# Annual Report
# The Czech Republic
# 2005 Drug Situation

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Annual Report: The Czech Republic – 2005 Drug Situation

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**CONTENTS**

## SUMMARY AND NEW TRENDS

The year **2005 was the first year of the implementation of the National Drug Policy Strategy for the Period 2005 to 2009** and the Action Plan of the National Drug Policy Strategy Implementation for the period 2005 to 2006. The Action Plan contains a total of 144 tasks which are mostly aimed at ministries. They are divided into 43 goals which relate to seven drug policy fields: (1) primary prevention; (2) treatment and aftercare; (3) harm reduction; (4) drug supply reduction and law enforcement; (5) coordination and funding; (6) the field of information, research, and evaluation, and (7) international cooperation.

The most significant system changes in the field of drug policy in 2005 involve:

- Adoption of **Act 379/2005 Coll.**, on Measures for Protection from Harm Caused by Tobacco Products, Alcohol, and Other Addictive Substances as amended, which, inter alia, **defines responsibilities** regarding the guaranteeing of drug policy by state administration and self-administration bodies. For the first time in the history of the Czech Republic, it **defines basic types of services for drug users**.
- Launch of the system of Certification of the Professional Competency of Services for Drug Users, which was approved by Government Resolution No. 300 in March 2005.
- Adoption of Rules for Drawing Financial Resources for Drug Policy from the State Budget, which were approved by Government Resolution No. 700 in June 2005.

**Drug policy expenditures increased** by approximately CZK 44 million (€ 1.48 million) in 2005 compared to 2004. There is an annual increase in the amount of financial resources provided by regions.

The situation in the field of drug use in the general population has remained stable; no significant change was recorded in 2005. No general population survey or national school survey was carried out in 2005. Approximately 20% of the adult population has tried an illicit drug, according to surveys from 2002 and 2004, and the prevalence of drug use among secondary school students is even higher (44% among 16-year-old and 56% among 18-year-old secondary school students). Cannabis and ecstasy are the most commonly used illicit drugs, and there is a very limited extent of experience with drugs with more serious health and social risks (opiates, pervitin, cocaine) in the general population.

**The estimated number of problem users of pervitin and opiates increased slightly in 2005**. As far as pervitin is concerned, the increase was most probably caused by the further dissemination of pervitin in night-life and dance settings, including small towns. The increase in the number of opiates users involves those who use Subutex obtained from the black market as their primary drug by injection. There are still significant regional differences in the prevalence of problem drug users and the types of the substances used (Prague and the Ústí region report a significant proportion of users of opiates, including Subutex, while pervitin users prevail in other regions and the use of Subutex is reported less frequently or seldom). **The average age of problem drug users who are in contact with helping facilities increased again**; the proportion of problem users aged under 19 has a decreasing tendency. Therefore, it is very likely that no new generation of young problem drug users is growing up.

Approximately **a third of the users who are in contact with helping facilities are infected with hepatitis C**, and approximately 10% are infected with hepatitis B. There was a decline in the number of new reported cases of drug users infected with hepatitis A and B. **HIV/AIDS prevalence** in the population of Czech injecting drug users **continues to remain under 1%**. The occurrence of infections among drug users has been stable in recent years; infections are not spreading in an epidemic manner. However, it is alarming that the **number of tested drug users is continually decreasing, which is largely caused by a shortage of quick screening tests** on the Czech market which can be used in low-threshold facilities, and that the number of problem drug users from Eastern Europe, where the occurrence of hepatitis and HIV/AIDS is markedly higher, is increasing. The **number of syringes distributed in exchange programmes continues to increase** – 3.3 million of them were exchanged in 2005.

The **number of drug-related deaths (overdoses) has remained stable**. Drug-related deaths most commonly involve opiates, pervitin, and inhalants – each of these accounts for approximately 20 deaths per year. Sporadic overdoses on ecstasy and cocaine have been reported in the last 2–3 years.

A wide spectrum of services with good accesibility provides for harm (risk) reduction and the treatment and resocialisation of drug users in the Czech Republic. **The network of low-threshold programmes has remained stable** (approximately 60% of problem drug users are in contact with them). **Outreach work with drug users has been developing** in recent years. The network of outpatient and inpatient health facilities has remained stable. Two therapeutic communities ceased to operate in 2005; on the other hand, aftercare programmes including sheltered housing and sheltered work programmes have been developing. **The number of specialised substitution centres is increasing**, and new methadone programmes were opened in the Southern Bohemia and in 2006 in Karlovy Vary regions. **A pilot methadone treatment programme started in two prisons** in 2006. The quantity of Subutex being consumed is increasing. The number of people who use Subutex (either prescribed by a physician or from the black market) is unknown. One of the reasons is that the Substitution Treatment Register does not yet allow for reporting from outpatient facilities which prescribe Subutex only. It is estimated that 20–30% of opiates users are in

substitution treatment programmes (it is difficult to make a more exact estimate because of unknown number of Subutex users).

**The number of drug offences, as well as the number of those prosecuted for or accused of these crimes in 2005, was approximately the same as in 2004**. Even the number and proportion (8%) of cases of the possession of drugs in a quantity greater than small as a percentage of overall drug offences has remained approximately the same. **The number of those sentenced for drug offences has decreased for the first time since the beginning of the 1990s**. Pervitin is the drug which is most commonly associated with drug-related crime and its proportion is increasing, while the proportion of cannabis drugs is decreasing. The proportion of custodial sentences is increasing among those sentenced. The proportion of suspended sentences, first offenders, and juveniles among those sentenced for cannabis-related offences is markedly higher than among those sentenced for offences which involved other drugs.

**The number of drug seizures by law enforcement bodies in 2005 was approximately the same as in 2004.** The only exception involved a decline in the volume of hashish and ecstasy seized and an increase in the volume of cocaine seizures. The Czech Republic is a country where pervitin (methamphetamine) is produced and from which it is also illegally exported abroad; an increase in pervitin production from freely available medicaments which contain pseudoephedrine occurred in 2005. A significant proportion of the cannabis consumed is also covered by domestic production. The Czech Republic continues to be a target and transit country for other drugs.

**Drug prices remain at a stable level**; street drug purity has been relatively stable, despite year-on-year differences in the purity of drugs which were analysed by the law enforcement authorities – the differences can also be caused by seizures of large quantities of pure drugs (namely heroin) before they were adulterated for sale to the end user.

## DATA CONSISTENCY

Despite partial insufficiencies, the quality of the data available in the Czech drug information system is satisfactory. It makes it possible to track multiple yearly trends and new phenomena on the drug scene.

Low and stable rates of mortality resulting from overdoses on opiates correspond to a decreasing estimated number of heroin users and to an increasing number of Subutex users. The number of pervitin users who are in contact with low-threshold and treatment programmes is not decreasing, which suggests that pervitin is readily available on the black market – an increase in pervitin production from freely available medicaments which contain pseudoephedrine was recorded in 2005. Sporadic deaths resulting from cocaine overdoses were recorded in the last two years – this corresponds to an increasing prevalence of cocaine among recreational drug users on the dance scene and an increasing number of cocaine-related crimes; nevertheless, the prevalence of cocaine and its use in the general population or among problem drug users is still low in the Czech Republic. The stable occurrence of hepatitis and HIV/AIDS and the decreasing number of reported clinical cases of hepatitis reflect the growing efficiency of needle exchange programmes and expansion of substitution treatment.

## PART A: DEVELOPMENTS AND NEW TRENDS IN 2005

# 1 National Drug Policy and Its Context

The Government of the Czech Republic is responsible for the preparation and enforcement of the national drug policy. The Council of the Government for Drug Policy Coordination (CGDPC) is the main initiating, counselling, and coordinating body of the Government for drug-related issues. Ministers of the appropriate ministries are members of this Council. The Council meets approximately four times a year. The Secretariat of the CGDPC is an organisational part of the Office of the Government of the Czech Republic and provides for the activities of the Council.

Act 379/2005 Coll., on Measures for Protection from Harm Caused by Tobacco Products, Alcohol, and Other Addictive Substances, was adopted in 2005. Inter alia, it defines responsibilities regarding the guaranteeing of drug policy by state administration and self-administration bodies. It defines basic types of services for drug users for the first time in the history of the Czech Republic.

The National Drug Policy Strategy for the period 2005 to 2009 (the 2005–2009 National Drug Strategy) has come into force. The Action Plan for the Implementation of the National Drug Policy Strategy for the period 2005–2006 (the 2005–2006 Action Plan) was also adopted in 2005, and it defines activities, deadlines, and responsibilities regarding the goals which were mentioned in the strategy.

The system of Certification of the Professional Competency of Services for Drug Users was launched.

Regional drug coordinators were appointed in 13 out of the 14 regions, and they make use of a network of contact workers in individual municipalities with extended competencies in their region. Most regions (with the exception of the Pilsen and Vysočina regions) have drawn up a regional drug policy document.

In comparison with 2004, drug policy expenditures increased by approximately CZK 44 million (€ 1.48 million) in 2005. The amount of financial resources provided by regions has also increased.

## 1.1 Legal Framework

### 1.1.1 Legislation

#### 1.1.1.1 Act 379/2005 Coll. on Measures for Protection from Harm Caused by Tobacco Products, Alcohol, and Other Addictive Substances

After several years of discussing the draft bill, the Lower House of the Parliament of the Czech Republic adopted the Act on Measures for Protection from Harm Caused by Tobacco Products, Alcohol, and Other Addictive Substances (No. 379/2005 Coll.) in August 2005. It came into force on January 1, 2006 and replaced the previous Act on Protection against Alcoholism and Other Drug Addictions (No. 37/1989 Coll.), which no longer complied with contemporary state of knowledge and needs in the field of drug prevention and did not take into account the new regional administration of the Czech Republic.

The new law defines legal measures which especially involve the prevention and harm reduction of substance use, as well as health care and the system of social services. According to the submitters of the bill, the main goals especially involved:

- to transfer responsibilities to regional and municipal level, in accordance with the reform of public administration, and increase their powers to implement preventive measures and address drug-related issues,
- to provide for the expedient and effective spending of financial resources for the reduction of the harms caused by tobacco products, alcohol, and addictive substances,
- to reduce the availability of and demand for tobacco products and alcohol by establishing rules for alcohol and tobacco sales and distribution and by introducing measures for the protection of the public, including sanctions for failure(s) to observe them,
- to reduce the harm caused by the use of addictive substances; unlike the previous one, this act briefly defines the types of professional care supplied to those who harmfully use tobacco products and alcohol and other addictive substances and those addicted to these substances.

The new Act codifies several codes and principles which were embedded in all previous national drug strategies (since the 1990s). These principles used to be applied in practice, but lacked clear legislative support. For the purposes of the Act, the term “drug policy” relates to illicit drugs, as well as tobacco products and alcohol. According to the Act, drug policy involves measures in primary, secondary, and tertiary prevention. The government coordinates the implementation of drug policy at the national level via ministries and other state administration bodies. The Act also gives the government an opportunity to establish a special advisory body for drug policy coordination (the CGDPC currently fulfils this role).

The Act also defines rules for examination for the presence of alcohol or another addictive substance. A professional examination which detects the content of alcohol and other addictive substances is mandatory for a

person about whom it is reasonable to assume that the use of the substances put him/her in a condition in which he/she could harm him/herself or other persons, or that he/she could cause bodily harm to someone else under the influence of the substance(s). It also specifies which bodies are entitled to carry out an orientation breath test or take a saliva sample (the police, prison service, or employer) and medical examination by means of a breath test and taking samples of biological material (only health care facilities with adequate professional and operational competency).

The transfer of a significant proportion of the competencies to individual territorial self-governing units (regions and municipalities) represents a substantial change from the previous legislative arrangement.

In particular, self-governing regions:

- coordinate and participate in the implementation of drug policy in their territory (while cooperating with state bodies, municipal bodies, and service providers);
- prepare a regional drug policy strategy;
- establish a position of a regional drug coordinator (his/her job description must not include the fulfilment of other tasks); the Act also defines his/her competencies, and
- collect and evaluate data on the drug situation in their territory.

#### 1.1.1.2 Act 411/2005 Coll. Amending Act 361/2000 Coll., on Traffic on Land Communications (Road Traffic Act) and Amending Certain Laws

Inter alia, adoption of the Act 411/2005 Coll. amended the merits of misdemeanours (Act 200/1990 Coll., on misdemeanours) and criminal offences (Act 140/1961 Coll., Penal Code) which penalise the driving of motor vehicles under the influence of addictive substances.

A misdemeanour against safety and the free flow of traffic on land communications (Section 22 of the Act on Misdemeanours) is committed by a person who does the following while driving or riding on land communications:

- drives a vehicle or rides an animal immediately after drinking an alcoholic beverage or using another addictive substance or during a period after drinking alcohol or using an addictive substance while he/she is still under the influence of it/them,
- drives a vehicle or rides an animal while in a state of incapability as a result of the use of alcohol or another addictive substance,
- refuses to submit to a test to indicate whether he/she was under the influence of alcohol or another addictive substance while driving a vehicle or riding an animal, even though the examination does not pose a danger to his/her health.

Section 201 of the Penal Code newly stipulates that it is a criminal offence of menace under the influence of addictive substances when a person "performs employment duties or another activity during which he/she could endanger the life or health of other persons or cause considerable damage to property while (even negligently) in an incapable state as a result of the use of an addictive substance". According to the previous legal regulations, the commission of this offence also required other circumstances (previous sanction, causing a serious consequence, especially risky activities) which nowadays represent the qualified facts of the case (Section 201, paragraph 2 of the Penal Code).

In comparison with the previous legislation, the new penalties for the above-mentioned misdemeanours and criminal offences are more stringent – see Table 1-1.

*Table 1-1: Changes in penalties for misdemeanours and criminal offences of driving under the influence of addictive substances which came into force on July 1, 2006*

| **Type of unlawful conduct** | **Driving immediately after using and under the influence** | | **Driving while in a state of incapability** | |
|---|---|---|---|---|
| | Before June 30, 2006 | From July 1, 2006 | Before June 30, 2006 | From July 1, 2006 |
| Misdemeanour | Statutory penalty up to CZK 10,000<br><br>Prohibition of activities for up to 1 year | Statutory penalty from CZK 10,000 up to 20,000<br><br>Prohibition of activities for 1 to 2 years | Statutory penalty to CZK 15,000<br><br>Prohibition of activities for up to 2 years | Statutory penalty from CZK 25,000 up to CZK 50,000<br><br>Prohibition of activities for 1 to 2 years |
| Criminal offence | It was not regarded as a criminal offence | It is not regarded as a criminal offence | It was not regarded as a criminal offence | Unsuspended sentence for up to 1 year, statutory penalty, prohibition of activities |
| | | | In combination with other circumstances (serious consequence, previous sanction etc.): Unsuspended sentence for up to 1 year, statutory penalty, prohibition of activities | In combination with other circumstances (serious consequence, previous sanction etc.): Unsuspended sentence from 6 months to 3 years, prohibition of activities |

*Note: A refusal to submit to a test for the presence of addictive substances was and still is classified as a misdemeanour; the sanctions are the same as for a misdemeanour committed in a "state of incapability". Accordingly, they have also become stricter since July 1, 2006.*

#### 1.1.1.3 Draft Bill of the New Penal Code

The Lower House of the Parliament of the Czech Republic definitively rejected the draft bill of the new Penal Code, which also contained changes regarding "drug-related" criminal offences, on February 21, 2006.

The changes proposed in the draft bill of the Penal Code involved drawing a distinction between cannabis drugs and other illicit drugs in cases of the possession of a quantity greater than small for personal use (currently, Section 187a of the Penal Code). The draft bill assumed that the penalty for cannabis drugs, i.e. marijuana or hashish, would be reduced (to a maximum of one year's imprisonment), while the penalties for other drugs would be increased (to up to two years' imprisonment). The draft bill also assumed that a new offence of "growing psychotropic plants" would be introduced. It was expected that this provision would introduce different sanctions for the unauthorised growing of cannabis for personal use (growing of a small quantity for personal use only would be regarded as a misdemeanour) and illegal production of drugs – including cannabis – for the purpose of distributing them.

The proposed draft bill represented an extensive and complex re-codification of the criminal law. For instance, it was supposed to increase the maximum length of the sentence for murder from 15 to 20 years and the maximum length of an exceptional sentence from 25 to 30 years, and to lower the age of criminal responsibility from 15 to 14 years of age. It also expected that so-called detention institutions for especially dangerous and insane offenders would be established, and that the possibility of a sentence of home confinement for up to two years would be introduced for criminal offences resulting from negligence. At the same time, the bill wanted to extend the list of racially motivated criminal offences and introduce other substantial changes.

The Lower House of the Parliament of the Czech Republic discussed the recodification of the Penal Code for nearly two years. After the government draft bill was approved in November 2005, the Senate rejected it and the draft bill was returned for renegotiation to the Lower House of the Parliament. At this stage of negotiations, the Constitution of the Czech Republic no longer makes it possible to raise new amendments. In the end, the draft bill did not receive the necessary majority of votes (March 2006) because of the deletion of the provisions which penalised the misuse of information in business relations and which were supposed to prevent the so-called tunnelling of firms.[1]

[1] Advocates of approving the bill of the Penal Code argued that the misuse of information can be punished by means of other provisions, for instance as fraud. They also pointed out that the provisions of this Section were only used in a few dozen cases, while most of the cases took place in combination with other criminal offences.

### 1.1.2 Implementation of the Law

Knowledge on the implementation of the law in the prosecution of drug offences or misdemeanours is not extensive. One of the reasons is the almost total absence of published studies in this field. The exceptions involve, for instance, the 'Impact Analysis Project of New Drugs Legislation in the Czech Republic' (Zábranský et al. 2001) or the study 'Drugs and the Czech Prison Population in the Context of the Drug Scene and Criminal Law Legislation' (Marešová, 2003).

According to the Report on the Activities of the Office of the Supreme Prosecutor, the provisions ensuring the protection of the identity and appearance of witnesses according to Section 55, paragraph 2 of the Code of Criminal Procedure, the surveillance of persons according to Section 158d of the Code of Criminal Procedure, and eavesdropping and recording of telecommunication operations according to Section 88 and Section 88a of the Code of Criminal Procedure are often used during preliminary proceedings pertaining to the prosecution of drug offences (Nejvyšší státní zastupitelství, 2006).

In 2005 and 2006, the Institute for Criminology and Social Prevention has implemented an extensive research project, 'Possibilities for Criminal Justice in Drug Policy'. The project aims to assess the mutual influence between legislation and the application of criminal law measures and the development of drug crime and the drug scene in the Czech Republic after 1989. An analysis of criminal law regulations, available literature, documents from relevant institutions, available statistical data, and selected criminal files was carried out within the framework of the research project. A questionnaire survey among experts in a given field (police officers, public prosecutors, judges, court-appointed experts etc.) and controlled interviews with experts were carried out. The final report of the project will be drawn up in December 2006 (Institut pro kriminologii a sociální prevenci, 2005).

As far as drug-related crime is concerned, statistical data on persons prosecuted, accused, and sentenced in connection with drug offences and other information, presented in the Annual Reports of the National Drug Squad (Národní protidrogová centrála , 2006a) and the General Customs Headquarters (Generální ředitelství cel , 2006b) and in the above-mentioned report of the Office of the Supreme Prosecutor (Nejvyšší státní zastupitelství, 2006) provide information on the practice of the bodies responsible for criminal proceedings – see the chapters Drug-Related Crime, page 56 and Drug Markets, page 66.

## 1.2 Institutional Framework, Strategies and Policies

### 1.2.1 National Strategy

The year 2005 was the first year of the implementation of the 2005–2009 National Drug Strategy, which was adopted by Government Resolution 1305 in December 2004, and the 2005–2006 Action Plan – see the 2004 Annual Report of the National Monitoring Centre for Drugs and Drug Addiction (NMC).

The Secretariat of the CGDPC drew up an evaluation report regarding the implementation of the 2005-2006 Action Plan in 2005. The government acknowledged it in Government Resolution No. 514 in May 2006.

The 2005–2006 Action Plan contains a total of 144 tasks which are divided into 43 goals which relate to seven drug policy fields: (1) primary prevention; (2) treatment and after-care; (3) risk reduction; (4) drug supply and demand reduction and law enforcement; (5) coordination and funding; (6) the field of information, research, and evaluation and (7) international collaboration.

72 (i.e. 50%) of the 144 tasks were to be fulfilled by December 31, 2005 or they were being fulfilled on a continual basis. 54 of these 72 tasks were fulfilled, 6 partially, 8 were not fulfilled and insufficient information was available about 4 tasks. Therefore, 85% of the tasks for the year 2005 were fulfilled completely or partially.

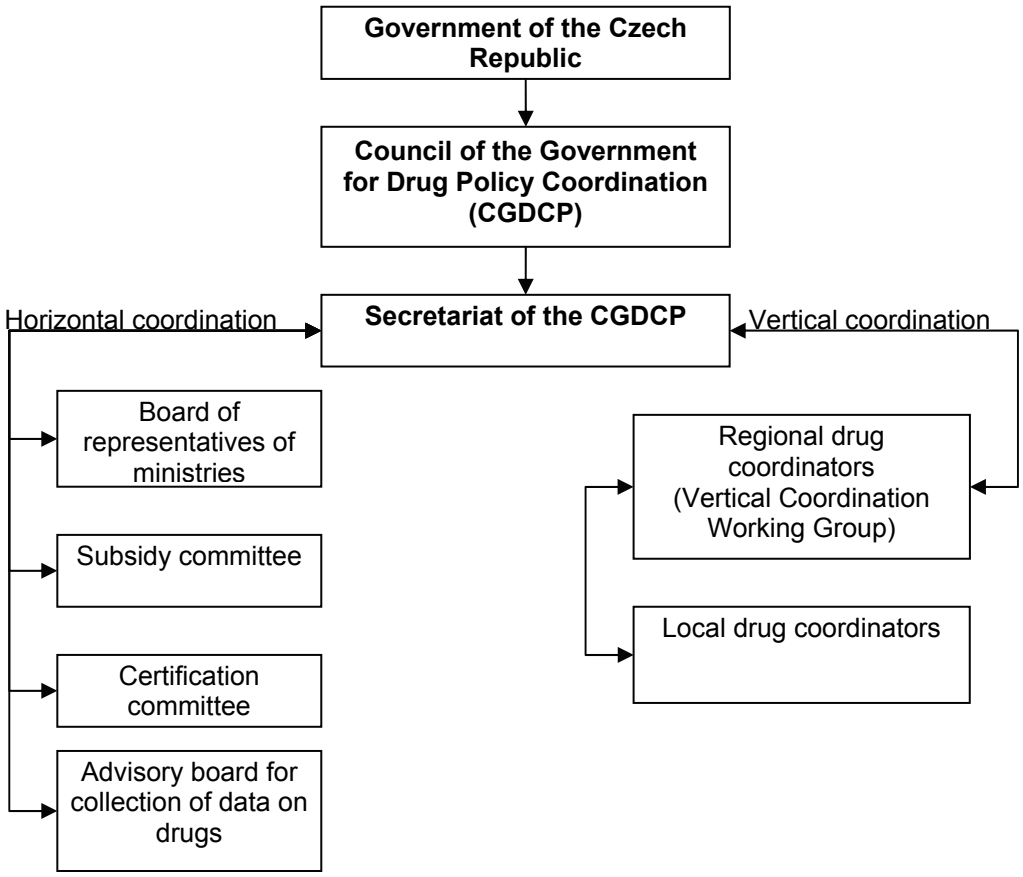
The most significant framework changes to the drug policy in 2005 involve:

- Adoption of Act 379/2005 Coll., on Measures for Protection from Harm Caused by Tobacco Products, Alcohol, and Other Addictive Substances as amended. Inter alia, the act defines responsibilities regarding the guaranteeing of drug policy by state administration and self-administration bodies. For the first time in the history of the Czech Republic, it defines basic types of services for drug users – see the chapter on Legislation, page 3 for more information.
- Launch of the system of Certification of the Professional Competency of Services for Drug Users, which was approved by Government Resolution No. 300 in March 2005 – see the chapter on Treatment, page 32.
- Approval of Rules for Drawing Financial Resources for Drug Policy from the State Budget, which was approved by Government Resolution No. 700 in June 2005.

### 1.2.2 Drug Policy Coordination

The Council of the Government for Drug Policy Coordination (CGDPC), an interministerial advisory body of the government which is in charge of the Czech Republic's drug policy coordination, met five times in 2005. The Secretariat of the CGDPC controls the activities of working committees and groups which are entrusted with horizontal (interministerial) and vertical coordination – see the overview in Figure 1-1.

*Figure 1-1: System of vertical and horizontal drug policy coordination in the Czech Republic*




Regional drug coordinators have been appointed in all regions except the Moravian-Silesian region, and they take advantage of a network of outreach workers in individual municipalities with extended competencies in their region. Most regions have prepared their regional drug policy strategies (with the exception of the Pilsen, Vysočina, and Olomouc regions) – see Table 1-2. The Secretariat of the CGDPC continued to collaborate with regions within the framework of the operation of the Vertical Coordination working group (regional drug coordinators from all regions are members of the working group).

*Table 1-2: Strategic documents and institutional responsibilities in drug policy coordination in the regions of the Czech Republic*

| Region | Strategic policy document of the drug policy in the region | Institutional assurance, advisory bodies, commissions, working groups |
|---|---|---|
| Prague | 2002–2006 Strategic Drug Policy Plan | – Regional drug coordinator and Regional Drug Prevention Department at the Office of the Mayor<br>– Drug Commission of the Prague City Council<br>– Working groups for (1) primary prevention, (2) harm reduction, (3) treatment and after-care, and (4) data collection |
| Central Bohemia | 2005–2009 Regional Drug Strategy | – Regional drug coordinator and Departments of Prevention and Humanitarian Activities at the Departments of Social Affairs<br>– Drug Commission as an advisory body of the President of the Region<br>– Working groups for (1) primary prevention, (2) harm reduction, and (3) treatment and resocialisation |
| Southern Bohemia | 2005–2009 Drug Policy Strategy, including 2005–2009 Action Plan | – Regional drug coordinator at the Department of Social Affairs and Health<br>Drug Coordination Group as an advisory body of the Deputy President of the region |
| Pilsen | – | – Regional drug coordinator at the Department of Health<br>– Drug Commission has not been appointed |
| Karlovy Vary | 2005–2009 Regional Drug Strategy and Action Plan | – Regional drug coordinator at the Department of Social Affairs<br>– Drug Commission of the Council of the Region |
| Ústí nad Labem | 2005–2009 Drug Policy Action Plan | – Regional drug coordinator at the Department of Social Affairs and Heallth<br>– Health Commission of the Council of the Region<br>– Working groups for (1) primary prevention, (2) harm reduction, (3) treatment and resocialisation, and (4) coordination |
| Liberec | 2005–2006 Drug Policy Action Plan | – Regional drug coordinator at the Department of Social Affairs<br>– Drug Commission of the Council of the Region<br>– Working groups for (1) primary prevention, (2) harm reduction, (3) treatment and resocialisation, and (4) coordination |
| Hradec Králové | 2002–2006 Drug Policy Strategy | – Regional drug coordinator at the Department of Health and Social Affairs<br>– Commission for Specific Commission at the Council of the Region<br>– Anti-drug working group |
| Pardubice | 2005–2009 Drug Policy Strategy, including Action Plan | – Regional drug coordinator at the Department of Health<br>– Drug Commission of the Council of the Region |
| Vysočina | – | – Regional drug coordinator at the Secretariat of the President of the Region<br>– Drug Commission has not been appointed<br>– Working groups for (1) primary prevention and (2) drug policy of the region |
| Southern Moravia | 2005–2009 Drug Policy Strategy, including Action Plan | – Regional drug coordinator at the Department of Social Affairs<br>– Drug Commission has not been appointed<br>– Working group for prevention |
| Olomouc | Strategic Anti-drug plan for the period 2005–2010, 2006–2007 Drug Policy Action Plan | – Regional drug coordinator at the Office of the President of the Region<br>– Commission for prevention of social-pathological phenomena at the Council of the Region |
| Zlín | 2005–2009 Drug Policy Strategy, and 2005–2006 Action Plan | – Regional drug coordinator at the Office of the Rpesident of the Region<br>– Commission for prevention of social-pathological phenomena at the Council of the Region |
| Moravian-Silesian | Strategic Antidrug Plan for the Period 2005–2010, Drug Policy Action Plan for the Period 2006–2007 | – The position of a regional drug coordinator has not been established – an officer of the Department of Social Affairs is in charge of the agenda<br>– Drug Commission has not been appointed<br>– Working group for drug prevention at the Department of Social Affairs of the Regional Board of Representatives |

### 1.3 Budget and Public Expenditure

The data in this chapter involve public budget expenditures which are identified as drug policy expenditures. Other expenditures in the field of supply and demand reduction cannot be calculated without further research.

As in previous years, drug policy funding was implemented on two levels, i.e. at the central and the local levels. The government gave the The Council of the Government for Drug Policy Coordination (CGDPC) the task of distributing financial resources from the budget chapter General Cash Administration – Drug Policy Expenditures. Since 2004, the Office of the Government of the Czech Republic has administered the provision of subsidies approved by the CGDPC. The following ministries had Drug Policy Programme expenditures in their budget in 2005: the Ministry of Health; Ministry of Education; Ministry of Labour and Social Affairs; Ministry of Finance – General Customs Headquarters, Ministry of Justice, and the Ministry of Defence. The Ministry of the Interior does not have Drug Policy Programme expenditures in its budget; however, it supports drug prevention activities within its Social and Crime Prevention Programme.

Table 1-3 shows the expenditures for drug policy from the state budget and regional budgets in 2005.

*Table 1-3: Drug policy expenditures from the state budget and local budgets (€ thousand)*

| Region | General Cash Administration via CGDPC | Ministry of Health | Ministry of Education | Ministry of Labour and Social Affairs | Ministry of Finance – General Customs Headquarters | Ministry of Justice | Ministry of Defence | Total state budget | Regional budgets | Municipal budgets | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Prague | 953 | 468 | 21 | 93 | 0 | 846 | 83 | **2,463** | **1,029** | **407** | **3,899** |
| Central Bohemia | 192 | 92 | 25 | 117 | 0 | 134 | 14 | **573** | **495** | **176** | **1,244** |
| Southern Bohemia | 170 | 119 | 14 | 142 | 0 | 3 | 5 | **454** | **175** | **55** | **683** |
| Pilsen | 246 | 10 | 12 | 7 | 0 | 9 | 5 | **288** | **113** | **133** | **534** |
| Karlovy Vary | 96 | 0 | 7 | 62 | 0 | 11 | 0 | **176** | **35** | **26** | **237** |
| Ústí nad Labem | 380 | 107 | 19 | 175 | 0 | 75 | 2 | **758** | **232** | **155** | **1,145** |
| Liberec | 162 | 58 | 10 | 3 | 0 | 51 | 0 | **284** | **271** | **36** | **591** |
| Hradec Králové | 67 | 45 | 13 | 44 | 0 | 16 | 2 | **186** | **69** | **28** | **284** |
| Pardubice | 50 | 2 | 12 | 23 | 0 | 5 | 4 | **96** | **185** | **39** | **320** |
| Vysočina | 141 | 142 | 12 | 161 | 0 | 3 | 0 | **459** | **233** | **33** | **726** |
| Southern Moravia | 370 | 37 | 30 | 227 | 0 | 21 | 13 | **698** | **249** | **159** | **1,106** |
| Olomouc | 224 | 32 | 14 | 131 | 0 | 21 | 6 | **427** | **67** | **47** | **541** |
| Zlín | 58 | 3 | 14 | 53 | 0 | 0 | 0 | **126** | **71** | **66** | **263** |
| Moravian-Silesian | 306 | 10 | 30 | 207 | 0 | 39 | 1 | **593** | **147** | **338** | **1,078** |
| **Total with regional destination** | **3,414** | **1,124** | **232** | **1,445** | **0** | **1,233** | **133** | **7,582** | **3,369** | **1,699** | **12,650** |
| **Projects without regional destination** | **133** | **0** | **83** | **101** | **487** | **0** | **0** | **804** | **0** | **0** | **804** |
| **Total** | **3,547** | **1,124** | **315** | **1,546** | **487** | **1,233** | **133** | **8,385** | **3,369** | **1,699** | **13,453** |

The CGDPC decided to support 173 local drug policy programmes with a total amount of € 3,414,000. The 2005 subsidy proceedings took place in two rounds: the original first round was completed with a second one in the course of the year so that the implementation of several programmes would not be endangered. The support especially involved projects of NGOs in the field of low-threshold services, outpatient treatment, intensive outpatient treatment, therapeutic communities, resocialisation, and aftercare. The amount of € 133,000 for the expenditure on the activities of the Secretariat of the CGDPC (including the National Monitoring Centre for Drugs and Drug Addiction) was withdrawn according to the classification presented in Table 1-4.

*Table 1-4: Expenditure of the Secretariat of the CGDPC from the General Cash Administration in 2005 (€)*

| Purpose of drawing | Withdrawn resources |
|---|---|
| Assessment of applications for subsidies of the CGDPC | 6,310 |
| Translations and other services | 11,950 |
| Pilot verification of Primary Prevention Standards and preparation of evaluation criteria | 1,310 |
| Training of regional drug coordinators and members of certification teams | 13,770 |
| Publication and information activities | 33,270 |
| Analyses of quality and availability of services | 24,810 |
| Studies and research outsourced | 41,570 |
| **Total** | **132.990** |

In 2005, the Ministry of Health gave priority to funding projects which met the priorities of the Ministry of Health. They involved substitution and detoxification treatment for drug users, outpatient treatment, including AT treatment, smoking cessation programmes, educational programmes for physicians and health care staff, inpatient treatment of drug users, and other secondary prevention programmes.

The Ministry of Education provided resources within the framework of two programmes which aimed to promote healthy lifestyles and the rejection of all forms of self-destruction, manifestations of aggressiveness, and lawbreaking among children. Regional authorities provided for preventive programmes implemented by schools, school facilities, and NGOs; the total budget was € 232,000. The Ministry of Education carried out separate subsidy proceedings and supported supragional and national projects with an amount of € 83,000.

The Ministry of Labour and Social Affairs earmarked a total of € 1.54 million for its drug policy programme. A total of 104 projects involving 50 organisations were subsidised; it is 18 projects less than in 2004 as a consequence of the merging of several projects and organisations. A critical part of the resources was expended on the operations of low-threshold centres (€ 561,000) and therapeutic communities (€ 272,000).

The expenditures of the Ministry of Finance for drug policy involved the budget of the General Customs Headquarters; an amount of € 487,000 was used for operational investigative activities and technical quipment.

The drug policy budget of the Ministry of Defence was especially used to fund the implementation of monitoring and preventive projects and for purchases of professional literature and training for future lecturers among Army personnel and prevention methodologists.

The budget of the Police of the Czech Republic provided for the operations of the National Drug Squad; the amount of resources for the activities of the National Drug Squad was not published, as they are a classified matter. Antidrug activities were also supported within the framework of the Crime Prevention Programme; it is impossible to express numerically the level of costs of these activities without further analysis.

The regions earmarked € 3.37 million for drug policy programmes in 2005; 11 of the 14 regions earmarked more resources in 2005 than in 2004 and 3 regions earmarked fewer resources – see Table 1-5.

*Table 1-5: Drawing of financial resources from regional budgets in 2002–2005 (€ thousand)*

| Region | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|
| Prague | 426.4 | 418.5 | 878.7 | 1,028.6 |
| Central Bohemia | 117.8 | 268.6 | 462.3 | 495.2 |
| Southern Bohemia | 97.8 | 94.2 | 194.1 | 174.6 |
| Pilsen | 0.0 | 33.6 | 50.4 | 113.0 |
| Karlovy Vary | 3.2 | 16.8 | 16.8 | 34.7 |
| Ústí nad Labem | 48.2 | 253.2 | 265.2 | 231.8 |
| Liberec | 0.0 | 91.7 | 193.4 | 271.1 |
| Hradec Králové | 24.8 | 31.7 | 67.8 | 68.8 |
| Pardubice | 50.4 | 50.4 | 60.4 | 184.7 |
| Vysočina | 0.0 | 60.4 | 138.7 | 232.7 |
| Southern Moravia | 100.7 | 67.2 | 167.9 | 248.9 |
| Olomouc | 2.7 | 10.3 | 43.6 | 67.2 |
| Zlín | 36.8 | 117.2 | 80.6 | 70.5 |
| Moravian-Silesian | 76.2 | 100.7 | 119.9 | 147.0 |
| **Total** | 985.0 | 1,614.4 | 2,739.7 | 3,368.7 |

*Note: Figures for 2002–2004 were re-calculated by the 2005 exchange rate (1 € = CZK 29,784)*

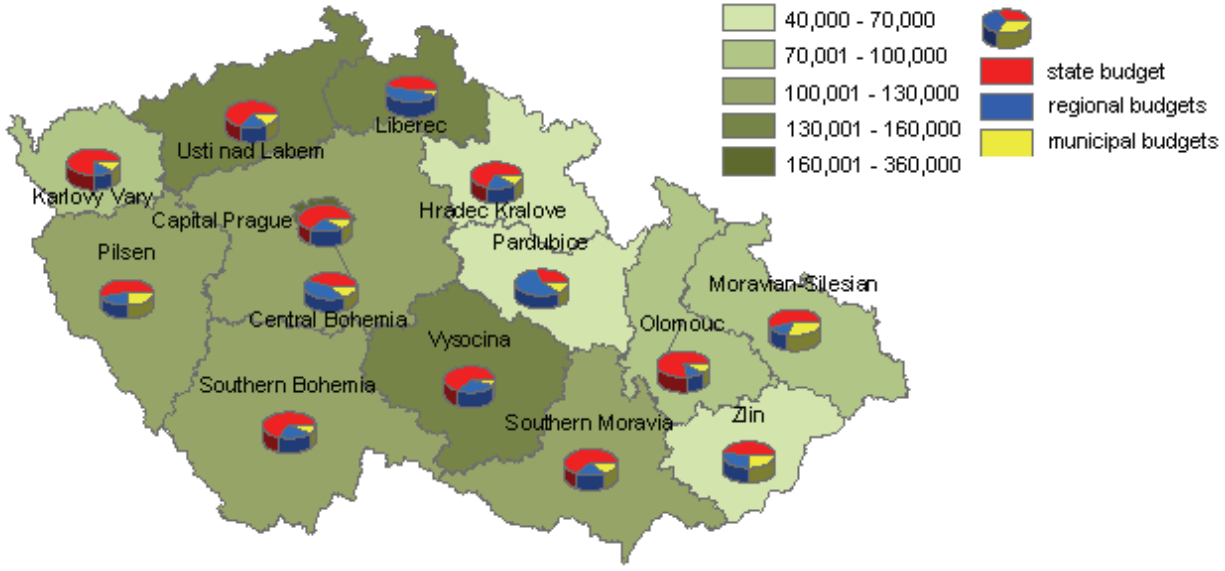
Table 1-6 provides an overview of the development of drug policy expenditures from state, regional, and municipal budgets. Map 1-1 gives an overview of financial resources drawn from public budgets for the implementation of drug policy programmes in 2005.

*Table 1-6: Drawing of financial resources from the state budget and from municipal budgets in 2002–2005 (€ thousand)*

| Year | State budget** | Regional budgets | Municipal budgets*** | Total |
|---|---|---|---|---|
| 2002* | 6,829 | 985 | n.a. | 7,814 |
| 2003* | 7,415 | 1,614 | n.a. | 9,029 |
| 2004* | 6,909 | 2,740 | 2,113 | 11,762 |
| 2005 | 8,385 | 3,369 | 1,699 | 13,453 |

*Notes: * Figures for 2002–2004 were re-calculated by the 2005 exchange rate (1 € = CZK 29,784), ** state budget without the budget of the National Drug Squad and other police branches, *** expenditures for drug policy from municipal budgets were not monitored in 2002 and 2003.*

*Map 1-1: Drawing of financial resources for drug policy from state and municipal budgets in regions of the Czech Republic in 2005 (€ per 100,000 inhabitants)*




## 1.4 Social and Cultural Context of the Drug Policy

Public attitudes towards drug use and drug users are described in the chapter on Drug Use in the Population, page 14.

### 1.4.1 Approaches Towards Drugs and Drug Users

A legal categorisation of drugs based on their degree of health and social risks according to an intent from 2001 which was approved by the government in 2001 (Vláda ČR, 2001) was originally included in the recodification of the Penal Code (House Print 265/2003). It was approved by the Lower House of the Parliament of the Czech Republic but then the Senate rejected the draft; the Lower House then failed to manage to outvote the so-called veto of the Senate[2] and so the draft was not adopted – see also the chapter on Legal Framework, page 3. The interest of the MPs and the professional public focused especially on the provisions which would change the approach to cannabis drugs.

Public debate about this topic practically faded away in 2005 and even the former (until June 2006) parliamentary party the Union of Freedom, which put the topic of the decriminalisation of drugs in its controversial programme for elections to the Lower House of the Parliament of the Czech Republic in June 2006, did not manage to reopen it. Seven articles in the daily press paid detailed attention to the wording of the new drug sections in the new Penal Code. It is especially worth mentioning the article in the daily newspaper Právo (Cihlářová, 2005), in which the Director of the National Drug Squad, Jiří Komorous, expressed his disapproval of the wording of the law, which was approved by the Lower House of the Parliament of the Czech Republic. According to the new wording, the possession of marijuana and hashish and growing cannabis for personal use would be punished less strictly than the possession or production of so-called hard drugs. On the other hand, drug professionals from the field of demand reduction who have publicly expressed their opinion on this topic welcomed the proposed arrangement.

[2] The controversial nature of other provisions, especially those concerning economic offences, is more likely to have been the cause of the rejection of this draft bill.

### 1.4.2 Initiatives in the Parliament and Civic Society

No initiatives regarding drugs issues were submitted by MPs in the Parliament of the Czech Republic in 2005; however, significant draft bills were discussed. See the chapter on Legal Framework, page 3.

Act 379/2005 Coll., on Measures for Protection from Harm Caused by Tobacco Products, Alcohol, and Other Addictive Substances was adopted in August 2005 with no major interest on the part of the public (it was a governmental draft bill). It came into force on January 1, 2006. The public was interested especially in the provision which banned smoking at public transport stops (even under the open sky). There was a media debate about the advantages and disadvantages of a ban on smoking in restaurants (which was not included in the Act, but the topic was medialised in connection with the legal regulations in several European countries).

The trend from 2004 continued – the issues of alcohol and illicit drugs gradually penetrated the agendas of political parties. Five parties which are still in the Parliament now (Czech Social Democratic Party, Civic Democratic Party, Communist Party of Bohemia and Moravia, Christian and Democratic Union – Czechoslovak People's Party, and Union of Freedom – Democratic Union[3]) and two non-parliamentary parties which were the most likely to get into the Parliament after the elections in June 2006 (the Green Party and the European Democrats) dedicated at least a short passage in their election programmes to drugs issues. The European Democrats[4] (Evropští demokraté, 2006) and the Christian and Democratic Union – Czechoslovak People's Party (Křesťanská a demokratická unie - Čs. strana lidová, 2006) gave the most extensive consideration to drugs issues in their election programmes. The Christian and Democratic Union changed its attitude in favour of a balanced drug policy and therefore it did not resume the War on Drugs campaign from 2004 (Křesťanská a demokratická unie - Čs. strana lidová, 2004); the topic of drugs is mentioned in the "Internal Security" section of the election programme. The Civic Democratic Party (the strongest parliamentary party after the elections) included a balanced programme, which involved drug policy, into the section "Safety of Citizens" (Občanská demokratická strana, 2006). An opposition party, the Communist Party of Bohemia and Moravia, also included its programme in the section entitled "Safety of the Citizen" (Haló noviny, 2006) and it focused on crime prevention and the protection of young people. The Green Party got into the Parliament for the first time in 2006, and it dealt in greater detail with issues concerning tobacco smoking (its further curtailment) and it mentioned in one sentence that it intends to support drug addiction prevention programmes; it mentioned drug crime in connection with the regulation of prostitution (Strana zelených, 2006). The 81-page election programme of the ruling Czech Social Democratic Party, whose minister has been responsible for drug policy coordination since 2004, only dealt with drugs marginally in connection with the leisure time activities of young people and prevention of socially pathological phenomena (Česká strana sociálně demokratická, 2005).

The cultural association Kontext[5] has been actively opposing the public promotion of alcohol; in particular, they file complaints to Trade Licensing Offices on the basis of the provisions of Act 40/1995 Coll., on the regulation of advertising and changes and amendments to Act 461/1991 Coll. on the Operation of Radio and Television Broadcasting, which bans advertisements for alcoholic beverages targeted at persons aged under 18. For instance, it highlighted the fact that alcoholic beverages were promoted during the Olympic Games for Children in 2005, which were held by the Southern Moravian regional authority. In the long term, the association has especially targeted trade fairs, celebrations, and festivals whose name and content is linked to alcoholic beverages and which take place with the participation of municipal and regional councils (Národní monitorovací středisko pro drogy a drogové závislosti, 2005).

### 1.4.3 Media

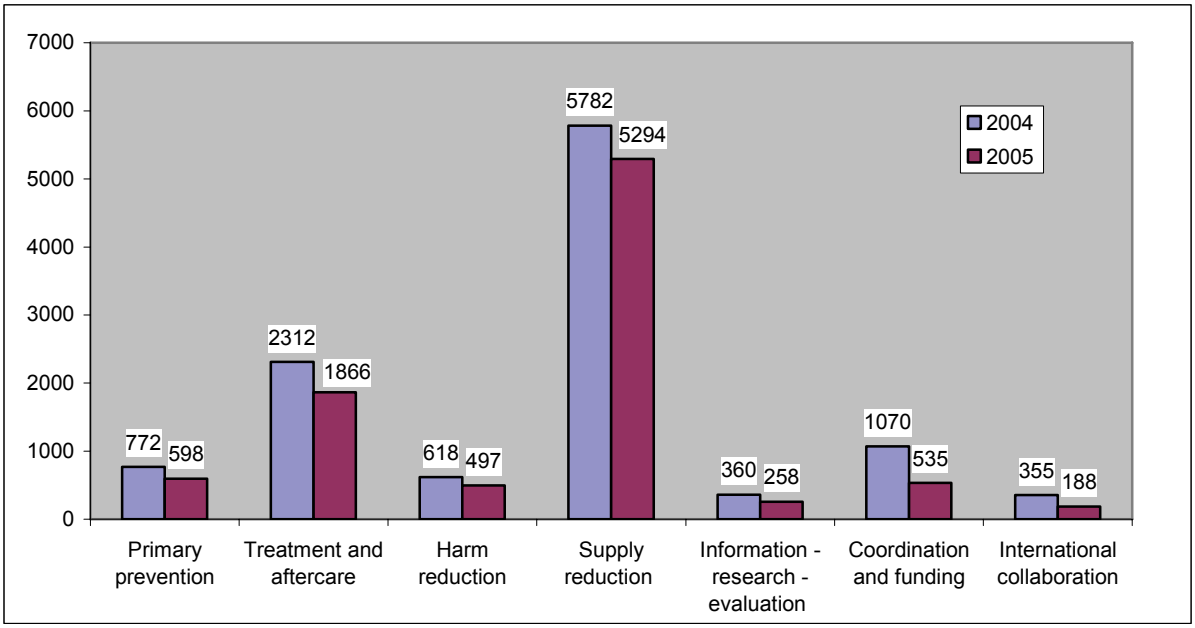
A media analysis was carried out on the basis of an assignment by the Secretariat of the CGDPC (NEWTON INFORMATION TECHNOLOGY, s.r.o., 2006a; NEWTON INFORMATION TECHNOLOGY, s.r.o., 2006b); some results were published in the Focused on Drugs periodical (Národní monitorovací středisko pro drogy a drogové závislosti, 2006b).

The medialisation of drugs issues in the Czech media was approximately the same in 2004 and 2005, from a quantitative perspective. However, significant differences appeared in a comparison of the medialisation of the activities of the Secretariat of the CGDPC and the NMC in 2004 and 2005. 383 contributions about these activities (press releases and press conferences) were published in 2004, while only 143 contributions were published in the media in 2005, i.e. the number of contributions declined by 58%.

The structure of the topics[6] in the medialisation of drugs issues (drugs in general) was approximately the same in both of the monitored years – see Figure 1-2.

[3] The Union of Freedom – Democratic Union was not successful in the 2006 elections.
[4] It did not succeed in the elections to the Lower House of the Parliament of the Czech Republic.
[5] An informal association which is based in Brno; it has been operating since 2001 (www.sweb.cz/sdruzenikontext).
[6] For the purposes of the analysis, the topics assigned were identical to those in the plan of implementation of the 2005–2006 Action Plan.

*Figure 1-2: Structure of topics in drug policy medialisation in 2004 and 2005; number of contributions (NEWTON INFORMATION TECHNOLOGY, s.r.o., 2006a)*




The proportion between the medialisation of drugs by type was very similar in both years. Other legal drugs (alcohol, tobacco, and medicaments) drew the most attention in the context of drugs issues. Alcohol became the most medialised drug mentioned in the context of drugs issues. Stimulants, and especially pervitin, got the biggest media attention after licit drugs. Cannabis was the third most commonly mentioned group of drugs in the media in both years. The media also focused on opiates in a significant manner.

The key findings of the media analysis of the drug policy are as follows:

- 29,539 contributions dealt with general drugs issues in 2005; 4,087 (14%) of them were about drug policy.
- 3% of the contributions were related to the activities of the CGDPC and the NMC. The Annual Report: The Czech Republic – 2004 Drug Situation and the certification of the professional competency of services for drug users attracted the greatest attention; at the same time, the EMCDDA´s Annual Report on the State of the Drugs Problem in Europe and the results of the international school survey ESPAD received high publicity.
- The most frequently mentioned topics involved supply reduction and law enforcement, for instance in connection with reports of drug trafficking and police raids, the operations of the National Drug Squad, or the process of approving the new Penal Code.

## 2 Drug Use in the Population

The situation in the field of drug use among the general population has remained stable, and no significant change was recorded in 2005. No general population survey or national school survey was carried out in 2005; only the results of several small-scale regional or local surveys are available.

Approximately 20% of the adult population have tried an illicit drug, and the prevalence of experiences with drugs among young people is even higher (44% of high school students aged 16 and 56% of students aged 18) – see (Mravčík et al. 2005a). Cannabis and ecstasy are the most commonly used illicit drugs, and the scope of experiences with drugs which pose more serious health and social risks (opiates, pervitin, cocaine) is very low in the Czech Republic.

The society shows low tolerance towards drug users, as well as towards heavy alcoholics. A large part of society still perceives drug use as unacceptable behaviour, similarly to, for instance, driving under the influence of alcohol.

### 2.1 Drug Use Among the General Population

The most recent general population survey which focused on the use of illicit drugs was carried out in 2004 (General Population Survey of the Health Status and Lifestyle of the Population in the Czech Republic); its results were summed up in the 2004 Annual Report. A further analysis of the results was carried out in 2005, and detailed results of the survey in the field of the health status of the population, smoking, alcohol drinking and illicit drugs use are being prepared for press. It is anticipated that the next wave of the General Population Survey will take place in 2008.

Data on the subjectively perceived drug use in one's own environment and data on the perceived availability of illicit drugs were analysed afresh. Nearly 37% of adults (aged 18–64) reported that they know someone who uses marijuana; more than 18% know an ecstasy user and nearly 13% know a user of magic mushrooms or other natural hallucinogens. 12.5% of the respondents know someone who uses inhalants and, surprisingly, as many as 11% know someone who uses pervitin. Approximately 4% of the respondents know someone who uses heroin or cocaine (Ústav zdravotnických informací a statistiky, 2005e).

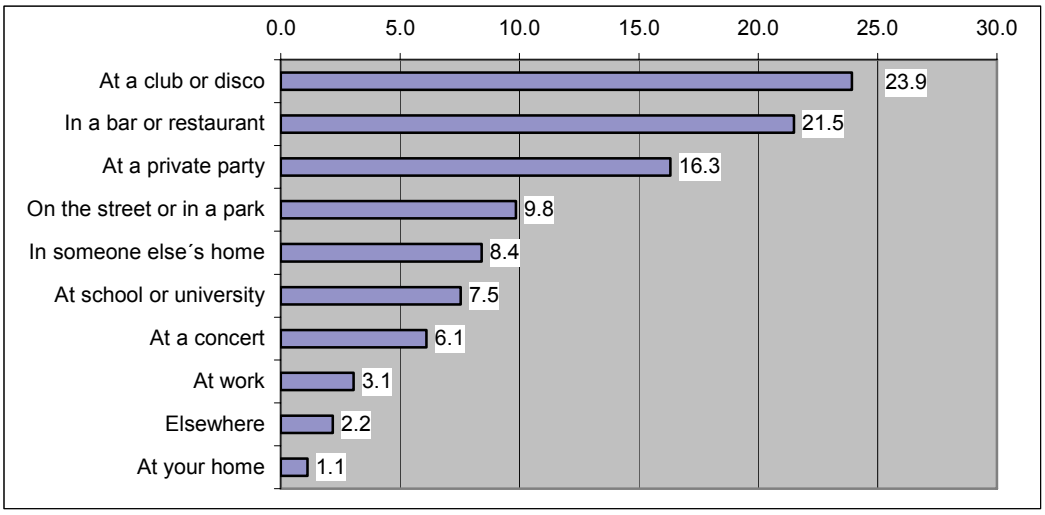
The question of how easy or difficult it is to get an illicit drug within 24 hours, if desired, was also tracked. It has been shown that the subjectively perceived availability of illicit drugs is relatively high – 36% of the respondents reported that they could get marijuana or hashish rather easily or very easily, 22% would be able to get ecstasy, 15% magic mushrooms or other natural hallucinogens, and 11% would be able to get pervitin or other amphetamines. 5–6% of the respondents would easily be able to get heroin or cocaine (Table 2-1). 60% of adults would know how to get sedatives (without medical prescription) and 53% would easily get inhalants. More than 40% of the respondents reported that they cannot assess whether they would be able to get all of the substances tracked, with the exception of sedatives, inhalants, and cannabis.

*Table 2-1: Subjectively perceived availability of drugs – answers to the question: "How difficult do you think it would be to get the following drugs within 24 hours if you intended to?" (%) (Ústav zdravotnických informací a statistiky, 2005e)*

| Drug | Impossible | Very difficult | Quite difficult | Quite easy | Very easy | I don't know |
|---|---|---|---|---|---|---|
| Sedatives, hypnotics | 3.9 | 6.9 | 9.9 | 27.7 | 31.9 | 19.6 |
| Marijuana, hashish | 11.6 | 8.7 | 10.0 | 18.0 | 17.9 | 33.8 |
| Ecstasy | 16.2 | 10.9 | 9.4 | 12.9 | 9.1 | 41.4 |
| Pervitin, amphetamines | 19.8 | 14.4 | 9.0 | 7.0 | 4.4 | 45.4 |
| Cocaine, crack | 22.4 | 16.6 | 7.4 | 3.7 | 2.1 | 47.7 |
| Heroin, opiates | 23.3 | 17.2 | 6.7 | 3.4 | 1.9 | 47.6 |
| LSD | 22.2 | 16.4 | 6.9 | 4.1 | 2.2 | 48.0 |
| Magic mushrooms, natural hallucinogens | 17.2 | 14.5 | 8.8 | 8.8 | 6.0 | 44.8 |
| Inhalants | 7.1 | 4.9 | 5.8 | 19.0 | 33.9 | 29.3 |

45.5% of the adult population had been offered an illicit drug for free or for money; 22.5% of the respondents reported that it was a one-off event. 14% of the adults mentioned that they had been offered illicit drugs more than five times in their lifetime. The persons who had been offered a drug most commonly reported that it had occurred at a club or disco (24%), in a bar or restaurant (21.5%), or at a private party (16%) – see Figure 2-1. The data from the survey do not make it possible to determine which illicit drug was involved.

*Figure 2-1: Place where a drug was offered to the respondents (%) (Ústav zdravotnických informací a statistiky, 2005e)*




The prevalence of experiences with illicit drug use was tracked in 2005 within the framework of a three-year project, 'Epidemiology of Psychiatric Diseases in the Population' (implemented by the Prague Psychiatric Centre); the results have not been made available so far.

The Institute of Health Information and Statistics of the Czech Republic did not carry out the expected fresh wave of the Sample Survey on the Health Status of the Population of the Czech Republic in 2005. The survey has been implemented on a periodical three-year basis since 1993, and it has also tracked the use of drugs, alcohol, and smoking in the population aged above 15.

### 2.2 Drug Use among the School Population

The most recent national school survey was carried out in 2003 (European School Survey on Alcohol and Other Drugs, ESPAD). The results of the study, which involved 16- and 18-year-old secondary school students, were summed up in the 2003 and the 2004 Annual Reports of the NMC. In 2006, a report summarising the results of ESPAD study was published. The results of the HBSC (Health Behaviour in School-aged Children) survey, which involved elementary school pupils aged 15, are also available; the most recent results are from 2002 and another wave of the study is due to be conducted in 2006.

Several regional school surveys were implemented in 2005. They usually focused on children aged under 15 – see the detailed results in the special chapter on Drug Use and Related Problems among Very Young People (Under 15 Years) , page 71.

### 2.3 Drug Use among University Students

A repeated survey of the Faculty of Pharmacy at Charles University in Hradec Králové which studies experiences with addictive substances among university students continued in 2005. A total of 1,239 students were surveyed in the 2004/2005 academic year, and 226 have been surveyed so far in the 2005/2006 academic year. The results indicate that more than 52% of the students have tried marijuana and nearly 16% have tried hashish. 9% of the respondents have tried magic mushrooms, nearly 8% have tried ecstasy, and 5.5% of the students have tried LSD. A relatively low number of respondents (4.1% and 2.8%) reported experiences with pervitin and cocaine respectively (Trojáčková and Višňovský, 2006).

At the same time, the Philosophical Faculty at Charles University in Prague carried out a survey in the 2004/2005 academic year. It targeted the field of the health, behaviour and attitudes of students at Czech universities and colleges towards the use of addictive substances. 1,232 respondents were surveyed; the results are comparable to those from the above-mentioned survey. The survey did not monitor magic mushrooms separately; it only tracked LSD and other hallucinogens (7.7%). The respondents mentioned ecstasy more frequently (9%), while heroin and other opiates were reported less often (1%) (Csémy and Hrachovinová, 2006). During the last 12 months, 32.5% of the respondents had used cannabis and 3% had used ecstasy. The prevalence of all the substances which were monitored was higher among males – see Table 2-2.

*Table 2-2: Prevalence of illicit drug use among university students (%) (Csémy and Hrachovinová, 2006)*

| Drug | Lifetime prevalence | | | Prevalence in the last 12 months | | |
|---|---|---|---|---|---|---|
| | Total | Males | Females | Total | Males | Females |
| Any illicit drug | 51.9 | 58.4 | 47.0 | – | – | – |
| Cannabis | 51.7 | 57.6 | 47.2 | 32.5 | 41.3 | 25.8 |
| Ecstasy | 8.9 | 9.6 | 8.4 | 3.2 | 4.2 | 2.5 |
| LSD, hallucinogens | 7.7 | 8.5 | 7.1 | 2.7 | 3.5 | 2.0 |
| Pervitin, amphetamines | 4.1 | 4.8 | 3.5 | 1.4 | 1.7 | 1.2 |
| Heroin, opiates | 1.1 | 1.1 | 1.0 | 0.2 | 0.4 | 0.1 |

## 2.4 Drug Use Among Specific Population Groups

The situation in the field of drug use among specific population groups is summed up in the chapter on Social Correlates and Consequences of Drug Use, page 54. The Social Workers Support Programme for workers who work in Roma communities continued in 2005; at the same time, a survey which tracked substance use among Prague's homeless people was carried out. However, the results of the survey among homeless people are not available because the Institute of Health Policy and the Economy, which implemented the survey within the framework of a project which focused on the health status of the homeless, has discontinued its activities.

## 2.5 Attitudes towards Drug Use and Drug Users

The Public Opinion Research Centre carried out two surveys which focused on tolerance towards certain groups of citizens and the acceptability of selected types of behaviour. The survey showed that 87% of the respondents (out of a total of 1,067 respondents aged above 15) would not like to have drug users or heavy alcoholics as their neighbours. This comparison also showed low tolerance towards persons with a criminal history and against the Roma people; Czech society is tolerant towards persons of different religious or political beliefs or disabled persons (2% would not like to have disabled persons as their neighbours) (Centrum pro výzkum veřejného mínění, 2005a). Table 2-3 shows a comparison with a similar survey from 2003.

*Table 2-3: Tolerance towards selected societal groups – proportion of the respondents who would not like to have a member of these groups as their neighbour (Centrum pro výzkum veřejného mínění, 2005a)*

| They would not like to have neighbours who are | March 2003 | March 2005 |
|---|---|---|
| Heavy alcoholics | 86 | 87 |
| People who use drugs | 85 | 87 |
| People with a criminal history | 78 | 77 |
| Roma people | 79 | 75 |
| Homosexuals | 42 | 34 |
| Foreigners who live in the Czech Republic | 24 | 22 |
| People of a different religious belief | 8 | 7 |

The respondents were also asked to assess the tolerance of the whole society towards these population groups – according to them, society is the least tolerant towards Roma people (61%), heavy alcoholics (60%), and drug users (57%). In comparison with 2003, there was a higher proportion of respondents who believe that society is tolerant towards drug users (an increase from 21% to 34%) and heavy alcoholics (from 18% to 34%) (Centrum pro výzkum veřejného mínění, 2005a).

In the September survey, respondents (1,072 persons aged above 15) expressed their opinion regarding the acceptability or unacceptability of selected types of behaviour – a ten-point scale was used, with 1 meaning total unacceptability and 10 meaning perfectly acceptable behaviour. Driving under the influence of alcohol (69%), not looking for a job (65%), smoking marijuana or hashish (62%), and engaging in a fight with a police officer (61%) were regarded as the least acceptable forms of behaviour (answers 1 or 2). Other unacceptable forms of behaviour involved under-the-counter employment, accepting bribes, and using public transport without paying, but also infidelity. Drinking alcohol and drunkenness (out of joy or to drown sorrow) and a divorce were the most acceptable of the types of behaviour that were monitored (Centrum pro výzkum veřejného mínění, 2005b) – see Figure 2-2.

A survey carried out by TNS Factum which focused on public informedness regarding drugs issues (it was carried out as early as in 2003; a total of 1,012 persons aged above 15) provided results showing a comparison of tolerance towards the use of individual drugs; more than 90% of the respondents condemn heroin and cocaine use and sniffing toluene and 86% condemn pervitin use. The opinion of the respondents regarding marijuana is not so strong – more than 20% of the respondents would allow its use and 3% would even allow children and juveniles to use it (TNS Factum, 2004). The respondents are the most tolerant towards alcohol and tobacco, and 5–6% of the respondents would also allow children to smoke tobacco and drink alcohol without any limitation. Nearly 22% of the respondents mentioned that they would ban smoking and 11% would ban alcohol drinking – see Figure 2-3.

*Figure 2-2: Moral acceptability of behaviours – on a scale of 1–10 (1=totally unacceptable, 10=perfectly acceptable) (Centrum pro výzkum veřejného mínění, 2005b)*

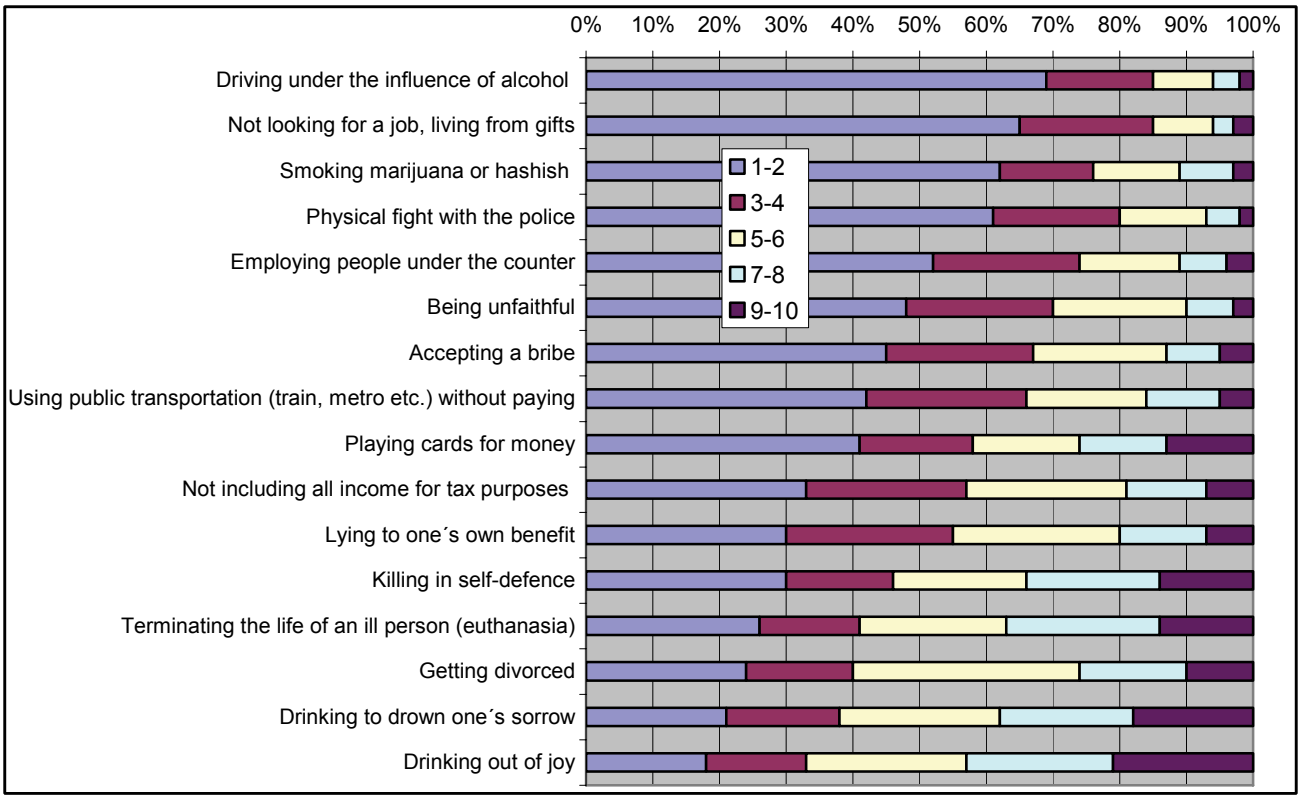
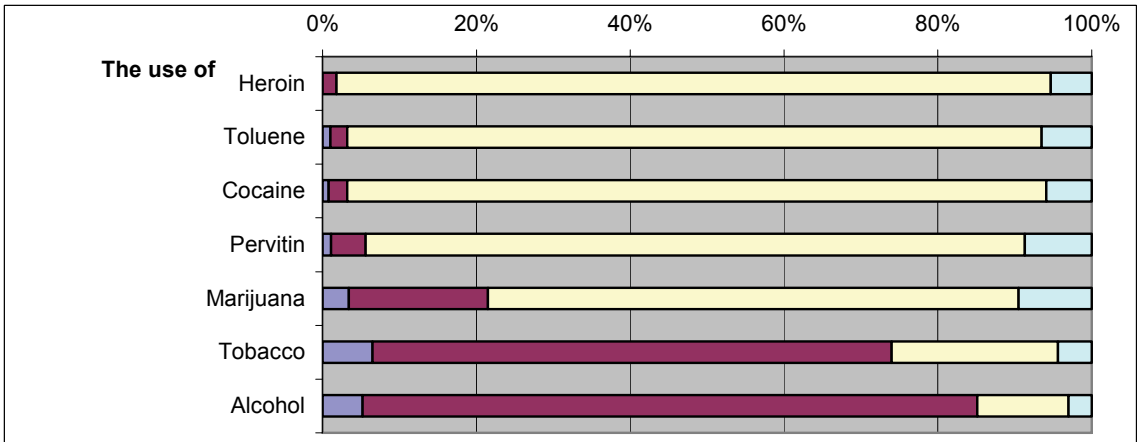



*Figure 2-3: Tolerance towards the use of individual drugs (TNS Factum, 2004)*




| | Alcohol | Tobacco | Marijuana | Pervitin | Cocaine | Toluene | Heroin |
|---|---|---|---|---|---|---|---|
| I don't know | 3.0 | 4.4 | 9.5 | 8.7 | 5.9 | 6.5 | 5.3 |
| Ban for children and adults | 11.9 | 21.6 | 69.0 | 85.7 | 90.9 | 90.3 | 92.1 |
| Allow adults only | 79.9 | 67.4 | 18.1 | 4.5 | 2.4 | 2.2 | 1.8 |
| Allow with no restrictions | 5.2 | 6.5 | 3.4 | 1.1 | 0.8 | 1.0 | 0 |

Other results showed that the Czech public is quite interested in drugs issues; 2/3 of the respondents are interested in drugs and their effects, 3/4 believe they have enough information about drugs. People most commonly get their information from the media, mostly from television, young people from friends, school, and the internet. Expert sources (physicians, psychologists, preventive workers, and also publications about drugs and theri effects) are perceived as most reliable.

According to the survey, most parents believe that they would be able to recognise if their child was using drugs (approximately 3/4) and know what to do in a situation like that (2/3). Nevertheless, every tenth parent would not recognise drug use and every fifth one would not know how to handle it. As far as drug prevention is concerned, the public requires both the direct and the indirect route to be taken, i.e. it recommends combining raising awareness, explaining consequences, proper upbringing, the use of leisure time, and sports (TNS Factum, 2004).

Parents of children aged 10–18 were also surveyed about their attitudes towards possible drug use by their child (225 respondents who live with their child in a household were surveyed). 40% of the parents agreed with the statement “I have nothing against my child trying a bit of alcohol during family celebrations”. On the contrary, 44.6% of the parents showed considerable concern regarding drug use by their child.

## 3 Prevention

All elementary and secondary schools in the Czech Republic have established the position of a school prevention methodologist and implement various forms of a minimum preventive programme; the system of primary drug prevention in schools is provided for by school and district prevention methodologists and regional school coordinators who work under the methodological guidance of the Ministry of Education.

NGOs participate significantly in school prevention, as well as in selective and indicated prevention, in the Czech Republic. Standards for the Professional Competency of Primary Drug Prevention Programmes were approved in 2005.

Approximately 130 organisations provide telephone or internet counselling on drugs and associated issues in the Czech Republic. About 20% of them work 24 hours a day, 7 days a week.

### 3.1 Primary Prevention Coordination

The 2005–2006 Action Plan defines many activities which relate to the following goals of primary prevention:

- Efficient coordination of primary prevention with clearly defined competencies of the organisations which participate in the field of primary prevention,
- Available, quality, and effective primary prevention programmes,
- Availability of targeted primary prevention and early intervention programmes which focus on the most at-risk target groups,
- Uniform data collection in the field of primary prevention.

The government gave the Ministry of Education the task of primary drug prevention coordination. In 2004, the Ministry of Education completed a 2005–2008 Strategy for the Prevention of Social-Pathological Phenomena among Children and Juveniles within the Sphere of Competence of the Ministry of Education. It defined the following goals:

- Education towards healthy lifestyles,
- Development and support of social competencies,
- To achieve better quality and efficiency of programmes through improved coordination and control of specific primary prevention.

Specific long-term, medium-term, and short-term goals involve, in particular, system changes, coordination of the prevention and distribution of competencies, the funding of programmes, legislation, and, exceptionally, also the training of school prevention methodologists and service providers.

The strategy emphasises “specific primary prevention”, i.e. activities and services which aim to prevent drug use or its further development. It also mentions that it is necessary to focus explicitly on target groups of more at-risk individuals (Ministerstvo školství, mládeže a tělovýchovy, 2004b). However, the strategy does not define the at-risk groups, and thus not even the specific target groups. The terminology used in the strategy is based on a classification of prevention into specific and non-specific primary prevention; terms such as universal, selective, and indicated prevention were not included in the strategy.

The strategy identified the following weaknesses in the field of prevention (Ministerstvo školství, mládeže a tělovýchovy, 2004b):

- Absence of preventive activities in family and out-of-school settings,
- Poor collaboration with parents,
- Lack of measurability of the efficiency of programmes, unclear definition of indicators,
- Insufficient training for teachers and preventive programme implementators,
- Counterproductive media policy with regard to primary prevention.

Threats in the field of prevention involve an absence of a feeling of responsibility for one’s own health, high public tolerance towards licit drugs, the disparagement of prevention, and also the reluctance of teachers to develop activities which do not bring an immediate result (Ministerstvo školství, mládeže a tělovýchovy, 2004b).

### 3.2 Universal Prevention – School Programmes

As in the previous period, drug prevention programmes in schools represent the highest proportion of the total number of preventive activities. The Minimum Preventive Programme (the Ministry of Education now uses the term School Prevention Strategy) continues to be the basis of activities in schools and school facilities. Professional and methodological guidance for the system of school prevention programmes is provided by a school and district prevention methodologist and a regional school coordinator – see the 2003 and 2004 Annual Reports of the NMC for more information.

No detail information on the number, scope, or types of programmes that have been implemented is available.

### 3.3 Selective and Indicated Prevention

No comprehensive overview of the situation in the field of selective and indicated prevention is currently available; there are only some programmes at the regional/local level which are being implemented by a number of NGOs.

None of the basic documents – the 2005–2009 National Strategy, the 2005–2006 Action Plan, or the 2005–2008 Strategy for the Prevention of Social-Pathological Phenomena among Children and Juveniles within the Sphere of Competence of the Ministry of Education – uses this classification of prevention or specifies activities in these fields.

### 3.4 Activities of NGOs in the Field of Prevention

Altogether 67 of 142 programmes which were subsidised via the subsidy proceedings of the The Council of the Government for Drug Policy Coordination (CGDPC) in 2005 reported activities in the field of primary prevention (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g). They involve specialised prevention centres, as well as organisations which provide other types of services; 44 cases involved programmes supplied by facilities which target harm reduction and prevention services – they especially involve low-threshold centres in small towns whose position makes them play the role of a so-called drug agency, i.e. they provide drug users with various types of services at the same time.

The above-mentioned 67 programmes operated in 1,150 schools in the Czech Republic (46 kindergartens, 701 basic schools (pupils aged 6–15), 387 secondary schools, 10 higher professional schools, and 6 universities), and they approached more than 131,000 persons (approximately 98,000 pupils of basic schools and approximately 31,000 secondary school students (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g). Cycles of lectures and seminars which are implemented in the course of a three-year period prevail at basic schools (nearly 46% of schools), followed by one-off lectures (nearly 21%). As concerns secondary schools, one-off lectures (30% of schools) and one-off composed programmes (25%) supplemented by 2-year cycles of lectures are the most common.

More than 7,000 pupils at basic schools and nearly 3,000 secondary school students were addressed within extracurricular activities which involve prevention for children and juveniles; the activities involved one-off lectures, as well as early intervention programmes and peer programmes. At the same time, there were specific programmes which focused on young Roma people endangered by social-pathological phenomena, children from a refuge for mothers with children, and students living in boarding houses (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g). Nearly 7,000 adults were contacted; they were mostly parents (4,000) and teachers (more than 1,500 persons). Nearly 20,000 more perople, mostly young people and young adults, were involved in the activities carried out by low-threshold clubs or adventure programmes and they were in contact via internet counselling.

### 3.5 Telephone and Internet Counselling, Help Lines

A survey on counselling activities which were available over the phone or on the internet in the Czech Republic was carried out in 2005 (April until September). On the one hand, counselling on drug addiction is provided by facilities which focus on crisis intervention over the phone or the internet; the facilities only deal marginally with drug addiction (for instance help lines, crisis lines, or internet counselling); when necessary, they refer the client to a specialised facility. The second group then involves facilities which specialise in prevention and drug addiction treatment and phone and internet counselling represents only one of their activities.

127 facilities provide counselling on addiction in the Czech Republic; 121 of them provided detailed information on their activities (Sadílek and Mravčík, 2006). There are three free-of-charge help lines (“800” numbers) in the Czech Republic; they deal only marginally with addiction-related issues. 20% of all the organisations provide counselling 24 hours a day, 7 days a week; approximately 40% of them provide counselling over the internet. The queries most commonly involve questions from parents and family members about what to do when their child or another relative uses drugs, and then requests for help with one's own drug addiction, questions about treatment options, and demands for the mediation of treatment.

Research has shown that phone counselling involves many practical issues (e.g. financial problems, insufficient collaboration between organisations in the region, or a distorted public image of the facilities which provide drug prevention and treatment). Recommendations for improving the situation involve establishing a free-of-charge help line which will target exclusively the issues of addiction prevention and treatment, training for the employees of preventive and treatment services in phone crisis intervention, and the introduction of uniform standardised recording of phone calls; it is a priority to draw up a methodology and standards for internet counselling (Sadílek and Mravčík, 2006). One of the outputs concerns a list of help lines and internet pages which provide counselling on drugs in the Czech Republic; the list is also available in the Map of Help on the web page of the NMC (www.drogy-info.cz).

The Czech Association of Helplines approved an Ethical Code for Internet Counselling in 2005. It had been lacking before then in the Czech environment.

Internet information provision and counselling has been developing quickly in the Czech Republic. The internet is an attractive medium for the target population of recreational drug users who do not make use of any other services for drug users; at the same time, internet services are a good way to establish the first contact with this hidden population. Family members and friends of drug users represent another group which often uses the internet services.

Altogether 98,904 internet users visited the internet drug counselling site www.drogovaporadna.cz, operated by the NGO SANANIM, in 2005; it is twice as many as in 2004 (48,195 visits). The popularity of the website has continued to increase – 61,628 visits have already been recorded during the first six months of 2006. Altogether, 2,989 queries (2,112 in 2004) were sent in 2005; the questions were most commonly asked by drug users (990 queries), parents and other relatives (431 queries), and partners (252). The queries were most commonly about pervitin (789) and cannabis (643), then about alcohol (336) and heroin (211); the type of drug was not specified in 707 queries. 861 queries were about the need for help (to the caller), 815 queries were about information on drugs, 469 were directly aimed at treatment, and another 464 involved getting help for another person. The expressions most commonly searched for involved pervitin, heroin, marijuana, and ecstasy (Marečková, 2006).

### 3.6 Other Activities in the Field of Prevention

Meal vouchers for elementary school pupils and secondary school students with pictures which relate to drug-related topics and focus on prevention were issued in January 2005. Seven versions which targeted different drugs were prepared for basic school pupils (see, for instance, Figure 3-1); three versions were designed for secondary school students and they contain links to web pages for young people, teachers, and parents (www.drogy-info.cz, www.odrogach.cz, www.drogovaporadna.cz). 254,619 meal vouchers were distributed in 2005 – 227,194 were for basic school pupils, 23,224 for secondary school students, and 4,201 were for adults. The distribution of the vouchers (cards) has also continued in 2006.

*Figure 3-1: Examples of the front side of meal vouchers for basic school pupils and secondary school students*



The distribution of DVDs with six authorial documentaries on drugs continued in 2005. The DVDs were distributed within the framework of a project entitled 'Jeden svět na školách' (One World in Schools), organised by the People in Need organisation (the films were broadcast on Czech TV in 2003 and VHS copies were distributed in 2003–2004 under the common title 'When you have to, you have to?'). 916 DVDs, together with a thematic brochure, were distributed to schools in 2005. The entire project was covered from the state budget resources for drug policy.

In collaboration with the SANANIM civic association and the Ministry of Education, the Secretariat of the CGDPC published a Czech version of 'Making Schools a Healthier Place' – a manual on effective school-based prevention – in 2005.[7] The publication summarises the principles underpinning the preparation, planning, and implementation of school-based drug prevention programmes; it gives an overview of effective interventions and also provides information on the significance and methods of evaluation of drug prevention programmes. It also contains many practical guides and tools for an assessment of the current situation and implementation and evaluation of school-based programmes (Lejčková, 2006).

The Prev-Centrum civic association published a Czech translation of the handbook 'Prevention: Drug, Alcohol, and Tobacco'[8] (Příručka prevence: drog, alkoholu a tabáku) in November 2004. The Embassy of the Kingdom of the Netherlands in Prague and the Prague Magistrate participated in its publishing. The publication was distributed to all basic and secondary schools in Prague and to pedagogical-psychological counselling offices, libraries, and other professional institutions which deal with the primary prevention of substance use. The publication is a source of detailed information necessary for the planning and implementation and subsequent evaluation of primary prevention programmes.

### 3.7 Evaluation of Preventive Programmes

The government adopted the Rules for Granting Financial Resources on Drug Policy in the Government Resolution 700/2005 in June 2005. It stipulated the certification of the professional competency of services for drug users as a prerequisite for the allocation of a subsidy for the year 2007. Certification is a formal acknowledgment that a

[7] 4,000 copies were printed; the publication was originally published in the Netherlands.
[8] A publication written by Dutch authors; it was originally published in 1998 with the help of the Pompidou Group of the Council of Europe.

programme is of good quality and complies with the criteria specified in the Standards of Professional Competency. The Standards for the Quality of Primary Prevention Programmes, which the CGDPC approved on September 30, 2005, were defined for specific primary prevention programmes which are provided in schools or as part of extracurricular activities, for early intervention programmes, educational programmes, and publication activities in the field of primary prevention. The following aspects of individual programmes are assessed (Ministerstvo školství, mládeže a tělovýchovy, 2004a):

- Accessibility (i.e. financial availability and equal approach to all clients),
- Observance of the rights of clients,
- Manner of implementation of programme,
- Professional competency and professional development of employees,
- Programme availability (territorial and time availability),
- Budget and management of financial resources,
- Level of quality of programme and efficiency evaluation.

The actual process of the certification of primary prevention services has not been launched yet. The Government Resolution No. 693/2006 stipulated that the process of the certification of primary prevention programmes is to be launched on October 2, 2006. At the same time, it stated that facilities will only be obliged to submit a certification of professional competency with an application for financial resources (subsidies) for their drug policy programme for the year 2008.

The Czech School Inspectorate is in charge of the evaluation of the efficiency of the prevention of social-pathological phenomena in schools and school facilities. It evaluates the implementation of preventive problems in selected schools every year. 90 schools were inspected in the spring of 2005 – 45 basic schools, 25 secondary schools, 16 schools for pupils with specific educational needs, and 4 children's homes. The evaluation especially concerned the activities of school prevention methodologists and the involvement of other workers in prevention, and it also targeted collaboration between schools and parents and providers of preventive programmes, the School Prevention Strategy (also called the Minimum Preventive Programme), and other activities of the school (Česká školní inspekce, 2005).

Altogether, 89 out of the total of 90 schools drew up their Minimum Preventive Programme; however, in 11% of basic schools and 12% of secondary schools it did not comply with the methodological guidelines of the Ministry of Education. At the same time, 11% of basic schools and 4% of secondary schools did not carry out a periodical evaluation of their preventive programme, and the content of the Minimum Preventive Programme was often not adjusted to the current situation in the school (18% of basic and 44% of secondary schools). Approximately 10% of the Minimum Preventive Programmes that were evaluated only contained a list of events. The individual schools reported the occurrence of the phenomena monitored in a given school year – vulgar behaviour and thefts were the most common in basic schools, and smoking and truancy in secondary schools (see Table 3-1). 22% of basic schools and 32% of secondary schools dealt with drug use and distribution during the year (Česká školní inspekce, 2005).

*Table 3-1: Occurrence of negative social phenomena in schools (% of assessed schools) (Česká školní inspekce, 2005)*

| **Phenomenon** | **Occurrence in elementary schools** | **Occurrence in secondary schools** |
|---|---|---|
| Vulgar behaviour | 86.7 | 60.0 |
| Vandalism | 71.1 | 36.0 |
| Smoking | 71.1 | 80.0 |
| Truancy | 68.9 | 72.0 |
| Bullying | 48.9 | 56.0 |
| Thefts | 80.0 | 68.0 |
| Alcohol consumption | 51.1 | 28.0 |
| Drug use and distribution | 22.2 | 32.0 |
| Racism and xenophobia | 15.6 | 0.0 |
| Virtual drugs | 8.9 | 0.0 |

The occurrence of the problems in the school was also investigated by means of a questionnaire survey in the schools monitored. A total of 2,906 elementary school pupils and 1,220 secondary school students were surveyed. Nearly 50% of secondary school students and almost 25% of basic school pupils admit drug use in school; 20% of secondary school students and 10% of elementary school pupils confirm that drugs were passed among pupils (Česká školní inspekce, 2005).

The Institute of Pedagogical and Psychological Counselling dealt with the assessment of the Minimum Preventive Programme in schools in the previous years; however, the most recent report available is for the school year 1998–1999 (Slavíková et al. 2000).

## 4 Problem Drug Use

In the Czech Republic, problem drug use is defined as the use of drugs by injection and/or the regular or long-term use of opiates and amphetamine-type drugs. Cocaine is not included in the national definition, and its occurrence in the Czech Republic is still sporadic – see the special chapter on Cocaine and Crack, page 80.

As far as the use of opiates is concerned, heroin is the most common. At the same time, buprenorphine (Subutex), either prescribed by a physician or obtained from the black market, is also being used increasingly often in some regions. Home-made opiates made from medicinal products or poppy heads are rather a (seasonal) exception. The problem use of amphetamine-type drugs in the Czech Republic is limited exclusively to the use of pervitin (methamphetamine).

The estimated number of problem drug users increased slightly to 32,000 in 2005; approximately 11,500 of them use opiates and 20,500 use pervitin; approximately 30,000 problem drug users inject drugs. The increase especially involves the number of (mostly injecting) users of Subutex and their proportion in the number of opiates users – even other data sources confirm this trend. The increase in the number of pervitin users is obvious from data on the clients of low-threshold facilities from which prevalence estimates are made (see also the chapter on Services Provided by Low-Threshold Facilities, page 49) as well as from data in the Register of Treatment Demands.

The number of treated drug users decreased in 2005. With the exception of all treatment demands relating to pervitin use, a decline in the number of both all treatment demands and first treatment demands occurred with regard to all the main groups of drugs. There has been a year-on-year decline in the number of injecting users, females, and users aged under 19 who have been treated. The average age of patients asking for treatment continues to increase.

At the same time, the proportion of injecting users among all problem drug users of pervitin and opiates (both heroin and Subutex) continues to be high (80–90%).

### 4.1 Estimates of Prevalence and Incidence of Problem Drug Use

A national prevalence estimate was carried out in 2005, using a multiplication method with the use of data from low-threshold facilities. The number of problem drug users in contact with reporting low-threshold facilities, extrapolated to the total number of these facilities in the Czech Republic, was used as the basis for the calculations. The multiplier (in-treatment rate), i.e. the estimated number of problem drug users in contact with such facilities, was obtained by means of a nomination technique[9] within the framework of the HCV Seroprevalence Among Injecting Drug Users survey; see the chapter on Drug-related Infections, page 42.

An overview of the prevalence estimates which were made using a multiplication method with the use of data from low-threshold facilities during the last four years is given in Table 4-1. There was a slight increase in the estimated number of pervitin users, as well as those of opiates. As far as pervitin is concerned, the increase is probably caused by a further dissemination of pervitin in the nightlife and dance environments, including small towns. The rise in the estimated number of opiates users is partly caused by an increase in the number of users who use Subutex obtained from the black market as their primary drug.

*Table 4-1: Development of prevalence estimates of problem drug use carried out using a multiplication method with the use of data from low-threshold facilities in 2002–2005 (Národní monitorovací středisko pro drogy a drogové závislosti, 2006c)*

| Year | Total number of problem drug users | | Number of opiates users | | Number of pervitin users | | Number of injecting drug users | |
|---|---|---|---|---|---|---|---|---|
| | Abs. | Per 1,000 inhabitants aged 15–64 | Abs. | Per 1,000 inhabitants aged 15–64 | Abs. | Per 1,000 inhabitants aged 15–64 | Abs. | Per 1,000 inhabitants aged 15–64 |
| 2002 | 35,100 | 4.89 | 13,300 | 1.85 | 21,800 | 3.04 | 31,700 | 4.41 |
| 2003 | 29,000 | 4.02 | 10,200 | 1.41 | 18,800 | 2.61 | 27,800 | 3.86 |
| 2004 | 30,000 | 4.14 | 9,700 | 1.34 | 20,300 | 2.80 | 27,000 | 3.73 |
| 2005 | 31,800 | 4.37 | 11,300 | 1.55 | 20,500 | 2.82 | 29,800 | 4.10 |

In addition, the agency INRES-SONES and the Medical Information Centre carried out a periodical national representative omnibus[10] survey among practitioners in the Czech Republic. As well as the 2003 survey, the survey included questions for general practitioners which aimed to find out the prevalence of problem opiates and pervitin users (Mravčík et al. 2005b). General practitioners for adults and children were asked three questions: (1) "How many registered patients do you have?", (2) "According to your information or estimate, how many of your patients inject heroin or other illicit opiates or use them on a regular or long-term basis?", (3) "According to your information

[9] As no new data were obtained in 2005, the multiplier used for the 2004 estimate was used.
[10] Omnibus surveys focus on multiple topics – they contain more thematic modules.

or estimate, how many patients inject pervitin (methamphetamine) or use it on a regular or long-term basis?".[11] 180 general practitioners for adults and 118 general practitioners for children participated in the survey in 2005. The results of the questionnaire surveys among general practitioners are given in Table 4-2.

*Table 4-2: Prevalence estimates of problem drug users obtained from questionnaire surveys among general practitioners (Národní monitorovací středisko pro drogy a drogové závislosti, 2006d)*

| Rok | Total number of problem drug users | | Number of opiates users | | Number of pervitin users | |
|---|---|---|---|---|---|---|
| | Abs. | Per 1,000 inhabitants aged 15–64 | Abs. | Per 1,000 inhabitants aged 15–64 | Abs. | Per 1,000 inhabitants aged 15–64 |
| **2003** | n.a. | n.a. | 21,200 | 2.6* | – | – |
| **2005** | 32,000 | 4.4 | 17,000 | 2.3 | 15,000 | 2.0 |

*Note: * Per 1,000 inhabitants aged 18 and above.*

The prevalence estimates obtained with the help of general practitioners most probably overestimate the number of users of opiates, and, on the contrary, they most probably underestimate the number of pervitin users. Opiates users can receive Subutex substitution treatment from general practitioners (and so they can be in better contact with them); however, no similar therapeutic method is available from general practitioners for pervitin users.

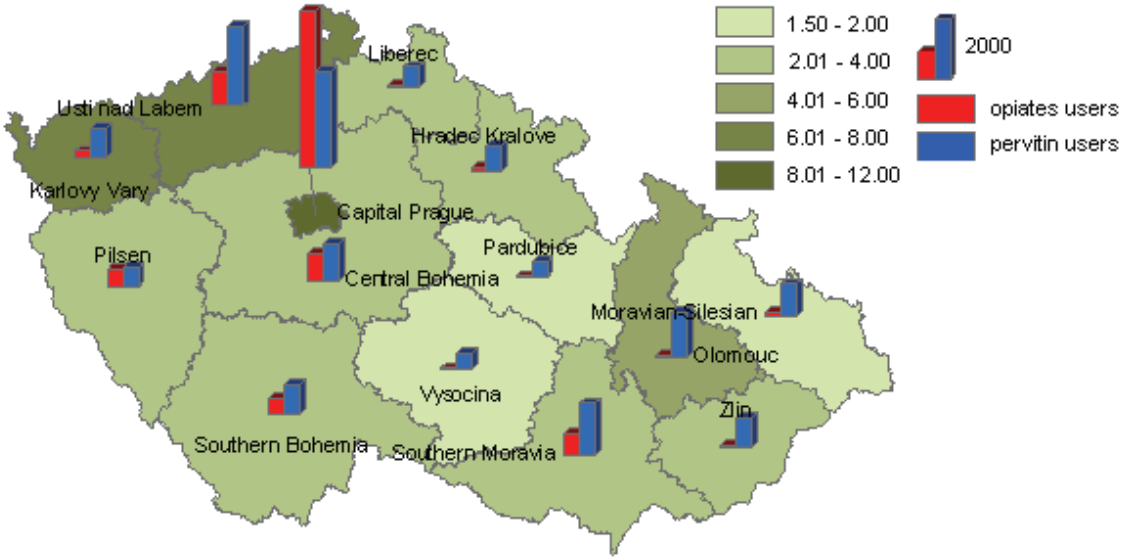
Prevalence estimates carried out using the multiplication method were also carried out on a regional level in 2005 – see Table 4-3 and Map 4-1. However, it is necessary to take the estimates according to individual regions as indicative numbers only because of the specifics of the source data from individual regions and the difference between the real proportion of problem drug users who are in contact with treatment services and the "average" value for the Czech Republic.

*Table 4-3: Prevalence estimates of the number of problem drug users in the Czech Republic in 2005 by regions (Národní monitorovací středisko pro drogy a drogové závislosti, 2006c)*

| Region | Total number of problem drug users | Number of opiates users | Number of pervitin users | Number of injecting users |
|---|---|---|---|---|
| **Prague** | 9,800 | 6,100 | 3,700 | 9,650 |
| **Central Bohemia** | 2,500 | 1,050 | 1,450 | 2,300 |
| **Southern Bohemia** | 1,700 | 600 | 1,100 | 1,600 |
| **Pilsen** | 1,450 | 700 | 750 | 1,350 |
| **Karlovy Vary** | 1,450 | 300 | 1,150 | 1,400 |
| **Ústí nad Labem** | 4,450 | 1,350 | 3,100 | 3,950 |
| **Liberec** | 750 | <50 | 750 | 750 |
| **Hradec Králové** | 1,150 | 150 | 1,000 | 1,050 |
| **Pardubice** | 600 | <50 | 600 | 500 |
| **Vysočina** | 600 | <50 | 600 | 550 |
| **Southern Moravia** | 2,800 | 800 | 2,000 | 2,550 |
| **Olomouc** | 1,900 | 100 | 1,800 | 1,650 |
| **Zlín** | 1,150 | <50 | 1,100 | 1,100 |
| **Moravian-Silesian** | 1,500 | 150 | 1,350 | 1,350 |
| **Total** | **31,800** | **11,300** | **20,500** | **29,800** |

[11] Fraction Σ(2) / Σ(1) and Σ(3) / Σ(1) respectively then gives the prevalence of problem opiates or pervitin users (recalculated to 1,000 adult inhabitants of the appropriate age).

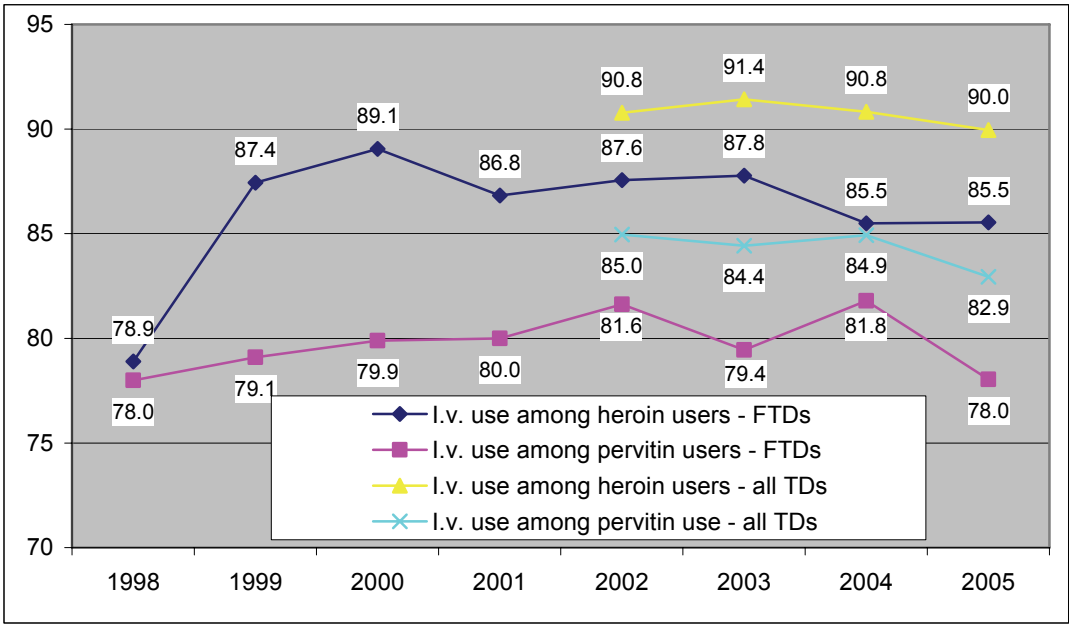
*Map 4-1: Number of problem drug users per 1,000 inhabitants aged 15-64 and the proportion of problem users of opiates and pervitin in the Czech Republic in 2005 (Národní monitorovací středisko pro drogy a drogové závislosti, 2006c)*




### 4.1.1 Injecting Drug Use

The proportion of injecting drug users among first treatment demands has varied between 85–90% on a long-term basis (with the exception of 1998, when it was just under 80%). Injecting drug use is less common among pervitin-related first treatment demands; it has been around 80% on a long-term basis. The proportion of injecting heroin and pervitin users among all treatment demands is higher by 3–5% than among first treatment demands – slightly above 90% for heroin, and under 85% for pervitin. The development in 1998–2005 is given in Figure 4-1; more information on treatment demands is included in the chapter on Profile of Drug Users in Treatment, page 27.

*Figure 4-1: Proportion of injecting use among heroin- and pervitin-related first treatment demands in 1998–2005 and among all treatment demands in relation to the use of heroin and pervitin in 2002–2005 (Polanecký et al. 2006)*

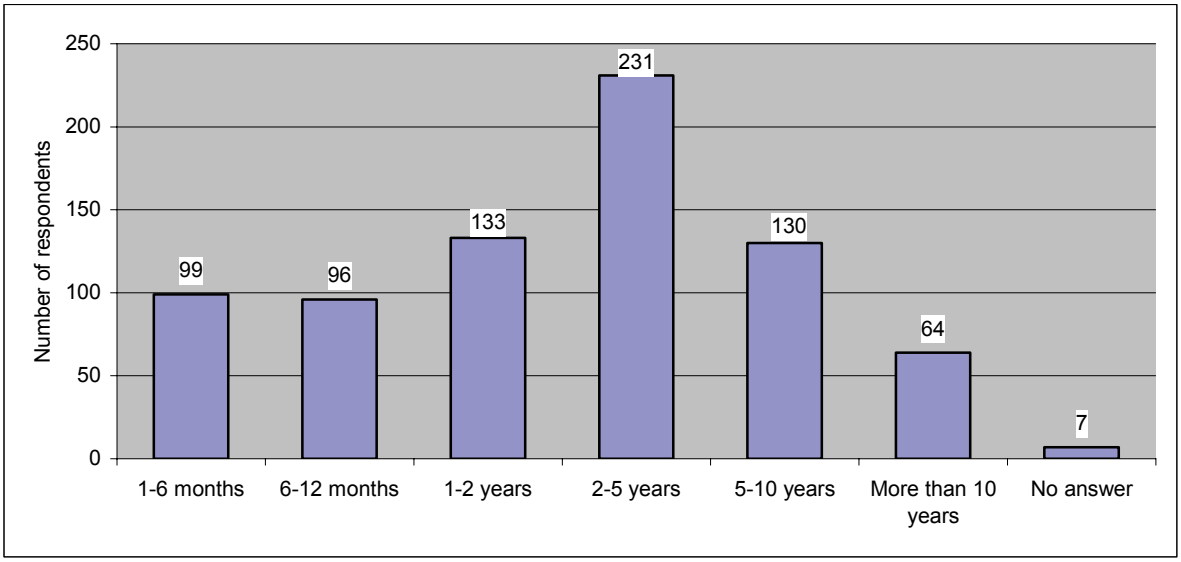



Altogether 760 respondents with a valid anti-HCV test result participated in the HCV Seroprevalence Among Injecting Users survey from September 2002 to December 2003; 495 (65.1%) of them were males and 265 (34.9%) females (Mravčík et al. 2006). The respondents were aged 15 to 59; the average age was 24.6 (modus 19, median 23) and the group aged 20–24 was the most represented (38.2%). All respondents were current injecting drug users (i.e. they had injected during the last 12 months). 740 (97.4%) respondents had injected a drug within the last six months, 661 (87%) within the last month, and only 1.8% (19 persons) mentioned that they had last injected a drug even before then.

232 (30.5%) respondents had injected a drug for the first time less than two years before the testing, 527 (69.3%) more than two years before the testing.

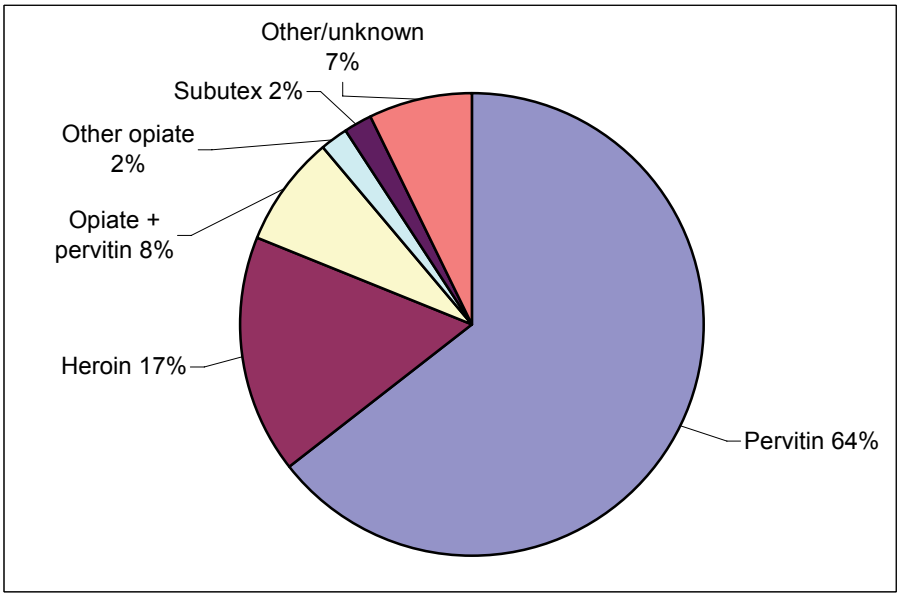
The length of the respondents' regular injecting use (a sum of all periods of regular use) is given in Figure 4-2.

*Figure 4-2: Length of regular injecting use among respondents of the HCV Seroprevalence Among Injecting Users survey (Mravčík et al. 2006)*




The sample had the following structure with regard to the substances used: 127 (16.7%) respondents mentioned heroin as their current primary drug, 14 (1.8%) mentioned Subutex, 16 (2.1%) another opiate (opium, codeine, braun[12], or methadone), 490 (64.7%) pervitin, and 58 (7.6%) respondents mentioned the combination of an opiate and pervitin. 55 (7%) respondents mentioned a primary drug other than those offered in the answers. Most commonly, this other primary drug involved cannabis – 43 persons. 3 persons mentioned inhalants as their primary drug, 2 persons mentioned ecstasy[13]; cocaine was mentioned in one case – see Figure 4-3.

*Figure 4-3: Primary drug of respondents of the HCV Seroprevalence among Injecting Drug Users survey (Mravčík et al. 2006)*




The frequency of current injecting drug use by the use of opiates is given in Table 4-4. It is apparent that the frequency is higher among opiates users.

[12] A home-made mixture of opiates made from medicines; it mostly contains codeine.
[13] These 48 cases probably involved a misunderstanding of the question, which was about a primary injection drug.

*Table 4-4: Frequency of injecting use by opiates use (Mravčík et al. 2006)*

| Frequency | Opiates use | | | | Total | |
|---|---|---|---|---|---|---|
| | Yes | | No | | | |
| | Abs. | % | Abs. | % | Abs. | % |
| Less than once a month | 27 | 12.6 | 104 | 19.3 | 131 | 17.4 |
| 1–4 times per month | 35 | 16.4 | 143 | 26.6 | 178 | 23.7 |
| 2–3 times per week | 29 | 13.6 | 141 | 26.2 | 170 | 22.6 |
| 4–6 times per week | 13 | 6.1 | 63 | 11.7 | 76 | 10.1 |
| Daily | 50 | 23.4 | 43 | 8.0 | 93 | 12.4 |
| More times per day | 60 | 28.0 | 44 | 8.2 | 104 | 13.8 |
| **Total** | **214** | **100.0** | **538** | **100.0** | **752** | **100.0** |

#### 4.1.1.1 Risky Behaviour among Injecting Drug Users

The occurrence of risk factors of injecting drug use, according to the HCV Seroprevalence among Injecting Drug Users survey:

- 585 (77%) respondents have used a syringe after someone else, 104 (13.7%) of them have only used a syringe after their partner. On the other hand, 158 (20.8%) denied that they have ever shared injecting equipment. The results regarding sharing other injecting equipment are similar. 228 (39.0% of those who mentioned that they have shared a needle) mentioned that they had shared a needle for the first time during the last year.
- 302 (39.7%) respondents have been in prison (90 were in custody and 212 were sentenced to prison). 120 (39.7%) of these 302 respondents mentioned that they had injected a drug while in prison; 10 of them mentioned that they injected in prison for the first time in their life.
- 163 (21.4%) respondents have injected a drug abroad, mostly in Germany (58), then in the Netherlands (22), France (15), Slovakia (15), and Spain (12).
- 96 (12.6%) respondents have shared a needle with a foreigner, mostly with Germans (14), Slovaks (12), Ukrainians (8), and Russians (8).
- 190 (25.0%) respondents were aware of having used a needle after someone who was HCV positive; other 273 (35.9%) did not know whether the person after whom they used a needle was or was not HCV positive.

Occurrence of risky sexual behaviour among respondents of the same survey:

- 425 (55.9%) respondents mentioned that they had had more than 10 sexual partners in their lifetime; 164 (21.7%) respondents mentioned five or fewer sexual partners. 580 (76.3%) mentioned that at least one of their sexual partners was a drug user.
- 75.2% respondents mentioned that they always or mostly do not use a condom during sexual intercourse.
- 100 (13.1%) respondents, mostly females, reported having performed sex for money, services, or drugs – see Table 4-5.

*Table 4-5: Experiences with having sex for money, services, or drugs according to the HCV Seroprevalence among Injecting Drug Users survey, by gender (Mravčík et al. 2006)*

| Gender | | Commercial sex | | | Total |
|---|---|---|---|---|---|
| | | Never | Exceptionally | Often | |
| Males* | Abs. | 450 | 36 | 8 | 494 |
| | % | 91.1 | 7.3 | 1.6 | 100.0 |
| Females | Abs. | 209 | 38 | 18 | 265 |
| | % | 78.9 | 14.3 | 6.8 | 100.0 |
| **Total** | **Abs.** | **659** | **74** | **26** | **759** |
| | **%** | **86.8** | **9.7** | **3.4** | **100.0** |

*Note: * 1 male did not answer the question.*

### 4.2 Profile of Drug Users in Treatment

Data about drug users who use the services of low-threshold and treatment facilities are mainly available through the nationwide system of reporting to the Treatment Demand Register, which has been administered by the Hygiene Service of the Czech Republic since 1995. The Treatment Demand Register involves drug users who have asked for treatment, counselling, or social services at a facility which provides services to drug users during the year; those who have done so for the first time in their life (so-called first treatment demands) are recorded separately (Polanecký et al. 2006).

Other sources of data on treated drug users involve data from the Institute of Health Information and Statistics of the Czech Republic (IHIS) on inpatient and outpatient psychiatric facilities and substitution treatment centres. The number of health care facilities which report to the register of the IHIS is higher than the number of facilities which report to the register kept by the Hygiene Service. The latter, for instance, does not include facilities which provide

substitution treatment, nor approximately a third of all outpatient health care facilities. The register kept by the Hygiene Service also gathers data from non-health care facilities for drug users, e.g. therapeutic communities, low-threshold centres, and non-health care outpatient facilities.

Data on clients of low-threshold facilities have been available since 2003 thanks to the uniform system of data collection in low-threshold facilities (FreeBase[14]) and final reports from subsidy proceedings of the The Council of the Government for Drug Policy Coordination (CGDPC).

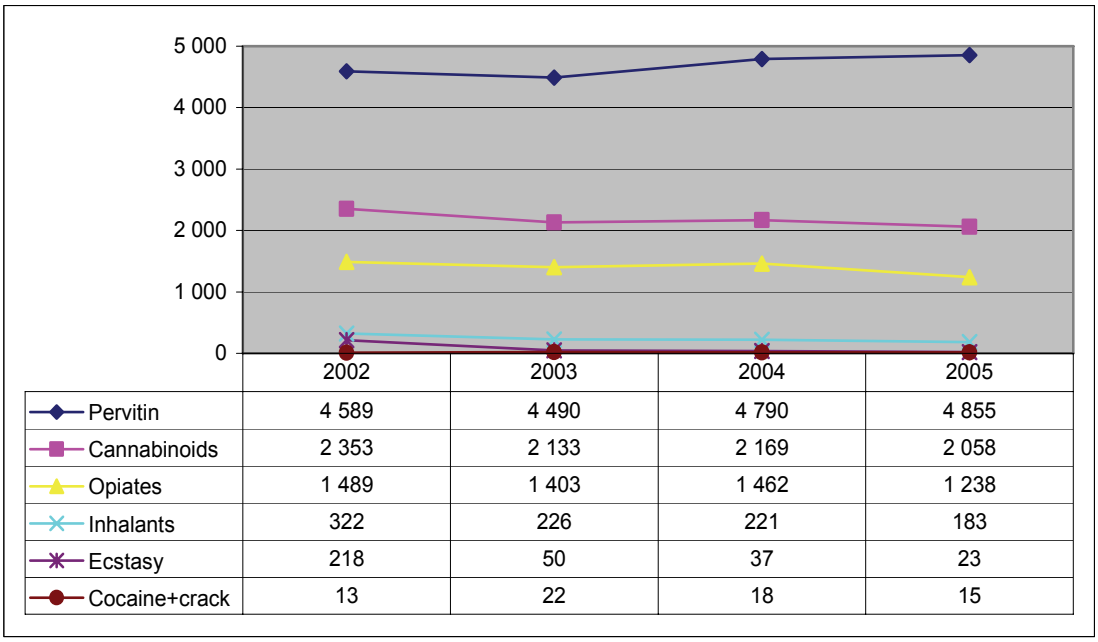
More detailed data of the IHIS are included in the chapter on Treatment, page 32; data on the clients of low-threshold facilities are included in the chapter on Services Provided by Low-Threshold Facilities, page 49.

### 4.2.1 Treatment Demand Register of the Hygiene Service of the Czech Republic

A total of 253 treatment and low-threshold centres (76 low-threshold, 122 outpatient, and 55 inpatient facilities) contributed to the Register in 2005. Low-threshold centres are the facilities that are visited most commonly; as in the previous years, clients of these facilities represented more than a half of all treatment demands.

8,534 (83.7 per 100,000 inhabitants) drug users, i.e. 3.5% less than in 2004, sought treatment at the above-mentioned centres in 2005. 4,372 (42.9 per 100,000 inhabitants) persons, i.e. 5% less than in 2004, sought treatment for the first time. Most of them, i.e. more than 57%, sought treatment in relation to the use of stimulants, especially pervitin. The proportion of stimulants users is even higher among first treatment demands (60%). Opiates users are the second most numerous group among all treatment demands (24%) and cannabis users are the second most represented group among first treatment demands (20%); 13% of first treatment demands involve opiates users. The sequence according to the drugs used has remained the same since 2002 (Figure 4-4, Figure 4-5). 225 (i.e. 2.6% of all treatment demands) Subutex users were reported in 2005 – see the chapter on Substitution and Maintenance Programmes, page 36, for more information.

*Figure 4-4 All treatment demands by type of drug in 2002–2005 ((Polanecký et al. 2006))*

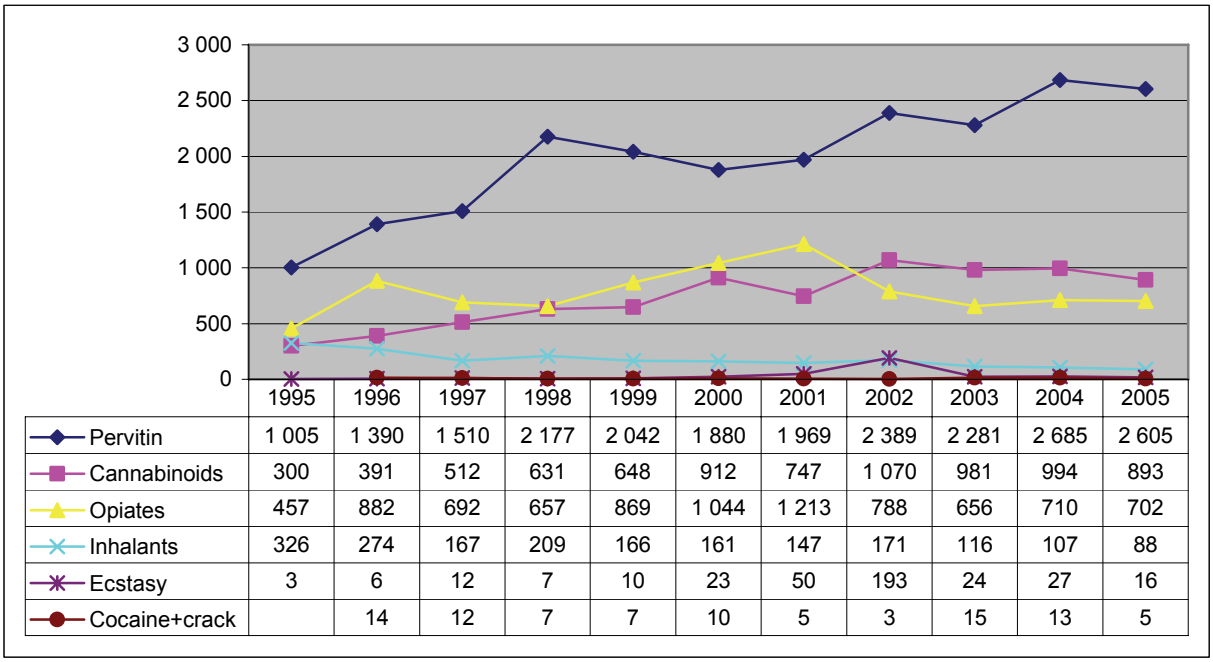



| | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|
| Pervitin | 4 589 | 4 490 | 4 790 | 4 855 |
| Cannabinoids | 2 353 | 2 133 | 2 169 | 2 058 |
| Opiates | 1 489 | 1 403 | 1 462 | 1 238 |
| Inhalants | 322 | 226 | 221 | 183 |
| Ecstasy | 218 | 50 | 37 | 23 |
| Cocaine+crack | 13 | 22 | 18 | 15 |

The prevalence and incidence of treatment demand rates and the proportion of drugs used vary between individual regions. The Ústí nad Labem and Prague regions report the highest prevalence, and the Karlovy Vary and Ústí nad Labem regions report the highest incidence. As in previous years, Prague is the only region where the proportion of opiates users is higher than the proportion of users of other drugs; in other regions, the proportion of pervitin users is the highest. Opiates users are also significantly represented in the Ústí nad Labem, Southern Bohemia, and Pilsen regions; the proportion of cannabis users was significant in the Vysočina and Central Bohemia regions – see Map 4-2.

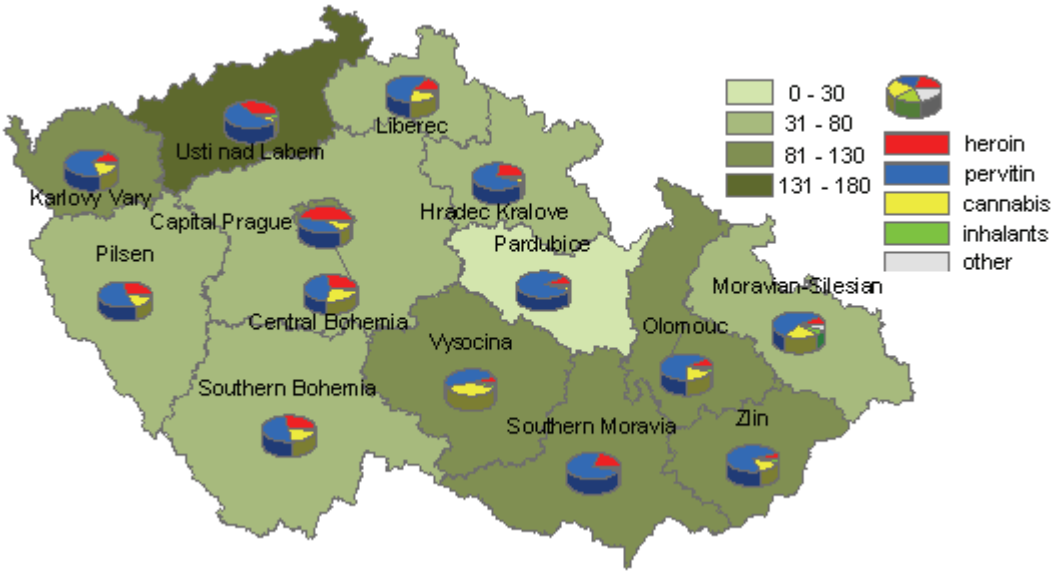
[14] See http://freebase.drogy-info.cz.

*Figure 4-5: First treatment demands by type of drug in 1995–2005 ((Polanecký et al. 2006)*




| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Pervitin | 1 005 | 1 390 | 1 510 | 2 177 | 2 042 | 1 880 | 1 969 | 2 389 | 2 281 | 2 685 | 2 605 |
| Cannabinoids | 300 | 391 | 512 | 631 | 648 | 912 | 747 | 1 070 | 981 | 994 | 893 |
| Opiates | 457 | 882 | 692 | 657 | 869 | 1 044 | 1 213 | 788 | 656 | 710 | 702 |
| Inhalants | 326 | 274 | 167 | 209 | 166 | 161 | 147 | 171 | 116 | 107 | 88 |
| Ecstasy | 3 | 6 | 12 | 7 | 10 | 23 | 50 | 193 | 24 | 27 | 16 |
| Cocaine+crack | | 14 | 12 | 7 | 7 | 10 | 5 | 3 | 15 | 13 | 5 |

*Map 4-2: Number of all treatment demands in 2005 by type of drug and regions (per 100,000 inhabitants) (Polanecký et al. 2006)*

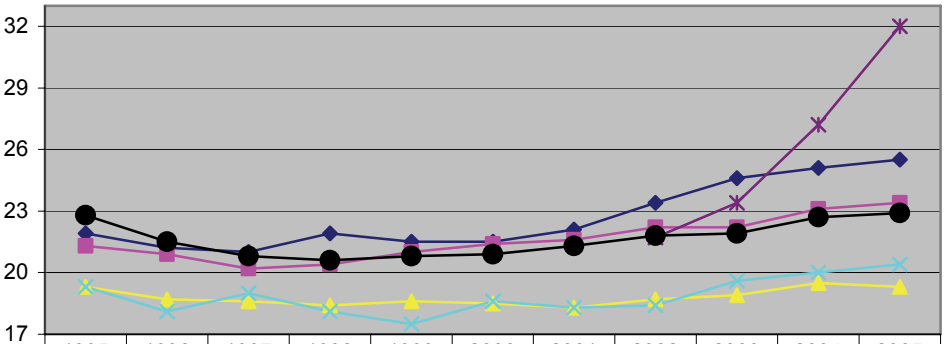



There are also differences between the basic characteristics of the users who seek treatment in relation to different drugs. Opiates users were the oldest[15] on average (26.4 years of age); 70% of the group were males. The proportion of males (67.5%) and the average age (24.5) were lower among the group of pervitin users. The highest proportion of males was among the users of inhalants (83.1%) and cannabis (74.6%). Cannabis users were the youngest, on average (20 years of age).

The average age of people demanding treatment is increasing; the group aged 25–39 was the most numerous in 2005 (39.4% of all users demanding treatment). The group aged 20–24 was the most represented among first treatment demands for the first time in 2005 (33.7%); the group of those aged 15–19 used to be the most represented in the past). The average age of those who seek treatment is increasing, most quickly among the users of opiates and inhalants – see Figure 4-6 and Figure 4-7.

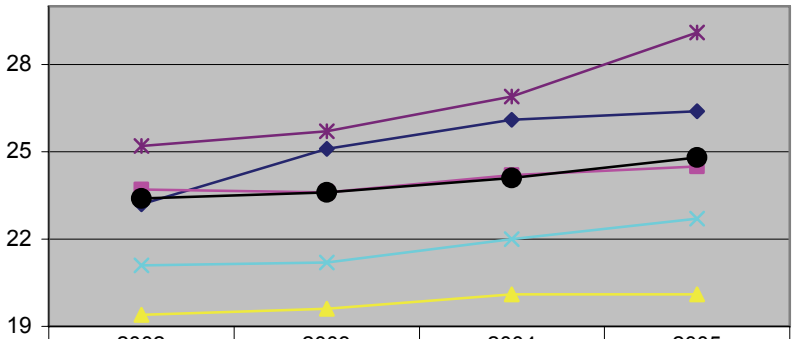
[15] Apart from cocaine users, whose number was very low.

*Figure 4-6: Average age of drug users demanding first treatment in 1995–2005 – selected drugs (Polanecký et al. 2006)*




| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Heroin | 21.9 | 21.2 | 21.0 | 21.9 | 21.5 | 21.5 | 22.1 | 23.4 | 24.6 | 25.1 | 25.5 |
| Pervitin | 21.3 | 20.9 | 20.2 | 20.4 | 21.0 | 21.4 | 21.6 | 22.2 | 22.2 | 23.1 | 23.4 |
| Marijuana | 19.3 | 18.7 | 18.6 | 18.4 | 18.6 | 18.5 | 18.3 | 18.7 | 18.9 | 19.5 | 19.3 |
| Inhalants | 19.3 | 18.1 | 19.0 | 18.1 | 17.5 | 18.6 | 18.3 | 18.4 | 19.6 | 20.0 | 20.4 |
| Cocaine+crack | | | | | | | | 21.7 | 23.4 | 27.2 | 32.0 |
| All drugs | 22.8 | 21.5 | 20.8 | 20.6 | 20.8 | 20.9 | 21.3 | 21.8 | 21.9 | 22.7 | 22.9 |

*Figure 4-7: Average age of all drug users demanding treatment in 2002–2005 – selected drugs (Polanecký et al. 2006)*



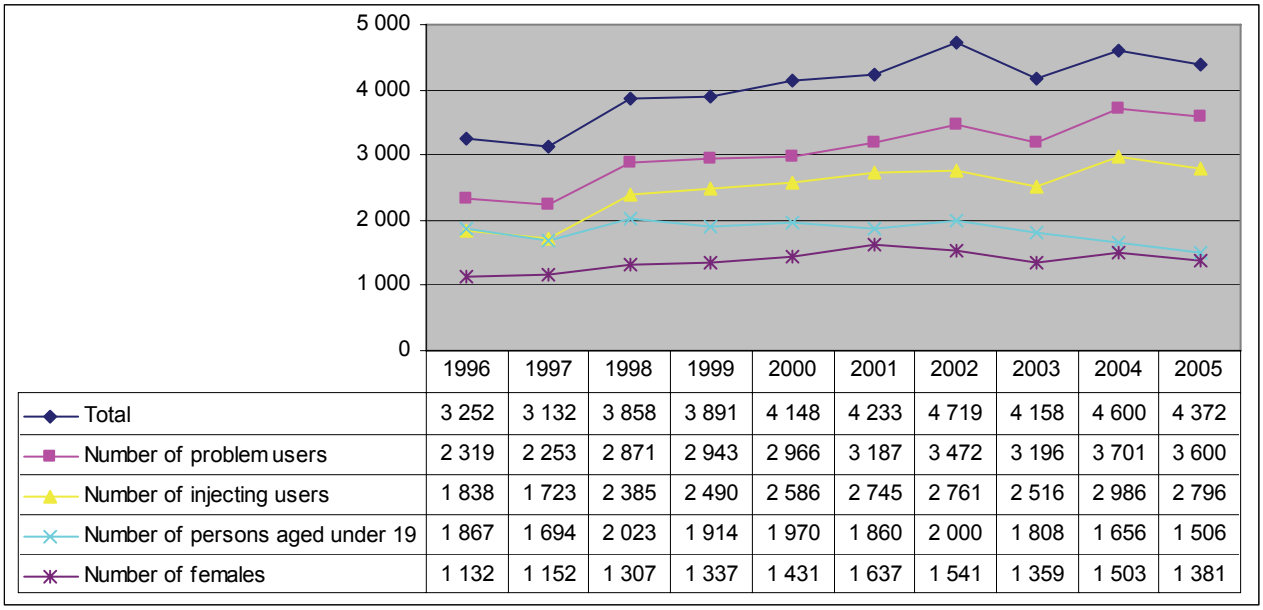

| | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|
| Heroin | 23.2 | 25.1 | 26.1 | 26.4 |
| Pervitin | 23.7 | 23.6 | 24.2 | 24.5 |
| Marijuana | 19.4 | 19.6 | 20.1 | 20.1 |
| Inhalants | 21.1 | 21.2 | 22.0 | 22.7 |
| Cocaine+crack | 25.2 | 25.7 | 26.9 | 29.1 |
| All drugs | 23.4 | 23.6 | 24.1 | 24.8 |

In the long term, the proportion between males and females among treatment demands has not changed much; females represent approximately a third of the treatment demands. The proportion of males has been increasing slightly since 2002. The proportion of males is the lowest among the group aged 15–19; females prevail slightly among pervitin users in this age group.

Altogether 7,372 (86.4%) of all treatment demands and 3,600 (82.3%) of first treatment demands complied with the EMCDDA definition of problem drug use[16] in 2005. The trend in the development of the proportion of problem users among those demanding treatment is given in Figure 4-8 and Figure 4-9; the curves copy the total number of drug users demanding treatment – no significant differences occurred during the nine years. In comparison with previous years, there was a slight decline in the proportion of injecting drug users among all treatment demands (by 3.5%) and first treatment demands (by 4.3%). Injecting drug use (including secondary drugs) was reported by 5,837 (68.4%) out of all drug users demanding treatment and 2,649 (60.6%) out of drug users demanding first treatment. (Polanecký et al. 2006).

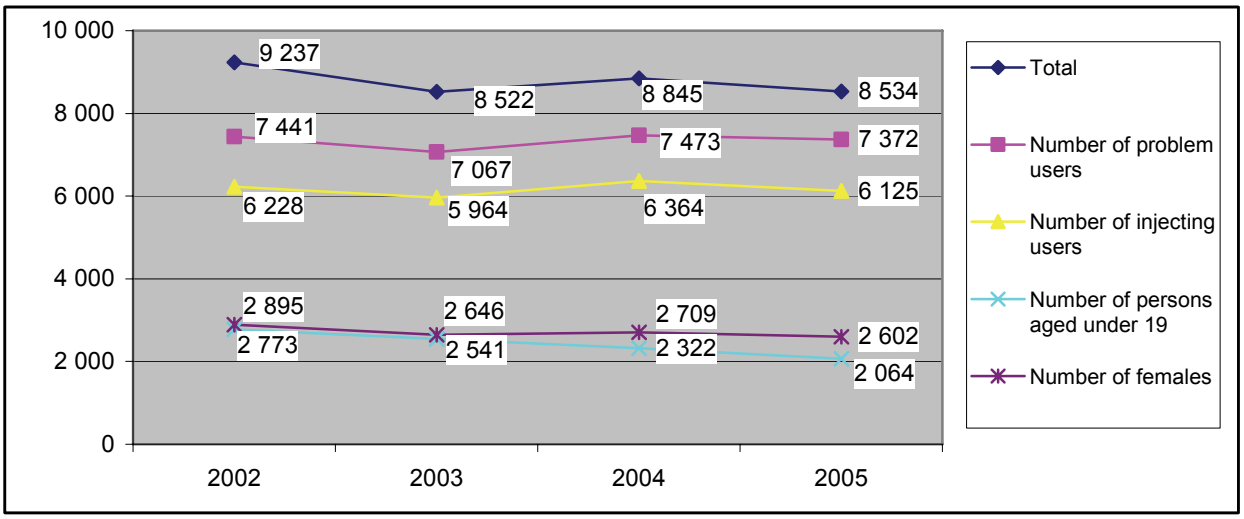
[16] The EMCDDA defines problem use as injecting drug use and/or the long-term and regular use of opiates and/or amphetamines and/or cocaine. The definition in the Czech Republic does not involve cocaine users.

*Figure 4-8: Selected characteristics of drug users demanding first treatment in 1996–2005 (Polanecký et al. 2006)*




| | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total | 3 252 | 3 132 | 3 858 | 3 891 | 4 148 | 4 233 | 4 719 | 4 158 | 4 600 | 4 372 |
| Number of problem users | 2 319 | 2 253 | 2 871 | 2 943 | 2 966 | 3 187 | 3 472 | 3 196 | 3 701 | 3 600 |
| Number of injecting users | 1 838 | 1 723 | 2 385 | 2 490 | 2 586 | 2 745 | 2 761 | 2 516 | 2 986 | 2 796 |
| Number of persons aged under 19 | 1 867 | 1 694 | 2 023 | 1 914 | 1 970 | 1 860 | 2 000 | 1 808 | 1 656 | 1 506 |
| Number of females | 1 132 | 1 152 | 1 307 | 1 337 | 1 431 | 1 637 | 1 541 | 1 359 | 1 503 | 1 381 |

*Figure 4-9: Selected characteristics of all drug users demanding treatment in 2002–2005 (Polanecký et al. 2006)*




## 4.3 Problem Drug Use in Other Data Sources

A questionnaire survey among clients of the low-threshold centre and the outreach programmes operated by the SANANIM civic association in Prague was carried out in 2006 (Mravčík, 2006). 198 questionnaires were collected, 99 in the low-threshold centre and 99 in the outreach programmes. Table 4-6 provides an overview by drugs used. 96.5% of the respondents reported injecting drugs, and there is also a high proportion of injecting drug users among those who use Subutex only (95.1%).

Other information on problem drug users is included in the chapters on Treatment, page 32, Services Provided by Low-Threshold Facilities, page 49, or Substitution and Maintenance Programmes, page 36.

*Table 4-6: Drugs used by the clients of the low-threshold programmes of the SANANIM NGO, Prague (Mravčík, 2006)*

| Type of drug | Number of clients | % |
|---|---|---|
| Subutex | 82 | 41.4 |
| Pervitin | 66 | 33.3 |
| Pervitin + Subutex | 23 | 11.6 |
| Heroin | 14 | 7.1 |
| Other combinations | 13 | 6.6 |
| **Total** | **198** | **100.0** |

## 5 Treatment

The treatment of addiction to psychoactive substances is understood as professional, focused, and structured work with a client with the objective of achieving abstinence or reduction of drug use, reduction of the frequency and severity of relapses, and the involvement of clients in productive life in the family, work, and society, thus improving the quality of their life to a maximum. A wide spectrum of interdisciplinary services provides treatment and social reintegration in the Czech Republic. By type, the following types of treatment are recognised: outpatient (AT clinics, day-care programmes, and structured aftercare programmes) and inpatient (therapeutic communities, specialised hospital departments, and psychiatric hospitals). Treatment is also divided into short-term (4–8 weeks), medium-term (3–6 months), and long-term (7 months and more).

*Table 5-1: Treatment programmes which supplied services to drug users in 2005 (Ústav zdravotnických informací a statistiky, 2006a, 2006b, 2006c, 2006d; Národní monitorovací středisko pro drogy a drogové závislosti, 2006g; Řeháček, 2006)*

| Programme type | Number | Capacity (places, beds) | Capacity utilisation (number of persons) |
|---|---|---|---|
| Sobering-up stations | 16 | n.a. | n.a. |
| Detoxification units | 19 | n.a. | n.a. |
| Outpatient health care facilities (clinics)[a)] | 401 | n.a. | 17,531 |
| Day-care centres | 2 | 10[b)] | 36[b)] |
| Substitution (methadone) centres | 10 | n.a. | 758 |
| Buprenorphine substitution in outpatient clinics | n.a. | n.a. | 1,000–2,500 |
| Psychiatric hospitals | 17 | 9,538[c)] | 3,104 |
| Psychiatric departments of hospitals | 32 | 1,439[c)] | 1,613 |
| Psychiatric hospitals for children | 3 | 320[c)] | 27 |
| Therapeutic communities | 15 | 193[d)] | 486[d)] |
| Aftercare programmes | 20 | 385[e)] | 865 |
| – out of which sheltered housing | 12 | 118 | 244 |
| Inpatient departments which specialise in treatment of children endangered by drug addiction (special education facilities | 5 | 66 | 104 |
| Detoxification units in prisons | 1 | n.a. | 172 |
| Departments for differentiated serving of sentence | 6 | 286 | 523 |
| Departments for compulsory treatment in prisons | 3 | 105 | 184 |
| Drug-free zones in prisons[f)] | 34 | 1,606 | 2,859 |

*Note: a) they involve outpatient health care facilities with various specialisations, not only the AT clinics, b) data from one day-care centre only, c) number of all psychiatric beds, d) data from 12 communities only, e) the data only involve intensive aftercare, f) drug-free zones do not provide therapy.*

A system for the certification of the professional competency of services for drug users started to operate in 2005 (see the chapter on Evaluation of Preventive Programmes, page 21, for more information on the certification of primary prevention programmes). It should especially provide for the availability of quality services in the field of harm reduction, treatment, and resocialisation in the following standard types: outreach programmes, low-threshold and counselling services, detoxification, substitution treatment, outpatient treatment, day-care programmes, short-term and medium-term institutional treatment, inpatient treatment in therapeutic communities, and outpatient aftercare programmes. Only certified programmes run by NGOs should be subsidised from the state budget after 2007.

Certification of professional competency had been granted to 16 treatment facilities by the end of 2005, and another 25 facilities had been certified by May 31, 2006. Table 5-2 shows the number of certifications granted to individual types of services in the field of treatment and resocialisation. So far, certification has been denied only to one treatment facility (which was asking for certification for an outpatient treatment service).

In the field of harm reduction, certification of professional competency had been granted to 16 facilities by the end of 2005 and 21 facilities by May 31, 2006 – see Table 5-2 for more information. Certification was not granted to 6 facilities; 3 of them were asking for certification for an "outreach programme" and three were asking for certification for "low-threshold and counselling services" (Národní monitorovací středisko pro drogy a drogové závislosti, 2006a). The chapter on Responses to Health Correlates and Consequences of Drug Use, page 49, deals with services which were provided in the field of harm reduction.

*Table 5-2: Number of certifications of professional competency of services for drug users granted by May 31, 2006 by type of service in the field of treatment and resocialisation (Národní monitorovací středisko pro drogy a drogové závislosti, 2006a)*

| Type of service | Number of certifications granted | Average point score | Maximum possible number of points |
|---|---|---|---|
| Detoxification | 4 | 933 | 960 |
| Outpatient treatment | 8 | 918 | 940 |
| Day-care programmes | 1 | 975 | 975 |
| Short-term and medium-term inpatient treatment | 3 | 960 | 995 |
| Inpatient care in therapeutic communities | 9 | 1 005 | 1 025 |
| Outpatient aftercare programmes | 12 | 1 034 | 1 055 |
| Substitution treatment | 4 | 1 001 | 1 015 |
| Outreach programmes | 17 | 924 | 955 |
| Low-threshold and counselling services | 20 | 937 | 975 |

## 5.1 Outpatient Treatment

401 outpatient health care facilities reported providing outpatient treatment to users of licit and illicit drugs (Ústav zdravotnických informací a statistiky, 2006b). The number of outpatient facilities which also report that they provide services to illicit drugs users has continued to increase since 2000. In 2005, 78% of outpatient clinics treated 50 or fewer and 44% only 10 or fewer patients who were drug users – see Table 5-3 and Table 5-4.

*Table 5-3: Number of outpatient health care facilities providing care to drug users in 2000–2005 (Ústav zdravotnických informací a statistiky, 2006b)*

| Year | Number of facilities* |
|---|---|
| 2000 | 320 |
| 2001 | 330 |
| 2002 | 342 |
| 2003 | 368 |
| 2004 | 382 |
| 2005 | 401 |

*Note: * This involves the facilities which filled in an A013 appendix of the AT psychiatric report.*

*Table 5-4: Number of outpatient health care facilities by number of patients in 2003–2005 (Ústav zdravotnických informací a statistiky, 2006b)*

| Number of patients | Number of facilities | | |
|---|---|---|---|
| | 2003 | 2004 | 2005 |
| 1–10 | 139 | 144 | 156 |
| 11–50 | 106 | 109 | 107 |
| 51–100 | 27 | 32 | 37 |
| 101–200 | 18 | 19 | 18 |
| 201–300 | 10 | 8 | 10 |
| 301–400 | 5 | 3 | 4 |
| 401 or more | 8 | 7 | 8 |

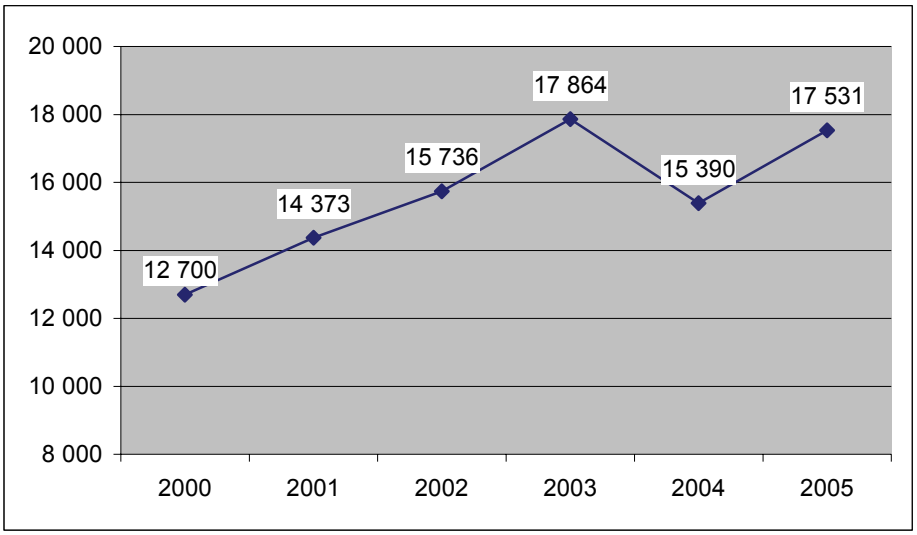
17,531 drug users (with the diagnosis F11–F19, i.e. including tobacco), i.e. 14% more than in 2004, were treated in outpatient clinics of health care facilities – see Table 5-5. The number of treated drug users has been increasing in a stable manner since 2000 (with a fluctuation in 2003) – see Figure 5-1.

*Table 5-5: Number of drug users (with diagnosis F11–F19) treated in outpatient health care facilities in 2003–2005 (Ústav zdravotnických informací a statistiky, 2006b)*

| Type of facility | 2003 | | 2004 | | 2005 | |
|---|---|---|---|---|---|---|
| | Number of facilities | Number of patients | Number of facilities | Number of patients | Number of facilities | Number of patients |
| Inpatient facilities with outpatient services | 53 | 4,105 | 49 | 3,896 | 49 | 4,131 |
| Outpatient facilities | 24 | 2,107 | 23 | 1,458 | 26 | 1,877 |
| General practitioners | 2 | 14 | 1 | 5 | 1 | 7 |
| Independent outpatient clinics of specialist physicians | 229 | 8,643 | 243 | 8,611 | 257 | 8,890 |
| Drug addiction treatment facilities* | n.a. | n.a. | n.a. | n.a. | 6 | 2,584 |
| Other outpatient facilities | 5 | 2,995 | 6 | 1,420 | 1 | 42 |
| **Total** | **313**** | **17,864** | **322**** | **15,390** | **340**** | **17,531** |

*Note: * Drug addiction treatment facilities were excluded from the group "other outpatient facilities" in 2005. ** The facilities are identified by their company identification number; at the same time, it holds true that each of them can have more surgeries.*

*Figure 5-1: Development in the number of drug users (with diagnosis F11–F19) treated in outpatient health care facilities in 2000–2005 (Ústav zdravotnických informací a statistiky, 2006b)*




In 2005, 18 NGOs funded by the Council of the Government for Drug Policy Coordination (CGDPC) from the General Cash Administration budget chapter also provided outpatient treatment. They supplied their services to 1,743 illicit drug users. The average age of the clients was 26.8. 1,034 (59%) clients injected drugs, 540 (31%) clients used pervitin, 391 (22%) used heroin, 169 (10%) used cannabis, and 126 (7%) used opiates other than heroin, i.e. especially illicitly procured Subutex (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g).

Only one facility in Prague provided intensive outpatient treatment in the form of a three-month day-care programme in 2005. The capacity of the programme was 10 persons, and the services were provided to a total of 36 clients (18 males, 18 females). The average age of the clients was 26.2. Altogether, 22 (61%) clients injected drugs, 15 (42%) clients used heroin, and 7 clients (19%) used pervitin. 61% of the clients successfully completed their treatment. The average length of treatment per client was 1.5 months. The Elysium day-care psychotherapeutic sanatorium in Brno provided a structured programme which targeted unemployed methadone programme clients – in the course of the year, the clients attended three one-week day-care sessions which lasted three hours per day (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g).

## 5.2 Inpatient Treatment (Residential Treatment Facilities)

There were no changes in the network of sobering-up stations and detoxification units in 2005 (Ústav zdravotnických informací a statistiky, 2006d).

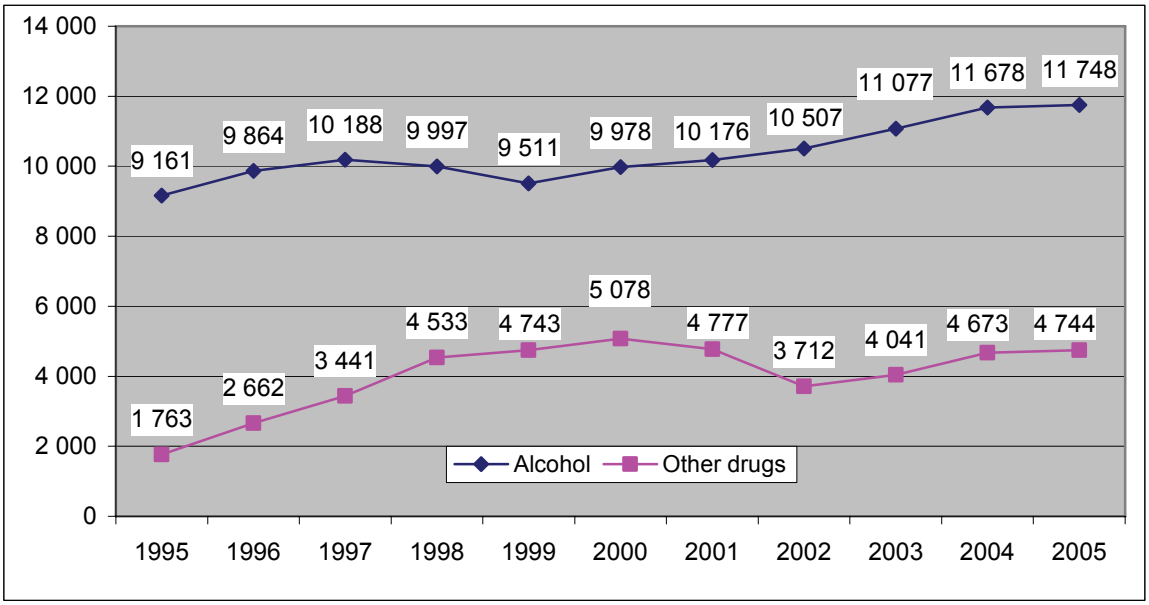
There was a slight decline in the number of psychiatric beds in 2005 (by 110 beds) as a result of the closure of the Psychiatric Hospital for Children in Branky na Moravě and one psychiatric department; the network and bed capacity of psychiatric hospitals for adults has not changed (Ústav zdravotnických informací a statistiky, 2006b).

Inpatient psychiatric facilities reported 16,492 hospitalisations resulting from disorders caused by drug use; 11,748 of them were due to alcohol-related disorders and 4,744 due to disorders caused by the use of other psychoactive substances. The development in the number of hospitalisations is given in Figure 5-2. Multiple drug use and the use of other substances (diagnosis F19) were the most common reasons for hospitalisations in 2005 (51.9% of children and 51.1% of adults). Other reasons for hospitalisations in psychiatric hospitals for children involve the use of cannabis and inhalants, and the use of stimulants (28.7%) and opioids (12.4%) in psychiatric hospitals for adults – see Table 5-6. The group of patients aged 20–29 was the most represented among the group of drug users hospitalised in psychiatric hospitals for adults (56%) and the group of patients aged 15–19 was the most represented in psychiatric hospitals for children (55.6%) (Ústav zdravotnických informací a statistiky, 2006b).

*Table 5-6: Number of hospitalisations caused by the use of alcohol and other psychoactive substances in inpatient psychiatric hospitals in 2005 by type of health care facilities, gender, and diagnosis (Ústav zdravotnických informací a statistiky, 2006b)*

| Diagnosis | Psychiatric hospitals for children | | | Psychiatric clinics for adults | | | Psychiatric departments of hospitals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| F11–19 (all illicit drugs) | 21 | 6 | 27 | 2,249 | 855 | 3,104 | 1,087 | 526 | 1,613 |
| – F11 (opioids) | 1 | 0 | 1 | 289 | 97 | 386 | n.a. | n.a. | n.a. |
| – F12 (cannabis) | 5 | 2 | 7 | 54 | 12 | 66 | n.a. | n.a. | n.a. |
| – F15 (stimulants) | 0 | 0 | 0 | 590 | 302 | 892 | n.a. | n.a. | n.a. |
| – F18 (inhalants) | 5 | 0 | 5 | 49 | 9 | 58 | n.a. | n.a. | n.a. |
| – F19 (multiple drug use and other substances) | 10 | 4 | 14 | 1,214 | 371 | 1,585 | n.a. | n.a. | n.a. |
| F10 (alcohol) | 0 | 1 | 1 | 6,549 | 2,295 | 8,844 | 1,796 | 1,108 | 2,903 |
| **Total** | **21** | **7** | **28** | **8,798** | **3,150** | **11,948** | **2,883** | **1,634** | **4,516** |

*Figure 5-2: Development of the number of hospitalisations in inpatient psychiatric facilities resulting from disorders caused by the use of alcohol and other psychoactive substances in 1995–2005 (Ústav zdravotnických informací a statistiky, 2006b)*




Fifteen therapeutic communities supplied inpatient treatment in 2005. The usual length of the programme was 6–15 months. The Helianna Therapeutic Community and the Domov Agapé Therapeutic Community ceased to operate in 2005. Data from twelve therapeutic communities are available. Their capacity was 183 beds (12 for juveniles and 9 for mothers with children), and 491 drug users (15 of them were mothers with children) were treated there in 2005. The average age of the patients was 24.9 (the average age of the mothers was 24). Altogether, 400 (81%) patients injected drugs, 287 (58%) patients used pervitin, and 132 (27%) used heroin. 16 (3%) patients were treated in connection with the use of cannabis. 102 patients (4 of them were mothers) successfully completed treatment and the average period of successful treatment was 314 days. 219 (45%) patients stopped their treatment prematurely, 62% after two weeks of treatment and 31% after two thirds of the treatment. The average period of treatment of all patients was 177 days (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g).

The NMC carried out a survey among school facilities which provide residential care and protective education and in school facilities for preventive educational care. The survey focused on treatment in relation to drug use among the children (aged under 18) who were placed in the facilities. 53 school facilities (out of 64 which were invited to participate) were involved in the survey; 60 questionnaires were sent back (some of the organisations operate in several school facilities). Tobacco, drug use, and aggression represent the three issues which the facilities had to address the most commonly. Nearly 97% of facilities deal with tobacco use, 78% deal with drug use, and 77% deal with alcohol use. While resolving drug-related issues, the school facilities collaborate the most with inpatient treatment facilities (psychiatric hospitals, therapeutic communities, and detoxification units), outpatient treatment facilities (psychological and psychiatric clinics and pedagogical-psychological counselling offices), and other school facilities which serve for the execution of residential care and protective education. Collaboration with NGOs and the family of the child is less common (Národní monitorovací středisko pro drogy a drogové závislosti, 2006f).

Specialised departments for the treatment of children at risk of drug addiction were part of five facilities in 2005. The total capacity of the departments was 66 beds and the average length of the stay was five months (within the range of 2–7 months). 104 children who had either experimented with drugs or use them were treated there (86 boys and 18 girls); their average age was 16.3 (within the 12–18 range). Altogether, 32 children (31%) were injecting drug users. Pervitin, cannabis, and inhalants were the most commonly used illicit drugs (Národní monitorovací středisko pro drogy a drogové závislosti, 2006f).

See the chapter on Prevention of Drug-Related Crime, page 65, for more information on treatment in prisons.

## 5.3 Substitution and Maintenance Programmes

### 5.3.1 Substitution Treatment with Opiate Agonists

Methadone prepared from an imported generic substance has been used for opiate substitution in the Czech Republic since 2000, and it has only been administered in specialised substitution centres. The medicinal product Subutex (buprenorphine) has been registered since 2000, and it can be prescribed by every physician, regardless of his/her specialisation. However, there is a certain limitation because of the fact that it is necessary to use a so-called “opiate prescription with a blue stripe” – i.e. a prescription with a higher degree of registration and control. Substitution preparations in the Czech Republic are administered exclusively orally.

The Substitution Treatment Standards (Ministerstvo zdravotnictví ČR, 2001a) define the methodology for substitution treatment in the Czech Republic, including the criteria for admission to treatment. The Substitution Treatment Register has been functioning in the Czech Republic since mid-2000 (Ministerstvo zdravotnictví ČR, 2001b). Treatment in all health centres, not only in specialised substitution centres, now has to be registered (since January 1, 2006), i.e. it also applies to treatment with Subutex in the clinics of outpatient general practitioners or specialists. Nationwide reporting from clinics other than the specialised centres has not been introduced yet.

#### 5.3.1.1 Specialised Substitution Centres

A substitution centre was opened in České Budějovice in 2005 and another in Karlovy Vary in February 2006. The Centre for Outpatient Detoxification and Substitution operated by the SANANIM civic association in Prague joined the Substitution Treatment Register in July 2006. Accordingly, there are currently twelve substitution centres in the Czech Republic and four of them are in Prague (Drop In operates two centres). In addition, substitution centres in the prisons in Prague-Pankrác and Příbram were opened within the framework of a pilot project of substitution treatment during the execution of sentence – see the chapter on Assistance to Drug Users in Prisons, page 65. Still, no coverage is available in the Pilsen, Karlovy Vary, Pardubice, Vysočina, and Zlín regions – see Map 5-1.

All of the programmes give patients methadone prepared from an imported generic substance and the mass-produced medicament Subutex (buprenorphine).

Altogether, 758 patients were treated in ten substitution programmes in 2005; methadone was administered to 525 of them and Subutex to 233.

Table 5-7 shows the development in the number of patients of the specialised centres (by December 31 of each year). It is apparent that the programmes in Prague and Ústí nad Labem have the highest volume and turnover of patients, which corresponds to the regional distribution of prevalence of problem opiates users, which is the highest in these regions.

*Map 5-1: Specialised substitution centres in the Czech Republic by July 31, 2006*

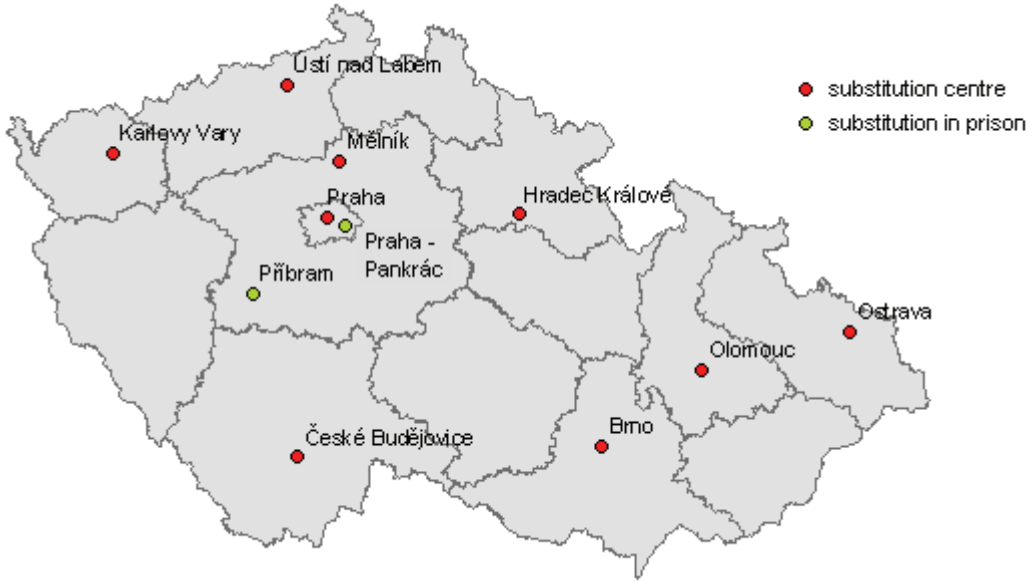



*Table 5-7: Patients of specialised substitution treatment programmes as of December 31 of each year (Ústav zdravotnických informací a statistiky, 2006c)*

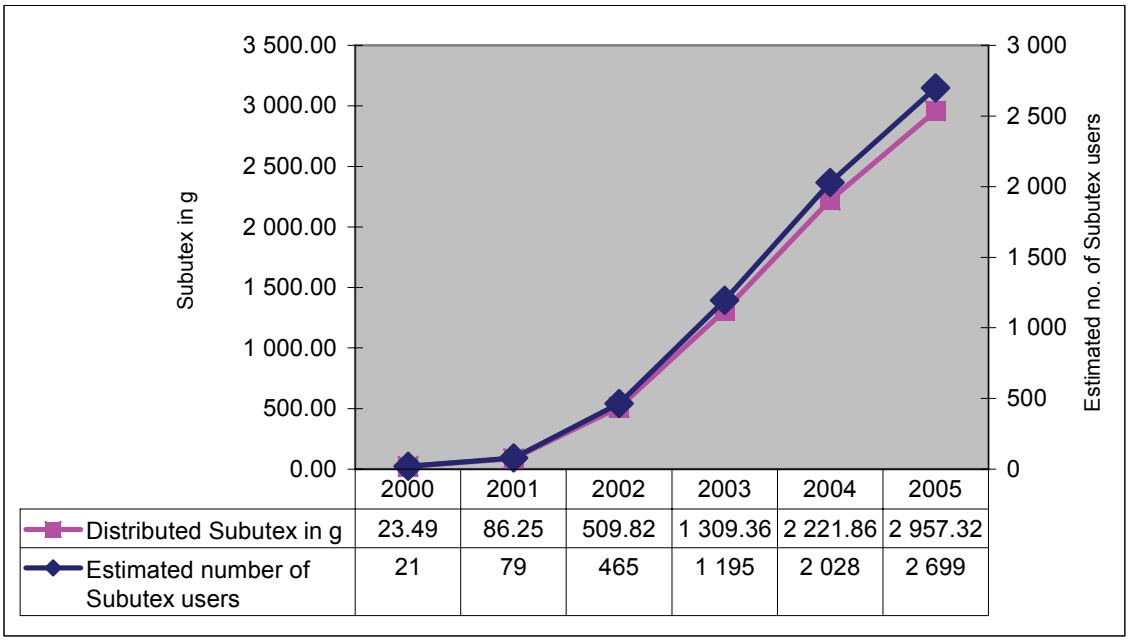
| Centre/year | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|
| Prague (General Teaching Hospital) | 50 | 60 | 54 | 117 | 96 | 115 |
| Ostrava | 0 | 1 | 4 | 10 | 11 | 10 |
| Olomouc | 2 | 2 | 5 | 4 | 6 | 12 |
| Brno | 4 | 50 | 53 | 46 | 46 | 63 |
| Ústí nad Labem | 54 | 124 | 123 | 190 | 182 | 184 |
| Prague (Drop In) | 71 | 110 | 100 | 142 | 135 | 135 |
| Hradec Králové | 5 | 9 | 13 | 13 | 18 | 32 |
| Mělník | 4 | 7 | 9 | 22 | 16 | 12 |
| České Budějovice | 0 | 0 | 0 | 0 | 0 | 8 |
| **Total** | **190** | **363** | **361** | **544** | **510** | **571** |

#### 5.3.1.2 Buprenorphine Substitution Treatment

Each practitioner, regardless of his/her specialisation, can prescribe Subutex; it is also administered to suitable patients in specialised substitution centres. The number of patients who receive Subutex in specialised centres is accurately known (see above), while the number of patients using Subutex prescribed by outpatient physicians, as well as the number of these physicians, is not known accurately.

Data from the State Institute for Drug Control about the distribution of Subutex on the Czech market are available (Státní ústav pro kontrolu léčiv, 2006). According to the data, the quantity of Subutex consumed is increasing. Given an average daily consumption of 6 mg and an average length of treatment of six months (Národní monitorovací středisko pro drogy a drogové závislosti, 2004), it is possible to estimate that there were approximately 2,700 Subutex users in the Czech Republic in 2005 – see Figure 5-3.

*Figure 5-3: Distributed quantities of Subutex and estimated number of Subutex users in 2000–2005 (Státní ústav pro kontrolu léčiv, 2005; Státní ústav pro kontrolu léčiv, 2006; Národní monitorovací středisko pro drogy a drogové závislosti, 2004)*




| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|
| Distributed Subutex in g | 23.49 | 86.25 | 509.82 | 1 309.36 | 2 221.86 | 2 957.32 |
| Estimated number of Subutex users | 21 | 79 | 465 | 1 195 | 2 028 | 2 699 |

Even the data from the Treatment Demand Register kept by the Hygiene Service confirm the increasing trend of the number of Subutex users; however, it is true that the absolute numbers are underestimated. It is unclear why there was a decline in the number of first treatment demands among clients who use Subutex – see Table 5-8.

*Table 5-8: First treatment demands and all treatment demands in relation to the use of Subutex as a primary or secondary drug (Polanecký et al. 2004; Polanecký et al. 2005; Polanecký et al. 2006)*

| Year | First treatment demands | | | All treatment demands | | |
|---|---|---|---|---|---|---|
| | Primary drug | Secondary drug | Total | Primary drug | Secondary drug | Total |
| 2003 | 4 | 13 | 17 | 16 | 41 | 57 |
| 2004 | 58 | 51 | 109 | 145 | 114 | 259 |
| 2005 | 6 | 72 | 78 | 223 | 187 | 410 |

### 5.3.2 Occurrence of Substitution Preparations on the Black Market

Methadone hardly ever appears on the black market. If it does, only anecdotal and unverified data are available.

Subutex appears on the black market and on the open drug scene, especially in Prague and Northern and Southern Bohemia. Injecting it is not exceptional – see also the 2003 and 2004 Annual Reports of the NMC.

The black market in Subutex in Prague most commonly involves the sales and purchases of small quantities of Subutex tablets among individual users. No large supplier or dealer who would offer a large quantity of illicitly procured Subutex is known. It is most likely that all the Subutex which appears on the black market comes from pharmacies where it was picked up with a prescription and then (a part of it) was sold under the counter.[17]

In collaboration between NMC and the SANANIM civic association, a questionnaire survey was carried out among the clients of an low-threshold centre and outreach programme in February – June 2006 – see the chapter on Problem Drug Use in Other Data Sources, page 31, for more information. Altogether, 56.1% of the respondents use Subutex which they get from their physician or on the black market (24.2% of the respondents use Subutex which they get from their physician, 37.9% of the respondents use Subutex from the black market).[18] 41.4% of the clients use Subutex only; 95.1% of them reported injecting it.

Three fatal overdoses with the presence of methadone were recorded in 2005; no overdose on Subutex was reported – see the chapter on Drug-Related Deaths and Mortality of Drug Users, page 40.

[17] Source: personal communication with workers of the low-threshold centre and outreach programme operated by the SANANIM civic association, July 2006.

[18] The proportion between Subutex prescribed by a physician and from the black market could then be 48/75. In other words, approximately 60% of Subutex which is consumed in Prague by clients of low-threshold facilities comes from the black market.

### 5.3.3 Evaluation of Substitution Treatment Results

The availability of substitution treatment increased in 2005. A new specialised centre in České Budějovice was opened in 2005, and others in Karlovy Vary and in two prisons in 2006 – see above.

Patients can only receive methadone in specialised centres; no methadone-based mass-produced medicament has yet been registered in the Czech Republic – it could further improve its availability. Subutex consumption increased in 2005 – see above.

On the basis of the above-mentioned data, it is possible to estimate that approximately 20–30% of problem drug users were in substitution treatment in 2005.

Table 5-9 shows the reasons for terminating treatment in specialised centres.

*Table 5-9: Reason for termination of substitution treatment in specialised centres from 2000 until May 31, 2006 (Ústav zdravotnických informací a statistiky, 2006c)*

| **Centre** | **Number of treatment episodes** | | **Reason for treatment termination** | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Admission | Termination | 1 | 2 | 3 | 4 | 5 | 6 | Total |
| Prague (General Teaching Hospital) | 469 | 358 | 50 | 40 | 152 | 6 | 1 | 109 | 358 |
| Ostrava | 46 | 34 | 5 | 1 | 15 | 1 | 0 | 12 | 34 |
| Olomouc | 34 | 20 | 3 | 1 | 11 | 0 | 0 | 5 | 20 |
| Brno | 104 | 41 | 1 | 0 | 27 | 6 | 0 | 7 | 41 |
| Ústí nad Labem | 857 | 681 | 11 | 30 | 552 | 39 | 2 | 47 | 681 |
| Prague (Drop In) | 1,439 | 1,327 | 55 | 59 | 1,088 | 11 | 3 | 111 | 1,327 |
| Hradec Králové | 53 | 27 | 4 | 7 | 10 | 1 | 1 | 4 | 27 |
| Mělník | 102 | 87 | 12 | 4 | 19 | 1 | 1 | 50 | 87 |
| České Budějovice | 36 | 24 | 1 | 4 | 16 | 0 | 0 | 3 | 24 |
| Karlovy Vary | 4 | 2 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
| Prison Praha-Pankrác | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **3,145** | **2,601** | **142** | **146** | **1,890** | **65** | **8** | **350** | **2,601** |

*Note: Reason for treatment termination: 1 – transfer of a patient to another facility, 2 – transfer of a patient to another type of treatment, 3 – failure to observe rules, 4 – imprisonment, 5 – death of a patient, 6 – another reason.*

## 6 Health Correlates and Consequences of Drug Use

The number of drug overdoses has remained stable. Opiates, pervitin, and inhalants represent the most common (street) drugs involved in drug-related deaths – there was a slight increase in opiates overdoses and a slight decline in overdoses on pervitin and inhalants. Sporadic overdoses on ecstasy and cocaine have been reported in the last 2–3 years.

There is a favourable trend in the occurrence of infectious diseases among drug users. HIV seroprevalence among injecting drug users continues to be under 1%. Despite low absolute numbers, the number of injecting drug users newly infected with HIV is increasing. Approximately 30–35% of injecting drug users are infected with hepatitis C; this proportion is higher among specific subpopulations (substitution treatment patients, drug users in prison). As in 2004, the availability of testing for infectious diseases directly among the at-risk population of injecting drug users can be regarded as insufficient; at the same time, the declining number of tests which are carried out among this population is alarming.

A study which examined morbidity among those hospitalised as a result of disorders caused by drug use showed that "psychiatric disorders" and "injuries, poisonings, and some other consequences of external reasons" were the most common reasons for hospitalisation.

### 6.1 Drug-Related Deaths and Mortality of Drug Users

Drug-related deaths (overdoses) have been monitored by means of a special register kept by all thirteen departments of forensic medicine and forensic toxicology departments since 1998. Czech laws (Ordinance 18/1988 Coll. of the Ministry of Health) specify mandatory autopsy in all cases of sudden death when the examining practitioner could not determine the cause of death and in all cases of violent deaths. Data on deaths "with the presence of narcotic and psychotropic substances" have been reported since 2003.[19] The entire automated system and coordination of the collection of this type of data in general has been developed in close collaboration between the NMC and the Professional Association of Forensic Medicine and Toxicology of the Czech Medical Association of J. E. Purkyně. The representatives of the association are also members of the appropriate working group of the NMC.

#### 6.1.1 Drug Overdoses

218 deaths resulting from drug overdoses were detected in 2005; 156 involved psychoactive medicines – see below. Leaving aside medicaments, presently and traditionally opiates (24), inhalants (18), and pervitin (14) have been the most common causes of these overdoses. Three overdose-related deaths with the presence of methadone were identified (one case in combination with ethanol, two in combination with other drugs). No fatal buprenorphine overdose was recorded. Furthermore, two fatal ecstasy (MDMA) overdoses and one cocaine overdose were reported (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2006) – see Table 6-1.

Overdoses on psychotropic medicaments represent a very heterogeneous category and it is difficult to provide an accurate assessment. The reason is that these include suicide overdoses, accidental overdoses with *lege artis* prescribed medicaments, and also accidental overdoses on abused medicaments and overdoses without an established cause. Altogether, 156 overdoses on psychotropic medicaments were recorded in 2005; 56 of these cases involved overdoses on benzodiazepines.

The number of overdoses on illicit opiates[20] increased in 2005 (from 19 in 2004 to 24 in 2005), while the number of overdoses on pervitin and inhalants declined slightly (from 16 in 2004 to 14 in 2005 and from 20 in 2004 to 18 in 2005 respectively). Sporadic cases of overdoses on MDMA and cocaine were reported during the last three years; no such cases had been reported prior to 2002 – see Figure 6-1.

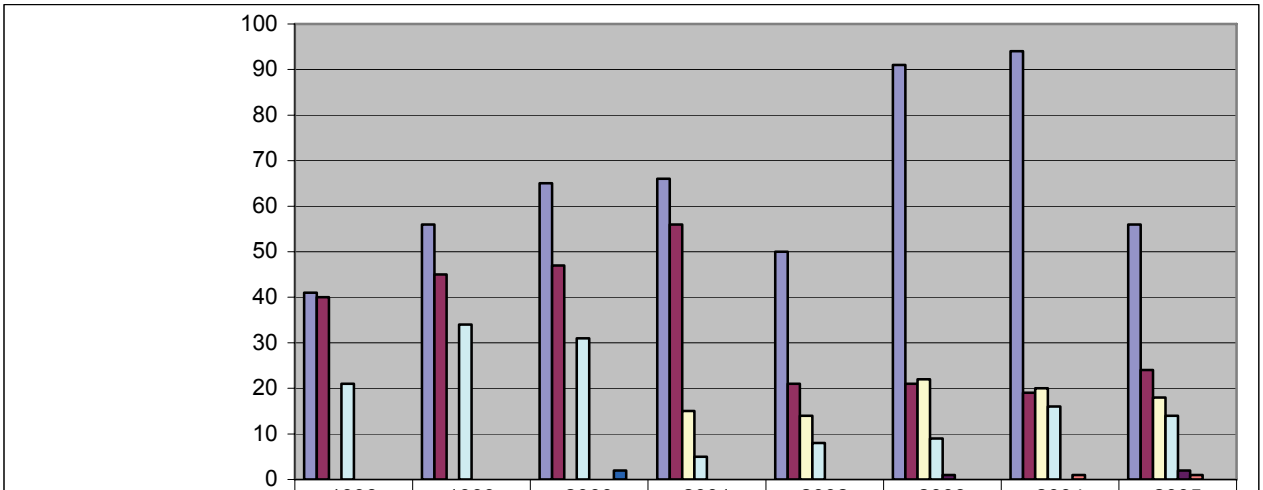
[19] A detailed methodological overview on how to determine drug-related deaths is included in a methodological publication which was published in 2004 (Zábranský et al., 2004).

[20] The number of opiates overdoses in 2004 was corrected. The number of 32 cases which was published last year was reduced to 19 – thirteen cases involved overdoses on medicaments which contained opiates; after the correction, these thirteen deaths were included in the category "overdoses on medicaments".

*Table 6-1: Fatal drug overdoses in the Czech Republic in 2005 by groups of drugs, age groups, and gender (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2006)*

| Drug / age group | <15 | 15–19 | 20–24 | 25–29 | 30–34 | 35–39 | 40–44 | 45–49 | 50–54 | 55–59 | 60–64 | >64 | Unknown | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | Males | Females | Total |
| Only opiates or opioids (excluding methadone) | 0 | 0 | 4 | 4 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **11** | **1** | **12** |
| Only methadone | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **1** | **1** |
| More substances including opiates/opioids | 0 | 0 | 2 | 3 | 3 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **10** | **1** | **11** |
| – of which methadone | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **0** | **2** |
| Opiates total | 0 | 0 | 6 | 7 | 7 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **21** | **3** | **24** |
| More substances or one substance – not opiates/opioids | 1 | 6 | 7 | 4 | 4 | 4 | 4 | 1 | 3 | 0 | 0 | 1 | 0 | **32** | **3** | **35** |
| – of which inhalants | 1 | 4 | 2 | 1 | 0 | 2 | 4 | 1 | 2 | 0 | 0 | 1 | 0 | **18** | **0** | **18** |
| – of which pervitin | 0 | 2 | 4 | 3 | 2 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | **12** | **2** | **14** |
| – of which cocaine | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | **0** | **1** |
| – of which dance drugs (e.g. MDMA) | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | **1** | **2** |
| – of which hallucinogens | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** | **0** |
| Psychoactive medicines | 0 | 4 | 9 | 8 | 9 | 17 | 15 | 18 | 31 | 14 | 6 | 23 | 2 | **77** | **79** | **156** |
| – of which benzodiazepines | 0 | 0 | 4 | 1 | 3 | 9 | 5 | 5 | 9 | 8 | 2 | 9 | 1 | **32** | **24** | **56** |
| Unspecified/uknown | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **3** | **0** | **3** |
| **Total excluding medicines** | **1** | **7** | **13** | **11** | **13** | **7** | **5** | **2** | **3** | **0** | **0** | **1** | **0** | **56** | **7** | **63** |
| **Total** | **1** | **11** | **22** | **19** | **22** | **24** | **20** | **19** | **34** | **14** | **6** | **24** | **2** | **133** | **85** | **218** |

*Figure 6-1: Fatal overdoses on selected drugs in 1998–2005 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2006)*




| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|---|---|
| Benzodiazepines | 41 | 56 | 65 | 66 | 50 | 91 | 94 | 56 |
| Opioids | 40 | 45 | 47 | 56 | 21 | 21 | 19 | 24 |
| Inhalants | 0 | 0 | 0 | 15 | 14 | 22 | 20 | 18 |
| Amphetamines (pervitin) | 21 | 34 | 31 | 5 | 8 | 9 | 16 | 14 |
| MDMA | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 |
| Cocaine | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Hallucinogens | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 |
| Canabinoids | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### 6.1.2 Deaths with the Presence of Drugs

Altogether, 151 deaths with the presence of drugs were identified in 2005; 2 were due to illness, 66 due to accidents, 76 were suicides, 4 were cases of manslaughter or murder, and 3 deaths were due to other causes. Table 6-2 gives a summary of the proportion of selected groups of drugs in the individual groups of deaths with the presence of drugs, and Table 6-3 gives the trend in the last three years. It is especially worth mentioning an increase in the number and proportion of deaths with the presence of pervitin.

*Table 6-2: Deaths with the presence of drugs detected by forensic medicine departments in the Czech Republic in 2005 by selected groups of drugs and causes of death (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2006)*

| Drug | Illness (n=2) | Accident (n=66) | Suicide (n=76) | Manslaughter /murder (n=4) | Other (n=3) | Total (n=151) | Proportion (%) |
|---|---|---|---|---|---|---|---|
| Benzodiazepines | 1 | 17 | 32 | 0 | 1 | 51 | 33.8 |
| Pervitin | 1 | 20 | 9 | 2 | 0 | 32 | 21.2 |
| THC | 0 | 11 | 4 | 1 | 2 | 18 | 11.9 |
| Inhalants | 0 | 8 | 5 | 0 | 1 | 14 | 9.3 |
| MDMA | 0 | 2 | 1 | 0 | 0 | 3 | 2.0 |
| Opiates/opioids | 0 | 1 | 0 | 0 | 0 | 1 | 0.7 |
| Cocaine | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 |

*Table 6-3: Proportion of selected groups of drugs among all deaths with the presence of drugs detected by forensic medicine departments in the Czech Republic in 2003–2005 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2006)*

| Drug | 2003 (n=251) | 2004 (n=164) | 2005 (n=151) |
|---|---|---|---|
| Benzodiazepines | 38.2 | 50.0 | 33.8 |
| Pervitin | 11.6 | 11.6 | 21.2 |
| THC | 16.7 | 6.1 | 11.9 |
| Inhalants | 4.8 | 3.7 | 9.3 |
| MDMA | 0.4 | 1.8 | 2.0 |
| Opiates/opioids | 4.8 | 8.5 | 0.7 |
| Cocaine | 0.0 | 0.6 | 0.0 |

Information about the detection of drugs in the bodies of persons who died in traffic accidents is included in the special chapter on Drugs and Driving, page 85.

### 6.1.3 Mortality of Drug Users

The most recent data are presented in the 2004 Annual Report.

## 6.2 Drug-related Infections

### 6.2.1 HIV/AIDS

The occurrence of new cases of HIV infection among injecting drug users and among the general population is relatively low in the Czech Republic; however, it seems to have been increasing during the last three years. 90 new cases of HIV were diagnosed in 2005 (i.e. 25% more than in the previous year); 6 of them may have become infected as a result of illicit drug use. 827 HIV-positive persons with a permanent place of residence in the Czech Republic were registered on December 31, 2005; 37 of them are injecting drug users and another 11 are injecting drug users and homo/bisexuals at the same time, (altogether, 5.8%, 4–10% in individual years) – see Table 6-4 (Brůčková et al. 2006).

*Table 6-4: HIV incidence in the Czech Republic by December 31, 2004 by route of transmission (Brůčková et al. 2006)*

| Route of transmission (risk group) | Before 2000 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | Total |
|---|---|---|---|---|---|---|---|---|
| Homo/bisexual intercourse | 236 | 27 | 27 | 28 | 37 | 30 | 49 | 434 |
| Heterosexual intercourse | 130 | 22 | 13 | 20 | 19 | 30 | 31 | 235 |
| Injecting drug use | 14 | 4 | 3 | 1 | 4 | 6 | 5 | 37 |
| Haemophiliac | 17 | 0 | 0 | 0 | 0 | 0 | 0 | 17 |
| Blood recipient | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 14 |
| Homo/bisexual intercourse and injecting drugs | 5 | 0 | 2 | 1 | 1 | 1 | 1 | 11 |
| Mother-child | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 4 |
| Nosocomial transfer | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Not ascertained | 23 | 4 | 6 | 0 | 1 | 5 | 4 | 43 |
| **Total** | **443** | **57** | **51** | **50** | **63** | **72** | **90** | **827** |

Altogether, 855,010 laboratory tests for HIV antibodies were carried out in the Czech Republic in 2004, and 0.11% were positive. 1,374 persons (15% less than in 2004) reported injecting drugs as the reason for testing; one of them was positive.[21] So far, positive injecting drug users have been diagnosed sporadically among this at-risk group (in 5 out of 48 cases). Furthermore, the number of tests for HIV antibodies among injecting drug users decreased by one half in 1999–2003 and efforts to increase the numbers proved unsuccessful – see Table 6-5 (Brůčková et al. 2006; Jedlička et al. 2006). Information on the availability of testing among injecting drug users is also included in the chapter on Responses to Health Correlates and Consequences of Drug Use, page 49.

*Table 6-5: Tests of injecting drug users for HIV antibodies in 1994–2005 (Brůčková et al. 2006; Jedlička et al. 2006)*

| Year | Blood tests | | Saliva tests | | Total | |
|---|---|---|---|---|---|---|
| | Number of tests | No.of positive results | Number of tests | Number of positive results | Number of tests | Number of positive results |
| Before 1998 | 2 101 | 1 | 895 | 0 | 2 996 | 1 |
| 1998 | 2 158 | 0 | 1 124 | 0 | 3 282 | 0 |
| 1999 | 2 320 | 0 | 1 219 | 0 | 3 593 | 0 |
| 2000 | 2 091 | 0 | 1 001 | 0 | 3 092 | 0 |
| 2001 | 2 169 | 1 | 961 | 0 | 3 130 | 1 |
| 2002 | 1 536 | 0 | 734 | 1 | 2 270 | 1 |
| 2003 | 985 | 1 | 652 | 0 | 1 637 | 1 |
| 2004 | 1 609 | 0 | 222 | 0 | 1 831 | 0 |
| 2005 | 1 374 | 1 | 449 | 1 | 1 823 | 1* |
| **Total** | **14 741** | **4** | **6 814** | **2** | **20 228** | **5** |

*Note: * It involves one newly identified case which was detected by a saliva test and then confirmed by a blood test.*

### 6.2.2 Viral Hepatitis

There was a decline in the number of reported new cases of acute HBV and all cases of HCV in the Czech Republic in 2005 – see Figure 6-2 and Figure 6-3 (Beneš and Částková, 2006).

[21] Other positive IDUs were diagnosed within examinations of a different group (e.g. psychiatric patients, other clinical diagnoses, prisoners, contacts of HIV-positive persons, pregnant women etc.).

*Figure 6-2: Reported HBV incidence and proportion of injecting drug users in the Czech Republic in 1996–2005 (Beneš and Částková, 2006)*

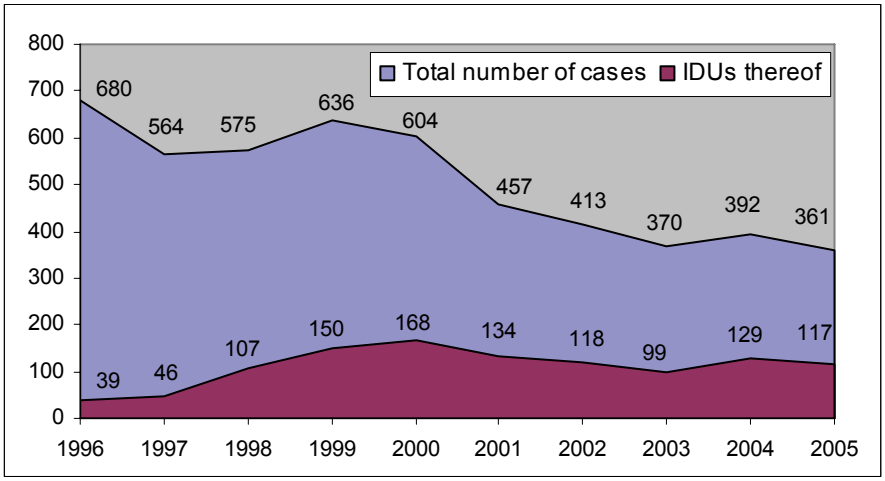
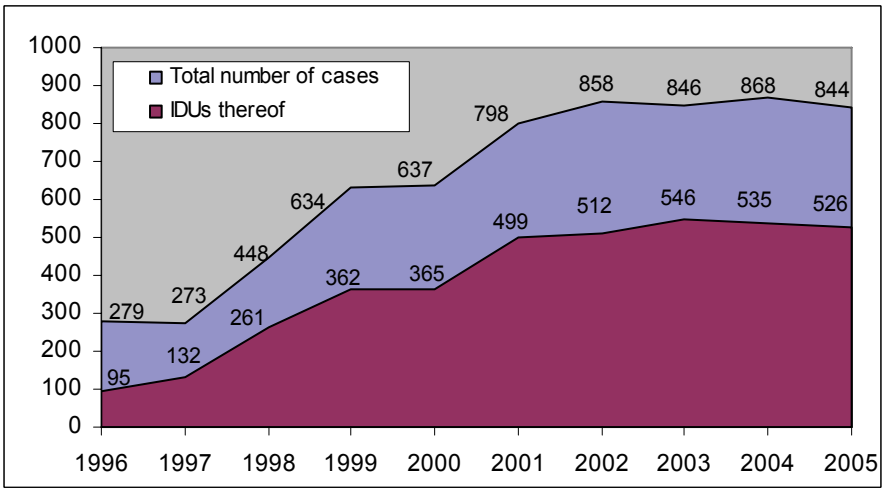



*Figure 6-3: Reported HCV incidence – acute and chronic cases and proportion of injecting drug users in the Czech Republic in 1996–2005 (Beneš and Částková, 2006)*




Most cases of hepatitis among injecting drug users do not get into the reporting system, and so data from seroprevalence studies or routine testing among injecting drug users provide a better picture of the situation.

Besides the prospective part of the "HCV Seroprevalence among Injecting Drug Users" survey carried out by the NMC, which ended in December 2005 (see below), no new data on the occurrence of hepatitis among injecting drug users in the Czech Republic are available. Available studies show that HCV seroprevalence among clients of low-threshold facilities is at 30–35% and HBV seroprevalence is at around 10%. Approximately 60% of the groups of users with a long history of drug use (clients in substitution treatment or in prison) are HCV positive, and approximately 15% are HBV positive.

#### 6.2.2.1 HCV Seroprevalence among Injecting Drug Users Survey

The most extensive survey on the seroprevalence and seroincidence of HCV among injecting drug users in the Czech Republic was carried out in 2002–2005. 760 persons were examined in the basic part of the study, and 226 tests[22] were reactive. After adjustments to the sensitivity and specificity of the tests, an HCV seroprevalence of 35.0%, with a 95% interval of reliability 31.6–38.4, was calculated (more detailed information is also included in the 2004 Annual Report). Besides a strong association between a history of HCV and factors associated with injecting use (especially the length and the intensity of injecting use and needle sharing), the place of residence (the highest prevalence was in Ústí nad Labem and Prague) and previous incarceration have shown to be significant predictive factors. In accordance with the results of similar studies from around the world, factors such as risky sexual behaviour and transfusion were insignificant (Zábranský et al. 2006; Mravčík et al. 2006). 176 persons, i.e. 33.0% of patients whose test was not reactive in the basic part, were examined at least once within the framework of the prospective part of the study. The total length of monitoring of all users was 52,213 person-days; the average length

[22] The test Hepatitis C Virus Whole Blood Test (Cassette) of Alfa Scientific Designs, Inc., USA was used. It is a quick orientative (screening) test from a drop of capillary blood taken from a fingertip. The test was evaluated prior to the start of the study, and it has been shown that it has a sensitivity of 86% and 100% specificity.

of monitoring was 297 days per person, with a minimum or 41 and a maximum of 1,017 days. The HCV incidence rate in the entire sample was 11.2 cases per 100 persons and year (Mravčík et al. 2006).

### 6.2.3 Monitoring of Infections among Specific Populations of Drug Users

Most Czech low-threshold centres for drug users offer testing for infectious diseases (see the chapter on Services Provided by Low-Threshold Facilities, page 49, for more information). The facilities carried out 6,513 tests for infections in 2005; results are available for 3,368 tests from 31 facilities. Orientative tests from capillary blood (66%) were the most common, followed by tests from venous blood (31%) and saliva tests (3%). The results of the monitoring indicate a lower occurrence of hepatitis than do the results of national and local seroprevalence surveys – see Table 6-6. A possible explanation involves the fact that, unlike in studies, monitoring also takes place in small towns where the occurrence of hepatitis is lower and the fact that new clients who are not infected very often take up the offer of being tested.[23]

*Table 6-6: Results of testing for infections among injecting drug users in low-threshold facilities in 2005 (Národní monitorovací středisko pro drogy a drogové závislosti, 2006e)*

| Examination for antibodies | Number of tests | Number of positive results | Proportion in % |
|---|---|---|---|
| HIV – capillary blood | 916 | 0 | 0.0 |
| HIV – venous blood | 317 | 0 | 0.0 |
| HIV – saliva | 87 | 0 | 0.0 |
| HCV – capillary blood | 1,321 | 49 | 3.7 |
| HCV – venous blood | 254 | 54 | 21.3 |
| HBV – venous blood | 242 | 15 | 6.2 |
| HAV – venous blood | 231 | 6 | 2.6 |

## 6.3 Other Drug-Related Disorders

### 6.3.1 Co-Morbidity among Hospitalised Drug Users

The NMC carried out an analysis of the 2001–2005 data from obligatory hospitalisation reports to the Institute of Health Information and Statistics of the Czech Republic. The survey involved all hospitalisations of persons who had been diagnosed with a primary or secondary diagnosis of a mental or behavioural disorder caused by drug use (F11–F16 and F18–F19) at least once during 2001 to 2005. The sample analysed consisted of 19,795 persons aged 30.7 on average in the range of 0–100 years; 64% of the sample were males. Altogether, there were 93,182 hospitalisations in the sample; the average was 4.7 hospitalisations per person; 4,370 persons were hospitalised only once. 1 person was hospitalised 243 times during the five-year period (Ústav zdravotnických informací a statistiky, 2006a).

Regardless of whether it was a primary or secondary analysis, multiple drug use and the use of other psychoactive substances, and the use of opioids and stimulants were the most common – see Table 6-7.

*Table 6-7: Number of hospitalised patients diagnosed with disorders caused by the use of individual groups of drugs in 2001–2005 (Ústav zdravotnických informací a statistiky, 2006a)*

| Diagnosis | Number of patients | Proportion in % |
|---|---|---|
| F11 – opioids | 5,723 | 28.9 |
| F12 – cannabinoids | 1,800 | 9.1 |
| F13 – sedatives or hypnotics | 2,545 | 12.9 |
| F14 – cocaine | 227 | 1.1 |
| F15 – stimulants | 4,688 | 23.7 |
| F16 – hallucinogens | 438 | 2.2 |
| F18 – inhalants | 756 | 3.8 |
| F19 – multiple drug use and other substances | 8,075 | 40.8 |
| **Total** | **19,795** | **100.0** |

*Note: The sum of cases according to diagnoses is higher than the total number of clients; the reason is that some patients have multiple diagnoses.*

5,044 (25.5%) persons were diagnosed with a disorder caused by multiple drug use and use of other substances (F19), 3,971 (20.1%) by the use of opioids, 2,831 (14.3%) by the use of stimulants, and 2,013 (10.2%) by the use of hypnotics. 3,749 were diagnosed with the use of two and more different psychoactive substances, most commonly multiple drug use and use of other substances use with the use of opioids and/or stimulants – see Table 6-8.

[23] Information from representatives of service providers from a meeting of the Infectious Diseases working group of the National Monitoring Centre for Drugs and Drug Addiction, June 2006.

*Table 6-8: Combination of diagnoses F11–F16 and F18–F19 among selected patients who were hospitalised in 2001–2005 (Ústav zdravotnických informací a statistiky, 2006a)*

| Diagnosis and combinations of diagnoses | Number of diagnoses in a combination | Number of patients | Proportion in % |
|---|---|---|---|
| F19 – multiple drug use and other substances | 1 | 5,044 | 25.5 |
| F11 – opioids | 1 | 3,971 | 20.1 |
| F15 – stimulants | 1 | 2,831 | 14.3 |
| F13 – sedatives or hypnotics | 1 | 2,013 | 10.2 |
| F12 – cannabis | 1 | 1,200 | 6.1 |
| F11 and F19 | 2 | 957 | 4.8 |
| F15 and F19 | 2 | 934 | 4.7 |
| F18 – inhalants | 1 | 532 | 2.7 |
| F16 – hallucinogens | 1 | 284 | 1.4 |
| F13 and F19 | 2 | 232 | 1.2 |
| F11 and F15 | 2 | 226 | 1.1 |
| F11, F15 and F19 | 3 | 202 | 1.0 |
| Other | 1–4 | 1,369 | 6.9 |
| **Total** | **1–4** | **19,795** | **100.0** |

Hospitalisations with a primary diagnosis of a mental and behavioural disorder[24] (86%) prevail among the sample; then, hospitalisations with a primary diagnosis of an injury, poisoning, and some other consequences or external causes (28%) and hospitalisations resulting from digestive disorders (13%) were the most common – see Table 6-9.

*Table 6-9: Primary diagnoses of hospitalisations of selected patients in 2001–2005 (Ústav zdravotnických informací a statistiky, 2006a)*

| Groups of primary diagnoses | Number of patients | % of patients |
|---|---|---|
| Mental and behavioural disorders | 16,984 | 85.8 |
| Injuries, poisonings, and other consequences of external causes | 5,506 | 27.8 |
| Digestive disorders | 2,494 | 12.6 |
| Infectious and parasitic diseases | 2,306 | 11.6 |
| Abnormalities unclassified elsewhere | 2,070 | 10.5 |
| Diseases of the circulatory system | 1,872 | 9.5 |
| Respiratory diseases | 1,517 | 7.7 |
| Diseases of the genito-urinary system | 1,403 | 7.1 |
| Pregnancy, delivery, and puerperium | 1,362 | 6.9 |
| Diseases of the musculo-skeletal system and connective tissue | 1,320 | 6.7 |
| Diseases of the nervous system | 1,181 | 6.0 |
| Factors which influence health and contact with health care services | 1,118 | 5.6 |
| Diseases of the skin and subcutaneous tissue | 758 | 3.8 |
| Neoplasms | 724 | 3.7 |
| Endocrine, nutritional, and metabolic diseases | 467 | 2.4 |
| Diseases of the eye and adnexa | 269 | 1.4 |
| Diseases of the blood and blood-forming organs and some disorders concerning the immune mechanism | 124 | 0.6 |
| Diseases of the ear and mastoid process | 118 | 0.6 |
| Congenital malformations, deformations, and chromosomal abnormalities | 49 | 0.2 |
| Certain conditions originating in the perinatal period | 9 | 0.0 |
| **Total** | **19,795** | **100.0** |

*Note: The sum of cases according to diagnoses is higher than the total number of patients; it is because the primary diagnosis of several patients contained several diagnostic groups in the period monitored.*

#### 6.3.1.1 Occurrence of Other Diagnoses Excluding Substance Addictions

The diagnoses F11–F16 and F18–F19 and other psychiatric diagnoses were the most common (they occurred among 7,387 patients, i.e. 37%, at least once during the period monitored), followed by injuries, poisonings, and other consequences of external causes (6,273 patients; 32%). The proportion of individual diagnostic groups which

[24] It is understandable because of the selection criteria for sample selection.

occurred at least once among the persons suffering from disorders caused by the use of individual drugs is given in Table 6-10.

*Table 6-10: Diagnoses which occur in combination with illicit drugs use among selected patients who were hospitalised in 2001–2005 (%) (Ústav zdravotnických informací a statistiky, 2006a)*

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

*Note: Three most common groups of diagnoses of users of individual drugs are in **bold**.*

*A00–B99 – Certain infectious and parasitic diseases*
*C00–D48 – Neoplasms*
*D50-D89 – Diseases of the blood and blood-forming organs and certain disorders concerning the immune mechanism*
*E00–E90 – Endocrine, nutritional, and metabolic diseases*
*F00–F99 – Mental and behavioural disorders*
*G00–G99 – Diseases of the nervous system*
*H00–H59 – Diseases of the eye and adnexa*
*H60–H95 – Diseases of the ear and mastoid process*
*I00–I99 – Diseases of the circulatory system*
*J00–J99 – Diseases of the respiratory system*
*K00–K93 – Diseases of the digestive system*
*L00–L99 – Diseases of the skin and subcutaneous tissue*
*M00–M99 – Diseases of the musculo-skeletal system and connective tissue*
*N00–N99 – Diseases of the genitourinary system*
*O00–O99 – Pregnancy, childbirth, and the puerperium*
*P00–P96 – Certain conditions originating in the perinatal period*
*Q00–Q99 – Congenital malformations, deformations, and chromosomal abnormalities*
*R00–R99 – Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified*
*S00–T98 – Injuries, poisonings, and other consequences of external reasons*
*V01–Y98 – External causes of morbidity and mortality*
*Z00–Z99 – Factors influencing health status and contact with health services*

*Mental and behavioural disorders caused by the use of opioids – F11, cannabis – F12, sedatives or hypnotics – F13, cocaine – F14, stimulants – F15, hallucinogens – F16, inhalants – F18, multiple drug use and use of other psychoactive substances – F19.*

Psychiatric disorders most commonly occur together with the use of hypnosedatives (66% of patients with the diagnosis F13) and cannabinoids (51% of patients with the diagnosis F12), and they occur the least in combination with the use of cocaine (29% of patients with the diagnosis F15) and opioids (20% of patients with the diagnosis F11). As far as opioid users are concerned, injuries, poisoning, and certain other consequences of external causes (28%) and infectious diseases (24%) prevail. Psychiatric disorders (30%) and injuries, poisoning, and certain other consequences of external causes (29%) were the most common among stimulants users.

#### 6.3.1.2 Psychiatric Co-morbidity

Psychiatric disorders which occurred at least once together with drug use in the period monitored concern especially disorders of adult personality and behaviour (F60–F69; 16%) and neurotic, stress-related and somatoform disorders (F40–F49; 15%), and then schizophrenia, schizotypal and delusional disorders (8%), among the users of cannabis, stimulants, hallucinogens and polydrug users and users other substances, and affective disorders (8%) among the users of opioids, hypnosedatives, and cocaine. A group of diagnoses of behavioural and emotional disorders of children (F90–F99) is associated with the use of inhalants (12%). The proportion of individual groups of psychiatric diagnoses which occur in combination with the use of illicit substances is given in Table 6-12.

*Table 6-11: Psychiatric diagnoses which occurred in combination with drug use among selected patients in 2001–2005 (%) (Ústav zdravotnických informací a statistiky, 2006a)*

| Diagnoses | F11 (n=5 723) | F12 (n=1 800) | F13 (n=2 545) | F14 (n=227) | F15 (n=4 688) | F16 (n=438) | F18 (n=756) | F19 (n=8,075) | Total (n=19,795) |
|---|---|---|---|---|---|---|---|---|---|
| F00–F09 | 2.9 | 1.8 | 11.1 | 3.1 | 1.2 | 1.8 | 3.6 | 3.6 | 3.8 |
| F20–F29 | 3.4 | **13.7** | 7.9 | 4.4 | **7.1** | **9.4** | 7.0 | **11.5** | **7.9** |
| F30–F39 | **4.6** | 6.0 | **25.5** | **6.2** | 3.9 | 5.7 | 3.4 | 8.1 | **7.9** |
| F40–F49 | **7.6** | **18.4** | **38.3** | **14.5** | **9.8** | **11.2** | **11.1** | **16.8** | **15.2** |
| F50–F59 | 0.9 | 1.2 | 3.4 | 3.1 | 1.4 | 1.1 | 0.8 | 1.6 | 1.4 |
| F60–F69 | **7.7** | **22.4** | **24.4** | **15.0** | **16.2** | **14.4** | **16.1** | **22.5** | **15.8** |
| F70–F79 | 1.0 | 2.0 | 1.1 | 0.9 | 0.8 | 2.3 | 7.1 | 2.1 | 1.6 |
| F80–F89 | 0.0 | 0.6 | 0.2 | 0.4 | 0.1 | 0.2 | 1.3 | 0.2 | 0.2 |
| F90–F98 | 1.4 | 10.9 | 2.8 | 3.5 | 3.4 | 3.4 | **12.4** | 4.2 | 3.6 |
| F99 | 0.2 | 0.4 | 0.6 | 1.8 | 0.3 | 0.7 | 0.4 | 0.4 | 0.4 |

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

*F00–F09 – Organic, including symptomatic, mental disorders*
*F20–F29 – Schizophrenia, schizotypal, and delusional disorders*
*F30–F39 – Mood (affective) disorders*
*F40–F49 – Neurotic, stress-related and somatoform disorders*
*F50–F59 – Behavioural syndromes associated with physiological disturbances and physical factors*
*F60–F69 – Disorders of adult personality and behaviour*
*F70–F79 – Mental retardation*
*F80–F89 – Disorders of psychological development*
*F90–F98 – Behavioural and emotional disorders of children*
*F99 – Unspecified mental disorder*

*Mental and behavioural disorders due to use of opioids – F11, cannabinoids – F12, sedatives or hypnotics – F13, cocaine – F14, stimulants – F15, hallucinogens – F16, inhalants – F18, multiple drug use and use of other psychoactive substances – F19.*

### 6.3.2 Non-Fatal Drug Intoxications

The collection of data about non-fatal intoxications[25] is based on the system administered by the Hygiene Service. Considerable regional differences in data collection systems have persisted. Various types of health care facilities represent a source of data. Intoxications caused by pervitin and heroin (20.5% and 18.6% of cases respectively) were those most commonly reported in 2005. A comparison of the rate of intoxications in 2001 to 2005 by drugs is included in Table 6-12.

*Table 6-12: Intoxications with drugs in the Czech Republic, a comparison of the years 2001–2005, by drugs (Polanecký et al, 2002–2006)*

| | 2001 | | 2002 | | 2003 | | 2004 | | 2005 | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Drug** | Abs. | % | Abs. | % | Abs. | % | Abs. | % | Abs. | % |
| Heroin | 285 | 24.1 | 176 | 17.6 | 152 | 17.3 | 179 | 18.8 | 244 | 20.5 |
| Pervitin | 163 | 13.8 | 191 | 19.1 | 149 | 16.9 | 180 | 18.9 | 222 | 18.6 |
| Benzodiazepines | 137 | 11.6 | 89 | 8.9 | 157 | 17.8 | 126 | 13.2 | 153 | 12.8 |
| Other drugs and medicines | 182 | 15.4 | 179 | 17.9 | 100 | 11.4 | 92 | 9.7 | 111 | 9.3 |
| Sedatives, hypnotics | 176 | 14.9 | 121 | 12.1 | 73 | 8.3 | 97 | 10.2 | 77 | 6.5 |
| Cannabis | 63 | 5.3 | 101 | 10.1 | 90 | 10.2 | 84 | 8.8 | 73 | 6.1 |
| Inhalants | 75 | 17.8 | 58 | 5.8 | 69 | 7.8 | 64 | 6.7 | 48 | 4.0 |
| Other opiates | 16 | 1.4 | 23 | 2.3 | 22 | 2.5 | 20 | 2.1 | 19 | 1.6 |
| Subutex | n.a. | – | n.a. | – | 2 | 0.2 | 12 | 1.3 | 14 | 1.2 |
| Amphetamines | 4 | 0.3 | 12 | 1.2 | 7 | 0.8 | 17 | 1.8 | 13 | 1.1 |
| Barbiturates | 19 | 1.6 | 16 | 1.6 | 9 | 1.0 | 6 | 0.6 | 11 | 0.9 |
| Methadone | 2 | 0.2 | 6 | 0.6 | 3 | 0.3 | 2 | 0.2 | 10 | 0.8 |
| Ecstasy | 15 | 1.3 | 4 | 0.4 | 8 | 0.9 | 3 | 0.3 | 8 | 0.7 |
| Cocaine, crack | 4 | 0.3 | 2 | 0.2 | 6 | 0.7 | 5 | 0.5 | 7 | 0.6 |
| Psilocybin | 15 | 1.3 | 7 | 0.7 | 4 | 0.5 | 10 | 1.1 | 6 | 0.5 |
| LSD | 3 | 0.3 | 2 | 0.2 | 3 | 0.3 | 7 | 0.7 | 3 | 0.3 |
| Thorn apple | 4 | 0.3 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 0.1 |
| Unknown | 20 | 1.7 | 13 | 1.3 | 27 | 3.1 | 48 | 5.0 | 173 | 14.5 |
| **Total** | **896** | **100.0** | **818** | **100.0** | **881** | **100.0** | **952** | **100.0** | **1193** | **100.0** |

### 6.3.3 Drugs and Traffic Accidents

See detailed information in the special chapter on Drugs and Driving, page 85.

[25] The system also includes the reporting of overdoses and other health complications which require hospitalisation.

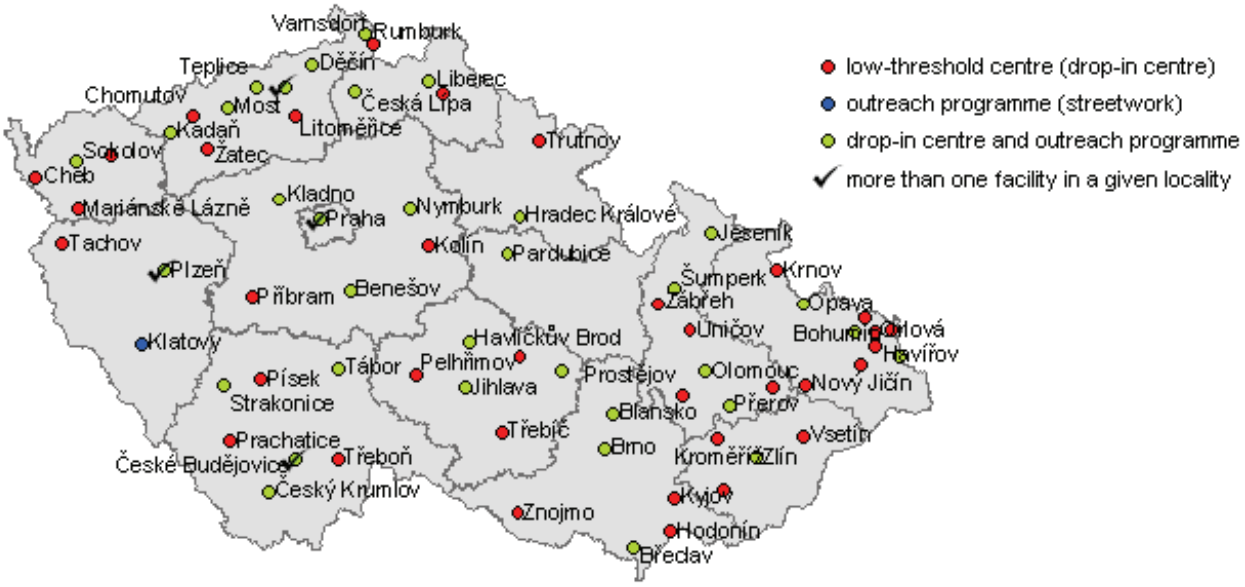
## 7 Responses to Health Correlates and Consequences of Drug Use

Harm reduction is one of the four pillars of the Czech Republic's drug policy. In the national strategy, activities from the field of harm reduction are specified within one of the six basic goals of the drug policy – the reduction of the potential risks posed by all types of drugs and the reduction of the economic, social, and health impacts of drug use for individuals and society. The measures targeted at the reduction of drug-related health risks are carried out by treatment institutions (see the chapter on Treatment, page 32) and, especially, by low-threshold facilities for drug users. The availability, capacity, and use of the facilities have been increasing continually since the second half of the 1990s. The proportion of problem users who are in contact with the facilities is relatively high. On the contrary, a decrease in the availability of testing for infectious diseases in the population of injecting drug users can be mentioned as a weakness.

### 7.1 Services Provided by Low-Threshold Facilities

The network of low-threshold facilities has been developing in the Czech Republic since 1992. It consists of low-hreshold centres, outreach programmes (streetwork), and needle exchange programmes; there were 92 of them in 2005 – see Map 7-1. The target population of the low-threshold facilities consists of problem drug users, experimenters, and their friends and relatives; some facilities also provide services to recreational users of dance drugs. The basic goals of the services provided in the field of health harm reduction involve improving the level of informedness of users about the effects of individual drugs, prevention of overdoses, prevention of the spread of hepatitis and HIV/AIDS, mediation of contact between users and other helping and treatment facilities, increasing users' motivation to engage in less risky behaviour and changing lifestyles towards abstinence, and regular exchange and safe disposal of used injecting equipment.

*Map 7-1: Low-threshold facilities in the Czech Republic in 2005*




Data on the services provided by low-threshold facilities and on persons who have received them are available in annual reports which were drawn up by the facilities for the purposes of the subsidy proceedings of the The Council of the Government for Drug Policy Coordination (CGDPC). 78 low-threshold facilities, i.e. 84% of the total number, participated in the subsidy proceedings. An estimate of the volume of services and the number of persons who have used them was made on the basis of data from these facilities – see Table 7-1 and Table 7-2 (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g). Information on the activities of the low-threshold facilities follows on from aggregated data on individual projects, and so it is not possible to exclude contingent duplications regarding persons who used services in several facilities during the respective year. The analysis of the outputs of the FreeBase database (data from 34 facilities which provided a list of codes of their clients[26]) showed that 1,965 (22%) of the total number of 8,921 codes were present in several facilities.

[26] Low-threshold facilities provide their services in an anonymous manner; they use codes to register their clients. The codes make it possible to distinguish between individual users while maintaining their confidentiality.

*Table 7-1: Number of clients of low-threshold facilities in 2005 – extrapolated to 92 facilities (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g)*

| **Indicator** | **Number** |
|---|---|
| Total number of persons | 32,800 |
| Number of drug users | 27,800 |
| Number of injecting drug users | 17,900 |
| Number of primary opiates users | 6,800 |
| Number of primary pervitin users | 12,300 |
| Number of primary cannabis users | 3,600 |
| Number of primary inhalant users | 470 |
| Average age of drug users | 25 years |

*Table 7-2: Selected activities of low-threshold facilities in 2005 – extrapolated to 92 facilities (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g)*

| Indicator | **Number** |
|---|---|
| Total number of visits | 403,900 |
| Needle and syringe exchange programme | 249,000 |
| Food service | 99,500 |
| Hygiene service | 40,900 |
| Medical treatment | 12,500 |
| Individual counselling | 25,800 |
| Group counselling | 1,500 |
| Crisis intervention | 2,500 |

In comparison with the previous years, attendance at low-threshold facilities increased markedly, together with the volume of services supplied, especially the one most commonly utilised – needle and syringe exchange (154,000 exchanges in 2002 and 249,000 in 2005) – see Table 7-3. The number of drug users who took advantage of the services supplied by these facilities and their structure by gender and drugs used has remained stable. In the long term, the average age of users increased from 22 in 2002 to 25 in 2005 (see also the 2002–2004 annual reports of the NMC). At the same time, the proportion of problem drug users in contact with the facilities has remained stable; 60%, according to data which were obtained in 2002–2005 within the framework of the survey 'HCV Seroprevalence among Injecting Drug Users' – see the chapter on Estimates of Prevalence and Incidence of Problem Drug Use, page 23. Other studies mention a 56% proportion of injecting drug users in contact with the facilities in 2004 (Staníček, 2005).

*Table 7-3: Clients of Czech low-threshold facilities in 2002–2005 (Mravčík et al. 2005a; Národní monitorovací středisko pro drogy a drogové závislosti, 2006g)*

| **Indicator** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|
| Number of low-threshold facilities | 92 | 93 | 92 | 92 |
| Number of drug users | n.a. | 25,200 | 24,200 | 27,800 |
| Number of injecting drug users | 19,000 | 16,700 | 16,200 | 17,900 |
| Number of opiates users | 8,000 | 6,100 | 6,000 | 6,800 |
| Number of pervitin users | 12,900 | 11,300 | 12,200 | 12,300 |
| Number of inhalant users | n.a. | 705 | 560 | 470 |
| Number of cannabis users | 3,400 | 5,500 | 4,100 | 3,600 |
| Number of contacts/visits | 290,000 | 315,000 | 318,000 | 403,900 |

### 7.1.1 Evaluation of Low-Threshold Services

Three analyses of the current state of the network of low-threshold facilities in the Czech Republic were carried out in 2005 (Staníček, 2005; Libra, 2006; Mravčík, 2005). They indicate the following findings:

- Differences between the network of facilities in individual regions involve accessibility for clients, the proportion of the estimated number of injecting drug users among the clients who use the services provided by the facilities (24–76%), average costs per injecting drug user and year (€ 87–363) and the amount of subsidies from the subsidy proceedings of the CGDPC (six regions were financially underestimated and five regions were financially overestimated against the proposed optimum). Prague and Central Bohemia (insufficient capacity) and Vysočina can be regarded as problematic regions (because of a low proportion of injecting drug users contacted, despite high costs) (Staníček, 2005).
- There are differences in the target population and in the spectrum of the services provided. Facilities which cover a greater area (with a higher number and density of inhabitants) rather focus on problem drug users, and facilities which cover a smaller area also focus on other groups of drug users and on persons who are at risk of drug addiction (Staníček, 2005).

- There are also differences in the costs per individual low-threshold facility. The costs per contact were between € 3 and € 305 (€ 35 on the average, compared with € 57 in 2001). Facilities with costs per contact above € 22 can be regarded as too costly, and facilities with less than 40 clients and 200 contacts per employee and year can be regarded as insufficiently effective (Mravčík, 2005).
- Although the costs of low-threshold facilities increase with inflation, the total amount of subsidies provided at the central level does not increase (Libra, 2006); selected data on the funding of low-threshold facilities within the subsidy proceedings of the CGDCP in 2002–2005 are given in Table 7-4.

*Table 7-4: Support to low-threshold facilities within subsidy proceedings of the CGDPC in 2002–2005*

| Indicator | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|
| Number of facilities supported | 88 | 83 | 86 | 75 |
| Total costs (in € thousand) | 4,469 | 4,644 | 5,036 | 5,035 |
| Subsidy from CGDPC (in € thousand) | 1,593 | 1,646 | 1,692 | 1,510 |
| Proportion of the subsidy from the CGDPC in total costs (%) | 35.6 | 35.4 | 33.6 | 30.0 |

On the basis of the above-mentioned findings, a suggestion was made to increase the involvement of institutions in the region (e.g. the regional drug policy council and the regional drug coordinator) in the process evaluation and optimisation of the network of services. At the same time, a recommendation was made to reassess the existing subsidy system – to consider the proportion of the part of the population of problem drug users contacted when the efficiency of individual programmes is being assessed, so as to evenly distribute financial resources to individual regions in order to systematically support suitable types of low-threshold services[27] with regard to the coverage area and character of the region (Staníček, 2005; Libra, 2006).

## 7.2 Overdose Prevention

In the Czech Republic, overdose prevention is only carried out through the education and training of drug users within the framework of services provided by low-threshold and treatment facilities. The main topics dealt with in education involve first aid in the case of an overdose, the risks of combining drugs, and principles of safer use.

Besides the above-mentioned services and substitution treatment programmes, no other specific activities which lead to overdose prevention (e.g. the use of the preventive distribution of opioid antagonists to users or injecting rooms) have been introduced in the Czech Republic.

## 7.3 Prevention of Infectious Diseases

The activities of low-threshold facilities involve the provision of information on infectious diseases, education and motivation towards safer drug use, exchange programmes, including the safe disposal of used syringes and a secondary exchange programme,[28] education and motivation towards safer sex, the distribution of condoms, motivational training to ascertain one's own state of health, and the mediation of vaccination and contact with a specialist physician in the event of (the suspicion of) a disease. The types of services provided by individual facilities vary according to capacity, financial means, and demand on the part of users.

### 7.3.1 Needle and Syringe Exchange Programmes

A needle and syringe exchange programme was provided by 96% of Czech low-threshold facilities in 2005. The number of needles and syringes distributed has been increasing for a number of years – see Table 7-5 and Table 7-6. According to information from final reports, each injecting user who visited a low-threshold facility in 2005 exchanged fourteen times on the average and received a total of 197 sterile syringes.

[27] Besides low-threshold centres, support should also be available to outreach programmes and so-called drug agencies.
[28] Involvement of active drug users who receive training and then, under professional supervision, exchange injecting materials and provide information to other drug users.

*Table 7-5: Exchange programmes in the Czech Republic in 1998–2005 (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g; Polanecký et al. 2006)*

| Year | Number of exchange programmes reporting | Number of syringes and needles exchanged |
|---|---|---|
| 1998 | 42 | 487,000 |
| 1999 | 64 | 850,000 |
| 2000 | 80 | 1,152,000 |
| 2001 | 77 | 1,567,000 |
| 2002 | 88 | 1,471,000 |
| 2003 | 87 | 1,780,000 |
| 2004 | 86 | 2,358,000 |
| 2005 | 88 | 3,274,000 |

*Table 7-6: Exchange programmes in regions of the Czech Republic in 2002–2005 (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g; Polanecký et al. 2006)*

| Region/year | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|
| Prague | 858,507 | 979,560 | 1,210,704 | 1,697,554 |
| Central Bohemia | 12,561 | 31,682 | 66,600 | 110,325 |
| Southern Bohemia | 14,883 | 69,004 | 102,621 | 124,454 |
| Pilsen | 23,221 | 44,670 | 88,450 | 116,611 |
| Karlovy Vary | 16,608 | 29,299 | 35,756 | 58,680 |
| Ústí nad Labem | 256,071 | 262,418 | 351,561 | 479,383 |
| Liberec | 12,273 | 21,108 | 33,467 | 32,800 |
| Hradec Králové | 22,250 | 45,089 | 41,021 | 86,221 |
| Pardubice | 23,622 | 23,330 | 36,081 | 38,725 |
| Vysočina | 11,254 | 29,363 | 39,348 | 61,425 |
| Southern Moravia | 134,285 | 122,137 | 165,846 | 173,090 |
| Olomouc | 21,809 | 33,832 | 85,872 | 96,416 |
| Zlín | 19,973 | 11,362 | 41,977 | 143,771 |
| Moravian-Silesian | 41,907 | 75,103 | 56,232 | 52,169 |
| **Total** | **1,471,000** | **1,780,000** | **2,358,000** | **3,274,000** |

*Map 7-2: Number of exchanged needles and syringes in regions of the Czech Republic in 2005, per 1,000 inhabitants (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g; Polanecký et al. 2006)*


### 7.3.2 Sales of Needles and Syringes in Pharmacies

Approximately 64% of 760 respondents to the 'HCV Seroprevalence among Injecting Drug Users' study mentioned that they had got clean needles and syringes from pharmacies during the previous six months; pharmacies represent the second biggest source of injecting equipment after low-threshold centres (68.8% of respondents). More than 40% of the respondents estimated that less than 20% of the pharmacies in the place of their residence

do not sell syringes to drug users; nearly 30% of the respondents believe that this proportion is 60% or more. 52% of the respondents had personal experience of a pharmacy refusing to sell them syringes; 40% of respondents reported that the staff of the pharmacies were asking a price which was higher than usual for the syringes[29] (Mravčík et al. 2006).

### 7.3.3 Testing for Infectious Diseases among Drug Users

In 2005, 59% of low-threshold facilities offered testing for HCV antibodies, 58% for HIV, 30% for VHB, and 2% for syphilis. Only 15% of more than 16,000 injecting drug users who used the services provided by low-threshold facilities asked for an HIV test, and 16% asked for HCV testing[30] (provided that the tests were not carried out repeatedly for the same persons)[31] (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g). The results of the tests are given in the chapter on Drug-related Infections, page 42.

*Table 7-7: Number of tests for infections carried out by low-threshold facilities in 2001–2005 (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g)*

| Test type | 2001 | | 2002 | | 2003 | | 2004 | | 2005 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Tests | Facilities | Tests | Facilities | Tests | Facilities | Tests | Facilities | Tests | Facilities |
| HIV | 2,307 | 47 | 1,158 | 35 | 2,629 | 64 | 2,178 | 58 | 2,425 | 54 |
| HBV | 901 | 36 | 515 | 26 | 739 | 21 | 932 | 25 | 1,370 | 28 |
| HCV | 1,257 | 40 | 1,202 | 33 | 2,499 | 60 | 2,582 | 53 | 2,664 | 55 |
| Syphilis | n.a. | n.a. | 176 | 2 | 209 | 4 | 84 | 1 | 54 | 2 |

## 7.4 Interventions Relating to Psychiatric Co-morbidity

The treatment of drug users who also suffer from other, dual diagnoses is carried out in an integrated manner, i.e. within the existing treatment system for drug users, and the specific needs of the patients are taken into consideration – see the chapter on Treatment, page 32.

[29] The common price is approximately CZK 4 (€ 0.15); respondents often mentioned that they were asked to pay CZK 10, 20, 30, or 50; the highest price mentioned was CZK 80 (€ 2.70) for a syringe.

[30] Governmental order 453/2004 Coll. came into force at the beginning of 2006. According to it, all *in vitro* diagnostic devices must meet the requirements of the European directive 98/79/EEC before they can be put on the market (inter alia, they must have a declaration of conformity which is issued for the diagnostic health device and a CE marking of the device). Previously, quick orientative capillary blood tests were the most common tool for testing drug users for VHC antibodies (1.2 million tests per year). Currently, no such test which would meet the new requirements is available on the Czech or the European market; therefore, it is possible to expect a decline in the number of HCV tests carried out.

[31] No data on the number of persons tested are available.

## 8 Social Correlates and Consequences of Drug Use

The most significant social problems of drug users involve family and work problems, unemployment, lower education, and poor housing, which sometimes even lead to homelessness; the accumulation of several social problems may lead to social exclusion. Social exclusion does not necessarily have to be a consequence of drug use (especially problem drug use); on the contrary, it can also be one of the causes of drug use.

Besides drug users, unemployed and homeless persons and people with a low level of education, the groups which are directly endangered by social exclusion also involve immigrants, members of minorities, or children who grow up in problem families; in the Czech Republic, social exclusion involves especially certain groups of the Roma population.

In 2005, the number of drug offences, as well as the number of prosecuted and accused drug offenders, was approximately the same as in 2004. Even the proportion of offences of the possession of drugs in a quantity greater than small (8%) among all detected drug offences has remained approximately the same. The number of those sentenced for drug offences declined for the first time since the beginning of the 1990s. Pervitin is the drug most associated with drug offences and this proportion is growing; the proportion of cannabis has been declining. The proportion of custodial sentences among those sentenced has been increasing. The proportion of suspended custodial sentences, first offenders, and juveniles among those sentenced for cannabis-related offences is markedly higher than among those sentenced for offences which involve other drugs.

### 8.1 Social Exclusion

It has been apparent in the long term that frequent drug-related social problems involve disturbed family relations, disturbed relationships in the workplace or at school, lower levels of education or even incomplete education, unemployment, lower socio-economic status, and/or poor housing, which sometimes even leads to homelessness. The accumulation of the above-mentioned social problems may lead to so-called social exclusion, i.e. the exclusion of an individual from society. However, social exclusion does not necessarily have to be a consequence of drug use (especially problem drug use); on the contrary, it can also be one of the causes of drug use.

Social exclusion is often also supported by negative attitudes on the part of the majority society towards a particular group of citizens (so-called symbolic exclusion); on the other hand, it is also supported by the so-called subjective exclusion, when an individual or a group of citizens feels excluded from society (Mareš, 2002; Kancelář Rady vlády pro záležitosti romské komunity, 2005).

The groups which are directly endangered by social exclusion involve, for instance, people who have been unemployed repeatedly or on a long-term basis, workers with uncertain and disadvantageous labour contracts, poor people and people with low incomes, unqualified people (especially those with incomplete elementary education), mentally or spiritually handicapped people, children who grow up in problem families (especially abused children), offenders (people with a record in the penal register), immigrants (illegal workers, asylum seekers, and refugees), minorities defined by race, religion, language, or culture, recipients of social benefits, homeless people, or people who live in ghetto-like localities (Mareš, 2006).

Social exclusion in the Czech Republic involves especially several specific groups of the Roma population (Kancelář Rady vlády pro záležitosti romské komunity, 2005). Exclusion is regarded as an accumulation of social problems in the Roma communities; long-term unemployment, low incomes, inaccessible and poor housing are primary factors in the social exclusion of the Roma (Mareš, 2003; Sirovátka, 2003; Vašečka, 2002). The 2005–2015 Action Plan for the Decade of Roma Inclusion was drawn up in 2005; the basic priorities of the action plan involve education, employment, housing, and health (Kancelář Rady vlády pro záležitosti romské komunity, 2006a).

#### 8.1.1 Roma Population and Drugs

The Office of the Governmental Council for Roma Community Issues deals with the long-term monitoring and evaluation of the situation in Roma communities within the framework of the Social Workers Support Programme. The primary goal of the programme, and, similarly, also the goal of the outreach workers is to “improve the social competencies of socially excluded people in the target community in order to increase their ability to participate in activities which are common for other citizens and prevent their social exclusion” (Winkler and Šimíková, 2005).

Altogether 57 municipalities with 87 outreach workers (and localities) were involved in the Social Workers Support Programme in 2005. Based on an analysis of the project carried out by the Research Institute for Labour and Social Affairs, the structure and content of monitored aspects of social issues in the Roma communities had changed considerably in comparison with the previous years (Winkler and Šimíková, 2005). A new form and a system for reporting activities within the framework of the programme were introduced. Therefore, unlike in previous years, it is no longer possible to assess, for instance, the degree of seriousness of individual monitored phenomena, including the seriousness of drugs issues, or which drugs are the most common.

Outreach social workers supplied services to 15,262 clients in 2005. The services most commonly involved housing (31%), debts (23%), and unemployment (20%). 464 interventions (3% of services) were carried out in relation to drug use – see Table 8-1. In comparison with the previous years, addressing the issues which relate to drugs, prostitution, usury, and gambling are on the decrease (Kancelář Rady vlády pro záležitosti romské komunity, 2006b). However, it does not necessarily mean that there really were fewer of these problems; a possible interpretation is that outreach social workers targeted other areas.

*Table 8-1: Numbers of clients who received services from outreach social workers in individual areas (Kancelář Rady vlády pro záležitosti romské komunity, 2006b)*

| Problem type | Number of clients | Proportion (%) |
|---|---|---|
| Debts | 3,513 | 23 |
| Quality of housing | 3,065 | 20 |
| Unemployment | 3,034 | 20 |
| Problematic tenant/landlord relations | 1,746 | 11 |
| Insufficient hygiene | 1,359 | 9 |
| Truancy | 805 | 5 |
| Criminality | 631 | 4 |
| Drug abuse | 464 | 3 |
| Gambling | 319 | 2 |
| Profiteering | 269 | 2 |
| Prostitution | 57 | 1 |
| **Total** | **15,262** | **100** |

In 2005, GAC Ltd. and the New School (Nová škola) started the project 'Analysis of Socially Excluded Roma Localities and Communities in the Czech Republic and of Absorption Capacity of Entities which Operate in this Area'. The Ministry of Labour and Social Affairs commissioned the project. The aim of the project is to map living conditions in socially excluded Roma localities in the Czech Republic and determine the capacity of the organisations which operate near the localities; the first results will be available in September 2006. The output of the project will involve an electronic map of the excluded localities, a proposal for changes in the policy relating to social exclusion and Roma integration, and the targeting of resources from the European Social Fund to needy localities (Gabal Analysis and Consulting, 2006).

### 8.1.2 Drugs and Homelessness

The project on 'Health of Homeless People and Its Determinants' was launched in 2004. Its goal was to map the health of socially excluded people and related aspects which involve lifestyles, including mapping the extent of alcohol and illicit drug use in this population (Barták, M. et al., 2004; Barták, M. et al., 2005). At the end of 2005, the Institute of Health Policy and Economics, in collaboration with the Salvation Army and the Naděje civic association, carried out a survey among 1,000 homeless people in Prague. Its results were expected to be available in 2006; however, the Ministry of Health decided to abolish the Institute of Health Policy and Economics and neither the project nor a subanalysis of the implemented survey was completed.

### 8.1.3 Social Characteristics of People Demanding Treatment

The Prague Hygiene Station has been carrying out long-term monitoring of selected social characteristics of clients who demand treatment in relation to drug use in individual facilities. The sample consisted of 8,534 treatment demands; 7% of the persons were homeless, and nearly 8% lived in a facility (e.g. in prison, diagnostic and educational institutions, in dormitories or in refuges). The proportion of homeless people (8%) and people who live in facilities (10%) is higher among repeated treatment demands than among first treatment demands – see Table 8-2.

More than 50% of the treatment demands (and nearly 60% of repeated treatment demands) involve unemployed people and people who only work on an occasional basis (Polanecký et al. 2006). The low level of education of the people who demand treatment is a significant problem – nearly 50% completed basic education only, and 4% did not even complete basic school. The educational level is higher among those who sought treatment for the first time; however, it may be due to their lower age.

The social characteristics of patients who seek treatment have not changed significantly since 2002; the proportion of homeless and unemployed people and people with a low level of education has remained stable from a long-term perspective – see the previous annual reports of the NMC (Mravčík et al. 2003; Mravčík et al. 2004; Mravčík et al. 2005a).

*Table 8-2: Selected social characteristics of people demanding treatment (%) (Polanecký et al. 2006)*

| Characteristic | All treatment demands | First treatment demands | Repeated treatment demands |
|---|---|---|---|
| Homeless | 7.2 | 6.4 | 8.0 |
| Living in an institution | 7.9 | 6.2 | 9.7 |
| Unemployed, occasional work | 53.4 | 48.5 | 58.6 |
| Incomplete elementary education | 3.5 | 4.8 | 2.3 |
| Elementary education | 49.4 | 51.7 | 46.9 |

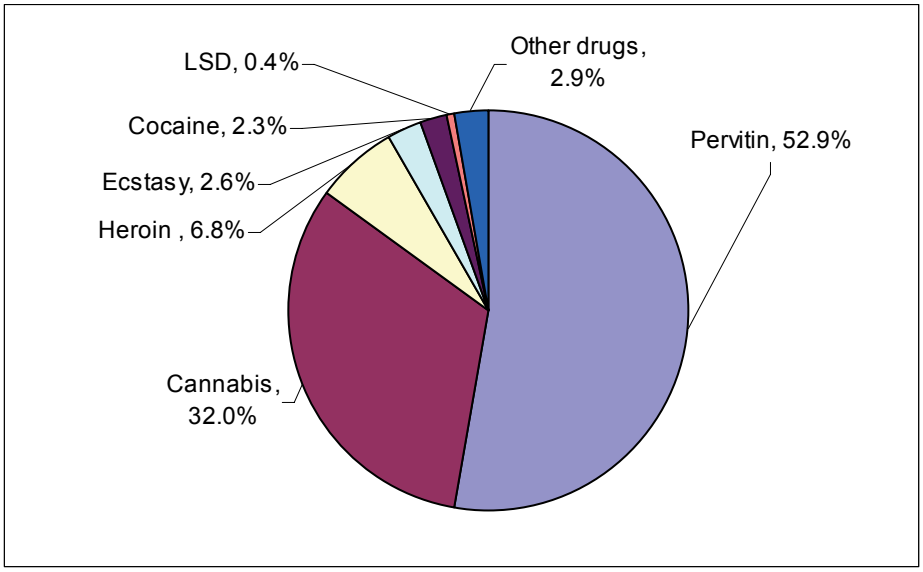
## 8.2 Drug-Related Crime

### 8.2.1 Drug-Related Crime according to the Statistics of the National Drug Squad

The National Drug Squad recorded 2,128 persons prosecuted for drug offences[32] in 2005, i.e. approximately the same number as in 2004 (2,100 persons). The proportion of offences involving the possession of a drug in a quantity greater than small for personal use (Section 187a of the Penal Code) has remained relatively low – 8% in 2005. The proportion varied slightly in terms of individual drugs; it was lower (5%) in all pervitin-related offences and higher in cannabis-related offences (10%) and heroin-related offences (15%).

Pervitin-related offences continue to represent the highest proportion of detected drug-related crime – see Figure 8-1. The trend of an increase in the proportion of pervitin-related offences continued in 2005 – 53%, against 39% in 2002. The proportion of cannabis-related offences has been decreasing slightly since 2002 – 32% in 2005, compared to 37% in 2002 – see Figure 8-2. The number of cocaine-related offences has been rising during the last four years; the number and proportion of cocaine-related offences in 2005 was nearly at the same level as ecstasy-related offences. There has been a slight increase in heroin-related drug offences during the last two years – see Figure 8-3 (Národní protidrogová centrála, 2006c).

*Figure 8-1: Prosecuted drug offenders by drug type in 2005 (Národní protidrogová centrála, 2006c)*




[32] Criminal offences of unauthorised production and possession of narcotic and psychotropic substances according to the provisions of Section 187, 187a, and 188 of the Penal Code (excluding criminal offences of the promotion of drug addiction according to Section 188a of the Penal Law).

*Figure 8-2: Proportion of pervitin, cannabis, and other drugs in drug offences (persons prosecuted) in 2002–2005 (Národní protidrogová centrála, 2006c)*

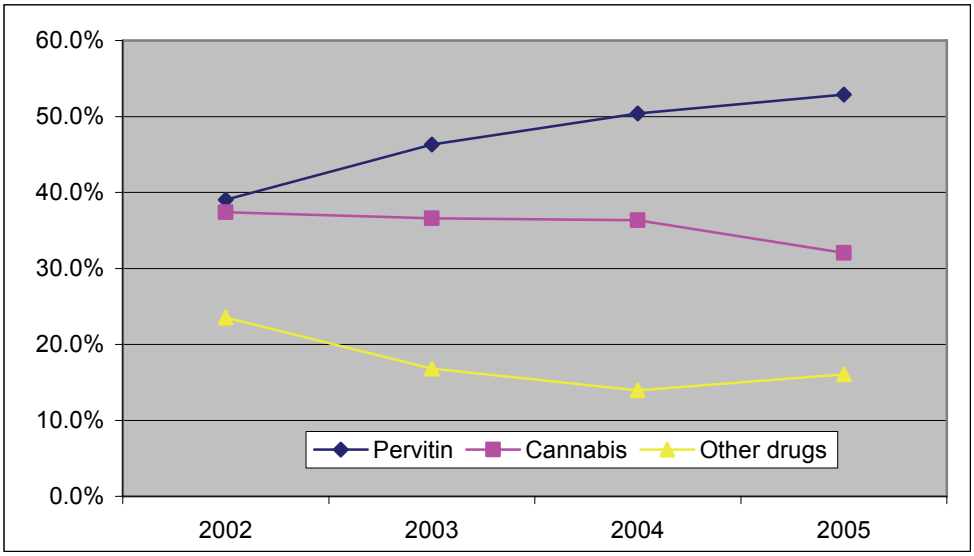
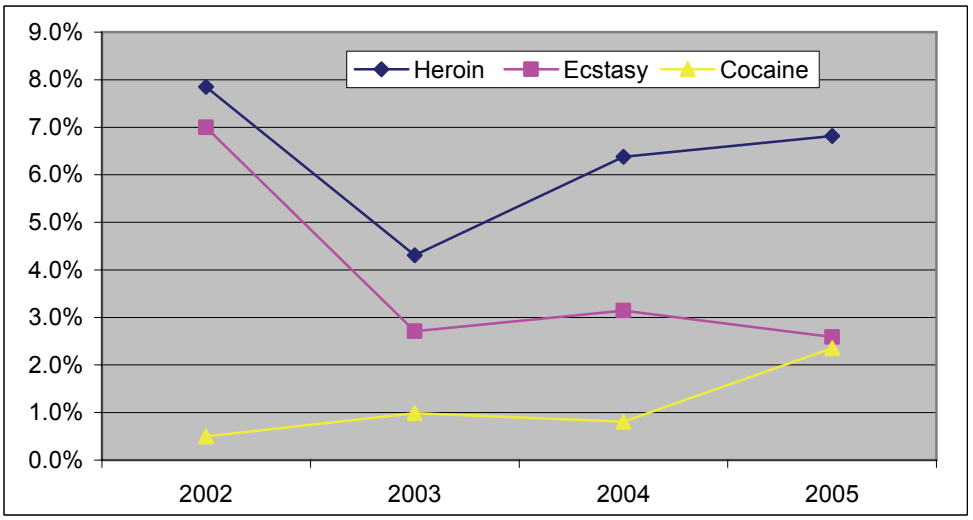


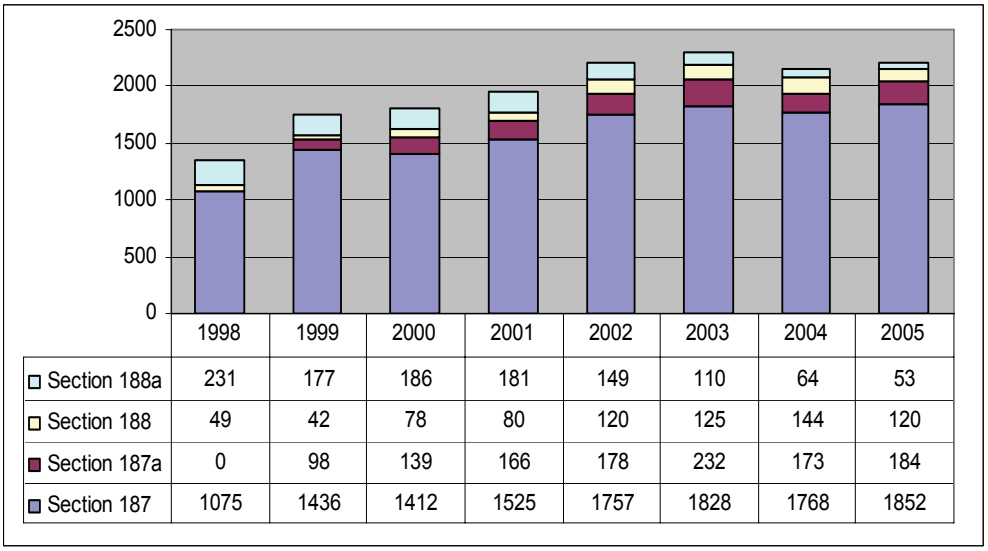

*Figure 8-3: Proportion of heroin, ecstasy, and cocaine in drug offences (persons prosecuted) in 2002–2005 (Národní protidrogová centrála, 2006c)*




### 8.2.2 Drug-Related Crime according to Statistics of the Police of the Czech Republic

In comparison with 2004, the number of those prosecuted for drug offences increased slightly according to the Statistical System of Criminality kept by the Police of the Czech Republic – see Figure 8-4. 2,209 prosecuted drug offenders were recorded in 2005 (2,149 in 2004) (Ministerstvo vnitra ČR, 2006); an overview by individual provisions of the Penal Code is shown Figure 8-4.

*Figure 8-4: Prosecuted drug offenders in 1998–2005 according to the Police Statistical System of Criminality (Ministerstvo vnitra ČR, 2006)*




| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|---|---|
| Section 188a | 231 | 177 | 186 | 181 | 149 | 110 | 64 | 53 |
| Section 188 | 49 | 42 | 78 | 80 | 120 | 125 | 144 | 120 |
| Section 187a | 0 | 98 | 139 | 166 | 178 | 232 | 173 | 184 |
| Section 187 | 1075 | 1436 | 1412 | 1525 | 1757 | 1828 | 1768 | 1852 |

As in the last year, the relatively[33] highest number of persons prosecuted for drug offences was recorded in the Usti nad Labem region (35 persons per 100,000 inhabitants), then in the Karlovy Vary, Vysocina, Liberec, and Prague regions (25 to 27 persons per 100,000 inhabitants). The lowest values were recorded in the Pardubice and Central Bohemia regions (13 and 15 persons per 100,000 inhabitants respectively). The highest year-on-year increase (by approximately 60%) occurred in the Hradec Kralove and Pardubice regions, which had recorded the lowest values in the previous year. A significant increase also occurred in the Zlin and Prague regions (by 34% and 26% respectively). Regional differences in the number of drug offences are shown in Map 8-1 and Figure 8-5 (it also includes a year-on-year comparison).

The highest rate of prosecutions for drug offences, as well as the highest rate of overall detected criminal offences, was recorded in the Ústí nad Labem region (1,900 persons prosecuted per 100,000 inhabitants) – see Figure 8-6. High rates of drug offences and overall detected criminal offences were also recorded in the Karlovy Vary and Liberec regions. There is a different situation in the Vysočina region; it has a high drug-related crime rate but it reported the lowest overall crime rate.

*Map 8-1: Offenders prosecuted for drug offences in regions of the Czech Republic in 2005 per 100,000 inhabitants (Ministerstvo vnitra ČR, 2006)*


[33] Per the number of inhabitants.

*Figure 8-5: Offenders prosecuted for drug offences in 2004 and 2005 by regions per 100,000 inhabitants (Ministerstvo vnitra ČR, 2006)*

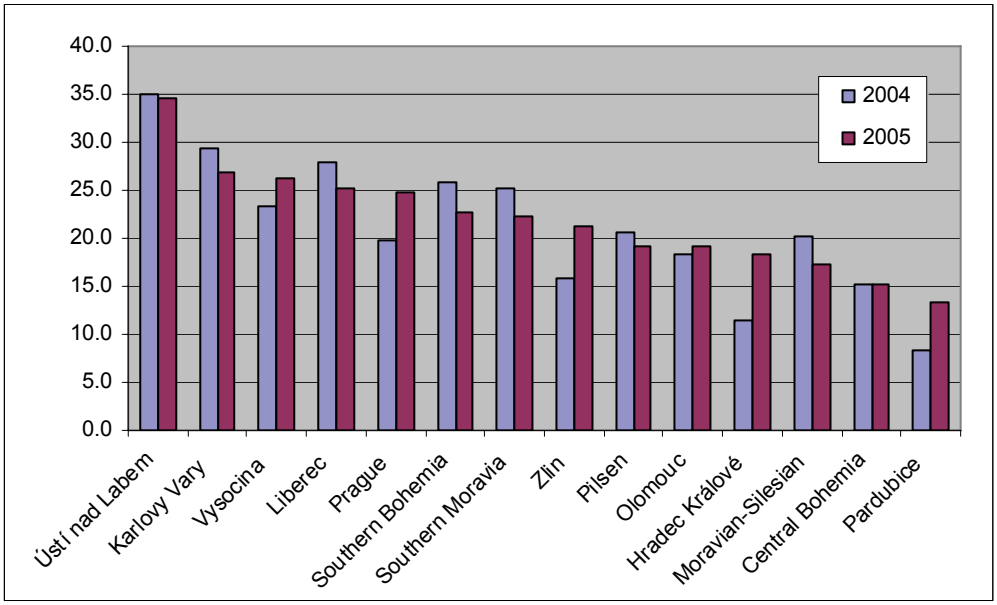
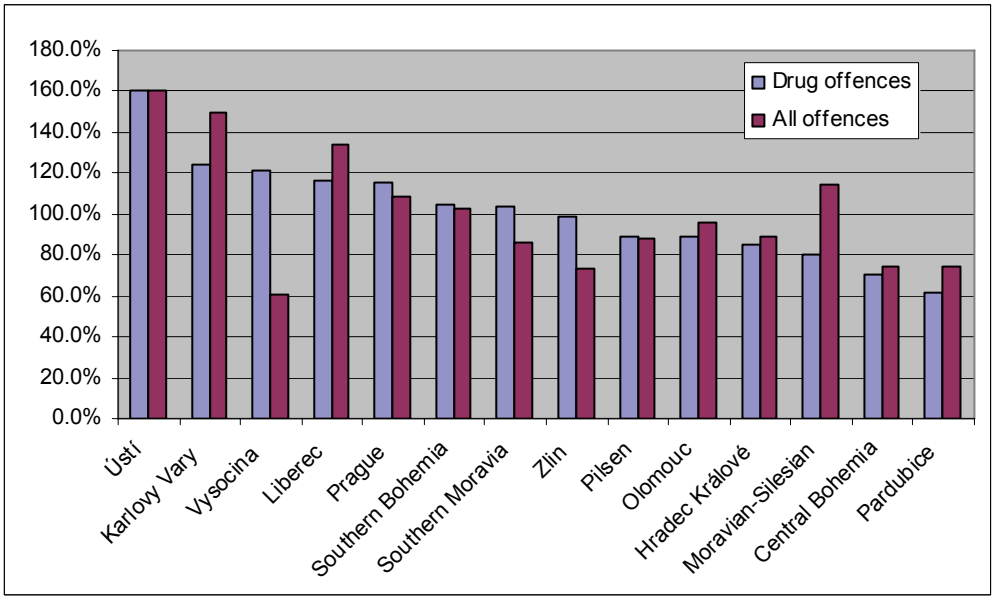



*Figure 8-6: Offenders prosecuted for drug offences and all criminal offences per 100,000 inhabitants (100% = values for the Czech Republic) (Ministerstvo vnitra ČR, 2006)*



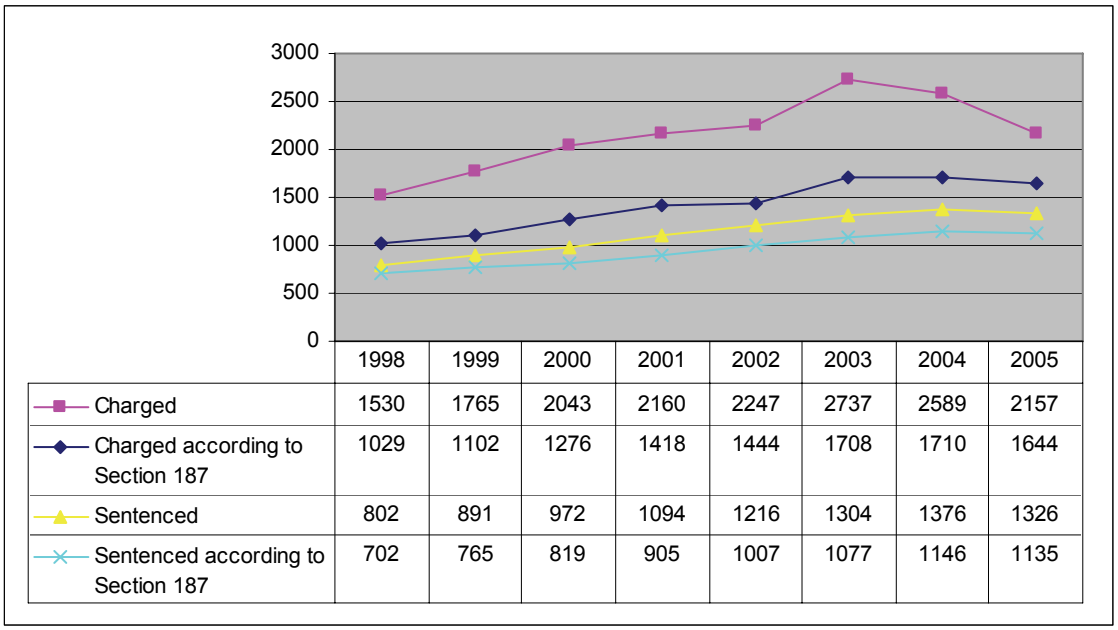

### 8.2.3 Drug-Related Crime according to Statistics of the Ministry of Justice

#### 8.2.3.1 Primary Statistics

According to the statistics of the Ministry of Justice, the number of persons accused of drug offences decreased by 16.7% in 2005 compared to 2004 and, more notably, by 21% compared to 2003. However, a closer look into the statistics of the Ministry of Justice shows that the above-mentioned decline can be attributed especially to a decline in the number of accused drug offenders according to Section 188a (promotion of drug addiction) and partly also according to Section 188 (possession of equipment for the production of drugs). A slight year-on-year decline in the number of sentenced drug offenders (by 3.6%) occurred for the first time since the beginning of the 1990s – see Figure 8-7.

The courts in the Czech Republic imposed 378 custodial sentences for drug offences in 2005; this number represents approximately 29% of the sentences imposed. Most commonly (in 74% of the cases), the custodial sentences imposed involved imprisonment for between 1 and 5 years. It corresponds to the basic sentence range for offences according to Section 187 and Section 188 of the Penal Code. Suspended sentences continue to be the most commonly imposed type of sentence for drug offences (51%). Community service was imposed in 9% of the cases – see Figure 8-8. The proportion of suspended sentences has been declining slightly and the proportion of custodial sentences has been increasing slightly since 2003 (Ministerstvo spravedlnosti ČR, 2006a).

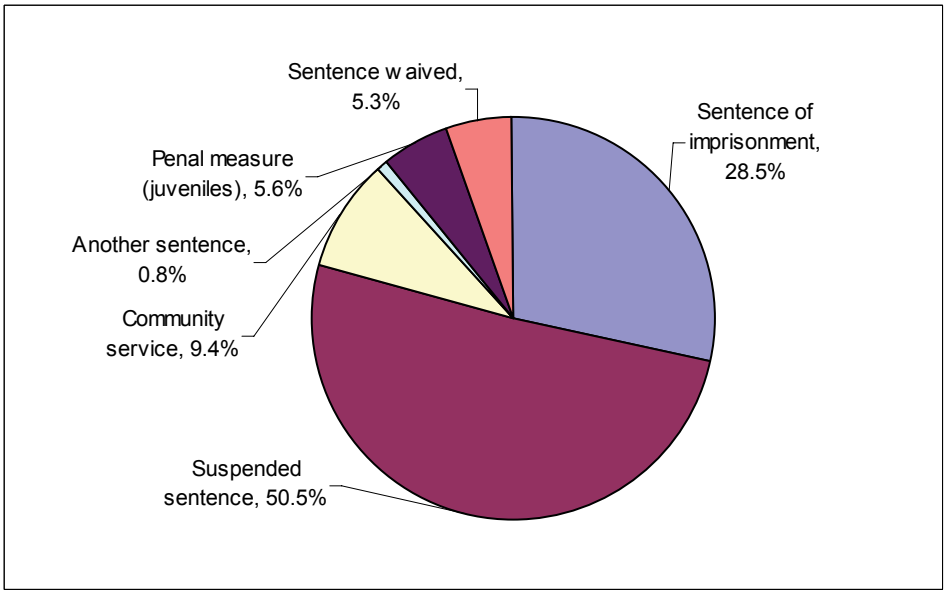
*Figure 8-7: Accused and sentenced drug offenders in 1998–2005 (Ministerstvo spravedlnosti ČR, 2006a)*




| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|---|---|
| Charged | 1530 | 1765 | 2043 | 2160 | 2247 | 2737 | 2589 | 2157 |
| Charged according to Section 187 | 1029 | 1102 | 1276 | 1418 | 1444 | 1708 | 1710 | 1644 |
| Sentenced | 802 | 891 | 972 | 1094 | 1216 | 1304 | 1376 | 1326 |
| Sentenced according to Section 187 | 702 | 765 | 819 | 905 | 1007 | 1077 | 1146 | 1135 |

*Note: Section 187 of the Penal Code – unauthorised production and/or distribution of drugs.*

*Figure 8-8: Composition of sentences for drug offences in 2005 (Ministerstvo spravedlnosti ČR, 2006a)*




### 8.2.3.2 Statistics by Drug Types

Changes have been made to the statistics of the Ministry of Justice which have been applicable since January 1, 2005. They make it possible to track individual cases according to the type of drug which was directly connected with the offences in question (Ministerstvo spravedlnosti ČR, 2006b). Employees of the courts and Public Prosecutors' Offices did not record the type of drug in all cases (only in 32% of charges and 68% of sentences for drug offences); however, the data still make it possible to gain a certain insight into differences in the prosecution of drug offences depending on the type of drug involved.

Pervitin is the most commonly represented drug (65% of charges and 50% of sentences for drug offences for which these data are available), followed by cannabis (identically 22% of charges and sentences) and heroin (6% of charges and sentences) – see Table 8-3.

The proportion of juvenile persons (aged 15–17) among those accused of or sentenced for cannabis-related offences is markedly higher than among those accused of or sentenced for other drug offences. As far as recorded cases for which the type of the drug involved was specified, juveniles represent 29% of those accused of and 32% of those sentenced for cannabis-related offences, whilst they only represent 4% of those accused of or sentenced for other drug offences. The proportion of persons aged 15–19 among those accused of cannabis-related offences is at 51%, and only at 15% among the offences which involved other drugs – see Figure 8-9 .

The proportion of first-time offenders is also higher among those sentenced for cannabis-related offences (69%) than among those sentenced for other drug offences (36%). A high proportion of first-time offenders also involved perpetrators of ecstasy-related offences (65% – 15 out of 23 persons). The proportion of females sentenced is lower in cannabis-related offences (6%) than in other drug offences (14% in pervitin-related offences and 19% in heroin-related offences) – see Figure 8-10.

There are also significant differences between individual drugs in terms of the types of sentences imposed on the drug offenders. A custodial sentence was imposed in 40% of pervitin-related drug offences, in 49% of heroin-related offences, and only in 7% of cannabis-related offences. This is associated with the above-mentioned differences in the proportion of juveniles and first-time offenders; but, to a certain extent, it indicates that courts assess drug offences taking into account the degree of social and health risks of individual types of drugs.

However, the proportions given may be distorted by the limited size of the sample – see also the information on the proportion of drugs among those prosecuted for drug offences according to the National Drug Squad in the chapter on Drug-Related Crime according to the Statistics of the National Drug Squad, page 56.

*Table 8-3: Prosecuted, accused and sentenced drug offenders by drug type (Ministerstvo spravedlnosti ČR, 2006b)*

| Monnitored group | Number of persons* | Cannabis (%) | Pervitin (%) | Ecstasy (%) | Heroin (%) | Cocaine (%) | Other drugs (%) |
|---|---|---|---|---|---|---|---|
| Prosecuted | 772 | 26.2 | 61.4 | 2.1 | 5.8 | 0.5 | 4.0 |
| Accused | 691 | 22.1 | 65.3 | 2.2 | 5.9 | 0.6 | 3.9 |
| Sentenced (courts) | 897 | 22.4 | 50.2 | 2.6 | 6.4 | 0.9 | 17.6 |

*Note: * It involves those persons for whom data on the type of the drug are available.*

*Figure 8-9: Age structure of accused drug offenders by drug type (Ministerstvo spravedlnosti ČR, 2006b)*

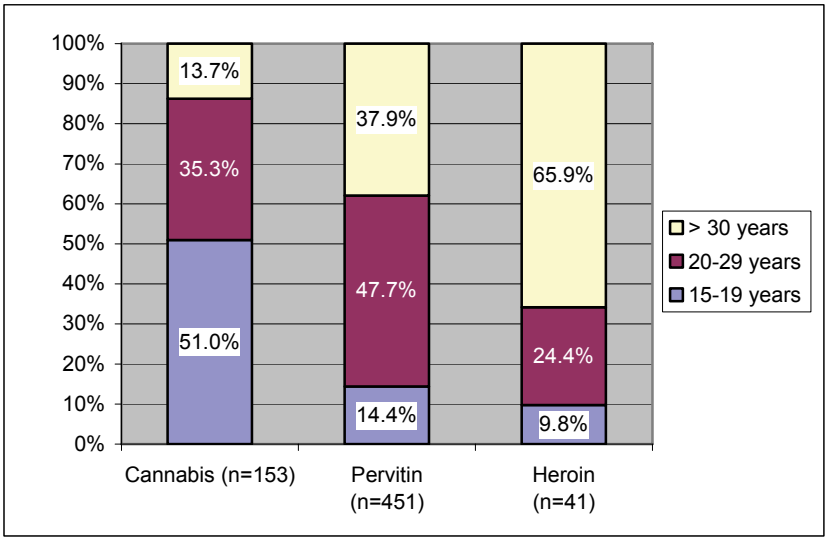
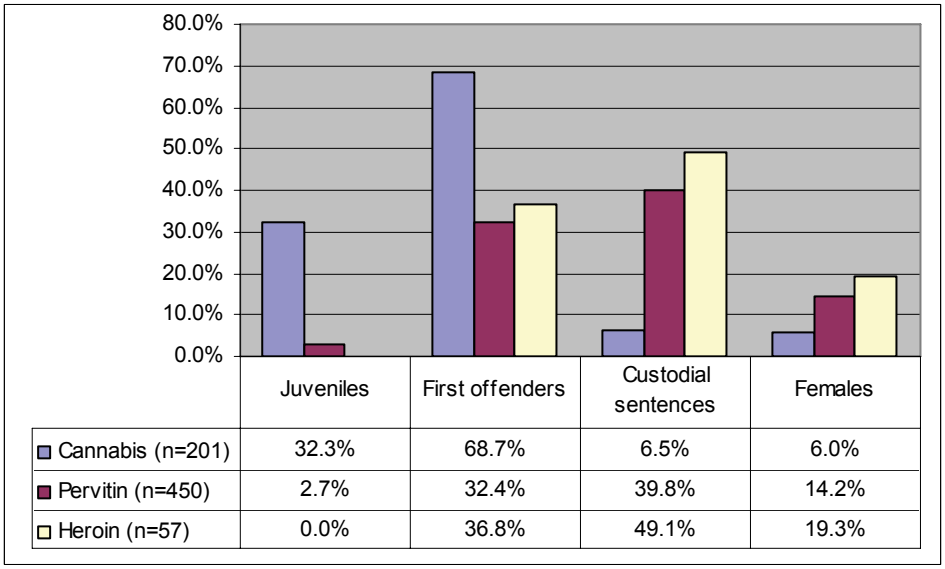



*Figure 8-10: Sentenced drug offenders – characteristics by drug type (Ministerstvo spravedlnosti ČR, 2006b)*




| | Juveniles | First offenders | Custodial sentences | Females |
|---|---|---|---|---|
| Cannabis (n=201) | 32.3% | 68.7% | 6.5% | 6.0% |
| Pervitin (n=450) | 2.7% | 32.4% | 39.8% | 14.2% |
| Heroin (n=57) | 0.0% | 36.8% | 49.1% | 19.3% |

### 8.2.4 Drug Misdemeanours

According to the data of the Police of the Czech Republic, 886 misdemeanours involving the possession of a small quantity of drugs for personal use (Section 30, paragraph 1, letter j, Act No. 200/1990 Coll. on Misdemeanours) were detected in 2005. It involves a slight year-on-year decrease (958 misdemeanours were recorded in 2004). 503 misdemeanours were dealt with in administrative proceedings. 45 cases were settled by a reprimand and 424 fines amounting to € 30,500 were imposed. 353 cases were ended with the suspension or discontinuance of the case or submission to another body and 9 cases were tentatively assessed as a criminal offence and placed in the hands of the bodies responsible for criminal proceedings (Národní protidrogová centrála , 2006a).

## 8.3 Secondary Drug-Related Crime

No estimate of the extent of secondary drug-related crime (i.e. criminal activities committed as a result of drug use, most commonly crimes against property) was made for the year 2005. According to the police estimate which was described in detail in the 2004 Annual Report, drug users committed approximately 46,000 financially motivated criminal offences, i.e. 16.6% of all detected criminal offences against property in 2004.

## 8.4 Drug Use in Prisons

The Prison Service of the Czech Republic has been monitoring the presence of drugs since 1996. It monitors the presence of drugs among persons entering the Pankrác and Ruzyně remand prisons in Prague and also among those who are already in prison.

Testing methodology has evolved continually since 1996. In the initial stage (1996–1998), the most appropriate testing method was being sought and only a few facilities (three per year on average) participated in the system. The number of prisons which were involved in monitoring continued to increase between 1999 and 2002 (12 per year on average); however, sending samples for laboratory analysis was only voluntary. Organisational basis for the involvement of all of the 35 prisons in the testing system was established in 2003–2005. According to an instruction of the General Directorate of the Prison Service, 10% of randomly selected inmates were to be tested four times a year, and there were no limitations on testing in cases of suspicion of drug use..

The proportion of positively tested persons entering remand prisons in Prague is several times higher than the proportion of inmates tested positive: 4.3% of inmates and 29.0% of those entering remand prisons in Prague were tested positive in 2005. In both groups, the most commonly detected drugs involved amphetamines and cannabis; a relatively high proportion of positive tests for the presence of opiates was found among those entering remand prisons (Vězeňská služba ČR, 2006) – see Table 8-4, Table 8-5, Figure 8-11, and Figure 8-12.

*Table 8-4: Results of testing among inmates in remand prisons and prisons (% of positive tests) (Vězeňská služba ČR, 2006)*

| Year | Number of tests | Amphetamines (%) | Cannabis (%) | Barbiturates (%) | Opiates (%) | Cocaine (%) | Total (%) |
|---|---|---|---|---|---|---|---|
| 1999 | 1,504 | 0.9 | 0.8 | 0.7 | 1.9 | 0.0 | 4.3 |
| 2000 | 1,236 | 2.9 | 1.2 | 2.3 | 0.5 | 0.2 | 7.1 |
| 2001 | 4,492 | 1.1 | 0.2 | 0.2 | 0.3 | 0.0 | 1.7 |
| 2002 | 1,808 | 2.4 | 0.7 | 1.4 | 1.4 | 0.0 | 5.9 |
| 2003 | 4,524 | 1.2 | 0.7 | 0.7 | 0.3 | 0.0 | 3.0 |
| 2004 | 9,380 | 1.4 | 0.8 | 0.7 | 0.4 | 0.0 | 3.3 |
| 2005 (1st half) | 2,732 | 1.6 | 1.1 | 0.9 | 0.7 | 0.0 | 4.3 |

*Note: The detection method changed in mid-2005, and so only the results from the first six months of 2005 were included in the comparison.*

*Table 8-5: Results of testing among persons entering remand prisons in Prague (% of positive tests) (Vězeňská služba ČR, 2006)*

| Year | Number of tests | Amphetamines (%) | Cannabis (%) | Barbiturates (%) | Opiates (%) | Cocaine (%) | Total (%) |
|---|---|---|---|---|---|---|---|
| 1999 | 4,180 | 8.3 | 4.6 | 4.6 | 2.1 | 0.1 | 19.8 |
| 2000 | 5,832 | 9.9 | 4.7 | 7.6 | 2.7 | 0.1 | 25.1 |
| 2001 | 5,840 | 9.3 | 4.9 | 5.9 | 1.3 | 0.2 | 21.5 |
| 2002 | 3,688 | 7.0 | 6.2 | 4.3 | 0.8 | 0.1 | 18.4 |
| 2003 | 4,568 | 10.8 | 6.6 | 3.6 | 0.9 | 0.2 | 22.1 |
| 2004 | 4,356 | 11.8 | 8.4 | 3.0 | 1.0 | 0.1 | 24.2 |
| 2005 (1st half) | 2,220 | 12.8 | 11.0 | 4.3 | 0.6 | 0.1 | 29.0 |

*Note: The detection method changed in mid-2005, and so only the results from the first six months of 2005 were included in the comparison.*

*Figure 8-11: Results of testing among inmates in remand prisons and prisons (% of positive tests) (Vězeňská služba ČR, 2006)*

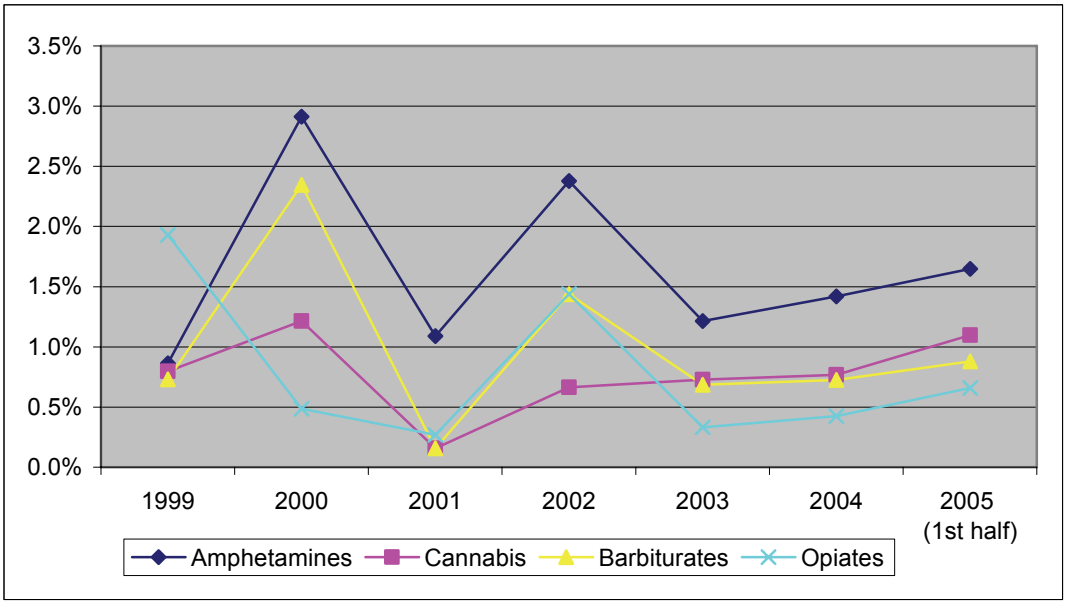
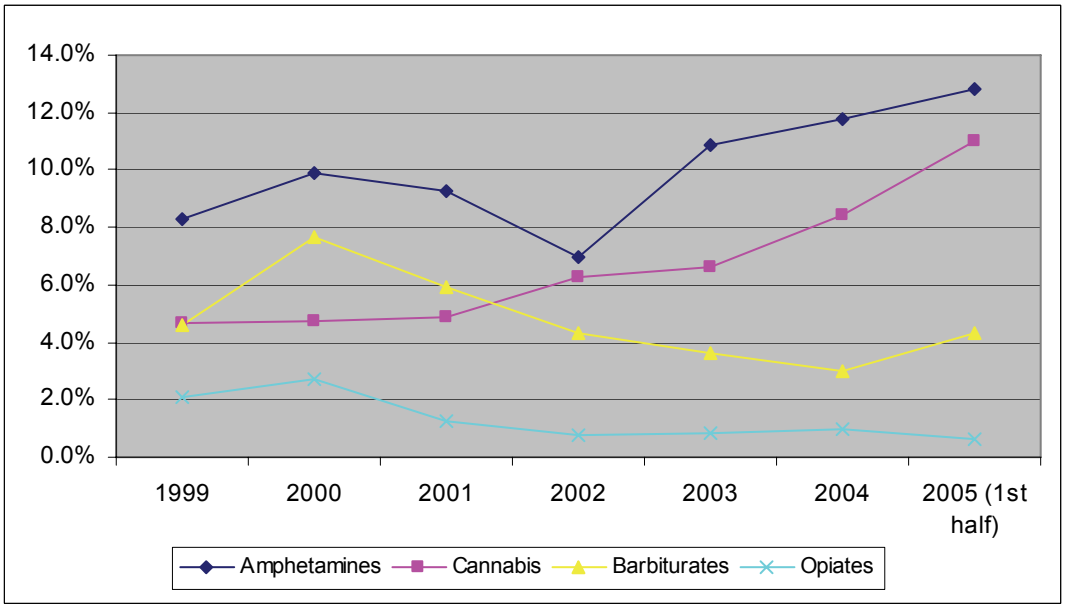



*Figure 8-12: Results of testing among persons entering remand prisons in Prague (% of positive tests) (Vězeňská služba ČR, 2006)*




## 8.5 Social Costs of Drug Use

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

## 9 Responses to Social Correlates and Consequences of Drug Use

The social reintegration and aftercare of drug users are provided particularly by means of structured outpatient aftercare programmes, which may also include sheltered housing and sheltered work programmes. The number and capacity of aftercare programmes has been increasing in recent years.

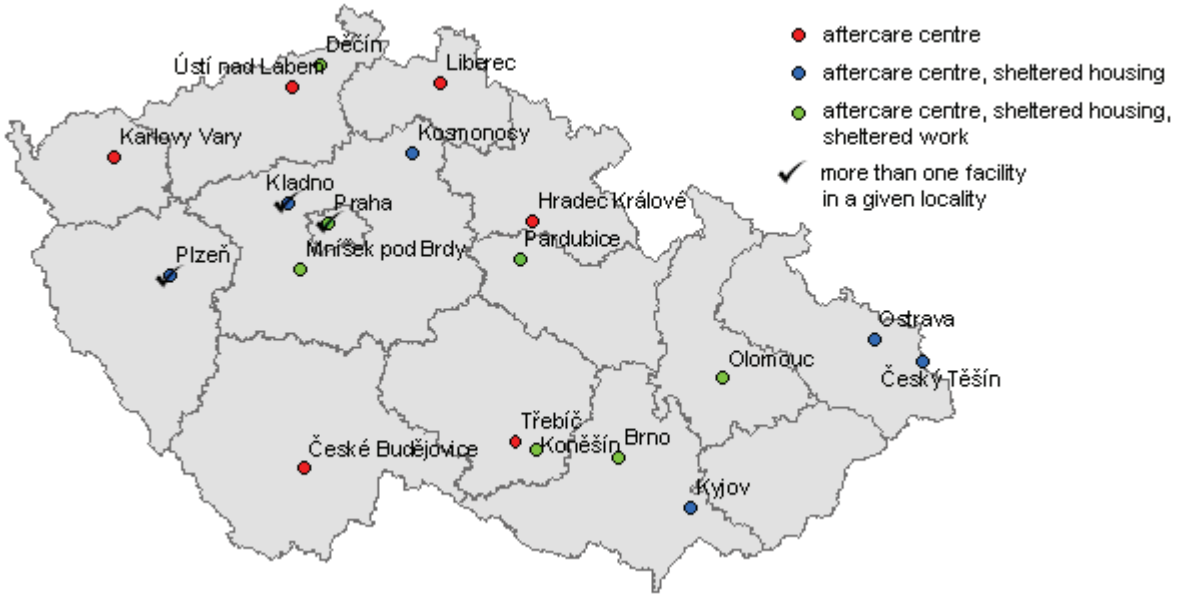
The number and capacity of drug-free zones in Czech prisons increased in 2005, and the number of inmates undergoing voluntary or compulsory drug treatment also increased. A pilot methadone substitution treatment programme with the ability to provide for 40 males started in two prisons in 2006.

NGOs provide services to drug users in 15 prisons; the number of persons who received services provided by NGOs in prisons increased in 2005.

### 9.1 Social Reintegration (Aftercare)

Outpatient aftercare programmes supply aftercare services. Certification standards define them as structured programmes of intensive outpatient treatment (for a period of at least six months) which partly follow on from the principle of afternoon day-care centres. The target group involves abstaining persons with a history of substance addiction, and it is recommended that they abstain for at least three months before they join the programme. persons who have gone through detoxification and received at least short-term treatment (outpatient or inpatient), persons with insight and motivation towards long-term abstinence, and persons with secured housing are preferred. Aftercare programmes may also include sheltered housing and sheltered work programmes. Sheltered housing provides temporary accommodation to clients and it serves as a means for social stabilisation. Sheltered work programmes aim to improve the work skills of clients, and they can help the clients receive requalification, reinforce their work habits, and possibly even find a job from an external employer. The number of aftercare centres has been increasing and they have been established in all regions with the exception of the Zlín region – see Map 9-1.

*Map 9-1: Aftercare facilities for drug users in the Czech Republic in July 2006 (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g)*




Twenty facilities subsidised from the General Cash Administration budget chapter provided aftercare in 2005; nine of them provided outpatient and intensive aftercare, six provided intensive aftercare only, and five provided outpatient aftercare only. Twelve facilities offered their clients sheltered housing and four offered work in sheltered programmes. Altogether, 865 clients (562 males, 303 females) used the services. 617 (71%) of them had a history of injecting drug use; 458 (53%) used pervitin and 201 (23%) used opiates (heroin or buprenorphine). The total volume of sheltered housing provided was 118 beds and this capacity was used by 244 clients. 59 clients worked in sheltered shops (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g).

Fourteen facilities supplied outpatient aftercare to 339 clients (212 males, 127 females). The average age of the clients was 27.2. Altogether, 218 (64%) clients had a history of injecting drug use. 182 (54%) used to use pervitin and 50 (15%) used to use opiates (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g).

Fifteen facilities with a total capacity of 385 places supplied intensive aftercare to 526 clients (350 males, 176 females). The average age of the clients was 26.4. Altogether, 399 (76%) clients used to inject drugs. 276 (53%) used to use pervitin and 143 (27%) used to use opiates. The average length of the programme was just under five months per client. Altogether, 117 (22%) clients successfully completed the programme, 113 (21%) ended the

treatment prematurely, and 60 (11%) were expelled from the programme (Národní monitorovací středisko pro drogy a drogové závislosti, 2006g).

Besides the above-mentioned facilities, other inpatient or outpatient treatment facilities can also provide aftercare services; however, it is difficult to identify how many of them there are and which types of services they provide.

The groups Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) work on the principle of self-help. There were 29 AA groups in 18 towns in the Czech Republic in 2005 (Anonymní alkoholici, 2005).

## 9.2 Prevention of Drug-Related Crime

### 9.2.1 Assistance to Drug Users in Prisons

In comparison with 2004, the number of persons requiring detoxification increased by 70% in 2005; detoxification was carried out for 172 persons, 90 of whom were detoxified with Subutex. The detoxification is carried out in the medical department of the Prague-Pankrác prison hospital.

Drug prevention counselling offices have been established in all 35 prisons and they provide individual and group therapy to addicted drug users.

The number of drug-free zones in prisons increased from 30 to 34 in 2005, and their capacity increased from 1,440 to 1,606 beds. 2,859 inmates served their sentences in drug-free zones in 2005 (331 more than in 2004). A specific regime for the serving of a sentence is used in the drug-free zones and it aims to prevent the inmates from having any contact with drugs. Therapy is not included in the programme of drug-free zones.

Drug-using inmates who decide to undergo treatment may be placed in specialised prison departments which focus on drug users. Specialised departments for the differentiated serving of sentence operate in six prisons (Bělušice, Nové Sedlo, Ostrov, Pilsen, Příbram, and Všehrdy) and their total capacity in 2005 was 286 beds, i.e. 6 beds less than in 2004. 523 inmates, i.e. 34 more than in 2004, were serving their sentences in the departments in 2005. The second type of specialised prison departments for drug users involves inpatient compulsory treatment; this treatment is provided in three prisons (Opava, Rýnovice, and Znojmo), and the total capacity in 2005 was 105 beds, i.e. 32 beds more than in 2004. 184 inmates, i.e. 62 more than in 2004, were treated in these departments in 2005 (Řeháček, 2006).

The Prison Service of the Czech Republic launched a pilot substitution treatment project in two prisons (Prague-Pankrác and Příbram) in April 2005. The total capacity is 40 beds and it can be increased if necessary. The Czech Medical Association of J. E. Purkyně – Association for Addictive Diseases and other experts were involved in preparing the project. The pilot phase of the project is designed especially for those entering prison who are already patients receiving this type of treatment before they were sentenced or for those who can be expected to continue the treatment after they are released from prison. Methadone is used as the substitution preparation; in exceptional cases and when recommended by an attending physician, Subutex can also be administered (Zábranský, 2006).

NGOs associated in the Section of Drug Services in Prison of the Association of Non-Governmental Organisations Dealing with Prevention and Treatment of Drug Addiction [34] continued to develop their services for drug-using inmates in 2005. The number of inmates to whom the organisations provided services in 15 prisons increased to 610 in 2005 (from 450 in 2004). There were 2,783 contacts with inmates (counselling). The frequency of these contacts varied from one-off meetings to periodical weekly contact. The NGOs held 60 educational seminars of a preventive nature for 706 inmates and supplied training to 170 employees of the Prison Service.

The Section of Drug Services in Prisons guaranteed the professional training programme ‘Client in Conflict with the Law’. The Institute for Education in the Field of Drug Addictions (I.E.S.) of the Podane Ruce NGO carried out the training in 2005 in collaboration with the Institute for Education of the Prison Service of the Czech Republic. It involved 125 lessons in the field of criminal law which were designed for staff members of the NGOs which provide services to drug-using inmates in prisons. The section also participated in the preparation and implementation of the course ‘Substitution Treatment in Prisons’, which the Institute for Post-Graduate Education in Medicine ran for employees of the Prison Service of the Czech Republic (Škvařilová, 2006).

[34] By the end of 2005, the following non-governmental organisations were involved: Podane ruce civic association (Brno and Olomouc), Agentura Walhalla Olomouc, the SANANIM Prague civic association, the LAXUS Hradec Králové civic association, the CPPT Pilsen public service company, the Legal Advice Bureau of the Association of Non-Governmental Organisations in Prague, and the Semiramis Nymburk civic association.

## 10 Drug Markets

The number of drug seizures by law enforcement bodies in 2005 was approximately the same as in 2004. The volume of seizures of hashish and ecstasy decreased and the number of cocaine seizures increased.

The Czech Republic is a country where pervitin (methamphetamine) is produced; it is also illegally exported from the country. An increase in the production of pervitin from freely available medicaments which contain pseudoephedrine occurred in 2005. The bulk of cannabis consumption is also covered from domestic production. The Czech Republic continues to be a target and transit country for other drugs.

Drug prices remain at a stable level; even street drug purity has remained relatively stable, although there are year-on-year differences in the purity of drugs analysed by law enforcement authorities – the differences are caused by including the seizures of large quantities of drugs with a high level of purity before adulteration.

### 10.1 Drug Availability and Supply

No survey or study focusing on the monitoring of drug availability was carried out in the Czech Republic in 2005. In general, it is possible to claim that all the basic types of drugs are readily available in all the large towns of the Czech Republic; availability in small towns and rural areas has been increasing in recent years, according to available information – see, for instance, (Národní protidrogová centrála , 2006a). Marijuana is unambiguously the most commonly available drug and its use is relatively widespread in all regions and social groups. Ecstasy is especially freely available in environments which young people visit for entertainment (dance events or discotheques). The stable availability of the basic types of drugs is also indicated by the stable level of drug prices on the black market for several years now[35].

### 10.2 Drugs Production and Trafficking

The Annual Reports of the National Drug Squad (Národní protidrogová centrála , 2006a) and the General Customs Headquarters (Generální ředitelství cel , 2006b) are the most important sources of information about drug production, trafficking, and distribution on the territory of the Czech Republic.

The number of cases and the quantity of marijuana seized by customs bodies are decreasing, according to the Annual Report of the General Customs Headquarters. There were 54 cases of marijuana seizures during import checks by the Customs Administration, 89 cases in 2003, and 126 cases in 2002[36] (Generální ředitelství cel, 2006a). Marijuana is mostly smuggled into the Czech Republic from the Netherlands. According to to the General Customs Headquarters, the vast majority of the demand for this drug is covered by domestic production; hydroponic marijuana growing has expanded at the same time.

According to information from the branch office of the National Drug Squad in Hradec Králové (which covers the Hradec Králové and Pardubice regions), a large quantity of small marijuana growing rooms was recorded in 2005. However, most of them served for marijuana growing for personal use. Nevertheless, the number of marijuana growing rooms detected in the Czech Republic decreased from 14 in 2004 to 11 in 2005 (Národní protidrogová centrála , 2006a).

Hashish production has not been recorded in the Czech Republic. Hashish is imported in small consignments, especially from the Netherlands, and, to a smaller extent, also from India or Spain. The General Customs Headquarters reported 53 cases of hashish seizures with a total volume of 696 g (15.7 g on the average, and the median is 4.4 g).

Pervitin (metamphetamine) is a traditional stimulant drug in the Czech Republic, and it comes exclusively from domestic production. The number of pervitin laboratories detected in 2005 increased to 261, compared to 248 in 2004 and 188 in 2003. The proportion of pervitin seized that was produced from medicaments which contain pseudoephedrine has been increasing in recent years. The Annual Report of the National Drug Squad mentions that approximately 90% of the cases of pervitin production examined involve pseudoephedrine from freely available medicaments as the source raw material.[37] However, most of the cases involved the production of small quantities. When ephedrine is used as the source raw material, large quantities (dozens of grams or several kilograms) are usually produced and the pervitin produced is then of higher purity. The ephedrine used for pervitin production is usually imported into the Czech Republic, most commonly from the countries of the former Yugoslavia and Germany. Organised groups from the former Yugoslavia not only provide for ephedrine transportation, they also organise pervitin production and distribution in the Czech Republic[38] (Národní protidrogová centrála , 2006a).

According to the reports of the National Drug Squad and the Customs Administration, the number of cases of pervitin exports, especially to Germany, is increasing. They usually involve pervitin with a high level of purity made

[35] However, as average wages are increasing, it is rather possible to argue that the real prices of the basic types of drugs have been decreasing in recent years.
[36] No data for the year 2004 are available.
[37] Neither the volume of pervitin made from medicaments nor its proportion in the total volume of pervitin produced is known.
[38] It was, for instance, recorded by a branch office of the National Drug Squad in Usti nad Labem.

directly from ephedrine. Illegal export often has links to organised crime. Germany has recorded cases of ephedrine trafficking in volumes of dozens of kilograms and export to the Czech Republic. An organised group which imported ephedrine from Germany to the Czech Republic and produced pervitin there was arrested. A large part of the pervitin produced was reexported for distribution to German drug users.

Ecstasy is imported into the Czech Republic, most commonly in small consignments in buses from the Netherlands, Belgium, or Poland. Ecstasy production in the Czech Republic has not been recorded. Two cases of seizures of tablets which contained mCPP (1,3-chlorphenylpiperazine) were reported in 2005; the seizures were reported in the Early Warning System on new psychoactive substances.[39]

Cocaine use still has a low prevalence in the Czech Republic and it is mostly imported from Western Europe (the Netherlands or Germany), and sporadically directly from South America. Crack has not yet been seized in the Czech Republic.

Heroin is mostly smuggled into the Czech Republic via the so-called Balkan route. Some information is available that it is also transported via the so-called silk route from Afghanistan via post-Soviet countries and Poland and then to Central and Western Europe. This route has a marginal role in the imports to the Czech Republic. Most heroin consignments found in the Czech Republic are on their way to Western Europe; a small part of them stays in the domestic market.

The National Drug Squad recorded a further increase in the illegal distribution of Subutex, a substance which is used for substitution therapy for opiates addiction – see the chapter on Substitution and Maintenance Programmes, page 36.

### 10.3 Drug Seizures

A slight decline in the number of cannabis seizures (i.e. seizures of marijuana and/or hashish) occurred in 2005. However, cannabis continues to be the most commonly seized type of drug – see Table 10-1, Figure 10-1 and Figure 10-2. A slight decline in the number of seizures and a marked decline in the quantity of hashish seized confirm that there is a trend for this drug to be imported in small volumes – see the chapter on Drugs Production and Trafficking, page 66. The number and volume of pervitin seizures has remained stable in the last three years. A considerable increase in cocaine-related crime was not associated with any corresponding increase in cocaine seizures; the figure is only slightly higher than in the last year and it is only a half of that in 2003. The number of ecstasy seizures continues to be low in comparison with the high prevalence of ecstasy use.

As far as other illicitly possessed psychoactive substances are concerned, 145 grams of magic mushrooms, 287 Subutex tablets, and 500 ml of GHB were, for instance, seized in 2005. At the same time, 27.3 kg of illicitly possessed ephedrine, a precursor for pervitin production, was also seized (Národní protidrogová centrála , 2006a).

*Table 10-1: Numbers and volumes of seizures of main types of drugs in 2002–2005 (Národní protidrogová centrála, 2006c)*

| Drug type | Units (volume) | 2002 | | 2003 | | 2004 | | 2005 | |
|---|---|---|---|---|---|---|---|---|---|
| | | Number | Volume | Number | Volume | Number | Volume | Number | Volume |
| Marijuana | kg | 293 | 100.7 | 465 | 77.82 | 423 | 168.53 | 397 | 103.34 |
| Hashish | kg | 58 | 11.4 | 96 | 64.81 | 149 | 22.69 | 116 | 4.63 |
| Cannabis plants | piece | 93 | 3,173 | 117 | 3,125 | 46 | 1,617 | 46 | 1,780 |
| Heroin | kg | 55 | 34.34 | 54 | 9.14 | 42 | 35.90 | 69 | 36.34 |
| Cocaine | kg | 12 | 6.04 | 20 | 2.62 | 7 | 3.28 | 11 | 10.20 |
| Pervitin | kg | 304 | 4.30 | 193 | 9.63 | 201 | 3.42 | 209 | 5.31 |
| Ecstasy | tablets | 42 | 88,391 | 31 | 51,692 | 39 | 108,379 | 32 | 19,010 |
| LSD | doses | 3 | 107 | 3 | 65 | 3 | 326 | 4 | 3,067 |

[39] The Early Warning System in the EU works on the basis of Council Decision 2005/387/JHA of 10 May 2005 on the information exchange, risk assessment and control of new psychoactive substances.

*Figure 10-1: Proportions of seizures of individual drugs in 2005 (Národní protidrogová centrála, 2006c))*

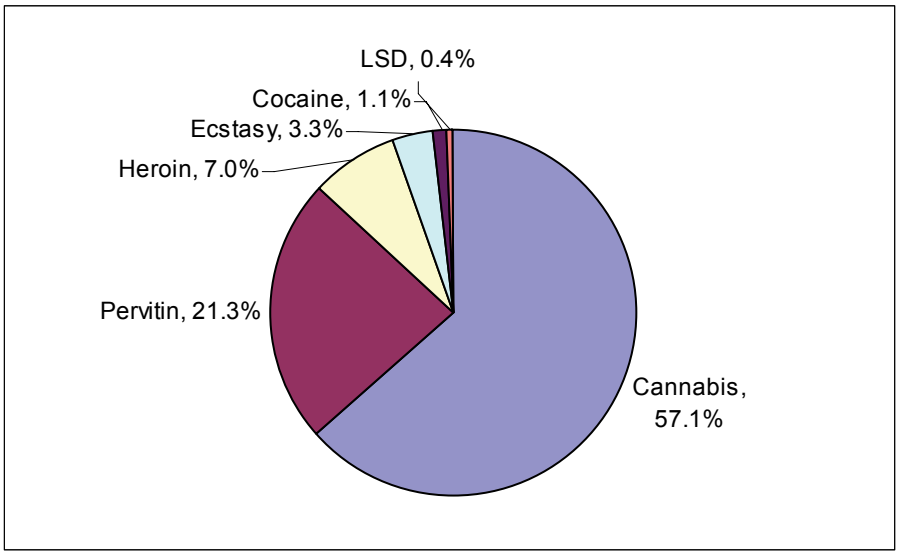
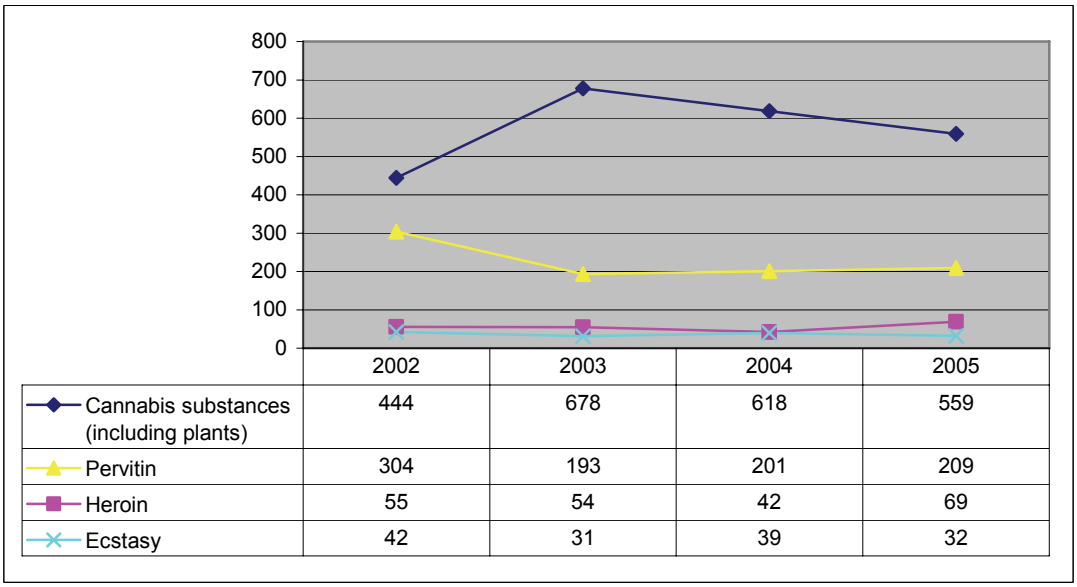


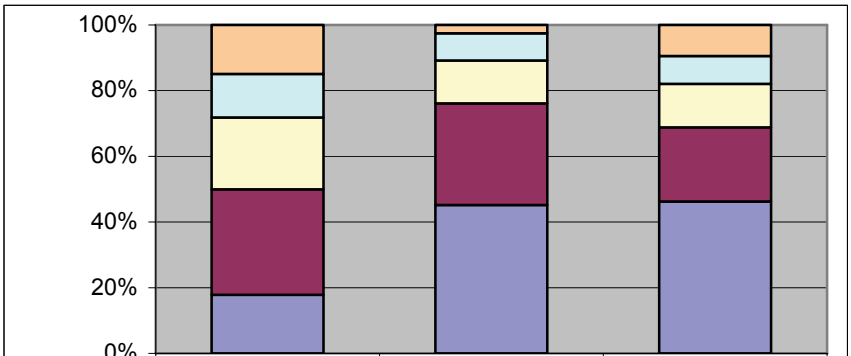

*Figure 10-2: Number of seizures of selected types of drugs in 2002–2005 (Národní protidrogová centrála, 2006c)*




| | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|
| Cannabis substances (including plants) | 444 | 678 | 618 | 559 |
| Pervitin | 304 | 193 | 201 | 209 |
| Heroin | 55 | 54 | 42 | 69 |
| Ecstasy | 42 | 31 | 39 | 32 |

The National Drug Squad has been providing a classification of seizures of the main types of drugs by volume since 2003. Pervitin and heroin seizures of quantities under one gram represent 45% and 46% respectively of the cases, and quantities up to five grams represent 76% and 69% respectively of the cases – see Figure 10-3 (Národní protidrogová centrála, 2006b).

*Figure 10-3: Distribution of seizures of selected types of drugs by volume in 2005 (Národní protidrogová centrála, 2006b)*




| | Cannabis | Pervitin | Heroin |
|---|---|---|---|
| > 100 g | 15% | 3% | 9% |
| 20-100 g | 13% | 8% | 8% |
| 5-20 g | 22% | 13% | 13% |
| 1-5 g | 32% | 31% | 23% |
| < 1g | 18% | 45% | 46% |

## 10.4 Drug Prices and Drug Purity

### 10.4.1 Drug Prices

The National Drug Squad is responsible for the collection of data on drug prices.[40] Average drug prices in 2005 remained on approximately the same level as in the previous year – see Table 10-2. It is hard to make a long-term comparison because data on drug prices were acquired in a different manner in the previous years.

*Table 10-2: Average drug prices in 2004 and 2005 (€) (Národní protidrogová centrála, 2006c)*

| Drug | 2004 | 2005 |
|---|---|---|
| Ecstasy (tbl) | 7.70 | 7.00 |
| Hashish (g) | 9.40 | 8.20 |
| Heroin (g) | 35.30 | 36.60 |
| Cocaine (g) | 77.20 | 75.90 |
| LSD (dose) | 5.70 | 6.00 |
| Marijuana (g) | 5.70 | 5.70 |
| Methamphetamine (g) | 36.90 | 34.30 |
| Subutex (8mg tbl) | 9.20 | 12.60 |

*Note: Figures for 2004 were re-calculated by the 2005 exchange rate (1 € = CZK 29,784).*

The text part of the Annual Report of the National Drug Squad contains some other information on drug prices which were recorded in individual regions of the Czech Republic or during specific police actions, e.g.:

- Pervitin prices in the Czech Republic vary according to quality and the quantity taken, from CZK 600–1,200 (€ 20 to € 40) per gram, while the same drug (sold as Crystal) sells for approximately € 65 per gram (National Drug Squad branch office in Ústí nad Labem).
- The price of imported ephedrine was around € 3,500 per kilogram. Approximately 800 g of pervitin can be made from this quantity of ephedrine. The price of pervitin made from this substance would then be around € 25,000 per kilogram (National Drug Squad branch office in Ústí nad Labem).
- The importing of ephedrine from former Yugoslavian countries was reported. The purchasing price in the former Yugoslavia was approximately € 2,000 per kilogram and it was sold for approximately € 6,000–7,000 per kilogram (National Drug Squad branch office in Ostrava).
- An ecstasy tablet costs CZK 45 to 80 (€ 1.50 to € 2,70) in large deliveries, and CZK 120 to 200 (€ 4.00 to € 6.70) when individual tablets are sold (National Drug Squad branch office in Hradec Králové).
- The quality of distributed heroin is often low, around 10%; in such cases, the price is usually CZK 800 to 1,000 (€ 27 to € 34) per gram (National Drug Squad branch office in Ostrava).

[40] The National Drug Squad receives data on drug prices from district headquarters of the Police of the Czech Republic. 62 district police headquarters provided data on drug prices in 2005. Only minimum and maximum prices are reported, and so it is only possible to calculate average minimum and maximum prices in individual regions or in the entire Czech Republic. Other possibilities involve averaging all price ranges repoted by each district (for instance, when the minimum price per gram of hashish is € 6.70 and the maximum price is € 11.80, € 9.25 is considered as the average price) and then calculating national or regional averages from the values. This is exactly the method by which the National Drug Squad obtains the values which it reports as the average prices of drugs in the Czech Republic in its annual report or in reports to international organisations.

- The price of cocaine varies from CZK 1,600 to 2,500 (€ 54 to 84) per gram; imported cocaine costs € 35 per gram (National Drug Squad branch office in Brno).

### 10.4.2 Drug Purity

The National Drug Squad obtains data on the purity of seized and analysed drugs from the Institute of Criminology in Prague and from reports from individual units of the Criminal Police and Investigation Service.

The Institute of Criminology in Prague provides a list of analyses which were carried out during the year, and so it makes it possible to track time trends. Data on the purity of drugs which were analysed by the Institute of Criminology in Prague during the last two years are included in Table 10-3; despite the year-on-year differences mentioned in the table, drug purity has remained relatively stable during the last two years.

*Table 10-3: Drug purity in 2004 and 2005 (Národní protidrogová centrála, 2006c)*

| Drug | 2004 | | | | | 2005 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Sample size | Min. | Max. | Average | Modus | Sample size | Min. | Max. | Average | Modus |
| Hashish | n.a. | 5.4 | 20 | 10 | n.a. | 10 | 4 | 17.3 | 7.4 | 10 |
| Marijuana | n.a. | 0.4 | 18 | 3 | n.a. | 108 | 0.1 | 20.6 | 3.8 | 1.6 |
| Heroin | n.a. | 0.8 | 26.9 | 12 | n.a. | 19 | 4.7 | 89 | 41.5 | 17 |
| Cocaine | n.a. | 21.7 | 88 | 65 | n.a. | 25 | 12.1 | 99.8 | 55.9 | 54 |
| Pervitin | n.a. | 23.3 | 80 | 50 | n.a. | 65 | 3.4 | 86 | 62.9 | 66 |

## PART B: SPECIAL CHAPTERS

Three special chapters are included in the Annual Report every year. The EMCDDA assigns the topics in collaboration with focal points in individual countries of the Reitox network with regard to their topicality and research needs.

# 11 Drug Use and Related Problems among Very Young People (Under 15 Years)

It has often been discussed in recent years that substance use – and its onset in particular – is occurring among very young age groups and drug use among children aged under 15 is becoming a problem. School surveys show that smoking and, especially, alcohol drinking are relatively common among Czech children. This is related to a high degree of social tolerance towards alcohol drinking and its high availability. Approximately a third of those aged 15 reported experiences with the use of illicit drugs, mostly with cannabis; however, it also applies to approximately 13–14% of children aged 13 and as many as 2–3% of children aged 11. Inhalants are the second most commonly used illicit drug among children. It is alarming that as many as half of the children who have tried a drug would like to use it again, and more than 10% of the children who have never used a drug would like to try one.

The number of children aged under 15 who have been in treatment is very low – AT clinics register approximately 100 children every year. Every year, approximately 120 children are hospitalised in relation to illicit drug use. Most of the hospitalisations of patients aged 14–15 were due to polydrug use and cannabis use, while inhalants were the most common cause of hospitalisation among younger children. The use of inhalants, as well as the use of psychoactive medicines among children, must not be underestimated – one or two deaths in relation to the use of inhalants occur every year.

There is a limited number of specialised treatment facilities for children aged under 15; they are poorly interlinked and the poor indication of children for treatment has also appeared to be problematic. The course and the success of the treatment are then also complicated by the fact that the treatment of children aged under 15 is not voluntary.

Nearly 100 cases of drug-related crime committed by children aged under 15 have been recorded every year; however, the prosecution is usually suspended because of their low age. The cases most commonly involve the unauthorised production of narcotic and psychotropic substances (Section 187), mostly cannabis.

## 11.1 Extent of Drug Use among Children Aged Under 15

The most recent national representative survey which targeted substance use among school pupils aged under 15 was carried out within the framework of the HBSC (Health Behaviour in School-aged Children) international survey. It focused on the health and lifestyles of children aged 11, 13, and 15; the questions regarding the use of illicit drugs were only included in the questionnaires for pupils aged 15 (in the 9$^{th}$ grade of basic schools).

29.7% of students aged 15 (28.6% of boys and 30.6% of girls) were regular smokers in 2002, i.e. they smoked at least once a week. They consumed an average of 33.6 cigarettes per person per week (Csémy et al. 2005). 9% of the respondents were heavy smokers (more than 40 cigarettes per week). 2% of those aged 11 (3% of boys and 1% of girls) and 11.1% of those aged 13 (13.8% of boys and 8.6% of girls) were regular smokers.

Besides their first experiences with smoking cigarettes, children aged 11 also get their first experiences with alcohol. 9% of boys and 4% of girls aged 11 and 21% of boys and 8% of girls aged 13 were regular beer drinkers, i.e. they drank beer at least once a week. Among those aged 15, 36.9% of boys and 23.1% of girls regularly drink beer, 10.9% of boys and 12.1% of girls drink wine and approximately 9% of the respondents drink spirits and mixed drinks (Csémy et al. 2005). 44.4% of those aged 15 reported drinking excessive amounts of alcohol, i.e. five or more glasses of alcohol, on one occasion at least once within the last 30 days, and 16.2% of the respondents (19.0% of boys and 13.5% of girls) three or more times within the last month.

31.0% of those aged 15 mentioned that they have tried an illicit drug in their lifetime, mostly marijuana (34.6% of boys and 26.7% of girls). Next, ecstasy (4.2% of respondents) and LSD (3.0%) were reported most commonly, and approximately 1–2% of respondents reported experiences with opiates and amphetamines – see Table 11-1. A high prevalence of the use of inhalants (7.3%) and the use of medicines with a sedative effect without a prescription (7.0%) is alarming. Similarly, the last-year prevalence of the use of the substances monitored is also high, and so it is possible to say that a considerable proportion of the experiences with drugs occurred exactly during the last year.

*Table 11-1: Lifetime and last-year prevalence of substance use among children aged 15 in the HBSC 2002 survey (%) (Csémy et al. 2005)*

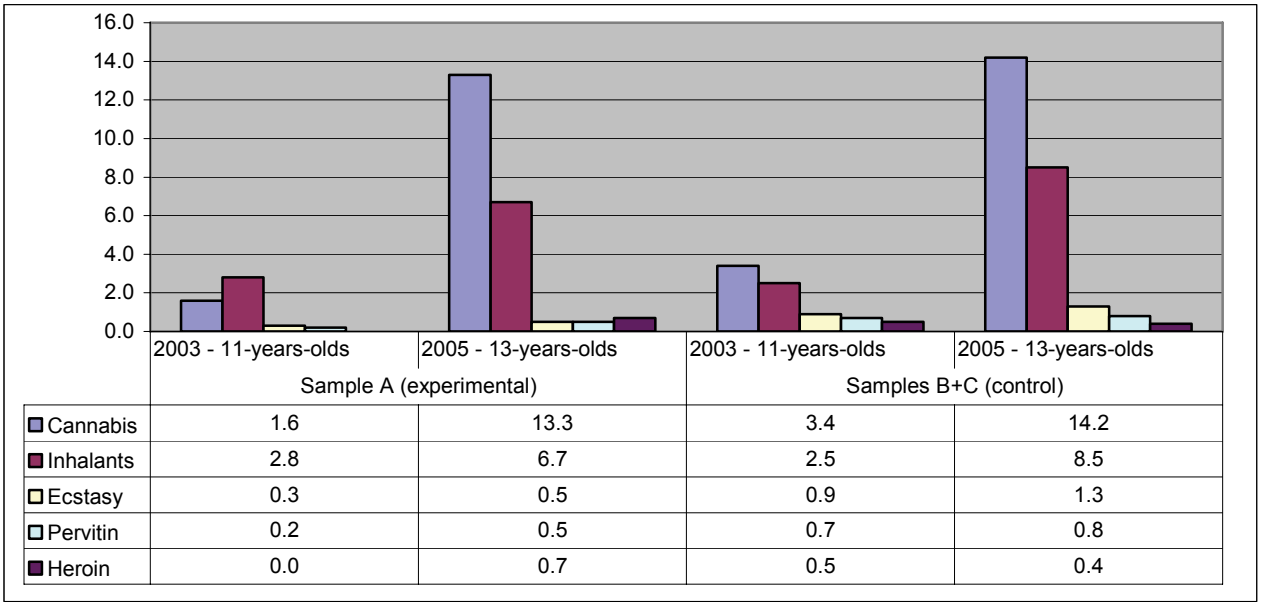
| Drug | Lifetime prevalence | | | Last-year prevalence | | |
|---|---|---|---|---|---|---|
| | Total | Boys | Girls | Total | Boys | Girls |
| Any illicit drug | 31.0 | 35.3 | 27.0 | 27.4 | 31.4 | 23.6 |
| Cannabis | 30.5 | 34.6 | 26.7 | 26.9 | 30.9 | 23.2 |
| Inhalants | 7.3 | 8.2 | 6.4 | 3.9 | 4.9 | 3.0 |
| Hypnotics and sedatives | 7.0 | 5.9 | 7.9 | 4.4 | 3.4 | 5.4 |
| Ecstasy | 4.5 | 5.0 | 4.2 | 3.2 | 3.0 | 3.3 |
| LSD | 3.0 | 3.7 | 2.5 | 2.1 | 2.2 | 2.0 |
| Amphetamines | 2.0 | 1.8 | 2.1 | 1.3 | 0.9 | 1.7 |
| Opiates | 1.2 | 1.7 | 0.7 | 1.0 | 1.3 | 0.7 |

The above-mentioned frequency of illicit drug use in the last year shows that 14.7% of boys (11.3% of girls) are experimental cannabis users (i.e. they have used cannabis once or twice). 12.9% of boys (9.5% of girls) belong in the category of recreational users (they have used it 3–39 times in the last year). 3.3% of boys (2.4% of girls) belong in the category of regular users (they have used cannabis 40 or more times during the last year). Experimental use prevails markedly as far as other illicit drugs are concerned; less than 1% of the respondents are recreational or even regular users (Csémy et al. 2005).

Data on young pupils were acquired within the framework of the Project on Evaluation of Primary Prevention Community Programme. It is a five-year project which targets especially the evaluation of the quality and efficiency of a preventive programme implemented by NGO Prev-Centrum in 25 basic schools in Prague 6. The situation among pupils aged 11 (in the 5th grade) was mapped in 2003, with a follow-up in 2005, i.e. when they were 13 years old (and in the 7th grade). Two groups of pupils were monitored within the project – an experimental sample of classes which participate in the preventive programme of the Prev-Centrum (Sample A, 619 pupils) and two control groups of classes which do not participate in the programme (Samples B and C, 559 pupils) (Miovský et al. 2004).

The prevalence of illicit drug use among those aged 11 was very low in 2003; cannabis was the most commonly reported illicit drug used (1.6% of respondents from the experimental sample and 3.4% of respondents from the control sample). Ecstasy and pervitin were the second most commonly reported drugs (nearly 1% of pupils in the control sample); the prevalence in the experimental sample was approaching zero. The prevalence of experiences with inhalants is high (2–3%); in the experimental sample, the prevalence of the use of inhalants was even higher than the prevalence of cannabis use (Figure 11-1).

*Figure 11-1: Lifetime prevalence of experiences with illicit drugs among those aged 11 and 13 (%) (Miovská, 2006)*




| | 2003 - 11-years-olds | 2005 - 13-years-olds | 2003 - 11-years-olds | 2005 - 13-years-olds |
|---|---|---|---|---|
| | Sample A (experimental) | | Samples B+C (control) | |
| Cannabis | 1.6 | 13.3 | 3.4 | 14.2 |
| Inhalants | 2.8 | 6.7 | 2.5 | 8.5 |
| Ecstasy | 0.3 | 0.5 | 0.9 | 1.3 |
| Pervitin | 0.2 | 0.5 | 0.7 | 0.8 |
| Heroin | 0.0 | 0.7 | 0.5 | 0.4 |

Data on pupils aged 13 show significantly higher prevalence of cannabis – 13–14% of respondents have tried marijuana or hashish at least once in their lifetime. Ecstasy continued to be the second favourite drug in the control sample (1.3% of respondents); however, heroin prevailed over ecstasy in the experimental sample (0.7%). The prevalence of the use of inhalants also increased considerably. 7–8% of respondents aged 13 have experience with sniffing inhalants (Miovská, 2006).

The 2005 survey of the Regional Hygiene Station of the Liberec region, 'Lifestyles of Children and Young People (Experiences and Attitudes in the Field of Smoking, Alcohol, and Drugs)' also provided comparable results at a regional level. It involved 1,430 pupils of the 8th grade of basic schools (aged 13–14). 76.2% of children of this age have experience with smoking, 23.9% are currently smokers (20.8% of boys and 26.7% of girls). 95.7% of respondents have tried alcohol, 6.4% of the children drink alcohol at least once a week (7.7% of boys and 5.2% of girls), and 9.5% of the respondents reported drunkenness in the last month (KHS Libereckého kraje, 2005).

Altogether, 31.2% of the children had been offered an illicit drug, 15.7% of the respondents (17.5% of boys and 14.4% of girls) have tried one at least once. 4.5% of the children reported repeated use, most commonly the use of cannabis. 50.2% of the children who have tried a drug will definitely or probably try it again; 10.8% of those who have not tried a drug would like to try one (KHS Libereckého kraje, 2005).

### 11.2 Treatment and Treatment Demands

84 patients aged under 15 were registered in outpatient AT clinics in 2004; 70 of them (49 boys and 21 girls) were registered in relation to illicit drug use, one in relation to tobacco. Half of all reported cases (36 persons) involved cannabis use, 20 cases involved the use of inhalants, and 10 involved the use of stimulants. The trends show that approximately 60–100 patients have been registered in AT clinics every year since 2000; another 20–50 have been registered every year in relation to the use of licit drugs (see Table 11-2). Similarly, cannabis and inhalants were the most commonly used drugs in the previous years; the significant representation of the users of sedatives and hypnotics in 2003 was an exception (47 cases).

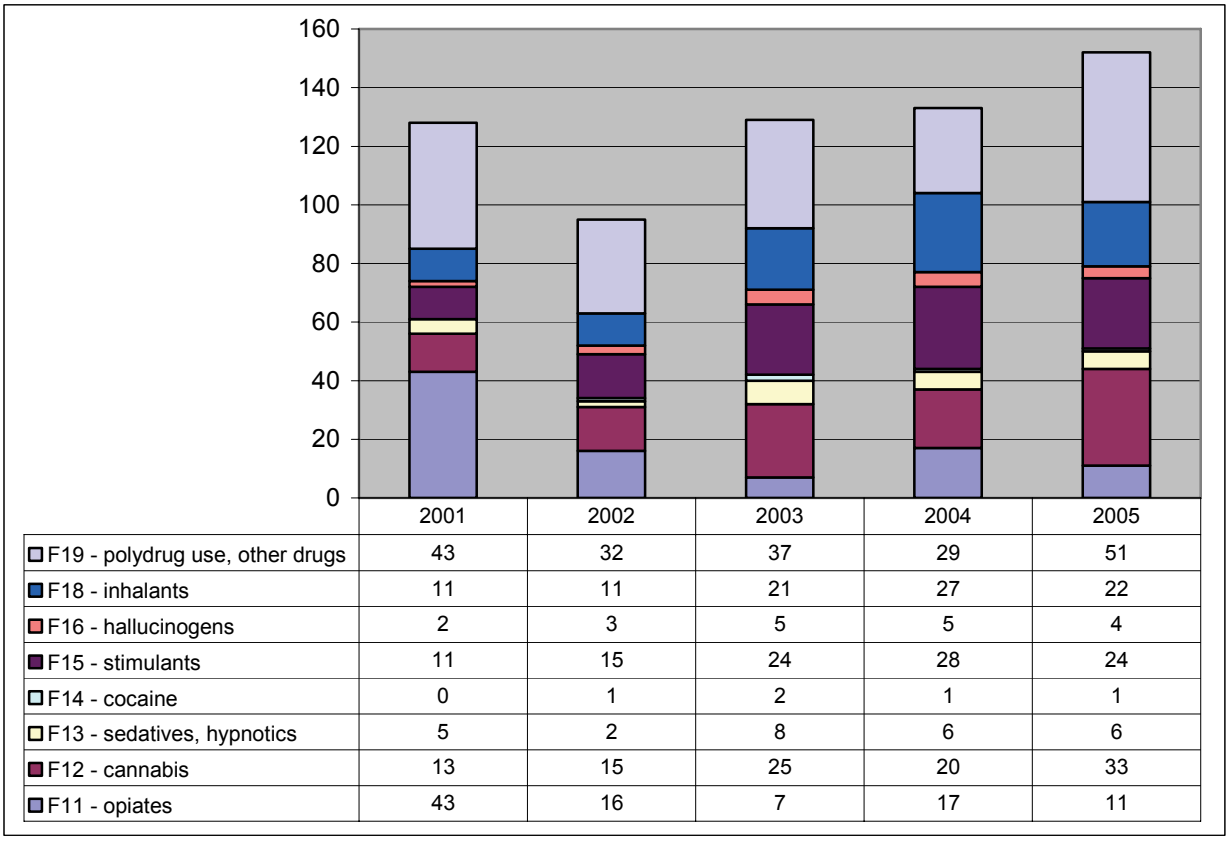
*Table 11-2: Patients aged 0–14 registered in outpatient AT clinics (Ústav zdravotnických informací a statistiky, 2005d)*

| **Diagnosis (ICD-10) – drug** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| F11 – opiates opioids | 1 | 4 | 6 | 1 | 3 |
| F12 – cannabinoids | 32 | 43 | 46 | 45 | 36 |
| F13 – sedatives, hypnotics | 1 | 3 | 1 | 47 | 1 |
| F14 – cocaine | 0 | 0 | 0 | 0 | 0 |
| F15 – stimulants | 6 | 5 | 11 | 2 | 10 |
| F16 – hallucinogens | 1 | 0 | 3 | 1 | 0 |
| F18 – inhalants | 12 | 24 | 14 | 8 | 20 |
| F19 – multiple drug use and other substances | 9 | 12 | 1 | 1 | 0 |
| **Drugs total** | **62** | **91** | **82** | **105** | **70** |
| F17 – tobacco | 30 | 22 | 4 | 17 | 1 |
| F10 – alcohol | 7 | 31 | 15 | 8 | 13 |
| **Psychoactive substances total** | **99** | **144** | **101** | **130** | **84** |

Outpatient psychiatric facilities reported 95,098 examinations of persons aged under 15 in 2004; 84 of the examinations were due to the use of illicit drugs (diagnoses F11–F16 and F18–F19 according to ICD-10), and 18 examinations were due to the use of alcohol (F10) (Ústav zdravotnických informací a statistiky, 2005d).

152 children aged 10–15 were hospitalised for behavioural disorders related to drug use in 2005; 78 of them were boys and 74 were girls. A third of them (51 persons) were hospitalised as in relation to multiple drug use and the use of other psychoactive substances (F19), 33 in relation to the use of cannabis, 24 in relation to the use of stimulants, and 22 in relation to the use of inhalants (Figure 11-2). The number of hospitalised patients aged under 15 has been increasing continually since 2002, from 95 in 2002 to 152 in 2005. The structure of the drugs used remains approximately the same; hospitalisations related to the use of opiates (F11) and the use of inhalants (F18) were reported more commonly in 2004 than hospitalisations related to the use of cannabis (F12) and multiple drug use and the use of other psychoactive substances (F19).

*Figure 11-2: Patients aged 11–15 hospitalised for behavioural disorders resulting from drug use (Ústav zdravotnických informací a statistiky, 2006a)*




| | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|
| F19 - polydrug use, other drugs | 43 | 32 | 37 | 29 | 51 |
| F18 - inhalants | 11 | 11 | 21 | 27 | 22 |
| F16 - hallucinogens | 2 | 3 | 5 | 5 | 4 |
| F15 - stimulants | 11 | 15 | 24 | 28 | 24 |
| F14 - cocaine | 0 | 1 | 2 | 1 | 1 |
| F13 - sedatives, hypnotics | 5 | 2 | 8 | 6 | 6 |
| F12 - cannabis | 13 | 15 | 25 | 20 | 33 |
| F11 - opiates | 43 | 16 | 7 | 17 | 11 |

Table 11-3 shows the structure of the hospitalised children by age and diagnoses. 82 of the 152 children were aged 15, 55 were aged 14, and 10 were aged 13; one patient aged 12 and four patients aged 11 were also reported. The use of cannabis, stimulants, and drug combinations prevails in the group of those aged 14–15, while the use of inhalants is the most common reason for hospitalisation among the youngest age groups (aged 11–13) (Ústav zdravotnických informací a statistiky, 2006a).

*Table 11-3: Hospitalised patients aged 11–15 in 2005 by age and diagnoses (Ústav zdravotnických informací a statistiky, 2006a)*

| Age/diagnosis | F11 | F12 | F13 | F14 | F15 | F16 | F18 | F19 | Total |
|---|---|---|---|---|---|---|---|---|---|
| 11 | 0 | 1 | 0 | 0 | 1 | 0 | 2 | 0 | 4 |
| 12 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| 13 | 0 | 1 | 2 | 0 | 0 | 0 | 5 | 2 | 10 |
| 14 | 7 | 12 | 2 | 0 | 5 | 1 | 9 | 19 | 55 |
| 15 | 4 | 19 | 2 | 1 | 18 | 3 | 5 | 30 | 82 |
| **Total** | **11** | **33** | **6** | **1** | **24** | **4** | **22** | **51** | **152** |

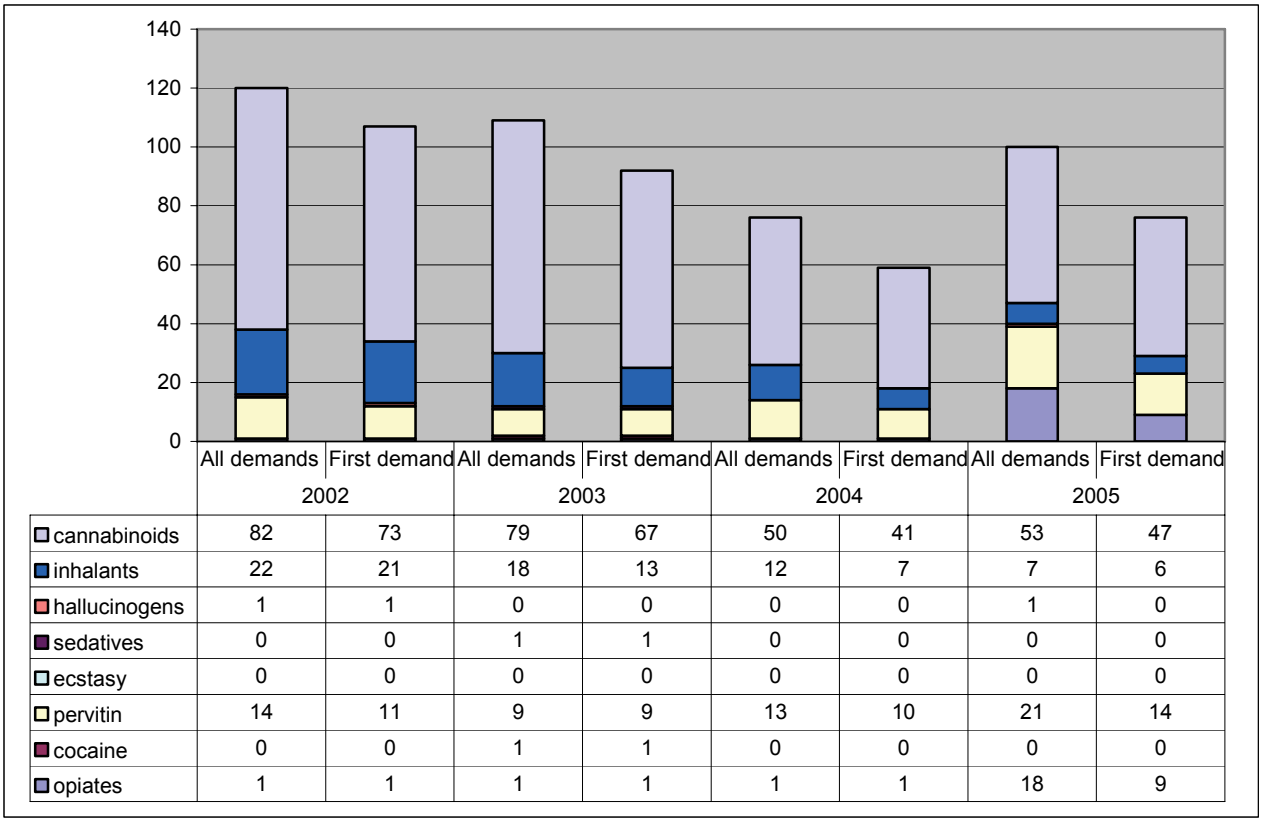
*Note: Diagnoses F11–F19 – see Table 11-2 a Figure 11-2.*

According to the data of the Prague Hygiene Service, 100 children aged under 15 (67 boys and 33 girls) sought treatment in 2005. It corresponds to approximately 1% of treatment demands in 2005 (Polanecký et al. 2006). More than half of them (53 persons) sought treatment in relation to cannabis use, 21 in relation to pervitin, and 18 in relation to the use of opiates; in total there were 37 injecting drug users. 76 persons (53 boys and 23 girls) sought treatment for the first time; 47 of them reported cannabis as their primary drug, 14 reported pervitin, and 9 reported opiates in this context – see Figure 11-3. In contrast to the prevalence of use, the number of patients in AT clinics, and the number of those hospitalised, users of inhalants are very rare among treatment demands – 7 out of all treatment demands and 6 out of first treatment demands were reported in 2005.

An obvious decline in the number of reported treatment demands among those aged under 15 occurred between 2002 and 2004. The number of all and first treatment demands decreased from 121 to 77 persons and from 108 to 59 persons respectively. It rose again in 2005. The increase in the number of treatment demands is especially apparent in relation to the use of opiates and pervitin (the number of injecting drug users increased from 7 in 2004 to 37 in 2005). The cause of this increase is uncertain. [41]

[41] Recent data show that the number of opiates users aged under 15 is again at a nearly zero level in 2006.

*Figure 11-3: Development in the number of all and first treatment demands among those aged under 15 (Polanecký et al. 2006)*




| | All demands | First demand | All demands | First demand | All demands | First demand | All demands | First demand |
|---|---|---|---|---|---|---|---|---|
| | 2002 | | 2003 | | 2004 | | 2005 | |
| cannabinoids | 82 | 73 | 79 | 67 | 50 | 41 | 53 | 47 |
| inhalants | 22 | 21 | 18 | 13 | 12 | 7 | 7 | 6 |
| hallucinogens | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| sedatives | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| ecstasy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| pervitin | 14 | 11 | 9 | 9 | 13 | 10 | 21 | 14 |
| cocaine | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| opiates | 1 | 1 | 1 | 1 | 1 | 1 | 18 | 9 |

A limited number of specialised treatment facilities dealing with the treatment of children aged under 15 operate in the Czech Republic. AT clinics, psychiatric departments in hospitals, and three psychiatric hospitals (for children and young people aged under 18) provide these services. A detoxification centre for children and adolescents started to operate in Prague (at the Sisters of Mercy of St Karel Boromejsky Hospital). Selected educational institutions, especially children's homes with a school, also have departments with an educational-treatment regime which target children at risk of drug addiction and preventive-educational departments (for children aged under 15). The residential department Alternativa in Kostelec nad Labem of the Klíčov Centre for Educational Care works on the basis of voluntariness and with the consent of the legal guardians of the child. It works with children aged 10–15 who are at risk of drugs.

The Centre for Addictology of the Psychiatric Clinic at the 1st Faculty of Medicine of Charles University in Prague drew up an Analysis of Needs and Current State of Addictological Services in Prague for Children Aged Under 15 in 2005. The Prague Magistrate's Office commissioned it. The analysis assessed school facilities and special facilities which work with children aged under 15. The results of the analysis were not available at the time of the drawing up of this report.

The factors which complicate drug treatment for children aged under 15 were identified. Specialised outpatient facilities are not available, individual types of facilities are not sufficiently interlinked, and the wrong indication of children for treatment (especially by social workers) takes place often. The treatment of children aged under 15 is often involuntary, and this negatively influences the course of treatment and its results. The Centre of Research into Drug Services and Public Health (CEPROS) drew up the Manual for Drug Prevention in the Practice of a General Practitioner for Children and Young People in 2004 (Centrum výzkumu protidrogových služeb a veřejného zdravotnictví, 2006). It is hoped that it could contribute to an improvement in the diagnostics of problems with addictive substances among children and consecutive referrals for treatment.

### 11.3 Health Consequences

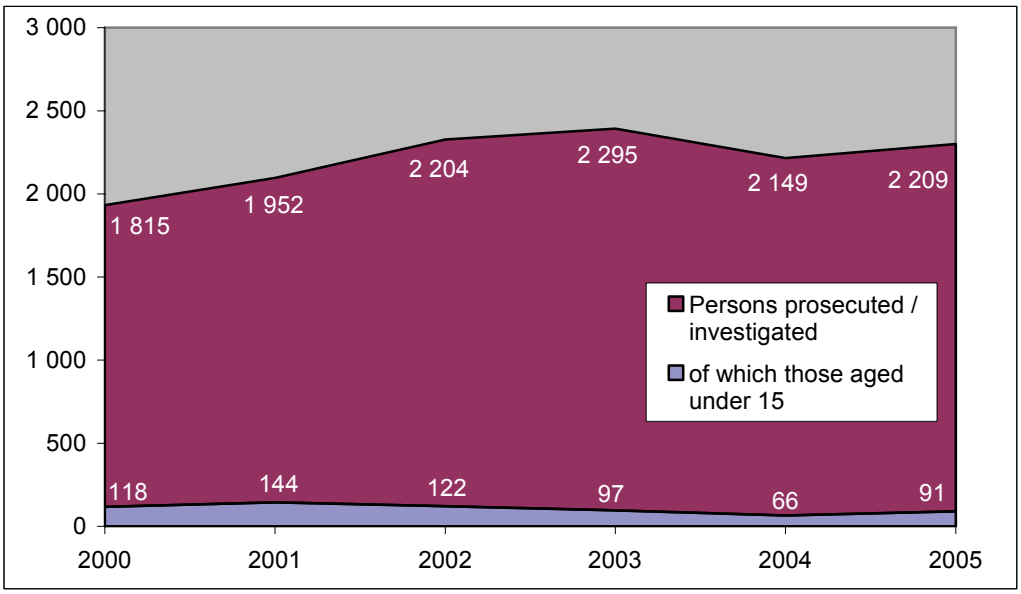
One overdose-related death of a person aged under 15 was recorded in 2005 – a boy aged 12 died as a result of an overdose on an inhalant (butane from a lighter). Altogether, 218 overdoses were recorded in the Czech Republic – see the chapter on Drug-Related Deaths and Mortality of Drug Users, page 40, for more information. Four fatal overdoses have been reported in recent years; two cases involved overdoses on psychoactive medicines in 2003, and there was one case of an overdose on inhalants and one overdose on psychoactive medicines in 2004 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2005).

## 11.4 Drug-Related Crime

According to the data from the Police Statistical System of Criminality, criminal prosecutions were launched against 2,209 persons suspected of drug offences in 2005; 91 (4.1%) of them were children aged under 15. 72 cases involved the unauthorised production and distribution of narcotic and psychotropic substances (Section 187 of the Penal Code), one case involved the unauthorised possession of narcotic and psychotropic substances for personal use (Section 187a), and 18 cases involved offences of the promotion of drug addiction (Section 188a). Children aged under 15 are not criminally liable, and so their prosecution is suspended as a result of the low age of the perpetrators.

Statistics on drug offences in 2000-2005 reported 60–120 offences committed by children every year. The number of perpetrators aged under 15 declined in 2001–2004, but it rose again in 2005. A similar trend occurred in the development of the proportion of persons aged under 15 among all drug offences (Figure 11-4).

*Figure 11-4: Development in the total number of all persons prosecuted and persons aged under 15 prosecuted (Ministerstvo vnitra ČR, 2006)*




A total of 2,6000 persons were accused in 2005; 120 of them were children, and their prosecution was suspended because of the low age (Section 159a paragraph 2, Section 11 paragraph 1 letter d) of the Code of Criminal Procedure). 89 cases involved the unauthorised production and distribution of narcotic and psychotropic substances (Section 187 of the Penal Code), 2 cases concerned the unauthorised possession of narcotic and psychotropic substances for personal use (Section 187a of the Penal Code), and 4 cases involved the production or possession of equipment for the production of narcotic and psychotropic substances (Section 188 of the Penal Code). 25 persons were accused of the promotion of drug addiction (Section 188a of the Penal Code). Cannabis was involved in 20 of the 21 cases which involved children and for which the type of the drug was recorded; one case involved pervitin.

## 11.5 Prevention Focused on At-Risk Groups of Children

As far as specific primary prevention is concerned, the Strategy for the Prevention of Socially Pathological Phenomena Among Children and Young People (Ministerstvo školství, mládeže a tělovýchovy, 2004b) places an emphasis on the prevention of drug use and its further development and it mentions that it is necessary to focus explicitly on target groups of more endangered or at-risk individuals – however, it does not provide a detailed definition of the groups. Accordingly, strategies and activities targeting individual at-risk groups of children and young people have not been formulated.

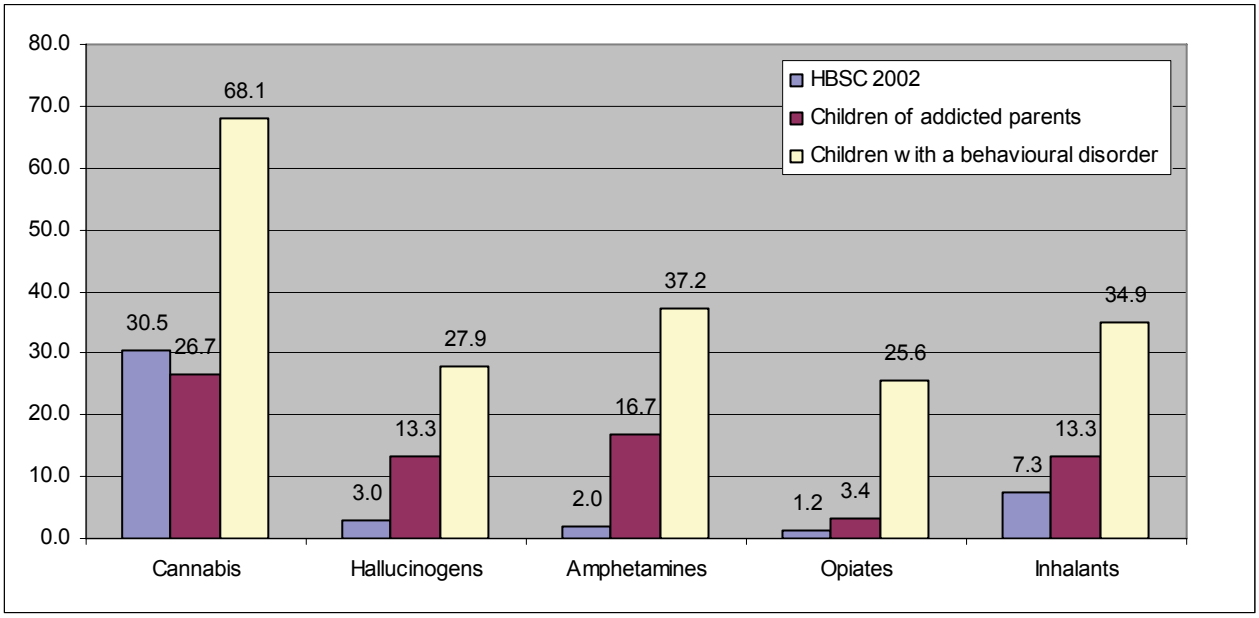
A study which targeted addictive behaviour and its context among groups of children at high risk was carried out in 2003; two groups of children aged 10–15 were monitored within the study: the first group consisted of children from families in which one of the parents had been treated for alcohol addiction, and the second group consisted of children who had been placed in the hands of a health care or educational facility as a consequence of behavioural disorders and who had records of running away from home in their anamnesis. Altogether 75 children participated in the study (the average age was 13.2); 45 of them had a behavioural disorder and 30 children lived with addicted parents (Csémy et al. 2003).

Approximately half of the children with a behavioural disorder who were monitored and a third of the children of addicted parents are regular tobacco smokers; a quarter of the children mentioned frequent alcohol drinking.

A restaurant (29%) or home (25%) was the most common place for alcohol consumption; it indicates a high tolerance of alcohol drinking in society and its availability even for children aged under 15.

Approximately a fourth of the children of addicted parents and two thirds of children with a behavioural disorder have experience with cannabis; the same applies to just under a third of 15-year-old pupils of normal basic schools. Experiences with other illicit drugs are markedly higher in the monitored groups of children than in the randomly selected sample of basic school pupils who were surveyed within the framework of the HBSC study in 2002, even though the respondents of the HBSC study were older. Experiences with hallucinogens, amphetamines, and inhalants were mentioned by 13.3%, 16.7%, and 13.3% respectively of the children of addicted parents and 27.9%, 37.2%, and 34.9% respectively of the children with a behavioural disorder (see Figure 11-5).

*Figure 11-5: Experiences with illicit drugs among children of addicted parents and children with a behavioural disorder in comparison with the results of the HBSC school survey (%) (Csémy et al. 2003; Csémy et al. 2005)*




There are significant differences between the groups with regard to the perception of the risks of the given drug. 53.5% of the children with a behavioural disorder and 76.7% of the children of addicted parents regard smoking cigarettes as risky (medium or high risk). 79.1% of the children with a behavioural disorder and 90% of the children of addicted parents regard drinking alcohol as risky. Both groups perceive marijuana use as less risky than alcohol consumption (58.1% of the children with a behavioural disorder and 83.3% of the children of addicted parents); the use of heroin or other drugs is perceived as very risky (86% of the children with a behavioural disorder and 96.7% of the children of addicted parents). The prevailing perception of the high risks of alcohol use among the children of addicted parents may be influenced by the presence of alcoholism in the family and direct confrontation with its consequences (Csémy et al. 2003). Gambling on slot machines is also very common among the children with behavioural disorders (a quarter of them reported frequent gambling).

The survey also tracked family structure, problems in the family, the habits of parents with regard to alcohol, and the behaviour of friends and peers. It has shown that only 40% and 30% of the children of addicted parents and children with behavioural disorders, respectively, live in a complete family with both parents (compare with 74% of children in the general school population). More than 30% of the children with behavioural disorders live in a different family configuration than with parents (their own parents or step-parents). A higher incidence of crime, addictions, and disturbed relationships was monitored in the groups of children with behavioural disorders.

Nearly 70% of the children with behavioural disorders and just under 25% of the children of addicted parents mentioned that their best friend is a regular smoker; approximately 25% of the best friends of the children with behavioural disorders and 10–12% of children of addicted parents consume alcohol on a regular basis. Nearly 20% of the friends of the children with behavioural disorders and 4% of the friends of the children of addicted parents use illicit drugs on an occasional or a regular basis (Csémy et al. 2003).

## 11.6 Policy and Legal Framework

### 11.6.1 Offences Committed by Children Aged Under 15

Persons aged under 15 are not criminally responsible according to the Czech legislation and the provisions of the Penal Code are not applicable to them. When children aged under 15 commit an offence which is otherwise

punishable by law[42], action is taken according to the provisions of Act 218/2003 Coll. on Juvenile Justice. Upon the proposal of the Public Prosecutor's Office or upon an initiative of the court, proceedings regarding imposing a measure on a child aged under 15 who has committed an offence which is otherwise punishable by law are launched. According to Section 93, the court for juveniles may impose the following measures in these proceedings:

- supervision by a probation officer,
- therapeutic, psychological, or other suitable educational programme in a educational care centre,
- protective education.

Protective education can only be imposed on children who were 12 years old at the time of the commission of the offence, and it can only be imposed for offences for which the Penal Code allows the imposition of an exceptional sentence, when justified by the nature of the crime, and only when it is necessary in order to provide for the due education of the child. The supervising probation officer regularly visits the child at school or his or her place of residence.

A juvenile court is a special senate, its presiding judge, or a single judge of a competent court of the place of domicile of the defendant. The participants in the proceedings on imposing a measure on a child aged under 15 always involve the juvenile him/herself, a body for the social and legal protection of children, and the legal guardians of the child. If what happened can be reliably proved otherwise, the child does not have to be examined during the proceedings; however, its opinion on the matter must always be ascertained.

During the proceedings and when imposing a measure according to Act 218/2003 Coll. on children aged under 15, the court always takes into consideration the personality of the child, including its age and intellectual and moral maturity, health, and personal, family, and social situation. It also pays attention to ensuring an educational influence on children and monitors the preventive effects of the measure. The personal data and privacy of the child are protected to a greater extent during the proceedings. Judges, public prosecutors, members of police bodies, and officers of the Probation and Mediation Service who deal with criminal cases which involve young people must undergo special training in handling young people.

### 11.6.2 Restricting Availability of Alcohol and Tobacco Products for Persons Aged Under 18

The legislation of the Czech Republic restricts the availability of tobacco and alcohol for those aged under 18; there is no special legislative arrangement for children aged under 15. Restrictions on the availability of alcohol and tobacco products are regulated by Act 379/2005 Coll. on Measures for Protection from Harm Caused by Tobacco Products, Alcohol, and Other Addictive Substances.

It is prohibited to sell tobacco products and alcohol to persons aged under 18. Tobacco products cannot be sold at cultural, social, and sport events for persons aged under 18; the ban on the serving and sales of alcohol applies to all events for persons aged under 18 and also in all types of schools and school facilities. The seller is obliged to place a clearly visible sign which bans sales to persons aged under 18 in places where tobacco products are sold. At the same time, it is also forbidden to sell tobacco products or alcoholic beverages in vending machines if it is not possible to restrict their sales to persons aged under 18. Even other forms of sales are banned when it is impossible to verify the age of the buyer. Other restrictions on the sales, serving, and consumption of alcoholic beverages can be laid down by an ordinance issued by a municipality with its own powers.

The Municipal Police, Police of the Czech Republic, and a municipality with delegated powers are especially responsible for monitoring adherence to the above-mentioned restrictions. A fine of up to CZK 50,000 (€ 1,680) can be imposed to a physical entity for a failure to observe the ban on the sales of tobacco products and alcohol and up to CZK 500,000 to a legal entity. The fine goes to the state budget or (when a municipality imposed it) to the municipal budget.

The sale, serving, or any other manner of facilitation of the consumption of alcohol to a person aged under 18 can also be prosecuted according to Act 200/1990 Coll. on Misdemeanours. The misdemeanour can be punished by a fine of up to CZK 3,000 (Section 30, paragraph 1, letter a)), or (Section 30, paragraph 1, letter e)) or by a fine of up to 5,000 and prohibition of activities for up to one year.

According to Act 40/1995 Coll. on the Regulation of Advertising, alcohol and tobacco advertisements must not be targeted at persons aged under 18, especially by depicting such persons or using elements or events which mostly appeal to such persons.

### 11.6.3 Penalties for Drug Offences Committed against Minors

The Penal Code (Act 40/1961 Coll.) increasingly protects minors against the negative effects of illicit drug use. It stipulates more stringent sanctions for some drug offences, if they were committed against persons aged under 15 or 18.

[42] When a child aged under 15 commits an act against the law other than those specified in the Penal Code, action is taken according to general regulations (for instance, according to the Act on Misdemeanours).

Section 187 penalises the unauthorised production and distribution and other forms of unauthorised handling of narcotic and psychotropic substances. Paragraph 3, letter b) stipulates a higher sentence of 8–12 years of imprisonment for offenders who committed the offence against a person aged under 15 (the basic range for an offence according to Section 187 is 1–5 years).

Even the penalty for the criminal offence of the promotion of drug addiction (Section 188a of the Penal Code), which penalises the incitement or promotion of the use of addictive substances, is higher when it is committed against a person aged under 18 (1–5 years of imprisonment as opposed to the basic range of up to 3 years).

### 11.6.4 Policy Targeting Drug Use among Children Aged Under 15

Two of the six main goals of the 2005–2009 National Strategy target the field of primary prevention, and therefore, also the target group of children aged under 15. The goals involve stopping the increase in experimental and occasional use of licit and illicit drugs and stabilisation or reduction of consumption of licit and illicit substances among society and especially among juveniles. According to the 2005–2006 Action Plan, one of the goals in the field of primary prevention is to provide for availability of quality and effective primary prevention programmes and targeted primary prevention programmes which will target the most endangered target groups. Concrete activities in the field for instance involve drawing up standards of professional competency of primary prevention providers and putting them into practice, introduction of a system for certification of the services and creation of a database of certified programmes.

The Ministry of Education has been given the task of coordinating primary prevention of drug use. The ministry drew up a 2005–2008 Strategy for the Prevention of Socially Pathological Phenomena among Children and Juveniles within the Sphere of Competence of the Ministry of Education in 2004.

More detailed information on the above-mentioned strategy of the Ministry of Education and on the goals of the 2005–2006 Action Plan is included in the chapter on Primary Prevention Coordination, page 19.

Another main goal of the 2005–2006 National Strategy is to reduce availability of licit and illicit drugs among the general population, especially among juveniles. As far as the field of supply reduction and law enforcement is concerned, the 2005–2006 Action Plan includes a goal of reducing alcohol and tobacco availability among the general population and juveniles. One of the activities to meet this goal involves more efficient and sound enforcement of legislation governing sales of alcohol and tobacco to persons aged under 18.

## 12 Cocaine and Crack

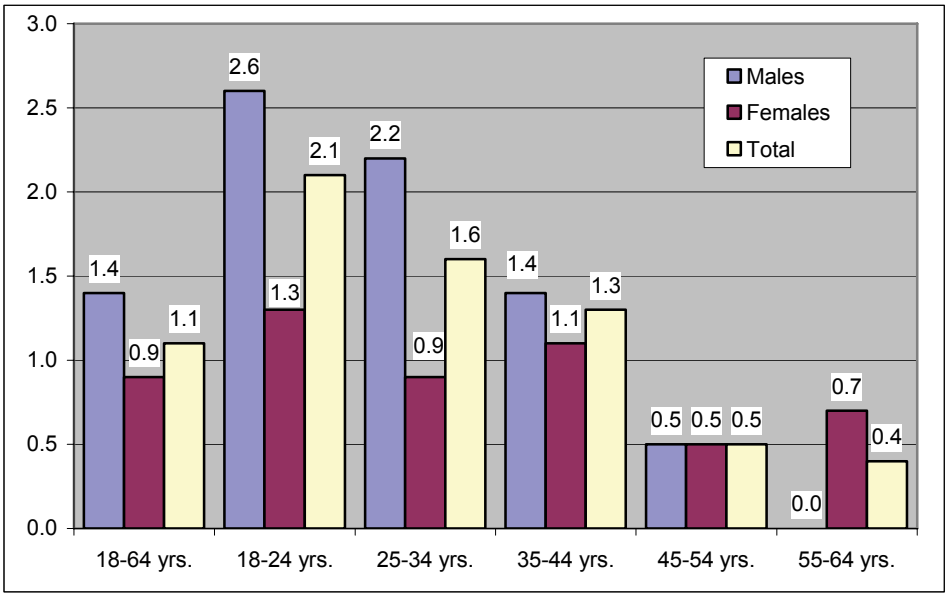
The lifetime prevalence of cocaine and crack use among the general and the school population is almost impossible to measure. Approximately a fifth of the respondents in the specific population of "dance drug" users have experience with cocaine. Several dozens of cocaine users are in contact with treatment facilities every year; most of them use it as their secondary drug. Sporadic deaths resulting from cocaine overdoses have been identified in recent years; at the same time, the number of cocaine-related criminal offences is also increasing. However, cocaine occurrence and use in the Czech Republic is still low in comparison with other drugs; crack practically does not occur in the Czech Republic.

### 12.1 Extent of Cocaine and Crack Use among the Population

#### 12.1.1 Use in the General Population

The frequency of cocaine use (including crack) has been below the limit of sensitivity of population surveys in recent years. The Institute of Health Information and Statistics of the Czech Republic carried out a General Population Survey on the Health Status and Lifestyle of the Population of the Czech Republic in 2004; it focused on the use of licit and illicit substances (Ústav zdravotnických informací a statistiky, 2005b). It was a questionnaire survey among 3,526 participants aged 18–64. 1.1% of the adult population had had at least one experience with the use of cocaine; only 0.2% of respondents have used this substance in the last 12 months, and zero prevalence of use in the last 30 days was reported. Cocaine use was most common in the group aged 18–24 and it decreased with the age of the participants – see Figure 12-1 (Ústav zdravotnických informací a statistiky, 2005a).

*Figure 12-1: Lifetime prevalence of cocaine use (including crack) by age groups in 2004 (%) (Ústav zdravotnických informací a statistiky, 2005a)*

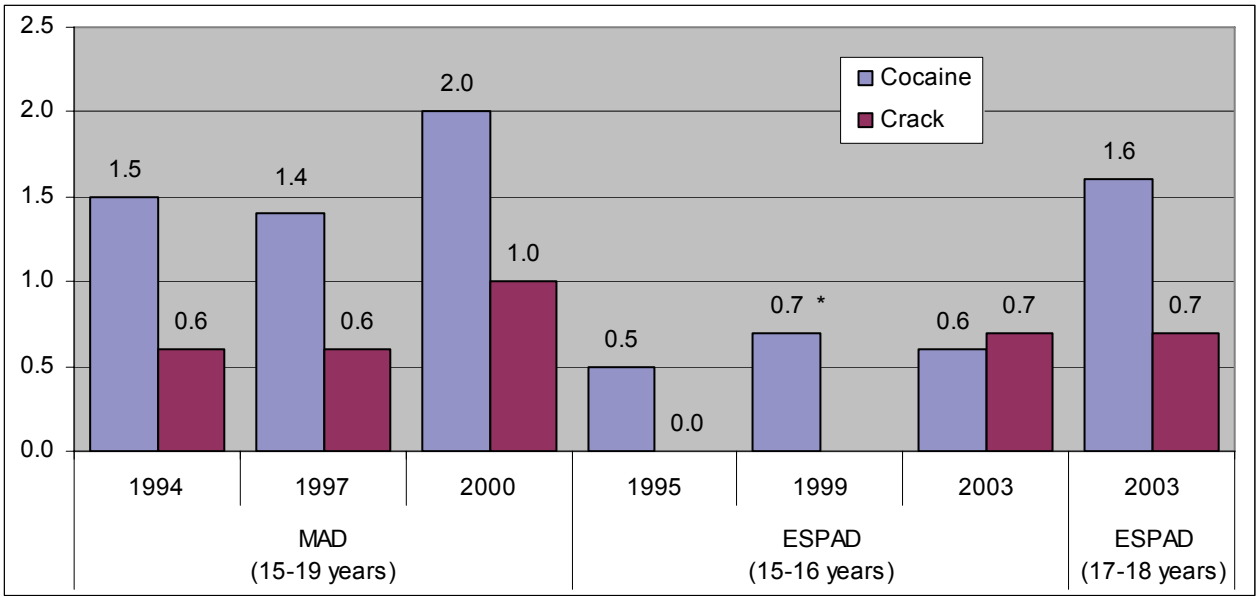



#### 12.1.2 Use among the School Population

Results of school surveys also show a very low prevalence of cocaine or crack among the entire population. Several surveys among young people of school age have been carried out in the Czech Republic in recent years; two of them were significant in terms of their extent and the opportunity they provided to monitor trends: the European School Survey on Alcohol and Other Drugs (ESPAD) and the Youth and Drugs survey. The international survey ESPAD was carried out in 1995, 1999, and 2003 and students aged 15–16 were targeted (the survey also involved 18-year-old students in 2003). The sample consisted of 2,962 students in 1995 and of 3,579 students in 1999, and 3,172 students aged 15–16 and 3,388 students aged 17–18 participated in the survey in 2003 (Csémy et al. 2006b). The Prague Hygiene Service carried out the Youth and Drugs survey in 1994, 1997, and 2000, and it covered a wider age spectrum of respondents (aged 15–19). The sample consisted of 3,997 respondents in 1994, 8,767 in 1997, and 6,340 high-school students in 2000 (Polanecký et al. 2001).

The lifetime prevalence of cocaine and crack use was higher in the Youth and Drugs surveys; the reasons may involve the fact that these substances are especially used by older students. The results of the 2003 ESPAD survey among students aged 18 also confirm this statement. The lifetime prevalence of cocaine and crack use is given in Figure 12-2. The prevalence of cocaine and crack use in the last 12 months and last 30 days are below the limit of sensitivity of school surveys (i.e. under 0.5%).

*Figure 12-2: Lifetime prevalence of cocaine and crack use in school surveys (%) (Csémy et al. 2006a; Polanecký et al. 2001)*

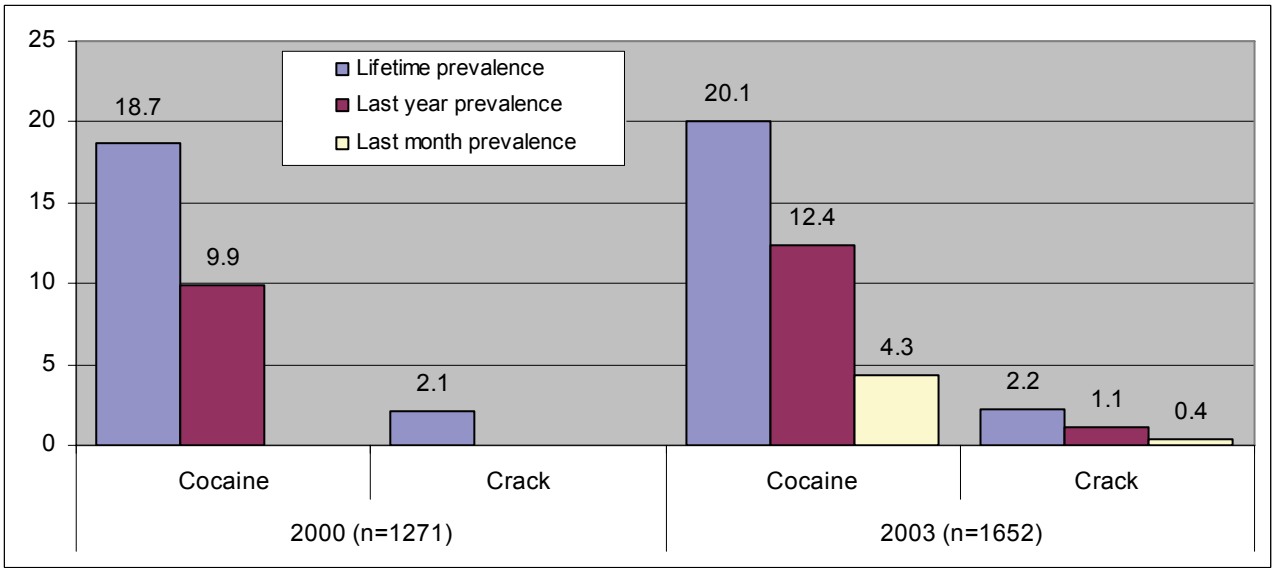



*Note: * Lifetime prevalence of the use of cocaine and crack together.*

### 12.1.3 Use among Specific Population Groups

The prevalence of cocaine and crack use is significantly higher among those attending dance events than among the general population. According to the Dance and Drugs survey in 2003, at least 20% of respondents have used cocaine at least once in their lifetime, 12% have used it in the last year, and 4% in the last month. In comparison with the Semtex Dance survey from 2000, the prevalence of cocaine use on the dance scene has increased slightly – see Figure 12-3 (Kubů et al. 2006)

*Figure 12-3: Lifetime, last year and last month prevalence of cocaine and crack among those attending dance events in 2000 and 2003 (%) (Kubů et al. 2006)*




A similar lifetime prevalence of cocaine use was also found in 2003 and 2004 in surveys among those attending dance events who used preventive and harm reduction services provided by NGOs – see Table 12-1 (Mravčík et al. 2005; Mravčík and Valnoha, 2005).

*Table 12-1: Prevalence of cocaine use among those attending dance events who used preventive and harm reduction services provided by NGOs in 2003 and 2004 (%) (Mravčík and Valnoha, 2005)*

| Prevalence | 2003 (n=468) | 2004 (n=92) |
|---|---|---|
| Lifetime | 17.5 | 22.8 |
| 3 or more times during the last 30 days | 2.1 | 3.3 |

## 12.2 Problems Associated with Cocaine and Crack Use

### 12.2.1 Cocaine- and Crack-Related Treatment Demands

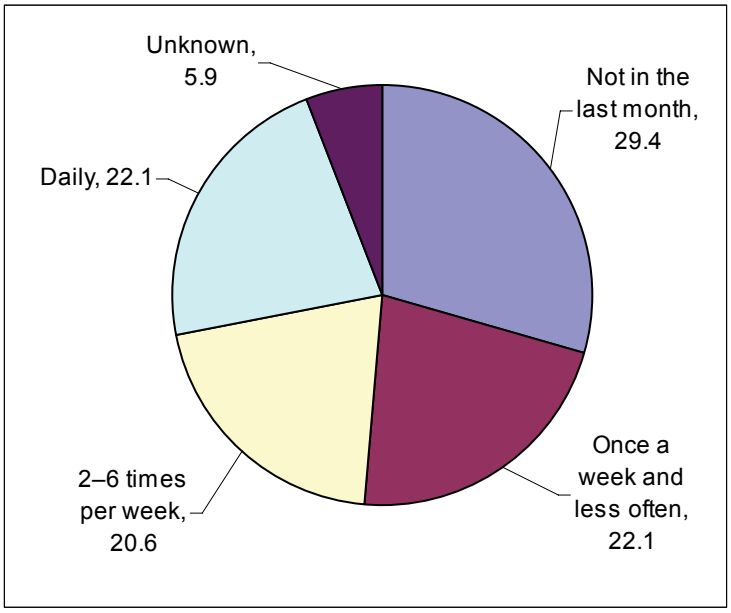
The register kept by the Hygiene Service provides information on treatment demands – see the chapter on Profile of Drug Users in Treatment, page 27, for more information. It has been gathering data on drug users who have visited a low-threshold or treatment facility for the first time in a given year since 1995, and it has been collecting data on all drug users who have used the services provided by these facilities since 2002. For the purposes of this chapter, an analysis of the data on cocaine and crack in the register was carried out (Trojáčková, 2006).

The proportion of those who use cocaine as their primary drug in all and first treatment demands has been under 0.5% since 1997. Their number and other characteristics (number of females and injecting drug users) are given in Table 12-2. It has been possible to monitor the average age of drug users demanding treatment in relation to the use of cocaine since 2002; it is higher than the average age of users of other drugs and it increases in a time line – see Figure 4-6 and Figure 4-7 on page 30 in the chapter on Profile of Drug Users in Treatment for more detailed information. 15 (22%) of all drug users demanding treatment in relation to the use of cocaine in 2002–2005 reported the daily use of cocaine – see Figure 12-4.

*Table 12-2: Number and basic characteristics of (first) treatment demands in relation to the use of cocaine and crack (%) (Trojáčková, 2006)*

| | First treatment demands | | | | | All treatment demands | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Year** | Cocaine | Crack | Total | Number of females | Number of IDUs | Cocaine | Crack | Total | Number of females | Number of IDUs |
| 1995 | 17 | 3 | 20 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| 1996 | 14 | 3 | 17 | 6 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| 1997 | 12 | 0 | 12 | 8 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| 1998 | 7 | 0 | 7 | 3 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| 1999 | 7 | 1 | 8 | 2 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| 2000 | 10 | 0 | 10 | 4 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| 2001 | 5 | 1 | 6 | 3 | 2 | n.a. | n.a. | n.a. | n.a. | n.a. |
| 2002 | 3 | 0 | 3 | 0 | 2 | 12 | 1 | 13 | 3 | 2 |
| 2003 | 14 | 1 | 15 | 8 | 1 | 21 | 1 | 22 | 10 | 1 |
| 2004 | 13 | 0 | 13 | 4 | 4 | 18 | 0 | 18 | 5 | 4 |
| 2005 | 3 | 2 | 5 | 1 | 1 | 13 | 2 | 15 | 5 | 2 |
| **Total** | **105** | **11** | **116** | **39** | **10** | **64** | **4** | **68** | **23** | **9** |

*Figure 12-4: Average frequency of cocaine use (including crack) among all treatment demands in relation to cocaine use in 2002–2005 (%, n=68) (Trojáčková, 2006)*




Cocaine is more often used as a secondary drug in combination with other substances, most commonly with other stimulants (especially pervitin) and opiates – see Table 12-3.

*Table 12-3: Number of drug users demanding treatment who report cocaine as their secondary drug (including crack) in 2002–2005 (Trojáčková, 2006)*

| Primary drug | First treatment demands | | | | All treatment demands | | | |
|---|---|---|---|---|---|---|---|---|
| | 2002 | 2003 | 2004 | 2005 | 2002 | 2003 | 2004 | 2005 |
| Stimulants | 28 | 28 | 38 | 41 | 59 | 52 | 58 | 73 |
| Opiates | 3 | 7 | 7 | 4 | 24 | 24 | 18 | 16 |
| Cannabis | 1 | 4 | 7 | 6 | 2 | 6 | 11 | 10 |
| Cocaine* | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 0 |
| Inhalants | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 1 |
| Hypnotics, sedatives | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Hallucinogens | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| **Total** | **32** | **39** | **54** | **51** | **86** | **86** | **89** | **100** |

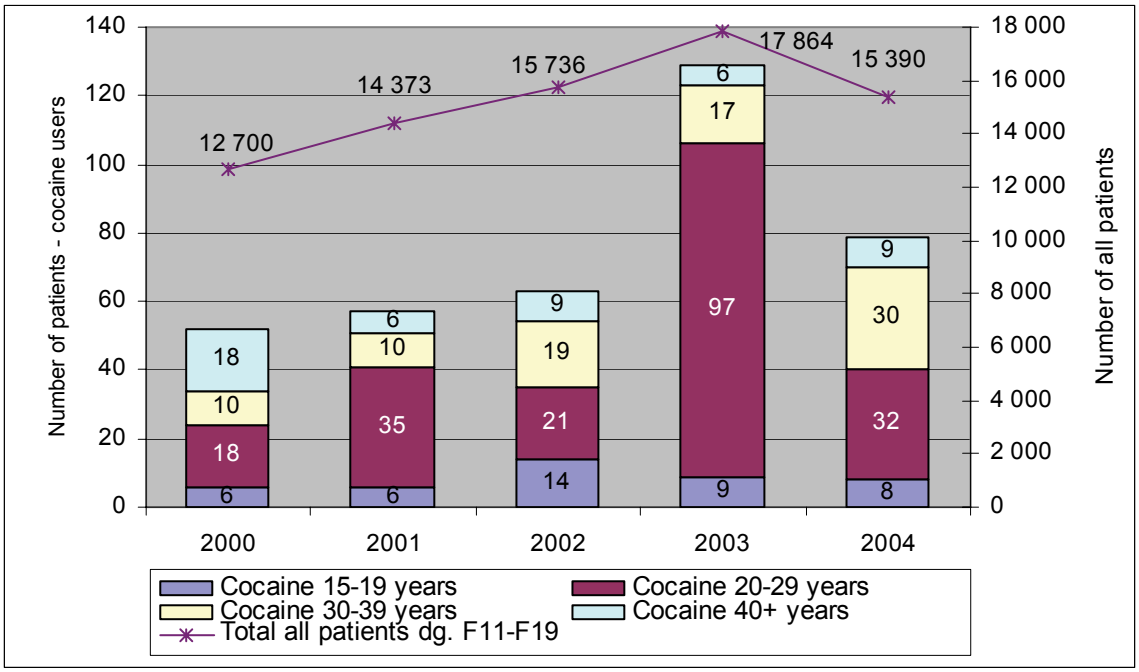
*Note: * Some cocaine users reported crack as their secondary drug, and vice versa.*

Reports on outpatient care in the field of psychiatry and obligatory reports on hospitalisations serve as other data sources. They are processed by the Institute of Health Information and Statistics of the Czech Republic.

Three patients (two males) were hospitalised in relation to cocaine use (diagnosis F14) in 2005 in psychiatric facilities for adults, and ten patients (7 males) in all hospital departments (Ústav zdravotnických informací a statistiky, 2006b).

Altogether 380 patients who used cocaine were registered in outpatient AT clinics[43] in 2000–2004; 273 (72%) of them were males and 107 (28%) were females; most of them (203 patients) were aged 20–29, and no patient aged 0–14 was registered. A higher year-on-year increase in the number of persons treated occurred in 2003; the number of patients treated in 2004 again corresponded to the stable increase of the previous years. The development copies the curve of all patients registered by outpatient AT clinics in 2000–2004 (Ústav zdravotnických informací a statistiky, 2002, 2003a, 2003b, 2005c, 2005d) – see Figure 12-5.

*Figure 12-5: Development in the number of patients who use cocaine (dg. F14) registered in outpatient AT clinics by age groups in 2000–2004 (Ústav zdravotnických informací a statistiky, 2002, 2003a, 2003b, 2005c, 2005d)*




### 12.2.2 Drug-Related Deaths in Relation to Cocaine and Crack Use

Data on drug overdoses have been available in the Czech Republic since 1998 – see the chapter on Drug-Related Deaths and Mortality of Drug Users, page 40, for more information. A single death resulting from a cocaine overdose among the total of 241 fatal drug overdoses (including overdoses on medicaments) and one death with the presence of cocaine out of the total number of 164 deaths with the presence of drugs was recorded for the first time in 2004. One death resulting from a cocaine overdose was also identified in 2005 (out of the total number of 218 fatal overdoses) (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2005; Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2006).

[43] This involves the facilities which filled in Appendix A013 of the AT psychiatric report.

An analysis of all autopsies carried out in forensic medicine and forensic toxicology departments in the Czech Republic was done in 2003–2005. The presence of cocaine was not confirmed in any of the cases – see the chapter on Drugs and Driving, page 85, for more information.

### 12.2.3 Infections in Relation to Cocaine and Crack Use

The number of cocaine and crack users who are infected with HIV and HBV and HCV is unknown.

### 12.2.4 Non-Fatal Intoxications with Cocaine and Crack

The Hygiene Service has been collecting data on non-fatal intoxications (i.e. on intoxications which do not result in a death) – see the chapter on Other Drug-Related Disorders, page 45, for more information. In recent years, they have involved 1 to 7 cases every year – see Table 6-12 in the chapter on Non-Fatal Drug Intoxications, page 48.

## 12.3 Cocaine and Crack Demand Reduction

In the Czech Republic, there are no harm reduction or treatment programmes which specifically focus on cocaine or crack users.

Therapeutic interventions for those addicted to cocaine involve a wide spectrum of counselling approaches, outpatient and intensive outpatient treatment, and inpatient and residential treatment in therapeutic communities, including aftercare. The interventions are always part of abstinence-oriented treatment (Minařík, 2003). Supportive pharmacological treatment of acute intoxications, withdrawal states, the actual addiction, and accompanying psychopathological states is not usually necessary and often it is not even appropriate. Antiarhythmics are only administered in cases of cardiovascular complications (especially tachycardia), and benzodiazepines are administered in cases of marked restlessness. Antidepressants can be used in the event of strong attacks of depression and neuroleptics can be used in cases of protracted toxic psychosis (Minařík, 2003; Bayer, 2003).

## 12.4 Drug-Related Crime and Drug Market

By drug-related crime, we understand criminal offences of the unauthorised production and possession of narcotic and psychotropic substances (Section 187, Section 187a, Section 188 of the Penal Code) and criminal offences involving the promotion of drug addiction (Section 188a of the Penal Code), for which the term “drug offences” is used, and secondary drug-related crime – see the chapter on Drug-Related Crime, page 56, for more detailed information.

2,128 persons suspected of the commission of drug offences[44] were prosecuted in 2005. 50 (2.3%) of them were prosecuted for cocaine-related offences. One person was prosecuted for cocaine possession in a quantity greater than small for personal use. The development of the number of those prosecuted for cocaine-related offences is given in Table 12-4 (Národní protidrogová centrála, 2006c).

*Table 12-4: Perpetrators of cocaine-related offences prosecuted in 2002–2005 (Národní protidrogová centrála, 2006c)*

| Criminal offences | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|
| Section 187a of the Penal Code (drug possession for personal use) | 1 | 3 | 0 | 1 |
| Section 187 and 188 of the Penal Code (production and distribution) | 9 | 21 | 17 | 49 |
| **Total** | **10** | **24** | **17** | **50** |

Data on drug seizures in the Czech Republic are recorded centrally by the National Drug Squad and the General Customs Headquarters. The number of seizures and quantities of cocaine seized in 2002–2005 are given in Table 12-5. Crack has not been seized in the Czech Republic.

*Table 12-5: Cocaine seizures in 2002–2005 (Mravčík et al. 2005; Národní protidrogová centrála, 2006)*

| Year | Number | Volume in kg |
|---|---|---|
| 2002 | 12 | 6.0 |
| 2003 | 20 | 2.6 |
| 2004 | 7 | 3.3 |
| 2005 | 11 | 10.2 |

[44] Offences of the promotion of drug addiction (Section 188a of the Penal Code) are not included.

## 13 Drugs and Driving

The prevalence of driving under the influence of cannabis in the Czech Republic is ten times lower than that under the influence of alcohol, according to available information. The prevalence of driving under the influence of other drugs is even lower. The frequency of driving under the influence of benzodiazepines is approximately the same as that under the influence of cannabis.

During the last two years, the government and the Ministry of the Interior and the Ministry of Transport have adopted strategic documents that aim to increase road safety. The documents contain tasks which concern increasing the control and prevention of driving under the influence of alcohol and drugs. The Road Traffic Act and several provisions of the Act on Misdemeanours and the Penal Code relating to driving under the influence of addictive substances were amended. The Police of the Czech Republic have introduced pilot orientative testing for drivers for the presence of drugs; the testing is expected to be extended and methodological guidelines will be completed after an evaluation of the pilot phase.

The implementation of preventive programmes during driver training is within the responsibility of individual driving schools; they are mostly uninterested, according to available information. The Ministry of Transport is implementing a preventive project promoting the strategy of a "designated driver" who abstains and takes his/her friends home from an event; the project targets recreational drug users at dance events, concerts etc.

The practice of using visible labelling for packages for medicaments (pictograms or symbols which warn against the possibility of their influencing psychomotor functions and reducing the ability to drive) is not widespread in the Czech Republic.

### 13.1 Legal Framework, Strategies and Policy

#### 13.1.1 Legal Framework

Act 411/2005 Coll. amended Act 361/2000 Coll. on Traffic on Road Communications (Road Traffic Act), Act 200/1990 Coll., on Misdemeanours and Acts 140/1961 Coll., Penal Code. Inter alia, it also changed the facts of the case of misdemeanours and offences involving driving motor vehicles under the influence of addictive substances and it established conditions for checks for driving under the influence of addictive substances other than alcohol – see the chapter on Legislation, page 3.

#### 13.1.2 Strategies and Policy

The 2005–2006 Action Plan targets reducing drug use among road traffic participants, especially drivers. Its Goal No. 17, Increased Road Traffic Safety, includes two activities which must be carried out by June 30, 2006. The Ministry of the Interior is responsible for the activities:

- To provide material and technical equipment for traffic police officers for orientative testing for the presence of narcotic and psychotropic substances among road users.
- All police officers who are employed by the Traffic Police Service shall receive training in the identification of the external signs of drug use.

The goal of introducing orientative drug testing for road users was already mentioned in the previous 2000–2004 strategy; however, the goal was not met.

The Government Resolution 883/2004 established the Governmental Council for Road Traffic Safety. The Minister of Transport is the chairman of the council. The council is a permanent advisory body of the government and a top coordinating body in the field of road traffic safety. The goal is provide maximum support for road safety, especially the fulfilment of the National Road Traffic Safety Strategy. The council coordinates the activities of central state administration bodies, the parliament, regions, municipalities, NGOs, and also entrepreneurs who are active in this field. The Road Safety Department of the Ministry of Transport deals with the everyday coordination of activities in the field of road safety.

The National Road Traffic Safety Strategy, which was approved by the government, contains nine main goals. One of them is to reduce the number of accidents and the consequences of those accidents which were caused under the influence of alcohol and other drugs (Ministerstvo dopravy, 2005). Individual priorities and activities for the implementation of the goal are given in Table 13-1.

The 2005 Road Safety and Traffic Flow Action Plan of the Ministry of the Interior (Ministerstvo vnitra, 2005) included three activities in the field of the prevention and control of alcohol and drug use in road traffic – see Table 13-2.

*Table 13-1: Priorities and activities of the Road Safety Strategy relating to reducing the influence of alcohol and other drugs (Ministerstvo dopravy, 2005)*

| Priority | Activities | Responsible | Term |
|---|---|---|---|
| C 1: Reducing the number of traffic accidents caused under the influence of alcohol and other drugs by way of educational influence | C 1.1: Annual campaign targeting the dangers of driving under the influence of alcohol, medicaments, and other addictive substances, with an emphasis on the responsibility of the consumer. | Ministry of Transport, Ministry of the Interior, Ministry of Health, Ministry of Labour and Social Affairs | Every year |
| | C 1.2: Application of knowledge on the influence of alcohol and other addictive substances on the ability to drive motor and non-motor vehicles and road traffic safety in educational programmes in schools and driving schools. | Ministry of Transport in collaboration with Ministry of Education, Ministry of Health, and Ministry of the Interior | Continuously |
| | C 1.3: Increasing informedness of patients about the influence of several medicaments on the ability to drive a motor vehicle and on the influence of the medicaments on the behaviour of other road users. | Ministry of Health in collaboration with Ministry of Transport and bodies of the Czech Medical Chamber, Czech Dental Chamber, and Czech Chamber of Pharmacists | Continuously |
| C 2: Reducing the number of accidents caused under the influence of alcohol through more intensive surveillance by the Police of the Czech Republic | C 2.1: Increasing the number of drivers checked during operations targeting the detection of alcohol and other addictive substances among cyclists and drivers of motor vehicles; to carry out traffic safety operations at night and during weekends. | Ministry of the Interior | Continuously |

*Note: Zkratky uvedené v tabulce viz kapitola Zkratky.*

*Table 13-2: Activities of the 2005 Road Safety and Traffic Flow Action Plan of the Ministry of the Interior relating to reducing the influence of alcohol and other drugs (Ministerstvo vnitra, 2005)*

| Activities | Responsible | Description |
|---|---|---|
| C 1.1: Annual campaign targeting the dangers of driving under the influence of alcohol, medicaments, and other addictive substances, with an emphasis on the responsibility of the consumer | Ministry of Transport in collaboration with Ministry of the Interior, Ministry of Health, and Ministry of Labour and Social Affairs | – informing on specific cases and their consequences in the media and on the web pages of the Ministry of the Interior (nationwide presentation, presentation in local media)<br>– collaboration during the preparation, publishing, and distribution of instructional videotapes which focus on traffic safety issues and during the implementation of accompanying contests<br>– preventive educational activities |
| C 1.2: Application of knowledge on the influence of alcohol and other addictive substances on the ability to drive motor and non-motor vehicles and road traffic safety in educational programmes in schools and driving schools | Ministry of Transport in collaboration with Ministry of Education, Ministry of Health, and Ministry of the Interior | – according to agreements and requirements from driving schools |
| C 2.1: Increasing the number of drivers checked during operations targeting the detection of alcohol and other addictive substances among cyclists and drivers of motor vehicles; to carry out traffic safety operations at night and during weekends. | Ministry of the Interior | – every year, at least three national traffic safety operations targeting the detection of alcohol and other addictive substances among drivers of motor vehicles and cyclists<br>– every year, at least one traffic safety operation targeting the detection of alcohol and other addictive substances among drivers of motor vehicles and cyclists at the regional and district levels<br>– to focus on periods of time and places where it is more likely that alcoholic beverages will be consumed according to assessments made by regional and district directors |

### 13.2 Prevalence of Driving under the Influence of Drugs

According to the official statistics of the Headquarters of the Traffic Police Service of the Police Presidium of the Czech Republic (Ředitelství služby dopravní policie Policejního prezidia ČR, 2004), 4–5% of traffic accidents took place under the influence of alcohol. 0.02–0.03% of accidents were caused by the use of medicaments and other drugs – see Table 13-3. The statistics do not distinguish between individual drugs. The rates of traffic accidents under the influence of alcohol in individual regions[45] in 2005, including the rates of deaths in these accidents, are given in Table 13-4.

*Table 13-3: Rates of traffic accidents on road communications in the Czech Republic in 2003–2005 – influence of alcohol and drugs (Ředitelství služby dopravní policie Policejního prezidia ČR, 2004; Ředitelství služby dopravní policie Policejního prezidia ČR, 2005; Ředitelství služby dopravní policie Policejního prezidia ČR, 2006a)*

| Year | Accidents | | | | | Fatal accidents | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Total | Under the influence of alcohol | | Under the influence of medicaments and other drugs | | Total | Under the influence of alcohol | | Under the ifluence of medicaments and other drugs | |
| | Abs. | Abs. | % | Abs. | % | Abs. | Abs. | % | Abs. | % |
| 2003 | 195,851 | 9,076 | 4.6 | 39 | 0.02 | 1,215 | 111 | 9.1 | 0 | 0.00 |
| 2004 | 196,484 | 8,445 | 4.3 | 53 | 0.03 | 1,215 | 59 | 4.9 | 1 | 0.08 |
| 2005 | 199,262 | 8,192 | 4.1 | 60 | 0.03 | 1,127 | 59 | 5.2 | 0 | 0.00 |

*Table 13-4: Traffic accidents under the influence of alcohol and deaths in the accidents by regions in 2005 (Ředitelství služby dopravní policie Policejního prezidia ČR, 2006a)*

| Region | Number of accidents | Proportion of all accidents (%) | Number of deaths | Proportion among all deaths (%) |
|---|---|---|---|---|
| Prague | 748 | 2.3 | 6 | 9.8 |
| Central Bohemia | 1,111 | 4.4 | 4 | 2.1 |
| Southern Bohemia | 679 | 5.1 | 5 | 4.2 |
| Western Bohemia | 802 | 4.7 | 10 | 10.2 |
| Northern Bohemia | 1,119 | 5.4 | 11 | 8.7 |
| Eastern Bohemia | 967 | 4.7 | 8 | 5.5 |
| Southern Moravia | 1,312 | 4.4 | 11 | 5.0 |
| Northern Moravia | 1,454 | 4.9 | 4 | 2.4 |
| **Total Czech Rep.** | **8,192** | **4.3** | **59** | **5.2** |

The police carry out periodic traffic safety operations in the Czech Republic. Some are carried out at the national level – the "Kryštof" operations are the best known. They involve checks on drivers and the technical state of vehicles and they aim to reduce the number of serious traffic accidents. Only alcohol tests are carried out within the framework of the operations; drug tests are not carried out – see Table 13-5.

*Table 13-5: Alcohol-impaired driving detected during the Kryštof police operation in 2003–2005 (Ředitelství služby dopravní policie Policejního prezidia ČR, 2006b)*

| Date of the operation | Vehicles checked | Driving under the influence of alcohol | Proportion in % |
|---|---|---|---|
| September 29 – October 3, 2003 | 361,685 | 952 | 0.26 |
| April 13 – April 16, 2004 | 206,846 | 210 | 0.10 |
| April 18 – April 21, 2005 | 150,601 | 186 | 0.12 |

It is very likely (even considering the results of the toxicological examinations of the dead victims of traffic accidents – see below) that the official police data on driving under the influence of alcohol and narcotic and psychotropic substances are considerably underestimated.

#### 13.2.1 Presence of Alcohol and Other Drugs among Dead Victims of Traffic Accidents

Detections of alcohol and other drugs among dissected victims of traffic accidents in all thirteen departments of forensic medicine and forensic toxicology in the Czech Republic have been analysed since 2003 – see the chapter on Drug-Related Deaths and Mortality of Drug Users, page 40, for more information; the 2003 data were published in professional journals (Mravčík et al. 2005). As far as alcohol is concerned, cases with an alcohol level higher than 0.2 g/kg are regarded as positive (Společnost soudního lékařství a soudní toxikologie, 1999). As far as

[45] The Police of the Czech Republic (as well as Public Prosecutors' Offices and courts) are divided according to the regional arrangement which was applicable before the public administration reform in 2000 (8 regions instead of the current 14).

cannabinoids are concerned, positive cases involved those cases where THC or its active metabolite (therefore, not, for instance, THC-COOH) were found, and positive cases of inhalants involve the detection of substances which do not develop *post mortem* or are not indicated in several physiological or pathological conditions (e.g. acetone, acetaldehyde, n-propanole, n-butanole). Blood alcohol level examinations are carried out according to the Guidelines for Ethanol Level Determination issued by the Professional Association of Forensic Medicine and Toxicology of the Czech Medical Association of J. E. Purkyně (Společnost soudního lékařství a soudní toxikologie, 1998). At the minimum, toxicological examinations involve urine screening by means of immunochemical methods and confirmation by means of a specific analytic method after previous extrapolation from blood or organs, and they focus on medicaments and other drugs. The entire sample was divided into four categories: pedestrians, cyclists, drivers of motor vehicles, and others. The category "others" especially involved co-passengers in motor vehicles and those who died and do not belong in any of the three above-mentioned categories (other than traffic accidents, e.g. plane crashes, accidents at building sites, etc.).

Approximately 50% of the dead victims of traffic accidents were tested toxicologically in 2003–2005[46] – see Table 13-6. The highest proportion of positive results involved alcohol; however, this proportion has a declining trend – from 40% in 2003 to 30% in 2005 among all active participants in traffic accidents (and from 32% to 19% among drivers). Every year, approximately 7% of the active participants in traffic accidents tested were positive for some drug besides alcohol; the cases most commonly involved benzodiazepines (3–4%), cannabis (1–3%), and stimulants (1–2% of active participants in traffic accidents) – see Table 13-7.

*Table 13-6: Overview of those dissected in forensic medicine departments in the Czech Republic in 2003–2005 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2006)*

| Year | Total number of dissected bodies | Dead victims of traffic accidents thereof | Toxicologically tested thereof |
|---|---|---|---|
| 2003 | 9,960 | 1,035 | 554 |
| 2004 | 12,731 | 1,255 | 590 |
| 2005 | 11,358 | 1,047 | 561 |

[46] I.e. tested for the presence of ethanol or some of the drugs belonging to the following groups: inhalants, opiates, stimulants, cannabis, cocaine, benzodiazepines, barbiturates

*Table 13-7: Detection of alcohol and narcotic and psychotropic substances among victims of traffic accidents (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2006)*

| Substance | Year | Category of victims of traffic accidents | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Pedestrians | | Cyclists | | Drivers | | Total | |
| | | Tests | Positive (%) | Tests | Positive (%) | Tests | Positive (%) | Tests | Positive (%) |
| Alcohol | 2003 | 141 | 51.8 | 50 | 40.0 | 203 | 32.0 | 394 | 40.1 |
| | 2004 | 150 | 48.7 | 44 | 29.5 | 209 | 23.9 | 403 | 33.7 |
| | 2005 | 148 | 45.3 | 35 | 34.3 | 198 | 18.7 | 381 | 30.4 |
| Inhalants | 2003 | 141 | 0.7 | 50 | 0.0 | 203 | 0.5 | 394 | 0.5 |
| | 2004 | 77 | 1.3 | 9 | 0.0 | 101 | 0.0 | 187 | 0.5 |
| | 2005 | 67 | 3.0 | 7 | 0.0 | 68 | 0.0 | 142 | 1.4 |
| Opiates (including heroin) | 2003 | 92 | 0.0 | 28 | 3.6 | 153 | 0.7 | 273 | 0.7 |
| | 2004 | 109 | 0.0 | 23 | 4.3 | 172 | 0.0 | 304 | 0.3 |
| | 2005 | 103 | 0.0 | 17 | 0.0 | 149 | 0.7 | 269 | 0.4 |
| Stimulants (including pervitin and ecstasy) | 2003 | 91 | 1.1 | 27 | 0.0 | 152 | 3.3 | 270 | 2.2 |
| | 2004 | 109 | 1.8 | 23 | 0.0 | 170 | 1.8 | 302 | 1.7 |
| | 2005 | 103 | 1.9 | 17 | 0.0 | 148 | 0.7 | 268 | 1.1 |
| Cocaine | 2003 | 39 | 0.0 | 8 | 0.0 | 54 | 0.0 | 101 | 0.0 |
| | 2004 | 50 | 0.0 | 13 | 0.0 | 75 | 0.0 | 138 | 0.0 |
| | 2005 | 45 | 0.0 | 10 | 0.0 | 71 | 0.0 | 126 | 0.0 |
| Cannabis (active metabolites of THC) | 2003 | 70 | 2.9 | 21 | 0.0 | 101 | 4.0 | 192 | 3.1 |
| | 2004 | 44 | 2.3 | 14 | 0.0 | 100 | 0.0 | 158 | 0.6 |
| | 2005 | 54 | 1.9 | 11 | 0.0 | 94 | 3.2 | 159 | 2.5 |
| Benzodiazepines | 2003 | 89 | 3.4 | 28 | 7.1 | 150 | 2.0 | 267 | 3.0 |
| | 2004 | 109 | 5.5 | 23 | 4.3 | 172 | 2.9 | 304 | 3.9 |
| | 2005 | 103 | 2.9 | 17 | 5.9 | 147 | 4.1 | 267 | 3.7 |
| Barbiturates | 2003 | 88 | 0.0 | 28 | 3.6 | 149 | 0.0 | 265 | 0.4 |
| | 2004 | 109 | 1.8 | 23 | 0.0 | 169 | 1.2 | 301 | 1.3 |
| | 2005 | 101 | 2.0 | 15 | 0.0 | 131 | 0.8 | 247 | 1.2 |
| Any drug besides alcohol | 2003 | 108 | 7.4 | 35 | 11.4 | 171 | 6.4 | 314 | 7.3 |
| | 2004 | 117 | 9.4 | 26 | 7.7 | 181 | 5.5 | 324 | 7.1 |
| | 2005 | 110 | 8.2 | 19 | 5.3 | 158 | 7.0 | 287 | 7.3 |
| Combination of alcohol and any other drug | 2003 | 106 | 3.8 | 35 | 5.7 | 170 | 0.6 | 311 | 2.3 |
| | 2004 | 154 | 3.2 | 44 | 0.0 | 219 | 0.5 | 417 | 1.4 |
| | 2005 | 104 | 2.9 | 19 | 0.0 | 147 | 2.0 | 270 | 2.2 |

Positive findings of ethanole were significantly more common among males than among females; on the other hand, benzodiazepines were detected much more frequently among females than among males – see Table 13-8.

*Table 13-8: Positive detection of alcohol and other narcotic and psychotropic substances among victims of traffic accidents by gender (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2006)*

| Substance | Year | Males | | Females | | Total | |
|---|---|---|---|---|---|---|---|
| | | Tests | Positive (%) | Tests | Positive (%) | Tests | Positive (%) |
| Alcohol | 2003** | 335 | 44.8 | 59 | 13.6 | 394 | 40.1 |
| | 2004** | 348 | 36.2 | 55 | 18.2 | 403 | 33.7 |
| | 2005** | 325 | 33.5 | 56 | 12.5 | 381 | 30.4 |
| Inhalants | 2003 | 335 | 0.6 | 59 | 0.0 | 394 | 0.5 |
| | 2004 | 165 | 0.6 | 22 | 0.0 | 187 | 0.5 |
| | 2005 | 121 | 1.7 | 21 | 0.0 | 142 | 1.4 |
| Opiates (including heroin) | 2003* | 238 | 0.0 | 35 | 5.7 | 273 | 0.7 |
| | 2004 | 265 | 0.4 | 39 | 0.0 | 304 | 0.3 |
| | 2005 | 228 | 0.4 | 41 | 0.0 | 269 | 0.4 |
| Stimulants (including pervitin and ecstasy) | 2003 | 236 | 2.1 | 34 | 2.9 | 270 | 2.2 |
| | 2004 | 263 | 1.5 | 39 | 2.6 | 302 | 1.7 |
| | 2005 | 227 | 1.3 | 41 | 0.0 | 268 | 1.1 |
| Cocaine | 2003 | 91 | 0.0 | 10 | 0.0 | 101 | 0.0 |
| | 2004 | 117 | 0.0 | 21 | 0.0 | 138 | 0.0 |
| | 2005 | 105 | 0.0 | 21 | 0.0 | 126 | 0.0 |
| Cannabis (active metabollites of THC) | 2003 | 167 | 3.6 | 25 | 0.0 | 192 | 3.1 |
| | 2004 | 141 | 0.7 | 17 | 0.0 | 158 | 0.6 |
| | 2005 | 135 | 3.0 | 24 | 0.0 | 159 | 2.5 |
| Benzodiazepines | 2003* | 233 | 2.1 | 34 | 8.8 | 267 | 3.0 |
| | 2004 | 265 | 3.4 | 39 | 7.7 | 304 | 3.9 |
| | 2005 | 226 | 3.1 | 41 | 7.3 | 267 | 3.7 |
| Barbiturates | 2003 | 231 | 0.4 | 34 | 0.0 | 265 | 0.4 |
| | 2004 | 262 | 1.1 | 39 | 2.6 | 301 | 1.3 |
| | 2005 | 209 | 1.0 | 38 | 2.6 | 247 | 1.2 |

*Note: * difference at significance level of p < 0.05, **difference at significance level of p < 0.01(chi-quadrate test).*

The age of those who tested positive was lower than the age of those who tested negative in the case of all drugs, with the exception of medicaments; the most significant differences involve ethanol and cannabis – see Table 13-9.

*Table 13-9: Average age of toxicologically positive and negative participants in traffic accidents (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2006)*

| Substance | Year | Positive | Negative | Total |
|---|---|---|---|---|
| Alcohol | 2003* | 39.1 | 43.3 | 41.6 |
| | 2004** | 40.4 | 46.3 | 44.3 |
| | 2005 | 41.1 | 42.9 | 42.4 |
| Inhalants | 2003 | 40.5 | 41.6 | 41.6 |
| | 2004 | 25.0 | 42.3 | 42.2 |
| | 2005 | 18.5 | 41.5 | 41.1 |
| Opiates (including heroin) | 2003 | 28.0 | 39.3 | 39.2 |
| | 2004 | 53.0 | 42.0 | 42.0 |
| | 2005 | 40.0 | 39.3 | 39.3 |
| Stimulants (including pervitin and ecstasy) | 2003 | 29.2 | 39.2 | 39.0 |
| | 2004 | 28.2 | 42.2 | 42.0 |
| | 2005 | 22.3 | 39.5 | 39.3 |
| Cocaine | 2003 | – | 36.1 | 36.1 |
| | 2004 | – | 42.0 | 42.0 |
| | 2005 | – | 38.1 | 38.1 |
| Cannabis (active metabollites of THC) | 2003* | 20.5 | 38.7 | 38.2 |
| | 2004 | 20.0 | 38.7 | 38.6 |
| | 2005 | 22.5 | 35.7 | 35.4 |
| Benzodiazepines | 2003 | 46.3 | 39.1 | 39.3 |
| | 2004 | 51.6 | 41.7 | 42.1 |
| | 2005 | 40.6 | 39.3 | 39.4 |
| Barbiturates | 2003 | 65.0 | 38.9 | 39.0 |
| | 2004 | 50.5 | 42.1 | 42.2 |
| | 2005** | 66.0 | 39.5 | 39.8 |

*Note: * difference at significance level of p < 0.05, **difference at significance level of p < 0.01(ANOVA test).*

A study was carried out in the Southern Bohemia region in 1998–2002 on a sample of 200 drivers who died in traffic accidents (166 of them were toxicologically examined). An illicit drug was detected in 2 of them (1.2%, pervitin in one case and THC in the second one). 4.8% of them were under the influence of pharmaceutical psychotropic substances at the moment of the fatal traffic accident, 4.8% were under the influence of other medicaments, and 37% were under the influence of alcohol (Vorel, 2003).

### 13.3 Drug Testing among Road Users

The traffic police carry out drink-driving checks on drivers within the framework of the so-called traffic safety operations and also during regular checks. Four national traffic safety operations targeted driving under the influence of alcohol and other drugs, 34 operations were carried out at a regional level, and 573 operations were carried out at a district level. Police officers also paid closer attention to cyclists during their operations in 2005. 15,077 cases of the consumption of alcoholic beverages were detected during checks on the drivers of motor vehicles (the influence of narcotic and psychotropic substances was not monitored).

Lately, the police have been abandoning extensive operations and adapting checks to local conditions; they especially target sport and other social events (Ministerstvo dopravy, 2006).

The traffic police have been practically testing four types of detection sets for saliva or sweat testing. Concurrently with the introduction of testing sets, training for traffic police officers on orientative testing for narcotics and recognising the signs of drug use has been taking place since December 2005. Altogether, 2,000 detection aids have been delivered, 500 of them from each manufacturer (Nováková, 2006). It is expected that pilot testing will be evaluated by the end of August 2006; no official interim results are available.

A sample for sweat testing is taken from objects which the person being tested has touched (e.g. driver's license, steering wheel). A sample for saliva testing is taken by means of inserting an absorption device into the mouth. Orientative testing in both of the above-mentioned manners is carried out in situ; the results are available within a few minutes. A reactive result must be confirmed by a forensic toxicology laboratory.

The experimental testing follows on from a methodological guideline of the Police Presidium. It stipulates that testing for drug use should be carried out in the following instances:

- When a driver shows external signs of drug use.
- When a driver answers positively a question whether he had used a drug before driving.
- When a driver committed a misdemeanour or caused a traffic accident in a manner which indicates drug use.

- In connection with holding an event at which an increased level of drug use can be expected (e.g. some dance parties etc.).

When the orientative test for the presence of drugs is positive, the police officer takes the following action:

- Notice of a misdemeanour with a detailed description of the actual detection of a sign of drug influence.
- Call for medical (confirmation) examination with advice.
- Submitting the driver to a medical examination.
- Drawing up a protocol on the medical examination.

Furthermore, the methodological guideline places the following obligations upon police officers:

- To conclusively prohibit further driving until the effects of the drug wear off.
- To draw up a detailed official record on the course of the reaction of the orientative test and the conditions under which it was administered.
- To describe the result of the intervention and which measures were taken.
- To announce the misdemeanour to an appropriate administrative body and make a proposal to invite an expert to determine whether the detected quantity of the drug in the body precludes the ability to drive a motor vehicle.

### 13.4 Prevention of Drug Use among Road Users

The Ministry of Transportation launched the campaign "Domluvený (Designated Driver)" at the Summer of Love festival in Pardubice, the Hip-Hop festival in Hradec Králové, and the Trnkobraní music festival in Slušovice in 2005. The philosophy of this campaign is based on the status of a designated driver who abstains during an event so that he/she can safely take his/her friends home. The campaign "Domluvený" is a parallel of the European Designated Driver Campaign and it is supported by the European Commission. Several interactive thematic activities were prepared for those attending the events and they targeted road traffic safety. These were, for instance, an impact simulator, computer games, first aid demonstrations, and counselling on the risks of the consumption of alcohol and other drugs in connection with driving.

Within the framework of the campaign, a new service, PROMILE SMS (www.promilesms.cz), was localised, verified in a pilot project, and launched. It makes it possible to check blood alcohol levels and find out when the alcohol consumer will be "sober" again, i.e. when he/she will be capable of driving a car again. The SANANIM Charity Services is implementing the project. It is based on the principle of entering basic parameters which influence the blood alcohol level into a text message and sending it. A text message reply is sent back almost immediately and it contains information on the current alcohol concentration in the blood, the time when the person will be sober once more, and a short preventive message. During the first three months of its full operation (September November 2005), the Promile SMS service replied to more than 11,460 queries. Males used the service markedly more often (82%), and the average age of clients was 32. Approximately 31% of clients had a zero blood alcohol level at the time of sending the text message. It is likely that these customers used the service the day after they had been drinking so that they could check whether they could carry out activities which it is forbidden to perform under the influence of alcohol. The average blood alcohol level was 1.03‰. The service is used the most between 9 and 12 p.m.

The issues of the influence of alcohol and other drugs on driving are included in several primary prevention projects which are implemented by the Police of the Czech Republic. For instance, they involve debates with secondary-school students during which the students watch a videotape, A Car Is a Gun (Auto je zbraň), produced by the Malina foundation (www.nadace-malina.cz), and documentary shots of traffic accidents. With a few exceptions, driving schools were not interested in the debates, although they received an offer from the Police of the Czech Republic (Ministerstvo dopravy, 2006).

The project 'The Action' was implemented in Pilsen in September 2005. It targeted the use of alcohol and its consequences for road traffic. Most secondary schools in Pilsen participated in the project (Ministerstvo dopravy, 2006).

#### 13.4.1 Labelling of Medicines

According to the registration ordinance on medicinal preparations (ordinance No. 288/2004 Coll.), a special notification is mentioned on a patient package leaflet or on the labelling of the package; it involves especially the possibility of the medication influencing the ability to drive or operate machinery. From this point of view, the ordinance classifies preparations into three groups: (1) safe preparations or preparations which are unlikely to have any influence; (2) preparations with the probability of a slight influence, and (3) preparations with the probability of a considerable influence, and that are potentially dangerous. The patient package leaflet or labelling of the outer package may also include symbols or pictograms or other data, e.g. a warning against the contents impairing the ability to drive a car (for instance, an exclamation mark or an exclamation mark in a triangle). However, the symbols are only used exceptionally in practice, even for medicaments with a considerable influence on psychomotor functions.

## LIST OF TABLES

## LIST OF FIGURES

## LIST OF MAPS

## SELECTED DRUG-RELATED WEB PAGES ON THE CZECH INTERNET

An extensive list of (not only) Czech websites that deal with drug issues is available at http://www.drogy-info.cz/index.php/web_a_drogy/. The following list provides selected official pages of key Czech institutions in the field of prevention, treatment and monitoring of drug use.

Adiktologie (Addictology – a professional journal for prevention, treatment and research of addiction): http://www.adiktologie.cz/

A.N.O. – Asociace nestátních organizací zabývajících se prevencí a léčbou drogových závislostí (Association of NGOs Dealing with Prevention and Treatment of Drug Addiction ): http://www.asociace.org/

Antidopingový výbor ČR (Antidoping Committee of the Czech Republic): http://www.antidoping.cz/

Celní správa ČR (Customs Administration of the Czech Republic): http://www.cs.mfcr.cz/

Centrum adiktologie – Psychiatrická klinika I. LF a VFN, Univerzita Karlova v Praze (Centre for Addictology, Psychiatric Clinic, 1st Faculty of Medicine, Charles University in Prague): http://www.adiktologie.cz/

Centrum epidemiologie a mikrobiologie SZÚ (Centre of Epidemiology and Microbiology of the National Institute of Public Health): http://www.szu.cz/cem/hpcem.htm

Centrum pro výzkum veřejného mínění – Sociologický ústav AV ČR (Public Opinion Research Centre of the Institute of Sociology of the Academy of Sciences of the Czech Republic): http://www.cvvm.cas.cz/

Česká asociace streetwork (Czech Streetwork Association): http://streetwork.ecn.cz/

Česká lékařská společnost JEP (Czech Medical Association of J. E. Purkyně): http://www.cls.cz/

Česká lékařská společnost JEP (Czech Medical Association of J. E. Purkyně – search in journals): http://www.clsjep.cz/hledani.asp

Česká neuropsychofarmakologická společnost (Czech Neuropsychopharmalogical Society): http://www.cnps.cz/

Český statistický úřad (Czech Statistical Office): http://www.czso.cz/

Drop-In, o.p.s.: http://www.dropin.cz/

EXTC (web councelling and prevention of synthetic drug abuse): http://www.extc.cz/

Informační centrum OSN v Praze (Information Centre of the UNO in Prague): http://www.osn.cz/

Informační portál primární prevence (Primary Prevention Information Portal, operated by the SANANIM civic association): http://www.odrogach.cz/

Institut pro kriminologii a sociální prevenci (Institute for Criminology and Social Prevention): http://www.ok.cz/iksp/

Ministerstvo spravedlnosti (Ministry of Justice – portal for Czech justice): http://portal.justice.cz/

Ministerstvo práce a sociálních věcí (Ministry of Labour and Social Affairs): http://www.mpsv.cz/

Ministerstvo školství, mládeže a tělovýchovy (Ministry of Education): http://www.msmt.cz/

Ministerstvo vnitra (Ministry of the Interior): http://www.mvcr.cz/

Ministerstvo zdravotnictví (Ministry of Health): http://www.mzcr.cz/

Národní monitorovací středisko pro drogy a drogové závislosti (National Monitoring Centre for Drugs and Drug Addiction): http://www.drogy-info.cz/

Národní program boje proti AIDS ČR (National Programme of Combating AIDS in the Czech Republic): http://www.aids-hiv.cz/

Národní protidrogová centrála Služby kriminální policie a vyšetřování Policie ČR (Police National Drug Squad): http://www.mvcr.cz/policie/npdc.html

Newton IT (press monitor and fulltext archives): http://www.newtonit.cz/

Poslanecká sněmovna Parlamentu ČR (Lower House of the Parliament of the Czech Republic, 2002–2006 electoral term, Committee for Social Policy and Health (it included the Subcommittee for Drugs and Addiction Issues): http://www.psp.cz/sqw/fsnem.sqw?id=669&o=4

Probační a mediační služba ČR (Probation and Mediation Service of the Czech Republic): http://www.pmscr.cz/

Prev-Centrum, o.s.: http://www.prevcentrum.cz/

Psychiatrické centrum Praha (Prague Psychiatric Centre): http://www.pcp.lf3.cuni.cz/pcpout/

Rada vlády pro koordinaci protidrogové politiky (Council of the Government for Drug Policy Coordination): http://www.vlada.cz/cs/rvk/rkpp/rvkpp_uvod.html

SANANIM, o.s. (drug information server, drug councelling: http://www.sananim.cz/

Sdružení Podané ruce, o.s. (civic association): http://www.podaneruce.cz/

Soudní lékařství v ČR (Forensic Medicine in the Czech Republic): http://www.nemcb.cz/soudni/

Státní zdravotní ústav (National Institute of Public Health): http://www.szu.cz/

Ústav farmakologie 3. LF UK – neuropsychofarmakologie a prevence drogových závislostí (Institute of Pharmacology of the 3rd Medical Faculty of Charles University in Prague – neuropsychopharmacology and prevention of drug addiction): http://www.lf3.cuni.cz/drogy/

Ústav zdravotnických informací a statistiky (Institute for Health Information and Statistics): http://www.uzis.cz/

Vězeňská služba ČR (Prison Service of the Czech Republic): http://www.vscr.cz/

Výzkumný ústav práce a sociálních věcí (Research Institute of Labour and Social Affairs): http://www.vupsv.cz/

## ABBREVIATIONS

2005–2006 Action Plan – Action Plan of the National Drug Policy Strategy Implementation for the period 2005 to 2006

2005–2009 National Drug Strategy – National Drug Policy Strategy for the Period 2005 to 2009

AT – Alcohol – toxicomania (designation of outpatient clinics dealing with addiction treatment)

CGDCP – Council of the Government for Drug Policy Coordination

ČLS JEP – Czech Medical Association of J.E. Purkyně

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

ESPAD – European School Survey on Alcohol and Other Drugs

EU – European Union

ICD-10 – International Classification of Diseases, Revision 10

IDU – injecting drug user(s)

IHIS – Institute of Health Information and Statistics

NMC – National Monitoring Centre for Drugs and Drug Addiction

NGO – non-governmental organisations

SSLST – Professional Association of Forensic Medicine and Toxicology

HAV – hepatitis A

HBV – hepatitis B

HCV – hepatitis C

WHO – World Health Organisation

## MAIN INSTITUTIONS REFFERED-TO IN THE REPORT:

Generální ředitelství cel – General Customs Headquarters

Ministerstvo dopravy – Ministry of Transport

Ministerstvo spravedlnosti – Ministry of Justice

Ministerstvo vnitra – Ministry of the Interior

Ministerstvo zdravotnictví – Ministry of Health

Ministerstvo školství, mládeže a tělovýchovy – Ministry of Education

Národní monitorovací středisko pro drogy a drogové závislosti – National Monitoring Centre for Drugs and Drug Addiction

Národní protidrogová centrála – Police National Drug Squad

Státní ústav pro kontrolu léčiv – State Institute for Drug *(pharmaceuticals)* Control

Vězeňská služba – The Prison Service

Ústav zdravotnických informací a statistiky – Institute of Health Information and Statistics

## INDEX

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