



European Monitoring Centre
for Drugs and Drug Addiction

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THE STATE OF THE DRUGS PROBLEM
IN THE ACCEDING AND CANDIDATE
COUNTRIES TO THE EUROPEAN UNION



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for Drugs and Drug Addiction

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Foreword

The enlargement of the European Union next year means that this is the last time that the EMCDDA will produce an annual report exclusively devoted to the drugs phenomenon in the acceding and candidate countries. It is appropriate, therefore, to take this opportunity to reflect on the historical evolution of the drug phenomenon in these countries and, at the same time, focus in detail on some of the key issues facing the region.

In terms of an effective response to the drugs problem, the enlargement of the European Union presents us with both challenges and opportunities. So far we have heard more about the potential problems that we may face rather than the benefits that can accrue from closer collaboration. In this report we seek to redress this imbalance. We cannot ignore the concerns of those who fear that an increase in drug trafficking from and through the central and east European countries will result from relaxation of border restrictions and greater free movement of goods and individuals. Nor can we ignore the concerns expressed by some new Member States that greater integration will result in escalating drug use among young people in communities in which drug problems were previously rare. We recognise, however, that both drug trafficking and the diffusion of drug use are independent of enlargement. Increasingly, drug problems have shown the ability to transcend national borders and, accordingly, the issue has become a global one to which no country is immune. EU enlargement provides us with the opportunity to work more closely together to understand and respond to this shared problem, based on a sound analysis of its nature and a developing understanding of what is likely to constitute effective action. This is the positive message that emerges from this report and is also reflected in the accompanying annual report on the drugs situation in the EU and Norway.

This review of key aspects of the drug situation leads us to a number of important conclusions. Central to these is that reliable and relevant information is essential for underpinning the new drug strategies and policies that are under development in all acceding and candidate countries. This need is not currently reflected in capacity, and all countries covered by this report need to invest in

developing the surveillance and reporting systems necessary for a sound understanding of the phenomenon and for tracking its evolution over time. In a region undergoing such rapid change, the early detection of new trends and emerging problems is likely to be of particular importance, as is reacting quickly when new problems are identified. The importance of this message is made clear from a reading of the sections of this document that address the potential for future HIV epidemics in many of the countries under review.

Monitoring is important as it allows us to target our actions and evaluate their impact. However, it is of little value if it does not result in effective programmes and well-developed interventions. It is therefore critically important that as responses are developed they benefit from the work already done in identifying what constitutes best practice. At European level, this is part of the rationale for the existence of the EMCDDA and the Reitox network. The national focal points, together with other centres at regional and local level, play a key role in this process by collecting and synthesising the information needed for sound policy development. This reminds us again that adequate and sustained investment in the human infrastructure is necessary for generating and disseminating information.

In reading this report, you may be struck by the thought that in many areas the potential for the future development of serious and destructive drug problems is acute. Drug problems complicate and thrive on other social ills, and communities undergoing social change may be particularly vulnerable. This document illuminates these issues, and the charting of the evolution of the drug phenomenon in the region is perhaps one of the strongest aspects of this report. However, we also hope that the reader reaches a positive conclusion regarding the potential for the acceding and candidate countries to play a full part in a concerted and coordinated response to the European drugs problem.

Marcel Reimen

Chairman, EMCDDA Management Board

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Note

The 10 countries acceding to the EU in 2004 are the Czech Republic, Cyprus, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. They are sometimes also referred to as the new Member States.

The three candidate countries aiming to join the EU are Bulgaria, Romania and Turkey (the first two are working towards the objective of joining in 2007).

For the purpose of this report, the central and east European countries (CEECs) are Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia.

An online version of this report is available (<http://candidates.emcdda.eu.int>) which provides links to data sources, national reports and background documents.



Introduction

In 2004, the European Union will enlarge to 25 Member States ⁽¹⁾ with a prospect of a further expansion to 28 members in 2007 ⁽²⁾. The EMCDDA, with the support of the Phare programme of the European Commission, has been working with the acceding and candidate central and east European countries (CEECs) ⁽³⁾ to build up a more comprehensive picture of the drug phenomenon in the region and also to prepare the CEECs for integration into the EMCDDA European reporting structures. This report marks the end of this preparatory phase of work and, in the future, data from these countries will form part of the overall picture of drug use in the European Union. It is therefore appropriate to take this opportunity to reflect on what has been learnt about the drug problem in the new Member States, to look in detail at some of the key issues, and to consider some of the likely challenges that will face us in the future, in terms of both developing information systems and responding to drug problems. To this end, this report from the EMCDDA is structured around four specially commissioned reviews prepared by experts with detailed knowledge of the field and supported by information collected as part of the technical cooperation between the Centre and the acceding countries. The report also makes use of the information available to the EMCDDA through the 2002 national reports on the drug situation produced by national drug information focal points (NFPs). Where possible, data from Cyprus, Malta and Turkey are also provided.

Chapter 1 provides a historical and global overview of how the drug situation and responses to drug problems developed in the 1990s and early 2000s. This analysis is placed in the broader contextual framework of the political, economic and social changes that were occurring during this period in central and eastern Europe. The emphasis is on drug demand and its reduction and the implications for the wider public health and social policy framework. The chapter concludes by identifying some of the key challenges that are likely to face candidate and acceding countries in

the region as they respond to more developed and entrenched drug problems.

Drug use in central and eastern Europe is very much a phenomenon of the young, and in public health terms has to be seen also in the context of changing patterns of alcohol consumption, a drug that has always had a significant health impact in many countries in the region. Patterns of drug use have to some extent been adopted by young people as part of a broader development of youth culture, music and fashion. These issues are explored in Chapter 2, which looks in detail at what is known about the changing picture of drug and alcohol use among the young and also mirrors a similar focus piece in the accompanying EMCDDA annual report on the state of the drugs problem in the European Union and Norway.

Although the prevalence of human immunodeficiency virus (HIV) infection is low in most of the acceding and candidate countries, a number of factors suggest that the potential for serious future problems remains considerable. This conclusion is reinforced by the recent and sudden increases in HIV infection in the Baltic States and their neighbouring countries to the east. Hepatitis C infection among drug users is also likely to result in considerable long-term public health costs. The increasing numbers of drug injectors in the region, together with continuing high-risk behaviours, suggests that strengthening public health measures to prevent the spread of HIV and HCV among this group is a critically important area for public health policy. For this reason the issue of drug-related infectious diseases is the subject of Chapter 3 of this report.

Chapter 4 provides a descriptive review of the main 'instruments' of drug policy in the region, namely laws, strategies and coordination arrangements in the field of drugs. The chapter concludes that the new drug strategies in the candidate countries are comprehensive and oriented towards a global long-term approach; some are also structured to monitor performance.

⁽¹⁾ The 10 countries acceding to the EU in 2004 are the Czech Republic, Cyprus, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. They are sometimes also referred to as the new Member States.

⁽²⁾ The three candidate countries aiming to join the EU are Bulgaria, Romania and Turkey (the first two are working towards the objective of joining in 2007).

⁽³⁾ For the purpose of this report the CEECs are Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia.

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Chapter 1

Overview of the drugs situation in the CEECs — situation and responses

This chapter provides a global overview of the drug situation in the acceding and candidate central and east European countries (CEECs) and their responses over the past 10 to 15 years. The emphasis is on drug demand and its reduction and the implications for the wider public health and social policy framework.

Historical overview

In this section, the evolution of the drugs situation during the 1990s, in the historical context of political, economic and social changes in central and eastern Europe, is described.

Political, economic and social context

Since the break-up of the Soviet Union in 1989, the CEECs have experienced rapid political, economic and social changes. Despite important differences between the countries in the manner, degree and rate of these changes, there are common elements. Centralised, one-party systems have generally been replaced by more decentralised, multiparty structures, often accompanied by devolution of powers to regional and local authorities. In addition, economies have moved towards less regulated market systems, social protection measures have been reduced and many State monopolies have been broken up and privatised. Open borders and convertible currencies have stimulated increased mobility of goods, money and people for both legal and illegal purposes.

These political and economic changes have had important social impacts. Often, unemployment, previously almost unknown in many CEECs, increased suddenly, and living standards for many declined sharply. Although broad economic indicators subsequently improved again, at least in some countries, recovery has been uneven, and long-term social dislocation still poses serious problems in some communities, especially in areas of industrial or agricultural decline. Increases in delinquency, prostitution, organised crime and trafficking in drugs or persons are further indicators of some of the negative consequences of political and economic liberalisation. The changes have also had an important impact upon the perceptions and expectations of young people. Some commentators have referred to a crisis of values and lack of social consensus that was reinforced by mistrust of official structures and institutions and reflected in intergenerational tensions. Although economic changes may have brought many benefits, and while political independence may have instilled a sense of identity and pride, the strains induced by rapid social changes also

engendered uncertainty and a sense of vulnerability among some sections of the community who felt that they were yet to see the benefits of change.

Although the focus here is on the CEECs, their geopolitical position means that any analysis of the situation in these 10 countries must be set in a wider regional context, in particular taking account of developments following the break-up of the former Soviet Union and the consequences of the war in Yugoslavia. These have had, and continue to have, major implications for the CEECs, for example in terms of drug trafficking, organised crime, the position of Russian minorities in some countries and the risks arising from the HIV/AIDS epidemic in Russia and the Ukraine.

Historical evolution of the drug phenomenon

In all CEECs, the most widely used and the most problematic psychoactive substance has been, and continues to be, alcohol. Long-term trends over the past four decades show large increases in consumption, especially of spirits. More recent trends vary, with alcohol use tending to stabilise in some, but increasing in most, countries, particularly among young people, and especially among young women. In addition to the influence of domestic social and economic factors on alcohol use, since 1989 marketing has played an increasingly important role in shaping patterns of both alcohol and tobacco consumption. At the same time, the importance attached to alcohol problems in both the public and political discourse that was apparent in the years prior to 1989 has diminished, despite increased consumption and the serious individual and social costs of alcoholism.

Reliable data on the historical development of drug use are scarce, as in the past official attitudes often reflected a reluctance to acknowledge the existence of drug use, with the result that little social research took place (although there was some medico-biological research and official registers of known users were maintained). Despite this, it is possible to describe the general historical evolution of the drug phenomenon.

In most of the CEECs, this evolution began before the dramatic political landmark of 1989. For example, drug

use among groups of young people was noted in several countries in the late 1960s, reflecting, albeit on a smaller scale, what was happening in western countries. Patterns of use, however, were usually quite different from those seen in western European countries at the time — for example, the use of cannabis, LSD, heroin and cocaine was rarely reported, although there were exceptions.

During the 1970s and 1980s, various patterns of drug use developed, although the extent of use is not clear. The drugs involved were largely domestically manufactured pharmaceutical products such as medicines containing codeine or morphine derivatives, barbiturates, benzodiazepines or other sedative-type drugs, e.g. glutethimide, anti-Parkinsonian drugs or central nervous system stimulants. Often, these medicines were combined with alcohol. And in some countries, such as the Baltic States, Bulgaria, Hungary and Poland, traditional use of locally grown drugs such as opium poppy preparations continued. In other countries, for example Czechoslovakia, Hungary and Romania, solvent misuse was reported, mostly among adolescents. Although cannabis grows in several countries, it is not clear if and how widely it was used during the 1970s and 1980s.

From the end of the 1970s, changes were observed in some countries, including increases in (non-medical) drug injecting. In Poland, the use of home-made 'Polish heroin' or 'kompot' emerged among young people, and the number of addicts in Warsaw and some other cities grew rapidly during the early 1980s before appearing to stabilise. In Czechoslovakia (mainly the Czech part), the use of illicitly manufactured opiates ('Braun') and methylamphetamine ('Pervitin') expanded over the course of the 1980s, while in Hungary there were reports of the use of 'poppy tea' by young people, and also of increasing use of glutethimide and codeine. The use of cannabis, as well as of heroin, increased in parts of Yugoslavia in the early 1980s, probably partly because of its position on the 'Balkan' heroin route and partly because of its open borders and relatively extensive contact with western countries. In view of the tourist trade and its proximity to Italy, it is likely that this phenomenon was also taking place on the Adriatic coast, including in Slovenia.

These changes were in part influenced by the changes in youth culture, which included the emergence of the drug phenomenon, that were occurring in the late 1960s and early 1970s in western countries. Thus, the student protests of 1968 were echoed in some east European cities, and demand for 'forbidden' cultural commodities enjoyed by young people in the west (rock music, denim jeans, long hair) entered into the consciousness of a new, youthful

eneration. There was a time-lag before patterns of drug use reflected this shift, partly because it takes time for new ideas to diffuse and become established and manifest in visible changes, especially when the cultural gap perpetuated through 'cold war' rhetoric appeared so wide, and partly because authoritarian structures and strict border controls slowed both the expression of those ideas and the development of new markets. Thus, there was a disjunction between the official, mainstream discourse and the largely hidden but slowly developing perceptions and aspirations of sections of the population, especially the young.

The existence of drug use and drug problems was officially denied or played down in many countries, especially to the outside world and to the general public. As a result, little public information was available and there was little discussion on the subject; the concept of drug use as a social phenomenon barely existed. There were, however, quite sophisticated regulatory and control mechanisms in place, including registration and monitoring systems maintained through police/psychiatric collaboration. This was especially marked in countries whose systems more closely resembled that of the Soviet Union. Treatment models were based on medico-biological theories of alcoholism, and drug addicts and drug users were usually registered and treated (often compulsorily) in the same in-patient psychiatric hospitals or narcology clinics as alcoholics. Other than this, in most countries there were very few services for drug users, and little in the way of specific policies regarding drugs and drug-related problems other than repression and institutionalisation. Sociological models were strongly influenced by social-pathological perspectives according to which drug use and dependence were seen as 'external' phenomena associated with the 'decadence' of western countries.

These constellations of historical factors constituted substantial barriers to change and left most countries totally unprepared to deal with the new patterns of drug use that started to emerge among the younger generations. Thus, the need for prevention was rarely recognised, the level of knowledge and awareness among both professionals and the general population, young and old alike, was very low, the concept of social processes such as youth subcultures in conflict with mainstream social values was not comprehensible (other than, perhaps, as a perverted form of political dissent), the stigma associated with drug taking was probably even more pronounced than in many western countries, the treatment system was perceived as repressive, coercive and something to be feared, and the involvement of civil society and opportunities for non-governmental activity were minimal.

During the 1980s, this situation slowly started to change in some countries, for example Czechoslovakia, Hungary, Poland and Slovenia. This was probably in part because these countries were (relatively) more developed, both in economic terms and in terms of greater cultural and political independence from the Soviet system. For example, the late 1980s saw increased references to drugs in films and music. Also, professionals from these countries enjoyed greater contact with colleagues in the international arena, thus opening the way towards recognition and analysis of the emerging drugs phenomenon from a different perspective. The first formal policy response to the emerging drug phenomenon occurred in Poland (in the form of the 1985 law on drug abuse prevention, which helped to stimulate prevention and treatment services, including those supplied by non-governmental organisations), and prevention programmes were instituted in some other countries, such as Hungary. In general, however, significant developments in policy did not take place until the 1990s.

Key themes from the 1990s

The main developments in the drug situation and responses over the 1990s are described later in this chapter. Several key themes can be identified that were of particular relevance to these developments and to future challenges.

Information, drug monitoring and research

The lack of reliable data, in the context of uncertainty and anxiety about what to do in an apparently rapidly changing situation, meant that the scale and nature of drug phenomena were either exaggerated or denied. Further, the lack of a conceptual framework for making sense of the data that did exist meant that these changes were often misunderstood. For example, in the early 1990s, confusion about the significance of drug seizure indicators led to the interpretation that interceptions of large quantities of heroin, cocaine or cannabis on the trafficking routes through the Balkans and up to western Europe reflected increased consumption of those drugs in the countries concerned. While trafficking routes can pose a risk in terms of spillage into, and stimulation of, local markets, the principal patterns of domestic consumption were at the time still dominated by pre-existing drug use patterns. The result was that attention was mainly focused on external factors (repressing the traffic) rather than on analysing and responding to actual patterns of consumption and internal factors (such as the social situation and the expectations and perceptions of young people) that were stimulating demand.

Data collection, monitoring and research developed throughout the 1990s, initially through a training programme

in epidemiology organised by the Pompidou Group of the Council of Europe and through the participation of many countries in the Pompidou multicity study. The development of epidemiological monitoring systems was subsequently reinforced through the drug information systems (DIS) project, which was part of the Phare multi-beneficiary drugs programme of the European Commission, and now continues under the aegis of the EMCDDA as part of the EU accession process. Many countries also participate in the European school survey project (ESPAD).

In parallel with work on indicators and statistical information systems, a project conducted jointly by the then United Nations drug control programme (UNDCP), now the UNODC, and the Pompidou Group stimulated the development of qualitative research on drug use in the region. The resulting publication, *Nine studies of emerging drug problems* (UNDCP/Pompidou Group, 2001), is a good example of how qualitative research can offer paradigms for analysis and interpretation that help to understand what data mean in a way that is useful for identifying problems and designing relevant interventions.

Privatisation and the impact of market philosophy

The economic changes of the 1990s had a major impact on social protection measures and on the delivery of medical care and treatment. In many countries, various forms of insurance replaced universal State provision, leading to major changes in treatment provision as well as to increases in inequality regarding access to health and social services. Poorer groups, including the newly unemployed, were particularly vulnerable, and this, together with a drop in living standards, led to increases in morbidity and mortality. In a broader sense, increased economic differences, resulting from the emergence of a nouveau riche group in parallel with others experiencing debilitating poverty for the first time, further widened the material and psychological gap between included and excluded sections of the population.

A second area where new market ideologies had an impact on the drug situation was privatisation and deregulation of the pharmaceutical industry, for example in the Czech Republic, Hungary, Latvia, Poland and Slovakia. This led, in the short term at least, to increased diversion of psychoactive medicaments into the non-medical drugs market and, in some cases, to covert manufacture of drugs such as amphetamines in previously State-owned factories. A third effect was that opening of borders and transformation of local currencies into convertible currencies meant that the formerly communist countries became part of the western capitalist economy, with all the elements of free

trade and extended markets that this implied. It is not surprising that illegal drug markets, while retaining some of their local characteristics, also tended to converge and resemble more closely the patterns of supply and demand observed in western countries.

The shift towards a market philosophy was also accompanied by the development of more consumer-oriented and individualistic perspectives, especially among younger and more urban sections of the population. It would be surprising if these changes in consciousness did not play an important role in influencing the evolution of lifestyles and consumption patterns among young people, including consumption of drugs such as cannabis, amphetamines, ecstasy or cocaine, as well as alcohol. It would also be surprising if the use of drugs such as heroin, or cheaper alternatives such as sedatives, solvents and/or combinations of these with alcohol, did not also increase among more vulnerable groups or those who see themselves as marginalised from the wider process of social change.

Finally, one effect of a reduction in the power of the central States was a growth in the non-governmental sector. This process has been uneven — non-governmental organisations (NGOs) evolved earlier and play a more extensive role in the Czech Republic, Hungary, Poland and Slovenia than in other countries — but in all countries NGOs are increasingly seeking to meet needs arising out of newly recognised social phenomena, such as drug use, that State institutions appear to be ill-equipped to tackle.

Tensions in policy-making and coordination

The rapid political and economic changes taking place in central and eastern Europe sparked a variety of power struggles not only at a political level but also within and between administrations and institutions. As drugs had not been seen as an important issue in most countries, the field was not well developed and was often dominated by a small number of individuals or by one institution. Increasing recognition of the drugs phenomenon and exposure to new ideas and concepts, as well as increased possibilities for involvement in European and international projects, attracted new professionals and institutions into the field. This, in turn, often led to both tensions and competition for control and resources between old and new bodies and between national and local organisations, but also between health and control and interdiction-oriented perspectives and, frequently, regarding the underlying philosophical approach to drugs. Thus, it is perhaps not surprising that the development of policies, legislation and coordination mechanisms in the 1990s was a contentious and often faltering process and that it has taken time for stable

structures and mechanisms based on a broad consensus to begin to emerge.

Influence of international interests

In parallel with the internal processes taking place in the CEECs following 1989, the region became the focus of increased attention from a wide range of international organisations and other external interest groups. These included international organisations such as the European Commission, the UNDCP (now the UNODC), the WHO, Unaid, Interpol, the Pompidou Group as well as NGOs such as the Lindesmith Centre of the Open Society Institute, the Nordic Council and the ECAD city network. In addition, the region was the focus of bilateral interventions, usually in the form of aid from national governments, including those of EU Member States and the USA. All these groups brought with them a variety of agendas for the drugs field that were not necessarily compatible. Some were concerned with 'modernising' legislation in line with Western requirements, while others sought to bring alternative ideological concepts of how to respond to drugs. Some were more concerned with organised crime, border control and drug trafficking, while others focused on health and social aspects or on monitoring, research and data collection. Western companies, including those with interests in the tobacco, alcohol and pharmaceutical industries, also saw important opportunities in the newly opened markets. As of 1997, the role of the European Commission shifted from providing technical assistance through the Phare regional programme on drugs towards promoting the Community *acquis* and harmonisation with EU standards as part of the accession process.

Differences between countries

There were, and still are, important differences between the CEECs regarding both the drug situation and their policy developments and responses. These reflect partly national, historical, cultural and institutional developments and partly the balance of external influences (geopolitical, market, impact of international pressures). This makes it difficult to generalise across all the countries, and the broad trends outlined below should be read in conjunction with the more differentiated information presented in subsequent chapters and also in the *2002 report on the drug situation in the candidate CEECs* (EMCDDA, 2002a).

There do appear to be some subregional differences. Independence came later to the Baltic States, and it seems that the development of new drug use patterns and of drug policies and responses is also taking place somewhat later there than in other countries, although there are also important differences between the three countries. In the Balkan subregion, Bulgaria, and even more so Romania,

are economically poorer than their central European neighbours, and structures and responses for dealing with drug problems appear to be less developed. As noted above, the countries of central Europe appear more similar to their western neighbours not only for historical reasons and because of the degree of contact they have enjoyed with the west over the past two decades, but also on account of their level of economic and social development. In most countries, however, drugs, although perceived as a threat, remain a relatively low political priority.

Thematic analysis of situation and responses

This section broadly follows the structure of the EU drug strategy targets. The underlying question for each theme is: How far are developments in responses adequate and appropriate to the situation regarding current trends in drug use and its consequences? Where possible and useful, comparisons are made with the global EU picture. This leads to identification of key challenges for the future.

Drug use, vulnerability, prevention and early intervention

Drug use

Consistent and comparable data on drug use in the general population do not exist for many countries, so it is possible to give only a broad descriptive overview. More data exist for the school population, but these do not cover non-school groups and older youths who have left school. A further limitation is a tendency to report lifetime prevalence as an indicator of trends in drug use, whereas in fact this is a cumulative measure that includes drug use that may have occurred many years ago (see EMCDDA, 2002e). A more appropriate measure of trends in drug use is current or recent use (e.g. last 30 days or last 12 months), but these data are not always available.

Drug use trends and patterns in the general population, especially young people

Trends over the early 1990s were mostly characterised by a continued evolution of pre-existing national and cultural patterns of drug use, with growing indications of the appearance of 'western' drugs (cannabis, heroin, LSD, cocaine) in some countries. For example, in Bulgaria, the Czech Republic, Hungary and Slovakia, the non-medical use of medicaments containing sedative-type compounds (often combined with alcohol) continued to predominate among young people. The use of codeine derivatives increased in the Czech Republic and Hungary, while use of various domestically produced poppy preparations containing opiates became more common in the Baltic States, Bulgaria

and Hungary and, after a pause in the late 1980s, increased again in Poland. The misuse of solvents by marginalised adolescents, street children and Romany children was important in Bulgaria, Romania, the Czech Republic and Slovakia (and also in the last two countries among older youths and students) as well as in Hungary, albeit at a lower level than previously. The use of 'Pervitin' continued to increase in the Czech Republic, and there was also some increase in amphetamine use in Poland and perhaps also in Bulgaria.

Imported heroin started to show up in the early 1990s in Bulgaria and, to a greater extent, in Slovenia (as well as in other parts of the former Yugoslavia), and also in Hungary, the Czech Republic and Slovakia. This accelerated in the mid-1990s in central Europe and Bulgaria, and somewhat later in Romania (although the picture is less clear). In the Baltic States, heroin use did not become significant until the second half of the 1990s, but it then increased rapidly from 1997–98 onwards, replacing domestically produced opiates. In Poland, too, a second 'wave' of new heroin users was seen from 1997 (smoking rather than injecting). By the end of the decade, heroin was the main 'problem drug' in all countries except the Czech Republic, where Pervitin was still predominant.

Cannabis use started to increase among young people in central Europe (Hungary, the Czech Republic, Poland, Slovakia and Slovenia), but in the early 1990s only Slovenia reported relatively high levels of use. The rate of increase rose from the mid-1990s, and by the end of the decade, in some but not all countries, the proportion of young people who had tried cannabis at some point in their life appeared to be approaching that found in many EU Member States. Among younger age groups, ESPAD school surveys found that in most countries both lifetime and last 30 days prevalence of cannabis use by 16-year-old schoolchildren doubled between 1995 and 1999 (Figure 1).

In the early 1990s, use of LSD, amphetamines and occasionally cocaine in nightspots was reported among a small, fashionable crowd. Subsequently, from the mid to the late 1990s, there was some increase among youth groups, especially in cities, of LSD, ecstasy and amphetamine use.

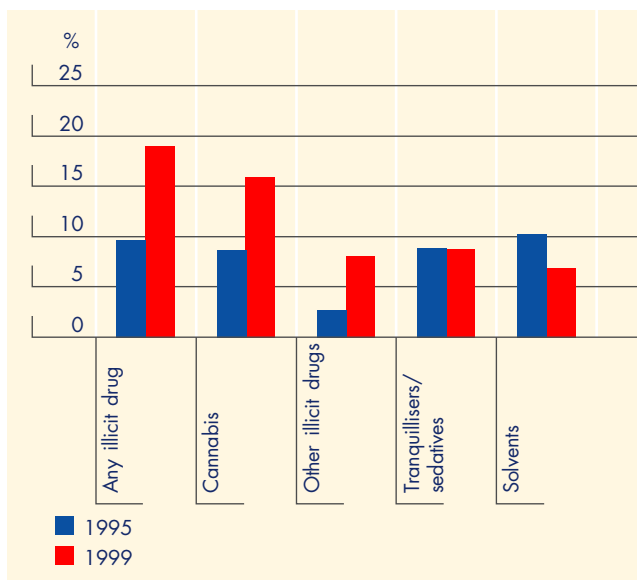
Thus, over the second half of the 1990s, while previous drug use patterns continued, there was evidence of a move towards a western pattern of drug use, notably cannabis use, among a cross-section of young people, of the use of heroin in various groups but increasingly among more marginalised communities, and of the use of so-called 'party drugs' (ecstasy and LSD), primarily among more affluent, city youth; cocaine use was still relatively rare.

Current trends are hard to assess, as very recent data are lacking in most countries. There are tentative indications from some studies that in some countries the increase in drug use may have started to stabilise in the early 2000s, especially in major cities, where prevalence levels are usually several times higher than in rural areas (e.g. in Warsaw as well as in cities in Hungary and the Czech Republic). In other countries, data are rare or only limited

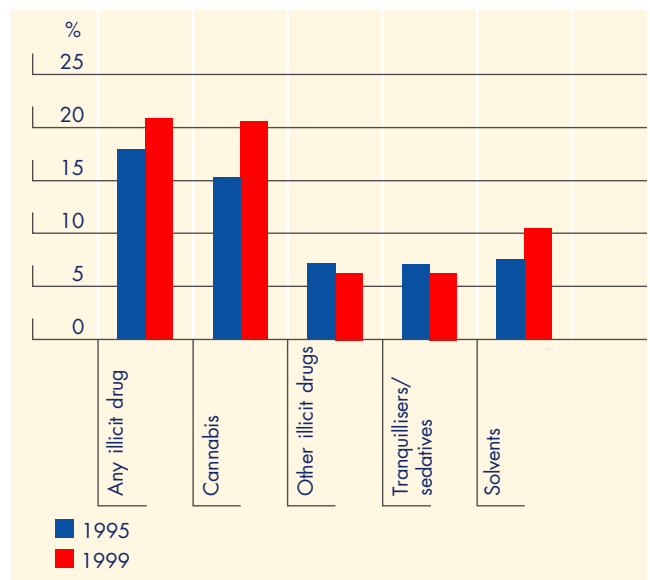
qualitative or impressionistic information suggesting continuing increases is available. In all countries, the pattern of use is dominated by experimental or occasional use, mainly of cannabis. At the same time, these studies suggest an increased intensity of use by those (the minority) who continue to use. In other reports, diffusion of drug use from cities to smaller towns and rural communities is described. The 2003 ESPAD study should help cast light on

Figure 1: Lifetime prevalence of use of cannabis, other illicit drugs, tranquillisers or sedatives among school students aged 15 or 16 years in the CEECs and the EU and Norway, 1995–99 (%)

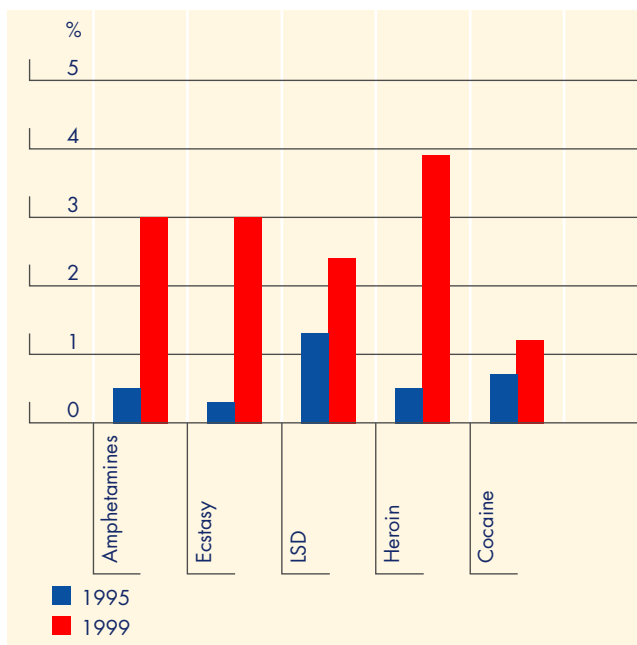
A: Use of cannabis, other illicit drugs, tranquillisers or sedatives and solvents in the CEECs



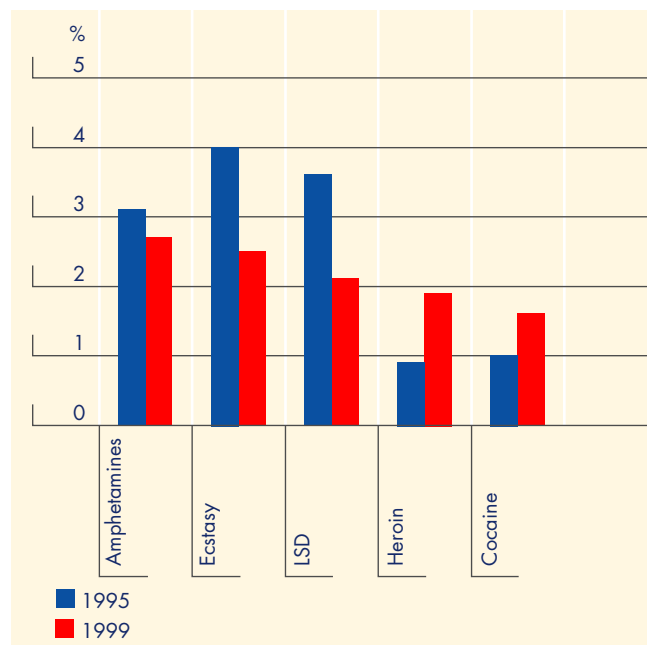
B: Use of cannabis, other illicit drugs, tranquillisers or sedatives and solvents in the EU and Norway



C: Use of amphetamines, ecstasy, LSD, heroin and cocaine in the CEECs



D: Use of amphetamines, ecstasy, LSD, heroin and cocaine in the EU and Norway



Sources: ESPAD school survey project (1995 and 1999).

trends among 16-year-old schoolchildren, although the results will not be available until 2004 and, as noted above, will not reflect trends in older groups of young people, up to the age of 25 or so, in whom drug use prevalence is likely to be higher.

While the convergence of drug use patterns with those seen in western Europe is not surprising, there remain certain aspects that may require specific attention in these countries. These include the continuing high level of use of pharmaceutical drugs (especially sedatives and tranquillisers) for non-medical purposes in some countries and the increased and often high level of use of drugs other than cannabis, especially heroin and/or amphetamines, among young populations in many countries.

Context, risk and vulnerability

It is apparent from the account given above that the changes in drug use observed in the CEECs in the 1990s did not suddenly appear out of the blue but rather were a manifestation of social trends in consciousness and behaviour that were already under way, especially among younger sections of the population, and most particularly in the larger cities. The rapid political and economic changes following 1989 brought new elements that fed into the pattern of youth opportunities, lifestyles and behaviours and helped accelerate the rate of change.

This analysis suggests that the driving forces underlying increases in drug use were predominantly demand related rather than an increased supply of drugs. It is, however, true that the opening up to western markets increased exposure to 'western' substances, including western brands of alcohol and cigarettes, and that over the decade this exposure played an important role in shaping the characteristics of the demand for drugs (and alcohol), which, as a result, has become more similar to the picture found in the current EU countries, especially as regards cannabis, ecstasy, LSD and heroin use. As in any situation, the demand for drugs is influenced by a complex interplay of different elements — pharmacological, individual, social and economic. However, it is important to distinguish factors that influence the level and pattern of drug demand in general from factors associated with increased vulnerability to riskier or potentially problematic patterns of use, as they are often different.

Factors affecting the demand for drugs

A wide range of explanations and risk factors for drug use can be found in the scientific and not so scientific literature. Many of these are not specific to the CEECs, for example, explanations based on the pharmacological properties of different drugs, curiosity, peer pressure or risk-taking are relevant across many situations. The comments below focus

on selected perspectives that may help understand the developments in the demand for drugs in these countries at this point in time.

In many CEECs, drug use increasingly may be coming to be perceived, especially among some sections of urban youth, as normative (drug use as part of modern lifestyles) rather than pathological. The reasons for this are not hard to see — exposure to perceived western ideals and lifestyles, including images of drugs in music, literature and advertising, and increased freedom to express them, may be accompanied by an increased willingness to experiment with drugs. This process is facilitated by increased mobility, travel and tourism, as well as by increased communication through the Internet and by increased commercialisation and the global promotion of youth culture and consumer products such as music, fashion or computer games. Pre-existing patterns of drug use associated with previous lifestyles and recreational activities are also changing in this process but are likely to be adapted and incorporated into new patterns of consumption (especially of alcohol) rather than abandoned altogether.

The rate and nature of social change are also of particular relevance. Such change includes a weakening of traditional social ties, changes in family relationships and in relationships with authority, generational conflict and the search for identity via new associations. This process is not limited to particular groups or strata. Children from socially integrated backgrounds as much as any other react against their parents' generation and values and seek status through the chic and the cool.

Economic factors are also likely to affect the patterns of drug use emerging in this process of change, although local variations and lack of research make generalisations unwise. Thus, the relationship between drug (and alcohol) use and socioeconomic status is not simple. In some settings, use is higher among the integrated, better-off sections of the population, perhaps reflecting higher disposable incomes available for spending on consumption. In other settings, higher levels of use are also found among more marginal or lower-income groups. The availability of drugs also reflects a range of domestic, international and geopolitical factors (see below) and is a further important factor in influencing the pattern of drug use in the countries concerned.

Vulnerability to high-risk drug use

Much drug use, as in western countries, is experimental or of limited duration and intensity. Mostly, it does not result in problems such as dependence, illness or drug-related criminal activity. However, some groups and individuals are more vulnerable. Many factors associated with vulnerability

are not specific to the CEECs, although knowledge of them could be useful in targeting interventions. Examples include individual factors such as depression, high anxiety and mental illness, as well as family circumstances such as rejection, sexual abuse and alcoholism. However, children ignored by parents preoccupied with economic survival or advancement may also be at higher risk, even where there are no overt problems or indications of dysfunction.

Vulnerability factors for high-risk drug use in the CEECs have been accentuated by rapid social and economic change such as a reduction in living standards, industrial decline, increasing unemployment (especially among young people) and limited options for the future. An increase in the rich-poor divide, the consequent gap between expectations and opportunities, the sense of alienation arising from the process of rapid social change and reduced access to health and social care are all likely to increase vulnerability. Marginalisation, social exclusion and stigmatisation appear to be particularly problematic among the Russian-speaking minorities in the Baltic region (Estonia and Latvia), Romany youth across much of central Europe and the Balkans (Bulgaria, the Czech Republic, Hungary, Romania, Slovakia), street children in Romania, poorer groups in all countries with lower education, lack of qualifications and experience of school exclusion, migrants, including those associated with rural-urban shift, and immigrants from the former Soviet States.

Personal or family factors affect the likelihood of high-risk drug use at an individual level, while social and economic processes render some communities or groups more vulnerable than others. The increased availability of drugs such as heroin in conjunction with these factors also plays a role in shaping drug choice and patterns of use, although, as suggested above, availability is not by itself the underlying causal factor. However, a broader question of vulnerability concerns the level of knowledge and awareness about drug use among the population, and especially among young people who are already using cannabis, amphetamines, ecstasy or other drugs in recreational contexts. In western countries, where drugs and drug use have for some time been part of the environment in which young people grow up, a greater awareness of drugs has developed and informal social mechanisms of information dissemination and self-regulation have evolved, especially among groups more involved in drug use. These may help to reduce some of the risks. In parallel, wider society, social institutions and professionals have experience of responding to drug-taking among young people. In contrast, in countries where drugs are a more recent phenomenon, risky patterns of use may be more likely to lead to inappropriate reactions that may inadvertently

increase rather than diminish risks, for example through labelling, stigmatisation or school exclusion.

In summary, in the CEECs four broad groups vulnerable to drug use can be delineated:

- young people in economically depressed areas and marginalised groups whose future options are limited — these groups and communities are most at risk of long-term, structurally embedded patterns of problem drug use;
- children from dysfunctional families regardless of economic status (i.e. including those from socially integrated and affluent backgrounds), especially those whose parents are heavy users of alcohol or prescription drugs or who have other social or behavioural problems, such as being exposed to conflict or rejection;
- young people, including the socially integrated, who are frequent users of various drugs, including alcohol, cannabis, amphetamines and ecstasy, within recreational settings but whose knowledge of possible consequences and risks is low and where professional experience of dealing with drug problems may be limited;
- successful entrepreneurs and others (and their children) with access to money and western commodities, including drugs such as heroin or cocaine, who are preoccupied with western sophistication and conspicuous consumption, as well as experiencing stress, frequent travel, etc.

Prevention and early intervention

Prevention strategies and interventions

The 2002 report on the drug situation in the candidate CEECs (EMCDDA, 2002a) describes recent developments and the range of approaches to prevention and early intervention found in the various countries. From a long-term perspective, it is important to remember that the concept of a comprehensive and systematic drug prevention policy is relatively recent in most of the CEECs. Although Poland passed a law on drug abuse prevention in 1985, by the mid-1990s only Hungary and the Czech Republic had set up specific prevention strategies at national level. Since then, these and other countries have revised or developed new prevention strategies. However, in practice, it is often difficult to know to what extent and in what manner programmes referred to in national reports or policy documents have been put into practice.

As in EU Member States, school-based activities are the most common approach reported. In the late 1980s, the greatest investment in school-based programmes was in

Hungary (although, even so, most pupils were not covered), although Poland had introduced the issue of drugs into the school curriculum under the 1985 law on drug abuse prevention, and Bulgaria started to train teachers about drugs in 1988. During the early 1990s, a variety of model programmes and local activities were implemented in these and other countries. Several points can be made about the situation up to the mid-1990s.

In many cases, drug prevention was largely information based rather than pedagogic, although this did not exclude teachers from making moral assertions about the undesirability of using drugs. At that time, it was common practice to translate prevention materials that had been developed for use in the USA or in west European countries and to use them without revising them to reflect local circumstances and needs. Implementation of programmes was usually informal, and frequently relied on training teachers, in the hope that this would translate into effective classroom education, rather than on developing more holistic approaches, although in some countries selected schools took part in the WHO health-promoting schools network.

Since then, some countries have started to elaborate more holistic and pedagogically based school programmes, often integrated within a wider perspective of health education and personal decision-making (EMCDDA, 2002b). However, evaluation of the manner and extent of implementation or the impact of such programmes is still rare.

There is little information on the evolution and application of mass media campaigns on drugs, although campaigns have been carried out in some of the CEECs, often linked to events such as the European Drug Prevention Week. It appears that there is considerable potential for improving how drugs are dealt with by the media in terms of providing more informed and discriminating coverage and promoting more thoughtful, less moralistic analyses.

In recent years, there has been an impressive development of a variety of community-based prevention activities in some countries. These are mostly based at local or regional level and are implemented through specific projects, NGOs or decentralised networks of local drug coordinators. Some are targeted at specific groups, such as prisoners or recreational drug users, while others are more concerned with enhancing prevention through the provision of information and training for local professionals, and others still aim at promoting a range of activities for young people. Projects funded by the Phare drug demand reduction programme are also promoting increased networking and information exchange between NGOs working on various aspects of prevention and risk reduction in different countries.

Issues and challenges

Drug use levels are becoming more similar to those in western European countries, and patterns of use often reflect very similar underlying factors, even though the specific historical and contextual elements have influenced both the local processes and the characteristics of the vulnerable populations and situations. The challenge is to acknowledge the reality of drug use and respond to it in a balanced way that neither denies nor exaggerates the risks and sets realistic goals about what can be achieved.

It is also important to adopt approaches based on an appreciation of the social and cultural dimensions that mould patterns of drug use and on an understanding of drug use as part of a broader lifestyle and consumer-oriented phenomenon in which some people and groups are more likely than others to experience problems. This contrasts with perspectives in which drug use is seen as external and pathological. This, in turn, implies a differentiated pedagogic and public health approach to the concepts of risk and vulnerability.

The most effective approach depends in part on the drugs involved and patterns of use. Cannabis is the most widely used illicit drug, but most users do not experience health or social problems, and the individual and social costs associated with cannabis use are relatively low in comparison with some other types of drugs, although some more vulnerable young people do encounter difficulties. Further, data show that the prevalence of current (last 30 days) or recent (last 12 months) use of cannabis is several times lower than lifetime prevalence, indicating that continuing, regular use of cannabis is relatively uncommon, even in so-called high-prevalence areas. Recreational use of 'party' drugs such as ecstasy or amphetamines may carry higher risks and potential costs, especially when part of a pattern of more frequent multiple drug consumption, although, as with cannabis, most people who use these drugs do so experimentally or intermittently rather than intensively. In contrast, major health and social costs arise from dependence on opiates, especially heroin, and especially when injected. The high prevalence of drug injecting in many of the CEECs means that preventing opiate use and drug injecting and reducing the damage that they cause is a substantial challenge.

Finally, the use of legal substances, especially alcohol and tobacco, is more prevalent and frequent than the use of any illegal drug and is more likely to continue into adulthood. The (non-medical) use of medicines, especially tranquillisers and sedatives, is also relatively high in the CEECs.

These common themes apart, there are also important local differences within and between countries not only in

traditions and patterns of drug and alcohol use, but also in the constellations of risk factors that are found. Responses need to take account of local circumstances such as demographic and cultural profile, socioeconomic situation or level of crime. Similarly, institutions, structures, services and networks have often developed their own local styles of functioning and inter-relating. While efforts at national level to develop and implement pedagogic approaches to prevention within the broader framework of school-based health education programmes are showing progress in some countries, a greater challenge is to assess needs, identify priorities and develop flexible responses that are appropriate to local circumstances.

Further, while preventative efforts are often focused on school-based interventions, it is essential to remember that high-risk patterns of drug use are observed among some not-at-school groups and that higher prevalence rates of drug use are found among older young people, often after they have left school. This is especially true of drugs such as heroin, amphetamines and cocaine. It is therefore important to stimulate and build on community-level actions that are broader and more comprehensive. A number of interesting projects and programmes are already under way in some countries, but they need to be expanded and more widely implemented.

A major challenge here is to identify appropriate strategies and responses and to build a consensus (social solidarity) to support a comprehensive and integrated approach based on reliable information. This approach would include addressing issues such as attitudes and levels of awareness about drugs and drug problems among both the public and professionals, how to implement relevant information and training policies, how to develop responses that are inclusive rather than stigmatising and excluding, how to coordinate effectively and how to involve civic society more constructively. The question of the role of the media is also crucial here.

A final challenge is to improve the quality of data collection and research so as to be able to base policies and responses on a sounder foundation of evidence. This should cover quantitative and qualitative methods to monitor and understand drug use patterns and trends among youths, as well as evaluation of the implementation and effectiveness of the various preventative measures. Although implementation of indicators for monitoring prevalence and trends is improving, there is still much to be done in many countries, and the level of evaluation is still very low. In the meantime, there is an existing and growing body of knowledge and research-based evidence that could be very helpful for developing policies, strategies and interventions.

Problem drug use and its consequences, treatment and harm reduction

Problem drug use

Prevalence

Reliable estimates of the prevalence of problem drug use exist for only a few CEECs. In the case of some other countries, 'informed estimates' are available, but it is not clear how reliable these are, or if they are based on comparable criteria.

For the purpose of estimating prevalence, 'problem drug use' is operationally defined by the EMCDDA as injecting drug use or long-duration/regular use of opiates, cocaine and/or amphetamines. Although useful for prevalence estimation, this definition is narrower than some clinical definitions, which also include heavy use of drugs such as cannabis or sedatives.

From available data, and subject to the reservations expressed above, it appears that the level of problem drug use in the CEECs is approaching, and in some cases has surpassed, levels reported for EU Member States. The 2002 report on the drug situation in the candidate CEECs (EMCDDA, 2002a) estimated the proportion of problem drug users among the population aged 15 to 64 to be over 1 % in Estonia and Latvia, around 0.5 % (the EU average) in Bulgaria, the Czech Republic and Slovenia, and around 0.25 % in Poland (lower than the EU average but based on older data). Rapid increases in new cases of heroin smoking reflected in treatment data over recent years suggest that the estimate for Poland would now be higher, while a new estimate for Slovenia implies a rate of problem drug use of over 1 %. No estimates are available for Hungary, Lithuania, Romania or Slovakia.

Most increases over the 1990s, and especially since the mid-1990s, were due to heroin, which is now the main drug involved in every country except the Czech Republic, where Pervitin use still predominates. Many of these increases have been accompanied by increases in injecting drug use, although smoking heroin is common in Poland and is also reported among young users in some other countries.

It is harder to be sure about current trends, as very recent data are often not available. In the Czech Republic, Hungary, Slovakia, Slovenia and perhaps Bulgaria, it appears that the overall level of problem drug use may be stabilising. In Poland, the Baltic States and Romania, problem drug use (in particular heroin use) seems to be increasing.

Current trends in the problem use of drugs other than heroin are variable. In most countries, use of locally

produced opiates is diminishing. Treatment demand data reflect some problem amphetamine use (e.g. around 10 % of treatment demand) in the Baltic region, Slovakia and Hungary, but not in the Czech Republic. However, an increase in problem amphetamine use is reported only from Estonia. Cocaine use is uncommon among treatment populations. Sedative users (in older groups) and solvent users (in young groups) continue to account for a significant minority of drug users entering treatment in a few countries, but it is likely that solvent use is under-reported. Cannabis is significant (over 10 %) in treatment data in some countries (Czech Republic, Hungary, Poland, Slovakia and Slovenia), but only in Hungary and the Czech Republic are increasing trends reported.

Within countries, problem drug use typically shows a very uneven geographical distribution. Prevalence is often considerably higher in regions with a high level of social problems in general and also in big cities, although this may in part reflect a temporal trend whereby increased drug use occurs first in the cities and subsequently diffuses to other parts of the country and to smaller towns.

The average age of problem drug users entering treatment for the first time is lower in the CEECs (early 20s) than in the EU Member States (late 20s), reflecting the more recent evolution of heroin use. In most countries for which data are available over several years, the age of people entering treatment is no longer falling and the proportion of first treatment demands as a proportion of the total demand is tending to decrease, consistent with a slowing or stabilisation in the rate of growth; however, there are exceptions, for example Poland.

Implications for treatment and harm reduction responses

Some of the factors affecting the susceptibility of high-risk drug use to develop into problem use were described earlier in this chapter. These include individual and family circumstances as well as social and economic factors and the supply and availability of drugs such as heroin. Although all social and economic sectors are to some extent affected, problem drug use tends to be concentrated in more marginal groups, for example among Russian speakers in parts of the Baltic region, Romany youth in the Balkans and central Europe, and more generally, although not exclusively, among young people living in more economically depressed communities or situations of social disruption and uncertainty. This means that delivering relevant treatment services and interventions to reduce the harmful consequences of problem drug use requires special efforts if the gaps arising from exclusion and stigmatisation are to be bridged and if the barriers of ignorance, suspicion of official institutions and reduced access to services are to be overcome. This, in turn, implies a

proactive, positive and culturally sensitive approach to promoting human rights, building trust, disseminating reliable and relevant information, training and developing accessible services.

Although increasing trends in problem drug use show signs of slowing or levelling off in several countries, the high prevalence levels described above imply a substantial need for treatment and care over the coming decade(s). In particular, the high, and in some countries increasing, level of drug injecting means that radical steps are needed to prevent or reduce serious health consequences such as infectious diseases and deaths. Further, the tendency for drug use to diffuse from large cities to other areas suggests that services and training are needed country-wide. Taken together, these findings emphasise the importance of long-term strategic planning and development of treatment, care and harm reduction responses.

Although heroin is the main drug involved, other significant patterns of problem drug use demand attention, including heavy use of amphetamines, multiple drug use with sedatives and/or alcohol and, in some countries, solvents. Qualitative research involving users of other drugs, e.g. amphetamine users in Poland or the Czech Republic, suggests that, depending on context, their perceptions and needs may differ substantially from those of heroin users. This underlines the importance of local needs assessment and of research that involves clients and potential clients of the services.

Treatment responses

Types and extent of drug treatment services

The 2002 report on the drug situation in the candidate CEECs (EMCDDA, 2002a) provides more details on treatment services. Traditionally, treatment consisted of inpatient detoxification, often compulsory, in psychiatric hospitals or narcology clinics. Known users were subject to registration, monitoring and control by the authorities, including the police. Only in Poland were non-governmental residential therapeutic facilities available for drug users. After 1989, the legacy of the 'narcology' system was widespread mistrust of State-based psychiatric treatment. By the mid-1990s, this system was rapidly breaking down under pressure of health care reforms — privatisation and insurance-based schemes introduced profit-driven provision, and new systems evolved, although they were often staffed by the same people, so individual attitudes towards addicts did not necessarily change so quickly.

In many of the CEECs (e.g. Bulgaria, the Czech Republic, Hungary, Slovakia and Slovenia), outpatient drug treatment services developed during the 1990s, usually as part of the

public health system and attached to psychiatric departments, but in a few cases also in the private sector. In other countries, treatment still consists primarily of inpatient detoxification. In a very few countries, primary health care providers are also involved, but in most they play little part.

Substitution treatment, in particular with methadone, has been slow to develop. The first (experimental) methadone programme started in Slovenia in 1990, to be followed by others in the Czech Republic (1992) and Poland (1993). In other countries, the first methadone programmes date from 1995 or later, although by 2001 all countries had introduced at least one. However, except in Slovenia, the number of programmes is limited and coverage remains very low indeed. In Slovenia, a nationwide network provides methadone treatment to perhaps 20 % of the estimated total heroin-dependent population. In all other countries, coverage is less than 5 %, and in many countries under 1 to 2 %. This contrasts with an average coverage of well over 30 % in the EU Member States (Figure 2). Other pharmacological treatments are available to a limited extent in some countries, including naltrexone and buprenorphine, but systematic information is not available.

NGOs' involvement has also been slow to develop in many countries, although in some (the Czech Republic, Hungary, Poland and Slovenia) NGOs play an important role in providing treatment and counselling to drug users. In Poland, this dates back almost 20 years, and in Hungary to the late 1980s, while in the Czech Republic and Slovenia extensive NGO networks evolved during the 1990s. Very recently, NGOs have started to play an important and increasing role in some of the other countries.

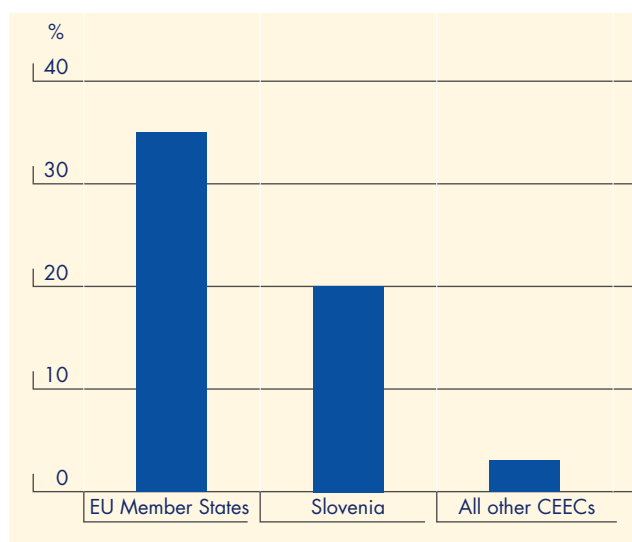
Issues and challenges

It is well established that an effective treatment system for problem drug users can produce important benefits not only to drug users themselves and those close to them, but also to the wider society through reducing social costs arising from disease and crime. While some countries have made impressive progress, a major challenge across much of central and eastern Europe is to increase the diversity, capacity and effectiveness of treatment services available to problem drug users.

This is closely linked to the need for long-term strategic planning based on the concept of a comprehensive treatment system offering a range of treatment and care services for a range of needs. While details depend on national and local circumstances, a comprehensive system may encompass:

- local, low-threshold services offering access, advice, counselling and referral;

Figure 2: Methadone coverage: estimated proportion of opiate-dependent drug users in methadone treatment, 2001



Sources: Multiple sources including EU and CEEC national reports.

- outpatient services offering structured programmes and individual and family therapy;
- methadone programmes offering maintenance as well as detoxification;
- inpatient detoxification and longer-term therapeutic communities;
- rehabilitation programmes, including education, vocational training and relapse prevention;
- user support and self-help groups;
- targeted services (e.g. women, street children, members of ethnic minorities, migrants, prisoners);
- training of professionals and health service administrators, in particular aiming to broaden the understanding of the issue and improve professional standards.

If treatment systems are to be able to cope with the long-term consequences of the high prevalence levels currently observed in many countries, some important challenges arise.

The first major challenge is to broaden the range of treatment options available and improve access to care. This process has started but needs reinforcing. Care delivery models vary between countries, but civil society and NGOs can play an important role in this area, and their involvement may be particularly appropriate for broadening the range of treatment options available to countries. A critical need exists to expand substantially the

capacity and coverage of treatment programmes and ensure that appropriate treatment options are available to meet the identified needs of different groups. Substitution programmes, using drugs such as methadone, can play an important role in addressing problems associated with heroin and other opiates. Although there is resistance among some political and professional circles, evidence from clinical experience and scientific research indicates that professionally managed programmes can be an effective component of a comprehensive treatment response to heroin dependence. Given the stigma and marginality surrounding problem drug use, it is important to promote in practice the concept of medical ethics and patients' rights, for example rights to privacy and confidentiality, access to services and treatment choice, and more broadly to link the development of treatment services to wider actions on social exclusion.

It is essential to improve the quality of information on prevalence, problems and needs in order to target treatment services more appropriately, and to evaluate the treatment that is provided in order to improve its effectiveness.

Health consequences

Drug-related infectious diseases

Infectious diseases such as HIV/AIDS, hepatitis B and C and tuberculosis are among the more serious health consequences of problem drug use, in particular drug injecting. Chapter 3 gives more detail on prevalence and trends in HIV and hepatitis B and C among injecting drug users in the different countries of central and eastern Europe.

The prevalence of HIV infection among drug injectors remained very low throughout the 1980s and into the 1990s in all the CEECs except Poland, where an epidemic occurred among injectors of 'Polish heroin' at the end of the 1980s. Otherwise, the overall picture of low prevalence was similar to that observed in northern and central EU countries but in contrast to high infection rates among drug injectors in some southern EU countries.

Throughout the 1990s, and especially towards the end of the decade, patterns of infection became more differentiated. In Poland, the annual incidence of new infections decreased from 1991 and remained at a stable and relatively low level from 1995 to 2002. As a result, the prevalence of HIV infection among injectors, although still above 10 %, is also stable.

At the end of the 1990s, sharp increases in the prevalence of HIV infection occurred in Estonia and Latvia, and a slowly increasing trend in Lithuania was reported. Neighbouring Finland also experienced a sudden outbreak

of new cases of HIV among drug injectors in 1999, but the rate subsequently dropped to almost zero, suggesting that the outbreak had been contained.

In all other CEECs from which data are available (not available from Romania), the prevalence of HIV among drug injectors remains very low.

The prevalence of HCV among injectors is high (70–80 % or more) in the Baltic States and Bulgaria, but lower in others (lower even than in most EU countries), although data are not available from Poland and Romania. In some countries, such as the Czech Republic, the rate of new infections may be declining, whereas in others, such as Hungary, it appears to be increasing among younger drug injectors.

Possible explanations for differences in HIV infection among drug injectors

There are several possible (not mutually exclusive) reasons for patterns and differences in HIV infection observed among drug injectors in different countries. These include:

- levels of high-risk behaviour such as drug injecting and sharing of injecting materials, as well as patterns of sexual behaviour, especially among commercial sex workers;
- geographical proximity to areas of high HIV prevalence, and the degree of mobility of and contact between high-risk populations;
- context-specific factors such as the prevalence of drug injecting in prisons or among socially marginalised groups;
- level of awareness of risk and protective factors among drug users;
- facilities for hygienic injection, including access to clean injecting material;
- police responses to drug injecting or syringe possession;
- more broadly, the extent to which HIV prevention policies exist and information and harm reduction services targeted at drug injectors are in place;
- wider economic and social factors that facilitate spread of HIV, such as poverty, exclusion and stigmatisation, as well as the state of development of health and social care structures, the degree of knowledge and awareness among professionals and the level of ignorance and fear among the general public.

A combination of most of these factors is relevant to recent rises in the prevalence of HIV infection among drug injectors in some Baltic States (in particular Estonia and Latvia). Sharp increases in the availability and use of heroin in the late 1990s were associated with high levels of

injecting and equipment sharing in populations with little prior experience of drug use and low awareness of risk, and occurred disproportionately among more marginalised groups, in particular the Russian-speaking community. Geographical proximity to Russia, the Russian enclave of Kaliningrad and Belarus, where HIV infection among drug injectors has also shown recent dramatic increases, is a further significant factor. High HIV prevalence is also reported among drug users in prison, indicating an important vector for further transmission of infection.

An increase in heroin injection in the Baltic region took place later but perhaps more rapidly than in other countries. Although harm reduction measures were introduced a little earlier in Lithuania, public health measures were slow to develop in the region. Needle exchange was introduced relatively late in Estonia and later still in Latvia, and the coverage of needle exchange programmes remains low in all Baltic States. The availability of methadone substitution treatment is also very limited.

Although Poland also has borders with Kaliningrad and Belarus, as well as with the Ukraine (which is also experiencing an HIV epidemic among drug injectors), and although a second 'wave' of new heroin use occurred during the second half of the 1990s, the incidence of new cases of HIV infection among drug users in Poland is not increasing. This may be because the recent increase in heroin use in Poland has mostly involved smoking rather than injecting, but it is also possible that the experience of the earlier epidemic of HIV among drug injectors in Poland led to a range of responses (information, education, harm reduction) and changes in behaviour that helped to protect Polish drug users, and it may be that there is little contact between Polish injectors and those from neighbouring countries. More information is needed to establish the relative importance of these and other factors. However, while treatment demand data reveal a declining trend in high-risk behaviour (i.e. equipment sharing) by injectors over some years, recent data indicate that there has been a large increase in needle sharing among new heroin injectors in Warsaw, suggesting a potential risk for increased HIV transmission in the future.

In the other countries in the central European and Balkan regions, drug injection increased during the 1990s, and injection is the most common route of administration of heroin. As in the Baltic States, sharing injecting material is also quite common, although this risk factor has decreased substantially in Slovenia and appears to be declining in the Czech Republic. Several countries also have borders to the east with areas of high HIV prevalence (Hungary, Romania

and Slovakia with the Ukraine). However, the extent to which there is contact between drug injectors across these borders is not clear. Slovenia has a border with Italy, and there has always been some cross-border contact, although rates in Italy are now declining. In addition, heroin use and injecting in these countries is often more prevalent in more socially problematic areas and there are significant marginal groups (e.g. Romany youth, street children, prisoners) that are at higher risk.

Thus, despite the presence of a range of important risk factors (injecting, needle sharing, proximity to areas of high HIV prevalence, vulnerable populations), the prevalence of reported HIV infection has remained low in these countries (data are not available for Romania). One explanation for this may be that Slovenia and the Czech Republic, as well as Poland and to some extent Lithuania, were quicker in introducing information, education and harm reduction activities aimed at preventing transmission of infectious diseases among drug injectors. Other countries, despite slower or more limited responses, may be lucky in that their drug-injecting populations were more closed or have had relatively little contact with other groups in which HIV (and HCV) infection is more prevalent, as there is evidence of continuing high-risk behaviours such as sharing injecting equipment in all countries. High rates of HCV infection in Bulgaria and medium rates (up to 40 %) elsewhere reinforce this point.

Mortality and drug-related deaths

Data on drug-related deaths are rather limited in most countries and are not comparable between countries. Where trend data are available, they indicate increases in many countries, largely linked to increases in injection of heroin.

If the scenario of increasing drug injecting (especially of heroin) continues, together with widespread use of alcohol and depressant psychoactive medicines, then substantial increases in drug-related deaths can be expected, as occurred in western European countries during the 1980s and early 1990s. The limited information available points in that direction, and improved monitoring and development of focused interventions to reduce overdoses should be considered.

It can be anticipated that, as has been observed in other countries, mortality rates among problem drug-using populations, in particular injectors, will be up to 20 times higher than among the general population of the same age, with the additional mortality attributable not only to inadvertent overdoses but also to accidents, suicides, AIDS and other infectious diseases.

Sharp increases in drug-related deaths received marked media and policy attention in western countries during the 1980s and 1990s. The public impact of drug deaths in the new Member States will depend also on other contemporaneous political and social concerns. It should be borne in mind that a substantial proportion of the 7 000 to 9 000 acute deaths reported each year in current EU countries are avoidable, and the same will be the case for the new Member States.

Harm reduction responses

In this chapter, ‘harm reduction’ refers to public health measures taken to reduce the health and social damage caused to individuals and communities by drug use, and especially by problem drug use.

Debates over harm reduction have taken place in western countries since the 1980s, mostly prompted by concern about HIV/AIDS among drug injectors. In some, harm reduction policies and measures date back over 20 years, while in others they are more recent. In some cases, resistance to the concept, and in particular to some activities conducted as harm reduction, still continues. However, in almost all EU countries harm reduction (although it may not always be called as such) is now a key element of any drug policy, and many countries have introduced harm reduction interventions or expanded the scale of established harm reduction interventions such as methadone substitution programmes, syringe exchange schemes and outreach programmes. At EU level, reducing drug-related health damage, especially drug-related infectious diseases and drug-related deaths, is one of the six key objectives of the EU strategy and action plan on drugs (2000–04), and the European Council has recently adopted a resolution calling on Member States to implement a range of harm reduction measures. However, this approach remains controversial in many parts of central and eastern Europe and, in general, harm reduction measures have been slow to develop (Figure 3). This is not surprising, given the historical context. Harm reduction in the CEECs began in the 1990s as an alien concept

imported from the west, initially through the activities of the Lindesmith Centre of the Open Society Institute, which promoted approaches such as methadone maintenance and needle exchange. While the projects that these institutions funded focused on local interventions such as low-threshold centres, information dissemination, outreach initiatives, needle exchange schemes and condom distribution, the wider discourse surrounding these efforts was often dominated by ideological debate. In some countries, other organisations were promoting training and other programmes focusing on primary prevention or treatment, while in the Baltic region organisations such as the European Cities Against Drugs (ECAD) were advocating alternative, drug-free approaches. Across central and eastern Europe as a whole, the UNDCP was encouraging governments to reform legislation in line with the UN conventions. This meant that policy priorities sometimes focused on criminalising drug use, and priority was given to law enforcement rather than demand reduction activities. Harm reduction approaches were also sometimes in conflict with deeply ingrained constructions of drug use and drug addiction held by some professional groups. As a consequence, at times the debate became polarised, emotional and occasionally even ill-informed, with drug control and harm reduction measure seen as contradictory. The result was counter-productive, hindering project development and the implementation of public health measures to deal with rising drug use and the consequences of increased drug injecting.

A number of other processes that evolved over the 1990s contributed to wider dissemination of information about harm reduction, for example participation by central and east European experts in international harm reduction and other conferences, activities and projects supported by Unaid, translation and dissemination of guidelines on outreach by the Pompidou Group, or the EC Phare demand reduction subproject on harm reduction, which helped stimulate development of harm reduction policies and responses in the Czech Republic and Slovenia. In some countries, the concept was taken up by key professional or political figures, who put

Figure 3: Time chart: year of introduction of the first methadone substitution programme and syringe exchange programme

First methadone programme		Slovenia		Czech Republic	Poland		Bulgaria Hungary Lithuania	Latvia		Romania Slovakia			Estonia
First syringe exchange programme	Poland			Czech Republic Slovenia		Slovakia	Bulgaria Hungary	Lithuania	Estonia		Latvia Romania		
Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001

harm reduction on the agenda and helped generate momentum towards its recognition and acceptance as an important element of a balanced drug policy. In other countries, that process is only now taking place.

Types and extent of harm reduction measures

Details of responses to drug-related health damage are given in the *2002 report on the drug situation in the candidate CEECs* (EMCDDA, 2002a) and in Chapter 3 of this report. All CEECs have now implemented harm reduction measures, at least to some degree. These include (as far as data are available) information dissemination, low-threshold drop-in centres, outreach programmes, access to clean injecting equipment, distribution of condoms, counselling and testing for HIV, HIV/AIDS treatment and, in some cases, hepatitis B vaccination.

Access to services varies considerably, however, and in some cases is quite limited. In most countries, provision and coverage of key preventative and harm reduction measures are very limited compared with the prevalence of problem drug use and the scale of potential consequences over the next few years. While needle and syringe exchange programmes (SEPs) have been implemented in all countries, only the Czech Republic reaches a substantial proportion (estimated at over 50 %) of drug injectors through a national network of SEPs and low-threshold projects, although in some countries, such as Slovenia, a reasonable level of coverage is achieved in some cities. As noted earlier, coverage of methadone substitution treatment, which can help reduce health damage, including drug-related deaths and infectious diseases, is extremely limited in all countries except Slovenia.

Most harm reduction responses are aimed at preventing drug-related infectious diseases. Relatively few focus on preventing drug-related deaths, although some measures, such as methadone programmes or outreach projects providing health information and improved access to services, may also make an important contribution in this area.

Issues and challenges

The risk of new epidemics of infectious diseases, not only HIV infection but also HCV, among drug injectors is a major public health challenge in the CEECs. Low HIV prevalence in most countries, and relatively low HCV in some, is no basis for complacency, as exemplified by recent and sudden increases in HIV in the Baltic States and neighbouring countries to the east. Furthermore, a wide range of continuing high-risk behaviours and broader high-risk contexts suggest that strengthening public health measures to prevent the spread of HIV and hepatitis C in drug-injecting populations and to minimise the number of drug-related deaths is a high priority.

The health and social costs for both the individual and the wider community are likely to be considerable and have an impact for many years to come. Intervening to reduce this potential problem is thus a clear priority for public health policy and will require significant investment in the development of national and local structures that are matched in scope and coverage to the nature and dimensions of the public health problem.

Implementation of effective harm reduction measures requires a national comprehensive strategy and commitment to put it into practice. Although there are interesting local developments in many countries, so far the Czech Republic and Slovenia seem to be most advanced in terms of national programmes, although progress is reported in other countries, such as Poland and Lithuania, and steps in this direction are being taken in Hungary and Slovakia. Measures to reduce drug-related health damage appear to be particularly urgently required in Estonia and Latvia. Implementation of strategies to prevent drug-related infectious diseases seems also to be urgent in Bulgaria and especially Romania for a combination of reasons that include a high level of high-risk behaviour among drug users, a relative lack of knowledge of the consequences of drug use, the existence of marginalised communities, their relatively weak economic situation and, in the case of Romania, a long border with the Ukraine.

In concrete terms, improving prevention of drug-related infectious diseases and deaths presents challenges at several levels, including:

- changing attitudes and increasing knowledge among the general population, politicians and professionals and providing increased training for professionals;
- the provision of information, education and outreach initiatives among drug injectors and high-risk groups;
- the introduction of harm reduction interventions (e.g. needle exchange schemes, methadone substitution programmes and overdose prevention initiatives);
- increasing coverage of such schemes and improving access among high-risk populations: marginalised groups such as the Russian-speaking community, Romany youth, prisoners, sex workers, migrants and immigrants;
- reducing stigmatisation and social exclusion.

The final challenge in many of the CEECs is to ensure the regular availability of good, up-to-date data on HIV and other drug-related infectious diseases, especially hepatitis C, as well as to improve the quality of mortality data. In particular, the lack of any data from Romania on

the prevalence of problem drug use, injecting, HIV infection and hepatitis C is cause for serious concern.

Drug markets

This section gives a brief summary of the evolution of illicit drug markets in central and eastern Europe over the past 15 years and comments on some implications. More information on drug markets and drug-related crime is provided in Chapter 4 of the *2002 report on the drug situation in the candidate CEECs* (EMCDDA, 2002a).

Drug trafficking

The geopolitical situation in central and eastern Europe has been a key element in drug trafficking patterns for over 20 years. Since the late 1970s, heroin from south-west Asia has been transported along the Balkan route from Pakistan and Afghanistan through Iran, Turkey, Bulgaria and Yugoslavia to western Europe. In other parts of the region, authoritarian regimes and strict controls on the movement of goods and people limited the extent of drug trafficking until the events of 1989 changed the situation. In the early 1990s, war in Yugoslavia disrupted the Balkan route and led to diversification of trafficking through Bulgaria, Romania, Hungary and, to some extent, Slovakia. While relaxation of border controls facilitated drug trafficking through the region, at that stage western rather than local markets were the primary destination. However, the war did contribute to increased heroin use in parts of Yugoslavia. While heroin was the main drug, significant seizures of cannabis and cocaine were also made.

Later in the 1990s, intensification of the conflict in Kosovo increased the significance of Albanian/Kosovan involvement in drug trafficking. This mainly affected Italy, Greece, and also Switzerland, until, in 1999, Italy tightened its borders to reduce refugees from Kosovo, leading to increases in trafficking through the Czech Republic.

The disintegration of the Soviet Union in 1989 was another important factor that increased the diversity of trafficking routes, one new route being the so-called Silk Route from the central Asian States through Russia, the Ukraine, Poland and the Baltic States. In addition to heroin, this also increased the supply of poppy straw to the Baltic States.

Currently, a wide range of routes are used for trafficking of heroin from south-west and central Asia, often variations of both the Balkan and Silk Routes. In contrast to the situation 10 years ago, end-markets now include the countries of central and eastern as well as western Europe. In addition, trafficking routes for cocaine and cannabis pass into and through the Baltic and Balkan regions, circumventing controls on traditional routes through west European

countries such as Spain, the Netherlands or the United Kingdom. Trafficking in amphetamines has also emerged, especially from eastern or central Europe to the west, and trafficking in ecstasy and other synthetic drugs, which initially came from western European countries such as the Netherlands, now occurs in both directions.

Domestic drug production

Where there is a tradition of opium poppy cultivation for legitimate purposes such as poppy seed for culinary use (the Baltic States, Bulgaria, Hungary and Poland), some domestic production of opiates continues, although generally at a lower level than in the past. This reduction partly reflects increased availability of imported heroin but also, as in Poland, a move towards cultivating strains of low-opium-producing poppies. Following privatisation and diminished regulation of the chemical and pharmaceutical industries after 1989, uncontrolled production of psychotropic substances, notably amphetamines, increased, for example in Poland. Since then, production of synthetic drugs, such as amphetamines and ecstasy, in illegal laboratories has also been found in other countries, including the Baltic States, Bulgaria, the Czech Republic and Hungary. Domestic demand for Pervitin, which is produced for home consumption in the Czech Republic, appears to be falling, as heroin replaces the drug in the domestic market. Some manufacture may now be intended for export. There are no reliable estimates of domestic cannabis cultivation, although it is reported from some countries.

Drug availability

Drug availability depends on the extent of drug distribution and supply in any particular country and on how the markets function in terms of who has access to drugs and under what conditions. Different indicators reflect different aspects of drug availability and are not always consistent either with each other or with indicators of the demand for drugs.

Statistics on quantities of drugs seized often combine drugs seized in transit with those destined for domestic markets, and in any case may not give a reliable indication of the true scale of the supply of different drugs as a few large seizures can seriously distort the picture. The number of seizures made by police (as opposed to customs officials) may sometimes give an indirect measure of availability in a country, although this too is affected by police priorities and activities. In most countries, the number of seizures of cannabis is increasing, while recent trends for heroin, amphetamines and cocaine vary, being stable or fluctuating in some countries and increasing in others. Price data are incomplete and rarely available on a consistent basis over time, especially not in a comparable format that takes

account of broader inflation rates. The limited data broadly suggest that prices are not increasing, regardless of the number of drug seizures or quantity of drugs seized.

Measures of the perceived availability of different drugs by potential consumers such as young people provide an alternative indicator of availability. For example, in all countries taking part in the ESPAD surveys in 1995 and 1999 there were significant increases over four years in the perceived availability of cannabis, LSD and ecstasy among 16-year-old school students. Similarly, perceived availability of inhalants increased but there were no corresponding increases in prevalence of this type of drug use.

Responses

It is outside of the scope of this chapter to review the development and characteristics of law enforcement strategies and responses to drug trafficking, supply and drug-related crime across the region. At a very general level, it appears that during the first half of the 1990s higher priority was often devoted to interdiction and law enforcement. This emphasis was in part encouraged by west European countries, which were alarmed by potential increases in drug trafficking and organised crime across borders that previously had been strictly controlled. Over the course of the decade several countries moved towards approaches that placed increased emphasis on prevention, treatment and reducing drug-related damage.

As explained in Chapter 4 of this report, all 10 CEECs have now adopted or are in the process of adopting new or revised drug strategies that are oriented towards global approaches that aim for a balance between demand and supply reduction. This shift was influenced by several factors, such as training and technical assistance in demand reduction provided through programmes supported by the Pompidou Group and the EC Phare programme and, more recently, through preparatory work for accession, including Phare twinning projects with EU Member States and participation in the activities of the EMCDDA.

Issues and challenges

Despite limitations, available data, including qualitative assessments and indicators of drug demand described above, suggest that the supply and availability of cannabis, ecstasy, LSD, amphetamines, heroin and, to a lesser extent, cocaine increased over the last decade in central and eastern Europe, as did their use. It was also suggested earlier that, although changes in drug availability influenced patterns of use, increases in drug use and in more risky, problem, use were primarily driven by underlying social and economic processes and by changes in youth culture, perceptions and expectations.

One implication is that, as in western Europe, it may be unrealistic to expect that drug use, and especially more damaging patterns of problem use and correlates such as drug-related crime, can be reduced through measures to reduce supply and availability alone. The challenge is, then, to develop drug control policies that balance supply reduction with adequate demand reduction responses. As with drug use, the expansion of drug trafficking and drug supply can be seen in the wider context of recent historical, economic and social changes in central and eastern Europe. Despite local variations in how drug trafficking and distribution are organised and differences in the characteristics of the groups involved, there are common elements cutting across all these developments, from the Balkans, through central Europe and the ex-Soviet States, to the Baltic region. All arose in a context of rapid political and economic change, with an associated breakdown in established structures and control mechanisms. In many cases these were replaced by free market systems that lacked effective regulatory processes, creating crises of legitimacy as well as opportunities to profit rapidly for those with power or influence. Civil wars, armed conflicts, economic impoverishment, migration and refugee crises all further contributed to this process. It was inevitable that these factors stimulated the growth of organised crime and corruption and that substantial increases in trafficking of people, sexual services, stolen cars, alcohol, tobacco and arms, as well as drugs, have been observed over the past 10 to 15 years.

The implication is that responses conceived from a policy perspective focused specifically on drugs, for example increasing border controls or improving drug detection technology, are too narrow. Broader strategies are needed to respond to the phenomenon of organised crime as a whole, including the financial structures and political associations that support it and the social and economic conditions that often underlie it. This, in turn, raises much broader social and economic issues, such as fostering inclusion and development, reinforcing the stability and legitimacy of political and social institutions or strengthening economic regulatory mechanisms for managing and reducing the negative consequences of social and economic change.

At the level of drug policy in particular, a major challenge for politicians, officials and professionals involved in law enforcement and criminal justice is to integrate their strategies and activities into the wider global approaches that are only now evolving in many countries. This entails developing cooperation at national and local levels with a range of new partners from diverse fields such as health, education and social welfare, including NGOs and other

sections of civil society. A further challenge will be to evaluate the impact and effectiveness of legislation and law enforcement as part of the process of identifying how they can contribute to achieving the goals of those global strategies. Recent evaluations in Hungary and the Czech Republic have touched on some aspects of this approach, but much remains to be done.

Public health and social policy: key challenges for the future

This section draws together conclusions of the analyses presented above and summarises major challenges for the future.

Social perceptions of drugs

How drug use and drug problems are perceived in society plays a fundamental role in the policy arena. Social perceptions not only help to shape the sorts of drug policies that are constructed and accepted but are themselves important consequences of drug policy. The historical account provided earlier in this chapter suggests that perceptions of drug use as a deviant, sociopathological phenomenon were a key element underpinning the particular forms of repressive policies that developed in much of central and eastern Europe. Those policies, in turn, had serious consequences in terms of maintaining ignorance, reinforcing stigmatisation and creating mistrust of official treatment institutions. As new drug use patterns emerged, and as the legitimacy of broader political and social structures came under increasing challenge, it became even more apparent that existing policies were ill-suited as a basis for responding, but the legacy of social perceptions of drug use among the general population, politicians and professionals alike presented significant barriers to change.

Over the course of the 1990s, several elements in this interconnected construction of policies, perceptions and the actual drug situation began to shift, more so in some countries than in others, and drug policies and perceptions of drugs began to change. Some possible reasons for this were noted earlier, such as wider social and economic changes, greater exposure to alternative perspectives on drugs and drug policy or improved information on drug use and its consequences. However, in many countries uncertainty and ambivalence are predominant characteristics of social attitudes and perceptions towards drugs and drug users among both the public and professionals. This makes it more difficult to develop and implement coherent and effective strategies that enjoy public, political and professional support.

Thus, a major challenge is to build a broad consensus that has public as well as political and professional support for long-term policies and strategies based on evidence and experience of what is likely to be effective.

Drug demand reduction

Major challenges for demand reduction responses were identified earlier and can be summarised as follows.

Prevention and early intervention

Build on initiatives giving priority to local, broadly conceived community-based initiatives adapted to local circumstances rather than rely exclusively on national school-based programmes or media campaigns. In particular:

- identify vulnerable groups and specific situations associated with riskier patterns of drug (and alcohol) use and develop more targeted, contextualised responses;
- invest in capacity building, especially awareness raising and training of teachers, youth workers, social workers, general practitioners, psychiatrists, local authority officials, health workers and police.

Treatment

Develop more comprehensive treatment systems, based on longer-term strategic planning, that offer a range of services to meet the substantial level of demand that will arise over the next decade. In particular:

- develop a comprehensive range of treatment options and strengthen the role of civil society and NGOs;
- expand substantially the provision of treatment, including, where appropriate, substitution programmes;
- develop treatment responses in the context of wider actions on social exclusion and improving access to services.

Harm reduction

Develop a comprehensive strategy and muster the political will and resources to implement it on a scale sufficient to meet the serious and worsening level of drug-related health and social damage associated with problem drug use, especially drug injecting. In particular:

- defuse anxiety about harm reduction through information provision, awareness raising and informed discussion among policy-makers, professionals and the public;
- expand substantially the range and coverage of appropriate harm reduction interventions to prevent the

spread of HIV and HCV and to minimise drug-related deaths;

- improve access to services for high-risk populations, including minorities and prisoners, and place a high priority on measures to counteract stigmatisation and exclusion.

Local needs assessments and monitoring local responses

Local diversity is a common theme cutting across all the domains of drug demand reduction. This means that national surveys and indicators should be complemented at regional and municipal level by local needs assessments to identify priorities for action and by monitoring local trends and interventions to keep track of the local situation and improve the match between responses and problematic developments in drug use. These need not be large-scale, expensive research programmes but can be based on intelligent exploitation of existing indicators and data from local agencies. Information dissemination and rapid feedback to local services and professionals are essential if local monitoring is to be useful in guiding policies.

Drug policy issues

Law enforcement and interdiction

Although drug supply, availability and drug-related crime are not covered in detail, it is suggested above that the countries of central and eastern Europe are now an integral part of wider European markets in terms of both international trafficking and domestic supply and demand. A major challenge is to accept that the role of law enforcement should now be viewed not as the relatively self-contained task of disrupting drug trafficking through the region, but rather as part of a global approach based on the implicit assumption that supply reduction activities are unlikely to be effective alone if they are not matched with investment in demand reduction work.

A balanced and comprehensive approach

The concept of a balanced approach to drug policy has become more prominent over the past 10 to 15 years and is now gaining wider acceptance in central and eastern Europe, with more attention being paid to demand reduction (see Chapter 4). The challenge now is to increase acceptance of this approach and broaden implementation of public health policies across the domains of information, prevention, early intervention, harm reduction and treatment.

The notion of a balanced approach implies one that is comprehensive in terms of covering the range of significant actors and parties involved. This raises two specific challenges.

- How to coordinate policies and responses across different domains (health, education, justice, international relations, research, etc.). Chapter 4 describes the progress that has been made in this respect.
- How to involve not only various government departments but also the wider community (civic society, media, NGOs, local authorities, etc.). While this poses challenges everywhere, it is of particular relevance in the recent historical context of central and eastern Europe.

Proportional and cost-effective policies

It should be clear from the analysis presented previously that many individual and contextual factors influence patterns of drug use and their consequences, and that there are important differences in terms of the resultant costs for individuals and society. A balanced and comprehensive approach to the drugs issue does not mean that all aspects should be given equal weight and allocated equal resources. Rather, as resources are inevitably limited, the policies adopted should be proportional, i.e. the importance accorded to them should be correlated with their perceived priority, and they should be cost-effective in terms of targeting interventions that give best value for money. Thus, a fundamental challenge is to develop policies that:

- are based on analysis of differential vulnerability, risks and consequences;
- specify priorities, objectives, target populations and settings;
- propose interventions based on evidence of effectiveness and cost.

Information, monitoring, evaluation and research

Reliable and relevant information is essential for underpinning policies aiming to be proportional and cost-effective. At European level, this is the rationale for the EMCDDA and its network of national focal points. However, the national focal points, along with other centres at regional and local level, can also play a key role in collecting and synthesising information to inform national policy development. It is therefore essential that national focal points in central and eastern Europe are given adequate and long-term support. Key points include the following.

- Improved data gathering and analysis is a necessary first step in determining the scale and characteristics

of the drug phenomenon and in describing current responses and assessing if they are sufficient and appropriate.

- Assessing the situation is not enough. Monitoring is needed to determine how both the drug situation and the responses are changing, and evaluation is needed to understand what is effective.
- Interpretation is the key to understanding what is happening and why, and to anticipating trends and identifying what is needed.

Assessing the drug situation and monitoring trends and responses at national or subnational level implies implementation of key indicators and regular collection of other core data, as well as discussion with key experts to interpret what these data imply for national or local policies and strategies. It also implies paying attention to standards and quality assurance. This, in turn, implies dedicating a (modest) proportion of national and local budgets to data collection and analysis.

Identification of explanatory factors and causal mechanisms, as well as scientific evaluation of interventions, often requires more substantial research, qualitative as well as quantitative, and is best carried out by specialised centres with accumulated expertise in the

area. This requires a specific budget to be allocated to the development of research programmes at national and, where relevant, regional level.

Wider social and ethical issues

Drug use and drug-related problems are closely interlinked with a variety of wider social issues across different domains and raise challenges for policy-makers extending far beyond the field of drugs. The account of the evolution of the drug phenomenon given in this chapter has stressed the central role of a range of social and economic factors. This implies that drug policies must be linked to policies on wider issues that influence drug use and its associated risks. These might include regional and local economic policies, youth employment and training schemes, housing and community regeneration programmes, public safety and crime prevention programmes, strategies on organised crime or equal opportunities and social inclusion policies.

The final and perhaps most critical challenge is to build drug policies based on respect for human rights and all that that implies in terms of promoting equal access to services, respecting medical ethics such as patient privacy and confidentiality, reducing stigma and, more broadly, encouraging social inclusion and democratic participation.

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Chapter 2

Drug and alcohol use among young people

This chapter looks in detail at what is known about the changing picture of drug and alcohol use among the young and complements a similar focus piece in the accompanying report on the state of the drugs problem in the European Union and Norway.

Main findings

The findings summarised in this chapter constitute only a part of what we know about the use of illicit drugs and alcohol among young people in the CEECs. It should be emphasised that the available information comes predominantly from students attending high schools; in the CEECs there has been no research into indicators of alcohol and illicit drug use in the most vulnerable groups of young people: those not attending schools and/or members of marginalised groups. This is the main weakness of the data presented.

Lifetime prevalence⁽⁴⁾ of the use of both licit⁽⁵⁾ and illicit drugs is the most commonly reported indicator (even if not necessarily the most informative either from the public health perspective or from the perspective of social risk). The two ESPAD studies for which results are so far available (Hibbell et al., 1997; 2000) show that lifetime prevalence of use of both alcohol and 'any illicit drug' increased markedly in the CEECs between 1995 and 1999. These findings have been confirmed by numerous local and national studies performed in nearly all of the CEECs as reported by their national focal points.

However, most 16-year-olds in the CEECs have never used illicit drugs and, among those who have, the vast majority have used only cannabis. On average, lifetime prevalence of illicit drug use by 16-year-olds in the CEECs is 19 %, ranging from 12 % in Romania to 35 % in the Czech Republic. On average, the lifetime prevalence of cannabis use by 16-year-olds in the CEECs is 16 %, ranging from 1 % of the surveyed population in Romania (although 8 % have tried smoking heroin at least once) to 34 % in the Czech Republic. In contrast, in almost all of the CEECs, more than 90 % of 16-year-olds have tried alcohol at least once, and nearly two thirds admit to having been drunk at least once in their life.

As regards attitudes to drug use among 16-year-olds in 1999, in all CEECs the percentage of young people who disapproved of getting drunk once a week was very similar

to the number who disapproved of experimenting with cannabis, although the actual rates of disapproval did vary between countries. This finding, already apparent from the limited data presented in the 1995 ESPAD study, is even clearer in the 1999 data set (Figure 4). This situation may reflect the increasing 'normalisation' of experimenting with cannabis (and of getting drunk) among young people.

In 1999, disapproval of 'getting drunk' was greater than or equal to disapproval of 'cannabis experimentation' in the Czech Republic, Latvia, Slovakia and Slovenia. Disapproval of cannabis experimentation was significantly higher than disapproval of alcohol use in Bulgaria, Hungary, Romania and Lithuania. In Estonia, the difference between the two ratings was statistically insignificant. Both disapproval ratings decreased in all countries for which data from both 1995 and 1999 are available, but especially those for cannabis experimentation. Given that alcohol use is culturally embedded in the CEECs, this could suggest that experimental and recreational use of cannabis will increase in the future among young people in these countries.

In any case, at least as far as attitudes are concerned, we can clearly distinguish a trend of rapidly increasing social acceptance of cannabis experimentation among young people in the CEECs. This trend is very similar to that experienced by the current Member States only a few years ago.

In two CEECs, disapproval of psychotropic substance use, and particularly cannabis use, is much lower than elsewhere. In the Czech Republic and Slovenia, the percentage of 16-year-olds who disapprove of experimenting with cannabis or getting drunk once a week is less than 50 % of the surveyed population (Figure 4B). These findings have been confirmed in other national as well as local studies and they fit well with the fact that lifetime prevalence of cannabis use is also highest in these two countries. Lifetime prevalence of any alcohol use is also higher than the CEEC average in the Czech Republic (98 %) and Slovenia (91 %), with the Czech Republic showing the highest level of all the CEECs. Thus, the Czech Republic is one of the three European countries which, according to ESPAD, have the highest lifetime prevalence of

(4) Lifetime prevalence is a cumulative indicator of the total number of people who have ever tried drugs, including many in the distant past; by definition, such use cannot be reversed (EMCDDA and Hartnoll, 2002e).

(5) Tobacco and alcohol; only the latter will be discussed in this chapter.

alcohol use (the other two are Denmark and Greece), whereas the figure for Slovenia is slightly above the ESPAD average of 89 %.

All CEECs have in place a large number and wide range of primary prevention initiatives, including the provision of sport and music facilities, mass media campaigns, distribution of educational materials and school and community programmes. However, considering the recent increase in the prevalence of lifetime use of psychotropic substances among young people and the corresponding

decrease in negative attitudes to their use described above, the effectiveness of primary prevention measures could be questioned. In practice, very little is known about the quality and effectiveness of prevention programmes in the CEECs. Moreover, there is a great deal of confusion about terminology: there is no general consensus as to whether the term 'drug (primary) prevention' describes only activities that specifically target drug use or if it also encompasses initiatives that promote a 'healthy lifestyle' in general, in other words, support for activities that are alternatives to drug use.

Figure 4: Disapproval of weekly drunkenness and cannabis use among 16-year-olds.

Figure 4A: 1995

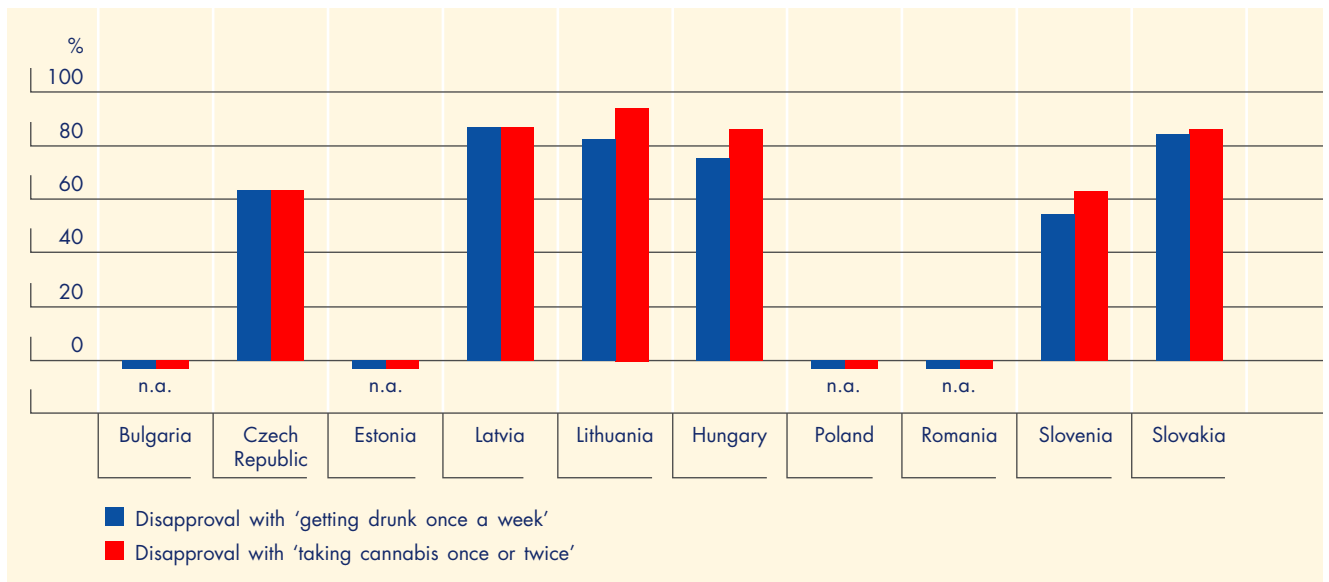
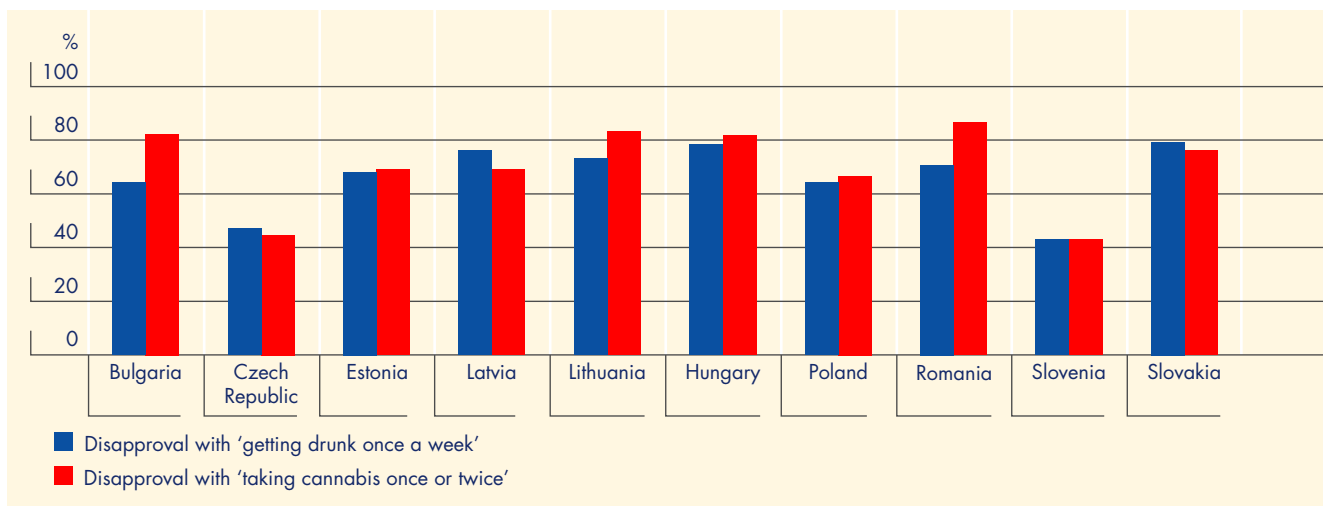


Figure 4B: 1999



Source: ESPAD school survey project (1995 and 1999).

Primary prevention is by far the most popular measure in the drug field in the CEECs (see, for example, Kenis et al., 2001); however, evaluations of primary prevention initiatives are usually limited to a listing of activities, persons/children involved in the activities, and in some cases also the costs of the initiative. This further supports the need for promotion of an evaluation culture, but it also highlights the opportunities for the CEECs to benefit from progress made by EU Member States in this field during the last decade.

Comparative analysis of available data

Prevalence, trends and patterns of use

According to ESPAD studies, lifetime prevalence of use of alcohol and illicit drugs increased in all CEECs between 1995 and 1999. Although the increase in lifetime prevalence of alcohol use was relatively small (but it should be borne in mind that levels were already high, around 90 %, in all CEECs in 1995), the lifetime prevalence of illicit drugs increased significantly in all CEECs without exception. Among the countries for which results from both 1995 and 1999 ESPAD studies are available, the greatest increases occurred in Lithuania (eightfold — from 2 to 16 %), Latvia (fourfold — from 5 to 21 %) and Hungary (threefold — from 4 to 13 %).

More important from the public health perspective is the increase in high-risk patterns of use of both alcohol and illicit drugs.

Alcohol

According to the WHO (1999), '[...] with the exception of the far eastern part of the region (e.g. the Islam-influenced republics of the former Soviet Union), countries in the European region have the highest adult prevalence of drinking in the world'. Indeed, some of the total values for recorded and unrecorded ⁽⁶⁾ alcohol consumption per person in the CEECs are striking (Table 1).

Traditionally, alcohol is widely accepted as a part of social activities among adults in the CEECs, and, understandably, the attitudes of young people reflect this.

According to Csémy et al. (2000), the average calculated consumption of 16-year-old heavy drinkers ⁽⁷⁾ in the Czech

Republic is 9.8 litres of pure alcohol (ethanol) per year — a level very similar to the average annual per capita consumption (10.2 litres).

An indicator that reflects the ability of minors to obtain large quantities of alcohol, 'being drunk up to 13 years of age', is also examined in the ESPAD studies. The value of this indicator in 1999 was highest in Romania (22 %), followed by Estonia and Slovenia. Starting to drink at a young age is generally considered to be an important indicator of future substance use, school failure and delinquent behaviour (see, for example, Ellickson et al., 2003).

The number of 16-year-olds who can be described as 'experienced drinkers' (defined as having consumed alcohol on 40 or more occasions in a lifetime) increased substantially in all countries except Hungary. The highest relative increases occurred in Lithuania ⁽⁸⁾, Estonia ⁽⁹⁾ and Slovenia ⁽¹⁰⁾, while the highest percentage of experienced drinkers was found in the Czech Republic ⁽¹¹⁾ (Figure 5).

An emerging trend that is even more serious from the public health perspective is a clear increase in high-risk

Table 1: Alcohol consumption per person in the CEECs (litres of pure alcohol per year)

Country	Recorded consumption	Estimated unrecorded consumption (where available)
Bulgaria	6.8	n.a.
Czech Republic	10.2	n.a.
Estonia	2.4	6.0
Hungary	9.4	10.1
Latvia	7.1	14.2
Lithuania	12.0	6.5
Poland	6.2	1.5
Romania	9.5	n.a.
Slovenia	11.7	7.5
Slovakia	8.3	n.a.

Source: 'World drink trends 1999' and 'Health for all' database, WHO Regional Office for Europe; quoted in Rehn et al. (2001).

⁽⁶⁾ Unrecorded alcohol consumption (i.e. consumption of illicit and/or home-made alcoholic beverages) values are included only when available.

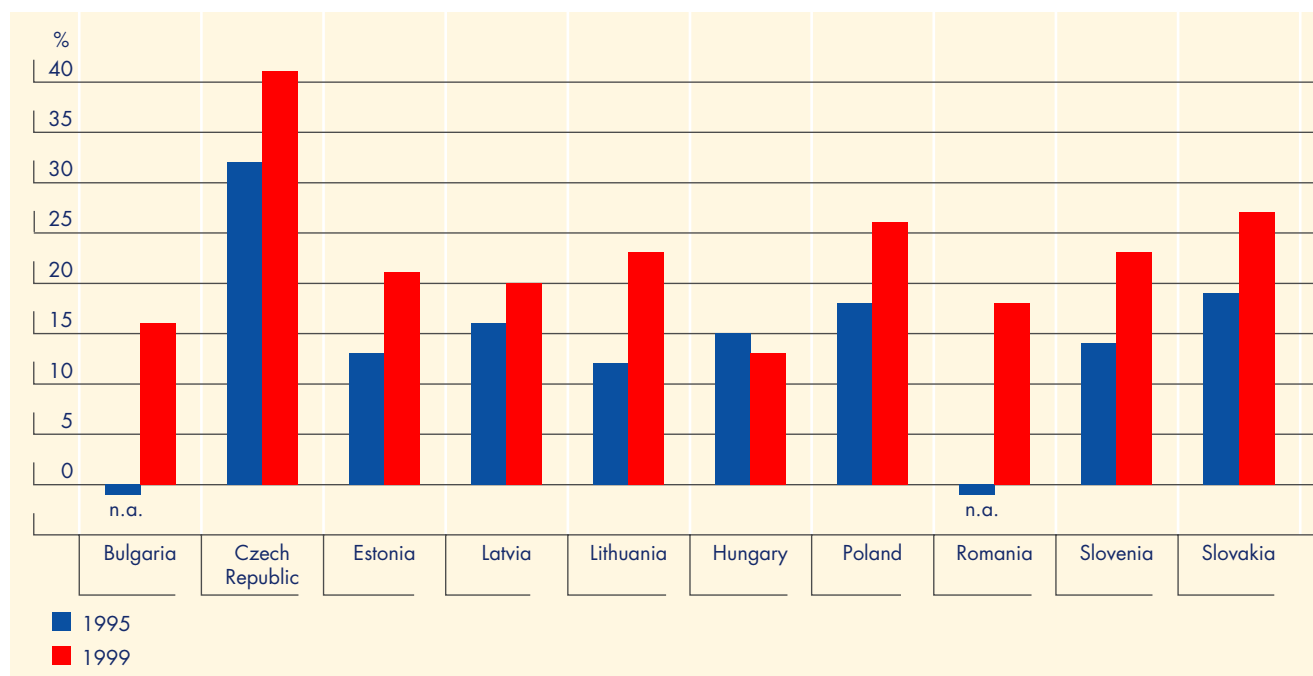
⁽⁷⁾ In the case of 16-year-olds, Csémy defined 'heavy drinking' as drinking alcoholic beverages containing in total at least 100 millilitres of pure alcohol (ethanol) on three or more occasions in one month.

⁽⁸⁾ From 12 % in 1995 to 23 % in 1999.

⁽⁹⁾ From 13 % in 1995 to 21 % in 1999.

⁽¹⁰⁾ From 14 % in 1995 to 23 % in 1999.

⁽¹¹⁾ From 32 % in 1995 to 41 % in 1999.

Figure 5: Percentage of 16-year-olds who have consumed alcohol on 40 or more occasions in their lifetime

Source: ESPAD school survey projects (1995 and 1999).

patterns of alcohol use, so-called 'binge drinking'. For some young people ('heavy drinkers') alcohol consumption is no longer just a social activity, but instead alcohol is valued also for its relaxant effect, being used to forget worries, calm down and 'chill out' — a development seen also in the United Kingdom and elsewhere (see, for example, Egginton et al., 2002). In other words, alcohol is appreciated for its 'mind-altering', psychotropic effects.

The pattern of binge drinking associated with the highest risks is frequent drinking of large amounts, a pattern that is risky not only from the medical point of view but also because of the risk of violence associated with it. Alcohol may be more likely than other drugs to be a contributory factor in acts of violence (Secretary of Health and Human Services, 2000). Among the CEECs, the greatest increase in the indicator 'consumption of five or more drinks on six or more occasions in the last 30 days' was found in Poland (up from 4 % in 1995 to 19 % in 1999) (Figure 6). This is an important indicator of very frequent high-risk 'binge' drinking. The highest value of this indicator in 1999 was also found in Poland, followed by Slovenia (14 %), which also experienced a sharp increase.

Illicit drugs

Overview

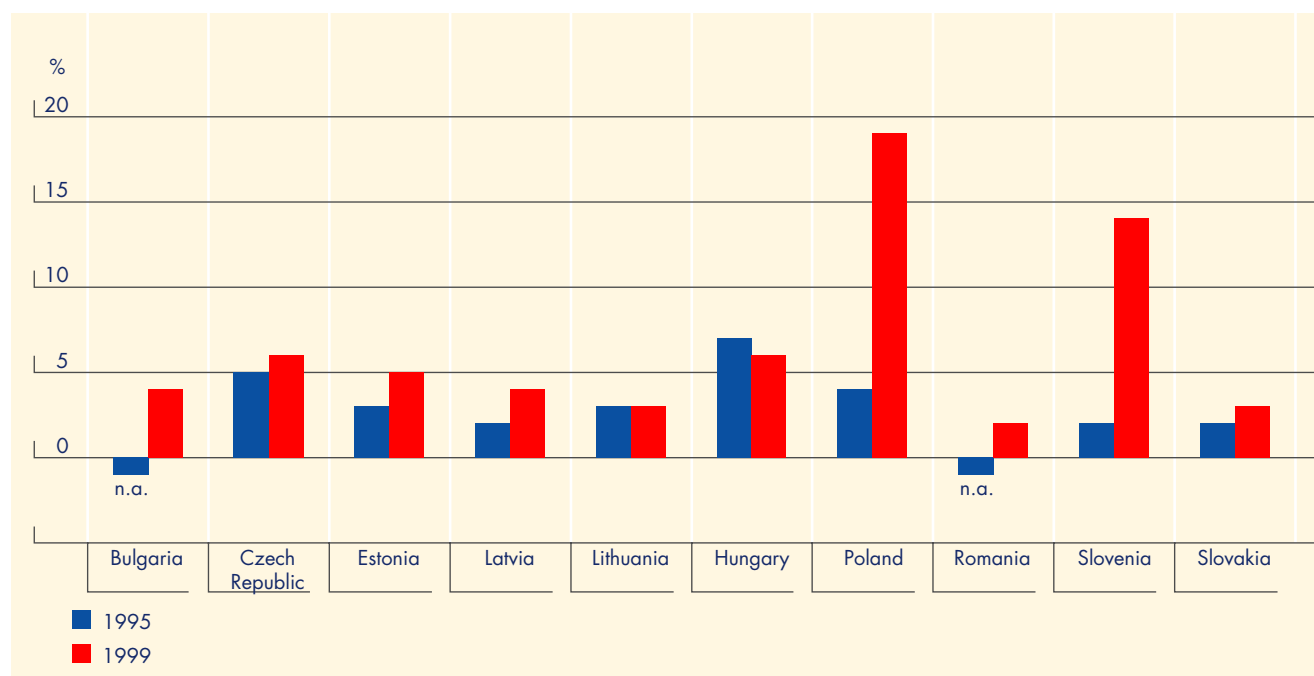
In the CEECs, surveys on illicit drugs are more common than those targeting alcohol ⁽¹²⁾ (or both licit and illicit

drugs). However, many of these studies do not meet the standards for sampling procedures or for the use of appropriate methods to address the questions to be answered. Further efforts are required to implement European standards in order to achieve better comparability at both national and international level.

Increases in the indicator of lifetime prevalence of use (of any illicit drug) found in the ESPAD studies have already been described and thoroughly analysed in the two previous EMCDDA reports dealing with the drug situation in the CEECs (EMCDDA, 2001; 2002a). Where new studies are available at either a national or regional level, they confirm that the trend in lifetime prevalence of cannabis use has continued upward since 1999. In addition, in some countries, e.g. Bulgaria and the Czech Republic (see Mravčík and Záborský, 2001), there has been a decrease in the use of 'hard drugs', i.e. opiates/heroin, amphetamines and cocaine, and sometimes also a decrease in solvents abuse.

A study of drug use among 15- to 16-year-olds carried out in the Bulgarian capital, Sofia, in 2001 found the lifetime prevalence of any illicit drug use in this group to be 27.2 % (compared with 14 % according to ESPAD 1999). Again, cannabis was the most commonly used drug (26.9 % admitted to having tried cannabis compared with 11 % of this age group in Bulgaria as a whole in 1999). In addition, lifetime ecstasy use was

⁽¹²⁾ The exceptions are the WHO coordinated studies 'Health behaviour in school-aged children' (see, for example, Settertobulte et al., 2001).

Figure 6: Percentage of 16-year-olds reporting having consumed five or more drinks on six or more occasions during the last 30 days

Source: ESPAD school survey projects (1995 and 1999).

significantly higher than in Bulgaria as a whole in 1999 — 4 % compared with 1 %. Nevertheless, there was no increase in lifetime prevalence of use of drugs associated with the highest risk patterns of use; cocaine use remained stable at 2 % and a decrease in the lifetime prevalence of heroin use among schoolchildren in Sofia was found compared with national ESPAD 1999 results.

In Lithuania, a new ESPAD-based study was carried out in vocational schools (schools that train students for particular careers) in the capital, Vilnius, in 2001, with the results showing a substantial increase when compared with the 1999 national data (Table 2).

Drugs use, dance and young people

Awareness of the importance of the phenomenon of recreational drug use is increasing in the CEECs — a chapter was devoted to this topic in last year's annual report on the drug situation in the CEECs (EMCDDA, 2002a) ⁽¹³⁾. The new information that is available suggests that experimental and recreational use of 'dance drugs', especially ecstasy, among young people is continuing to increase, especially among party-goers. In addition, according to research conducted since 1999, the popularity of cannabis is not decreasing — a trend that remains to be confirmed or refuted by the 2003 ESPAD study.

The highest lifetime prevalence ⁽¹⁴⁾ of ecstasy use among 16-year-olds in the CEECs is found in Latvia (6 %), followed by Lithuania, the Czech Republic and Slovenia (4 % in each case), and use among party-goers in the CEECs differs little from that elsewhere in the EU. A study conducted in Prague and six capital cities in the EU in 1999–2000 (Tossmann et al., 2001) as well as a number of other recent studies of the recreational drug scene, conducted in various settings and employing both quantitative and qualitative methodologies, have produced similar results (see, for example, Kubů et al., 2000; Demetrovics, 2001; Allaste and Lagerspetz, 2002).

In Hungary, data from two studies were compared in all age groups, lifetime prevalence was higher (by a factor of 1.5–2) among a population surveyed in places of entertainment in Budapest (Demetrovics, 2001) than in a secondary school student population (ESPAD 1999). However, when those born between 1981 and 1984 were excluded from the analysis, lifetime prevalence among party-goers was found to be 76.3 %, three times that found in the population as a whole (25.3 %).

In 2001, the WHO conducted a study of ecstasy users in Estonia, mostly students and schoolchildren living with their parents ⁽¹⁵⁾. According to the preliminary results of the

⁽¹³⁾ Also covered by EMCDDA's *Drugs in focus 6* (EMCDDA, 2002f).

⁽¹⁴⁾ Used at least once during one's lifetime.

⁽¹⁵⁾ The study, 'Ecstasy and young people', was led by John Marsden and conducted within the framework of the WHO global research programme on amphetamine-type stimulants (ATS) to examine ecstasy use among young people aged 16–25. The total sample size was 100.

study, young people start to use ecstasy at an early age, mostly at the weekends. During the three-month period before the study, approximately one sixth of the sample surveyed had used ecstasy once a week and about one third had used it two or three times a month. The results of the study also revealed that young people who use ecstasy are likely to be polydrug users, consuming various drug combinations including some of the following substances: alcohol, cannabis, amphetamine, gamma-hydroxybutyrate (GHB), cocaine and ketamine (quoted in Talu and Hammer-Pratka, 2002).

Health and social consequences

Alcohol

Generally, there is agreement among CEEC experts that since the fall of the communist regimes, and the consequent removal of taboos surrounding public discussion of drug use, the emergence of new illicit drugs has drawn the attention of the public (and to some extent also scientists) away from alcohol-related issues. This development has been accompanied by increased underestimating of the association between drug and alcohol use.

No recent research into the harmful effects of alcohol use in young people was described in the national reports of the CEECs to the EMCDDA.

Regarding alcohol-related mortality, among young people aged 12–18, only two deaths due to alcohol overdose were reported from the CEECs, both in Estonia. However, available data show that a number of deaths occurred in the presence of alcohol — usually attributable to consumption of psychoactive medicines (such as benzodiazepines). In general, data regarding alcohol-related deaths in the CEECs are almost non-existent.

Recently, interest has been aroused in the relationship between early onset of alcohol (ab)use and abuse of cannabis and more harmful drugs. Csemy and Nešpor (2002a,b) analysed the ESPAD data, and found a correlation between (ab)use of licit and illicit substances. This has led to some discussion about primary prevention principles and about the relevance for prevention of the legal status of different substances (see also Mioviský, 2003). In a study in Slovakia that analysed national ESPAD data (Nociar and Miller, 2002), it was found that students who rapidly developed alcohol tolerance were more likely than others to have used illicit drugs. This finding was true

Table 2: Lifetime prevalence of illicit drug use in Lithuania, 1999, and Vilnius, 2001 (%)

Narcotic/psychotropic substance	Vilnius vocational schools			ESPAD 1999		
	Overall	Boys	Girls	Overall	Boys	Girls
Any	44.1	48.6	38.2	15.5	21.0	9.6
Marijuana/hashish	32.2	41.5	20.1	11.9	17.4	6.1
Amphetamine	11.5	13.9	8.3	1.5	1.9	1.0
LSD	6.1	8.4	3.2	1.4	2.9	0.7
Ecstasy	4.5	5.5	3.2	4.4	6.4	2.3
Cocaine	3.0	4.0	1.7	1.1	1.3	0.8
Crack	0.6	1.1	—	0.3	0.5	0.1
Heroin by smoking	10.6	13.2	6.6	4.1	4.9	3.3
Heroin consumed by other methods	2.9	3.8	1.7	0.7	1.0	0.3
Injection	2.5	3.5	1.1	0.5	0.6	0.4
Alcohol together with pills	9.4	10.4	8.0	6.5	7.2	5.6
Alcohol together with marijuana	12.9	16.3	8.3	4.6	7.2	1.8
'Magic mushrooms'	0.7	1.3	—	0.3	0.5	0.1
Anabolic steroids	3.2	5.1	0.9	0.8	1.4	0.2

Source: Lithuanian annual report 2002 and ESPAD school surveys project. Both studies used ESPAD methodology.

even after taking into account levels of alcohol consumption.

Illicit drugs

Problem drug use

School surveys usually reveal little about high-risk patterns of illicit or problem drug use because the prevalence of this behaviour is very low in this environment, i.e. below the statistical sensitivity of the surveys. The only indicator that can be used to illustrate higher-risk patterns of drug use is 'any drug by injection'. In both the 1995 and 1999 ESPAD surveys, levels of this indicator were between 0 and 1 % in all the CEECs, with only insignificant changes either way over the four-year period.

Solvent abuse

Very little is known about the nature and scale of recent solvent abuse by young people in the CEECs, or about the resulting harmful effects. One reason for this is the status of solvents as licit substances and another is the fact that solvents are predominantly abused by the very young and/or marginalised populations who are not reached by routine monitoring systems or research. Solvent abuse is clearly an area where more and better information is essential, especially because, where data about fatal overdoses are available (e.g. in the Czech Republic), solvents rank highly among the causes of death.

Ecstasy and amphetamine-type stimulants (ATS)

An important finding of the Estonian research in the recreational drug use setting (quoted in Talu and Hammer-Pratka, 2002) was that half of the respondents in the sample group fulfilled the criteria of dependency. Furthermore, their access to information, counselling and treatment was very limited. The results of the study also found that these young people were exposed to a risk of harm resulting from their (poly)drug use. The high dependence rate (assessed according to DSM-IV criteria) suggests that there is an urgent need to establish a system of services for users of synthetic drugs.

In 2001, one ecstasy-related death was reported from the Czech Republic. A 27-year-old man died of an overdose after swallowing a PMA (para-methoxyamphetamine) pill that he bought as 'ecstasy' in Germany. In Slovenia, two ecstasy-related deaths were reported in 2001: one person died from brain oedema (a possible MDMA-induced side-effect) and the other died of heat stroke. There were more non-fatal emergency cases of brain oedema connected with MDMA use in Slovenia in 2001, but they were successfully treated in hospital.

Slovenian research on ATS concluded that the use of synthetic (and other drugs) in Slovenia by young people is risky owing to the frequency and chaotic nature of use. Young party-goers often mix different drugs (37.4 % of the sample) or combine drugs with alcohol (21.0 % of the sample). Almost half of the research sample (42.8 %) reported having consumed a mixture of ecstasy and amphetamines.

Demand and harm reduction responses

Alcohol

Legal control of alcohol

In only three CEECs — the Czech Republic, Slovakia and Slovenia — are there no licensing laws related to alcohol (Rehn et al., 2001) and all outlets have the right to sell and serve alcohol. This probably accounts for the high degree of acceptance of alcohol use in these three countries. In all other CEECs, a licence is required ⁽¹⁶⁾.

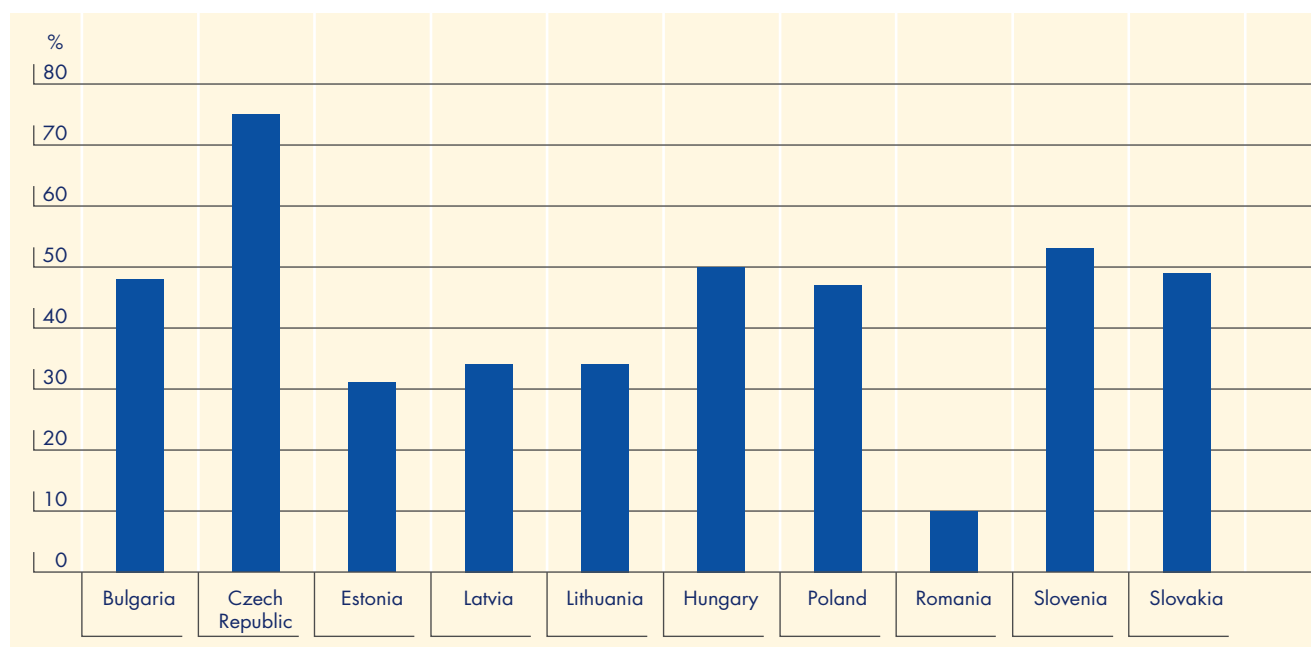
In all CEECs, there are legal restrictions on the sale of alcohol to people under 18, with variations in the severity of sanctions. Little information is available regarding the extent to which such laws are enforced.

An interesting study of 1999 ESPAD data analysed the extent of enforcement of under-age drinking laws and public (dis)approval of drinking among 16-year-olds. The total number of respondents who answered 'bar, pub', 'disco' or 'restaurant' ⁽¹⁷⁾ in reply to the indicator 'drinking places of the last drinking day' was very similar to the lifetime prevalence of alcohol consumption, suggesting that most alcohol consumption by under-age drinkers takes place in public places. Enforcement of alcohol laws seems to be weakest by far in the Czech Republic, which also shows the most lenient public attitudes to under-age drinking. Again, Slovenia is the second country in this regard (Figure 7).

Restrictions on alcohol advertising are also an important factor in preventing early onset of drinking as well as its acceptance. In stable and saturated markets, the main role of advertisements is to ensure that old consumers are replaced by new ones and that educational messages do not diminish alcohol consumption. Alcohol advertising presents alcohol consumption as a safe and problem-free practice, playing down the potential health risks and negative consequences. Through its messages, alcohol advertising maintains the social desirability of drinking,

⁽¹⁶⁾ As is the case in all current Member States except Austria and Spain (Rehn et al., 2001).

⁽¹⁷⁾ These are all the public places where alcohol can be sold. Other possible answers to the question of where alcohol is consumed are 'at someone else's home,' 'street, park, beach', 'other places' and 'never been drinking'.

Figure 7: Drinking in commercial enterprises among 15- and 16-year-olds

Source: ESPAD school survey project (1999).

ignores the adverse effects of alcohol use on individual and public health and challenges prevention objectives. These indirect effects alone are sufficient to justify the need to control the volume and content of alcohol advertising (Rehn et al., 2001). Restrictions on alcohol advertising in the CEECs are shown in Table 3.

Prevention of alcohol use

No systematic information is available from the CEECs regarding initiatives targeted at young people to prevent tobacco and alcohol use. A rare example comes from Hungary and takes the form of kindergarten programmes that are linked to the developmental psychological needs of the relevant age group and formulate drug prevention targets ('Heart — Treasure chest', 'Adventures in the land of fragrances', etc.). Such programmes highlight the dangers of legitimate drugs (mainly smoking) in the context of health promotion, and they mostly use communication of knowledge as the main tool. As a positive feature, they require children's active involvement and they have proved to be effective. Kindergarten programmes are also reported from Slovenia.

In Slovenia, a school-based primary prevention programme targeting alcohol use in youth, called 'Alcohol? Adults may have the influence', is being piloted in the capital, Ljubljana, and two other regions of the country. The methodology is based on the results of pre-testing

in all targeted groups (parents, teachers, pupils) and the programme will be rolled out throughout Slovenia in 2003/04.

Slovenia also provides an example of an attempt to introduce an innovative systematic approach to school-based health prevention, based on good practices found throughout Europe and identified by international organisations and experts. The initiative⁽¹⁸⁾ takes a 'holistic approach' to psychotropic substances and covers nine main areas (see online box 1).

In countries that are members of the Organisation for Economic Cooperation and Development (OECD), and thus in which advertising of spirits is banned, alcohol consumption is approximately 16 % lower than in countries where no such bans are in place. In countries where advertising of beer and wine is also banned, alcohol consumption is about 11 % lower than in countries where only spirits advertising is banned. Fatalities in motor vehicle accidents are about 10 % lower in countries in which spirits advertising is banned and about 23 % lower in countries where beer and wine advertising is also banned. It has been shown that a five-minute increase in exposure to alcohol advertising increases alcohol consumption by young people by 5 g a day (Rehn et al., 2001).

⁽¹⁸⁾ The programme should receive final approval and be introduced during 2003.

Table 3: Restrictions on alcohol advertising in the CEECs, 2002

Country	Spirits				Table wine				Beer			
	TV	Radio	Print media	Billboards	TV	Radio	Print media	Billboards	TV	Radio	Print media	Billboards
Bulgaria	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted
Czech Republic	Voluntary code	Voluntary code	Voluntary code	Voluntary code	Voluntary code	Voluntary code	Voluntary code	Voluntary code	Voluntary code	Voluntary code	Voluntary code	Voluntary code
Estonia	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted
Latvia	Banned	Banned	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted
Lithuania	Restricted	Restricted	?	?	Restricted	Restricted	?	?	Restricted	Restricted	?	?
Hungary	None	None	None	None	None	None	None	None	none	none	none	none
Poland	Banned	Banned	Banned	Banned	Banned	Banned	Banned	Banned	Banned	Banned	Banned	Banned
Romania	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted	Restricted
Slovenia	Banned	Banned	Banned	Banned	Banned	Banned	Banned	Banned	Banned	Banned	Banned	Banned
Slovakia	Banned	Banned	Restricted	Restricted	Banned	Banned	Restricted	Restricted	Voluntary code	Voluntary code	Voluntary code	Voluntary code

Source: Based on Rehn et al. (2001) as updated by national focal points.

Illicit drugs

Drug prevention programmes focused (exclusively) on illicit substances are far more widespread in the CEECs.

All available national reports prepared by Reitox national focal points (see <http://candidates.emcdda.eu.int>) cite a full array of prevention initiatives, including school-based programmes, peer programmes, telephone help lines and, more recently, community-based programmes.

Nevertheless, only in a very small number of cases does the information provided extend further than quantification of the number of people who have been exposed to the programme(s) with no scientific evidence of any benefit. Despite this, a few examples indicating a nascent culture of evaluation of preventative activities can be listed ⁽¹⁹⁾.

The major methodological problem that needs to be mentioned here is that, in all CEECs, school surveys fail to target the youth groups at greatest risk — the socially marginalised or excluded. This fact obviously reduces the reliability of such surveys. Although all of the countries have 'special' ⁽²⁰⁾ elementary schools for so-called disadvantaged children, and qualitative information suggests that abuse of illicit drugs, alcohol and solvents is substantially higher in this group than in the population as a whole (see, for example, Grund et al., 2000), to date no research into this issue has been carried out in the CEECs.

In the Czech Republic, a study entitled 'Influencing attitudes against use of drugs and other addictive substances' was carried out by the Hygienic Station Teplice (Ševčík, 2001). A sociological survey was conducted in three districts at two time points to determine attitudes to drug use. In only one of the districts were prevention initiatives (following the principles of community-based prevention) implemented during the study period. The results showed an increase in disapproval of drug use in the district where prevention was delivered compared with two other districts. The outcome of this study lends support to those who believe in the positive effects of complex community-based prevention programmes.

Some evaluation has also been carried out regarding the preventative role of sport activities in childhood, most recently in Slovakia and Hungary.

Okruhlica et al. (2001) administered a simple questionnaire survey to heroin users and, as controls, a random sample of high-school students. They found no statistically significant difference between the groups, in either males or females, in terms of history of sports activities up to the age of 15.

Vingender and Sipos (2001) examined the relationship between sports and smoking, alcohol use and drug use. The authors divided a sample of 1 103 secondary school students into four groups (those performing at a competitive level; those for whom sport was a leisure pursuit; those who

⁽¹⁹⁾ See also the Hungarian 2001 evaluation of school prevention programmes described in EMCDDA and Olszewski et al. (2002: 13).

⁽²⁰⁾ Pupils from the ethnic minorities and other marginalised groups are over-represented in such schools.

used to do sports but had stopped by the time of the study; and students doing no sports), and compared the intensity of use of various substances in the different groups. They found that taking part in sports activities does not protect against substance use, but that giving up sport is associated with drug use and could be predictive of future drug use (Vingender and Sipos, 2001). However, the correlation is not strong, and step-by-step regression analysis was unable to add any sports-related variables to the model of drug use.

Recreational users whose drug consumption occurs principally in places of entertainment constitute another important target for effective prevention. In the recreational setting, the use of both licit and illicit drugs is widely accepted, although 'addiction' and/or problem drug use remains frowned upon (see, for example, Allaste and Lagerspetz, 2002).

Neither general 'education' campaigns nor measures aimed specifically at problem drug users have had an impact on drug users in the techno and dance scene. In addition, it is difficult to carry out a focused campaign because of the social diversity of such users. One possible setting for a targeted campaign could be places and social events where young people who are potential users of 'new synthetic drugs' meet, i.e. raves, parties, dance events, dance clubs, etc.

The Czech Republic, Estonia, Hungary, Latvia and Slovenia report targeted prevention efforts in this environment. In Estonia in 2000, efforts were made to target recreational users, especially female party-goers, and to provide them

Programmes aimed at preventing illicit drug use or problem drug use should only be part of a wider curriculum designed to prevent problems associated with the use of all psychoactive substances, including alcohol and tobacco.

According to recent estimates from the WHO, in Europe and other developed countries, alcohol and tobacco account for a much larger proportion of disease and disability than illicit drugs: more than 21 % compared with less than 2 % respectively (Ezzati et al., 2002).

Prevention programmes aimed at young people need to take into account the strong overlaps between smoking, drinking and illicit drug use in youth culture, and particularly between intoxication from alcohol and from drugs. In view of these links, there is a risk that a narrowly based illicit drug prevention approach will lack credibility among young people (Room, 2003).

with realistic information about the dangers of drug overdose and the potential harmful effects of so-called recreational drugs. The initiative attracted criticism and was not repeated in 2001. However, the other CEECs continue to develop specialised services according to local needs.

In Hungary, a programme for safe entertainment venues was developed and launched, with the primary aims of reducing drug use in music and dance clubs and discos and of managing health risks resulting from drug use. Subsequently, the Hungarian Association for Safe Entertainment Venues was formed.

Of all the CEECs, only the Czech Republic conducts harm reduction activities in this setting. This involves on-the-spot (qualitative) pill testing combined with quantitative testing of pill samples and publication of results on the Internet.

Conclusions

From the rather patchy information available regarding alcohol and illicit drug use among young people and relevant responses in CEECs, we can draw the following conclusions:

- Although lifetime prevalence of cannabis (and probably ecstasy) use is still increasing in the countries for which new data are available, the situation regarding use of higher-risk drugs such as heroin and amphetamines among 16-year-olds is much less clear.
- Alcohol use in young people is widespread in the CEECs, and the prevalence of high-risk 'binge drinking' is increasing.
- Neither licit nor illicit drug use among marginalised groups (outside school or in special schools) receives sufficient attention in the CEECs.
- The importance of the phenomenon of recreational drug use for interventions and drug policy as a whole is increasingly recognised in the CEECs, although a clear consensus on appropriate intervention strategies in this area does not exist.
- In some countries, the link between illicit and licit drugs use is attracting increasing attention. Among 16-year-olds in most of the CEECs, disapproval of weekly drunkenness and cannabis experimentation is more or less equal.
- Evaluation of prevention activities in the CEECs remains patchy.
- Laws intended to protect children and young people from alcohol use are often poorly enforced.



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Chapter 3

Drug-related infectious diseases

This chapter analyses data available from the region on drug-related infectious diseases and the measures in place to prevent their spread.

Introduction

Drug-related infectious diseases among injecting drug users (IDUs) are an important challenge to public health. Such diseases include HIV, hepatitis C virus (HCV) and hepatitis B virus (HBV) infection as well as some other serious diseases. As HIV, and to a lesser extent HBV and HCV, can be transmitted by sexual intercourse, the potential for spread via unprotected intercourse to the sexual partners of IDUs as well to the sexually active general population that does not inject illicit drugs is high. All three infections are also transmitted vertically (from mother to child) and, in addition, represent a risk for nosocomial transmission (transmission in a healthcare setting, if precautions for prevention are not adhered to). Hepatitis B infection can be prevented by vaccination. The potential vaccination population includes IDUs and other groups who may be at risk of infection by coming into contact with contaminated blood or body fluids as well as groups at high risk of transmission through unsafe sex, or even the entire general population. In contrast, vaccination against HIV and HCV infection is unlikely to be available in the near future. Thus, prevention mostly depends on preventing high-risk behaviour and encouraging behavioural change.

A substantial reduction in the incidence of drug-related health damage, including HIV, HCV and HBV infection, is one of the six main targets of the EU drug strategy (2000–04). This target is also of great public health importance in the acceding and candidate countries. To enable evidence-based national and internationally coordinated prevention and harm reduction responses it is essential to monitor the level of infectious diseases among IDUs and trends over time. The EMCDDA has been supporting acceding and candidate CEECs to improve the collection, analysis and dissemination of objective, reliable and comparable information about these infections among IDUs. Information about HIV infection among IDUs collected by EuroHIV complements this information (European Centre for the Epidemiological Monitoring of AIDS, 2002).

Most CEECs collect some information to enable them to monitor trends in HIV infection prevalence among accessible population groups of IDUs. Less information is available about the prevalence of HCV and HBV infection.

All CEECs also collect relatively valid information on newly diagnosed cases of HIV infection. In contrast, even when available, most reported national incidence rates for HCV and HBV are likely to be substantially underestimated, and reliable information on transmission route is often unavailable. Both the degree of under-reporting and the availability of reliable information about transmission route may vary greatly between countries. In addition, case definitions may be different. Thus, for all these reasons, any attempted comparison of reported incidence rates of newly diagnosed HCV and HBV infections between countries is of questionable benefit. Nevertheless, if testing and reporting patterns are stable over time in an individual country, monitoring reported incidence rates provides information about trends in the burden of the disease.

The spread of HIV, HBV and HCV among IDUs is determined mainly by injecting risk behaviour, notably sharing of injecting equipment. However, transmission through unprotected sexual intercourse among IDUs and their non-IDU sexual partners is also important, especially in the case of HIV and HBV; sexual transmission of HCV is thought to be low. As prevention and control depend mostly on preventing high-risk behaviour and encouraging behavioural change, information on high-risk and risk reduction behaviour is necessarily an integral part of drug-related infectious diseases surveillance among IDUs. As far as HIV surveillance is concerned, in countries with a low prevalence of infection or concentrated epidemics, which currently includes all CEECs (Hamers and Downs, 2003), the behavioural component is even more important (Unaid/WHO, 2000). It informs the design of prevention and harm reduction interventions targeted at IDUs and also contributes to efforts to evaluate their impact. In settings in which the prevalence of HIV infection is low, an increase in high-risk behaviour among IDUs is an early warning of the potential for rapid spread. In addition, as HCV is more readily transmitted by injecting drug use than HIV, and as HCV can easily be transmitted through sharing of injecting equipment other than needles and syringes, such as cotton, spoons and water, information about HCV infection prevalence can provide useful information about injecting risk behaviour and the effectiveness of prevention measures. In addition, routine surveillance information on other sexually transmitted

infections, such as syphilis, can indicate high-risk sexual behaviour among IDUs, prior to HIV transmission.

Drug-related infectious diseases can be prevented or minimised by providing access to sterile injecting equipment through pharmacies or community-based initiatives as well as via outreach prevention and harm reduction programmes. Access to information about safer drug use, promotion of safer sex, including condom use, drug treatment, in particular substitution with methadone or other drugs, and immunisation against hepatitis B are further important measures. The impact of these infections on individuals as well as on the wider society, including development of severe disease and prevention of secondary transmission, can be reduced by ensuring adequate access to counselling and testing and effective treatment of diagnosed infections.

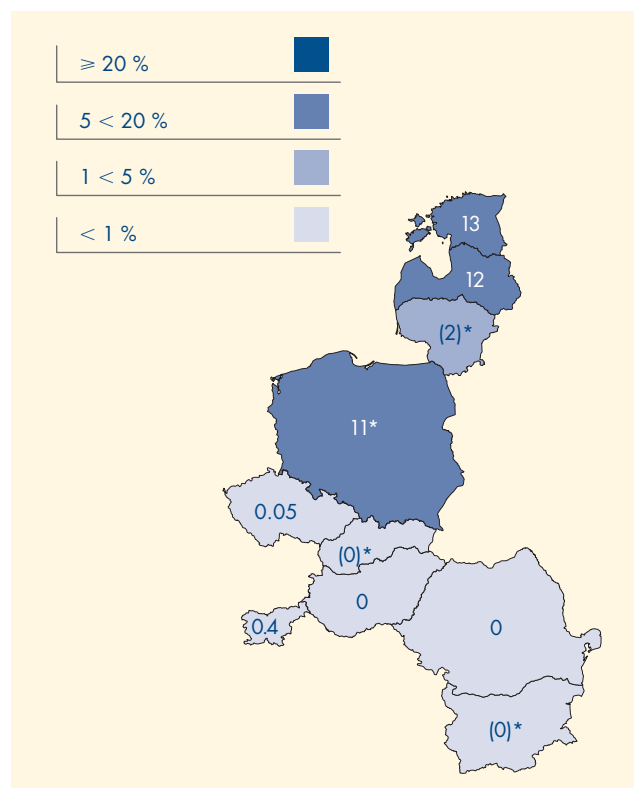
Information submitted by the Reitox national focal points has been used in the preparation of this chapter, which complements Chapter 3 of last year's *Report on the drug situation in the candidate CEECs* (EMCDDA, 2002a). If other sources of information were used, this is noted and the reference is cited.

Prevalence of and trends in HIV infection

Although in most CEECs IDUs have largely avoided the HIV epidemic, HIV infection is currently spreading at an alarmingly rapid rate among IDUs in two Baltic States: Estonia and Latvia.

Information on HIV infection prevalence among IDUs in the CEECs is presented in Figure 8 (for 2001 or for the last year or period for which information was available). Relatively high national rates of HIV prevalence among different subgroups of IDUs tested during 2001 were reported from Estonia (13 %) and Latvia (12 %). However, in the capital of Estonia, Tallin, the local HIV prevalence rate in 2001 reached the alarmingly high value of 41 %. In Latvia and Poland, HIV prevalence among IDUs rose above 5 % in 1998 and has remained above 5 % since. In Lithuania, HIV prevalence increased to more than 1 % in 1997 but remained consistently below 5 % until 2001. In contrast, between 1996 and 2001, HIV prevalence among IDUs remained consistently below 1 % in Bulgaria, the Czech Republic, Hungary, Slovakia and Slovenia (European Centre for the Epidemiological Monitoring of AIDS, 2002). In these countries, HIV prevalence rates among IDUs are lower than those in any EU Member State, where levels of infection in different subgroups of IDUs vary from about 1 % in the UK (surveys and unlinked anonymous screening) to 34 % in Spain (routine diagnostic tests in drug treatment) (EMCDDA, 2002c).

Figure 8: Prevalence (%) of HIV infection among IDUs in the CEECs, 2001 or most recent year for which an estimate is available



NB: Data in brackets are (local) or of (unspecified) geographical coverage. If an estimate was available only for a different year and not the year 2001, it is marked with *. Differences between countries have to be interpreted with caution due to different data sources or different IDU sub-populations tested as well as different surveillance or study methods used.

Sources: Reitox national focal points and EuroHIV for Slovakia.

Bulgaria Year: 2000; coverage: Sofia; data sources: treatment centres, low-threshold services, needle exchanges, outreach; sample size: 711.

Czech Republic Year: 2001; coverage: national; data source: (public health) laboratories; sample size: 2 169.

Estonia Year 2001; coverage: national and Tallin; data source: public health laboratories and treatment centres, hospitals, syringe exchanges; sample sizes: 2 078 and 964.

Hungary Year 2001; coverage: data source: those registered with the treatment system; sample size: 315.

Latvia Year 2001; coverage: national; data source: treatment centres; sample size: 687.

Lithuania Year 2000; coverage: not specified; data source: not specified; sample size: 772.

Poland Year 2000; coverage: national; data source: treatment centres, STD clinics, hospitals, testing site; sample size: 3 106.

Romania Year 2001; coverage: national; data source: public health departments; sample size: 2 135

Slovakia Year 2000; coverage: Bratislava, Kosice; data source: treatment centres; sample size: 801; source of information: EuroHIV.

Slovenia Year 2001; coverage: national; data source: treatment centres; sample size: 559.

Information about newly diagnosed cases of HIV infection provides further evidence for large differences between the CEECs in recent HIV infection spread among IDUs. Annual reported incidence rates of newly diagnosed HIV infections among IDUs per million total population are shown in Figures 9 A and B (European Centre for the

Epidemiological Monitoring of AIDS, 2002; Hamers and Downs, 2003). During the last few years these rates have increased most dramatically in Estonia but also quite substantially in Latvia. In 2001, the rates reached 970 per million population in Estonia and 271 per million population in Latvia (an increase of 282 % and 67 %, respectively, in comparison with the previous year). These rates are much higher than the total rates of new HIV diagnoses (not just among IDUs) reported from any EU Member State, among which overall HIV infection rates in 2001 varied from 16 per million population in Germany to 251 per million in Portugal (European Centre for the Epidemiological Monitoring of AIDS, 2002). In fact, some east European countries are threatened by the most rapidly developing HIV epidemic in the world. The reported rates of newly diagnosed HIV infections among IDUs per million general population for the year 2001 were considerably lower in Lithuania and Poland, 15 and 6 per million population respectively, and much lower still, below 1 per million population, in all other CEECs.

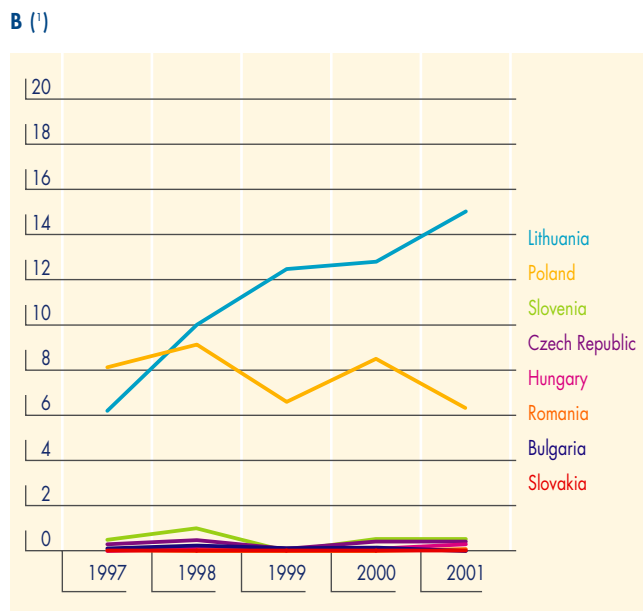
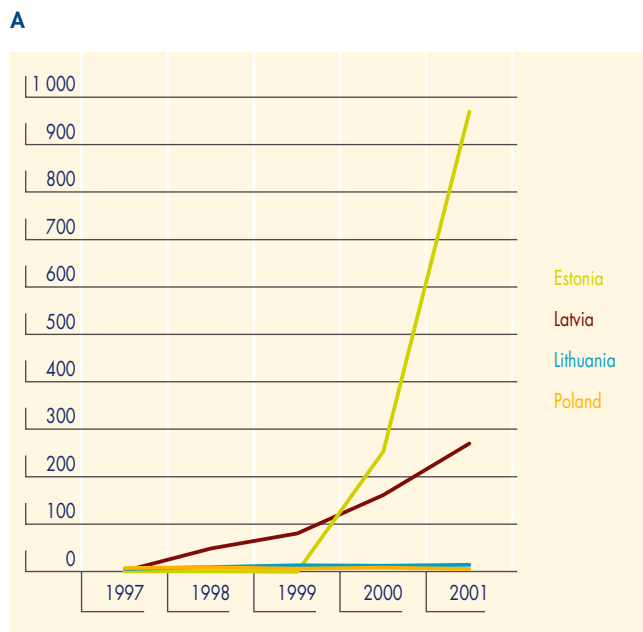
Reflecting earlier spread of HIV infection among IDUs, annual rates of AIDS incidence among IDUs have been rising in Latvia and reached 12 per million total population in 2001 (European Centre for the Epidemiological Monitoring of AIDS, 2002). Between 1997 and 2001 the reported incidence of AIDS among IDUs stabilised at just under 2 per million population in Poland and remains, for the time being, below 1 per million population in all other CEECs, including Estonia.

Prevalence of and trends in hepatitis C infection

Chronic infection with HCV, which occurs in most, but not all, individuals who have been infected, may have serious health consequences, including severe liver damage and premature death. Available information about the prevalence of antibodies to HCV among IDUs for 2001 or the last year or period for which the information was available is presented in Figure 10. For all CEECs for which prevalence estimates are available, the data indicate a much higher prevalence of hepatitis C infection than of HIV infection. Thus, in the near future, at least in some CEECs, hepatitis C infection may present a greater challenge for control among IDUs than HIV infection.

The prevalence of antibodies to HCV among IDUs in the Czech Republic, Hungary, Slovakia and Slovenia varies up to 40 %. This indicates much lower levels of hepatitis C infection among IDUs in these four countries than in any EU Member State, where rates of HCV infection among IDUs vary between 40 and 90 %, except in the UK, where the

Figure 9: Reported newly diagnosed HIV infection cases among IDUs per million population in the CEECs, 1997–2001

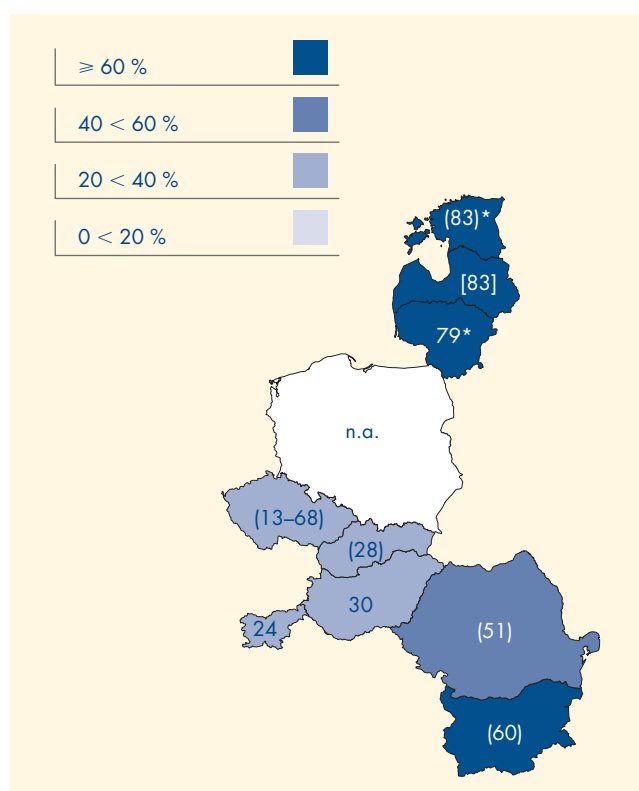


(1) Estonia and Latvia not shown.

Source: Adapted from European Centre for the Epidemiological Monitoring of AIDS (2002).

rate is lower (EMCDDA, 2002c). In Bulgaria, Estonia, Latvia and Lithuania, the estimated prevalence rates of HCV infection are higher and closer to those in EU Member States. Some CEECs collect HCV surveillance information among IDUs that enables monitoring of trends. In the last few years, the prevalence of antibodies to HCV among IDUs has remained fairly stable in Slovenia and has fallen in Lithuania as well as in one subpopulation of IDUs in the Karvina district in the Czech Republic. In contrast, the rate has increased in Sofia, Bulgaria, from below 60 % during

Figure 10: Prevalence (%) of antibodies to hepatitis C among IDUs in the CEECs, 2001 or most recent year for which an estimate is available



NB: n.a. = not available. Data in brackets are (local) or of (unspecified) geographical coverage. If an estimate was available for a different year and not the year 2001, it is marked with *. If several estimates were available, range is given. Differences between countries have to be interpreted with caution due to different data sources or different IDU sub-populations tested as well as different surveillance or study methods used.

Sources: Reitox national focal points.

Bulgaria	Year 2001; coverage: Sofia; IDU sub-populations: treatment centres, needle exchanges, low threshold services, outreach; sample size: 435.
Czech Republic	Year 2001; coverage: Karvina district and Prague; data sources: low-threshold and methadone substitution; sample sizes: 38 and 60.
Estonia	Period 1994-95; coverage: Tallin; data source: not specified; sample size: 57.
Hungary	Period 2001; coverage: data source: those registered with the treatment system; sample size: 315.
Latvia	Year 2001; coverage: Riga; data source: syringe exchange; sample size: 261.
Lithuania	Year 2000; coverage: national; data source: not specified; sample size: 693.
Romania	Year 2001, coverage: Bucharest; data source: drug treatment centres; sample size: app. 1 200.
Slovakia	Year 2001; coverage: Bratislava; data source: first treatment demand; sample size: 183.
Slovenia	Year 2001; coverage: national; data source: treatment centres; sample size: 554.

the period 1996 to 1998 to above 70 % during the period 1999 to 2001. These trends may reflect true changes in prevalence rates. However, we should be cautious in drawing such a conclusion in all cases. The differences may also reflect changes in testing patterns or changes in some characteristics of the mix of IDU subpopulations tested, for example differences in the history or duration of injecting, or some other methodological inconsistencies over time.

Estimates of the prevalence of HCV infection among new IDUs who have been injecting illicit drugs for less than two years are available for only two CEECs, the Czech Republic, where the prevalence is below 20 %, and Slovenia, where it ranged from 0 % in 1996 to a peak of 13 % in 1999 before falling again, to 7 %, in 2001. These HCV prevalence estimates are much lower than corresponding estimates reported from EU countries, where they are generally 40 % or higher (EMCDDA, 2000c).

Information about newly diagnosed cases of HCV infection among IDUs may enable national trends to be monitored in countries with stable testing patterns among IDUs as well as unchanging reporting patterns. For example, it was reported from the Czech Republic that the annual incidence of acute HCV infection among IDUs declined from 21 per million general population in 1999 and 2000 to 16 per million in 2001, suggesting a recent decrease in high-risk injecting behaviour among IDUs.

Hepatitis B infection

Information about the prevalence of HBsAg (the serological marker that indicates that HBV infection is still present) among IDUs was available only for Bulgaria, Hungary and Romania; information about the prevalence of antibodies to HBV was available from the Czech Republic, Estonia, Latvia, Lithuania, Slovakia and Slovenia (Figure 11).

The presence of antibodies to HBV (HBcAb, HBsAb) may indicate either current or previous infection, or vaccination against hepatitis B. Thus, differences in vaccination practices between countries must be taken into account when comparing information about the prevalence of antibodies to HBV among IDUs. The proportion of IDUs who have none of the HBV markers (HBcAb, HBsAb, HBsAg) in their blood indicates those who are still at risk of infection and thus represents the potential vaccination population. If information on the prevalence of some or all markers of HBV infection were available from all CEECs, the data would be much easier to interpret and compare.

Bulgaria, the Czech Republic, Lithuania and Slovenia collect HBV surveillance information that enables monitoring of trends. In most cases, it is difficult to conclude whether these trends reflect true changes in prevalence rates. In Bulgaria, for example, the prevalence of HBsAg among tested IDUs in Sofia gradually declined from 16 % in 1996 to 5 % in 2001. Possible explanations for this finding, other than a true decrease in prevalence, include changes in access to testing and criteria for testing (e.g. more IDUs without clinical signs of infection tested more recently), changes in the characteristics of IDUs (e.g. an increase in

younger users or users who have been sharing injecting equipment for a shorter period, or changes in the patterns of equipment sharing with IDUs who are not HbsAg carriers) and increased access to, or uptake of, vaccination against hepatitis B.

Tuberculosis and other diseases

Information on the burden of tuberculosis (TB), sexually transmitted infections (STIs) and some other serious health problems that are associated with injecting drug use is scarce. Although in some CEECs TB may present a substantial health problem among IDUs, with reported incidence rates much higher than in the general population and many HIV/TB co-infections (Latvia, Romania), in others TB among IDUs does not seem to be a major problem. In Slovenia, for example, among 372 acute TB cases

diagnosed in 2001 (18.7 per 100 000 population), only two had a history of injecting drug use.

Drug-related infectious diseases' risk behaviour

Although surveillance of high-risk injecting and sexual behaviour should ideally be an integral part of drug-related infectious diseases surveillance among IDUs, such information is scarce. Systematic collection of comparable information on two high-risk injecting behaviour indicators (sharing needles and syringes, lifetime and last 30 days prevalence) was promoted by the Pompidou Group project on treatment demand. The project was designed to monitor trends relevant to problem drug use by collecting comparable data at the point of treatment demand. A total of 23 European cities participated, including some in the

Figure 11: (A) Prevalence (%) of HbsAg among IDUs in the CEECs, 2001 or most recent year for which an estimate is available (B) Prevalence (%) of antibodies to HBV among IDUs in the CEECs, year 2001 or most recent year for which an estimate is available

Figure 11A: HbsAG

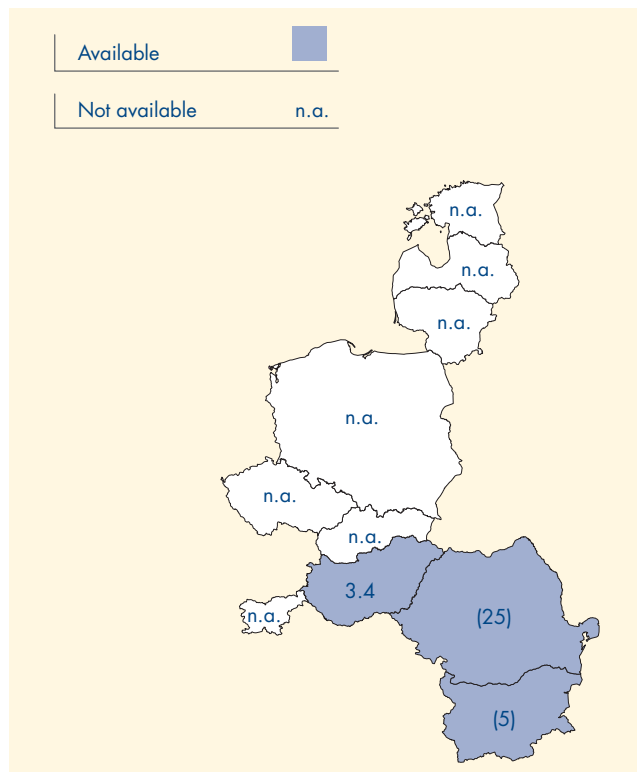
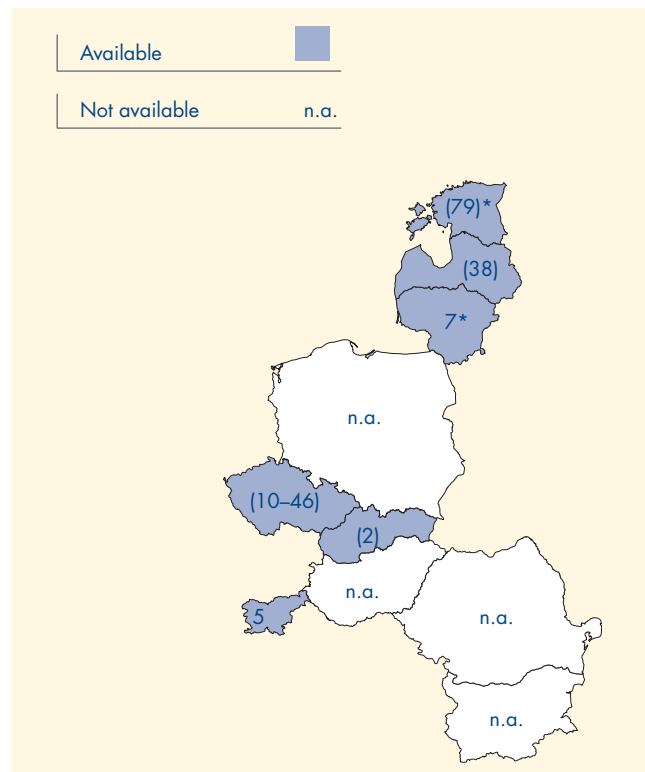


Figure 11B: HBV



NB: Data in brackets are local. If an estimate was only available for a different year and not the year 2001, it is marked with *. If several estimates were available, the range is given. Differences between countries have to be interpreted with caution due to different data sources or different IDU sub-populations tested as well as different surveillance or study methods used.

Sources: Reitox national focal points.

Bulgaria	Year 2001; coverage: Sofia; data source: treatment centres, needle exchanges, low threshold services, outreach; sample size: 689.
Czech Republic	Year 2001; coverage: Karvina district and Prague; data sources: low-threshold and methadone substitution; sample sizes: 39 and 60.
Estonia	Period 1994-95; coverage: Tallin; data sources: not specified; sample size: 57.
Hungary	Period 2001; coverage: data source: those registered with the treatment system; sample size: 315.
Latvia	Year 2001; coverage: Riga; data source: syringe exchange; sample size: 261.
Lithuania	Year 2000; coverage: national; data source: not specified; sample size 698.
Romania	Year 2000; coverage: Bucharest; data source: drug treatment centres; sample size: approximately 1 200.
Slovakia	Year 2001; coverage: Bratislava; data source: first treatment demand; sample size: 101.
Slovenia	Year 2001; coverage: national; data source: treatment centres; sample size: 550.

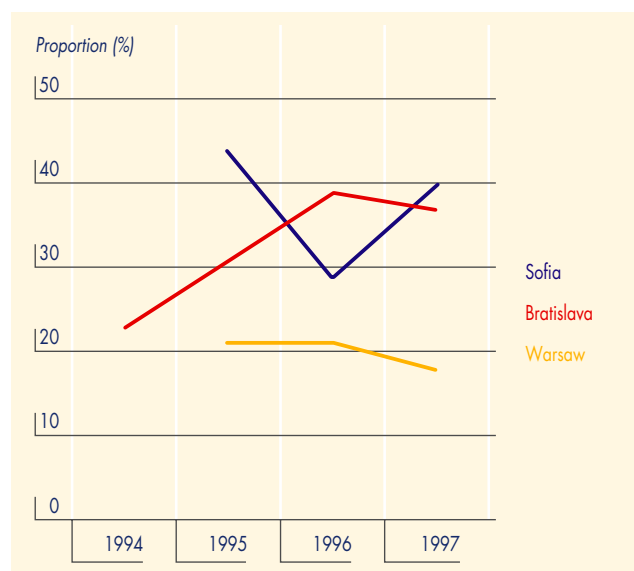
CEECs. The proportions of current IDUs (i.e. who had injected in the last month) who reported sharing needles and syringes in the month prior to treatment demand are shown in Figure 12 for three selected cities for a period of several years (Pompidou Group, 1999). Results are shown only for those cities that could supply data for at least 100 IDUs each year. Although validity is obviously a concern with self-reported information, the results are informative. Such an approach is clearly appropriate for monitoring trends and has the potential to reflect changes in the access of IDUs to sterile injecting equipment, e.g. through syringe exchange programmes (SEPs). The proportion of IDUs who reported sharing injecting equipment was disturbingly high and does not provide support for the desired beneficial effect of SEPs. Data collection was stopped in 2001.

Various one-off research projects on high-risk injecting and sexual behaviour among IDUs have been conducted in the CEECs. It is difficult to use the results of such studies to draw comparisons between countries, as surveyed populations, data collection methods and time frames may all differ, as may the high-risk behaviour indicators measured as well as the presentation of results. However, such studies are very informative and extremely valuable for the design of prevention and harm reduction interventions among IDUs in the specific local context, and can also contribute to evaluation of their impact.

In 2001, a major survey of injecting and sexual risk behaviour among IDUs, combined with testing for HCV and HBV infection, was conducted in Ida-Virumaa, a region of Estonia. A total of 2 930 IDUs who visited different SEPs completed the survey questionnaire. The overall survey response was very high (98 %). Sharing syringes was reported by 45 % of clients. Purchasing syringes from pharmacies was reported by 31 %. Fifty per cent of respondents admitted to having at least four sexual partners in the preceding year but only 15 % claimed to use condoms regularly.

Smaller-scale studies have been carried out in many other CEECs. For example, in 2001, 95 IDUs were interviewed at several different locations in Budapest. They were asked questions about high-risk injecting and sexual behaviour, including sex with non-IDUs, and about their perception of their risk of contracting infections, previous exposure to preventative messages or interventions, access to testing for HIV, HCV and HBV and whether they had been vaccinated against hepatitis B. Sharing needles and syringes during the previous month was reported by 33 % and sharing of other paraphernalia was admitted by 41 %. More than one sexual partner during the preceding month was reported by 34 % of sexually active IDUs and exclusively non-IDU partners by 26 %. Twenty-eight per cent reported having

Figure 12: Proportion of current IDUs (injected last month) who reported sharing needles and syringes within the month prior to treatment demand, 1994–97 (Pompidou Group multi-city project on treatment demand)



Source: Adapted from Pompidou Group (1999).

received drugs in exchange for sex in the past month and 21 % had received money for sex. Seventy-two per cent of respondents perceived themselves to be at risk for HIV infection, but only 14 % believed themselves to be at risk for hepatitis (HAV, HBV or HCV). Eighty-six per cent had received preventative information or a protective device at some time in their life, 47 % had been tested for HIV and 40 % for any of the hepatitis viruses, and 14 % had been vaccinated against HBV.

The results of several other studies in CEECs were reported in the 2002 report on the drug situation in the candidate CEECs (EMCDDA, 2002a).

Harm reduction

Access to sterile injection equipment and information on safer drug use is essential to minimise the spread of drug-related infectious diseases among IDUs. In addition, promotion of safer sex, including the use of condoms, among IDUs as well as with non-users helps to contain sexual transmission of these infections.

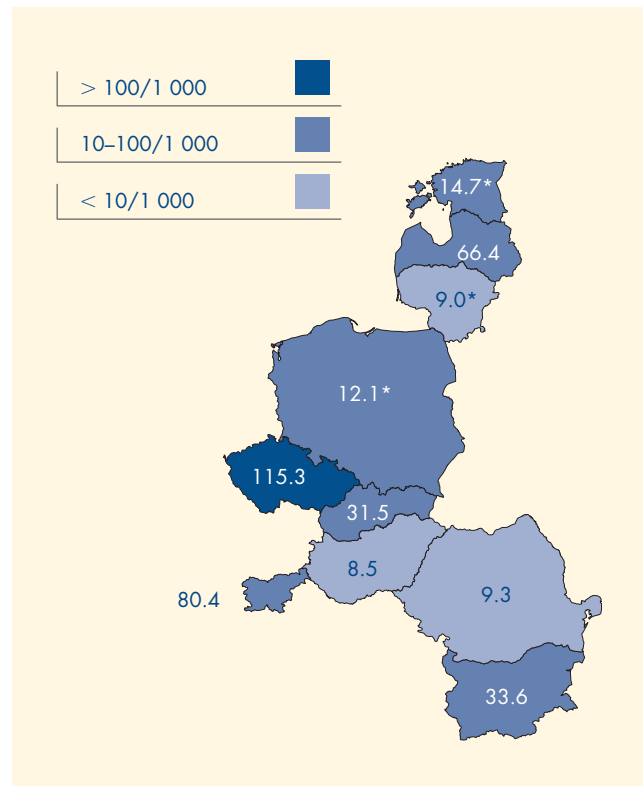
In all CEECs for which information is available, sterile injection equipment can be purchased from pharmacies without a prescription. In 2001, in most CEECs the price of syringes in pharmacies was EUR 0.1. The exceptions were Estonia, where the price was lower (EUR 0.06), and Slovenia and Romania, where it was higher (EUR 0.14 and up to EUR 0.2 respectively). Only in Slovenia and Latvia can syringes also be exchanged or distributed through

pharmacies. Not a single CEEC reported the existence of a national programme to support the sale of syringes to IDUs in pharmacies, although Estonia and Latvia reported sporadic efforts to provide at least some training for pharmacists with the aim of raising awareness of the need to prevent drug-related infectious diseases among IDUs. With the exception of Lithuania, no CEEC reported the distribution of prevention information targeted specifically at IDUs through pharmacies. Information on the numbers of syringes sold to IDUs through pharmacies would be very valuable in assessing the overall access of IDUs. The Czech Republic reported that in 2001 approximately one million syringes were sold to IDUs through pharmacies (97.8 syringes per 1 000 total population). National estimates of the proportion of IDUs who purchase sterile injecting equipment through pharmacies are generally not available, except in Hungary, where the figure in 2001 was approximately 30–40 %.

All CEECs have in place some community-based or outreach harm reduction programmes that provide access to sterile injecting equipment and information on safer drug use and often also promote safer sex, including the distribution of condoms. In Poland, the 'National programme for prevention and counteracting of AIDS', adopted in 1988, recommended the introduction of SEPs, and the largest non-governmental organisation, Monar, started distribution in 1988 (UN ODCCP/Unaid, 2003). In 1989, the Minister for Health and Social Welfare required provincial head physicians to appoint special centres to initiate free distribution of sterile injecting equipment and to allocate appropriate financial resources for that purpose. Slovenia and the Czech Republic implemented SEPs in 1992 and 1993 respectively, to be followed by several central European countries in the mid-1990s: Slovakia in 1994, Bulgaria and Hungary in 1995 and Romania in 1998. Among the Baltic States, Lithuania and Estonia were the first to introduce SEPs, in 1996 and 1997 respectively, followed by Latvia in 1999. In CEECs for which information is available, the number of syringes exchanged or distributed in 2001 varied from 8.5 per 1 000 total population in Hungary to 115.3 per 1 000 in the Czech Republic. Thus, in the Czech Republic in 2001, an estimated 213.1 syringes per 1 000 population were either obtained through SEPs or bought in pharmacies. The numbers of syringes exchanged or distributed among IDUs per 1 000 population in 2001 or the last year for which information was available are shown in Figure 13.

The wide differences in rates are informative about the coverage of SEPs. More meaningful figures would take account of estimated numbers of IDUs; however, the accuracy and comparability of available IDU prevalence estimates vary substantially between CEECs. In several

Figure 13: Total estimated numbers of syringes exchanged or distributed among IDUs per 1 000 general population in CEECs, year 2001 or most recent year for which an estimate is available



NB: If an estimate was available for a different year and not year 2001, it is marked with *. Differences between countries have to be interpreted with caution due to different availability of information and possible validity constraints.

Sources: Reitox national focal points.

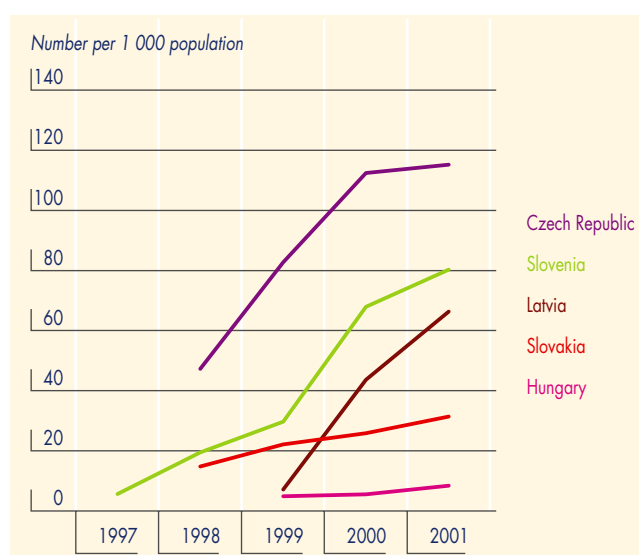
Bulgaria	Year: 2001; coverage: 5 programmes, in Sofia (2), Pleven, Plovdiv, and Burgas; year of implementation of the first programme: 1995; ratio of exchanged versus distributed syringes: not available.
Czech Republic	Year 2001; coverage: national (65 sites); year of implementation of the first programme: 1992; ratio of exchanged versus distributed syringes: 1/1.
Estonia	Year 2000; coverage: 20 programmes, in Tallin, Tartu, Narva, Sillamae, Kohla-Jarve, Johvi, Kivioli; year of implementation of the first programme: 1997; ratio of exchanged versus distributed syringes: not available.
Hungary	Year 2001; coverage: 7 programmes, in Budapest (3), Miskolc, Veszpren, Pecs, Szeged; year of implementation of the first programme: 1995; ratio of exchanged versus distributed syringes: not available.
Latvia	Year 2001; coverage: 7 programmes, in Riga, Jurmala, Tukums, Liepaja, Olaine; year of implementation of the first programme: 1999; ratio of exchanged versus distributed syringes in 2001: 1/0.89.
Lithuania	Year 2000; coverage: in 5 cities; year of implementation of the first programme: 1996; ratio of exchanged versus distributed syringes: not available.
Poland	Year 2000; coverage: not available; year of implementation of the first programme: not available; ratio of exchanged versus distributed syringes: not available.
Romania	Year 2001; coverage: 4 programmes, in Timisoara (Timisiensis XXI), Bucharest (ARAS, ALIAT, Open doors), some other cities (ARAS); year of implementation of the first programme: 1998; ratio of exchanged versus distributed syringes in 2001: 2.88/1.
Slovakia	Year 2001; coverage: 4 programmes, in Bratislava (3), Banska Bystrica (1); year of implementation of the first programme: 1994; ratio of exchanged versus distributed syringes: not available.
Slovenia	Year 2001; coverage: 3 programmes at least, in Ljubljana, Celje, Zalec (last two through pharmacies); year of implementation of the first programme: 1992; ratio of exchanged versus distributed syringes in 2001: 1/0.80.

CEECs for which information is available, the increase in the numbers of sterile syringes exchanged or distributed in recent years indicates a gradual improvement in the availability of sterile injecting equipment (Figure 14). This trend is encouraging, but still availability does not meet demand. If demand for sterile exchanges were satisfied (the ideal situation), trends in exchanged or distributed sterile injecting equipment would reflect increases or decreases in demand, and could provide a means of monitoring changes in the extent of injecting drug use.

In most CEECs for which information is available (Bulgaria, Hungary, Latvia, Slovenia), there are no major limitations on SEPs, such as requiring a used needle in exchange for a new one, and sterile syringes are distributed relatively liberally. In contrast, in Estonia, one-for-one exchange is strictly enforced. Information on the ratio of sterile syringes supplied in exchange for used ones in SEPs in 2001 was available for only three countries and was 1 to 0.98 in Latvia, 1 to 0.80 in Slovenia and 1 to 0.35 in Romania. The perception that funding for SEPs is inadequate and geographical coverage insufficient is almost universal, although in most CEECs some SEPs have been established outside the capital cities.

Promotion of safer sex among IDUs, including the promotion of condom use, should be an integral part of any community-based or outreach harm reduction programme for IDUs. Nevertheless, information on such interventions, for example on the numbers of condoms distributed, is less readily available, although it is known that condoms have been distributed to IDUs through SEPs in

Figure 14: Trends in estimated numbers of syringes exchanged or distributed among IDUs per 1 000 general population in selected CEECs, 1997–2001



Source: Reitox national focal points.

several countries (Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Romania and Slovenia). SEPs are less reliable as a source of condoms than of sterile injecting equipment. However, condoms can be purchased readily in all CEECs, the price varying from EUR 0.3 to EUR 0.7 each in countries which provided this information (the Czech Republic, Hungary, Latvia, Slovenia).

Substitution treatment

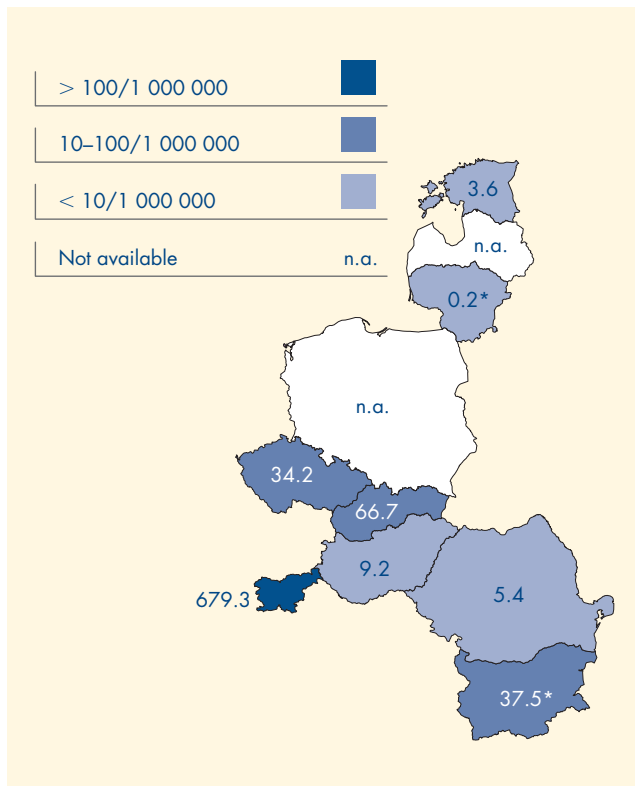
Substitution treatment is available to IDUs in all CEECs; however, availability varies considerably. In 2001 in Slovenia, 679 IDUs per million total population were on methadone maintenance, but the corresponding rate in Estonia was only 3.6. Total estimated numbers of IDUs receiving methadone substitution treatment per million population in 2001 or the most recent year for which an estimate is available are shown in Figure 15. With the possible exception of Slovenia, access to methadone substitution is clearly insufficient. The next highest rates were in Slovakia and the Czech Republic, but here the numbers of drug users receiving methadone were approximately 10–20 times lower. Like coverage of SEPs, more meaningful rates would take account of the estimated numbers of IDUs.

Information on trends was available from some CEECs. It is encouraging that from 1997 to 2001 the numbers of clients on methadone increased from 464.2 per million population to 679.3 in Slovenia, from 4.1 to 66.7 per million in Slovakia and from 2.1 to 3.6 per million in Estonia. Information on the extent to which substitution treatment is available through general practitioners in the CEECs, if at all, is not available. Thus, caution is needed when interpreting available information on substitution with methadone as availability of substitution treatment in general. In Slovakia, for example, buprenorphine can be prescribed by general practitioners, indicating greater availability of substitution treatment than suggested by methadone substitution data only.

Vaccination against hepatitis B

Vaccination against hepatitis B is, in principle, available to IDUs in most CEECs. In practice, coverage is far from ideal and is very low in most countries. Information about shorter basic vaccination schedules, which are sometimes used to increase completion rates among IDUs, is scant, although the Czech Republic reports the use of such schedules during HBV epidemics. Vaccination of IDUs against HBV is not usually covered by health insurance schemes, except in Slovenia, where most clients on methadone substitution who are in regular contact with primary healthcare services have therefore been vaccinated. In the future, all IDUs will

Figure 15: Total estimated numbers of IDU clients on substitution treatment per million general population in the CEECs, year 2001 or most recent year for which an estimate is available



NB: If an estimate was available for a different year and not year 2001, it is marked with *. Differences between countries have to be interpreted with caution due to different availability of information and possible validity constraints.

Sources: Reitox national focal points.

Bulgaria	Year 2002; first programme in 1995; coverage 1 site in Sofia; substitution drug: methadone.
Czech Republic	Year 2001; pilot programme: approved programmes started in 1997; coverage: 8 sites: in Prague and in 7 other cities; substitution drug: methadone.
Estonia	Year 2001; first programme: in 1997; coverage: 2 sites; substitution drug: methadone.
Hungary	Year 2001; first programme: 2001; coverage 4 sites; substitution drug: methadone; data on individual prescriptions since 1993 not included.
Lithuania	Year 2000; first programme: 1995; coverage: 4 cities; substitution drug: methadone.
Romania	Year 2001; first programme: information not available; substitution drug: methadone.
Slovakia	Year 2001; first programme: 1997; coverage: 1 site, in Bratislava; substitution drug: methadone; bupronorphine can be prescribed by any general practitioner.
Slovenia	Year 2001; first programme in 1990; coverage: 17 sites, countrywide; substitution drug: methadone.

have been vaccinated, as immunisation against hepatitis B has been introduced for the general population in all CEECs. In many countries, the basic immunisation series should be completed within the first year of life, but in some, i.e. the Czech Republic, Estonia, Hungary, Slovenia and Romania, older age groups are targeted, either exclusively or in addition to children in the first year of life (at age 12, 13, 14, 6 and 9 respectively). The estimated coverage in 2001 was generally high, ranging from 90 %

in Estonia to as high as 99 % in the Czech Republic, Poland and Slovakia (WHO, 2003). Thus, for example, in the Czech Republic, where 12-year-olds have been vaccinated since 2001, the vast majority of 16-year-old adolescents will have been vaccinated by 2005, and in Slovenia, where immunisation of six-year-olds was introduced in 1998, this target will be achieved by 2008.

Access to counselling and testing

Many CEECs provide access to anonymous HIV counselling and testing, but testing policies and practices vary. In Lithuania, for example, a Ministry of Health decree makes HIV testing mandatory for all known IDUs at least once per year. In contrast, in Slovenia, optional confidential testing is offered annually to all clients on methadone maintenance. Estonia reports that testing for HCV infection, available previously, has now been stopped as all available resources have been reassigned to diagnosing HIV infection.

Access to treatment

Good comparable information on IDUs' access to treatment for HIV and HCV is not readily available. In all CEECs for which information is available, treatment, if provided, is free of charge. Generally, access to good-quality treatment for HIV or HCV infection seems to be very limited. Highly active anti-retroviral therapy (HAART) for all HIV-infected IDUs seems to be readily available only in the Czech Republic, Hungary and Slovenia.

Summary and conclusions

- Drug-related infectious diseases among injecting drug users (IDUs), i.e. HIV, HCV and HBV infection and some other serious diseases, including TB and sexually transmitted diseases, are key public health problems arising from drug use-related harm. The high prevalence of these infections among IDUs also represents a potential threat for the spread in the general population.
- To reduce substantially the incidence of drug-related health damage, including HIV, HCV and HBV infection, is one of the six main targets of the EU drug strategy (2000–04).
- Recently, HIV infection has spread among IDUs in Estonia and Latvia at an alarming rate, and in 2001 HIV prevalence among a group of IDUs in Tallin reached 41 %. HIV prevalence remained below 20 % in Poland, below 5 % in Lithuania and below 1 % in all other CEECs, the last figure being lower than in any EU Member State.

- In many CEECs (Bulgaria, Estonia, Latvia, Lithuania), the prevalence of antibodies to HCV among IDUs is higher than 60 %, as it is in most EU Member States. In some others (the Czech Republic, Hungary, Slovakia, Slovenia), although still high, the figure is below 40 %.
- Reasons for variation in the burden of drug-related infectious diseases between countries include differences in high-risk behaviour patterns, the time of introduction of infections, access of IDUs to sterile injecting equipment, information on safer drug use and treatment programmes (notably substitution treatment) and coverage of hepatitis B vaccination programmes. It is very difficult to isolate the individual effects of these and other potential factors.
- Prevention of HIV and HCV infections among IDUs mostly depends on preventing high-risk injecting and sexual behaviour and encouraging behavioural change. Thus, high-risk behavioural surveillance that monitors changes in such behaviour over time should be an integral part of drug-related infectious diseases surveillance. Unfortunately, at present, such information is scant.
- In all CEECs for which information is available, sterile injection equipment can be purchased in pharmacies without prescription and community-based or outreach harm reduction programmes that provide access to sterile injecting equipment are in place. However, national programmes to support easy access to syringes through pharmacies do not exist, and insufficient funding for and geographical coverage of SEPs is almost universal. Similarly, although substitution treatment programmes (mostly methadone maintenance, which has proved effective in reducing unsafe injecting) do exist, availability is even more limited.
- In principle, vaccination against hepatitis B is available to IDUs in all CEECs, but the coverage is far from ideal. However, vaccination coverage among IDUs is expected to improve in the future, as immunisation of the general population against hepatitis B has been introduced in all CEECs. Targeted vaccination programmes should be implemented in the short term to protect current cohorts of injectors, while coverage of IDUs should be continuously monitored.
- Extensive harm reduction interventions are essential in lowering the burden of HIV, HCV and HBV infections. In countries where widespread introduction of harm reduction interventions preceded the introduction of HIV infection, the future burden of AIDS among IDUs, as well as among the general population, will probably be much lower than elsewhere.
- Good comparable information on IDUs' access to testing for HIV, HCV and HBV as well as treatment for HIV and HCV is not readily available. Testing policies and practices vary between CEECs. In the majority of CEECs, access to high-quality treatment for either HIV and HCV infection seems to be very limited.
- Reitox national focal points in CEECs should continue to support further development of infectious diseases' indicators at a national level, the introduction of evidence-based measures and the collection of data on the type and coverage of specific responses.
- Evidence has been accumulating that the introduction of harm reduction programmes with good coverage, as well as provision of substitution treatment that is easy to access, contributes to lower levels of drug-related infectious diseases (Hurley et al., 1997). It is known that HIV infection, once introduced in the IDU community, may, depending on the level of high-risk behaviour, spread extremely rapidly (Unaided/WHO, 2000). This is currently occurring in Estonia and Latvia. The introduction of harm reduction interventions with good coverage contributes to lower

Further challenges for meaningful data collection

Evidence-based national and internationally coordinated prevention and harm reduction interventions, aimed at reducing the incidence of drug-related HIV, HCV and HBV infection among IDUs and minimising the risk of spread of these infections to the general population, requires improved collection, analysis and dissemination of objective, reliable and comparable information about the burden of and trends in drug-related infectious diseases among IDUs. Sufficient resources should be allocated at both the international and national level, and options for more intensive collaboration between relevant institutions, in particular those specialising in drug use and infectious diseases, should be explored.

Regular, harmonised routine information collection on drug-related infectious diseases, complemented by data collection on relevant behavioural indicators and in-depth studies, should be encouraged as an integral part of infectious disease surveillance among IDUs.

With regard to prevention of drug-related infectious diseases among IDUs, the provision of objective information about risks, risk behaviour education, vaccination against hepatitis B, methadone maintenance and other types of treatment and access to sterile syringes and other injecting equipment is important and should be monitored and evaluated against the background of infectious disease prevention as a concrete policy target.

HIV infection prevalence at a later stage of the epidemic. In Poland, the timely introduction of SEPs (in 1988) is assumed to have been responsible, at least in part, for the low number of cases of HIV infections occurring among IDUs (UN ODCCP/Unaid, 2003). HIV infection has not yet begun to spread rapidly in many CEECs. Harm reduction interventions and widely available substitution treatment will, if introduced

promptly, before HIV infection takes hold of the IDU population, result in a lower prevalence of HIV infection in the future than if interventions are introduced only once infection has started to spread. Those countries in which extensive harm reduction interventions have preceded the introduction of HIV infection in the IDU community, for example the Czech Republic and Slovenia, have invested well.

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Chapter 4

Characteristics of drug strategies in the acceding and candidate countries

This chapter provides a descriptive review of the main instruments of drug policy, namely laws, strategies and coordination arrangements in the field of drugs.

Introduction

This chapter is based on the Reitox national reports, the official drug strategies and the legal texts included in the European legal database on drugs (ELDD) (<http://eldd.emcdda.eu.int>). The chapter is also the fruit of a close collaboration within the national focal points and other professionals in the acceding and candidate countries.

Owing to the limitations of the data and information available, the chapter is confined to a description of the formal arrangements currently in place in the countries reviewed. More in-depth aspects, such as implementation of laws, assessment of national strategies or effectiveness of drug coordination mechanisms, are therefore outside the scope of this review. Clearly, comparing only the formal structures of drug policy, i.e. laws, plans and coordination systems, precludes a more accurate analysis and can mask the differences between those countries in which official positions are effectively translated into practices and those in which good intentions remain 'on paper'. Only accurate case studies can reveal the extent of implementation of a national drug strategy; however, taking into account the above-mentioned constraints, it is important, as a first step, to report on formal structures, recording the commitment of governments to face the drug problem.

This chapter discusses the 13 EU acceding and candidate countries to the EU. However, because of the scarcity of the available information, the principal focus is on the 10 countries of central and eastern Europe, confining consideration of Malta, Cyprus and Turkey to the legislative aspects.

Legislation ⁽²¹⁾

Development of laws

Since 1991, most of the acceding and candidate countries have been active in making major changes to their legislation in order to address the drug problem. As well as being in conformity with the UN conventions, before 1990

the drug laws in a number of the countries concerned seem to have been similar to the legislative framework of the former Soviet Union. This effectively provided a relatively homogeneous basis from which each country is independently developing its national legislation. In these countries, changes or consolidation of legislation in the drugs field have been particularly noticeable since the mid-1990s.

Most acceding and candidate countries have chosen to address the offences of drug possession and trafficking in their penal code. In the last 10 years, seven ⁽²²⁾ have replaced or significantly revised their penal codes to include revision of drug offences and/or penalties. Among those countries that have specific laws to describe drug offences, Romania and Poland have passed comprehensive new laws in the past five years, and Malta's main drug control laws, which date back several decades, last underwent a major update in 1985.

Despite their comparatively recent changes of legislation, the Czech Republic and Hungary have already undertaken selective studies to try to assess the implementation of these laws. In the Czech Republic, the preliminary results of these studies showed that the 1999 criminalisation of 'possession of amounts greater than small' brought more social costs than benefits — at a minimum, the situation would have been aided by definition of the threshold quantity, for which prosecutorial guidelines were issued in 2000, and identification of different categories of drugs based on harm ⁽²³⁾. In Hungary, the criminalisation of any use, again in 1999, was considered to have had more negative consequences than positive effects, and so this specific offence was removed in 2003.

Legal attitudes to drug users

Three countries (Cyprus, Malta, Turkey) consider use per se to be a criminal offence, although in one (Malta) the offence applies only to the use of prepared opium. Between 1999 and 2003, use was also an offence in Hungary, but this was changed following evaluation, as reported above. A number of countries (Romania, Estonia, Latvia and

⁽²¹⁾ Information was not available from the ELDD network for Slovenia for this section.

⁽²²⁾ Slovakia (1996), the Czech Republic (1999), Latvia (1999), Bulgaria (2000), Romania (2000), Estonia (2002), Lithuania (2003) and Hungary (1999, 2003).

⁽²³⁾ In preparation at the time of writing.

Lithuania) prohibit consumption of controlled substances without prescription, but this is usually punishable by an administrative sanction for a first offence.

There are clear differences between countries in the interpretation of 'possession of small amounts of drugs for personal use'. Of the nine countries (Bulgaria, Cyprus, Hungary, Lithuania, Malta, Poland, Romania, Slovakia and Turkey) that treat this as a criminal offence, four (Cyprus, Malta, Romania and Turkey) criminalise all unauthorised possession regardless of quantity and two (Bulgaria and Hungary) do not consider the intent behind the possession. Poland and Lithuania have chosen to establish this act as a criminal offence only recently, when previously it was an administrative offence. These countries may recognise mitigating circumstances to reduce the punishment.

Three countries (the Czech Republic, Estonia and Latvia) maintain administrative measures to punish the first offence of possession of a small quantity of drugs for personal use. This is similar to the Soviet code, which held that possession of a small quantity of any narcotic drug for personal use was an administrative rather than a criminal offence (Babayán, 1990). These countries nevertheless retain the option to prosecute the offender under the criminal code if the offence is repeated or if the quantity of drugs is greater than small. All have set specific limits in their legislation or guidelines for prosecutors to indicate the maximum amount of a 'small quantity', whereas many countries in the EU leave this to the discretion of the judge or prosecutor (ELDD, 2003).

It is interesting to note that a number of acceding and candidate countries have moved towards criminalising possession for personal use, or use itself, over the past 12 years, while the most recent drug law modifications within the European Union countries have addressed the same question in a different way (ELDD, 2002).

Trafficking

As stated above, in some of the acceding and candidate countries a 'small quantity' of drugs is clearly defined in law, and possession of more than this amount is considered a crime, although not necessarily as trafficking. In three countries (the Czech Republic, Estonia and Latvia), the criminal offence committed in possessing more than a small amount of drug varies depending on intent, and the sentences that can be imposed are more severe if the reason for possession is sale or profit. For example, in Poland, the maximum penalty for possessing a considerable quantity of drugs is lower than the maximum penalty for supplying any quantity with intent to benefit. As already

noted, in Bulgaria and Hungary the motive is generally not taken into account in the description of the offence. In Hungary, offences are distinguished by small or large quantities of drugs, while in Bulgaria a wide range of sentences can be imposed for all illegal acts related to possession or supply. The law in Bulgaria provides for a separate offence only if the offender is drug dependent and the quantity possessed suggests intention of personal use.

Small-scale selling to finance one's own addiction is addressed by specific legal provisions in Hungary, and certain provisions might cover this in Estonia and Poland. However, it would require a more detailed survey on the implementation of the law to clarify whether or not these provisions are used in such circumstances, or if this is taken into account when sentencing for a trafficking offence.

Most of the acceding and candidate countries provide for separate offences of cultivation and of trafficking (possession or supply for sale or benefit, which also normally includes production). In some countries (including Estonia, Latvia, Lithuania and Poland), cultivation attracts a lesser maximum sentence than production or trafficking, but in Bulgaria a group formed for the purposes of production or cultivation, rather than trafficking, could attract the most severe sentences.

Finally, in many of the acceding and candidate countries the law accommodates specific increases in sentences when a group or criminal organisation is involved in drug trafficking. This may take the form of aggravating circumstances or a separate offence.

Penalties for drug possession and trafficking in the acceding and candidate countries are shown in Table 4.

National drug strategies

Current national drug strategies

The information in this section comes from the 10 candidate or acceding countries of central and eastern Europe (CEECs), i.e. Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia. Information from Malta, Cyprus and Turkey was not available. National drug strategies are in place, or are in the process of being adopted, in all 10 CEECs. This trend to develop policy plans, also visible at EU level, shows that the CEECs are increasingly planning and committing to the implementation of drugs-related activities as part of a wider, more comprehensive approach that embraces a global national drug policy (Table 5). Indeed, in many cases, drug strategies in the CEECs appear to have drawn on

Table 4: Penalties for drug possession and trafficking in the acceding and candidate countries

Country	Penalties for possession for personal use ⁽¹⁾ ⁽²⁾	Penalties for trafficking (imprisonment) ⁽³⁾
Bulgaria	High-risk drugs: 10–15 years Risk drugs: 3–15 years	High-risk drugs: 10–15 years Risk drugs: 3–15 years Smuggling large quantities: up to 20 years Involvement in a group: up to 15 years for trafficking, up to life for production
Cyprus	Up to life imprisonment, and/or a fine	Up to life imprisonment depending on class of drug
Czech Republic	Administrative fine If quantity greater than small: up to 2 years	1–5 years If a larger extent, or involving an organised group: 2–10 years Involvement in international criminal organisation, or large financial benefit: 10–15 years
Estonia	Small quantities: administrative fine or administrative detention up to 30 days Large quantities: as trafficking	Small quantities: fine or 1 year Large quantities: 1–5 years (if a repeated offence or involved in a group: 2–10 years)
Hungary	Small quantity: up to 2 years	2–8 years If involved in an organised group: 5–10 years If a large quantity: 5 years to life
Latvia	If a small amount (defined): administrative fine or administrative detention up to 15 days Up to 3 years	Up to 10 years If by group: 5–12 years If large amounts or especially dangerous substances: 8–15 years
Lithuania	Up to 2 years	Up to 3 years If a large amount: 2–8 years If a very large amount: 5–15 years
Malta ⁽⁴⁾	Magistrates court: 3–12 months and/or a fine Criminal court: 1–10 years	Psychotropic medicines: Magistrates court: 3–12 months and/or a fine Criminal court: up to 10 years All drugs except psychotropic medicines: Magistrates court: up to 10 years Criminal court: life, or up to 30 years
Poland	If lesser gravity: up to 1 year, limitation of liberty or a fine Up to 3 years	Up to 8 years If considerable quantity: up to 10 years
Romania	2–5 years	High risk: 10–20 years Risk drugs: 3–15 years Smuggling: up to 25 years If by an organised group, then up to life
Slovakia	Up to 3 years	2–8 years If of considerable or substantial value: up to 10 years If in conjunction with an organised group: 12–15 years, or up to life if exceptional
Turkey	1–2 years	Sale and related acts: 4–10 years Sale of cocaine, heroin, morphine: 6–15 years Import or manufacture: up to 30 years If by an organised group: increase sentence by half

⁽¹⁾ Countries may have offences addressing any possession/possession for personal use/possession without intent of trafficking.

⁽²⁾ Many countries have more than one offence that might describe the behaviour of the offender, with different sanctions. The prosecutor chooses which is the most appropriate in each case.

⁽³⁾ Here, trafficking describes any offence that includes sale or distribution of drugs.

⁽⁴⁾ The Maltese system allows the prosecutor to choose the court for the trial, which will affect the range of sanctions available.

management criteria, being comprehensive, oriented towards targets and implementation, and emphasising coordination.

Most national drug strategies in the CEECs have direct links to the EU drug strategy and the EU action plan on drugs (2000–04). For example, the six objectives of the EU plan constitute a core set of aims for the Czech strategy and are expressly mentioned in the new texts of Estonia and Latvia as well as in the national drug strategies of Poland and Romania and in the draft strategies of Lithuania and Slovenia. This trend also reflects response to the international demand for a ‘balanced, comprehensive and multidisciplinary approach’, made to the countries of the UN system by the United Nations General Assembly Special Session (Ungass) on drugs in June 1998.

All national drug strategies analysed in this section are structured to cover actions in the areas of both demand reduction and supply reduction. In each case, the strategies outline measures to reinforce or upgrade law enforcement activities (e.g. police, customs, border patrols), as well as to establish or strengthen structures and programmes geared towards improving drug prevention in the community and treatment and rehabilitation, including, in many cases, measures to reduce the negative consequences of drug use. Although this does not automatically ensure that a ‘balanced approach’ is implemented, the fact that both sides of the drug problem (demand and supply) are taken into account in national strategies can be considered a good starting point.

Generally, national drug strategies appear to be intended to last for four to five years. However, in some CEECs it is felt that longer-term planning is needed if the strategy is to have an impact on the drug phenomenon. In Hungary, the 2000 drug strategy set targets up to 2009; and in Slovakia the national programme against drugs, updated in 1999, will cover up to the year 2003 with the prospect of extending it to 2008. Estonia is expected to adopt a strategy that would remain in place until 2012.

The status of the national drug strategies is another interesting area. In Romania and Slovakia, the strategy is reported to be binding on all ministries involved in its implementation. In particular, the Slovak strategy calls on each ministry to report annually, in a so-called actualisation meeting, on its own activities in relation to the national programme, if necessary revising, goals, tasks, time frames and financing. In the Czech Republic, activities covered by the drug strategy are binding to the extent that each ministry is obliged to adopt its own plan, and to evaluate the resulting budgetary impact. Similarly, the new Estonian drug strategy will require administrations to plan their own activities to meet predefined deadlines. These methods and instruments ensure greater accountability and execution of anticipated tasks, even if the national drug strategy in itself lacks ‘official’ binding powers.

Many of the national drug strategies in the CEECs are revisions of previous strategies on the drug situation in the country. In some cases, failure to implement the previous drug strategy (for political or financial reasons) was the

Table 5: Current national drug strategies in the candidate countries

Date of adoption	Country	National strategy
1999	Lithuania	National drug control and drug prevention programme, 1999–2003
	Slovakia	National programme for the fight against drugs (adopted in 1995 and updated in 1999) until 2003 with the prospect of extension to 2008
2000	Hungary	National strategy to combat the drug problem
2001	Czech Republic	National drug policy strategy, 2001–04
2002	Bulgaria	National anti-drug strategy, 2002–07
	Poland	National programme for counteracting drug addiction, 2002–05
	Romania	National strategy on drugs, 2002–04
	Slovenia	National programme on drugs, 2003–08
2003 (under way; provisional titles and dates)	Slovenia	National programme on drugs, 2003–08 (not yet adopted at the time of writing)
	Estonia	National drug strategy, 2012
	Latvia	Drug control and drug abuse prevention programme, 2004–08
	Lithuania	National drug control and drug prevention programme, 2004–07

motive for conceiving a new document focused more on the issues of financing, performance and implementation. An attempt to apply an evidence-based approach lies behind most of the revision processes. Revision of the current situation and the involvement of a large number of professionals are also two key aspects of current national drug strategies elsewhere in the EU (EMCDDA, 2002d).

In the Czech Republic, for example, the national drug strategy presents the results of a detailed analysis of the strengths, weaknesses, opportunities and threats (so-called SWOT analysis) of current drug policy. This analysis contributed to the definition of priorities, objectives and tasks of the new strategy. In Poland, the national programme against drugs (2002–05) is the result of an extensive revision of the previous drug strategy (1999–2001), put together during a three-week seminar. The seminar closed with a total of nearly 30 experts contributing to the drafting of the new strategy. Analysis of the current drug situation and foreseeable trends forms the basis of new strategy documents in Slovenia and in Estonia. In the latter, cooperation with Germany in a twinning project was reported to be a key factor. In Romania, the national strategy on drugs (2002–04) anticipates broad participation by governmental and non-governmental institutions working in the field of drugs, as well as guidance from Spanish experts as part of a Phare twinning project.

The work undertaken by the Phare assistance programme and, more recently, under the aegis of Phare twinning projects (Table 6) seems to have contributed to the promotion of best practice (at least in the area of

establishing institutions), shaping a culture focused on delivery and performance. This has had the beneficial effect of promoting the sharing of competencies and experiences among old and new members of the EU.

In Latvia, Lithuania and Romania, a twinning project with Spain played a major role in promoting the adoption of a new structured policy plan and of a central coordination agency, along the lines of the Spanish governmental delegation for the national plan on drugs. In Bulgaria, the twinning project with the UK has had a clear effect on the organisation of the delivery of the national drug strategy at local level by instituting a system of municipal drug councils, similar in concept to the UK drugs action teams⁽²⁴⁾. In addition, French twinning partners have helped to evaluate the Polish drug strategy.

Goals and themes

In examining national drug strategies three common goals emerge:

- improve effective implementation and delivery of coordinated actions in the field;
- establish a realistic approach to illegal drug use and trafficking;
- reduce problems caused by drugs.

Improving implementation

Improving the effectiveness of implementation appears to assume particular emphasis in the national strategy of Bulgaria, where a renewal of national structures and a new action plan is envisaged, and of Latvia, via better coordination and guaranteed financing. The new strategy in Lithuania aims to create a new policy framework for coherent and widely integrated drug policy, whereas in the Czech Republic ‘real responsibility’, ‘active participation’ and cooperation among all governmental and non-governmental organisations are advocated. Finally, Slovenia’s priorities generally focus on reinforcing structures and programmes.

Establishing a realistic approach

In Romania and Hungary, more emphasis is placed on achieving predetermined drugs policy objectives. In Romania, the overall goal of the strategy is to provide, through demand and supply reduction, a realistic approach to illegal drug use and trafficking. The Hungarian strategy favours a ‘free, confident and productive society’, ‘managing the health, social and criminal hazards and harms related to drug use and trade’.

Reducing problems

Reducing the problems posed by drugs is emphasised in the new Estonian strategy and in the national drug strategy of

Table 6: Phare twinning projects

Country	Twinning partner
Bulgaria	United Kingdom
Czech Republic	Austria
Estonia	Germany
Hungary	Spain
Latvia	Spain
Lithuania	Spain (leading partner) and Sweden
Poland	France
Romania	Spain
Slovakia	France
Slovenia	Spain (leading partner) and Austria

Similar twinning projects are expected to start between Cyprus, Spain and Greece, and Turkey, Spain and Greece.

⁽²⁴⁾ In the UK, drugs action teams are local permanent structures composed of all actors in the community who are involved with the delivery of the drug policy.

Poland. Similarly, the strategy adopted in Slovakia aims to tackle the health, psychological and social damage caused by drugs.

The four traditional pillars on which drug policies are based — prevention, treatment, law enforcement and international cooperation — are present, to varying degrees, in all of the national drug strategies that were reviewed. In addition, cross-analysis reveals three other common principles: partnership, coordination and scientific monitoring. Partnership, defined as interaction between ministries and agencies, is strongly emphasised in many national documents. Coordination, or the improvement of coordination and cooperation systems in the field of drugs, is also the focus of many strategies. Scientific monitoring is considered important with the aim of basing drugs policy on scientific evidence rather than assumptions. These three guiding principles are particularly evident in the national drug strategies of Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Poland and Romania.

In addition, harm reduction is expressly referred to as a guiding principle of drug strategy in some countries (the Czech Republic and Estonia); in Poland, the term used is 'health risks reduction'. Other pillars of drug strategies include mass media policy in Slovakia, intervention in prisons in Estonia and implementation at local level in Bulgaria (Table 7).

Implementation

As far as the implementation of national drug strategies is concerned, it is clear that without a rigorous evaluation it is

impossible to verify whether the envisaged activities have (a) been fully implemented, (b) contributed to the achievement of the fixed objectives or (c) had an impact on the drug situation. Nevertheless, confining the analysis to the formal structures of the national strategies, some criteria that could facilitate the implementation of the stated goals and objectives can be identified. Most national drug strategies include performance indicators set against evaluation tools and detailed objectives for different areas of intervention. Moreover, the fact that a large number of professionals have been involved in the conception of most of the national strategies, and also form part of the implementation process, is a positive finding.

The national drug strategies of the Czech Republic, Hungary and Poland, in particular, set down performance indicators and evaluation tools for short-, medium- and long-term objectives in the form of a matrix. In addition, the Estonian strategy includes a biannual implementation plan (annexed to the new national strategy, 2003), and the draft of the new Slovenian national programme on drugs (2003–08) includes a national drug strategy and an action plan. In Lithuania, the draft drug strategy (2004–07) comprises an action plan detailing activities, budget and responsible authorities.

Thus, improving the management and scientific culture seems to be a key element in the process of implementing the new national drug strategies. However, as reported by some countries, this objective-oriented approach might be cancelled out, in reality, by the lack of appropriate resources or political will to be allocated to the field of drugs (Table 8).

Table 7: Main themes in national drug strategies

Bulgaria	Balanced policy	Strategic coordination	Information exchange	Local policy delivery			
Czech Republic	Primary prevention	Harm reduction	Treatment and rehabilitation	Repression			
Estonia	Prevention	Treatment and rehabilitation	Harm reduction	Supply reduction	Drugs in prison	Monitoring and evaluation	
Hungary	Community	Prevention	Social work	Therapy and rehabilitation	Supply reduction		
Latvia	Coordination	Drug demand reduction	Drug supply reduction	Monitoring information research evaluation training	International cooperation		
Lithuania	Drug demand reduction	Drug supply reduction	Monitoring assessment information research evaluation	International cooperation			
Poland	Prevention	Treatment rehabilitation	Health risks reduction	Supply reduction	Research monitoring assessment		
Romania	Drug demand reduction	Drug supply reduction	International cooperation				
Slovakia	Drug demand reduction	Drug supply reduction	Mass media policy	International cooperation			
Slovenia	Human rights	Coordination	Support to programmes	Global action	Decentralisation	Public order	Special groups in populations

Table 8: Examples of the objective-oriented approach in the CEECs' national drug strategies

Bulgaria	The national drug strategy sets out 22 tasks divided between demand reduction (12) and drug supply reduction (10).
Czech Republic	The strategy, which is to be implemented by both public and private authorities, identifies over 80 tasks, presented in an annex to the strategy document.
Estonia	Each chapter of the strategy includes one long-term objective for the year 2012 and mid-term objectives for the year 2007.
Hungary	Each of the four main objectives is subdivided into short-, medium- and long-term objectives. Dates for achievement are, respectively, 2000, 2002 and 2009.
Latvia	The new drug programme to be adopted in 2003 puts the accent on delivery and measurable performance, being structured by goals, objectives and targets.
Lithuania	The draft of the national drug strategy contains a detailed list of measures to be carried out, identifying who is responsible for execution, the date for achievement and anticipated expenditure for the year of reference, together with the required funds and the financing source.
Poland	Objectives and tasks are identified and developed, looking at their measurability. The strategy focuses particularly on clear identification of accountability, responsibility and financial allocation. Time scales and estimated costs for each institution are also included.
Romania	General and specific objectives and action plans are identified, and each ministry has its own plan of action in line with the aims of the national drug strategy. Deadlines for evaluation are set for 2003 and 2004.
Slovakia	Each general objective has a set of sub-objectives to be achieved: nine in the area of demand reduction, eight in the area of drug supply reduction and law enforcement, three in the mass media policy area, and six in the international cooperation area.
Slovenia	In the future strategy, objectives are divided into general objectives (to 2002–08), mid-term objectives (from 2004 to 2006) and priorities (until the year 2004). Concrete actions with clear definitions will be listed in the action plan.

Evaluation

Despite the proliferation of national strategy documents, the concept of evaluation is generally considered infrequently or is less structured than might be expected. In general, the aim of providing detailed objectives, tasks, financing, accountability and a timetable is to identify potential improvements and resolve eventual problems. While some activities suggestive of an evaluation culture are emerging in some countries, across the region as a whole an evaluation culture tends to be lacking. Only a few examples can be found: in Poland, drug strategy is evaluated with the support of its twinning programme with France, and in Bulgaria it appears that the proposed national anti-drug agency will be in charge of evaluation of the Bulgarian strategy.

As far as the other countries are concerned, it would be more accurate to say that a more or less structured 'process of monitoring' is in place. For example, in Hungary, the Secretariat of the Coordination Committee routinely conducts interviews and collects data on the implementation of the national drug strategy. In the Czech Republic, the various ministerial tasks are annually revised by the government. This process is coordinated by the Secretariat of the National Drug Commission. In Slovakia, 'the actualisation system' (see above) allows for annual review and redirection of national drug strategy activities, and in Slovenia the new national action plan (envisaged in the 2004–04 drug strategy) is to be audited biannually, in

association with preparation of the national budget, which takes place every two years. In addition, the new Lithuanian strategy foresees the establishment of a drug control department, which will report to the government and will be responsible for management, control, evaluation and implementation of the strategy.

Some countries are in the process of implementing, or are about to adopt, their second or third national strategic plan, and yet still make no clear reference to scientific evaluation. Further work could be carried out in this area.

Financing

Out of 10 national drug strategies analysed, only that of Lithuania provides an indication, 'on paper', of the costs of planned activities. In the other countries, the national drug strategy does not have a specific budget, and the ministries or institutions involved are more or less expected to finance their tasks out of their own budget allocation.

The issue of financing in general is considered in the national strategies of Poland and Romania, each of which dedicates a specific chapter of the document to this subject. In the Czech Republic, where the issue of financing is regarded as an objective with long, medium and short-term goals, each ministry is called on to evaluate the budgetary impact of the activities identified in the strategy. In Estonia, too, the new strategy envisages that each ministry will earmark funds to be used in the implementation of its own activities.

Lack of financing was frequently cited as the reason for non-implementation of previous policy plans and/or coordination structures, especially in Latvia and Lithuania. In some countries, although the issue of financing the national drug strategy is important, more serious problems than drug abuse (e.g. poverty and alcoholism) are higher in the list of national priorities.

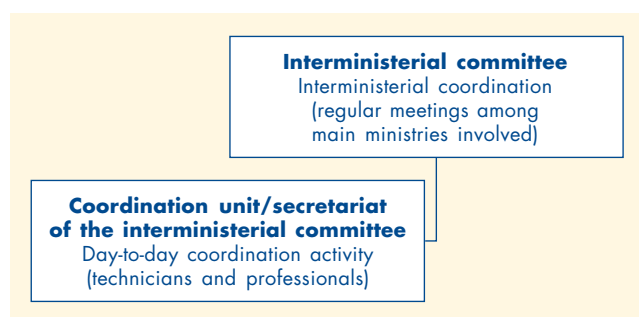
Coordination

There is widespread consensus in the CEECs about the need to enhance cooperation and coordination among all actors involved at governmental and non-governmental level in order to implement drug policy effectively. Indeed, national drug strategies often cite improved coordination as a main objective, a prerequisite for the achievement of which is a stronger political will and greater resources. The lack of uniform data and information from all countries makes it difficult to present comprehensive and in-depth comparisons. However, one observation that can be made is that, throughout the region, coordination seems to rely on a uniform, two-level model composed of an interministerial committee and a technical body (Figure 16).

Interministerial committee

In all the CEECs, an interministerial committee, whether designated National Drugs Commission, Board of Ministers or National Drugs Council, ensures drug coordination at a political level. The interministerial committee is the main coordination authority and is made up of representatives of all ministries and public agencies involved in the delivery of drug policy. In most cases, it acts as the government's advisory, coordination and initiation body in the field of drugs. In some cases, it is also responsible for control activities. The committees normally meet two to four times a year, with meetings often timed to coincide with important events, such as revision of laws, drawing up of drug plans or preparation of strategic documents. Ministers and Secretaries of State are required to participate, in person, in those meetings (Table 9).

Figure 16: Model of coordination of national drug policy



Permanent coordination units

The second level is represented by a more technical unit composed of technicians and professionals. Its role usually includes coordinating and planning national drug strategy on a permanent basis and, depending on the country, perhaps also monitoring and exchange of information. In four countries (Bulgaria, the Czech Republic, Hungary and Slovakia), these functions are performed by the secretariats of the interministerial committees. In the remaining countries the task of permanent coordination is performed by other governmental drug coordination units (Table 10). In the Czech Republic, Poland, Slovakia, and in the future in Romania, the national focal points of the Reitox network come under the auspices of these coordination units.

The two-level structure is similar to the model of coordination adopted in many EU countries. However, in the current Member States, the technical coordination units tend to have a more important role, being increasingly responsible for coordinating the day-to-day implementation of drug strategy, leaving interministerial committees to make the strategic and political decisions.

Responsibility for drug coordination appears to lie with one of the government departments traditionally involved in drug policy, but which one varies from country to country. As shown in Figure 17, responsibility for drug coordination lies in five cases within the Ministry of Health or Social Affairs, in two cases with the Ministry of the Interior and in three countries with the Council of Ministers. In Slovenia, it is intended that responsibility for drug coordination will in the near future be transferred from the Prime Minister's office to the Ministry of Health. These findings reflect the situation in the EU at present, with 12 out of 16 Member States ⁽²⁵⁾ having allocated the responsibility of drug coordination to ministries dealing with social matters.

Although responsibility for drug coordination is relatively clear-cut in the 10 CEECs, the role of national coordinator (as found in the EU countries) is less well developed. In the CEECs, the head of either the interministerial committee or the permanent coordination unit (Tables 9 and 10) usually assumes the typical role of national drug coordinator ⁽²⁶⁾, which mainly involves control and reporting at a political level, acting as a link between workers in the field and decision-makers, and coordinating, managing and assuming public accountability. However, comparison between countries is not possible as the term 'national drug coordinator' is not defined in the national drug strategies of the CEECs.

⁽²⁵⁾ The 15 EU Member States plus Norway.

⁽²⁶⁾ This is the expression used in current terminology (especially in the international arena) to label those responsible for drug coordination at national level. The expression 'national drug coordinator' is not consolidated at European level.

Table 9: Interministerial committees in charge of coordination in the field of drugs

Country	Interministerial committee	Chair
Bulgaria	National Drugs Council	Minister for Health
Czech Republic	National Drugs Commission	Prime Minister; Executive Vice-Chairman: Deputy Prime Minister
Estonia	Ministers' Committee on Drug Policy	Minister for Social Affairs
Hungary	Coordination Committee on Drug Affairs	Co-Chairs: Ministers for Children, Youth and Sport and Health, Social and Family Affairs
Latvia	National Drug Control and Drug Abuse Prevention Coordination Commission ⁽¹⁾	Minister for the Interior
Lithuania	Governmental Drug Control Commission ⁽²⁾	Minister for Health
Poland	Council for Counteracting Drug Addiction	Deputy Minister for Health
Romania	n.a. ⁽³⁾	
Slovakia	Board of Ministers for Drug Dependencies and Drug Control	Deputy Prime Minister for EU Integration, Human Rights and Minorities
Slovenia	Interministerial Drug Commission	Minister for Health

⁽¹⁾ In Latvia, the new strategy envisages the establishment of a new central coordination body.
⁽²⁾ In Lithuania, the draft strategy envisages the establishment of a new central coordination body, the drug control department, reporting to the government.
⁽³⁾ In Romania, the Interministerial Committee for the Fight against Drugs was wound up in December 2002 when the new Anti-Drugs National Agency was created.

Table 10: Permanent coordination units and their location within governmental administrations

Country	Permanent coordination offices	Location
Bulgaria	Secretariat of the National Drug Council ⁽¹⁾	Ministry of Health
Czech Republic	Secretariat of the National Drugs Commission	Council of Ministers
Estonia	Department of Public Health	Ministry of Social Affairs
Hungary	Secretariat of the Coordination Committee on Drug Affairs	Ministry of Children, Youth and Sport
Latvia	n.a.	
Lithuania	Secretariat of the Governmental Drug Control Commission	State Public Health Service
Poland	National Bureau for Drug Prevention (including the Secretariat of the Interministerial Council)	Ministry of Health
Romania	Anti-Drugs National Agency	Ministry of the Interior
Slovakia	Secretariat of the Board of Ministers for Drug Dependencies and Drug Control	Council of Ministers
Slovenia	Government Office for Drugs	Council of Ministers

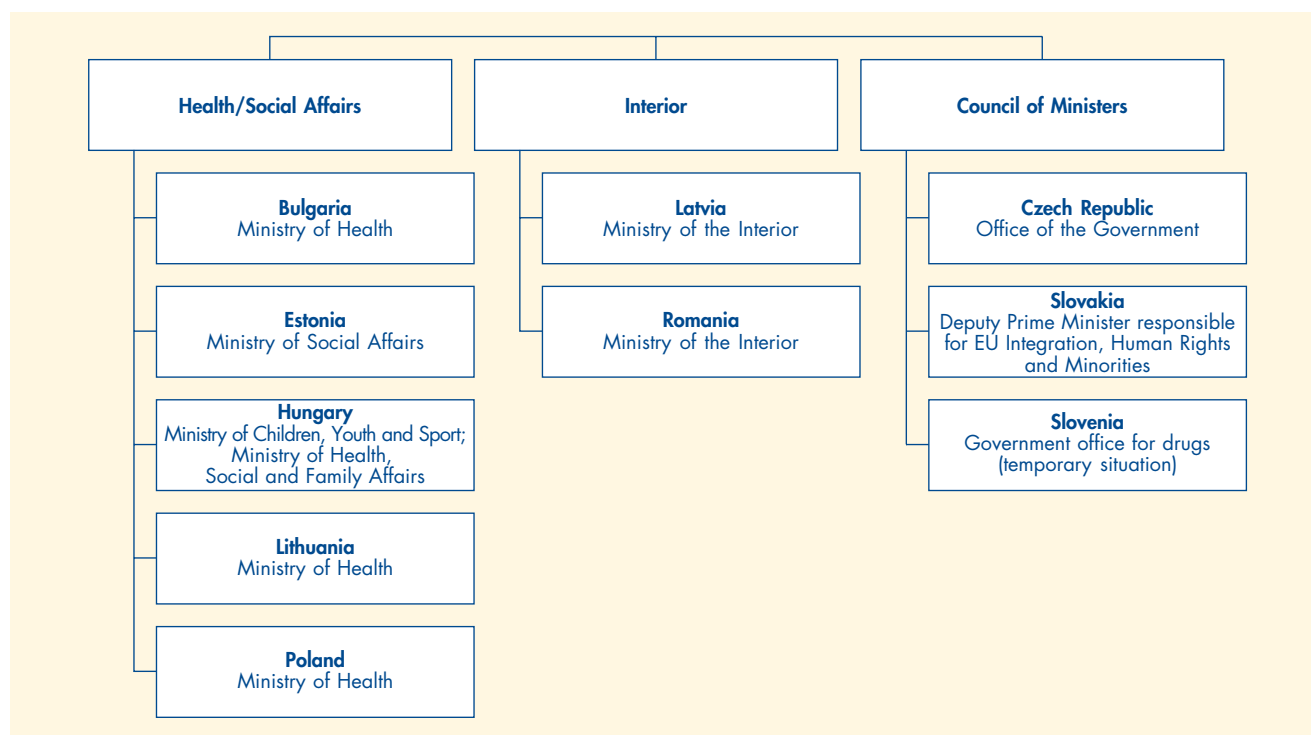
⁽¹⁾ In Bulgaria, the new strategy proposes the establishment of a drugs policy coordination and analysis unit.

The implementation of drug coordination, despite appearing well structured 'on paper', has run into some obstacles in some countries. For example, in Estonia, the interministerial committee established in 1996 to ensure coordination of national drug policy held no meetings between 2000 and 2002. And in Latvia, the National Drug Control and Drug Abuse Prevention Coordination Commission, created in 1993, has hardly been operational since 1996 and was not operational at all in 2002 because

it lacked an executive secretary, staff members and a specific budget. Finally, in Romania, the interministerial committee met only on rare occasions, and in December 2002 it was replaced by the National Anti-Drugs Agency.

Modification of institutional frameworks and the creation of new central permanent coordination bodies, especially with the assistance of twinning partners, is often seen by the CEECs as a chance to introduce more effective concepts

Figure 17: Main responsibility for coordination in the field of drugs in the national administrations



and instruments of coordination. In this regard, a drugs policy coordination and analysis unit is to be established in Bulgaria to support the National Drug Council and to coordinate the delivery of the strategy across ministries. In Latvia, a new, central coordination body is envisaged (the national drug agency).

As far as the scope of coordination is concerned, insufficient information is available to analyse the remit of coordination bodies, either interministerial committees or permanent coordination units, and to analyse whether their powers extend to global coordination, involving all aspects of drugs policy, or only to specific areas, e.g. demand or supply reduction. Further research is needed to assess the true extent of global coordination.

Coordination in the field of drugs is, of course, very important, particularly at regional and local level, where the political objectives of national drug strategies have to be translated into actions on the ground. Local drug coordination initiatives are reported from several CEECs. In the Czech Republic, drugs commissions are responsible for overseeing the implementation of regional drug policy strategies and are headed by a regional coordinator. In Hungary, the Coordination Fora on Drug Affairs have started to operate at local level to coordinate local drug demand reduction activities. In Estonia, Councils of Drug Prevention have been established in all counties since 2002, and in Romania a network of 47 centres for counselling and anti-drugs activities is in place. Finally, in

Bulgaria, following the twinning project with the UK, Municipal Drugs Councils (MDCs) have been established at local level. Made up of senior representatives of all agencies, institutions and organisations dealing with drug issues in the municipality, their main objective is the delivery of the national strategy and the action plan at local/municipal level. To this end, MDCs are asked to adopt municipal and regional action plans for the prevention of drug use and treatment of drug users. Once again, only further investigation can reveal the true extent of drug coordination at the local level.

Conclusions

All acceding and candidate countries have been active in the legislative field since 1990. Although, initially, for historical reasons, legislation shared similarities in many of the countries, it is clear that subsequent movements have taken very different directions. As amendments to the penal code have been enacted in a number of countries even in the last three years, the dust has not yet settled. The majority of countries treat possession of a small amount of drugs for personal use as a criminal offence, but three countries consider this to be an administrative violation. Bulgaria and Hungary do not address the intent of any possession in their legal provisions but take into account the degree of addiction of the offender as a reason for leniency. Sentences for trafficking are similar to those in the current EU Member States.

It is commendable that, even within this relatively short time scale, the Czech Republic and Hungary have planned and carried out some form of scientific evaluation or impact analysis of their legal changes, and then have had the confidence to take action on the results of that evaluation.

Policy plans in the form of national drug strategies are in place, or are about to be adopted, in all CEECs. These documents are based on a global approach, set objectives and deadlines, refer to the EU drug strategy's objectives and identify responsibility for implementation. Therefore 'formally' and in general terms, the CEECs seem to be moving in the direction of a 'balanced, comprehensive and multidisciplinary approach' (Ungass, 1998). However, this official picture should be compared with the implementation of these national strategies in the field at regional and local level.

As far as coordination is concerned, joining together the few elements collected it is apparent that coordination of drug policy in the CEECs appears to be quite a new concept. In some countries, the national coordination systems are very new and are therefore not yet fully operational, while in others coordination structures, although they have been in place for some time, have not been implemented owing to lack of resources. In a few countries, the coordination bodies seem to focus specifically on drug demand reduction rather than on all aspects of drug policy. In some, the systems of regular ministerial reporting and auditing are reported to be efficient. This picture should be revisited when more detailed and accurate data become available.

In the course of drafting this chapter professionals working in the national focal points as well as government officials were asked for their opinion on what, if necessary, could be done to improve the national strategy and drug coordination system. The answers, which took into account local characteristics and needs, revealed some common views.

In general, it is recognised that the new national drug strategies, compared with the previous ones, more closely meet the requirements of a 'balanced, multidisciplinary and comprehensive approach' to drug policy. It is also acknowledged that more effort should be put into ensuring the effectiveness of programmes and projects and in the overall management of the strategy. This could perhaps be achieved by improving collaboration among institutions involved in the implementation and upgrading the skills of the staff and actors involved. A second aspect on which there is broad agreement is that coordination units should have some executive power in terms of management and coordination of the national drug strategy. The lack of executive power is sometimes seen as the weak point of coordination bodies. A management culture should also be encouraged and implemented, with the focus on intensive communication and clarification of competencies and roles. Finally, it was emphasised that at EU level it would be extremely helpful to organise regular annual meetings of those responsible for coordination, implementation and evaluation of national strategies.

The research conducted during the preparation of this chapter suggests that the drug strategies of the CEECs broadly satisfy the vision outlined by professionals and officials interviewed. They tend to be comprehensive, centrally coordinated and orientated towards a global long-term approach, and some are also structured to monitor performance. This might be the result of the involvement of experts and professionals in the field (from EU countries too), in the drafting and sometimes also in the conception phase.

However, it is clear that the desire to work towards a 'modern drug policy', centrally coordinated and structured in objectives, targets and performance indicators, if it is to be fulfilled, needs a strong political and financial will and greater attention to effectiveness.

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The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of the European Union's decentralised agencies. Established in 1993 and based in Lisbon, it is the central source of comprehensive information on drugs and drug addiction in Europe.

The EMCDDA collects, analyses and disseminates objective, reliable and comparable information on drugs and drug addiction. In doing so, it provides its audiences with an evidence-based picture of the drug phenomenon at European level.

The Centre's publications are a prime source of information for a wide range of audiences including policy-makers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public.

This annual report presents the EMCDDA's yearly overview of the drug phenomenon in the acceding and candidate countries to the European Union. The printed publication is complemented by an online version available at: <http://candidates.emcdda.eu.int>.



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