49.1	35	43.5

NB: * average MDMA content in a single tablet, given in milligrams; ** the high average purity of heroin resulted from the inclusion of several seizures of highly concentrated heroin.

PART B: SELECTED ISSUES

Selected issues are included in the Annual Report every year. The topics are set by the EMCDDA in co-operation with the focal points in the individual Reitox countries with regard to the topics' relevance and the research needs. On the basis of the agreement between the EMCDDA and the focal points, a single issue (Sentencing Statistics) was selected for the 2007 Annual Report rather than three issues, as had been the case in previous years. From this year on, all the countries are to prepare chapters on two selected issues, one of which is mandatory (Cannabis Markets and Production this year) and one is selected by the focal point from two options offered. The Czech National Focal Point has chosen to cover both of the voluntary selected issues.

11 Cannabis Markets and Production

Cannabis is the most widely consumed illicit drug worldwide. While there is relatively enough information on issues relating to the use of and demand for cannabis, its production and market have not been described in satisfactory detail. The objective of this chapter is to present the available information about cannabis production and trafficking in the Czech Republic, the cannabis products market, the users' practices on the market, and the prices and the factors that influence them.

In the second half of the 20th century, cannabis was grown and used in the Czech Republic mostly within isolated groups. In commercial terms, the market in cannabis products (marijuana and hashish) opened up in the 1990s. The political approach to the growing and use of marijuana has been unsteady since the end of the last century. The use of cannabis is not illegal and its possession is classified as a misdemeanour or as an offence, depending on the quantity of the drug. The new penal code, which will come into effect in 2010, mitigates the punishment for individuals who possess or grow cannabis for their personal use.

The Czech Republic ranks among the European countries with the highest prevalence of cannabis use; the lifetime prevalence among people aged 15-64 was 34% in 2008 (it was higher in men, and the highest levels were reported by the 15-24 age group).

The seeds for growing cannabis can be procured within social networks or via the internet. In June 2009, there were several dozen "grow shops" supplying equipment for cannabis growing. Most of the respondents of the general population survey considered procuring cannabis difficult but the task was described as relatively easy for three-quarters of the respondents aged 15-24. Cannabis can most commonly be obtained in the Czech Republic in bars, restaurants, or clubs. Almost three-quarters of the respondents stated that on the most recent occasion they had acquired cannabis it was free of charge. Cannabis can most usually be obtained from a friend, a relative, or a partner. The dealers are often also consumers and they usually do not sell other drugs. The retail prices of marijuana and hashish remain stable, they are sold at approximately CZK 200 (€ 8) and CZK 250 (€ 10) per gram, respectively. Three out of four respondents had purchased cannabis in a quantity of less than 2 grams in their most recent transaction. While the average potency of marijuana is increasing, that of hashish is dropping. Marijuana grown indoors accounts for the larger proportion of cannabis, including that on the commercial market, followed by marijuana grown outdoors. Most cannabis users identified the Czech Republic as the country of origin of the marijuana they had acquired most recently. The number of marijuana seizures is usually 550-600 per year; the total quantity of marijuana seized is increasing progressively. Approximately 5% of the marijuana seizures and only one seizure of hashish in the last 3 years involved a quantity of over 1 kg. Every second seizure of cannabis plants in 2008 involved a quantity of over 100 plants. A growing number of large-scale indoor plantations detected has been observed since 2005; a total of 79 of them were detected in 2008.

650-750 persons were arrested or prosecuted in connection with cannabis in 2008 (approximately 30% of all those arrested or prosecuted for drug-related offences), 524 persons were charged (25% of all those charged), and 231 persons were sentenced (17% of all those sentenced) in 2008; there is a slight increase in the total number of people charged in relation to cannabis but the number of persons sentenced remains stable. In terms of sentencing, a slight increase can be noted in recent years in the proportion of unsuspended sentences and penal measures, with a falling proportion of suspended prison sentences.

11.1 History of Cannabis Use in the Czech Republic

Cannabis was traditionally grown on the territory of the former Czechoslovakia for industrial purposes until the 1980s. The use of marijuana for its psychotropic effects saw a significant increase in the Czech Republic especially in the 1990s but marijuana had been home-grown before that. The use of cannabis before 1989 was characterised by a link between an individual user and a particular community or group with its own system of procuring the drug, most typically on a self-supply basis.⁶⁴ The commercial market in cannabis, which opened up in the 1990s, managed to replace the self-supplying social network only partially. A significant commercialisation of the Czech cannabis market

⁶⁴ During the socialist period in Czechoslovakia, marijuana was obtained and used within isolated groups. Two types of user groups have been described: (1) the so-called hard core of the drug scene, for whom marijuana was an additional drug in polydrug use, and (2) groups around and within the then dissident movement (Miovský et al., 2008).

occurred in the period 1997-2000. For example, the range of cannabis products supplied was extended, the prices between indoor and outdoor cannabis were differentiated, and more intensive links were established between the cannabis market and the market in other drugs. A number of users also moved to indoor growing in the same period, as this method also reduces the risk of seizure or theft, in addition to producing a drug with greater potency (Miovský et al. 2008).

11.2 Legal Framework of Cannabis Use

Since the beginning of a systematic drug policy in 1993, an ever-changing approach on the part of the Czech executive and legislative powers to the growing, possession, and use of cannabis can be observed. This is demonstrated in changes in the political attitudes to this issue, which range from an emphasis on a knowledge-based, balanced, and rational approach on the one hand to an overpoliticised and populist abuse of the topic by certain politicians or political parties (Miovský et al. 2008).

Act No. 140/1961 Coll. (the Penal Code), as amended mainly in 1990 and 1998⁶⁵ as far as drug-related offences are concerned, is of particular importance in terms of the legislation concerning cannabis products in the post-1990 history of the Czech Republic. Drug crime is currently defined by four provisions of the Penal Code: Sections 187, 188, 188a (unauthorised production and other handling of drugs; manufacturing and possession of equipment for the production of drugs; promotion of drug use) and Section 187a, which, effective from 1 January 1999, introduced the illicit status of the possession of drugs for personal use in a quantity greater than small. The possession of a small quantity of drugs qualifies as a misdemeanour punishable through administrative proceedings according to Act No. 200/1990 Coll. on misdemeanours. The relevant directives of the Police President and of the Supreme Prosecutor which define the “quantity greater than small” for the most common drugs, or the amount of the drugs which may be grounds for criminal prosecution, are used for practical policing and public prosecution purposes. Nevertheless, such directives are not binding for the decision making of the courts.

Act No 40/2009 Coll. (the Penal Code), which will come into effect on 1 January 2010, will mitigate the penalties applicable to persons possessing cannabis (Section 284), as well as cannabis growers (Section 285). The greater-than-small quantity of drugs which will be the grounds for criminal prosecution will be defined by a regulation adopted by the Government. For additional information, see the chapter on Legal Framework, page 5.

11.3 Prevalence of Cannabis Use

The 2008 general population survey on the use of psychotropic substances in the Czech Republic (CS 2008) revealed a lifetime prevalence of cannabis (marijuana, hashish) use of 34% among respondents aged 15-64 (the highest figure was reported in the 15-24 age group with 59%, an increase by 15 percentage points against 2004). The prevalence of use in the past year was 15.2% (topped by 37% in the 15-24 age group), and the prevalence of use in the past month was 8.5% (with the 15-24 age group leading the statistics with 22%). 57% of the respondents who had used cannabis in the previous month used it once a week and 9% of them used it on a daily or almost-daily basis. Extrapolated to the population of the Czech Republic aged 15-64, the number of daily or almost-daily users of cannabis can be estimated to 57,000. There are apparent differences between men and women in the frequency of use: men smoked marijuana statistically more significantly often than women (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d). For details see the chapter on Drug Use in the General Population and Specific Targeted Groups, page 16.

The respondents of the CS 2008 general population survey who stated that they had used marijuana in the past 12 months were asked about other aspects of the cannabis market in the Czech Republic. These data, complemented with information from the National Drug Headquarters and information from an online search, are provided and interpreted below.

11.4 Cannabis Market Organisation

11.4.1 Sale of Cannabis Seeds and Cannabis-Growing Equipment

The seeds of high-potency cannabis are not officially offered by any of the Czech “grow shops” (formally gardening supply shops, unofficially cannabis growing supply shops). Nevertheless, seeds for growing cannabis plants with a higher content of THC or scions of cannabis plants can be obtained via social networks or through internet discussion fora in the community of cannabis growers. Seeds can also be ordered commercially online, e.g. in Slovak “grow shops” or in other foreign online shops.

As of June 2009, internet search identified over 25 brick-and-mortar “grow shops” in the regional capitals (except Olomouc, Zlín, and Karlovy Vary). The biggest number of grow shops (10) is found in Prague. A number of them also offer online sales. In addition, there are also exclusively online shops. The grow shops sell a full range of indoor growing equipment starting at approximately CZK 7,000 (€ 280). However, a number of growers also buy these supplies in ordinary gardening shops, where some of the items may be purchased at a lower price.

⁶⁵ By Act No. 175/1990 Coll. and Act No. 112/1998 Coll.

11.4.2 Cannabis Retail Outlets

Over one half (54%) of all the respondents in the CS 2008 survey found procuring cannabis rather difficult to impossible. On the contrary, 20% considered it very easy. However, cannabis is easy or very easy to obtain for three quarters of young people aged 15-24. The most common places for procuring cannabis in the Czech Republic in 2008 were bars, restaurants, or clubs (36% of the most recently acquired cannabis among the respondents in the CS 2008 survey). It was there that the users obtained (i.e. purchased, were given, or shared) cannabis from friends or acquaintances. Even when they paid for it, the price was usually low. The second most common place for procuring cannabis was a private event or home (31%), where cannabis was usually given for free or shared. The third most common place for obtaining cannabis was a public space⁶⁶ (20%), where 28% of the commercial transactions took place. They predominantly involved purchasing the drug, mostly indoor marijuana, from an unknown person for a relatively high price. In addition to the locations and circumstances mentioned above, a number of transactions took place in the dealer's home (13%). One tenth of the respondents purchased their most recent batch of marijuana at school or at work (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d).

11.4.3 Cannabis Transaction Types

Almost three-quarters (72%) of the respondents stated that on the most recent occasion they had received marijuana it had been for free or by sharing it⁶⁷, with sharing accounting for the higher proportion of the cases. 17% of the respondents purchased cannabis, and 8.5% stated their own cannabis growing as the source (11% of the cannabis most recently procured in men, 2.5% in women). In terms of the type of relationship between the user and the provider of the cannabis the user had obtained most recently, they were predominantly (61%) friends, relatives, or partners. 20% of the respondents received cannabis from an acquaintance and approximately 9.3% of the respondents from a dealer or an unknown person. In their most recent purchase, the users received cannabis from a friend, relative, or partner (35%) who has easier access to the drug; 32% received the cannabis from an acquaintance and 28% from a dealer. As far as cannabis product transactions are concerned, no statistically significant differences were found. They did, however, occur in the way the respondents handled the drug upon its acquisition; an average 70.5% of the users gave their last cannabis to others or shared it with them. However, over 90% of the respondents in the Zlín, Karlovy Vary, and Ústí nad Labem shared it, compared to cannabis sharing by less than one-half of the respondents in the Pardubice region (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d).

In 2007, cannabis markets were the topic of a bachelor's thesis based on research conducted using a sample of 50 marijuana consumers and dealers aged 15-30 in Prague and in Central Bohemia. The thesis divided the marijuana dealers into two categories: traffickers, who purchase the drug from a large-scale cultivator or home grower and sell exclusively indoor marijuana, and dealers who are at the same time growers, usually selling outdoor marijuana. The dealers are often also consumers and they usually do not sell other drugs together with marijuana. According to the thesis, the cannabis market is relatively relaxed, with a rather low risk of robbery or other kinds of violence. The dealers mostly expected activity on the part of the buyers (e.g. a telephone call) and there are no fixed locations or times for the sale. The dealers perform only a superficial assessment of the buyers' risk level and often only judge them by their "coolness" and "friendliness", appropriate language, appearance, etc. A specific phenomenon associated with this market is the fact that the price of marijuana and the growing socioeconomic independence of a number of the buyers result in them becoming growers and subsequently starting to offer the surplus of their own marijuana. This surplus is usually not sold but rather given for free or exchanged for other marijuana. The marijuana market is also characterised by a close relationship between the dealer and the buyer, which is often referred to as "friendly". This relationship leads to the dealer giving various discounts and providing additional premium services such as home deliveries, purchase by phone, or purchase on credit. Open communities are established among marijuana consumers, in which dealers come not only to sell their goods but also to smoke and have fun. Solidarity, exchange, and assistance are present among the consumers, both horizontally (e.g. by lending or providing money and items, including marijuana, to each other) and vertically (with the socioeconomically more independent consumers supporting users, usually the younger ones, with a higher degree of social dependence) (Procházka, 2008).

11.4.4 Retail and Wholesale Prices and Amounts and the Macroeconomic Context

According to the drug prices reported by the National Drug Headquarters on an annual basis, the retail prices of marijuana and hashish remained relatively steady in 2006-2008. However, the information about the prices obtained from the district police headquarters is not given in the context of the amount or type of marijuana (outdoor, indoor) and hashish. In the period 2006-2008, marijuana and hashish were sold for an average of CZK 180 (€ 7) and CZK 250 (€ 10), per gram respectively (Národní protidrogová centrála, 2009d); see Table 10-3 (page 94) in the chapter on Drug Markets, page 92.

⁶⁶ This may include cars or other environments providing more safety than the open street.

⁶⁷ In a number of indicators, the "shared" and "free" ways of procuring marijuana overlap and are not clearly distinguished by the users, which resulted in different responses to the question: "How did you procure the marijuana you used most recently?" depending on which of the options "for free" and "shared" was offered to the respondent first.

A survey conducted in 2007 among marijuana consumers and dealers showed that the consumers usually differentiated between “grass”, i.e. marijuana with a lower THC content, and the more potent “skunk”. The price of “grass” was CZK 100-200 (€ 4-8) per gram, while that of “skunk” was most usually around CZK 250 (€ 10) per gram. According to most respondents, these prices had been stable for the last 9 years (Procházka, 2008). According to the CS 2008 survey, two thirds (65%) of the respondents who obtained their most recent batch of marijuana by purchasing it paid less than CZK 200 (€ 8) per gram, most commonly between CZK 100 and 150 (€ 4 and 6). The price under CZK 200 (€ 8) was also consistent with the replies from participants in internet discussions regarding the price of indoor-grown marijuana on the commercial market. The average price was CZK 134 (€ 5,4) for outdoor marijuana (median of CZK 150 (€ 6)), CZK 164 (€ 6,6) for indoor marijuana (median of CZK 150 (€ 6)), and CZK 225 / € 9 for hashish (median of CZK 175 (€ 7)) (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d).

On the occasion of their last sales transaction, three out of four respondents purchased less than 2 grams of marijuana, with approximately two thirds of the respondents purchasing a quantity of one gram and less. Almost one half of the respondents (47%) who stated they had received marijuana for free most commonly reported receiving quantities of less than 1 gram (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d). The participants in internet discussions mentioned that the amount of marijuana purchased often does not correspond to the agreed price or that the dealers sometimes moisten the drug to achieve a greater weight.

The wholesale prices of cannabis products are difficult to determine with a higher degree of accuracy. This is mainly due to two facts. Firstly, most transactions involve lower quantities of marijuana. Secondly, the range of prices reported by the National Drug Headquarters in connection with “wholesale” is very wide. The data do not contain additional information about the amounts of the individual seizures from which the price was determined and about the quality of the cannabis products (indoor/outdoor, potency). Finally, the exact methodology for establishing the wholesale prices (e.g. by estimate, interrogation, interviews with producers and dealers, monitoring of communication by the police, etc.) is not known. See Table 10-3 (page 94) in the chapter on Drug Markets, page 92.

On the basis of the CS 2008 general population survey, the size of the commercial marijuana market can be estimated at CZK 2.7 billion (€ 108,260 thousand), i.e. 0.07% of the GDP (according to the 2008 prices). The average amount spent on marijuana in the past year by its users was CZK 12,000 (€ 481) (one half of the respondents spent under CZK 4,200 (€ 168) per year, but up to CZK 73,000 (€ 2,927) per year was spent in individual cases). The financial value of the marijuana grown mainly for personal use and for non-commercial distribution within social networks corresponded to CZK 1.5 billion (€ 60,144 thousand) (0.04% of the GDP), which did not go through the black market because of the self-supply of users with cannabis.⁶⁸

11.5 Origin of Cannabis on the Domestic Market

According to the CS 2008 survey, marijuana cultivated indoors accounted for the largest proportion of cannabis products in the Czech Republic in 2008 and was acquired⁶⁹ by 37.1% of the respondents, including those who grew indoor marijuana themselves. Outdoor marijuana accounted for 26.8% and hashish for 2.7% of the cannabis products acquired most recently. A third of the respondents (33.3%) could not determine the type of cannabis they had last obtained. The results of an online poll conducted by the National Focal Point via its website starting in February 2009 (with 1,681 respondents as of 24 August 2009) concerning the type of cannabis most usually used in the past year were relatively consistent with the results of the CS 2008 general population survey: 35% of the respondents mainly used domestic indoor marijuana, 30% used domestic outdoor marijuana, 8% used imported indoor or outdoor marijuana, 6% used hashish, and 22% were uncertain of the origin of the drug. It is possible to draw a simplified conclusion from these results that approximately one third to a half of cannabis consumers use indoor marijuana, one third use outdoor marijuana, and the remaining one fifth to one third do not know the origin of the cannabis; hashish is used by an estimated 5-10% of cannabis users (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d).

The commercial market in cannabis products is dominated by indoor production, as almost half of the respondents had bought marijuana grown indoors in their most recent purchase (47.6% bought indoor and 18.3% outdoor marijuana, 4.6% bought hashish, and 29.4% bought cannabis of an unknown origin). 31% of the respondents who had shared or received their most recent batch of marijuana free of charge reported having obtained indoor marijuana, 23% outdoor marijuana, and almost half (45%) had no knowledge of the type. The respondents who grew marijuana themselves (8.5% of the respondents who had used marijuana in the past year) mainly reported outdoor cultivation (62%) but the validity of the information may be reduced by the fact that the survey was

⁶⁸ The calculation based on the available data presumes several types of simplification: the most recent way of procuring marijuana, as stated by the respondents, is taken as their regular method of obtaining the drug; the overall calculation relies on average prices (CZK 134 (€ 5,4) per gram for outdoor marijuana, CZK 164 (€ 6,6) per gram for indoor marijuana, and CZK 225 (€ 9) per gram for hashish); for each day on which marijuana was used in the past 12 months, the consumption of one gram of marijuana was presumed. The calculation also uses an estimate of the proportion of indoor and outdoor marijuana and hashish on the commercial market and data on the frequency of use collected from the respondents who purchased or grew marijuana.

⁶⁹ The data provided include all the methods of the most recent procurement of marijuana, including sharing and receiving the drug free of charge.

conducted in the respondents' homes, which may have influenced their willingness to admit growing cannabis at home (indoors) (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d).

In the CS 2008 survey, most cannabis users (57%) identified the Czech Republic as the country of origin of the cannabis product most recently obtained, followed by the Netherlands (6.5%), other European countries (2%), and other non-European countries (0.3%). One third of the respondents could not determine the country of origin of the drug (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d). Some Czech experts estimate that 20% of the marijuana available on the domestic market is imported, with Holland accounting for approximately 60% of the imports (Národní monitorovací středisko pro drogy a drogové závislosti, 2009b). The imported hashish mainly originates in North Africa (Morocco). The National Drug Headquarters and the Customs Administration of the Czech Republic often report seizures of marijuana imported by post (mainly sent from the Netherlands)⁷⁰. Hashish is mainly smuggled to the Czech Republic from the Netherlands or from Spain using postal consignments or couriers. The average weight of individual seizures was 12 g (see also the 2007 Annual Report).

11.6 Potency

Drug purity data are only available in the Czech Republic for a part of the drugs seized and are mostly obtained from regional forensic laboratories and from the Forensic Science Institute in Prague. A comparison of the data available from the period 2006-2008 shows a slight increase in the average potency of marijuana and a decrease in that of hashish; see Table 11-1 and also Table 10-4 (page 95) in the chapter on Drug Markets, page 92.

Table 11-1: Potency of cannabis products in 2006-2008 (percentage) (Národní protidrogová centrála, 2009d)

Cannabis product	2006		2007		2008	
	Average	Min.-max.	Average	Min.-max.	Average	Min.-max.
Marijuana	4.5	0.37-32.0	4.7	0.2-26.9	5.5	0.3-21.1
Hashish	11	–	8.1	4.7-11.5	5.2	3.0-15.6

11.7 Seizures

The usual number of marijuana seizures is 550-600 per year; the total quantity of marijuana seized is increasing progressively. In the past three years, approximately 5% of marijuana seizures and only one hashish seizure involved an amount exceeding 1 kg. Sixty-nine seizures of cannabis plants were reported in 2008, with approximately one in two seizures being of over 100 plants. The number of cannabis plants seized increased nearly fourfold on a year-on-year basis; see Table 11-2. The amount of hashish seized (700 g) in 2008 was almost double the 2006 or 2007 figures; see Table 11-3 (Národní protidrogová centrála, 2009d).

A relatively recent trend in the Czech Republic can be seen in the increasing number of large-scale indoor plantations seized since 2005. Seventeen plantations were detected in 2005, 34 in 2007, and 79 in 2008. Vietnamese nationals are often involved in the organised large-scale growing of marijuana and have been confirmed to be connected to Vietnamese groups living in the Netherlands and in Canada. For example, over 70 criminal prosecutions related to indoor cannabis growing were instigated in 2008, with most of the cases involving Vietnamese offenders. The cannabis produced by the large-scale plantations is intended both for the domestic market and for export to European countries, mainly to Germany, the Netherlands, Belgium, and Poland (Národní protidrogová centrála, 2009b).

Table 11-2: Cannabis plant seizures by amount and number of seizures in 2006-2008 (Národní protidrogová centrála, 2009d)

Year	Total number of plants	Number of cannabis plant seizures			
		1-50 pcs	51-100 pcs	> 101 pcs	Total
2006	2,276 pcs	38	4	2	44
2007	6,992 pcs	30	6	10	46
2008	25,223 pcs	25	5	39	69

⁷⁰ In 2007, the Customs Administration reported 11 seizures of imported marijuana, 8 of which were transported by air in postal consignments, mostly from the Netherlands (Celní správa ČR, 2008).

Table 11-3: Marijuana and hashish seizures by amount and number of seizures in 2006-2008 (Národní protidrogová centrála, 2009d)

Cannabis product	Year	Total number of seizures	Number of seizures by amount			
			0-100 g	101-1,000 g	> 1 kg	Total
Marijuana	2006	108 kg	459	75	22	556
	2007	122 kg	464	69	30	563
	2008	393 kg	483	84	35	602
Hashish	2006	466 g	40	2	0	42
	2007	387 g	23	1	1	25
	2008	700 g	28	2	0	30

11.8 Offences

Primary drug-related crime in the Czech Republic is defined by four sections of the Penal Code; see the chapter on Legal Framework, page 5.

In the period 2006-2008, the total number of persons arrested or prosecuted for drug-related offences in the Czech Republic was between 2,023 and 2,630 per year, depending on the source (see also the chapter on Drug-related Crime, Prevention of Drug-related Crime, and Prison, page 81). 650-750 people were arrested or prosecuted in connection with cannabis in 2008 (approximately 30% of all those arrested or prosecuted for drug-related offences), 524 persons were charged (25% of all those charged), and 231 persons were sentenced (17% of all those sentenced) in 2008. There is an increase in the total number of persons charged in connection with cannabis but the number of the persons sentenced remains stable; see Table 11-4. While a slight decrease can be observed in the last 3 years both in the total number and in the proportion of persons sentenced for producing and trafficking cannabis (Section 187), there is a slight increase in the total number and proportion of individuals sentenced for the possession of a greater than small quantity of cannabis for personal use (Section 187a); see Table 11-5. In terms of sentences for cannabis-related offences, a slightly increasing trend can be observed in recent years in the proportion of unsuspended sentences and penal measures, while the proportion of suspended sentences is decreasing; the proportion of community service sentences remains stable; see Table 11-6.

Table 11-4: Persons prosecuted, charged, and sentenced in connection with cannabis in 2006-2008 (Ministerstvo spravedlnosti ČR, 2009b; Ministerstvo spravedlnosti ČR, 2009c)

Year	Prosecuted		Charged		Sentenced	
	Number	Proportion (%)	Number	Proportion (%)	Number	Proportion (%)
2006	638	30	285	21	255	21
2007	503	25	387	16	226	19
2008	655	28	524	25	231	17

Table 11-5: Persons sentenced according to Sections 187 and 187a of the Penal Code in connection with cannabis in 2006-2008 (Ministerstvo spravedlnosti ČR, 2009a; Ministerstvo spravedlnosti ČR, 2009c)

Year	Section 187		Section 187a	
	Number	Proportion (%)	Number	Proportion (%)
2006	215	84	28	11
2007	184	81	28	12
2008	176	76	44	19

Table 11-6: Main types of sentences for drug-related offences committed in connection with cannabis in 2006-2008 (Ministerstvo spravedlnosti ČR, 2009a; Ministerstvo spravedlnosti ČR, 2009c)

Year	Total sentences	Unsuspended sentences (%)	Suspended sentences (%)	Community service sentences (%)	Penal measures (%)
2006	223	9	69	9	13
2007	226	12	56	12	12
2008	251	14	54	11	18

12 Problem Amphetamine and Methamphetamine Use, Related Consequences and Responses

The objective of this chapter is to provide information about the situation concerning the use of amphetamines, i.e. amphetamine and methamphetamine, particularly the chronic or intensive (problem) use of such substances, and describe the health and social correlates and consequences of the use, production, and markets of amphetamines, as well as the preventive and treatment measures taken in the Czech Republic in relation to (meth)amphetamine use.

In the past thirty years, methamphetamine (pervitin) has had a dominant position among problem drug users in the Czech Republic, which makes the Czech situation exceptional within the European context. Therefore, this chapter deals almost exclusively with methamphetamine – pervitin.

In the Czech Republic, pervitin is the number one “hard drug”. It is estimated that there are approximately 20 thousand problem pervitin users, which amounts to two thirds of all the problem drug users; 80-90% of those are injecting users. The level of pervitin use in the general population has remained very low over the years, although it has a rising tendency in nightlife settings.

Pervitin users are the main group of users in contact with treatment and counselling services (from the long-term perspective, they account for approximately 60% of all the registered cases of drug-related treatment demands); this applies to services of all types, with outpatient medical facilities having the fewest clients from among pervitin users. Pervitin is often used in combination with other drugs, mostly cannabis, opiates, and alcohol.

Long-term pervitin use is associated with psychiatric co-morbidity, involving toxic psychoses especially. Pervitin users show a higher suicide rate than opiate users. The incidence of infections among pervitin users is mainly related to injecting. However, it does not seem to differ significantly from that in (injecting) opiate users. In the Czech Republic, there are approximately 15-20 cases of pervitin overdoses annually, which accounts for about one third of overdoses on street drugs (illicit drugs plus inhalants).

Pervitin use treatment has long been integrated into the system of general drug services. No pervitin use-specific programmes are provided; the treatment of pervitin use is not even set apart as requiring a different regimen and/or protocol. There are differences in the provision of certain services: harm reduction organisations have recently conducted programmes featuring the distribution of gelatine capsules intended almost exclusively for pervitin users, and, as far as treatment is concerned, variations can be found in its pharmacotherapy. These are determined by a different course of withdrawal and detoxification, different psychological complications and, in particular, the development of psychotic symptomatology and psychosis. There is rare, although long-term, experience with the substitution therapy of pervitin addicts using various psychostimulants, presently methylphenidate.

12.1 Epidemiology of Amphetamine and Methamphetamine Use with Emphasis on Chronic/Intensive Use

12.1.1 History of (Meth)amphetamine Use

The history of the use of amphetamines, including the most common amphetamine in the Czech Republic – methamphetamine (pervitin) – needs to be perceived within the context of the history of stimulant and psychotropic substance use in general.

As elsewhere in Europe in the 1920s and 1930s (e.g. France, Germany), cocaine use was widespread in Czechoslovakia, particularly among artists and intellectuals, as well as among criminals and people associated with the underworld, mainly in the environment which is now referred to as the nightlife setting (Urban, 1973; Janota, 1941). As far as the Czech professional literature is concerned, cocaine dependency with psychotic bizarre hallucinatory symptomatology was probably described for the first time by Janota (Janota, 1924). In the late 1930s and 1940s, “psychotonism”, abuse of, and dependency on, benzedrine, a left-handed form of amphetamine (Psychoton®) – used for the treatment of somnolence – again featuring psychotic paranoid-hallucinatory symptomatology, was described within the territory of today’s Czech Republic (Janota, 1941)⁷¹; It is noteworthy that this work referred to benzedrine use as a new phenomenon among individuals on the verge of law-breaking, such as prostitutes using cocaine. As regards non-alcohol drugs, the post-World War II period, or the period following the 1948 Communist coup d’état, was marked by the misuse of psychotropic pills falling under the heading of stimulants, as well as narcotics, painkillers (including opiates), and sedatives, especially barbiturates and benzodiazepines (Zábranský, 2007). In the 1950s, the abuse of, and dependency on, l-amphetamine (benzedrine, Psychoton®), referred to as “psychotonism”, was seen as the most serious problem in terms of non-alcohol dependencies. These developments led to stricter controls on l-amphetamine prescription (Petráň). In parallel to the occurrences of amphetamine misuse, the late 1950s experienced reports on the misuse of Yastil, an asthma medication containing ephedrine, again associated with psychotic paranoid hallucinatory symptomatology, agitation, restlessness, and

⁷¹ The same work by Janota mentions German reports from the late 1930s describing the misuse of, and dependency on, a similar stimulant, Pervitin.

aggressiveness (Dvořák, 1956; Helcl, 1957); This form of dependency was referred to as “yastilism”; it should be noted that a combined, or subsequent, dependency on Psychoton® and Yastil® was described (Dvořák, 1956). The misuse of Yastil, “yastilism”, among prisoners was also documented, which later resulted in Yastil, previously an over-the-counter medicine, being included in medications available on prescription only (Urban, 1973). The 1960s saw another wave of the misuse of, and dependency on, psychostimulants, which was brought about by dexphenmetrazine and, in particular, phenmetrazine (Preludin®); phenmetrazine misuse was referred to as “phenmetrazinism”. While reports on their abuse had already appeared in the late 1950s, a major increase in the consumption of these substances occurred between 1959 and 1960 (Urban, 1973) and from 1963 to 1965 the individuals dependent on phenmetrazine accounted for approximately 40% of those dependent on non-alcohol drugs who were treated in inpatient psychiatric facilities; again, typical psychotic symptomatology resulting from chronic use was described (Vondráček et al. 1968).

The use of methamphetamine (pervitin, as it is referred to in the Czech Republic, also within the professional community), manufactured on a home-made basis using ephedrine and ephedrine-containing medicines, emerged in the then socialist Czechoslovakia, particularly in today's Czech Republic, in the 1970s⁷². By the 1980s, pervitin (in addition to pills and a home-made opiate drug, “braun”⁷³) had taken a dominant position on the then drug scene (Zábranský, 2007; Kalina and Bém, 1994; Hampl, 1994). From the beginning, pervitin use in the Czech Republic has been associated with injecting (similar to the use of “braun”); during the era of socialism pervitin use was limited to closed groups of users (problem drug users, using the present-day terminology) around a drug producer. The period before 1989 is characterised by a lack of information on the extent of illicit drug use and the forms of such use, both in general terms and, specifically, as far as amphetamines and/or pervitin are concerned. Nevertheless, in the late 1980s, the total number of people in the Czech Republic dependent on non-alcohol drugs was estimated to be 25-30 thousand (Nožina, 1997), which is a figure corresponding to the current prevalence estimates, including pervitin and opiate users.

After 1989 a pervitin black market emerged (see below) and the drug spread outside closed groups of users and producers to the whole of the Czech Republic (Zábranský, 2007). Heroin use became common in the Czech Republic in the mid-1990s⁷⁴. While problem heroin use remained concentrated mainly in Prague, North Bohemia, and the Bohemian regions in general (in Moravia, only Brno shows significant levels of heroin use), problem pervitin use is widespread throughout the Czech Republic, including provincial areas. In the past decade pervitin also gradually spread from the subpopulation of problem users into the environment of dance and music events and nightlife settings in general (Mravčík et al. 2006).

The use of other amphetamine-type drugs is almost non-existent and the incidence of cocaine use in the Czech Republic, however much it may be on the rise, continues to be low. Accordingly, pervitin is currently the predominant psychostimulant drug in the Czech Republic and a drug of choice among problem drug users⁷⁵.

Therefore, the following sections of this chapter deal almost exclusively with pervitin. In view of the fact that pervitin has played a key role in the drug problem in the Czech Republic for many decades and also constitutes an integral part of all the annual reports on the Czech drug situation, including this one, the following text will often refer to other chapters of this annual report, as well as the previous ones.

12.1.2 Trends and Patterns of (Meth)amphetamine Use

In the Czech Republic, the level of use of pervitin or amphetamine in the general population is relatively low, both in the adult population and among children and adolescents.

According to the 2008 general population survey on the use of psychotropic substances in the Czech Republic (CS 2008), employing a representative sample of 4,500 respondents aged 15-64, 4.3% of the population (5.7% of men, 3.0% of women) had a lifetime experience of amphetamine, or pervitin, use, and the prevalence in the past year and the past month was 1.7% and 0.7% respectively. The highest lifetime prevalence, i.e. 8.5%, was reported for the 25-34 age group; men in this age group reached a level of 10.6% (Národní monitorovací středisko pro drogy a drogové závislosti, 2009d). The results from the Czech part of the European Core Health Interview Survey for 2008 are also available (Ústav zdravotnických informací a statistiky, 2009a). They indicate that amphetamines, or pervitin, had been used by 1.4% of the adult population, and 0.6% and 0.3% had used the drugs in the past year and the past month, respectively. Possible reasons for the differences between both studies, as well as contextual information on the prevalence levels of other drugs and trends, are covered in more detail in the chapter on Drug Use in the General Population and Specific Targeted Groups, page 16.

⁷² Rather in the late 1970s – the early 1970s literature does not yet mention any methamphetamine (pervitin) abuse in Czechoslovakia (Vondráček, 1971; Urban, 1973).

⁷³ A typical opiate drug in socialist Czechoslovakia in the 1980s - a hydrocodone mix prepared on a homemade basis from medicines containing codeine.

⁷⁴ In 1994 Hampl still refers to the spread of heroin in the Czech Republic as a potential risk and indicates the number of the first 43 heroin users treated in outpatient drug services in the Czech Republic (Hampl, 1994); in 1997, when the first official data from the Institute of Health Information and Statistics were available, 1,813 had been registered.

⁷⁵ Such a high level of methamphetamine use makes the Czech Republic exceptional even in the European context; only Slovakia shows levels of methamphetamine use similar to the Czech Republic (Griffiths et al., 2008).

The 2002 and 2004 levels of lifetime prevalence of amphetamine use in the adult population were 2.3% and 2.5% respectively; the levels of use in the past year reached 0.5% and 0.7% respectively (Psychiatrické centrum Praha, 2002; Ústav zdravotnických informací a statistiky, 2006). As far as age is concerned, the highest lifetime prevalence of amphetamine use in 2004, i.e. 4.9%, was recorded for the 18-24 age category; the group of men aged 18-24 reached a level of 6.2%.

A decline in the prevalence of pervitin use among the school population has been observed since the late 1990s (Mravčík and Zábranský, 2001). Both the ESPAD survey among 16-year-olds and the HBSC study conducted with 15-year-old pupils provided evidence of this trend. The results of the ESPAD study show that in 2007 3.5% of 16-year-olds had lifetime experience with pervitin, while in 1999 it was 5.6% (Csémy et al. 2008). Equally, the HBSC survey among 15-year-old pupils of basic schools found a decline in lifetime prevalence, namely from 2.0% in 2002 to 1.5% in 2006 (Csémy, 2007); for more details see the 2007 and 2006 annual reports.

An increase in the use of pervitin in the nightlife setting, i.e. among those attending dance and music events, has been recorded since the beginning of the 21st century. Comparable results of three studies carried out among this population between 2000 and 2007 are available (in 2007, as in the previous years, 95% of the sample consisted of people aged 15-30 and two thirds of the sample comprised men); see Table 12-1.

Table 12-1: Prevalence of pervitin use among dance partygoers in the Czech Republic between 2000 and 2007 (%) (Kubů et al. 2000; Kubů et al. 2006; Škařupová, 2007)

Year	Lifetime (%)	12 months (%)	30 days (%)
2000	33.4	21.7	n.a.
2003	44.6	24.9	13.8
2007	47.6	28.0	15.8

The common routes of pervitin administration among dance partygoers include snorting or oral use; injecting is exceptional.

12.1.3 Prevalence Estimates of Problem (Meth)amphetamine Users

The estimated number of problem pervitin users in the period 2002-2008 was approximately 20 to 22 thousand. In the long term, pervitin users account for about two thirds of the approximately 30 thousand estimated problem drug users in the Czech Republic; the majority of problem users inject drugs. For more information see the chapter on Problem Drug Use, page 28.

In 1999, when a standard method was first used to estimate the prevalence of problem drug users in the Czech Republic, the estimated number of problem pervitin users was slightly higher – 22,500 individuals (95% CI: 18,000-27,000), and so was the estimate of the total number of problem drug users, including opiate users – 37,500 individuals (Mravčík and Zábranský, 2002; Mravčík et al. 2005b).

12.1.4 Treatment Demand for (Meth)amphetamine Use

In the long term, pervitin is the most common drug of choice among those people demanding drug treatment. According to the treatment demand register maintained by the Public Health Office, pervitin is the most common drug of choice in the Czech Republic; pervitin users accounted for about 60% of all the treatment demands in recent years (Studničková and Petrášová, 2009); The development of the absolute numbers of reported cases in the 1990s should be understood within the context of the growing network of drug services; see Table 12-2.

Table 12-2: Numbers and proportions of pervitin-related treatment demands in 1995-2008 (Mravčík et al. 2007; Mravčík et al. 2008; Studničková and Petrášová, 2009)

Year	First Treatment Demands			All Treatment Demands		
	Total number	Pervitin users		Total number	Pervitin users	
		Number	%		Number	%
1995	2,905	1,005	34.6	n.a.	n.a.	n.a.
1996	3,252	1,390	42.7	n.a.	n.a.	n.a.
1997	3,132	1,510	48.2	n.a.	n.a.	n.a.
1998	3,858	2,177	56.4	n.a.	n.a.	n.a.
1999	3,891	2,042	52.5	n.a.	n.a.	n.a.
2000	4,148	1,880	45.3	n.a.	n.a.	n.a.
2001	4,232	1,969	46.5	n.a.	n.a.	n.a.
2002	4,719	2,389	50.6	9,237	4,589	49.7
2003	4,158	2,281	54.9	8,522	4,490	52.7
2004	4,600	2,685	58.4	8,845	4,790	54.2
2005	4,372	2,605	59.6	8,534	4,855	56.9
2006	4,199	2,528	60.2	8,366	4,889	58.4
2007	4,346	2,749	63.3	8,487	5,177	61.0
2008	3,981	2,492	62.6	8,279	4,925	59.5

In the long term, the reported numbers of treatment demands in relation to amphetamine and other psychostimulants are sporadic; among all treatment demands in 2008, there were 3 amphetamine users, 10 phenmetrazine users, and one user of ephedrine. Additionally, 14 ecstasy users and 24 cocaine/crack users were reported in 2008 (Studničková and Petrášová, 2009).

In the long term, pervitin-related treatment demands involve a higher proportion of women in comparison to other drugs; in 2008 women accounted for 37.3% of first demands and 35.7% of all treatment demands. As far as heroin users are concerned, these rates were 30.4% and 29.2% respectively, and 33.8% and 32.2% respectively among all treatment demands, regardless of the primary drug (Studničková and Petrášová, 2009). The proportion of women is generally higher among younger age groups, which especially applies to pervitin users: women consistently predominate over men in the lowest age group, up to 19 years old. In 2008 women comprised 57.5% of both first and all treatment demands, and, as regards the total number of treatment demands, irrespective of the primary drug, the rates were 47.1% and 47.9% respectively (Studničková and Petrášová, 2009).

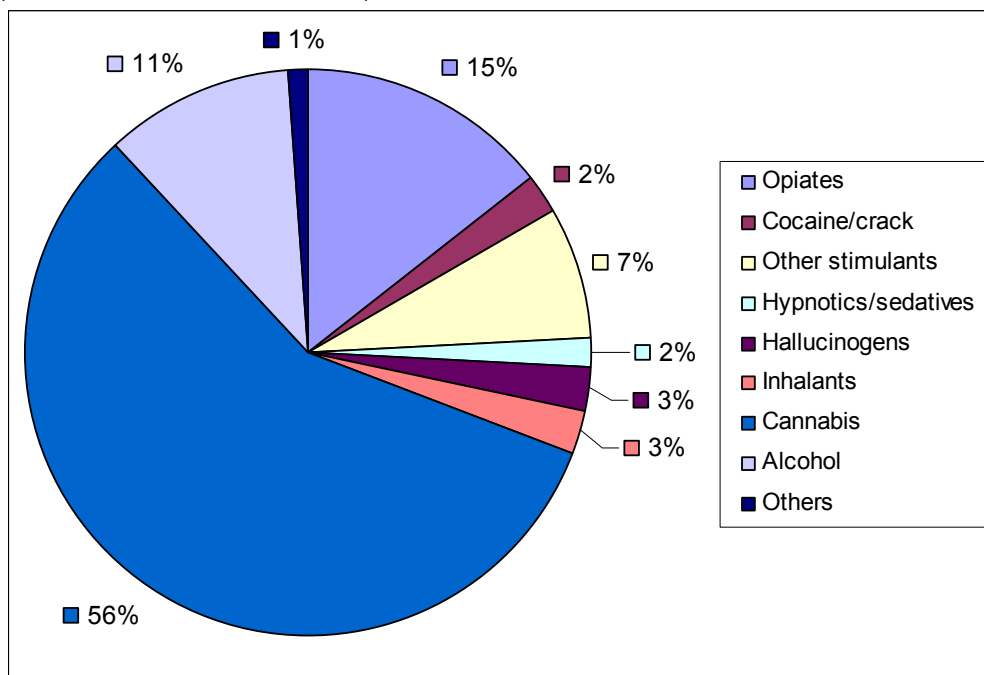
Pervitin users show a significantly lower average age (by more than three years) than heroin users and are also below the average age for all treatment demands. 26.4% of first treatment demands and 19.5% of all treatment demands related to pervitin are from people under 19 years of age, while the respective rates for heroin are reported to be 11.4% and 4.0%. In 2008 the average age of pervitin users was 24.0 years among first treatment demands and 25.4 years among all treatment demands. The respective figures for heroin users were 27.3 and 28.7 years, while for all treatment demands, irrespective of the primary drug, the average age was 24.3 and 25.9, respectively (Studničková and Petrášová, 2009). There has been a long-term increase in the pervitin users' average age – in 1996-1997 the average age of pervitin users demanding treatment for the first time in their lives was about 20 years; see Figure 5-4 and Figure 5-5 (p. 45).

Pervitin use occurs in all the regions of the Czech Republic, although its extent varies. Pervitin users predominate in treatment facilities in all the regions. Nevertheless, Prague, the Capital City, and the regions of Hradec Králové, Central Bohemia, and Moravia-Silesia show the lowest rates of pervitin users among all the users in treatment; see Map 5-1 (p. 45). Until 2006, Prague, the Capital City, reported higher proportions of opiate users in treatment than of pervitin users (see the 2005 and 2006 annual reports); in Prague, this situation has not changed as regards prevalence estimates and clients of low-threshold centres (which provide information for prevalence estimates), in which opiate users are still predominant; see Map 4-1 (p. 29).

Injecting is the most common route of pervitin administration among users in treatment. There is a higher proportion (by about 5 percentage points) of injecting users among all treatment demands. In the last five years the rate of injecting users has dropped from about 80-85% to 75-80%; see Figure 6-6 (p. 59).

Polydrug use, i.e. the concurrent use of more than one drug, is a common phenomenon. After cannabis, pervitin is reported as the second most likely secondary (illicit) drug: apart from 4,925 users who reported it as their primary drug in 2008, pervitin was used as the secondary drug in 1,315 cases. In most cases (876), these were primary opiate users (including 686 heroin users and 137 Subutex[®] users); 382 cases involved cannabis users. 88% of people who use pervitin as their primary drug take another secondary drug; a chart of pervitin users' secondary drugs is provided in Figure 12-1.

Figure 12-1: Proportions of secondary drugs among all treatment demands involving pervitin as the primary drug (Studničková and Petrášová, 2009)



Pervitin users include a significantly higher proportion of students than heroin users (13.3% versus 2.7%), while the rate of both unemployed people and those who report having regular jobs is lower among pervitin users, which is likely to be mainly associated with pervitin users' younger age. Both pervitin and heroin users show a similar housing situation (Studničková, 2009a).

In comparison to heroin users, pervitin users are less likely to seek treatment by themselves (51.8% and 61.6% respectively in 2008) or be referred by another agency (7.6% and 10.4% respectively), but are more likely to enter treatment as a result of pressure exerted on them by their family and friends (8.5% and 5.8% respectively) (Studničková, 2009a).

Pervitin users also represent the largest, or one of the largest, groups in all of the other sources of data about the clients of treatment or low-threshold facilities.

- In 2008 pervitin users accounted for 52.7% of clients of low-threshold facilities; for more information and trends refer to Table 7-1 (p. 69).
- In 2008 pervitin users accounted for 21.2% of clients of outpatient psychiatric clinics; a higher representation was recorded for opiate users, and polydrug users and the users of sedatives and hypnotics also showed significant proportions among the patients of these facilities; for more data and trends see Figure 5-8 (p. 48).
- Pervitin users also comprised 21.2% of those individuals admitted to inpatient psychiatric facilities in 2008; a higher representation was reported for polydrug users, and opiate users also accounted for significant rates; for more data and trends see Figure 5-11 (p. 51).
- In addition, pervitin users account for the majority of clients of outpatient facilities operated by NGOs, therapeutic communities, and aftercare agencies; for more data and trends refer to Table 5-6 (p. 38), Table 5-12 (p. 52), and Table 8-2 (p. 79).

More information about the clients of different types of services, including pervitin users, can be found in the chapters on Characteristics of Clients in Treatment (p. 43), Prevention and Treatment of Drug-Related Infectious Diseases, page 68) and Social Reintegration, page 78.

12.1.5 Out-of-treatment Populations of (Meth)amphetamine Users

More information on problem pervitin users can also be found in other chapters of this report, including Data on Problem Drug Use from Non-treatment Sources, page 30.

Qualitative research conducted from September 2008 to January 2009 and involving three focus groups with the staff of low-threshold programmes showed that the majority of low-threshold programmes in the Czech Republic work with clients who mostly use pervitin, usually in combination with other substances, including opiates. The concurrent use of pervitin and benzodiazepines has also been recorded (Radimecký et al. 2009).

The previous studies concerning drug users, especially those from among the clients of low-threshold facilities, support the data provided in this chapter. Pervitin users comprised the largest group in a study carried out in 2004–2005; they accounted for 78% of the clients of low-threshold facilities (Petroš et al. 2005), and a significant proportion of the clients (16%) used pervitin in combination with opiates, mainly Subutex[®]. A high rate of polydrug users and, in particular, the concurrent use of pervitin and opiates (again, especially Subutex[®]) among the clients of Prague's low-threshold facilities were also reported (Mravčík and Orliková, 2007; Větrovec and Porubský, 2008).

12.1.6 Production Sites and Laboratories, Origin of Products and Trafficking Routes, Seizures of Precursors

The illicit production of pervitin in the Czech Republic dates back to the 1970s, when a simple procedure for reducing ephedrine to methamphetamine using readily available chemicals was rediscovered (Zábranský, 2007). Prior to 1989, pervitin was manufactured from pure ephedrine or medicines containing ephedrine that were available at that time (typically, Solutan[®], a cough medicine). The relatively easy availability of ephedrine probably played its role in the development of pervitin production and use. From 1971 pure ephedrine was manufactured by the VUAB (Research Institute of Antibiotics and Biotransformations) plant in Roztoky u Prahy, from where it was smuggled out. By the late 1990s VUAB had become a leading producer of ephedrine worldwide. Following a series of privatisation projects in the 1990s, the production of ephedrine was gradually reduced and, finally, came to an end in 2003–2004. It was known that ephedrine produced in the plant had been diverted to the black market. However, such cases were formally detected and reported only rarely and no estimates of the total amount of ephedrine smuggled out to the black market were ever made.

Nowadays, pervitin is manufactured using both ephedrine (which is mostly smuggled into the Czech Republic from the Balkans) and, in particular, pseudoephedrine, which is easier to obtain, as it can be extracted from over-the-counter medicines, such as Modafen[®], Nurofen Stop Grip[®], Paralen Plus[®], and Panadol Plus Grip[®]. The massive misuse of medicines containing pseudoephedrine for the production of pervitin has been observed by the National Drug Headquarters since 2003–2004, and, at present, pseudoephedrine obtained from these pharmaceutical products is the main precursor used to manufacture pervitin. However, the National Institute for Drug Control has adopted a decision concerning a change in marketing authorisation for medicines containing pseudoephedrine in an amount of up to 30 mg, which has restricted their availability significantly. The measure became effective on 1 May 2009. In this respect, since June 2009 the Customs Administration of the Czech Republic has recorded illegal imports of large quantities of these medicines from abroad; for more details see the chapters on Legal Framework, page 5 and Drug Markets, page 92.

The medicines which were the most likely to be misused for the production of pervitin in 2008 were those containing a combination of pseudoephedrine and ibuprofen (Modafen[®] and Nurofen Stop Grip[®]). The Czech Chamber of Pharmacists assumes that up to 80% of the consumption of large packs of these medicinal products was used for illicit pervitin production, resulting in 1.2 tonnes of pure substance (Havlíček, 2008). The number of cooking labs detected by the police increased from 188 in 2003 to 434 in 2008 (which has been the highest annual rate thus far); for more details see Table 10-1 (p. 93) and the 2007 and 2006 annual reports.

The post-1989 development experienced by the illicit drug market in general also applied to pervitin production and the market in it. Until 1989, its production, distribution, and use were limited to small groups hiding from the repressive policies of the Communist regime. Individual members of these groups were assigned specific roles in the manufacturing process (e.g. supplying precursors and chemicals, providing laboratory glassware and instruments, and 'cooking'), and the final product was shared among them. Since the mid-1990s the pervitin market has become professionalised and partly merged with the heroin market (Miovský, 2007; Zábranský, 2007).

The estimated pervitin consumption in the Czech Republic has maintained a level of about 4 tonnes in recent years. In 2003 (the latest data available) the estimate was 3.7 tonnes; 166 kg were used in the nightlife setting, and the remaining amount was consumed by problem drug users (Vopravil, 2005; Petroš et al. 2005). Every year, law enforcement agencies seize approximately 5 kg of pervitin on 300–400 occasions – see Table 10-2 (p. 94). The price of pervitin remains stable at CZK 1,000 (€ 40) per 1 g and its purity is approximately 60%; see Table 10-3 and Table 10-4 (p. 94).

In 2008, the Government Council for Drug Policy Coordination established the Methamphetamine Working Group, an inter-agency multidisciplinary body whose task is to address the issue of methamphetamine, including its manufacturing and the related health and environmental risks, comprehensively and on a long-term basis; for more details see the chapter on National Action Plan, Strategy, Evaluation, and Coordination, page 7.

12.2 Health and Social Correlates of Chronic (Meth)amphetamine Use

12.2.1 Physical Health Consequences

In 2006 the National Focal Point carried out an analysis of comorbidity of drug users hospitalised in the period 2001–2005; for more details see the 2005 Annual Report. The survey involved all hospitalisations of patients who had been admitted, at least once, for drug use disorders classified as either a primary or secondary diagnosis (i.e. F11–F19, excluding F17). As far as stimulant (pervitin) users are concerned, the three most common diagnostic groups,

apart from dependency-related conditions, included mental and behavioural disorders (F00-F99, excluding F10-F19), injury, poisoning, and other consequences of external causes (S00-T98), and infectious and parasitic diseases (A00-B99), found in 30.2%, 29.2%, and 19.8%, respectively, of the pervitin users admitted to hospital. In comparison to heroin users, the rate of external causes of morbidity is similar, while the frequency of infections is lower and that of mental disorders higher. The relatively high rate of infections seems to be associated with the frequent use of pervitin by injecting (as is the case among opiate users and polydrug users); see Table 12-3.

Table 12-3: Diagnoses which occurred in combination with illicit drug use among selected patients hospitalised in 2001-2005 (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2006a)

Diagnoses	F11 (%) n=5,723	F12 (%) n=1,800	F13 (%) n=2,545	F14 (%) n=227	F15 (%) n=4,688	F16 (%) n=438	F18 (%) n=756	F19 (%) n=8,075	Total (%) N=19,795
A00-B99	24.2	11.1	8.5	14.1	19.8	14.6	9.8	18.6	15.6
C00-D48	5.9	2.9	8.6	11.9	1.9	4.6	3.2	3.3	4.7
D50-D89	3.9	2.3	5.2	4.0	1.9	4.6	3.2	2.8	3.3
E00-E90	14.6	8.7	21.6	30.8	5.0	14.4	9.3	7.8	11.7
F00-F99 (w/o F10-F19)	20.2	51.1	66.1	29.1	30.2	31.7	42.7	44.9	37.3
G00-G99	8.9	7.8	16.6	15.0	4.5	11.0	7.9	8.8	8.9
H00-H59	2.3	2.2	3.7	11.5	1.1	2.3	1.5	1.7	2.2
H60-H95	1.2	1.4	2.1	2.6	0.6	1.4	1.6	1.1	1.2
I00-I99	20.7	11.5	31.9	44.5	7.5	21.2	16.8	12.0	17.3
J00-J99	14.4	15.4	17.0	26.0	10.5	18.9	14.0	13.1	13.6
K00-K93	19.8	16.7	27.8	25.6	13.2	23.1	18.8	18.5	18.8
L00-L99	7.2	4.9	5.0	7.0	6.1	5.5	6.6	6.4	5.7
M00-M99	10.6	8.6	20.2	22.5	5.1	9.6	8.5	8.3	10.3
N00-N99	11.6	8.5	17.5	19.8	8.2	9.8	9.5	9.6	10.8
O00-O99	8.9	4.4	5.0	4.8	9.2	7.5	2.2	6.7	7.0
P00-P96	0.1	0.1	0.1	0.0	0.1	0.0	0.3	0.0	0.1
Q00-Q99	0.6	1.3	0.9	0.9	0.6	1.1	0.9	0.6	0.7
R00-R99	15.3	17.1	23.3	21.6	12.1	20.5	18.0	14.6	15.4
S00-T98	28.2	31.8	38.4	31.3	29.2	43.8	39.9	35.7	31.7
V01-Y98	0.4	6.1	9.1	5.3	4.1	8.7	5.8	6.1	5.3
Z00-Z99	17.1	18.8	20.0	19.4	14.2	18.9	16.4	16.2	15.9

NB: The three most common groups of diagnoses in users of individual drugs are in bold.

A00-B99 – Certain infectious and parasitic diseases

C00-D48 – Neoplasms

D50-D89 – Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism

E00-E90 – Endocrine, nutritional, and metabolic diseases

F00-F99 – Mental and behavioural disorders

G00-G99 – Diseases of the nervous system

H00-H59 – Diseases of the eye and adnexa

H60-H95 – Diseases of the ear and mastoid process

I00-I99 – Diseases of the circulatory system

J00-J99 – Diseases of the respiratory system

K00-K93 – Diseases of the digestive system

L00-L99 – Diseases of the skin and subcutaneous tissue

M00-M99 – Diseases of the musculoskeletal system and connective tissue

N00-N99 – Diseases of the genitourinary system

O00-O99 – Pregnancy, childbirth, and puerperium

P00-P96 – Certain conditions originating in the perinatal period

Q00-Q99 – Congenital malformations, deformations, and chromosomal abnormalities

R00-R99 – Abnormal findings not classified elsewhere

S00-T98 – Injury, poisoning, and other consequences of external causes

V01-Y98 – External causes of morbidity and mortality

Z00-Z99 – Factors influencing health status

Mental and behavioural disorders resulting from the use of opioids – F11, cannabinoids – F12, sedatives or hypnotics – F13, cocaine – F14, stimulants – F15, hallucinogens – F16, inhalants – F18, polydrug use and other psychoactive substances – F19.

Data on non-fatal intoxications (emergency conditions accompanying acute drug intoxication which require hospitalisation) collected by the Public Health Service in the Czech Republic are available; for more information see the chapter on Other Drug-related Health Correlates and Consequences (p. 59). Pervitin was responsible for 31.8% of all the cases of non-fatal intoxication reported in the Czech Republic in 2008, which reflects a long-term rise in the number and rate of non-fatal intoxications caused by pervitin; for more details see Table 6-7.

12.2.2 Mental Health Consequences

The prolonged use of pervitin induces psychological symptoms and complications such as agitation, tension, anxiety, fear, irritability, sleep disorders, panic, touchiness, depression, suspiciousness, pathological jealousy, confusion, memory and concentration disorders, hallucinations, and suicidal tendencies. Chronic and/or intensive use leads to the development of toxic psychosis with the appearance of a paranoid or paranoid-hallucinatory syndrome. The onset of psychosis is slow, beginning with sensitive self-reference and the loss of insight. The main features of developed toxic psychosis include paranoia, pronounced mood changes, and visual, auditory, and tactile hallucinations. In clinical terms, it may often be difficult to distinguish toxic psychosis from schizophrenia. People who

develop psychosis should be referred to inpatient treatment; their response to antipsychotics is very good (Minařík, 2003). The historical summary at the beginning of this chapter suggests that the Czech professional community has long-term experience with the occurrence and treatment (see below) of psychiatric comorbidity and toxic psychoses among the users of stimulants, including pervitin.

Groups of psychiatric diagnoses were also looked into as part of the analysis of comorbidity of drug users admitted to hospital in the period 2001-2005; for more information refer to the 2005 Annual Report. Stimulant users showed the highest rate of psychiatric diagnoses falling under the group of personality and behaviour disorders; see Table 12-4.

Table 12-4: Psychiatric diagnoses which occurred in combination with illicit drug use among selected patients in 2001-2005 (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2006a)

Diagnoses	F11 (%) n=5,723	F12 (%) n=1,800	F13 (%) n=2,545	F14 (%) n=227	F15 (%) n=4,688	F16 (%) n=438	F18 (%) n=756	F19 (%) n=8,075	Total (%) N=19,795
F00-F09	2.9	1.8	11.1	3.1	1.2	1.8	3.6	3.6	3.8
F20-F29	3.4	13.7	7.9	4.4	7.1	9.4	7.0	11.5	7.9
F30-F39	4.6	6.0	25.5	6.2	3.9	5.7	3.4	8.1	7.9
F40-F49	7.6	18.4	38.3	14.5	9.8	11.2	11.1	16.8	15.2
F50-F59	0.9	1.2	3.4	3.1	1.4	1.1	0.8	1.6	1.4
F60-F69	7.7	22.4	24.4	15.0	16.2	14.4	16.1	22.5	15.8
F70-F79	1.0	2.0	1.1	0.9	0.8	2.3	7.1	2.1	1.6
F80-F89	0.0	0.6	0.2	0.4	0.1	0.2	1.3	0.2	0.2
F90-F99	1.6	11.3	3.3	5.3	3.8	4.1	12.8	4.6	3.9

NB: Three most common groups of psychiatric diagnoses in users of individual drugs are in bold.

F00-F09 – Organic, including symptomatic, mental disorders

F10-F19 – Disorders resulting from psychoactive substance use

F20-F29 – Schizophrenia, schizotypal, and delusional disorders

F30-F39 – Affective (mood) disorders

F40-F49 – Neurotic, stress-related, and somatoform disorders

F50-F59 – Behavioural syndromes associated with physiological disturbances and physical factors

F60-F69 – Disorders of adult personality and behaviour

F70-F79 – Mental retardation

F80-F89 – Disorder of psychological development

F90-F99 – Behavioural disorders in children

Mental and behavioural disorders resulting from the use of opioids – F11, cannabinoids – F12, sedatives or hypnotics – F13, cocaine – F14, stimulants – F15, hallucinogens – F16, inhalants – F18, polydrug use and other psychoactive substances – F19.

An analysis of the same sample, conducted by the National Focal Point for the purposes of this selected issue and intended to record the occurrence of toxic psychoses in users of different types of drugs referred to hospital (i.e. F1X.5, psychotic disorder, and F1X.7, residual and late-onset psychotic disorder), confirmed the high rate of psychoses among stimulant (pervitin) users; see Table 12-5.

Table 12-5: Toxic psychoses among patients hospitalised with disorders induced by psychoactive substance use in 2001-2005 by drug type (Národní monitorovací středisko pro drogy a drogové závislosti, 2009h)

Diagnosis (Drug type)	Psychotic disorder		Residual psychotic disorder		Toxic psychoses in total		Total number of people
	Number	%	Number	%	Number	%	
F11 (opiates)	99	1.7	27	0.5	126	2.2	5,723
F12 (cannabis)	160	8.9	27	1.5	187	10.4	1,800
F13 (sedatives/hypnotics)	35	1.4	16	0.6	51	2.0	2,545
F14 (cocaine)	14	6.2	2	0.9	16	7.0	227
F15 (stimulants)	565	12.1	67	1.4	632	13.5	4,688
F16 (hallucinogens)	35	8.0	11	2.5	46	10.5	438
F17 (inhalants)	43	5.7	17	2.2	60	7.9	756
F19 (polydrug use)	691	8.6	166	2.1	857	10.6	8,075
Total	1,163	5.9	235	1.2	1,398	7.1	19,795

In addition, the majority of the psychiatrists/addiction specialists interviewed as part of a survey on pervitin use treatment conducted by the National Focal Point in 2009 reported that pervitin users who had experienced psychotic symptomatology or developed toxic psychosis required specific treatment procedures (see below).

12.2.3 Infections – HIV, HCV, HBV

Apart from blood-borne infections (HIV, HBV, HCV) occurring as a result of sharing equipment and paraphernalia when injecting drugs, drug users show an increased level of other diseases, such as infections of the skin and soft tissues around the site of injection, system infections (sepsis, endocarditis), and respiratory infections.

In particular, infections among pervitin users result from their high rate of injecting drug use. General data on infections among (injecting) users are common, but specific figures pertaining to pervitin users are rare.

A high rate of abscesses and infections at injection sites was found by the analysis of a sample of drug users admitted to the centre for the treatment and prevention of infection-related complications in drug users at the Motol University Hospital in Prague; for more information see the 2006 Annual Report. Inflammations at injection sites were also one of the most frequently reported health complications among injecting drug users who sought the services of Prague's low-threshold facilities in 2008 (approximately one third of the sample comprised pervitin users); they were reported by almost half of the respondents (Šejvl, 2008); see Table 6-8 (p. 60).

Data on the reported incidence of HIV, HAV, HBV, and HCV are available for the group of injecting drug users (IDUs), but no information on the drugs used is available; for more details see the chapter Drug-Related Infectious Diseases, page 53. The number of reported cases of HIV among injecting drug users in the Czech Republic is very low. A total of 1,190 HIV-positive persons, including 83 injecting drug users (7%), had been recorded by 2008. Nevertheless, in the last two years there has been an increase in the number of cases among IDUs; see Table 6-1 (p. 53). The prevalence of HIV is less than 1%; various studies and/or monitoring systems only refer to sporadic cases of HIV-positive IDUs; see Table 6-2 and Table 6-3 (p. 55).

A national study of HCV seroprevalence among the clients of low-threshold centres revealed an HCV seroprevalence of 35% among IDUs; after adjustment to the period of injecting drug use, no statistically significant difference between pervitin and opiate users was identified as far as the incidence rate of HCV is concerned (Zábranský et al. 2006; Mravčík et al. 2009).

Testing for infections has been carried out in low-threshold facilities. The process is monitored and the results show lower levels of HCV prevalence among IDUs (less than 20%), which, however, may be the effect of the higher representation of younger users (i.e. users with a shorter history of injecting) among the reported clients. The data generated by the process of the monitoring of infection tests performed in low-threshold facilities, as well as the data on the incidence of infections available from the register of treatment demands, suggest that pervitin users show a lower rate of HCV than heroin users (Figure 6-4 and Figure 6-5, p. 57). However, this difference may be caused by pervitin users' younger age and a shorter history of injecting drug use.

In comparison to the general population and opiate users, pervitin users show a higher rate of promiscuous sexual behaviour (Justinová and Weiss, 2009), which increases the risk of sexually transmitted infections.

12.2.4 Deaths Related to (Meth)amphetamine

Fatal overdoses (direct drug-related deaths) and other deaths with the presence of narcotic and psychotropic substances (indirect drug-related deaths) are covered by the chapter on Drug-Related Deaths and Mortality of Drug Users, page 63. Between 2007 and 2008 the number of fatal overdoses on pervitin rose from 11 to 19 cases; in the long term, fatal pervitin intoxications account for approximately one third of all the overdose deaths on street drugs (illicit drugs and inhalants) in the Czech Republic; see Table 6-11 and Figure 6-7 (p. 64).

The rate of other pervitin-related deaths is higher. Forty-nine deaths with the presence of pervitin (often in combination with alcohol and/or other substances), mainly resulting from accidents and injuries (24 cases) or suicides other than by overdose (21 cases), were reported in 2008. Since 2004, when the data on indirect drug-related deaths became available for the first time, their number has risen (in 2004, 19 cases involving pervitin were reported); for more details see Table 6-12 and Figure 6-8 (p. 65). In 2008, stimulants (especially pervitin) were detected in the bodies of 9.2% of the drivers who had been killed in traffic accidents; see Table 6-9 (p. 62).

The results of a retrospective cohort study of the mortality of people hospitalised for substance use disorders in the period 1997-2002 have been published (Lejčková and Mravčík, 2007). The overall mortality rate of stimulant (pervitin) users was approximately half that of heroin users (4.9 cases per 1,000 persons and study year versus 8.6 cases, respectively); after controlling for age, the rate was approximately three times lower.

A study of a cohort of people hospitalised for substance use disorders and people undergoing opiate substitution treatment in the period 1997-2007 was conducted in 2008 (Zábranský et al. 2009); see also the chapter on Drug-Related Deaths and Mortality of Drug Users (p. 63). The overall mortality rate among stimulant (pervitin) users reached a level of 5.0 cases (95% CI: 4.3-5.7) per 1,000 persons and year, while 6.5 cases were recorded as far as opiate users were concerned. However, pervitin and opiate users differ in their mortality structure – pervitin users appear to show a higher rate of deaths caused by external factors, especially suicides; see Table 12-6.

Table 12-6: Causes of deaths of pervitin and heroin users hospitalised or undergoing substitution treatment between 1997 and 2007 (%) (Zábranský et al. 2009)

Cause of death	Stimulants (%)	Opiates (%)
HBV	0.0	0.3
HCV	0.5	0.7
HIV/AIDS	0.0	0.0
Tuberculosis	0.0	0.0
Septicaemia/viraemia	0.0	0.0
Endocarditis	0.5	2.4
Liver diseases/carcinoma	2.0	3.0
Other diseases	15.8	24.6
Diseases in total	18.8	31.0
Suicides	37.6	16.2
Road accidents	13.4	3.0
Other injuries/accidents	18.8	34.0
Assaults	1.0	2.0
Other external causes	10.4	13.8
External causes in total	81.2	69.0
Total	100.0	100.0

12.2.5 Social Problems

Selected socio-economic characteristics of pervitin users in treatment compared to the users of other drugs (especially heroin) are indicated above in the section on Treatment Demand for (Meth)amphetamine Use, page 104.

Pervitin has been involved in approximately 60-65% of the offences of the illicit production and trafficking of drugs and approximately 40-50% of the offences of possession of a drug (for personal use) in a quantity greater than small; for more details see the chapter on Drug-related Crime, page 81. No specific information on secondary (economic) crimes committed by pervitin users is available; this issue is addressed in general terms in the chapter on Drug-related Crime, Prevention of Drug-related Crime, and Prison, page 81.

12.3 Health and Social Responses to Chronic (Meth)amphetamine Use

The analysis of pervitin use, data on pervitin users in treatment, and the findings about the consequences of pervitin use suggest that, historically, pervitin users comprise a significant, or major, group of illicit drug users in the Czech Republic. This makes them a “natural” part of the Czech drug scene and the preventive, treatment, harm reduction, and after-care programmes have also been designed to meet pervitin users’ needs. Each professional working in the field of drug treatment (particularly that involving illicit, non-alcohol substances) encounters pervitin users in their work on a day-to-day basis. In spite of this (or, maybe, because of this), no programmes (with a few exceptions – see below) intended specifically for pervitin users are provided in the Czech Republic. Pervitin users are one of the groups targeted by programmes designed for (problem) drug users in general; in the Czech Republic, treatment approaches specific to different substances are not monitored and covered on a systematic basis.

No specific prevention programme addressing pervitin use is delivered in the Czech Republic. To a great extent, the same assertion can be made about harm reduction and/or treatment programmes. Nevertheless, certain specific needs of pervitin users are considered in treatment regimens or incorporated in individual treatment plans. A project developed by *Sdružení Podané ruce*, a civic association, that commenced in September 2009 is rather an isolated initiative. Its objective is to adapt the 12-Step programme, used in the United Kingdom for the treatment of cocaine and crack users, to the target group of (meth)amphetamine users.

Certain specific aspects of the treatment of dependency on stimulants are referred to in the recommended procedures for psychiatric care in relation to the treatment of dependency on psychoactive substances. In view of the absence of severe physical withdrawal symptoms, withdrawal management does not require specific pharmacotherapy. Quiet, the treatment of the symptoms, and supporting psychotherapy are recommended. Therapy with antipsychotics is recommended in indicated cases. As in other forms of substance dependency, psychotherapeutic interventions such as psychodynamic psychotherapy, motivation building, family therapy, cognitive-behavioural therapy, therapeutic contract, and contingency management are recommended as part of the treatment of stimulant users. The utilisation of short-term inpatient treatment episodes is mentioned. It is also recommended that motivated patients should undergo residential treatment in a therapeutic community. It is emphasised that pharmacotherapy is not a method of first choice in the treatment of stimulant dependency. If the condition so requires, antidepressant drugs are considered suitable. However, it is necessary to take into account interactions with substances which the patient obtains by themselves. The use of antipsychotic drugs is recommended when patients experience feelings of threat or psychotic symptoms, or when psychotic decompensation is a concern (Popov and Nešpor, 2006).

12.3.1 Harm Reduction Interventions

The majority (80-90%) of pervitin users in contact with counselling and/or treatment facilities are injecting drug users. Thus, they make use of harm reduction interventions provided by low-threshold programmes and designed for injecting drug users in general (information, distribution of leaflets describing the risks of infectious diseases and other health problems, education about and motivation to safer routes of drug administration, needle and syringe exchange programmes, education about and motivation to safer sex, the distribution of condoms, the provision of/referral to testing for infections and other health care as needed, the newly introduced automated dispensing machines for harm reduction supplies, etc.); for more details refer to the chapter on Responses to Health Correlates and Consequences, page 67.

The distribution of gelatine capsules as a safer alternative to injecting drug use is intended specifically for pervitin users⁷⁶; for more information see the chapter on Responses to Health Correlates and Consequences, page 67. The latest information suggests that the capsules are distributed by approximately 20 low-threshold programmes and another 20 are planning to introduce the capsule distribution project. The information available indicates that the primary target group comprises injecting pervitin users who are seeking an alternative to the injection route of administration, particularly because of (momentarily) damaged veins. The reason why opiate users do not use the capsules may be the lower metabolic availability of opiates from the digestive tract. In comparison to regular oral use, the capsules eliminate the bitter taste of pervitin; the onset of the effect of the drug remains present. It is easy to prepare the drug for use in a capsule. Clients have shown increased interest in the capsules (Škařupová et al. 2009).

Prevention and harm reduction in relation to drug use in nightlife settings are an issue of interest for certain low-threshold programmes. The Safer Party Tour project has also been in progress; for more details refer to the chapter on Selective Prevention, page 26 and Low-Threshold Harm Reduction Programmes, page 68.

12.3.2 Treatment

As part of the preparation for this selected issue, the National Focal Point conducted two surveys among counselling and treatment facilities. A questionnaire survey aimed at identifying specific aspects of services for pervitin users and drug users over 40 was conducted in May and June 2009 (see also the selected issue of Treatment and Care for Older Drug Users, page 120). The questionnaires were completed by 15 facilities: 10 outpatient programmes, 2 low-threshold facilities, 2 methadone substitution centres, and a detox facility (Národní monitorovací středisko pro drogy a drogové závislosti, 2009e). A survey in outpatient psychiatric facilities/alcohol and drug treatment outpatient clinics and inpatient addiction treatment departments was carried out in August 2009; responses were collected from 13 outpatient centres (8 completed the questionnaire; the remaining five do not treat pervitin users) and 5 inpatient facilities (Národní monitorovací středisko pro drogy a drogové závislosti, 2009g). The information is provided in aggregate form for both surveys. The only exception is the issue of pharmacotherapy, which was included in the second survey addressing healthcare facilities.

As far as pervitin users' specific needs are concerned, the professionals mentioned repeatedly that pervitin users' behaviour is similar to that of other drug users; it shows signs of addictive behaviour in general and, also, the therapeutic relationship and process involving pervitin users do not differ significantly from those with other drug users. Nevertheless, certain specific features pertaining to pervitin users and addicts were identified. These need to be considered because of their impact on the process and outcomes of the treatment.

On average, pervitin users are younger than opiate users and are more likely to be single and without children (which may increase the probability of them entering residential treatment). Generally, they show better (physical) health and better social circumstances (although the positive effect of substitution treatment on the social stabilisation of opiate users was repeatedly underlined).

According to the therapists, complicating factors in contact and work with pervitin users include digressive thinking, nervousness, distrust, impulsivity, aggressiveness, low concentration, and a lack of consideration on the part of the clients. In comparison to opiates, pervitin use results in low physical dependency and only a moderate acute withdrawal syndrome, which hampers the user's insight, causes the client to minimise their problems, and reduces the motivation to change. Conflicts in the family were mentioned very often, and work with the family is a common component of the therapeutic process. Pervitin users, too, are often urged by their family members to seek contact with a helping agency.

The responses further suggested that pervitin users seem to be in a better financial situation – their debts tend to be lower – than opiate users. In comparison to opiate users, pervitin users are reported to have a lower record of acquisitive offences committed in order to purchase drugs (“for opiate users, to get their daily dose is the priority;” pervitin users are “often in connection with ‘cooks’ or can prepare the drug themselves”). Pervitin users are more likely to be involved in violent crime.

⁷⁶ The distribution of aluminium foil to inhale heroin is specifically aimed at heroin users.

The combination of pervitin with other drugs was described. It was stressed repeatedly that this often happens after pervitin has been used for a certain period of time and marks a new stage in the use of pervitin which is more difficult to deal with in therapeutic terms. The combination of pervitin with opiates, alcohol, cannabis, and benzodiazepines was reported. In addition, the occurrence of pathological gambling among pervitin users (“getting hooked on slot machines”) was mentioned several times.

Reported mental and behavioural disorders included higher psychological and emotional instability, depression and anxiety, suicidal thoughts, and aggressiveness. These need to be addressed as part of the treatment process involving pervitin users. Pervitin-related eating disorders in girls were mentioned repeatedly. Somatic disorders (and the health status in general) are similar to those experienced by opiate users, which is mainly associated with injecting drug use. Dental difficulties were mentioned repeatedly as problems specific to pervitin users. The development of toxic psychosis, with hallucinations, paranoia, and aggressiveness, is considered the most serious health complication of pervitin dependency and compromises the treatment prospects.

As for treatment and treatment procedures and rules, it was consistently reported across all the types of the services that there are no specific rules, procedures, standards, or even special programmes designed for pervitin users and addicts. It was frequently stated that, in principle, the treatment of pervitin users does not differ from that of users of other addictive substances, with the exception of pharmacotherapy. It was pointed out that every client should be treated on an equal and individual basis, the client’s demands and needs should play a crucial role, individual objectives, plans, and treatment contracts should be developed, and a rapport between the client and the therapist should be established and maintained.

On initial contact, communication with pervitin users is usually difficult. The first contact is often associated with a crisis and the provision of crisis intervention. A specific problem with pervitin users is their lack of insight into their problem and a lack of motivation to change. The success rate of treatment for both groups is perceived as comparable. However, some of the respondents suggested that the success rate of treatment in people dependent on pervitin is higher. The impact and significance of the stabilisation of opiate users in a substitution programme, which is not available for pervitin users, were often mentioned. It was also noted that pervitin users are more likely to leave treatment soon after admission and the first few appointments. If they remain in treatment, however, their success rate is high (“pervitin users tend to fail treatment at the very beginning, while heroin addicts are retained in treatment by substitution therapy”).

The professionals did not find significant differences between opiate and pervitin users in terms of trust. Pervitin users tend to be less reliable in keeping appointments. As a result, the initial stage of treatment tends to involve a higher frequency of attendance and contacts with the client. The low-threshold centres’ staff expressed the opinion that clients using pervitin are less likely to enter individual motivational counselling and have fewer treatment referrals.

Given pervitin users’ relatively low age, issues such as their relationships with their parents and other family members, as well as their separation from their original family, are often brought up during treatment. Therefore, when treating pervitin users, it is more common to work with the entire family as part of family therapy. Younger pervitin users often make contact with treatment facilities in response to the pressure exerted on them by their family members and, accordingly, their retention rate is low. The treatment process is then extended to the family as a whole. When they are older, pervitin users coming to drug services already have a perspective on their problems, but often also have a dependency on other substances. However, older pervitin users’ conditions are often complicated by psychotic symptomatology, which worsens the prognosis. On a standard basis, psychotic conditions are dealt with by pharmacotherapy in inpatient psychiatric/AT facilities.

The detox department staff reported that pervitin users are very often referred to them involuntarily (for example, brought by the police) in a state of acute toxic psychosis, which is typically accompanied by aggressiveness towards both themselves and their environment. In view of their acute psychotic condition, patients often need to be restrained in movement, communication with them is difficult, and they usually reject any care.

In the setting of inpatient psychiatric care provided in addiction treatment departments, pervitin users are not separated. They are assigned to the same treatment regimen and programme as the other patients, but, again, an individual approach to patients/clients is emphasised. The principles and procedures of the treatment, apart from the previously mentioned pharmacotherapy, are basically identical. The more problematic treatment of the withdrawal syndrome and detoxification was mentioned in relation to opiate users. Pervitin users show more difficulties in participating in a therapeutic group because of their interpersonal touchiness; more caution is exercised in building a therapeutic relationship. It was suggested that in recent years pervitin users have been more likely to seek inpatient treatment than opiate users (which may correlate with the higher availability of outpatient substitution treatment for opiate users). There seem to be no significant differences between drug users as far as the duration of their hospitalisation is concerned.

Specific aspects of pharmacotherapy applied to people dependent on pervitin were noted, but, again, it has been underlined several times that the treatment of any psychiatric co-morbidity in users of various psychoactive substances is usually similar and an individual procedure needs to be followed, according to the condition of the

patient under consideration. As regards pervitin users, the administration of diazepam to respond to (fading) intoxication was mentioned repeatedly. Additionally, treatment with mood stabilisers (such as lamotrigine), antidepressants, and anxiolytics (including bupropion, trazodon, SSRIs, and SSREs) was often reported. Atypical antipsychotics (such as risperidon, olanzapin, and melperon) are administered in response to the development of psychotic symptomatology. In comparison, substitution preparations are regularly administered or prescribed to opiate users during detoxification or maintenance treatment. More frequent treatment using spasmolytics, anticonvulsants, hypnotics, and benzodiazepines (as a short-term alternative to substitution opioids) was mentioned with reference to opiates.

The therapeutic approach known as contingency management has not been introduced in the Czech Republic (thus far). One of the questions included in the survey among psychiatrists/alcohol and drug specialists inquired about their opinions on this type of treatment and any motivational tools which could be utilised with pervitin users. It was often stated that drug users should not receive any material rewards for treatment. In fact, some respondents found the question about rewards absurd. The psychiatrists suggested repeatedly that good-quality treatment and the patient's opportunity to improve their situation and grow personally should be viewed as rewards in themselves. Still, some psychiatrists referred to material rewards as a possible incentive; out of the given alternatives, goods vouchers or goods were mostly identified as appropriate tokens, but *not* money. Other suggested rewards included a certificate for the court indicating that the patient is in treatment or their admission to a social reintegration programme, even if they do not have enough financial resources of their own. None of the reported incentives seemed specific to pervitin only.

12.3.2.1 Substitution Treatment of Methamphetamine Dependency

A paper on the oral substitution of pervitin using an amphetamine derivate, methylphenidate (Ritalin[®]), was published in 2004. Ritalin[®] is used in the treatment of attention-deficit hyperactivity disorder (ADHD) in children, obesity, narcolepsy, and treatment-resistant depression. The author of the paper first used methylphenidate for pervitin substitution therapy in 1995. The article includes a case study of a man born in 1972. Prior to methylphenidate being administered, other stimulants had been prescribed for him, including phenmetrazine, dexphenmetrazine (no longer marketed in the Czech Republic), and phentermine (Adipex Retard[®]), an appetite suppressant, by the author of the article. Several lapses occurred during the treatment. The treatment with methylphenidate lasted almost half a year. Six weeks after its completion the client relapsed. At the time the article was published, the patient had abstained from pervitin for two years and become socially reintegrated, although he remained in aftercare for his high level of alcohol consumption. Safe treatment rules were defined: correct assessment, informed consent, a low dosage – 10-20 mg daily, and comprehensive treatment, including psychotherapy, a treatment review, conditions for completion of the treatment, and aftercare. The paper concludes that the use of stimulant medication can lead to abstinence which may even be maintained after the completion of treatment (Hampl, 2004).

The survey among psychiatrists/AT specialists revealed that substitution with methylphenidate is carried out, in indicated cases, by two physicians in the Czech Republic. It was emphasised that positive outcomes require the careful selection of patients. Methylphenidate is administered in daily doses of up to 60 mg. A one-off positive experience with follow-up treatment with bupropion after the discontinuation of methylphenidate was described (Národní monitorovací středisko pro drogy a drogové závislosti, 2009g).

13 Treatment and Care for Older Drug Users

This chapter on a selected issue aims to describe the prevalence, trends, and characteristics of older drug users, both in treatment and outside it, and to describe the services designed specifically for older drug users. An older drug user in the context of this chapter is a drug user of 40 or more years of age.

According to a median variant of the prognosis published by the Czech Statistical Office (Český statistický úřad, 2004), persons over 65 years of age will make up 31% of the population in the Czech Republic in 2050. Demographic ageing of the population has been seen in all developed countries in the recent years, and comes as a result of the declining birth rate and growing mean life expectancy, which in turn stems from today's improved health care and quality of life. Available statistics show that the drug user population in the Czech Republic is also ageing.

The average age of persons in contact with low-threshold facilities is increasing, as is the number of older drug users in treatment; their proportion to the whole population of drug users is still, however, relatively small. Compared to younger drug users, there are more unemployed and homeless people in the 40-plus age group, which also has a greater proportion of drug users with a higher level of education.

The rising average age of problem drug users cannot be explained only by the general ageing of the whole population. In this context, an important role is played by the system of services in the area of the prevention and treatment of addictions, infectious diseases, or overdoses in drug users. At present the Czech drug policy does not respond to the ageing of the drug user population – neither by formulating specific measures, nor by implementing them. There is only one facility in the Czech Republic that specialises in treating older users of non-alcohol drugs. The vast majority of existing programmes are coping with the specific difficulties involved in contact with older clients and the treatment of them on a case-by-case basis. In the Czech Republic there are four old people's homes with a special regime for senior citizens dependent on alcohol.

13.1 Ageing of Problem Drug Users

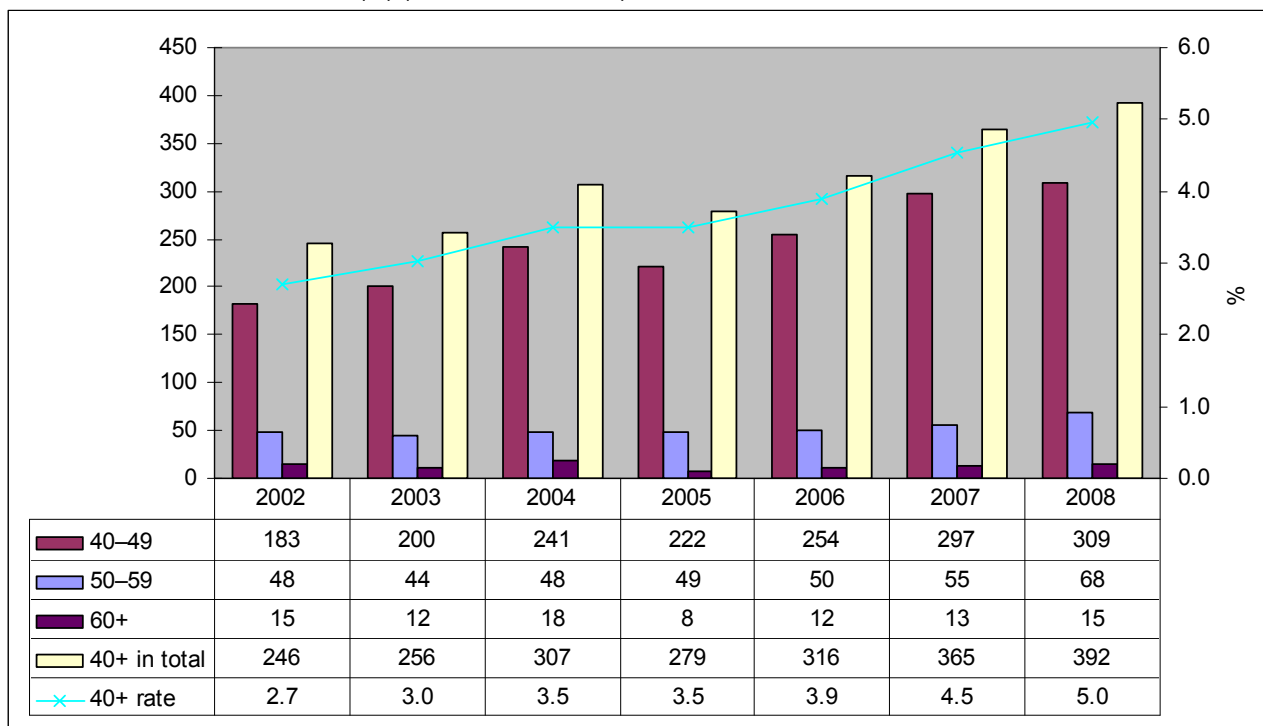
13.1.1 Trends in Ageing of Drug Users in and outside Treatment

The average age of drug users in contact with treatment services has been rising in the Czech Republic. According to data from the final reports of low-threshold facilities, in 2002, the average age of the clients of these facilities was 22, and in 2007 and 2008 it was already 26 years; see also the chapter on Low-Threshold Harm Reduction Programmes, page 68. The average age of people seeking treatment in counselling and treatment centres has also been on the rise; see the chapter on Drug-related Treatment: treatment demand and treatment availability, page 32.

The number of people in the 40-plus age group who are recorded in the Register of Treatment Demands⁷⁷ has increased – in 2002, 240 persons sought the services of treatment facilities; six years later it had increased to 392. That said, the proportion in all treatment demands of drug users who are 40 years old or older has not exceeded 5% in any of the years for which data were collected; see Figure 13-1.

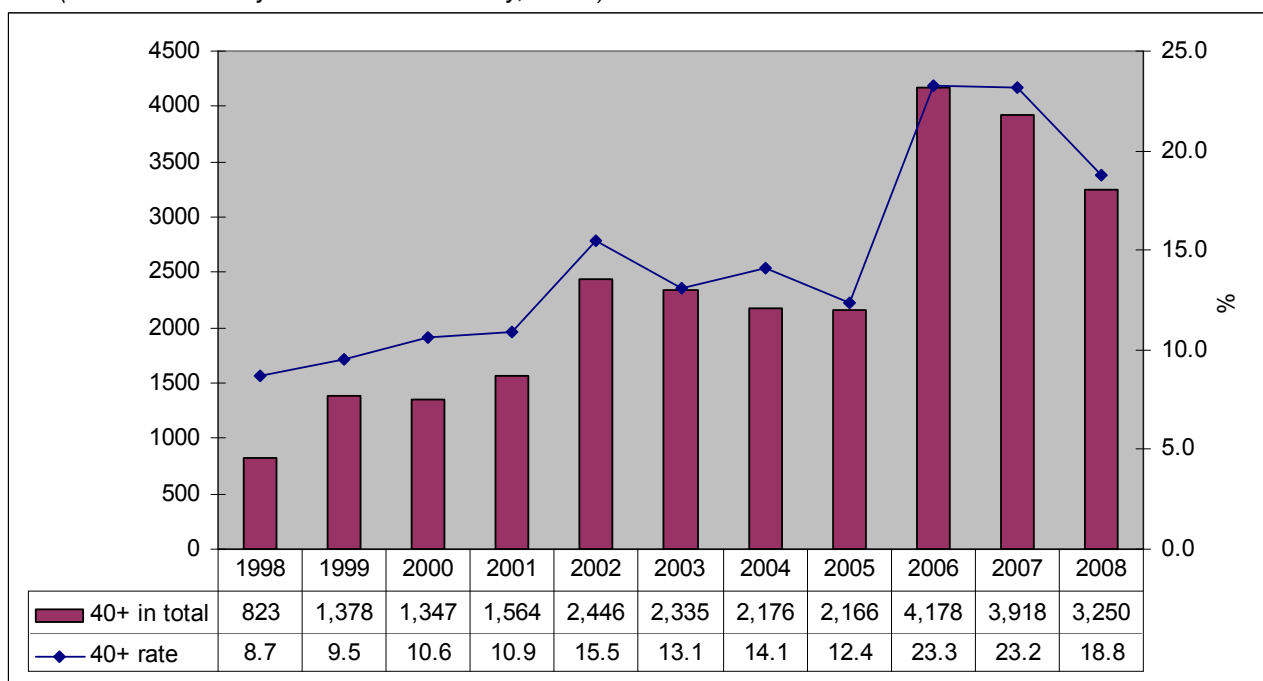
⁷⁷ The Register of Treatment Demands is discussed in Chapter 5 of the Annual Report. Data on all 2008 treatment demands were used to illustrate the trends and characteristics pertaining to the 40+ users in treatment.

Figure 13-1: The numbers and proportion of treatment demands from the 40-or-older age category in relation to all treatment demands in 2002-2008 (%) (Studničková, 2009a)



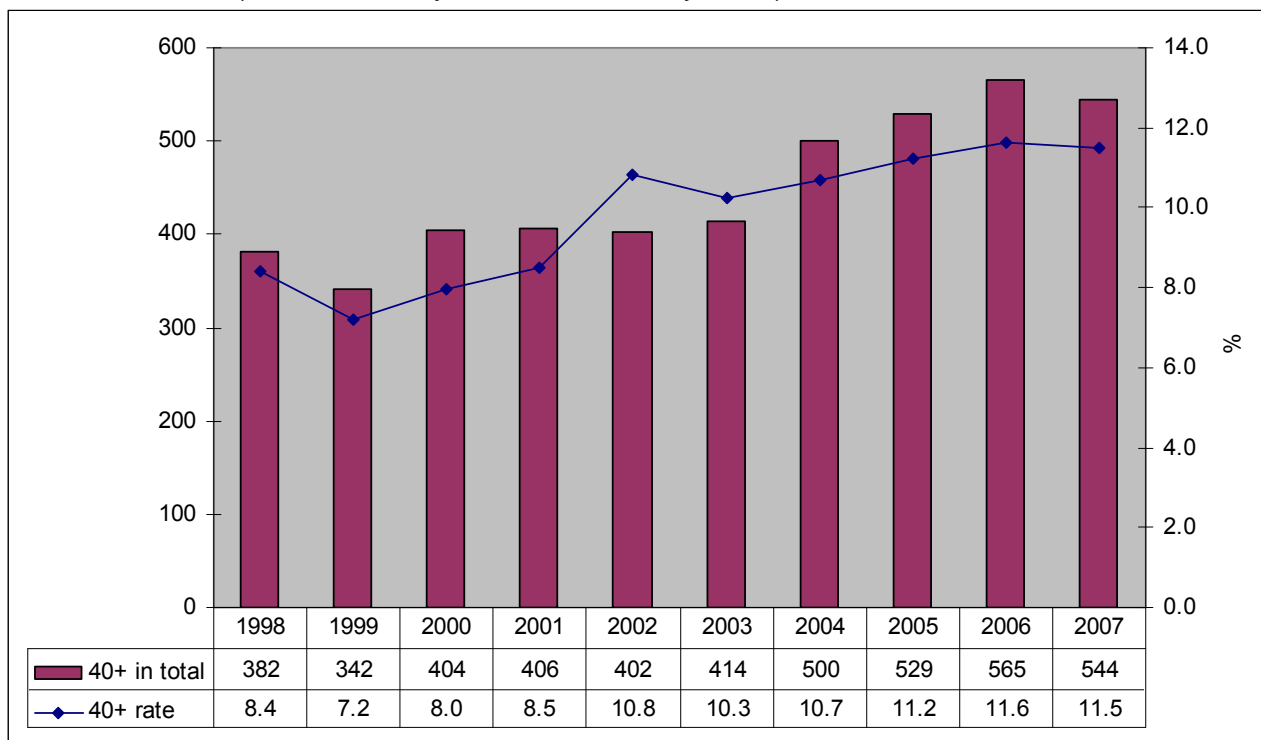
The data available for drug users in outpatient treatment (Ústav zdravotníckých informáci a statistiky, 2009b) also show that there is a trend for the number of people in higher age groups to increase. Whereas in 1998 people in the 40-plus age group made up 9% of the total, by 2008 almost one fifth of all outpatient clients were in this age group; see Figure 13-2; in the period between 2006 and 2008, however, the number and proportion of older clients receiving treatment declined again.

Figure 13-2: The numbers and proportion of drug users in the 40-or-older age category in outpatient treatment in 1998-2008 (Ústav zdravotníckých informáci a statistiky, 2009b)



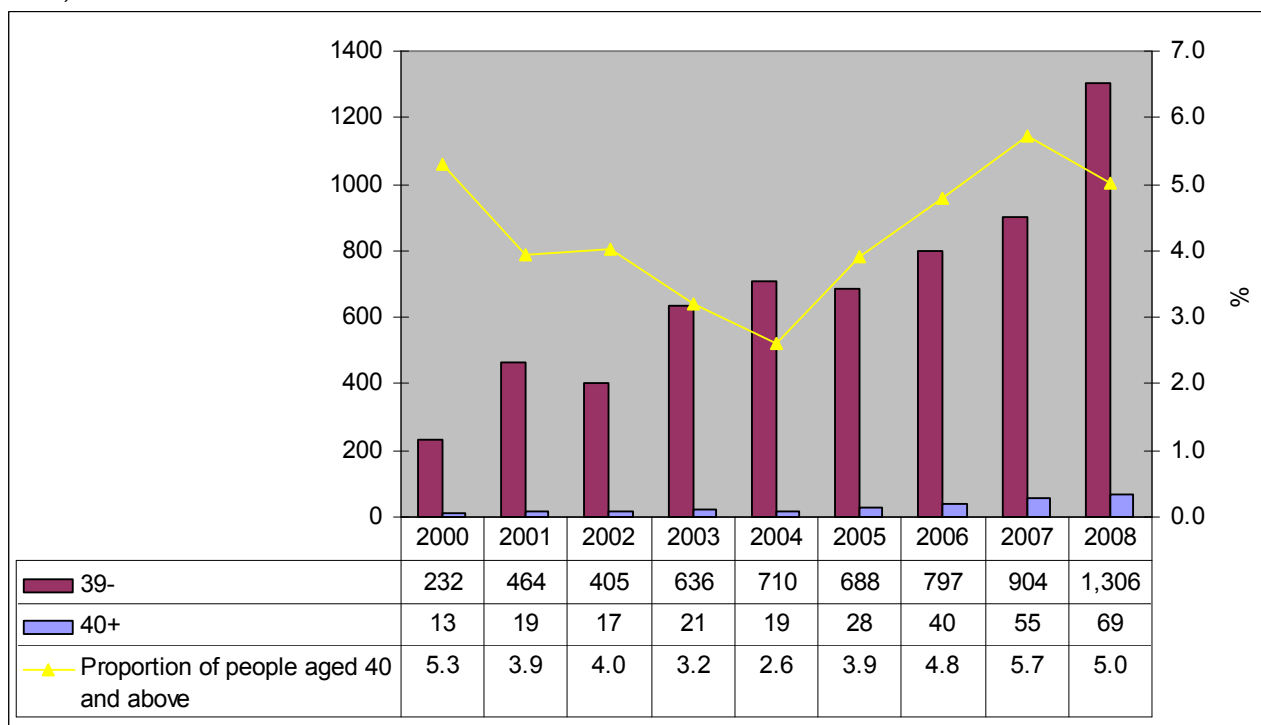
Since 1998, the number of older drug users among patients admitted to inpatient psychiatric facilities (in psychiatric departments of hospitals and in psychiatric hospitals) has been growing; see Figure 13-3.

Figure 13-3: The numbers and proportion of drug users in the 40-or-older age category admitted to inpatient psychiatric facilities in 1998-2007 (Ústav zdravotnických informací a statistiky, 2009b)



The number of older patients receiving substitution treatment and recorded in the National Register of Users of Medically Indicated Substitution Substances (NRULISL Register) has also been rising since 2000; see Figure 13-4. It is, however, evident that the increase in the number of older drug users is related to the generally rising demand for substitution treatment; as concerns substitution treatment, in this area too the 40-plus age group comprises approximately 5% of all the persons treated.

Figure 13-4: The number of patients treated in specialist substitution centres in 2000-2008 by gender, and the proportion of persons aged 40 or older to all patients in substitution treatment (%) (Ústav zdravotnických informací a statistiky, 2009b)



In recent years low-threshold facilities have been collecting data on their clients; the data also provide an insight into the age structure of problem drug users; see Table 13-1. Although in neither study was the selection of participants

made by random sampling – the data were collected from available and willing respondents – the data can still be taken as an indicator of ageing in the drug user population.

Table 13-1: The age of respondents in surveys among the clients of low-threshold facilities in the Czech Republic in 2002-2008 (Mravčík et al. 2009; Větrovec and Porubský, 2008; Národní monitorovací středisko pro drogy a drogové závislosti, 2008c; Sejvl, 2008)

Indicator	2002–2003	2007	2008	2008
Average age	24.6	27.5–28.0	27.8	28.7
Proportion of people aged 40+	4%	n.a.	7%	8%
Number of persons in the study	757	583	677	730
Territorial coverage	National	Prague	National	Prague

Persons in the 40-plus category have traditionally accounted for 10-20% of all fatal overdoses caused by street drugs (illicit substances and inhalants), and for 70% of all fatal overdoses on prescription medications; see Table 13-2. The average age of people who overdosed on street drugs was 30-33 years; men represent approximately 80-90% of the total; for overdoses on prescription medication, the average age was 48-50 years and men accounted for 50-60%; see also the 2007 Annual Report.

Table 13-2: Fatal overdoses drugs in 2003-2008 – the proportion of persons aged 40 or older (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2009)

Substance		2003	2004	2005	2006	2007	2008
Street drugs	Total number of cases	53	56	59	37	40	44
	Proportion of people aged 40+ (%)	22.6	16.1	16.9	21.6	20.0	11.4
Medicines	Total number of cases	167	171	156	170	173	194
	Proportion of people aged 40+ (%)	74.3	71.3	68.6	72.9	68.2	70.6

13.1.2 Factors Related to Ageing and the Increasing Life Expectancy of Drug Users

To date, no study has been undertaken in the Czech Republic which addressed the factors contributing to the ageing of the problem drug user population. However, several studies on the subject are in the pipeline. A qualitative study of long-term drug users is under way, with the working title Toxicomania – the 1970s and 1980s in the Czech Republic. The study will use semi-structured biographical interviews to map out the life stories of a generation of drug users from the 1970s until the mid-1990s. In addition to the contextual focus of problem drug use in Communist Czechoslovakia, the research will also focus on the progress of drug use and the factors that may play a role in sustaining abstinence or survival.

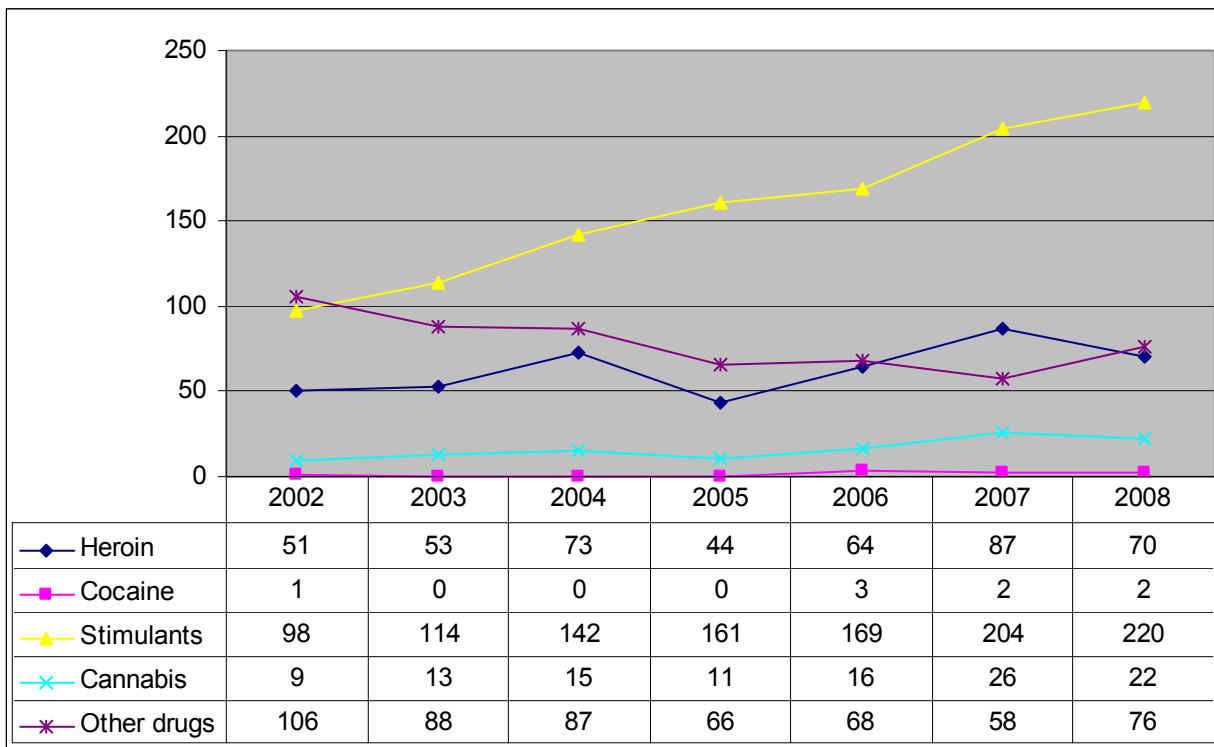
A research study entitled Effective Behavioural Strategies to Prevent Blood-borne and Sexually Transmitted Viral Diseases in the Population of Chronic Injecting Drug Users, which is the Czech branch of the Staying Safe study (Friedman et al. 2008), was registered with the Ministry of Health's Internal Grant Agency as a candidate for a grant in the 2009-2011 cycle. The study aims to establish how chronic drug users had managed to prevent infection or risk factors. The concept of Staying Safe was developed in New York, and the following countries are also presently preparing or implementing a local branch of the research: the United Kingdom, Spain, Australia, Canada, and Argentina.

13.2 Drug Use, Health, and Social Characteristics of Older Drug Users

A study to determine the multiplier of prevalence estimate in 2008 (Národní monitorovací středisko pro drogy a drogové závislosti, 2008c) monitored one or more primary drugs used by the clients of low-threshold facilities, and whether the client applies the drug(s) by injecting. Among persons in the 40-plus age group, a significantly higher number were users of pervitin (80% compared to 68% among younger drug users), and a significantly lower number reported the use of opiates/opioids (17% compared to 25% for heroin; 19% compared to 11% for Subutex®). Both client groups showed no difference in terms of the proportion of injecting drug users.

People on stimulant drugs are much more prevalent among older users, as is attested by data from the Register of Treatment Demands of the Public Health Service (Studničková and Petrášová, 2009; Studničková, 2009a). Figure 13-5 shows that the number of older people treated in connection with stimulants has been rising since 2000, whereas the number of treatment demands in connection with other drugs has remained stable. In 2008, 27% of the drug users in this age bracket sought treatment for opiate addiction (18% heroin and 3% substitution preparations – methadone or Subutex®); in connection with stimulants it was 56% of users; 6% sought treatment in treatment facilities in connection with cannabis. The majority of older drug users seeking treatment (70%) were injecting drug users.

Figure 13-5: The numbers of persons aged 40 or older in treatment by type of drug (Studničková, 2009a)

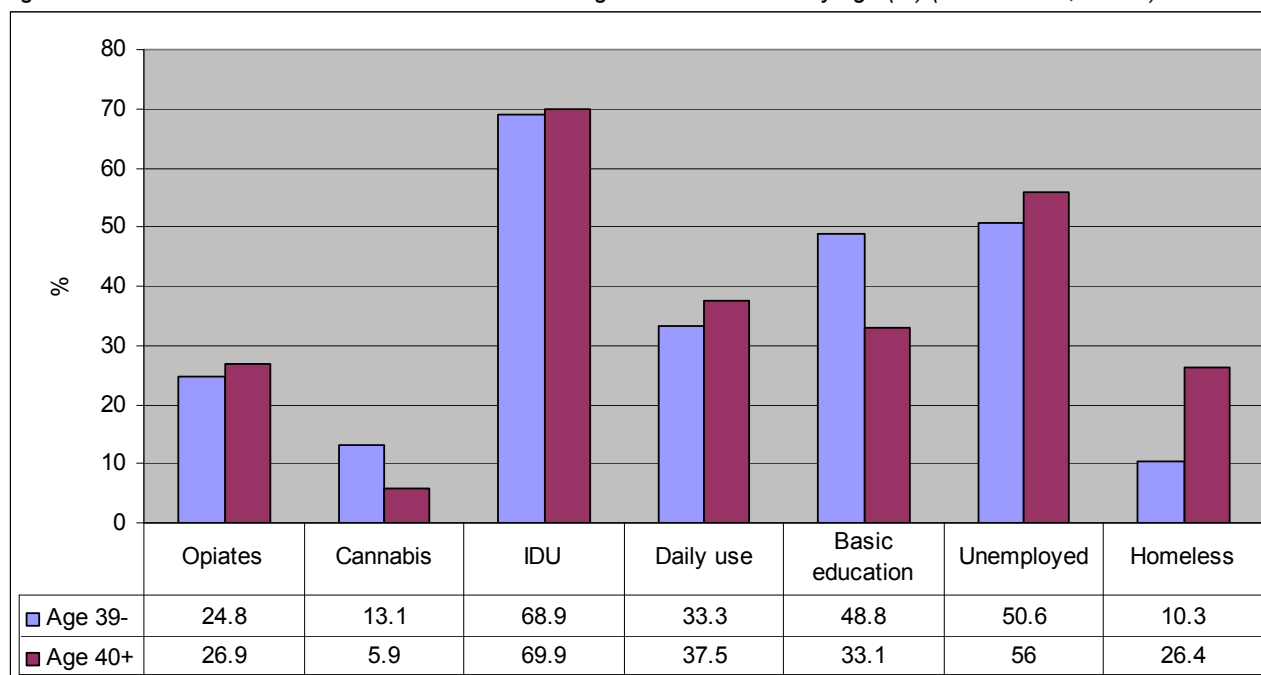


The Register of Treatment Demands also contains data concerning some other characteristics of drug users. A majority of older drug users are people who have sought treatment repeatedly – especially compared to treatment demands from the below-39 age group, where 49% were first treatment demands, while only 32% were first treatment demands among the older drug users. Persons in the 40-plus age group are also more likely to seek treatment themselves (61% compared to 52% in the younger age group).

The vast majority (84%) of older drug users were men. More than one third (35%) of older treatment demands were from people living alone; a little under one fifth (17%) lived with a partner; 14% lived with friends, and 8% lived with their parents. This age group had a higher proportion of homeless people (26%) and a lower proportion of people with stable housing (33%). More than a half (56%) were unemployed. Older drug users tend to have a higher level of education: 33% of drug users in the 40-plus age group completed their elementary education, 47% had graduated from a secondary school or vocational college, and 5% were educated to a higher level. Figure 13-6 compares selected characteristics of older and younger drug users.

The proportion of unemployed people over 40 years of age among patients admitted to psychiatric hospitals has been stable since 1998 at a relatively high 72-80% (Ústav zdravotnických informací a statistiky, 2009b).

Figure 13-6: Selected characteristics of users demanding treatment in 2008 by age (%) (Studničková, 2009a)



13.3 Treatment and Care for Older Drug Users

13.3.1 Policies

On 9 January 2008, the government adopted a resolution, effectively approving the National Programme of Preparation for Ageing for the period 2008-2012 (Quality of Life in Old Age), which provides a follow-up to a similar document for the period 2003-2007 and responds to the challenge of the demographic ageing of the population, outlines the principles for handling issues related to older citizens, and formulates a number of measures. The paper addresses drug policy issues only in terms of the prevention of social exclusion: “Mental health and the quality of social relationships improve the firmness of health, resistance, and adaptability of a human being. Depression increases the risk of alcohol or drug abuse and the risk of self-neglect, and makes coping with the changes brought on by old age more difficult – it is a risk factor of social exclusion.”

The Czech drug policy is currently vested in the 2005-2009 National Strategy and in the 2007-2009 Action Plan. Neither of these documents presupposes the existence of a specific “higher age” group of drug users or formulates goals or tasks concerning older drug users specifically.

13.3.2 Health and Social Responses

Presently only one treatment facility specialises in the treatment of older drug users – it is the Němčice therapeutic community (SANANIM civic association). The average age of the new clients in 2008 was 32 years for men and 31 years for women (SANANIM, o.s. 2009), while the average age of all treatment demands in the Czech Republic in 2008 was 25.9 years (see Figure 5-5 on page 46), and the average age of the clients of therapeutic communities in the Czech Republic in 2008 was 23.8 years (see Table 5-12 on page 52).

The Czech Republic has a special type of social care facility – old people’s homes with a special regime; 4 such facilities are reserved exclusively for senior citizens addicted to alcohol and they do not admit clients addicted to illegal drugs. The existing low-threshold, outpatient, and residential programmes for drug users do not, however, discriminate against potential clients on the basis of age, so they are also open to people over 40 years of age. Unlike other groups of drug users (e.g. women), for which specialised groups or programmes exist in some facilities, older clients are not worked with systematically. Older drug users tend to be treated in regular health care facilities – for their drug use as well as for any other problem stemming from their older age.

In May and June 2009, the National Focal Point – as part of the work on selected issues for this Annual Report – carried out a questionnaire survey seeking to identify the specific features of the treatment of pervitin users and the users of other drugs over 40 years of age. The questionnaire was completed and returned by 15 facilities: 10 outpatient programmes, 2 low-threshold facilities, 2 methadone substitution centres, and one detoxification facility (Národní monitorovací středisko pro drogy a drogové závislosti, 2009e).

The proportion of clients in the 40-plus age group in those programmes that completed the questionnaire ranged between 2 and 25%⁷⁸, while some programmes reported a preponderance of pervitin users, other programmes a preponderance of opiate users. The responses indicate that no specific or non-standard services were supplied to the age group in question. Employees and physicians from outpatient facilities highlighted the point that the treatment was always adjusted to the individual situation of the client, and that the age was not the principal factor.

The greater age of drug users does, however, imply certain specifics which were also mentioned in the questionnaires. Staff of low-threshold facilities are of the view, for instance, that older clients are less distrustful, they use the services more effectively, and that they violate the rules less frequently. As the older clients are often homeless or lacking in terms of social infrastructure, they tend to use mainly the food and hygiene services. Older clients are, on the other hand, less motivated to change – they frequently regard addiction as something immutable and untreatable. Older drug users often do not seek and enrol in treatment; typically, they have attempted treatment on a number of previous occasions. If they were in treatment prior to 1989, or if they were in compulsory treatment, they often do not trust such interventions (Národní monitorovací středisko pro drogy a drogové závislosti, 2009e).

An argument exists that the success of treatment is indirectly proportional to the age of the drug user and the length of the time they have been using drugs: the longer their drug career, the more difficult it is for them to change their lifestyle, user habits, and routines, and the so-called addiction to the needle is more commonplace. The degree of somatic damage (related to the long-term intravenous application of drugs) and social handicaps also grow with age – many older users have served time in prison, which reduces their chances on the labour market; they are often in debt, and they lack hope. Older clients in substitution treatment with methadone more frequently rely on a lifelong course of substitution and they are less able or willing to abstain (Národní monitorovací středisko pro drogy a drogové závislosti, 2009e).

13.3.3 Quality Assurance and Best Practice

Services for drug users that are subsidised from the state budget are subject to certification for the professional competency of drug services, and they must also meet the criteria of the professional competency standard; for more see the chapter Drug Policy: legislation, strategies, and economic analysis, page 5. The general part of the standard stipulates, among other things, that in access to services, the client/patient must not be discriminated against on the basis of age. The standards are formulated without any reference to client characteristics and they do not address any particulars of caring for older users and senior citizens.

⁷⁸ The A-Klub low-threshold centre was an exception, with 70% of its clients all battling alcohol addiction. The results from this facility were excluded from the survey summary.

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SELECTED DRUG-RELATED WEB PAGES ON THE CZECH INTERNET

The following list provides selected official websites of key institutions concerned with drug-related issues. An exhaustive list of helping organisations is provided in the Help Map application available at drogy-info.cz.

Adiktologie – odborný časopis pro prevenci, léčbu a výzkum závislostí (Addictology – a professional journal for the prevention and treatment of and research into addiction): <http://www.adiktologie.cz/Casopis-Adiktologie.html>

A.N.O. – Asociace nestátních organizací zabývajících se prevencí a léčbou drogových závislostí (Association of NGOs Concerned with the Prevention and Treatment of Drug Addiction): <http://www.asociace.org/>

An application used to register drug-related services and their clients: <http://www.drogovesluzby.cz>

Celní správa ČR (Customs Administration of the Czech Republic): <http://www.cs.mfcr.cz/>

Centrum adiktologie Psychiatrické kliniky 1. LF UK a VFN v Praze (Centre for Addictology, Psychiatric Clinic, 1st Faculty of Medicine, Charles University, and General University Hospital, Prague): <http://www.adiktologie.cz/>

Centrum pro výzkum veřejného mínění – Sociologický ústav AV ČR (Public Opinion Poll Centre – Institute of Sociology of the Academy of Science of the Czech Republic): <http://www.cvvm.cas.cz/>

Česká asociace streetwork (Czech Outreach Work Association): <http://www.streetwork.cz/>

Česká lékařská společnost JEP (Czech Medical Association of J. E. Purkyně): <http://www.cls.cz/>

Česká neuropsychofarmakologická společnost (Czech Neuropsychopharmacological Society): <http://www.cnps.cz/>

Český statistický úřad (Czech Statistical Office): <http://www.czso.cz/>

Database of social prevention services: <https://www.sluzbyprevence.mpsv.cz/>

Drug information server (administered by SANANIM, a civic association): <http://www.drogy.net/>

Drug counselling service (administered by SANANIM, a civic association): <http://www.drogovaporadna.cz/>

EXTC – web counselling – prevention of synthetic drug abuse: <http://www.extc.cz/>

UN Information Centre in Prague: <http://www.osn.cz/>

Primary prevention information portal (administered by SANANIM, a civic association): <http://www.odrogach.cz/>

“Safer Party” initiative: <http://www.saferparty.cz>

Institut pedagogicko-psychologického poradenství (Institute for Pedagogical and Psychological Counselling): <http://www.ippp.cz/>

Institut pro kriminologii a sociální prevenci (Institute for Criminology and Social Prevention): <http://www.ok.cz/iksp/>

Ministerstvo spravedlnosti (Ministry of Justice – portal of Czech judiciary): <http://portal.justice.cz/>

Ministerstvo práce a sociálních věcí (Ministry of Labour and Social Affairs): <http://www.mpsv.cz/>

Ministerstvo školství, mládeže a tělovýchovy (Ministry of Education, Youth, and Physical Education): <http://www.msmt.cz/>

Ministerstvo vnitra (Ministry of the Interior): <http://www.mvcr.cz/>

Ministerstvo zdravotnictví (Ministry of Health): <http://www.mzcr.cz/>

Národní monitorovací středisko pro drogy a drogové závislosti (National Monitoring Centre for Drugs and Drug Addiction – National Focal Point): <http://www.drogy-info.cz/>

Národní program řešení problematiky HIV/AIDS (National HIV/AIDS Programme): <http://www.mzcr.cz/Verejne/Pages/133-narodni-program-reseni-problematiky-hiv-aids.html>; Národní program boje proti AIDS ČR (National Programme for Combating AIDS in the Czech Republic): <http://www.aids-hiv.cz/>

Národní protidrogová centrála Služby kriminální policie a vyšetřování, Policie ČR (Police National Drug Headquarters): <http://www.policie.cz/clanek/narodni-protidrogova-centrala-skpv-prezentace-utvaru.aspx>

Poslanecká sněmovna Parlamentu ČR, Výbor pro zdravotnictví, Podvýbor pro problematiku civilizačních onemocnění a závislostí (Chamber of Deputies of the Parliament of the Czech Republic, Health Committee – Subcommittee for Drugs and Addiction Issues): <http://www.psp.cz/sqw/snem.sqw?id=779>

Probační a mediální služba ČR (Probation and Mediation Service of the Czech Republic): <http://www.pmscr.cz/>

Psychiatrické centrum Praha (Prague Psychiatric Centre): <http://www.pcp.lf3.cuni.cz/pcpout/>

Rada vlády pro koordinaci protidrogové politiky (Government Council for Drug Policy Coordination): <http://rvkpp.vlada.cz>

Register of social service providers: <http://www.mpsv.cz/cs/3880>

Sekce terapeutických komunit A.N.O. (Therapeutic Communities Section, Association of NGOs): <http://www.terapeutickekomunity.org/>

Státní zdravotní ústav (National Institute of Public Health): <http://www.szu.cz/>

Ústav farmakologie 3. LF UK – neuropsychofarmakologie a prevence drogových závislostí (Institute of Pharmacology of the 3rd Medical Faculty of Charles University in Prague – Neuropsychopharmacology and Prevention of Drug Addiction): <http://www.lf3.cuni.cz/drogy/>

Ústav zdravotnických informací a statistiky (Institute of Health Information and Statistics of the Czech Republic): <http://www.uzis.cz/>

Vězeňská služba ČR (Prison Service of the Czech Republic): <http://www.vscr.cz/>

Výzkumný ústav práce a sociálních věcí (Research Institute of Labour and Social Affairs): <http://www.vupsv.cz/>

ABBREVIATIONS

2005–2006 Action Plan – Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2005 to 2006

2007–2009 Action Plan – Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2007 to 2009

2005–2009 National Strategy – National Drug Policy Strategy for the Period 2005-2009

ADHD – Attention Deficit Hyperactivity Disorder

Annual Report – Annual Report: The Czech Republic – Drug Situation

AT – Alcohol – Toxicomania (AT clinic – a name for an outpatient medical facility dealing with addiction treatment)

Centre for Addictology - Centre for Addictology at the Psychiatric Clinic of the 1st Medical Faculty and General Teaching Hospital in Prague

CS 2008 – General population survey on the use of psychotropic substances in the Czech Republic in 2008

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

ESPAD– European School Survey on Alcohol and Other Drugs

EU – European Union

GCDPC – Government Council for Drug Policy Coordination

HAV – hepatitis A virus, viral hepatitis A

HBV – hepatitis B virus, viral hepatitis B

HCV – hepatitis C virus, viral hepatitis C

ICD-10 – International Classification of Diseases, 10th Revision

IDU(s) – injecting drug user(s)

NFP – National Focal Point (Czech National Monitoring Centre for Drugs and Drug Addiction)

NGO(s) – non-governmental organisation(s)

PMS – Probation and Mediation Service of the Czech Republic

WHO – World Health Organisation

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