European Monitoring Centre for Drugs and Drug Addiction

CZECH NATIONAL FOCAL POINT FOR DRUGS AND DRUG ADDICTION

2010 NATIONAL REPORT (2009 data) TO THE EMCDDA
by the Reitox National Focal Point

THE CZECH REPUBLIC
New Development, Trends and in-depth information on selected issues

REITOX

Annual Report
The Czech Republic
2009 Drug Situation

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SUMMARY

The preparation and enforcement of the national drug policy is the responsibility of the Government of the Czech Republic. Its main counselling body for drug-related issues is the *Government Council for Drug Policy Coordination*, which met three times in 2009. In the first half of 2009, as part of its EU presidency, the Czech Republic led the *Horizontal Drugs Group*, a working group of the EU Council.

2009 was the last year of the implementation of the *National Drug Policy Strategy for the Period 2005-2009* and the respective Action Plan for the period 2007-2009. All 14 regions had drawn up their regional drug policy strategies in 2009 (in the Pilsen region, drug issues are incorporated into the Policy Document on the Prevention of Crime and Socio-pathological Phenomena). At the turn of 2010 both national strategic documents were subjected to evaluation and new strategies for the forthcoming period were prepared.

The evaluation of the 2005-2009 National Strategy was pursued on an internal basis. In addition to assessing the results (objectives), the evaluation process also focused on the phase of the strategy's articulation and implementation. The results showed that three strategic objectives had been achieved: the number of problem users of illicit drugs had been kept relatively stable, the rate of infectious diseases and other health risks among drug users remained low, and the network of services for drug users had been maintained. On the contrary, the experimental use of drugs continued to rise and efforts to stabilise or reduce drug consumption and the availability of drugs failed. It turned out that the character and potential of activities in individual areas of the action plan and also the level of their successful implementation corresponded with the accomplishment of the respective strategic objectives. Shortcomings were identified in inter-agency coordination and liaison. The evaluation also concluded that the drug policy had faced a shortage of financial and human resources in the recent past.

In May 2010 the Government approved the new *National Drug Policy Strategy for the Period 2010-2018*, which builds upon the previous strategy, but is different from it in being conceived as a long-term vision providing for the next nine years. The 2010-2018 National Strategy defines four key objectives: (I) to reduce the level of experimental and occasional drug use, particularly among young people; (II) to reduce the level of problem and intensive drug use; (III) to reduce potential drug-related risks to individuals and society, and (IV) to reduce drug availability, particularly to young people. The Strategy will be complemented with three-year action plans.

A new Penal Code became effective on 1 January 2010. It includes significant changes in how to address illegal drugs. In particular, the changes concern drug possession for personal use, where drugs are differentiated according to their social and health risks. In comparison to the previous sentencing guidelines, a lower punishment range will apply to the possession of cannabis in a quantity greater than small; other types of drugs will carry stricter sentences. Another significant change is the new provision concerning the illegal cultivation of plants and mushrooms containing a narcotic or psychotropic substance. This activity will be covered by less strict sentencing guidelines than the production of drugs. In addition, the cultivation of a small quantity of plants or mushrooms for personal use will now be a misdemeanour. By virtue of two of its regulations, the Government determined drug quantities greater than small, as well as greater-than-small quantities of plants or mushrooms containing narcotic or psychotropic substances. This is a crucial change, as until now specific quantities were only accounted for by internal regulations intended for the police and public prosecutors. The Government regulations are generally binding legal rules which are also followed by courts in their decision-making.

Labelled public expenditure on drug policy reached a level of CZK 607.5 million (€ 22,973 thousand) in 2009. This amount included CZK 375.4 million (€ 14,196 thousand) provided from the state budget, and the regions and municipalities contributed CZK 172.6 million (€ 6,528 thousand) and CZK 59.5 million (€ 2,249 thousand), respectively. In comparison to 2008, total expenses showed a nominal increase on all three levels by 1.7%; on the central level, there was a decrease in expenditure on the part of all the ministries and central agencies under scrutiny, with the exception of the Ministries of Justice and of Labour and Social Affairs and the National Drug Headquarters of the Police of the Czech Republic. On the regional level, there was a slight increase in aggregate year-on-year expenditure; a significant increase was recorded in the region of South Moravia, while the region of Central Bohemia reported a marked decline. Over one third of regional expenditures, however, was earmarked to finance sobering-up stations. The aggregate of funds expended by municipalities experienced a slight decline. Out of a total amount of CZK 607.5 million (€ 22,973 thousand), CZK 177.2 million (€ 6,699 thousand) was earmarked for treatment, including the sobering-up stations (4% less than in 2008), CZK 175.0 million (€ 6,616 thousand) for harm reduction (10% more), CZK 154.7 million (€ 5,851 thousand) for law enforcement (2% more than in 2008), CZK 54.0 million (€ 2,078 thousand) for primary prevention (6% less), and CZK 31.8 million (€ 1,201 thousand) for aftercare(28% more). These labelled expenditures do not include most of the resources spent on repressive activities intended to curtail drug crime, such as those pursued by the police, public prosecutors, courts, and the prison system, or the cost of treatment covered by health insurance (it is estimated that approximately CZK 200 million (€ 7,563 thousand) from health insurance is used annually in the Czech Republic to cover the treatment of non-alcohol drug dependency – for more details see the 'selected issues' section). The long-term decline in the funds available to the Government Council for Drug Policy Coordination continued in 2010, which led to the providers of drug services publicising the initiative *We Have Had Enough of This ("Máme toho dost!").* Its purpose

was to bring attention to the problems concerning the provision of subsidies and underfunding in general which endanger the quality and even the very existence of the services.

No school-based study looking into the issue of drugs was conducted in the Czech Republic in 2009 (the latest results were provided in the 2008 Annual Report). However, a few small-scale surveys and projects focusing on the adult population were carried out. Taking into account the findings of the studies conducted with the adult population in the years 2008-2009, the lifetime prevalence of the use of cannabis, ecstasy, pervitin, and cocaine among the Czech adult population is 30%, 5-10%, about 4%, and 2%, respectively. The prevalence of the last-year use of cannabis, ecstasy, pervitin, and cocaine among Czech adults reached the respective levels of 11-15%, 3-4%, about 1.5%, and about 0.5%. The use of cannabis, ecstasy, pervitin, and cocaine by young adults (aged 15-34) in the last year showed prevalence rates of 22-28%, 3-8%, up to 3%, and about 0.5-1.5%, respectively. Surveys carried out at dance events and in other nightlife settings suggest dramatically higher prevalence rates of illicit drug use among this specific subpopulation of young adults: in addition to cannabis, they tend to use mainly ecstasy, followed by pervitin, cocaine, and hallucinogens.

The year 2009 saw a significant rise in the mean estimate of the number of problem drug users, which reached the level of approximately 37.4 thousand. Pervitin users (approximately 25.3 thousand) made the greatest contribution to the increase. The number of injecting drug users also rose (to about 35.3 thousand). In addition, there was a slight increase in the number of opiate users (to 12.1 thousand), including an estimated 7.1 thousand heroin users and 5.1 thousand Subutex® users. As confidence intervals for the estimates from recent years overlap, the observed increase should be interpreted with caution. Nevertheless, there was a statistically significant year-on-year increase in the numbers of problem pervitin users and injecting drug users. Traditionally, Prague and Ústí nad Labem are the regions showing the highest rates of problem drug users, as well as opiate users. Of all the regions, in addition, Ústí nad Labem has the highest estimated number of problem pervitin users. While the capital city reported a decline in the number of problem drug users in its territory for the first time since 2005, the estimated number of problem users in the region of Ústí nad Labem rose.

The relatively favourable situation concerning the occurrence of infections among (injecting) drug users continued in 2009; HIV seroprevalence remains far below 1%. In 2009 seven HIV positive people who may have contracted the virus through injecting drug use were newly identified, which is less than in 2007 and 2008. Thus, the reported incidence of HIV among drug users returned to the more favourable levels experienced in the earlier years (the total incidence rate of HIV in the Czech Republic is on the rise, however, as a result of the spread of infection among gay men). The numbers of newly reported cases of HBV and HCV among injecting drug users have been declining in recent years; depending on the study sample's characteristics and selection criteria, the prevalence of HCV among drug users ranges from approximately 20% in low-threshold programmes to 40% in prisons. The relatively highest rate of infections was recorded for incarcerated injecting drug users (for example, an HIV prevalence of over 2% was identified in 2009). However, the results need to be interpreted with caution, bearing in mind the possibility of a sampling error. The rate of injecting among pervitin and opiate users in contact with counselling and treatment agencies has been decreasing slightly in the long term, but for the majority of these users it is still the most common route of administration.

In 2009, for the first time, data on new cases of sexually transmitted infections among injecting drug users are available. A rising trend in the incidence of syphilis among injecting drug users has been observed in recent years: 103 cases of syphilis among IDUs were reported in 2009 (i.e. 10% of all the cases recorded), while 17% of the individuals were found to be engaged in prostitution (mostly women).

According to a special register, the year 2009 witnessed a slight increase in the number of fatal overdoses on illicit drugs and inhalants (49 cases in total) reported by forensic medicine departments, which suggests the continuation of the slightly rising tendency already experienced in the previous year. In particular, the number of fatal opiate overdoses increased on a year-on-year basis, from 15 cases in 2008 to 20 in 2009. The rates of fatal overdoses on pervitin and inhalants showed almost no changes. After several years of no records of fatal overdoses on (new) synthetic drugs, three deaths by TMA, 4-MTA, and GHB respectively were reported in 2009. Cocaine was present in two deaths classified as pervitin overdoses. From the mid-term perspective, the growing numbers of indirect pervitin- and THC-related deaths (i.e. deaths other than by overdose, especially resulting from accidents and suicides) can be observed, although their 2009 levels remained the same as in 2008. For the first time, the Annual Report presents data on fatal drug overdoses contained in the Czech Republic's general mortality register (*Deaths* information system). These data show a rising trend for the past three years.

The traffic police records indicate that the number and proportion of accidents caused under the influence of alcohol and drugs, as well as the number of people killed in accidents caused by impaired drivers, continued to grow in 2009. There has also been an increase in both the number and proportion of people killed in accidents caused by drivers under the influence of other drugs, although the numbers of these reported by the police still tend to be much lower in comparison to the results of autopsies on individuals killed in road accidents investigated at forensic medicine departments.

In the Czech Republic, drug users and addicts may seek help from a network of services providing a wide range of easy-to-access interventions. The network of helping agencies experienced no major changes in 2009. There was a decrease in the capacity of sheltered housing provided as part of after-care programmes for drug users. Early assessment and intervention tools aimed especially at children and young people have been introduced into treatment and counselling practice at a growing rate in recent years.

There was a year-on-year increase in the number of drug users listed in the *Register of Treatment Demands* maintained by the Public Health Service. A total of 8,763 drug users sought treatment services in 2009, i.e. 500 persons more than in 2008. In comparison to the previous years, a slightly declining trend has been reversed, and the numbers of treatment demands returned to their 2004 and 2005 levels.

Traditionally, stimulant users predominate as far as treatment demands are concerned. In 2009, too, they comprised the largest group among all treatment demands (59.5%), as well as first treatment demands (60.9%); the number of pervitin users also showed the highest year-on-year increase. The second most numerous group was made up of opiate users (23.4%), while cannabis users ranked second among first treatment demands (18.3%). The age structure perspective reveals a slight aging of the treatment demand population. While the year-on-year increase in average age is small, a rising trend is apparent from the mid-term perspective. In 2009, the average age of first treatment demands and all treatment demands was 24.2 and 25.9 years, respectively. The average age of people seeking treatment for the first time has increased by more than three years over the past decade and that of all the people demanding treatment has risen by 3.5 years. Women continue to account for one third of treatment demands. Traditionally, the region of Ústí nad Labem and the Capital City, Prague, report the highest relative prevalence and incidence of people demanding treatment.

There was also an increase in the number of drug users reported by psychiatric outpatient facilities. As regards the three largest user groups, there were slightly more opiate (heroin) users and fewer stimulant (pervitin) users, and polydrug users showed a more significant rise in their numbers.

The year 2009 also experienced a growing number of illicit drug users admitted to psychiatric inpatient facilities, which resulted from an increase in the number of admissions to psychiatric hospitals. First and foremost, this increase was due to patients being admitted for disorders caused by polydrug use; the numbers of opiate and stimulant users who were hospitalised dropped.

The number of patients in substitution treatment has also been on the rise. This may apply to both specialised centres and other physicians who prescribe products containing buprenorphine (Subutex® and Suboxone®); however, treatment with these preparations has not been fully included in the substitution register. In Prague, especially, the diversion of Subutex® to the black market occurs.

A wide range of counselling and treatment services is available to drug users in prisons. Nine (out of a total of 36) prisons provided methadone substitution treatment in 2009. The care of drug-using inmates was complemented by additional services delivered by 15 non-governmental organisations in 30 prisons.

The number of low-threshold facilities for drug users has oscillated around 100 on a year-on-year basis. In recent years, however, a significant increase in the number of clients engaged with these low-threshold programmes has been observed. It is estimated that approximately 70% (up to 80% in Prague) of problem drug users maintain contact with these services. There has also been a continuous rise in the number of contacts with IDUs and the amount of injecting equipment and paraphernalia exchanged, although the year-on-year increase in the amount of injecting material distributed in 2009 did not reach the previous years' levels; almost 4.9 million hypodermic needles and syringes were distributed in 2009.

Although the low level of availability of testing for infectious diseases and the very low degree of tests performed on the population of problem drug users may be seen as an enduring negative trend, the data from the past two years suggest that the negative trend is slowly being reversed. In 2009 and 2010 the staff of low-threshold services, particularly in Prague, repeatedly referred to clashes between street workers and police officers and the complex nature of work with ethnic minorities. In view of drug users' presence on the open drug scene and the related problems in terms of public order, ideas promoting the establishment of drug consumption rooms and the installation of injecting equipment vending machines in Prague were raised.

There has been a long-term increase in the number of individuals arrested, prosecuted for, and charged with drug-related criminal offences. Specifically, more people were prosecuted for and charged with drug possession (Section 187a), while fewer people were adjudged to have promoted drug use (Section 188a). The most common drug-related charges are associated with pervitin, cannabis, and heroin; currently, the involvement of cannabis in drug offences is on the rise, while that of pervitin has dropped. The regions reporting the highest numbers of individuals pending prosecution include Moravia-Silesia, Ústí nad Labem, and the Capital City, Prague. From the long-term perspective, approximately 90% of the people arrested and prosecuted for drug-related offences are finally indicted. Among those convicted, an increase in the proportion and the number of offences of drug possession under Section § 187a can also be noted. As far as the structure of the sentences is concerned, the situation remains stable: for the past three years, unsuspended prison sentences have accounted for about 30%, while suspended sentences

comprised 50% of the sanctions imposed. The highest number of sentences is awarded in relation to drug production and trafficking (Section 187) and in connection with pervitin.

Since 2009 misdemeanours involving drug possession for personal use (and since 2010 also misdemeanours involving the cultivation of plants or mushrooms containing a narcotic and psychotropic substance for personal use) have been dealt with by the local authorities of municipalities with extended competences instead of the Police of the Czech Republic. The relevant 2009 data were not available at the time of writing of this report.

According to expert estimates, drug users are annually responsible for approximately 71-74 thousand criminal offences, which accounts for approximately one fifth of all the offences detected in the Czech Republic (about 345 thousand per year). Their most common crime is vehicle burglary. Other estimates indicate that approximately 14% of the new clients of the Probation and Mediation Service of the Czech Republic have committed a drug-related criminal offence. The police records show that 22.2 thousand offences were committed under the influence of alcohol, while 2.3 thousand crimes occurred under the influence of non-alcohol drugs. The largest number of criminal offences on the part of non-alcohol drug users was committed under the influence of pervitin and cannabis. On the basis of a rough estimate in relation to the total number of detected crimes, the offences committed annually under the influence of alcohol may be about 62 thousand (18% of all the crimes detected) and those committed under the influence of non-alcohol drugs about seven thousand (2%).

Cannabis is the most widely available drug in the Czech Republic. In this country, cannabis is frequently grown in artificial conditions which contribute to its higher THC content. 117 seizures resulted in the confiscation of 33,427 cannabis plants, the largest quantity since 2006. The number of large-scale indoor cannabis growing sites detected is increasing (84 in 2009). Pervitin remains the second most frequently seized drug, although the year 2009 experienced the detection of the smallest number of pervitin-cooking laboratories in the past three years (342). From May 2009 pharmacies were restricted in terms of their supply of medicines containing pseudoephedrine, which is used as the main precursor in the production of pervitin. Although this measure led to a reduction in the sale of these pharmaceuticals in the Czech Republic, an increase in illegal imports of the products from abroad, mainly from Poland, was recorded. For this reason, measures intended to control the availability of medicines containing pseudoephedrine at the European level have been recommended.

Cocaine has become a well-established stimulant drug, particularly in the nightlife setting. Twenty-six cocaine seizures were recorded. The total quantity of 12.9 kg makes it the second largest amount of cocaine seized in the past four years. The number and the total volume of heroin seizures have remained relatively stable.

The fewest seizures and the smallest quantity of the drug seized in the past four years were recorded for ecstasy in 2009; tablets containing mCPP as the active ingredient have a significantly larger share of the Czech market than those containing MDMA. On the dance scene, in particular, growing interest in mephedrone was observed in 2009. The emerging popularity of this stimulant substance may be partly explained by the lack of ecstasy tablets containing MDMA and by mephedrone, like a number of other (new) synthetic drugs, not being controlled, or banned, in many countries. This also applies to the Czech Republic, where the handling of mephedrone and other (new) synthetic drugs may, under specific circumstances, be prosecuted as the offence of promotion of drug use, but it cannot be classified as drug production and trafficking.

According to the drug market estimates, almost 19 tonnes of cannabis, 4.7 million tablets of ecstasy, and one million doses of LSD were consumed in the Czech Republic in 2009. 550 kg of 70% cocaine were imported into the Czech Republic and almost a tonne of cocaine of 45% purity was consumed. 4.2 tonnes of 80% pervitin were manufactured and 4.4 tonnes of 70-80% pervitin were consumed. 330 kg of 40% heroin were imported into the Czech Republic and 1.3 tonnes of heroin of 10% purity were consumed.

The prices of most common drugs remained stable in 2009, although a slight increase in both the average and most frequent prices for cannabis could be observed at the retail level.

The Report concludes with three chapters on selected issues, including treatment guidelines, drug use-related mortality, and the cost of drug-related treatment.

The first chapter addresses the treatment guidelines (standards) covering the area of the treatment of drug users in the Czech Republic. These standards are tools guiding the process of the maintenance and assurance of the quality of services, which makes it possible to assess whether, and to what extent, a specific service is provided in good quality. There are several types of guidelines: training guidelines, guidelines for centres, facilities, and programmes, case- and diagnosis-based procedural guidelines, methodological guidelines, and ethical guidelines. The Czech Republic has elaborated the type of guidelines (standards) governing the operation of centres, facilities, and programmes. Such guidelines are primarily represented by the so-called Certification Standards of the Government Council for Drug Policy Coordination. Compliance with these standards is tested as part of the certification process. Conceived as an inter-agency instrument, these guidelines cover a wide range of health, social health, and social services. The Standards for Quality in Social Services of the Ministry of Labour and Social Affairs and the standards for primary drug prevention programmes developed by the Ministry of Education, Youth, and Sports also fall under this category. Czech examples of guidelines for case- and diagnosis-based procedures include the Recommended

Treatment Procedures for Addiction Disorders and Pathological Gambling developed by the *Psychiatric Society of the J.E. Purkyně Czech Medical Association*. The only Czech methodological guidelines in the field of addiction, in fact, are the Health Ministry's standards for substitution treatment.

The purpose of the second selected issue is to provide information about mortality related to drug use and its significance in terms of public health. This chapter presents an overview of the mortality (cohort) studies among drug users carried out hitherto in the Czech Republic and summarises their results. Drug users in the Czech Republic show a higher mortality rate in comparison to their peers in the general population. The available studies suggest that their relative risk of death is at least 10 times higher than is the case for the comparable general population age group. Women and very young adults show the highest risk, given the respective low mortality rates for these demographic groups in the general population. The most common cause of death of drug users (in 75% of cases) includes external (violent) causes of death and intoxication. In proportion, the highest risk of death occurs shortly after the onset of (problem) drug use, which is usually at a very early age.

The third chapter on a selected issue provides an overview of the cost of drug-related treatment in the Czech Republic, which is addressed in the context of primary prevention and harm reduction and structured according to types of treatment interventions. It covers the costs incurred in relation to addiction and drug use counselling, treatment, and after-care, not those of the treatment of health consequences and complications, such as infectious diseases and injuries, brought about by drug use. In the Czech Republic, drug addiction treatment is funded using health insurance, public resources (ministries, the *Government Council for Drug Policy Coordination*, regions, and municipalities), services' own resources, and private resources (clients' and patients' fees, contributions, and sponsorship). The data reflect the 2007 situation, as more recent data concerning the expenses of the General Health Insurance Company spent on drug-related treatment were not available for analysis. The identified costs of prevention, harm reduction, and drug use treatment and aftercare in the Czech Republic in 2007 amounted to CZK 741.1 million (€ 28,024 thousand); CZK 53.5 million (€ 2,023 thousand), CZK 148.9 million (€ 5,631 thousand), and CZK 505.9 million (€ 19,130 thousand) were spent on prevention, harm reduction, and treatment and aftercare, respectively. The most resources to fund treatment and aftercare, CZK 204.4 million (€ 7,729 thousand), were provided by health insurance. Treatment and aftercare receives less financial support from the budget of the *Government Council for Drug Policy Coordination* than harm reduction programmes, but significantly more than primary prevention. When different types of programmes covering the domain of treatment and aftercare are compared, the greatest proportion of all the resources is earmarked for institutional treatment. The resources spent on abstinence-oriented outpatient treatment rank second, followed by substitution treatment in third place. The smallest amount of resources is dedicated to treatment in therapeutic communities and aftercare. An additional comparison of treatment interventions indicates that therapeutic communities and aftercare programmes, which are not covered by health insurance, as they do not have the status of a healthcare facility, have the relatively smallest amount of financial resources to use. When the cost is calculated in relation to the number of clients, therapeutic communities turn out to be the most expensive, although the average period of treatment in a community is much longer than in an institutional setting.

PART A: NEW DEVELOPMENTS AND TRENDS

1 Drug Policy: legislation, strategies, and economic analysis

A new Penal Code became effective on 1 January 2010. It includes significant changes in how to address illegal drugs. In particular, the changes concern drug possession for personal use, where drugs are differentiated according to their social and health risks. In comparison to the previous sentencing guidelines, a lower punishment range will apply to the possession of cannabis in a quantity greater than small; other types of drugs will carry stricter sentences. Another significant change is the new provision concerning the illegal cultivation of plants and mushrooms containing a narcotic or psychotropic substance. This activity will be covered by less strict sentencing guidelines than the production of drugs. In addition, the cultivation of a small quantity of plants or mushrooms for personal use will now be a misdemeanour. By virtue of two of its regulations, the Government has determined quantities greater than small for drugs, plants, or mushrooms which contain narcotic or psychotropic substances. The governmental regulations represent a crucial change, as until now specific quantities were only accounted for by internal regulations intended for the police and public prosecutors.

2009 was the last year of the implementation of the 2005-2009 National Strategy and the respective 2007-2009 Action Plan. At the turn of 2010 both strategic documents were subjected to evaluation and new strategic documents for the next period were prepared. All 14 regions had drawn up their regional drug policy strategies in 2009.

The evaluation of the 2005-2009 National Strategy was pursued on an internal basis. In addition to assessing the results, the evaluation process also focused on the phase of the strategy's formulation and implementation. The results showed that three specific objectives of the strategy had been achieved: the number of problem users of illicit drugs was kept relatively stable, the rate of infectious diseases among injecting drug users and other health risks remained at a low level, and the network of services for drug users was maintained. On the contrary, the experimental use of drugs continued to rise and efforts to stabilise/reduce drug consumption and the availability of drugs failed. It turned out that the nature and potential of the activities pertaining to specific areas of the 2007-2009 Action Plan and their successful implementation corresponded with the accomplishment of the relevant strategic objectives. Shortcomings were identified in inter-agency coordination and liaison. The drug policy also faced a shortage of financial and human resources in the recent past.

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1.1 Legal Framework

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

1.1.1.1 Penal Code

Act. No. 40/2009, Coll., the Penal Code, was included in the Collection of Laws, under Title 11, on 9 February 2009 and became a valid part of the Czech legal system. The law became effective on 1 January 2010. This step marked the culmination of the recodification of the material criminal law. The new Penal Code has also brought significant changes in the legal definitions of drug-related criminal offences.

Drug-related offences, which, until 31 December 2009, were provided for by the stipulations of Sections 187 to 188a of Act No. 140/1961, Coll., the Penal Code (the old Penal Code) are newly covered by Sections 283 to 287 of the

new Penal Code, as specified below (the corresponding provisions of the old Penal Code effective until 31 December 2009 are indicated in brackets): Section 283 – Unauthorised production and other handling of narcotic and psychotropic substances and poisons (Section 187 of the old Penal Code); Section 284 – Possession of a narcotic or psychotropic substance or poison (Section 187a of the old Penal Code); Section 285 – Unauthorised cultivation of plants containing a narcotic or psychotropic substance (not defined by the old Penal Code as a specific offence); Section 286 – Manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison (Section 188 of the old Penal Code), and Section 287 – Promotion of drug use (Section 188a of the old Penal Code).[1]

The comparison of selected sections of the old Penal Code and the new Penal Code addressing the unauthorised handling of drugs, poisons, and substances with hormonal effects is provided in Appendix 14.2 (p. 139).

Although the definitions of offences partly correspond to the previous legal regulations, the new Penal Code introduces certain changes. In particular, the new law details the circumstances under which stricter sentencing guidelines or a specific type of punishment may be applied. An innovation is the offence defined by Section 285 – Unauthorised cultivation of plants containing a narcotic or psychotropic substance. The changes at the punishment level are demonstrated below by means of examples of amendments to sentencing guidelines governing unsuspended prison sentences; however, the definitions of the individual crimes also make it possible to impose alternative sentences.

For example, the stipulations of Section 283 (2) (b) of the new Penal Code newly prescribe that reoffending is to be considered as a circumstance conditioning the use of a stricter punishment range, i.e. according to this provision, an offender who repeatedly committed the offence of the Unauthorised production and other handling of narcotic or psychotropic substances and poisons under Section 283 of the new Penal Code, despite their having been sentenced or punished for such an offence in the past three years, may receive a prison sentence ranging from 2 to 10 years, unlike the 1 to 5 years which was the case until 31 December 2009. Among other implications, this modification may have a great impact on small-time dealers in narcotic and psychotropic substances and producers of pervitin who manufacture the drug in small makeshift labs or the kitchens in their homes and who are usually also problem drug users. The stipulations of Section 283 (4) of the new Penal Code raise the maximum sentence from the previous 15 years' imprisonment to 18.

The stipulations of Section 286 of the new Penal Code concerning the manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison, namely Subsection 1 thereof, newly allows the offender to be sentenced to 0 to 5 years, in comparison to the previous punishment range of 1 to 5 years. In addition, Subsection 2, providing for the first-degree classification of the offence, i.e. carrying a stricter sentence, may now be used to sanction offenders who committed the crime as members of an organised group. A similar change in relation to members of organised groups is covered by the stipulations of Section 287 (2) of the new Penal Code defining the offence of the promotion of drug use. This provision also lays down a new circumstance conditioning a stricter punishment, namely the commission of the offence of the promotion of drug use involving a child under 15 years of age, for which, according to the new Penal Code, an offender may be imprisoned for 2 to 8 years; the previous legal regulation only provided for terms between 1 and 5 years.

The new Penal Code introduced substantial changes in the offences regarding the possession of narcotic and psychotropic substances and poisons for personal use and the unauthorised cultivation of plants containing a narcotic or psychotropic substance. These variations concern the partial division of drugs according to their health and social risks, which should facilitate the consideration of these offences. The stipulations of Section 284 of the new Penal Code, accounting for the criminal offence of Possession of a narcotic or psychotropic substance or poison, distinguish between the possession of cannabis and other drugs, but only when a quantity greater than small is concerned. As a result, the possession of cannabis in a quantity greater than small carries a sentence of up to a year's imprisonment (the previous legal regulation prescribed a term of up to two years), while an offender found guilty of the possession of other narcotic or psychotropic substances or poisons in a quantity greater than small may be sent to prison for up to two years. A person convicted of the possession of any narcotic or psychotropic substance or poison, i.e. including cannabis, to a significant extent may be sentenced to imprisonment for a term of between six months and five years (the previous legal regulation prescribed one to five years) and, in the event of the same offence being committed to a substantial extent, an offender may receive a prison sentence ranging from two to eight years (the previous legal regulation imposed a term of between one and five years).

The provisions of Section 285 articulate the merits of a totally new offence, Unauthorised cultivation of plants containing a narcotic or psychotropic substance, which concerns the growing of plants and mushrooms containing narcotic and psychotropic substances for personal use. These provisions also differentiate between cannabis growers and the growers of other plants and mushrooms containing narcotic and psychotropic substances, but only

[1] The following Section 288 accounts for the criminal offences of the production and other handling of substances with hormonal effects. By virtue of its Regulation No. 454/2009 Coll., the Government determined which substances should be deemed those with anabolic and other hormonal effects and what quantities of them should be considered "significant" in terms of the Penal Code. For the purposes of the Penal Code, the decree further specifies methods which should be considered those involving enhanced oxygen transfer in the human body and other methods producing doping effects.

if such an offence was committed to a small extent. The new Penal Code no longer makes a distinction between the growers of cannabis and other plants containing narcotic and psychotropic substances if the offence involves cultivation to a significant and substantial extent. The cultivation of cannabis in a quantity greater than small carries a sentence of imprisonment for a term of up to six months, while the grower of a plant or mushroom containing a narcotic or psychotropic substance in a quantity greater than small may be punished by a prison term of up to one year. The cultivation of plants or mushrooms containing a narcotic or psychotropic substance on a significant scale is punishable by imprisonment for up to three years, and the same offence committed on a substantial scale carries a prison sentence ranging from six months to five years. It should be noted that until 31 December 2009 cannabis growing was classified as an offence or attempted offence specified by the stipulations of Section 187 of the old Penal Code, with the general punishment range of 1 to 5 years' imprisonment.

The possession of a narcotic or psychotropic substance in a small quantity and the cultivation of plants and mushrooms containing a small quantity of narcotic or psychotropic substances are sanctioned as misdemeanours – for more details see Section Changes in the Misdemeanour Act (p. 9).

Apart from specific definitions of drug-related crimes, the changes in the legal consideration of drugs presented by the new Penal Code also had a bearing on the general provisions. Under Section 42 of the new Penal Code, providing for aggravating circumstances, item p) lists reoffending as one such circumstance. At the same time, however, the law stipulates that the court is allowed not to consider such a circumstance as aggravating should this concern the perpetrator of an offence committed by a drug user under the influence of or in connection to drugs in the event that the offender entered treatment or took other steps needed to start it. According to the previous legal regulation, the court could only disregard the aggravating circumstance of reoffending in the case of drug users who were repeatedly charged with the possession of a narcotic or psychotropic substance for personal use under Section 187a (1) of the old Penal Code. Thus, the new legislation explicitly underlines the role of the treatment of drug users in relation to their offending, in terms of both primary and secondary drug crime.

The new Penal Code authorised the Government to adopt a regulation specifying which substances should be considered poisons under Sections 283, 284, and 286 of the new Penal Code and what quantities of narcotic and psychotropic substances, products containing such substances, and poisons are to be regarded as greater than small. The Government was further authorised to issue a regulation setting out which plants and mushrooms should be considered plants and mushrooms containing a narcotic or psychotropic substance under Section 285 of the new Penal Code and what quantities of them are considered greater than small according to Section 285 of the new Penal Code. The Government fulfilled this task by adopting two regulations, namely No. 455/2009, Coll. and No. 467/2009, Coll. The quantities greater than small for the purposes of Section 284 of the new Penal Code in relation to the most common narcotic and psychotropic substances are summarised in Table 1-1, and a list of plants and mushrooms and their respective quantities for the purposes of Section 285 of the new Penal Code is provided in Table 1-2. The formal stipulation of specific greater-than-small quantities of narcotic and psychotropic substances in a generally binding legal regulation is considered a groundbreaking innovation, as until 31 December 2009 such quantities were only specified by internal guidelines intended for the police and public prosecutors for the purposes of criminal proceedings.

Table 1-1: Possession of narcotic and psychotropic substances for personal use – greater-than-small quantities of selected narcotic and psychotropic substances according to Government Regulation No. 467/2009, Coll.

Type of substance (name in general usage)	**International non-proprietary name (INN)**	**Quantity greater than small**	**Active principle**	**The smallest quantity of the active principle which a substance designated as a drug must contain for its quantity under examination to be deemed greater than small**
Pervitin	Methamphetamine	more than 2 g	(+)-1-phenyl-2-methylaminopropane	0.6 g 0.72 g (hydrochloride)
Heroin	Heroin	more than 1.5 g	3,6-diacetylmorphine	0.2 g 0.22 g (hydrochloride)
Cocaine	Cocaine	more than 1 g	Benzoylecgonine methylester	0.54 g 0.6 g (hydrochloride)
Marijuana	Cannabis	more than 15 g of dry matter	Delta-9-tetrahydrocannabinol	1.5 g
Hashish	Cannabis resin	more than 5 g	Delta-9-tetrahydrocannabinol	1 g
Ecstasy (MDMA)	3,4-methylen-dioxy-methamphetamine	more than 4 tablets/capsules or more than 0.4 g of powdery or crystalline substance	1-(3,4-methylendioxyphenyl)-2-methylaminopropane	0.4 g 0.40 g (hydrochloride)

Table 1-2: Cultivation of plants and mushrooms containing narcotic and psychotropic substances for personal use – a list and greater-than-small quantities according to Government Regulation No. 455/2009 Coll.

List of plants and mushrooms	Quantity greater than small
Plants of cannabis (Cannabis sp.) containing more than 0.3% of substances comprising the tetrahydrocannabinol group	more than 5
Plants containing DMT	more than 5
Plants containing 5-methoxy-DMT	more than 5
Plants containing mescaline	more than 5
Coca shrub (Erythroxylum coca)	more than 5
Mushrooms containing psilocybin and psilocin	more than 40

Note: In order to provide a better overview, the plants and mushrooms and their respective greater-than-small quantities were summarised in a single table.

As far as the general principles of the new Penal Code are concerned, a shift from the material/formal to the formal notion of a criminal offence should be noted, and, with certain exceptions, this change does not make it possible for the court to take into account circumstances other than those identified as constituent elements of an offence in the respective definition of such an offence (a material element pertaining to the assessment of the crime's degree of dangerousness for society is no longer applied).

The changes to the legal regulation of drug-related crime are dealt with in detail by the first 2010 issue of the "*Zaostřeno na drogy*" ("Focused on Drugs") bulletin (available in English as "Czech Drug-related Legislation (2010) – summary of relevant information and full texts" (Zeman and Gajdošíková, 2010).

1.1.1.2 Changes in the Misdemeanour Act

The modifications concerning the recodification of material criminal law were projected into the domain of misdemeanour (administrative) law: with effect from 1 January 2010, Section 30 – Misdemeanours against protection from alcoholism and other substance abuse – of Act No. 200/1990 Coll., on misdemeanours, includes a new item (k) which provides that a misdemeanour is also committed by anyone who cultivates without authorisation a small quantity of a plant or mushroom containing a narcotic or psychotropic substance for personal use. This petty offence carries a maximum fine of CZK 15,000 (€ 567), as is the case with a misdemeanour under Item j) of the above-cited section providing for the possession of a small quantity of a narcotic or psychotropic substance for personal use – Table 1-1.

1.1.1.3 Changes in the Handling of Medicinal Products Containing Pseudoephedrine

In relation to the new law on pharmaceuticals, as of 1 May 2009 restrictions were imposed on the supply of medicines containing up to 30 mg of pseudoephedrine per tablet (the sale of which was completely unlimited until the above date). This measure was introduced on the basis of a decision of the *State Institute for Drug Control* (*SUKL*), which, according to the stipulations of Section 39 (3) of the Act on Pharmaceuticals, made a change to the marketing authorisation for these medicines and introduced the following measures: (1) a ban on mail order sales; (2) the setting of a maximum monthly dose per patient, i.e. the quantity which a pharmacy may supply to a patient without a prescription (1,800 mg, i.e. 60 tbl. of 30 mg), and (3) registration in the central database of electronic prescriptions. In practice, this implies that, in consideration of the restrictions mentioned above, medicinal products containing pseudoephedrine could only be supplied by pharmacies connected to the central database of electronic prescriptions.

The practical application of this new legal regulation turned out to be highly problematic, particularly in terms of personal data protection in relation to the central database of electronic prescriptions. Having inspected the compliance with the requirements prescribed by Act No. 101/2000 Coll., on personal data protection, the Office for Personal Data Protection concluded that the system established on the basis of the law on pharmaceuticals did not ensure the appropriate processing and handling of personal data and did not provide sufficient protection for such data. Moreover, the Office for Personal Data Protection instructed the State Institute for Drug Control to no longer collect personal data in the central database and to destroy such data as were already stored. From November 2009, in response to the personal data protection office's ruling, the State Institute for Drug Control changed the restrictions imposed on the dispensing of medicines containing pseudoephedrine to the effect that the maximum quantity for an individual purchase not controlled by the central database of electronic prescriptions was reduced to 900 mg, which is equivalent to 30 tablets or sachets of any of six products (Aspirin® Complex, Daleron®, Modafen®, Nurofen® StopGrip, Panadol® Plus Grip, Paralen® Plus)[2]. In February 2010 the Office for Personal Data Protection

[2] In practice, different modalities of pseudoephedrine-containing medicines being supplied by pharmacies can be observed. Some pharmacies make them available on prescription only, others practise restricted over-the-counter sales, and there are pharmacies which do not provide these products at all (communication of the President of the Czech Chamber of Pharmacists at the Methamphetamine Working Group's meeting on 9 December 2009).

decided to levy a fine on the State Institute for Drug Control in relation to the collection of personal data[3]. On 24 February 2010, in response to the situation, the Government submitted to the Chamber of Deputies of the Parliament of the Czech Republic a draft amendment to Act No. 378/2007 Coll., on pharmaceuticals, which would redefine the status and operation of the central database to ensure that it adheres to the regulations governing the protection of personal data[4].

The first half of 2009 saw another variation involving the handling of pseudoephedrine. With effect from 1 June 2009, Act No. 167/1998 Coll., on addictive substances, was amended (see also the 2008 Annual Report). In addition to other modifications, the above-mentioned amendment tightened up the legal conditions for the handling of ephedrine and pseudoephedrine. In practical terms, this implies that distributors of all pharmaceutical products containing pseudoephedrine, including those containing less than 30 mg of pseudoephedrine, must obtain from the *Ministry of Health* a certificate authorising them to handle narcotic and psychotropic substances and that pharmacies working with precursors (e.g. using ephedrine to prepare medicinal products on-site) must be registered with the *Ministry of Health*.

The above-specified measures reduced the availability of products containing pseudoephedrine from Czech pharmacies. Although pseudoephedrine is used as a precursor in the manufacturing of pervitin, these restrictive measures had no major impact on the production of pervitin in the Czech Republic, given the increase in illegal imports of medicines containing pseudoephedrine from abroad – for more information see the chapter on Drug Markets (p. 105).

1.1.1.4 Protection from Harm Caused by Tobacco Products, Alcohol, and Other Addictive Substances

In 2009 the Parliament of the Czech Republic concluded the debate on an amendment to Act No. 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances, which was submitted to the Chamber of Deputies as a parliamentary motion in February 2007. The amendment, effective from 1 July 2010, was promulgated in the Collection of Laws under No. 305/2009 Coll. The amendment to the law sought to specify in more accurate terms the measures intended to ensure protection from harm caused by tobacco products, with a special focus on passive smoking, including the stronger protection of children and young people against the adverse effects of smoking[5].

The amendment introduced a number of changes and detailed specifications, including more accurate definitions of public places where smoking is prohibited, the exact division of the competences of the regulatory authorities, and stricter sanctions for selling tobacco, electronic cigarettes, and alcohol to individuals under 18 years of age, which now involve a fine from CZK 50 to 500 thousand (€ 1,891 to 18,907), which may be further combined with the punishment of a prohibition on undertaking a specific activity for up to two years (previously, individuals operating retail outlets violating the regulation could be fined a maximum of CZK 50 thousand (€ 1,891), while corporate retailers could be given a fine of up to CZK 500 thousand (€ 18,907); both entities could be prohibited to undertake a certain activity, but not in addition to the fine). As far as a ban on smoking in restaurants and other similar establishments is concerned, the legal regulation has remained lenient and rather ineffective in terms of the prevention of passive smoking and protection against it. The recent amendment failed to include an absolute ban on smoking in restaurants and other public places serving food and drinks, which has been introduced in some EU member states. A controversial variation was adopted in relation to a smoking ban in public areas such as tram or railway platforms: the ban newly applies to covered platforms, shelters, and public transportation waiting rooms only.

1.1.2 Implementation of Laws

In comparison to the previous periods, no major changes in the practical application of legal regulations covering alcohol, narcotic and psychotropic substances, and tobacco were observed.

A noteworthy issue is the criminal prosecution of pharmacists who were adjudged to have sold an excessive quantity of medicinal products containing pseudoephedrine. These cases involved these medicines being sold in quantities which dramatically exceeded the common volume of sales reported by other pharmacies. According to the police, the pharmacists must have known that the products they sold were intended for the manufacturing of pervitin and, accordingly, were accomplices in the production of the drug.

Specifically, in May 2010 a pharmacist from Prague was convicted, with final effect, by the High Court of Justice in Prague of aiding and abetting the production of pervitin by selling medicines needed to manufacture the drug. He was sentenced to eight years' imprisonment, a fine amounting to CZK 3 million (€ 113 thousand), and a prohibition on following the profession of a pharmacist for a period of 10 years. A similar case was considered by the District

[3] Both the decision of the Office for Personal Data Protection and the wording of the remonstrance filed by the State Institute for Drug Control are available from http://www.sukl.cz/tiskova-zprava-ze-dne-16-3-2010.
[4] For more details see Chamber Print No. 1056/0, distributed among the deputies on 26 February 2010, available from: http://www.psp.cz/sqw/text/tiskt.sqw?O=5&CT=1056&CT1=0.
[5] For more details see Chamber Print No. 142/0, distributed among the deputies on 7 February 2007, available from: http://www.psp.cz/sqw/text/tiskt.sqw?O=5&CT=142&CT1=0.

Court in Kladno at the end of March 2010. There, a pharmacist charged with selling medicinal products intended for the production of pervitin was sentenced to four years' imprisonment. In addition, the court also barred her from following her profession for five years. The defendant appealed immediately to a court of higher instance.[6]

Criminal activities associated with drug use are covered in more detail in the chapter on Drug-Related Crime (p. 91).

1.2 National Action Plan, Strategy, Evaluation, and Coordination

1.2.1 National Action Plan and Strategy

2009 was the fifth and last year of the implementation of the 2005-2009 National Drug Policy Strategy, as well as the last year of the implementation of the respective Action Plan for the period 2007-2009. Therefore, at the turn of 2010 both strategic documents were subjected to evaluation and new strategies for the forthcoming period were prepared.

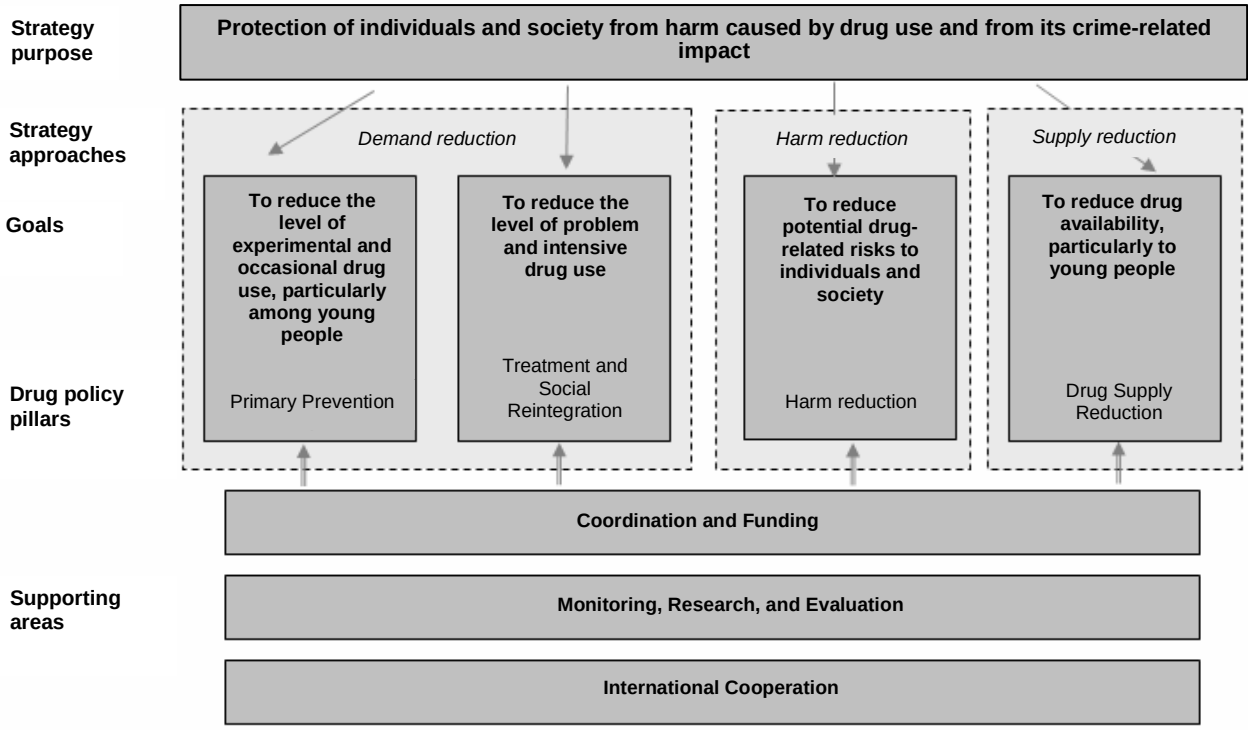
1.2.1.1 National Drug Policy Strategy for the Period 2010-2018

The new *National Drug Policy Strategy for the Period 2010-2018* was approved by virtue of Government Resolution No. 340 on 10 May 2010. The new document was drawn up using the conclusions from the evaluation of the previous strategy. It builds upon and, to a great degree, updates the previous document.

In comparison to the previous mid-term one, the new strategy is conceived as a long-term strategic document spanning a period of 9 years. Outlining a conceptual framework, the national drug policy strategy seeks to define the key areas of interest and the principles and approaches underpinning the Czech drug policy. Given its long-term perspective, the document defines four general objectives: (I) to reduce the level of experimental and occasional drug use, particularly among young people; (II) to reduce the level of problem and intensive drug use; (III) to reduce potential drug-related risks to individuals and society, and (IV) to reduce drug availability, particularly to young people. The objectives correspond to the four pillars of the drug policy: (1) Primary Prevention; (2) Treatment and Social Reintegration; (3) Harm Reduction, and (4) Drug Supply Reduction. To ensure appropriate conditions for the accomplishment of the objectives that have been set, the strategy also encompasses three supporting areas: (1) Coordination and Funding; (2) Monitoring, Research, and Evaluation, and (3) International Cooperation. The prospects are that three action plans, each for a period of three years, will be drawn up while the new national strategy is in operation. The actions plans are intended to define the priorities for the given period and the specific tools, procedures, and activities needed to achieve the strategic goals.

A graphic representation of the Czech drug policy's framework is provided in Figure 1-1.

Figure 1-1: Objectives, pillars, and supporting areas of the Czech drug policy as specified in the 2010-2018 National Strategy



[6] Information from the media, see for example http://www.lidovky.cz/za-prodej-leku-na-vyrobu-pervitinu-dostali-lekarnici-osm-a-ctyri-roky-vezeni-1wc-/ln_domov.asp?c=A100331_155937_ln_domov_tai.

1.2.1.2 Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2010-2012

It is planned that the Government will consider the new 2010-2012 Action Plan in October/November 2010. The action plan was developed in the first half of 2010 with the assistance of working groups on each of the areas of intervention[7]. It was created using the results of the evaluation of the previous strategic documents, a SWOT analysis of the situation, and a discussion on the ways in which the weaknesses and problems identified could be tackled.

Each intervention area encompasses activities, milestones, and deadlines for the completion of such activities, indicators of completion, and the party responsible for the task and/or cooperating on the fulfilment thereof. In view of the drug policy makers' efforts to ensure that the action plans are linked to financial resources provided from the state budget, "Requirements" were newly defined for each activity. They refer to conditions which must be met for a given activity to be pursued. In particular, the requirements include the specification of the financial amounts needed for the implementation of the activity and the adoption of the relevant legislation.

Additionally, the Action Plan newly sets out priorities for the forthcoming three years. The priorities devised for the period 2010-2012 include: (1) to implement interventions aimed at reducing the high level of the use of cannabis, in particular, and other legal and illegal drugs; (2) to reduce the high level of problem pervitin use by applying specific interventions and programmes; (3) to strengthen the drug policy in relation to legal drugs (alcohol and tobacco), primarily in terms of policy and coordination mechanisms and treatment, and (4) to develop and improve the drug policy's overall legislative, financial, and coordination mechanisms.

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

1.2.2.1 Implementation of the 2007-2009 Action Plan

The final evaluation of the implementation of the 2007-2009 Action Plan was conducted in 2009. The drug policy stakeholders, either directly or indirectly responsible for the implementation of the activities articulated in the action plan, were asked to complete a questionnaire. Apart from the ministries, professional associations and regions participated in the evaluation process for the first time. The report on the evaluation of the implementation of the 2007-2009 Action Plan was discussed by the *Government Council for Drug Policy Coordination* in May 2010 and acknowledged by the Government of the Czech Republic in June 2010.

A total of 88 (52%) out of all the 170 activities set out by the 2007-2009 Action Plan (almost 21 percentage points less than in the previous 2005-2006 Action Plan) were successfully completed, 34 (20%) were partly completed, and 49 activities (29%) were found unaccomplished or impossible to evaluate. The most activities were completed in the areas of International Cooperation (65%), Supply Reduction and Law Enforcement (60%), and Information, Research, and Evaluation (59%); the smallest number of activities was accomplished in the areas of Primary Prevention (35%) and Coordination and Funding (40%). A general summary of the activities in terms of their being or not being completed is provided in Table 1-3.

Table 1-3: Degree of completion of the 2007-2009 Action Plan activities according to areas of intervention

Area	**Activities in total**	**Completed**		**Partly completed**		**Not completed**		**Impossible to evaluate**	
		Abs.	%	Abs.	%	Abs.	%	Abs.	%
Prevention	20	7	35.0	5	25.0	8	40.0	0	0.0
Treatment and Aftercare	24	14	58.0	3	13.0	7	29.0	0	0.0
Harm Reduction	17	7	41.0	7	41.0	3	18.0	0	0.0
Supply Reduction and Law Enforcement	15	9	60.0	3	20.0	3	20.0	0	0.0
Coordination and Funding	30	12	40.0	9	30.0	9	30.0	0	0.0
Information, Research, and Evaluation	44	26	59.0	6	14.0	12	27.0	0	0.0
International Cooperation	20	13	65.0	1	5.0	5	25.0	1	5.0
Total	**170**	**88**	**52.0**	**34**	**20.0**	**47**	**28.0**	**1**	**1.0**

Note: "Impossible to evaluate" refers to the lack of sufficient information preventing accountable evaluation of activities.

Areas for improvement were identified in coordination and liaison between the relevant entities, especially in relation to activities of an interdepartmental, interdisciplinary, and inter-agency nature. The evaluation also revealed the insufficient utilisation of, or misunderstanding of the significance of, indicators of the implementation of an activity used to provide an objective evaluation of the degree to which it has been fulfilled.

[7] Primary Prevention; Treatment and Social Reintegration; Harm Reduction; Drug Supply Reduction; Monitoring, Research, and Evaluation; Coordination and Funding; International Cooperation.

Online surveys involving 35 respondents in charge of drug-related issues in the institutions which were responsible for the implementation of one or more action plan activities were used to inquire about the positive and negative factors influencing the implementation of the drug policy. The survey concluded that successful implementation is made possible by, first and foremost, experts' professional potential, the availability of relevant information, and institutional framework of the drug policy (network of services and efficient operation of institutions designated to coordinate and manage the implementation of the drug policy on both the national and regional levels). On the contrary, insufficient implementation may result from the governmental agencies' different baseline approaches to the drug policy or the perfunctory identification and performance of activities. Finally, the drug policy has faced a shortage of financial and human resources.

1.2.2.2 Evaluation of the 2005-2009 National Strategy

After being discussed by the *Government Council for Drug Policy Coordination* in May, a Report on the Evaluation of the 2005-2009 National Drug Policy Strategy was also submitted to the Government of the Czech Republic for reference in June 2010. The evaluation process took place from May 2009 to March 2010. It involved an internal evaluation managed by the Secretariat of the *Government Council for Drug Policy Coordination.* Professionals and entities responsible for the implementation of the drug policy activities participated in the project.

The evaluation sought to identify the extent to which the objectives articulated in the 2005-2009 National Strategy were achieved, the Strategy's effect on the drug situation, and its successes and failures in the period under scrutiny. The evaluation was based on the policy cycle model (Howlet and Ramesh, 1995). In addition to the evaluation of the drug policy's results, therefore, it also focused on the evaluation of the stage of the articulation and implementation of the policy.

Different methods of data collection and analysis were used with respect to the focus (of the individual segments) of evaluation, including the method used for the analysis and comparison of official and internal documents, a semi-structured interview administered to the national drug coordinator during the formulation of the 2005-2009 strategy, a questionnaire inquiring about the status and methods of the completion of the activities specified in the action plan (administered to the entities responsible for the implementation of the activities), an anonymous questionnaire inquiring about opinions on the strategic documents and the factors influencing their implementation, expert working groups carrying out SWOT analyses to assess the developments in the individual drug policy areas for the past five years, a survey among regional drug coordinators mapping the conditions for the implementation of the national strategy on the regional level, and analysis of the developments in quantitative indicators of the drug situation.

The evaluation succeeded in describing the level and status of the accomplishment of the strategic objectives in broader terms: the evaluation identified factors which may have had an influence on the achievement of the strategic objectives during both the formulation and implementation of the drug policy. It was shown that the nature and potential of the activities incorporated in the action plan and the successful implementation of such activities correspond with the level of fulfilment of the strategic objectives, the achievement of which they were intended to facilitate. For example, the failure to reduce the experimental use of drugs corresponded with the vague definition of activities pertaining to the area of primary prevention in the 2007-2009 Action Plan, with their low potential to facilitate a change in the situation and, eventually, with the insufficient level of implementation of such activities. On the contrary, the relative success in the area of harm reduction corresponded with the clearer articulation of the activities, with the formulation of mostly those activities showing a potential to facilitate a change in the situation in the area under consideration, and with the higher level of success in their implementation.

In summary, three specific objectives of the strategy were achieved: to maintain the relatively stable situation concerning the number of problem users of illicit drugs[8] (Objective I); to maintain the low level of infectious diseases among injecting drug users and other health risks (Objective IV), and to maintain a network of services with a relatively wide offer of programmes for users of drugs (especially illegal ones) (Objective V). An exception with regard to Objective V is the long-term declining trend in the number of outpatient healthcare facilities specialising in drug treatment (AT counselling centres), which affects their availability. For the full wording of all the strategy's objectives see Appendix 14.1 (p. 138).

On the contrary, the remaining three specific objectives, which are interrelated, fell short of complete fulfilment: they aimed at halting the rise in experimental drug use (Objective II), stabilising/reducing drug consumption (Objective III), and reducing the availability of drugs (Objective VI). As far as experimental use is concerned, the rising trend in use among young people has been stopped. Nevertheless, the levels of experimental use of drugs, cannabis in particular, in the Czech Republic rank among the highest in Europe. The consumption of alcohol and tobacco remains stabilised at high levels, while illegal drug consumption has risen. Efforts to reduce the availability of both legal and illegal drugs were to no avail.

As regards the technical and organisational objectives designed to facilitate the pursuit of the strategy's specific objectives, a favourable situation has been maintained in the area of international cooperation (Objective X); this area also shows the highest success rate in terms of the implementation of the activities as planned. Although some

[8] However, remarkable increase of problem drug users was observed in 2009 – one year after the period of the evaluated strategy.

success has been achieved in the areas of funding (Objective VII) and coordination (Objective VIII), the set goals have not been met in their entirety.

Two objectives were impossible to evaluate. Insufficient information was available to assess the objective pertaining to the evaluation of activities (Objective XI). Neither was any specific study conducted in this respect. The objective of public awareness (Objective IX) was not linked to any action plan activities which would give rise to a flexible model of communication, the development of which was a part of the objectives as postulated (no activity assigned by the action plan was directed towards the development of such a communication model).

Finally, in the past five years, the drug policy has failed to fully incorporate and address the issue concerning the use of legal drugs, which has been manifested by inconsistencies in coordination mechanisms, the poor availability of data on alcohol and tobacco use, and the insufficient network and range of services for users of legal drugs and the low level of support and inadequate coordination it receives and shows, respectively.

1.2.2.3 Study on Drug Policy Stakeholders

Research into the key stakeholders in the Czech drug policy was carried out in 2009 (Nekola, 2010). Its aim was to identify the drug policy stakeholders' standpoints and perspectives concerning the use of illegal drugs and related problems, i.e. stakeholders' (stakeholder groups') understanding of the field under consideration, the way they think about it, and their attitudes, subjective perception, and interpretation of the field. The Q method (Brown, 1996) was used on a sample of 24 participants. Three independent factors representing three varying perspectives were identified.

The preliminary results suggest that the perspective of pragmatism and expertise predominate among the drug policy stakeholders. This perspective is displayed by the stakeholders defining the use of drugs as rather an individual problem which only pertains to specific substances and specific ways of using them; problem drug use tends to be the preferred focus of the drug policy. From the pragmatic/expert's point of view, the core features of the drug policy include prevention, a focus on problem drug users, harm reduction, and substitution treatment. The perspective of pragmatism and expertise underlines the technical aspect of the problem; the role of politicians is viewed more as involving the adoption of measures proposed by experts and their communication with the public.

To a certain extent, the remaining two perspectives are complementary, with one preferring law enforcement, while the other opts for prevention. Both, however, show accord in aspects of drug policy such as perceiving the drug use problem as being of a higher level of severity, viewing the drug problem as not only a technical problem, and emphasising the role of the government in tackling it. They are also strict about rejecting any forms of legalisation or normalisation of illicit drugs.

1.2.3 Other Drug Policy Developments

1.2.3.1 Initiatives in the Parliament

In April 2010 the Chamber of Deputies hosted a seminar entitled *Prospects of Treatment with Cannabis: Health, Legislation, Politics* ("*Perspektivy léčby konopím: Zdraví, legislativa, politika")*[9], the main purpose of which was to explore the possibilities of making effective treatment with cannabis and cannabis derivatives accessible to people who are ill. The seminar summarised the current state of research into, and medicinal use of, cannabis-based substances both in the Czech Republic and abroad and described the Czech laws and regulations, as well as the international conventions, which provide the framework for the process of making cannabis-based substances and cannabis accessible to the ill. Both Czech and foreign experts presented their views at the seminar. It opened a discussion among both the professional and lay public on the use of cannabis for medical purposes in the Czech Republic and postulated the following recommendations intended to increase the availability of cannabis or products based on it for medical purposes in the Czech Republic.

- To amend the act on addictive substances to the effect that – on the basis of a licence – the cultivation of cannabis with a THC content exceeding 0.3% is allowed.
- To appoint a governmental authority responsible for the control of the licensed cultivation, distribution, and prescription of cannabis and/or its products for medical purposes in compliance with the UN conventions.
- To register cannabis and/or its products with the State Institute for Drug Control as pharmaceuticals, medicinal products, or nutritional supplements subjected to a special marketing authorisation regime.
- In order to accelerate the process, the Czech Pharmacopoeia may adopt an article on medicinal cannabis or products thereof, similar to the article concerning dronabinol being adopted by the U.S. Pharmacopoeia Commission.

[9] For more details see http://www.adiktologie.cz/articles/cz/57/1818/Seminar-Perspektivy-lecby-konopim-Zdravi-legislativa-politika-.html. The seminar was organised by the Centre for Addictology of the Department of Psychiatry of the First Faculty of Medicine of Charles University in Prague and of the General University Hospital in Prague under the auspices of a member of the Chamber of Deputies of the Parliament of the Czech Republic, Ivan Langer, and the Dean of the First Faculty of Medicine, Charles University in Prague, Tomáš Zima.

1.2.3.2 Initiatives in Civil Society

In 2009 and in the first half of the following year the Czech public sphere experienced several initiatives/proclamations associated with the drug issue. In most cases these campaigns were launched and promoted by activists, professional associations, and/or non-governmental organisations. They were generally aimed at penetrating the public sphere, as well as seeking to change the course of the political agenda in relation to the areas of concern. Two areas in particular were pointed out: (1) the insufficiency of the long-term financial support for drug interventions and the ensuing risks and (2) the decriminalisation of cannabis cultivation and its possible utilisation for medicinal purposes.

The first area is represented by an initiative of several non-governmental organisations entitled *Stop HIV!*[10] The aim of this public appeal is to draw attention to the risk of epidemics of infectious diseases and fight activities which may lead to an increase in the incidence of infectious diseases, particularly among high-risk populations such as injecting drug users and sex workers. *We Have Had Enough of This! ("Máme toho dost!")*[11], an initiative supported by a range of non-governmental organisations and associations of addiction professionals, calls for the solution of protracted problems related to the provision of subsidies and underfunding which jeopardise the quality and the very existence of the network of drug services.

A whole-day seminar entitled *Prospects of Treatment with Cannabis: Health, Legislation, Politics* ("*Perspektivy léčby konopím: Zdraví, legislativa, politika")* held on the premises of the Chamber of Deputies of the Parliament of the Czech Republic in April 2010, is an initiative pertaining to the second area. The discussion reflected a wide range of perspectives assumed by professionals, manufacturers of cannabis products, patients, and activists (see also above). The decriminalisation and the treatment potential of cannabis have been promoted on a long-term basis by the civil association *Cannabis is Medicine ("Konopí je lék")*[12], which strives to popularise and raise awareness about the medical use of cannabis, as well as educating the professional community and the general public about the issue.

The *Million Marijuana March 2010,* already the thirteenth annual event in support of the decriminalisation of Cannabis Indica and its users, took place in Prague on 8 May 2010. According to the organisers, approximately 12 thousand supporters, which is the largest number recorded in the history of the Czech version of the *Million Marijuana March,* participated in the procession and the subsequent cultural events. The entire event had a peaceful course and was free from any conflicts with the *Police of the Czech Republic*, who were overseeing the activities.[13]

The moving of the *K-centrum* low-threshold facility, operated by the *SANANIM* civic association, to the *Na Skalce* street in the Prague 5 District (Smíchov) met with strong resentment on the part of the public. The facility's staff and premises became the targets of violent attacks from angry citizens. On repeated occasions, the staff were verbally assaulted and damage to property, including the breaking of windows and the throwing of excrement into the *K-centrum*'s premises, was caused[14]. The precarious situation concerning the operation of the low-threshold centre was used by some local politicians as a pretext for populist statements during the campaign preceding the election to the Chamber of Deputies of the Parliament of the Czech Republic held in May 2010[15]. The populist rhetoric associated with the ostracisation of drug users continued to be pursued by a local organisation of the Czech Social Democratic Party in the Prague 5 District during the campaign before the election to municipal authorities in the autumn of 2010[16] – Figure 1-2. This way of waging a local campaign was soon rejected by the party's national leaders[17], and the slogan containing the phrase "down with drug addicts" was replaced. A campaign featuring a similar tone was run by the *Citizens' Rights Party – Zeman's Followers* before the same municipal elections in Prague. Their slogan read "In our children's interest – zero tolerance of junkies" – Figure 1-3. According to the party's candidate for the mayor of Prague, who found the slogan "rather unfortunate", the party used the words to promise that they would vote "against the tolerance of narcotics"[18].

[10] http://www.stophiv.cz.
[11] http://www.adiktologie.cz/articles/cz/57/1945/Mame-toho-dost.html?acc=enb.
[12] http://www.konopijelek.cz.
[13] http://www.legalizace.cz.
[14] See, for example, http://www.sananim.cz/aktualita-120/vysledky-konstruktivniho-dialogu-vedeneho-s-rezidenty-v-okoli-kc.html.
[15] See, for example, the text by Milan Kudrys, the chair of the Security Committee for the Prague 5 District, entitled "Both Drugs and Addicts Must Vanish from Santoška!" (*Nový horizont*, May 2010, page 3; see http://praha.cssd.cz/s2796/s8186/).
[16] See, for example, http://www.oranzovapetka.cz (downloaded on 6 September 2010).
[17] See, for example, http://www.novinky.cz/domaci/210642-sobotka-zatrhl-cssd-na-praze-5-plakaty-proti-bezdomovcum.html (downloaded on 6 September 2010).
[18] See, for example, http://www.novinky.cz/domaci/211701-strany-cili-na-lidi-z-okraje-spolecnosti-politologove-varuji-pred-napetim.html or http://www.lidovky.cz/politici-vytahli-proti-fetakum-volice-lakaji-na-ostra-hesla-pgr-/ln_domov.asp?c=A100912_112634_ln_domov_tsh.

Figure 1-2: Banner posted on the website of the Czech Social Democratic Party in the Prague 5 District as part of the campaign before the elections to the Prague 5 local government bodies in the autumn of 2010.

Note: The same slogan, "Down with Addicts, the Homeless, and Gambling Arcades", appeared on billboards in the Prague 5 District.

Figure 1-3: Poster of the Citizens' Rights Party – Zeman's Followers used in the municipal election campaign in Prague in the autumn of 2010.

Note: The headline reads "In our children's interest – zero tolerance of junkies".

1.2.4 Coordination Arrangements

1.2.4.1 Coordination at the National Level

The *Government Council for Drug Policy Coordination* (*GCDPC*), the main coordinating body of the Government for issues related to the drug policy, met three times in 2009. For more details on the composition of the GCDPC, see

the 2007 Annual Report. The *GCDPC* shelters committees and working groups, a summary of which is provided in the 2008 Annual Report (no changes occurred in this respect in 2009).

In the first half of 2009, the Czech Republic held the presidency of the *EU Council*. In relation to that, the *Government Council for Drug Policy Coordination* considered a number of documents pertaining to the course of the presidency of the Horizontal Drugs Group, a working group of the *Council of the European Union*. (Kalina, 2009b; Kalina, 2009a) – see also the *2008 Annual Report*. The final report on the presidency was discussed by the *GCDPC* in October 2009.

The Czech presidency focused on and identified priorities in relation to the following areas (Radimecký, 2009):

- Review of the UN's ten-year drug control plan (1998-2008)[19] carried out at a session of the Commission on Narcotic Drugs (*CND*). The session also adopted documents of significance for the international coordination of the drug policy, namely the Political Declaration and the Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. The *EU*'s standpoint and the standpoints of the individual member states were coordinated by the Czech Republic as the presiding country. However, efforts to have these documents incorporated all the priorities failed.
- Evaluation of the effectiveness of drug supply reduction; the Czech presidency played a major role in drawing up proposals for indicators used to evaluate interventions aimed at reducing drug supply and in introducing them into the *EU* countries' systems of drug policy evaluation. The proposed Council Conclusions concerning drug supply reduction indicators were approved by the *Justice and Home Affairs Council of the EU* in June 2009.
- Health risks associated with the migration of injecting drug users from third world countries to the *EU*. This topic was addressed by a thematic discussion held in Prague in April 2009. The event suggested that the issue is rather sensitive and that it will be very difficult to agree on a common *EU* standpoint – some countries refuse to deal with the topic because of its discriminatory and stigmatising potential.
- Issues related to the production and use of methamphetamine and service quality standards – both areas were explored by means of themed debates allowing the exchange of information among the individual countries.

Following up on the results and recommendations ensuing from the evaluation study concerning the system and process of quality assurance of drug services (professional competency certification) conducted in 2007, in October 2009 the *Government Council for Drug Policy Coordination* adopted changes in the relevant documents: Certification Rules, On-site Inspection Guidelines, and the statutes of the Certification Committee. The *Government Council for Drug Policy Coordination* remains the certification body authorised to grant and suspend the certification of professional competency; the *GCDPC's* chair newly functions as the appellate authority. The innovation is also the instrument of targeted certification intended to facilitate continuous quality checks on services which have already been certified. The validity of certificates for good-quality services has been prolonged. They are now good for four years, which, among other benefits, should reduce the financial burden of certification process. The certification team leader's tasks and certifier's responsibilities have also been newly stipulated. A Certifier's Code of Conduct has been added to the Certification Rules. Another change involves the Certification Committee being enlarged and reinforced with regional representatives and expert certifiers.

In March 2010 the *Government Council for Drug Policy Coordination* considered the report on the activities of its Working Group for Non-Substance Addiction. The working group was established in 2008 for the purpose of its collaboration on the articulation of a Material Intent of the law on lotteries and other similar games and on amendments to other related acts, a new comprehensive piece of legislation concerning lotteries, betting, and other similar games. Although the legislative process was discontinued, the group agreed on the basic principles of the law and invited the Government to carry on with the preparation of this new regulation. In addition, the group formulated a number of recommendations: to ban long-distance gambling, to restrict gambling on the part of individuals dependent on social security benefits, to levy territorial restrictions on the operation of gambling and lotteries, to limit opening hours, to ensure that the handing over of the share of proceeds from gambling and lotteries be used for publicly beneficial purposes, to eliminate financial motives encouraging municipalities to allow new gambling establishments, to restrict advertising for gambling to designated areas, and to ensure the enforceability of the law by financial and other sanctions.

1.2.4.2 Coordination at the Local Level

The coordination at the regional level is assured by the regional drug coordinators. Created in 2004, these positions have been maintained in all the regions, with the exception of Moravia-Silesia, where the office was abolished in 2005 and has not been renewed since that time. The regional coordinators are supported by the network of local drug coordinators who are based in the authorities of the municipalities with extended competencies – for more detailed information on the system of coordination at both the regional and local levels see the 2007 and 2008 annual reports.

[19] Fulfilment of the conclusions of the 20th UN General Assembly Special Session (UNGASS) held in 1998.

The 2009 survey among the regional drug coordinators, conducted as part of the evaluation of the 2005-2009 National Strategy and the 2005-2009 Action Plan, showed that the regional drug coordinators usually work as junior officials; only in two regions do regional drug coordinators perform as department or unit managers. Although a regional drug coordinator is a full-time position, only three of them reported that the drug agenda makes up 100% of their workload. Another six coordinators stated that an average of 18% of their time at work is devoted to other tasks, two coordinators mentioned other issues taking up 50% of their working time, and three coordinators responded that 70-90% of their workload comprises issues other than drugs. Most of the regional drug coordinators are members of the relevant regional advisory bodies related to the drugs issue; however, their presence at important sessions of regional bodies where decisions on drug policy issues are adopted is less frequent. It seems, nevertheless, that the status of the regional drug coordinators has no major impact on their being able to exert a direct influence on the development and implementation of the region's drug policy. All the coordinators responded that they more or less had this opportunity. The only exception is the Ústí nad Labem regional coordinator, who has the opportunity to influence the formulation of drug policy, but not its implementation.

All 14 regions have drawn up their regional drug policy strategies (in the Pilsen region, drug issues are incorporated into the Policy Document on the Prevention of Crime and Socio-pathological Phenomena). In the majority of regions (10 out of 14)[20] 2009 was the last year of validity of their strategic drug policy documents; in three regions, the effect of these documents expires in 2010, while one region's drug policy strategy is good until 2011.

The regional strategic drug policy documents are generally based on the national strategy and the national action plans. The above-mentioned survey indicated that the objectives set out by the National Drug Policy Strategy for the Period 2005-2009 were, in varying numbers – ranging from three to eleven – translated into regional strategic documents. The first national action plan, for the period 2005-2006, was projected into strategic drug policy documents in eight regions, the second, the *2007-2009* Action Plan, was used as the basis in ten regions; none of the national action plans was reflected in the strategic documents of three Czech regions. Furthermore, the questionnaire survey inquired about the regional drug coordinators' attitudes to the activities which were specified in the *2007-2009 Action Plan* as recommendations for regions. A total of nine coordinators reported that they found these recommendations useful in asserting the drug policy in their respective regions; four stated that it was not really the case.

According to the regional drug coordinators, the level of financial support for the drug policy remains the greatest limiting factor which hampers the implementation of drug policy activities at the regional level. Other frequently mentioned limiting factors included the status of a regional or local drug coordinator in itself (the lack of time to fulfil the specific tasks of the drug coordinator as a result of the accumulation of responsibilities), the absence of certain types of drug services in the region, and inadequate expertise on the part of the entities pursuing the drug policy. Out of four areas (political support, the network of services for drug users, human resources, and funding), the most significant improvement was recorded in terms of the availability of a network of programmes for drug users – an improvement was reported by 11 regional drug coordinators.

In eight out of a total of 14 regions, the regional strategic documents (especially the respective action plans) were subjected to evaluation in 2009. A half of the instances involved interim internal evaluations; the other half of them were conceived as a final evaluation using a combination of internal and external evaluation. Working groups and expert panels were employed as evaluation methods; either drug commissions and working groups that already existed or groups established specifically for the purposes of the evaluation were used. The evaluation included the data generated by the monitoring of the drug situation and the results of existing studies. In most cases, however, no specific studies to evaluate the regional strategic documents were conducted.

The coordination mechanisms of regional drug policies experienced changes following the regional elections in the autumn of 2008. The drug commissions were dissolved in the regions of Central Bohemia, Hradec Králové, and Olomouc. The Central Bohemian region's drug commission was reappointed with a different composition in 2009, while in the Hradec Králové and Olomouc regions the drug policy was incorporated into the agenda of commissions with a broader scope of interest. Other changes in coordination occurred in the Central Bohemian region after the 2008 elections: working groups were dissolved, the regional drug coordinator's senior position at the Department of Prevention and Humanitarian Activities was abolished, and the scheme of perennial funding of addiction services was suspended.

1.3 Economic Analysis

1.3.1 Public Expenditures

This chapter summarises data on special-purpose labelled expenditures from the state and local (regional and municipal) budgets which are specifically earmarked for the funding of the drug policy, or may be connected to drug policy interventions. The (investment) capital expenditures are indicated separately.

[20] In Prague, the Drug Policy Strategy of the Capital City, Prague, for the period 2008-2012 is still effective, but the operation of the 2008-2009 Action Plan has expired.

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

2009 expenditures from the state budget amounted to a total of CZK 375.4 million (€ 14,196 thousand)[21]; the trends of ministries and institutions from 2002 to 2009 are summarised in Table 1-4.

The Office of the Government of the Czech Republic provides subsidies for drug policy programmes endorsed by the *Government Council for Drug Policy Coordination*. In 2009 such subsidies were used to support 153 local-level projects to the tune of almost CZK 71.7 million (€ 2,711 thousand), and another CZK 22.1 million (€ 836 thousand) was spent on nationwide projects. The resources were utilised for programmes focusing on prevention, harm reduction, treatment, and aftercare. The expenditure designated for the activities developed by the *GCDPC*, including the *National Monitoring Centre for Drugs and Drug Addiction* (*National Focal Point*), amounted to CZK 3.6 million (€ 136 thousand) and was predominantly used to fund monitoring and research, publication and information activities, the management of the subsidy proceedings, and the process of the certification of the quality of professional services provided as part of the drug policy.

According to the final national accounts, the *Ministry of Education, Youth, and Sports* (*the Ministry of Education*) spent a total of CZK 11.2 million (€ 426 thousand) on the drug policy in 2009. The resources provided by the *Ministry of Education* concerned prevention. Subsidy proceedings involved three programmes: Programme I covered schools and educational facilities by means of subsidies to regions (CZK 7.7 million (€ 293 thousand) was distributed in this way in 2009); Programme II was intended for national and regional projects implemented mostly by non-governmental organisations (NGOs), and Programme III addressed educational facilities for young people in institutional care and educational establishments for preventive care (a total of CZK 3.5 million (€ 133 thousand) was allocated to projects under Programme I and II) – for more details on the *Ministry of Education's* subsidy programme and its changes planned from 2011 see the chapter on Prevention (p. 36).

The resources from the budget of the *Ministry of Defence* spent on the drug policy programme in 2009 amounted to CZK 4.3 million (€ 162 thousand). This money was used to purchase diagnostic equipment for the detection of drugs, professional books and journals, and services involving the provision of professional seminars and lectures.

Although the budget of the *Ministry of Labour and Social Affairs* no longer includes expenses earmarked for the drug policy programme, in 2009 it provided CZK 86.8 million (€ 3,282 thousand) worth of subsidies to deliverers of drug policy projects at the local level. Principally, these funds were used to operate low-threshold centres (CZK 31.1 million) (€ 1,176 thousand), therapeutic communities (CZK 19.8 million) (€ 751 thousand), outreach programmes (CZK 17.5 million) (€ 663 thousand), aftercare services (CZK 9.8 million) (€ 372 thousand), and social counselling (CZK 8.5 million) (€ 320 thousand)[22].

In 2009 the *Ministry of Health* provided a total amount of CZK 15.0 million (€ 569 thousand) for the drug policy, including CZK 1.2 million (€ 45 thousand) used as capital expenditure. The sum of CZK 10.4 million (€ 393 thousand) was made available to fund projects ensuring both outpatient and inpatient addiction treatment, substitution treatment, and detoxification. The operation of low-threshold centres and outreach programmes consumed CZK 4.3 million (€ 163 thousand).

In 2009 the *Ministry of Justice* provided CZK 10.8 million (€ 409 thousand) for the drug policy. The Judicial Academy spent CZK 0.2 million (€ 8 thousand) on hosting seminars and the Institute for Criminology and Social Prevention used CZK 27.3 thousand (€ 1, 032) to purchase professional publications on drug-related issues and to participate in conferences. The largest portion of the funds (CZK 10.0 million) (€ 378 thousand) was forwarded to the Prison Service, where CZK 4.9 million (€ 189 thousand) was used to reduce drug supply (particularly to monitor the presence of narcotic and psychotropic substances) and CZK 4.5 million (€ 171 thousand) was provided for the treatment of drug-dependent inmates.

The budget of the *General Customs Headquarters* did not involve any expenditure on the drug policy programme in 2009. However, it provided investment expenditure of CZK 3.2 million (€ 120 thousand) associated with searching for illegal drugs (the purchase of special search equipment and technology).

Neither does the budget of the *Ministry of the Interior* involve any expenditure on the drug policy programme. However, this ministry is responsible for the National Drug Headquarters, whose expenses are included in the figures reported for the *Ministry of the Interior*. In 2009 they amounted to a total of CZK 146.5 million (€ 5,542 thousand), including (investment) capital expenditure of CZK 2.1 million (€ 80 thousand).

[21] 2009 average exchange rate was used (1€ = CZK 26.445).
[22] The expenditures on the part of the Ministry of Labour and Social Affairs do not include subsidies for special-regime homes providing services for older clients dependent on alcohol.

Table 1-4: Drug policy expenditures from Czech state budget in 2002-2009 by ministries/departments (€ thousand)

Allocation	2002	2003	2004	2005	2006	2007	2008	2009
GCDPC	2,886	3,261	3,153	3,547	3,838	3,762	4,008	3,686
Ministry of Education	299	293	316	315	381	452	499	426
Ministry of Defence	125	147	109	133	172	129	212	162
Ministry of Labour and Social Affairs	1,104	1,391	1,323	1,546	1,753	2,054	3,186	3,282
Ministry of Health	808	692	829	1,124	635	801	757	569
Ministry of Justice	302	442	427	1,233	1,455	454	296	409
General Customs Headquarters	863	708	292	487	829	963	427	120
National Drug Headquarters	n.a.	3,022	2,711	3,189	3,757	4,601	5,527	5,542
Total	**6,387**	**9,957**	**9,161**	**11,574**	**12,821**	**13,217**	**14,912**	**14,196**

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

In addition to the state budget, the drug policy is also funded by local budgets, i.e. those of regions and municipalities[23]. In 2009 regions and municipalities provided CZK 172.6 million (€ 6,528 thousand) and CZK 59.5 million (€ 2,249 thousand), respectively, for this field. The funds provided by regions and municipalities in 2009 and the trends since 2002 are indicated in Table 1-5 to Table 1-10.

Table 1-5: Drug policy expenditures from Czech regional budgets in 2002-2009 (€ thousand)

Regions	2002	2003	2004	2005	2006	2007	2008	2009
Prague	399	391	820	1,029	1,147	1,463	2,006	1,852
Central Bohemia	114	251	432	495	505	625	713	473
South Bohemia	95	88	181	175	212	223	408	379
Pilsen	0	31	47	113	82	65	256	250
Karlovy Vary	3	16	16	35	29	41	53	23
Ústí nad Labem	47	237	248	232	242	174	203	189
Liberec	0	86	181	271	285	233	459	314
Hradec Králové	24	30	63	69	102	244	277	364
Pardubice	49	47	56	185	58	198	224	200
Vysočina	0	57	129	233	109	285	157	134
South Moravia	97	63	157	249	300	306	341	713
Olomouc	3	10	41	67	72	90	334	333
Zlín	36	110	75	71	49	170	178	334
Moravia-Silesia	74	94	112	147	157	505	921	968
Total	**952**	**1,510**	**2,558**	**3,369**	**3,349**	**4,624**	**6,530**	**6,528**

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

2009 drug policy expenditures from the state, regional, and municipal budgets are provided in Table 1-9. The detailed summary of the data on funding at the regional level is divided according to the locations where resources were utilised by the providers of the projects and programmes. The total sum of labelled expenditures on the drug policy in 2009 amounted to CZK 607.5 million (€ 22,973 thousand), which is a 1.7% increase in comparison to 2008[24]. The 2009 drug policy expenditures from the state and local budgets designated for use on regional levels are depicted by regions in Map 1-1.

[23] The data on regional and municipal expenditure are based on the annual reports of drug policy implementation in regions and/or the specifying information requested from regional drug coordinators.
[24] All expenditures and their variations are indicated in nominal values.

The developments in drug policy expenditure on drug demand reduction (prevention, treatment, aftercare, and harm reduction) and drug supply reduction (law enforcement) in the Czech Republic in the years 2002-2009 are summarised in Table 1-6. Until 2006 the expenditure on demand reduction included resources expended by the *GCDPC*; the *Ministry of Education, Youth, and Sports*; the *Ministry of Defence*; the *Ministry of Labour and Social Affairs*, and the *Ministry of Health*, while expenditure on supply reduction included resources consumed by the *Ministry of Justice*, the *General Customs Headquarters*, and the *National Drug Headquarters*. Since 2007 the data have been more accurate, and the Ministry of Justice's expenditures have been divided into the two areas to reflect their actual purpose. As a result, the consistency of the data over time is impaired.

An overview of expenditures from state and local budgets in 2009 by service category is provided in Table 1-10. The first category is Prevention. The Harm Reduction category includes low-threshold drop-in centres, low-threshold day care centres, and outreach (streetwork) programmes. The Treatment category encompasses health care (substitution programmes, detoxification, outpatient and inpatient alcohol/drug treatment services, and social services provided in institutional care), non-health outpatient care (crisis intervention, social counselling, and outpatient treatment provided by NGOs), and therapeutic communities, and a separate category has been created for sobering-up stations. Other categories include Aftercare, Law Enforcement, Coordination (covering coordination, as well as monitoring and research, the evaluation of services, information, and training), and Others (not specified under the previous headings). Out of labelled 2009 drug policy expenditures amounting to a total of CZK 607.5 million (€ 22,973 thousand) (1.7% more than in 2008), CZK 177.2 million (€ 6,699 thousand) was earmarked for treatment (4.0% less than in 2008), CZK 175.0 million (€ 6,616 thousand) was allocated to harm reduction services (9.8% more), CZK 154.7 million (€ 5,851 thousand) was reserved for law enforcement (1.7% more than in 2008), CZK 54.0 million (€ 2,078 thousand) for primary prevention (5.8% less), and CZK 31.8 million (€ 1,201 thousand) for aftercare (an increase by 27.5%). A comparison of expenditures from public budgets from 2007 to 2009, by service category, is provided in Table 1-7.

Map 1-1: 2009 drug policy expenditures from state and local budgets in regions of the Czech Republic (€ thousand per 100,000 inhabitants)

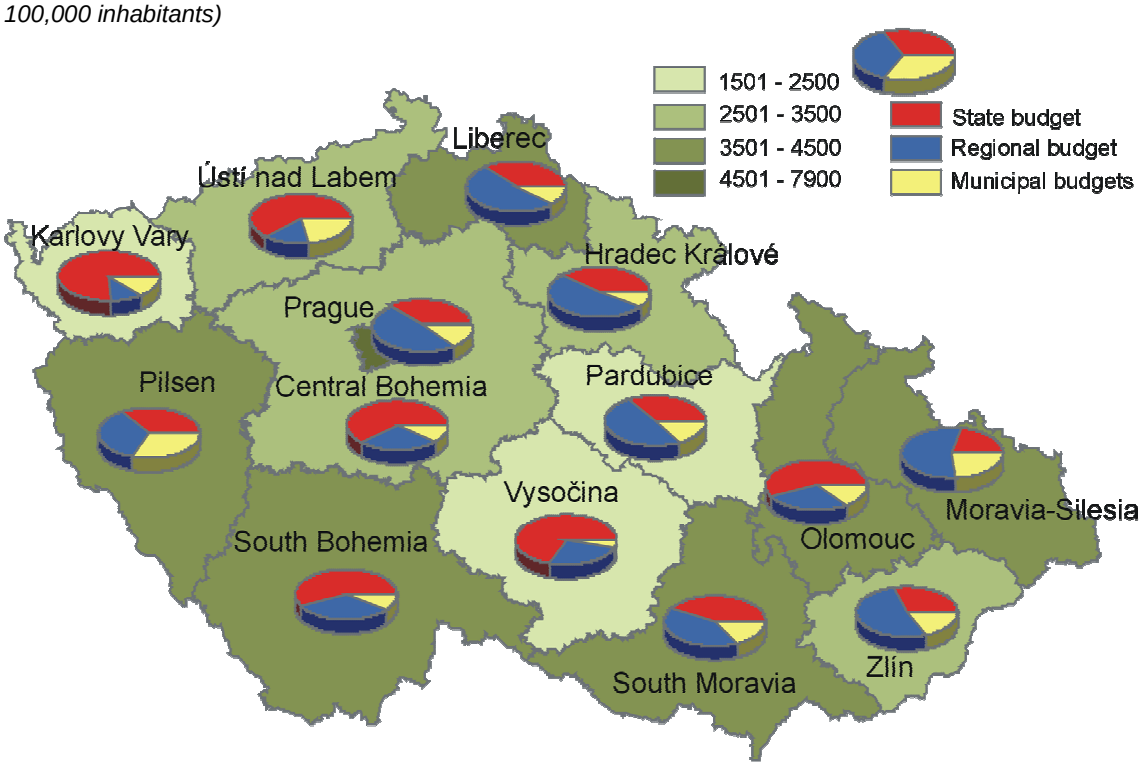


Table 1-6: Drug policy expenditures from state and local budgets in 2002-2009 (€ thousand)

Year	Demand reduction*				Supply reduction**	Total
	State budget	Regional budgets	Municipal budgets	Total	State budget	
2002***	5,397	952	n.a.	6,349	1,204	7,553
2003	5,785	1,510	n.a.	7,295	4,172	11,467
2004	5,731	2,558	1,972	10,261	3,430	13,691
2005	6,666	3,369	1,699	11,733	4,909	16,642
2006	6,780	3,349	1,699	11,828	6,041	17,869
2007	7,425	4,624	2,243	14,292	5,792	20,084
2008	8,812	6,530	2,505	17,847	6,100	23,947
2009	8,345	6,528	2,249	17,122	5,851	22,973

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

Table 1-7: Comparison of expenditures provided from public budgets by service category from 2007 to 2009

Category	2007		2008		2009	
	€ thousand	%	€ thousand	%	€ thousand	%
Prevention	1,753	8.7	2,340	9.8	2,078	9.0
Harm reduction	5,078	25.3	6,389	26.7	6,616	28.8
Treatment	5,496	27.4	7,399	30.9	6,699	29.2
Aftercare	739	3.7	999	4.2	1,201	5.2
Coordination, research, evaluation	605	3.0	504	2.1	5,851	1.8
Law enforcement	5,792	28.8	6,100	25.5	421	25.5
Others, unspecified	620	3.1	217	0.9	106	0.5
Total	**20,084**	**100.0**	**23,947**	**100.0**	**22,973**	**100.0**

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

A new source of data is provided in Table 1-8, which outlines the structure of budgets for projects subsidised by the *Government Council for Drug Policy Coordination*, including resources other than those made available from the state and local budgets. In 2009 most of these services' income (54.0%) originated from the state budget; the *GCDPC* provided 30.3% of all the income. Another 36.1% of all the income originated from local budgets, 8.5% from other home sources (mainly the services' own earnings), and 1.3% of all the income was provided from abroad (EU funds). In the period from 2006 to 2009 there was a rise in the proportion of income provided by local budgets and the *Ministry of Labour and Social Affairs*, while the amount of funds supplied by the *GCDPC* declined.

Table 1-8: Income of providers of drug policy programmes subsidised by the GCDPC in 2006-2009 by source

Source	2006		2007		2008		2009	
	€ thousand	%	€ thousand	%	€ thousand	%	€ thousand	%
State budget	**5,585**	**51,3**	**5,984**	**52,9**	**6,352**	**53,9**	**6,283**	**54,0**
GCDPC	3,841	35,3	3,798	33,6	3,573	30,3	3,527	30,3
Ministry of Education	56	0,5	59	0,5	115	1,0	54	0,5
Ministry of Labour and Social Affairs	1,460	13,4	1,872	16,6	2,350	19,9	2,441	21,0
Ministry of the Interior	4	0,0	5	0,0	5	0,0	0	0,0
Ministry of Health	134	1,2	203	1,8	240	2,0	238	2,0
Ministry of Justice	4	0,0	14	0,1	22	0,2	21	0,2
Other ministries	0	0,0	0	0,0	18	0,1	0	0,0
Labour Office	86	0,8	34	0,3	29	0,2	0	0,0
Local budgets	**3,504**	**32,2**	**3,821**	**33,8**	**4,033**	**34,2**	**4,204**	**36,1**
Regions	1,886	17,3	2,312	20,4	1,796	15,2	2,441	21,0
Municipalities	1,618	14,9	1,508	13,3	2,237	19,0	1,763	15,2
Other home resources	**1,790**	**16,5**	**1,213**	**10,7**	**1,249**	**10,6**	**990**	**8,5**
Sponsorship and fundraising	306	2,8	212	1,9	240	2,0	199	1,7
Services' own earnings and clients' contributions	542	5,0	516	4,6	480	4,1	538	4,6
Endowments	362	3,3	55	0,5	51	0,4	0	0,0
Others	579	5,3	430	3,8	477	4,1	253	2,2
Foreign resources	**0**	**0,0**	**291**	**2,6**	**154**	**1,3**	**153**	**1,3**
EU funds	0	0,0	237	2,1	111	0,9	153	1,3
Other foreign resources	0	0,0	55	0,5	43	0,4	0	0,0
Total	**10,879**	**100,0**	**11,309**	**100,0**	**11,787**	**100,0**	**11,630**	**100,0**

Note: 2009 average exchange rate was used (1€ = CZK 26.445) for recalculation in all years.

1.3.2 Social Costs

A summary of the 2007 costs of drug treatment in the Czech Republic, including health insurance, is a part of the Special Issue on Cost of Drug-related Treatment (p. 130).

Supported by the internal grant agency of the Ministry of Health, in 2009 the *Centre for Addictology of the Department of Psychiatry of the First Faculty of Medicine of Charles University in Prague and of the General University Hospital in Prague* (*the Centre for Addictology*) began carrying out a study of the 2007 social costs of the use of alcohol, tobacco, and illicit drugs in the Czech Republic. The results will be available in 2012.

Table 1-9: 2009 drug policy expenditures from state and local budgets by location (region) of use (€ thousand)

Regions	GCDPC	Ministry of Education	Ministry of Defence	Ministry of Labour and Social Affairs	Ministry of Health	Ministry of Justice	General Customs Head-quarters	National Drug Head-quarters	Total state budget	Regions	Munici-palities	Total local budgets	Total	Total (%)
Prague	876	33	-	314	194	-	-	-	**1,416**	1,852	436	2,288	**3,703**	**16.1**
Central Bohemia	118	31	-	690	56	-	-	-	**895**	473	135	608	**1,503**	**6.5**
South Bohemia	197	19	-	315	58	-	-	-	**589**	379	85	464	**1,052**	**4.6**
Pilsen	170	15	-	100	15	-	-	-	**299**	250	266	516	**816**	**3.6**
Karlovy Vary	65	8	-	42	26	-	-	-	**141**	23	21	44	**185**	**0.8**
Ústí nad Labem	309	24	-	263	31	-	-	-	**627**	189	229	418	**1,044**	**4.5**
Liberec	51	13	-	168	0	-	-	-	**232**	314	58	372	**604**	**2.6**
Hradec Králové	98	16	-	127	44	-	-	-	**286**	364	48	413	**698**	**3.0**
Pardubice	52	15	-	62	25	-	-	-	**154**	200	60	260	**414**	**1.8**
Vysočina	44	14	-	252	9	-	-	-	**319**	134	19	153	**472**	**2.1**
South Moravia	281	32	-	366	77	-	-	-	**756**	713	254	967	**1,723**	**7.5**
Olomouc	241	18	-	293	23	-	-	-	**575**	333	127	460	**1,035**	**4.5**
Zlín	68	17	-	103	8	-	-	-	**197**	334	107	441	**638**	**2.8**
Moravia-Silesia	141	37	-	187	2	-	-	-	**367**	968	405	1,372	**1,739**	**7.6**
Expenditure with regional designation	2,711	293	-	3,282	566	-	-	-	**6,851**	6,528	2,249	8,777	**15,628**	**68.0**
Expenditure with central designation	975	133	162	-	4	409	120	5,542	**7,345**	-	-	-	**7,345**	**32.0**
Total	**3,686**	**426**	**162**	**3,282**	**569**	**409**	**120**	**5,542**	**14,196**	**6,528**	**2,249**	**8,777**	**22,973**	**100.0**
– including investment expenditure	876	33	-	314	194	-	-	-	**1,416**	1,852	436	2,288	**3,703**	**1.1**
Total (%)	**16.0**	**1.9**	**0.7**	**14.3**	**2.5**	**1.8**	**0.5**	**24.1**	**61.8**	**28.4**	**9.8**	**38.2**	**100.0**	**–**

Table 1-10: 2009 drug policy expenditures in the Czech Republic by service categories (€ thousand)

Service category		GCDPC	Ministry of Education	Ministry of Defence	Ministry of Labour and Social Affairs	Ministry of Health	Ministry of Justice	General Customs Head-quarters	National Drug Head-quarters	Total state budget	Regions	Munici-palities	Total local budgets	Total	Total (%)
Prevention		145	426	162	0	0	0	0	0	**732**	854	492	**1,346**	**2,078**	**9.0**
Harm Reduction	Low-threshold centres	1,004	0	0	1,176	105	0	0	0	**2,284**	972	658	**1,630**	**3,914**	**17.0**
	Outreach programmes	618	0	0	663	55	0	0	0	**1,337**	631	420	**1,051**	**2,388**	**10.4**
	Unspecified *	218	0	0	0	3	0	0	0	**220**	75	19	**94**	**314**	**1.4**
	Total	1,840	0	0	1,839	163	0	0	0	**3,841**	1,678	1,097	**2,775**	**6,616**	**28.8**
Treatment	Health care**	66	0	0	0	393	48	0	0	**507**	297	66	**364**	**871**	**3.8**
	Non-health outpatient care***	307	0	0	320	0	122	0	0	**749**	321	207	**529**	**1,278**	**5.6**
	Therapeutic communities	788	0	0	751	0	0	0	0	**1,539**	471	119	**591**	**2,129**	**9.3**
	Sobering-up stations	0	0	0	0	0	0	0	0	**0**	2,421	0	**2,421**	**2,421**	**10.5**
	Unspecified	0	0	0	0	0	0	0	0	**0**	0	0	**0**	**0**	**0.0**
	Total	1,161	0	0	1,071	393	171	0	0	**2,796**	3,511	393	**3,904**	**6,699**	**29.2**
Aftercare		321	0	0	372	0	0	0	0	**693**	367	140	**508**	**1,201**	**5.2**
Coordination, research, evaluation		0	0	0	0	0	189	120	5,542	**5,851**	0	0	**0**	**5,851**	**1.8**
Law enforcement		220	0	0	0	14	50	0	0	**283**	72	67	**138**	**421**	**25.5**
Others, unspecified		0	0	0	0	0	0	0	0	**0**	46	60	**106**	**106**	**0.5**
Total		**3,686**	**426**	**162**	**3,282**	**569**	**409**	**120**	**5,542**	**14,196**	**6,528**	**2,249**	**8,777**	**22,973**	**100.0**

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

2 Drug Use in the General Population and Specific Targeted Groups

No general population survey focused on the issue of drugs was conducted in the Czech Republic in 2009. However, a few small-scale studies and projects were carried out.

A *Citizen Survey* was carried out in the autumn of 2009. The prevalence levels it found were significantly lower than those reported by the 2008 general population survey. Taking into account the results of both studies, the lifetime prevalence of the use of cannabis, ecstasy, pervitin, and cocaine among the Czech adult population is 30%, 5-10%, about 4%, and 2%, respectively. The prevalence of the last-year use of cannabis, ecstasy, pervitin, and cocaine among Czech adults reached the respective levels of 11-15%, 3-4%, about 1.5%, and about 0.5%. The use of cannabis, ecstasy, pervitin, and cocaine by young adults (aged 15-34) in the last year showed prevalence rates of 22-28%, 3-8%, up to 3%, and about 0.5-1.5%, respectively.

The yearly prevalence of illicit drug use among respondents aged 18-39 was measured as part of the *Drinking among Young Adults* project. Being comparable to the prevalence rates identified by the 2008 general population survey, the findings confirm that in the Czech Republic the prevalence of the use of marijuana, ecstasy, pervitin, and cocaine among people aged 18-39 (i.e. a population covering the group referred to as young adults) in the past 12 months reached the levels of 22-23%, 6.5-7%, 3-3.5%, and 0.5-1.5%, respectively.

Dance partygoers show higher prevalence rates of illicit drug use – apart from cannabis, they tend to use mainly ecstasy, followed by pervitin, cocaine, and hallucinogens.

A study was conducted on the use of addictive substances among young people in excluded Roma areas of the city of Brno. The school-based questionnaire survey carried out in excluded areas showed that 32% of children in the sixth to ninth grades had used cannabis at least once, and experience with other drugs (ecstasy, pervitin, or heroin) was reported by 6% of the children. As far as other drugs are concerned, toluene ranked among the most frequently used substances. The use of toluene, however, appears to be associated with the lowest social status.

The *DRUID (Driving under the Influence of Drugs, Alcohol, and Medicines)* project involved the investigation of illegal drug use among drivers. The overall level of prevalence of driving under the influence of psychoactive substances, including alcohol, is estimated to be 10-15%, with marijuana being the most commonly used non-alcohol drug. The results suggest that the rate of use of non-alcohol drugs, including illicit substances, among Czech drivers is comparable to that of alcohol use.

According to a survey conducted by the *Public Opinion Poll Centre of the Institute of Sociology of the Academy of Science of the Czech Republic,* citizens perceive drug use as more of a problem of the Czech Republic in general; to a much smaller degree, they see the drug situation as a pressing issue in their community. The people living in small municipalities (up to 2,000 inhabitants) thought of the situation in their communities in the most positive terms.

2.1 Drug Use in the General Population

Data originating from two studies conducted in the autumn of 2008 were processed in 2009. The studies included a general population survey focusing specifically on the use of psychotropic substances in the Czech Republic (2008 General Population Survey) and a set of items enquiring about experience with alcohol, cigarettes, and illegal drugs contained in the questionnaire administered as part of the European Core Health Interview Survey (*2008 EHIS*). The first findings were summarised in the 2008 Annual Report; more detailed results of the *2008 General Population Survey* will be available at the end of the year 2010 (Běláčková and Horáková, 2010). It turned out that the prevalence levels of experience with drugs found by the *2008 EHIS* study were significantly lower than those reported in the *2008 General Population Survey*. A special study commissioned by the National Focal Point in order to explain the differences between the results of both studies (Linek, 2010) and experts – members of the National Focal Point's working group for population and school surveys on drugs (Národní monitorovací středisko pro drogy a drogové závislosti, 2010e) – have identified several possible reasons for such variations, including the different formulations of the questions and their context in the questionnaires, varying data collection methodologies and procedures, and differences in the construction of the samples. The lower prevalence rates shown in the 2008 *EHIS* may have been caused by the survey's focus on health aspects, the lower degree of privacy in asking questions, and the lower response rate. In addition, it may be inferred that individuals who could not be reached at their home address tend to be engaged in risk behaviours to a greater extent and may be assumed to show a higher level of drug use. Finally, the more thorough analyses support the idea that it was the context of the questions asked that played the crucial role. They argued that, in the *EHIS* study, the items under consideration followed the module pertaining to a healthy lifestyle and health status, which could have a bearing on the responses to the questions concerning drug use.

The same phenomenon can be observed when comparing the international multi-centre studies *ESPAD* (a survey looking into tobacco, alcohol, and illegal drugs) and *HBSC* (a survey focusing on health and healthy lifestyles): in

most countries, including the Czech Republic, the *ESPAD* survey regularly reports higher levels of drug use[25]. A research study seeking to explain the reasons for such variations has identified several factors which may have resulted in the differences (Škařupová, 2010):

- personal interpretation of the question in view of the focus of research – the respondent tends to adjust their answers according to what they think they are expected to report (for example, to lead a healthy lifestyle, to be "IN");
- the more elaborate questions asked in a monothematic drug survey – the respondent may be offered examples which help them recall their behaviour and specify what the question really means;
- priming – respondents are better at recalling a topic to which they have been exposed over time;
- a tendency to provide consistent responses, which may result in the underestimation of the prevalence of drug use in research concerned with health issues and, on the contrary, in the overestimation of prevalence rates in research studies focusing specifically on drugs;
- social expectations which the focus of some research studies may, albeit involuntarily, arouse.

In the autumn of 2009 a control study was carried out using questions from both studies in order to collect additional information about the possible reasons for the differences between the respective studies. It showed that the way in which the questions were formulated had no significant effect on the differences in prevalence levels; see also the chapter on Survey on Citizens' Opinions about and Attitudes to the Issues of Health and Healthy Lifestyles (p. 28).

2.1.1 Study of the Young Adult Population

A questionnaire survey, the *Determinants of Risk Forms of Alcohol Use among the Population of Young Adults: analysis of health, social, and psychological correlations (Drinking among Young Adults),* involving 2,221 respondents in the 18-39 age category, was conducted in 2009[26]. A structured interview administered as part of the project included several questions concerning the use of specific illegal drugs in the last year. The most frequently used drug among the population aged 18-39 was marijuana, showing a prevalence rate of 21.8%, followed by ecstasy and pervitin, tried by 7.0% and 3.5% of the respondents, respectively, in the last year. The highest prevalence was found among the youngest age group, 18-24, where marijuana had been used by 38.1% of the respondents during the previous year. The distribution of patterns of illicit drug use suggests that the prevalence of the use of ecstasy among the youngest age groups is significantly higher than that reported by people who are older and the ecstasy use prevalence levels also show the smallest gender differences; no such significant relative differences between age groups were found as regards other drugs – Table 2-1.

Table 2-1: Prevalence of illicit drug use in the last year by gender and age (%) (Sovinová and Csémy, 2010)

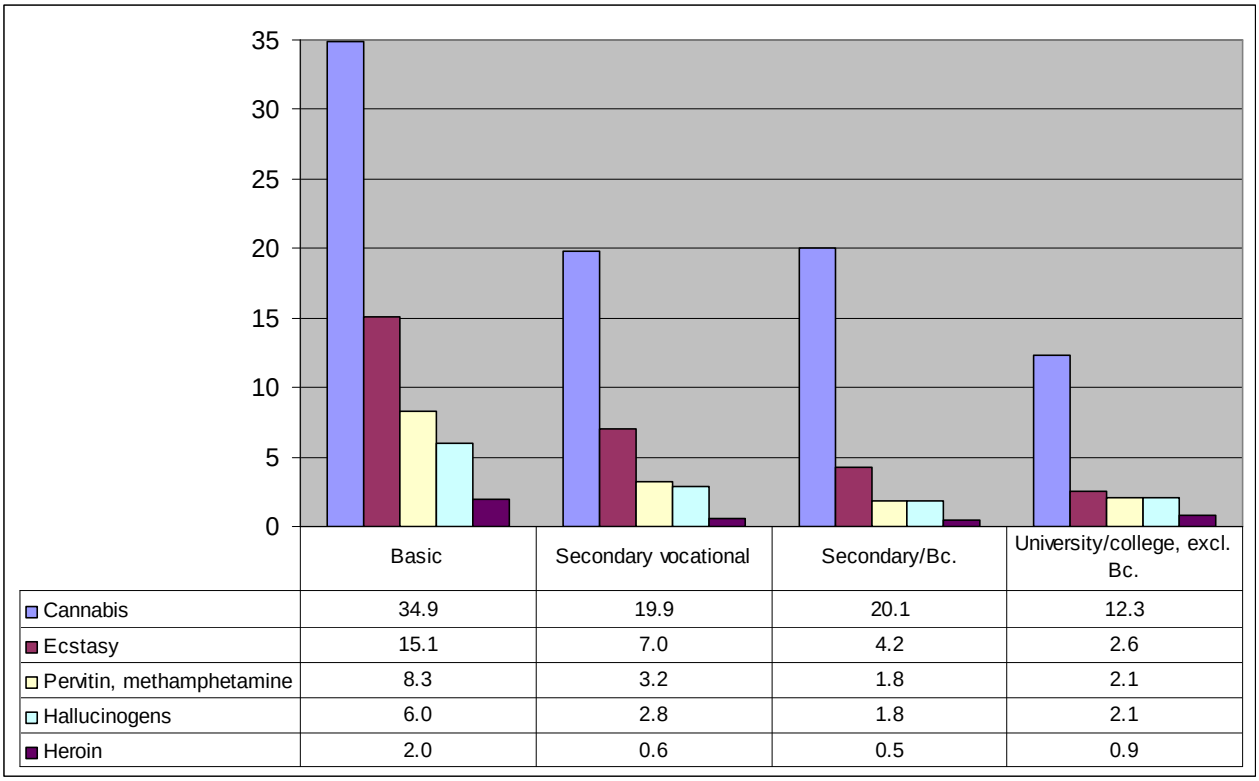
Last-year prevalence	**Gender**		**Age**				**Total (N=2221)**
	Males (n=1141)	Females (n=1080)	18-24 (n=485)	25-29 (n=542)	30-34 (n=651)	35-39 (n=543)	
Cannabis	28.7	14.6	38.1	27.3	16.3	8.5	21.8
Ecstasy	8.7	5.3	16.5	7.6	3.8	1.8	7.0
Pervitin	4.8	2.1	6.2	4.2	2.2	2.0	3.5
Hallucinogens	4.4	1.5	4.1	3.7	2.9	1.3	3.0
Heroin	1.0	0.7	1.6	0.9	0.6	0.4	0.9

Apparently, education has an impact on the level of drug use. Respondents with the lowest level of education show by far the highest prevalence rates. The last-year use of marijuana was reported by 34.9% of respondents with basic education, in comparison to only 12.3% of respondents with university degrees. A similar pattern can also be observed in all the other drugs; see Figure 2-1. As far as the correct interpretation of data is concerned, it should be pointed out that the respondents with basic education may often include students who have not finished secondary school yet and are at the age which is the most typical in terms of drug use. Thus, to a certain extent, the high prevalence among the respondents with basic education may be due to their young age.

[25] Taking into account the different ages of the respondents participating in both studies – 15-16 years in the *ESPAD* survey (approximately one third was recruited from the ninth grades of basic schools, and two thirds of the sample originated from the first grades of secondary schools) and 15 years of age in the *HBSC* study (the ninth grades of basic schools only).

[26] Grant No. NS9645-4/2008, Internal Grant Agency, Czech Ministry of Health, Principal Investigator Hana Sovinová, MD; the beneficiary of the grant is the National Institute of Public Health in Prague.

Figure 2-1: Prevalence of illicit drug use in the last year by education (%) (Sovinová and Csémy, 2010)



	Basic	Secondary vocational	Secondary/Bc.	University/college, excl. Bc.
Cannabis	34.9	19.9	20.1	12.3
Ecstasy	15.1	7.0	4.2	2.6
Pervitin, methamphetamine	8.3	3.2	1.8	2.1
Hallucinogens	6.0	2.8	1.8	2.1
Heroin	2.0	0.6	0.5	0.9

2.1.2 Survey on Citizens' Opinions about and Attitudes to the Issues of Health and Healthy Lifestyles

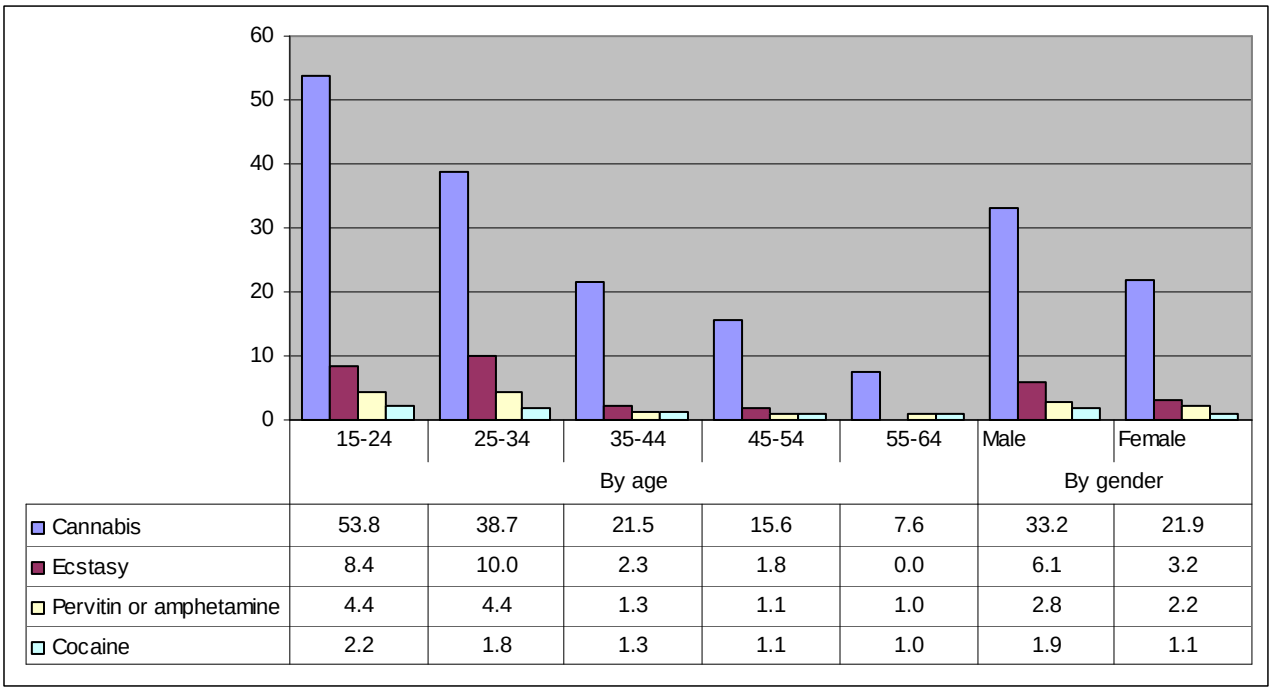
The *Citizen Survey* project, carried out in the autumn of 2009, involved the taking of control measures of substance use prevalence rates by means of two different methods of interviewing applied as part of the *2008 General Population Survey* and the *2008 EHIS*. The rationale was to simulate the different interviewing approaches and contexts and explain the reasons which may have led to the two studies differing in their results: one half of the respondents was asked the first type of question set at the beginning of the questionnaire, the other half of the respondents was asked the second type of question set at the end of the questionnaire. Neither the way in which the questions were formulated nor their sequencing in the questionnaire produced any significant differences in the prevalence levels as identified. Therefore, the results are summarised for the entire sample of respondents; see Table 2-2. The lifetime use of cannabis, ecstasy, pervitin, and cocaine was reported by 27.6%, 4.6%, almost 2.5%, and 1.5%, respectively, of respondents aged 15-64.

Table 2-2: Prevalence of illicit drug use in three time spans by gender and age (%) (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2009)

Prevalence	**Drug**	**Gender**		**Age**					**Total (N=1486)**
		Males (n=743)	Females (n=743)	15-24 (n=275)	25-34 (n=341)	35-44 (n=303)	45-54 (n=276)	55-64 (n=291)	
Lifetime prevalence	Cannabis	33.2	21.9	53.8	38.7	21.5	15.6	7.6	27.6
	Ecstasy	6.1	3.2	8.4	10.0	2.3	1.8	0.0	4.6
	Pervitin or amphetamines	2.8	2.2	4.4	4.4	1.3	1.1	1.0	2.5
	Cocaine	1.9	1.1	2.2	1.8	1.3	1.1	1.0	1.5
Last-year prevalence	Cannabis	15.1	7.1	29.5	15.2	4.6	4.0	2.4	11.1
	Ecstasy	2.0	0.8	4.0	1.8	0.3	1.1	0.0	1.4
	Pervitin or amphetamines	0.4	0.0	0.0	0.6	0.0	0.4	0.0	0.2
	Cocaine	0.4	0.4	0.7	0.3	0.3	0.4	0.3	0.4
Last-month prevalence	Cannabis	7.0	1.2	11.6	6.2	1.0	0.7	1.0	4.1
	Ecstasy	0.1	0.1	0.7	0.0	0.0	0.0	0.0	0.1
	Pervitin or amphetamines	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Cocaine	0.1	0.1	0.0	0.3	0.3	0.0	0.0	0.1

The results showed that males had had significantly wider experience of illegal drugs. The number of men who had used cannabis in the last year was double that of women (15.1% vs. 7.1%). Similar figures were registered for ecstasy. Experience with cocaine in the last year was reported by the same proportions of males and females (0.4%). The prevalence of drug use declined with increasing age, which confirmed the traditional age-related patterns of use. Over one half of young adults aged 15-24 had used cannabis in their lifetime; almost one third of them reported cannabis use in the previous 12 months.

Figure 2-2: Lifetime prevalence of experience with illicit drugs by gender and age (%) (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2009)



	15-24	25-34	35-44	45-54	55-64	Male	Female
Cannabis	53.8	38.7	21.5	15.6	7.6	33.2	21.9
Ecstasy	8.4	10.0	2.3	1.8	0.0	6.1	3.2
Pervitin or amphetamine	4.4	4.4	1.3	1.1	1.0	2.8	2.2
Cocaine	2.2	1.8	1.3	1.1	1.0	1.9	1.1

2.1.3 Comparison of Drug Use Prevalence Levels in the 2008-2009 Surveys

In view of the respondents' different age range, the prevalence rates from all four general population surveys carried out from 2008 to 2009 can only be compared for the 18-39 age category in terms of the last-year prevalence indicator; see Table 2-3. This comparison indicates that the lowest prevalence rates were found in the *2008 EHIS* survey focused on health and healthy lifestyles (for possible reasons see above). Research projects examining substance use-related issues and working with large enough samples (such as *Drinking among Young Adults* and the *2008 General Population Survey*) show congruent prevalence levels which indicate that in the Czech Republic the prevalence of the use of cannabis, ecstasy, pervitin, and cocaine among people aged 18-39 in the last year reached the levels of 22-24%, 6.5-7%, 3-3.5%, and 0.5-1.5%, respectively.

Table 2-3: Comparison of prevalence rates of the use of specific drugs in the past 12 months identified by different surveys for the population aged 18-39 (%) (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2009; Sovinová and Csémy, 2010; Běláčková and Horáková, 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2010e)

Drug	**2009 Citizen Survey (n=712)**	**2009 Drinking among Young Adults (n=2221)**	***2008 General Population Survey* (n=2114)**	***2008 EHIS* (n=803)**
Cannabis	19.1	21.8	23.6	8.2
Ecstasy	2.4	7.0	6.4	1.4
Pervitin or amphetamines	0.3	3.5	2.9	1.0
Hallucinogens	–	3.0	6.8	2.9
Cocaine	0.6	–	1.4	0.9
Heroin	–	0.9	0.8	0.6

As regards the *2008 General Population Survey* and the *2009 Citizen Survey* studies, prevalence levels pertaining to all three time spans under scrutiny and the entire adult population aged 15-64 can be compared. The prevalence rates reported as part of the *Citizen Survey* show significantly lower levels than those found in the *2008 General Population Survey.* Nevertheless, they confirm the higher level of the Czech population's experience with drug use than that identified by the 2008 *EHIS* research project. Given that the *Citizen Survey* was carried out just one year after the *2008 General Population Survey*, the differences between both studies should be attributed to

methodological variations and the different contexts of the data collection process rather than being interpreted as the beginning of a declining trend in drug use in society[27]. The *Citizen Survey* was designed as an omnibus study[28], while the *2008 General Population Survey* was a monothematic research project focusing on drug issues only; see Table 2-4.

Table 2-4: Comparison of prevalence rates of use of specific drugs recorded by the 2009 Citizen Survey and the 2008 General Population Survey (%) (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2009; Běláčková and Horáková, 2010)

Prevalence	Drug	2009 Citizen Survey			2008 General Population Survey		
		Age 15-24 (n=275)	Age 15-34 (n=616)	Total age 15-64 (N=1486)	Age 15-24 (n=827)	Age 15-34 (n=1891)	Total age 15-64 (N=4500)
Lifetime prevalence	Cannabis	53.8	45.5	27.6	58.7	53.3	34.3
	Ecstasy	8.4	9.3	4.6	20.8	18.4	9.6
	Pervitin or amphetamines	4.4	4.4	2.5	7.2	7.8	4.3
	Cocaine	2.2	1.9	1.5	2.8	3.6	2.0
Last-year prevalence	Cannabis	29.5	21.6	11.1	37.3	28.2	15.2
	Ecstasy	4.0	2.8	1.4	11.2	7.7	3.7
	Pervitin or amphetamines	0.0	0.3	0.2	3.6	3.2	1.7
	Cocaine	0.7	0.5	0.4	1.9	1.6	0.7
Last-month prevalence	Cannabis	11.6	8.6	4.1	22.4	16.7	8.5
	Ecstasy	0.7	0.3	0.1	3.3	2.6	1.2
	Pervitin or amphetamines	0.0	0.0	0.0	1.5	1.4	0.7
	Cocaine	0.0	0.2	0.1	0.8	0.8	0.4

In conclusion, the lifetime prevalence rate of the use of cannabis, ecstasy, pervitin, and cocaine among the Czech adult population is 30%, 5-10%, about 4%, and 2%, respectively. The prevalence of the last-year use of cannabis, ecstasy, pervitin, and cocaine among Czech adults reached the respective levels of 11-15%, 3-4%, about 1.5%, and about 0.5%. The use of cannabis, ecstasy, pervitin, and cocaine by young adults (aged 15-34) showed prevalence rates of 22-28%, 3-8%, up to 3%, and about 0.5-1.5%, respectively.

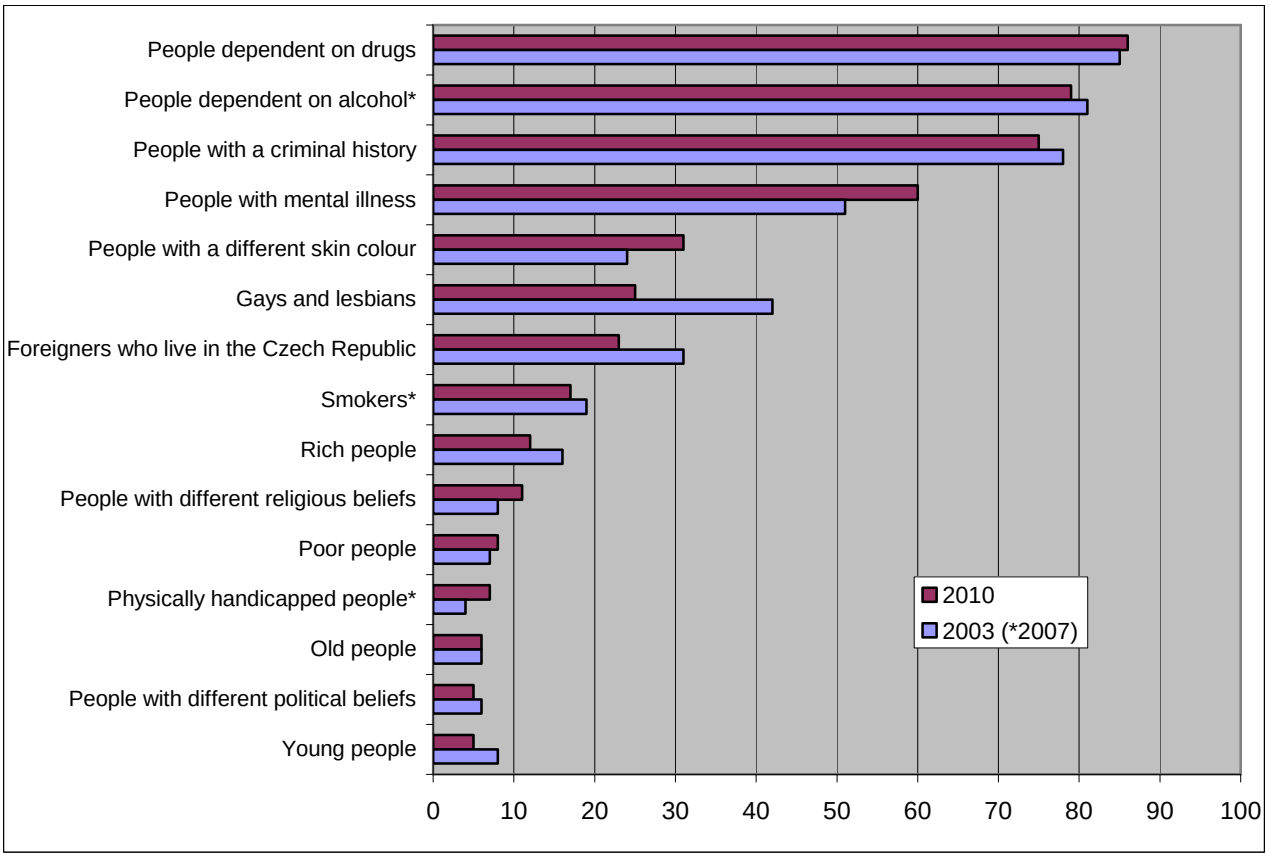
The lifetime prevalence of cannabis use was also covered by a survey conducted by the *Public Opinion Poll Centre of the Institute of Sociology of the Academy of Science of the Czech Republic,* a public research institution (the *Public Opinion Poll Centre*), which showed that 28% of respondents of the age of 15 and over had used cannabis at least once in their lifetime – see below.

2.1.4 Attitudes to Substance Use

The *Public Opinion Poll Centre's* annual survey of tolerance towards selected groups of citizens was conducted in March 2010. Items concerning drug addicts and people dependent on alcohol are included in the research project. The level of tolerance is identified by means of a question in which the respondents were asked to choose groups of people whom they would not like to have as their neighbours. Traditionally, Czech citizens were the least tolerant towards drug addicts, people dependent on alcohol, and people with a criminal history. In all these groups, however, relatively stable levels with a slight increase in tolerance can be observed; see Figure 2-3. The public acceptance of gays and lesbians is also rising. On the contrary, growing intolerance towards the mentally ill and people with a different skin colour has been experienced since 2003.

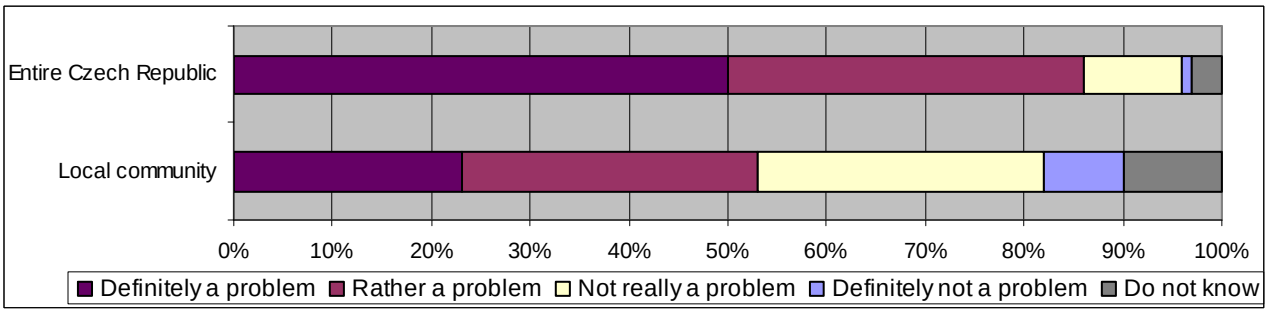
[27] The greatest differences between both studies appear as regards younger age groups and drug use in recent recall periods – for example, the prevalence of cannabis use among young people aged 15-24 in the last month as recorded by the *2008 General Population Survey* is almost double the comparable variable measured by the *Citizen Survey*.
[28] I.e. concerned with a wider range of topics, including more thematic modules.

Figure 2-3: Year-to-year comparison of responses to the question "Who would you like not to have as your neighbours?" for the years 2003 (2007 as applicable) and 2010; respondents aged 15+ (%) (Centrum pro výzkum veřejného mínění, 2010b)



In May 2010 the *Public Opinion Poll Centre* conducted another representative survey using a sample of 1,061 respondents which examined the citizens' perception of the current drug use situation in both their community and the Czech Republic as a whole. It was shown that the public perceives drug use as a problem of the Czech Republic (86% of respondents) rather than an issue of concern in their own community (53%); see Figure 2-4. The people from small municipalities of up to 2,000 inhabitants thought of the situation in the most positive terms in relation to their communities, while the inhabitants of towns and cities showed a more positive perception of the situation in the Czech Republic in general.

Figure 2-4: Czech citizens' perception of the current drug use situation; respondents aged 15+ (Centrum pro výzkum veřejného mínění, 2010a)

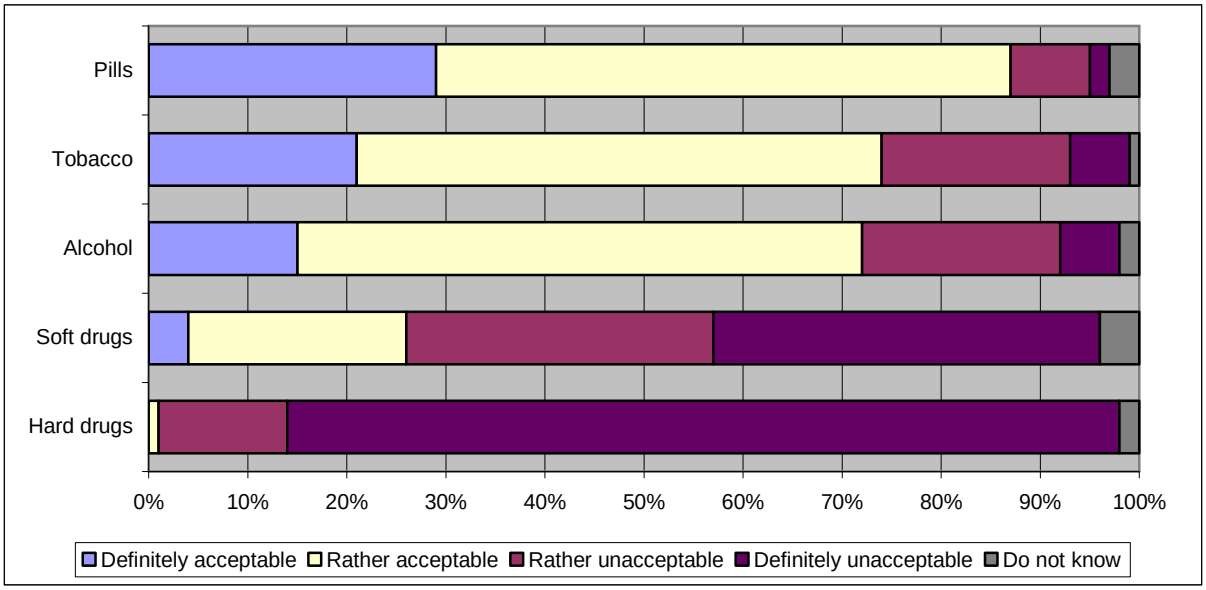


Almost half of the respondents (47%) believe that Czech institutions address the problem of drug use to a reasonable degree, 38% believe that their activities are insufficient in this respect, 6% answered that the institutions paid excessive attention to the issue (this opinion was mainly held by the respondents who had had experience with drugs), and 9% of the people did not know how to respond to the question. In addition, questions about the level of acceptability of specific addictive substances and the direct or indirect experience of drug use were asked; see Figure 2-5. Most respondents found the use of painkillers, sleeping pills, and tranquillisers the most acceptable (87%). A significant majority also accepted the traditional legal drugs such as tobacco and alcohol (74% and 72%, respectively). Both "hard" (heroin, pervitin, ecstasy) and "soft" (marijuana and hashish) drugs were among the least accepted substances. They were found unacceptable by 99% and 74% of the respondents, respectively[29].

[29] The terms *hard* and *soft* drugs, as well as the substances assigned to these categories, were used in the questions by the agency which carried out the research. The distinction between *hard* and *soft* drugs is inaccurate, unclear, and informal. In principle, it generally

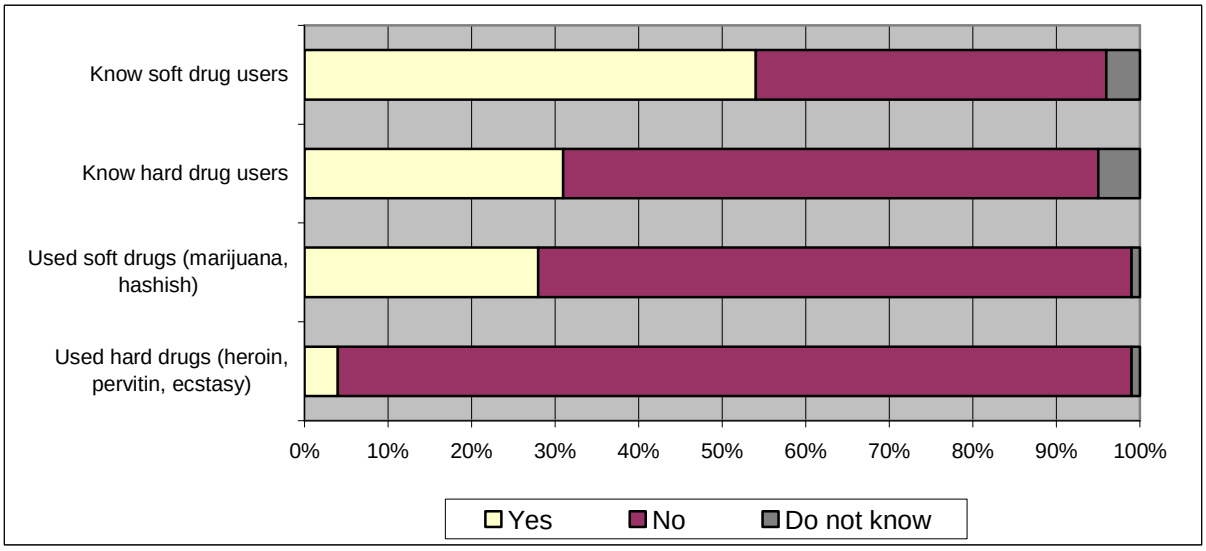
According to the *Public Opinion Poll Centre*, a more liberal attitude to the use of soft drugs is expressed by men, people under 30, people living in Prague, and those who had used a drug themselves or at least know somebody who had.

Figure 2-5: Degree of acceptability of the use of specific addictive substances; respondents aged 15+ (Centrum pro výzkum veřejného mínění, 2010a)



Furthermore, the respondents were asked, although in general terms only, about their experience with drugs. The answers indicated 28% of the respondents of the age of 15 and over had tried marijuana or hashish and 54% also knew somebody who had tried or used the drugs. Four per cent of the respondents had tried heroin, pervitin, or ecstasy, and 31% of the respondents knew somebody with similar experience; see Figure 2-6. This survey, too, confirmed that men and individuals up to 30 years of age have more direct and indirect experience with drug use. Direct personal experience with marijuana or hashish was reported by 54%, 55%, 35%, and 15% of the respondents in the 15-19, 20-29, 30-44, and 45-59 age categories respectively, while among people over sixty the rate was only 5%.

Figure 2-6: Personal and mediated experiences with illicit drugs; respondents aged 15+ (Centrum pro výzkum veřejného mínění, 2010a)



2.2 Drug Use in the School Population and among Young People

2.2.1 *ESPAD Study*

Coordinated by the Swedish Council for Information on Alcohol and Other Drugs (CAN), the *ESPAD* survey has been carried out every four years since 1995. The Czech Republic has participated in this research project since its beginning. The 2007 results, including the trends observed from 1995, can be found in a summary publication (Csémy et al. 2009); the major findings were also included in the 2007 and 2008 Czech national reports. A report

refers to a varied level of health and social risks and effects associated with using them. As far as illegal drugs are concerned, the most common drug considered *soft* is cannabis.

summarising the 2007 ESPAD survey results from all of Europe, including international comparisons, were also published (Hibell et al. 2009). The fifth round of the survey, scheduled for the spring of 2011, is currently under preparation.

2.2.2 *HBSC Study*

Health Behaviour in School-aged Children (*HBSC*) is an international survey focused on health and health behaviours among children aged 11, 13, and 15 (organised by the *WHO* every four years since 1985; the Czech Republic has participated in the project since 1993). Questions enquiring about experience with the use of illicit drugs were only included in the questionnaire for 15-year-old students. The last round but one of the survey was conducted in 2006; for a summary of the results see the 2006 Annual Report. The international report was published in 2008 (World Health Organization, Regional Office for Europe, 2008). In the Czech Republic, the latest round of data collection took place in the spring of 2010.

2.2.3 Other Surveys of the School Population

A survey conducted by *A Clubs Czech Republic* took place in 2009. It involved 19 schools from the city of Brno and another 10 schools located in the South Moravian region. The total number of respondents recruited for this survey was 3,486. They included pupils at the second level of basic schools, secondary school students (including those receiving training in vocational centres), and students at higher vocational schools, mostly from 11 to 20 years old. Given the low response rate on the part of secondary schools, the sample cannot be regarded as representative for the age category under consideration (A Kluby ČR, o.p.s., 2009). The study sought to determine the state of substance abuse in basic and secondary schools in Brno.[30]

In 2009, the *Institute for Criminology and Social Prevention* published the results of a study in which 464 second- and third-year students (56% females, 44% males) at secondary vocational schools and apprentice centres were surveyed about their attitudes to various aspects of stimulus stories. One of the stories, entitled *Cannabis*, featured secondary school students who grew, possessed, used, gave out, and bought marijuana. Later one of them was caught by the police with a supply of the drug on him, which was a transgression resulting in the student being expelled from school. Analysis of students' attitudes to this fictitious story suggests that young people find marijuana a natural part of their peer culture and generally consider the use of it everybody's own business. The only lapse on the part of the protagonists of this "cannabis" story, as viewed by their peers, was their not being careful enough, i.e. that they "got caught" doing something illegal. At the same time, the respondents seemed to have a generally good understanding of the risks associated with such conduct and showed no particular sympathy for those on whom sanctions were imposed for using and distributing cannabis. A large number of the respondents agreed to expulsion from school as a sanction for marijuana excesses and the punishment of a "professional" dealer met with a completely positive response (Večerka et al. 2009).

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

2.3.1 Drug Use among Children in Socially Excluded Roma Localities

Commissioned by the Agency for Social Inclusion in Roma Localities, *SocioFactor*, a limited-liability company, developed the Methodology for Research into the Use of Addictive Substances among Young People in Socially Excluded Localities (SocioFactor s.r.o., 2010). The study focused on Roma areas in the city of Brno. It tested four different methods: interviews with drug and/or social exclusion experts operating in Roma localities; individual interviews with drug users; focus groups with basic school pupils, and a questionnaire survey among 117 pupils in the sixth to ninth grades, out of which Roma accounted for 80%. As for illegal drugs, the experts report marijuana to be the most common addictive substance among the children; their estimates indicate that 80-90% of the children had experienced cannabis use by the age of 15. According to the experts, the degree of tolerance towards marijuana is comparable to that towards cigarettes, and is probably higher than the tolerance towards alcohol. Other frequently used drugs include toluene. The use of toluene, however, appears to be associated with the lowest social status and children consider it "the drug of the stupid". It is noteworthy that the questionnaire survey showed that 32% of the children in the sixth to ninth grades had used cannabis at least once, while experience with other drugs (ecstasy, pervitin, or heroin) was reported by 6% of the children.

2.3.2 Drug Use among Drivers

From March 2008 to June 2009, as part of the *DRUID*[31] project, investigators of the *Transport Research Centre* collected the basic demographic data and saliva samples of drivers stopped during regular police checks. The aim of this international project was to enhance road safety at the EU level and reduce the number of individuals driving under the influence of addictive substances. The first of the seven steps of the project was to get a general idea of the prevalence of the use of psychoactive substances among drivers. A total of 2,039 saliva samples, from 1,593 and 446 male and female drivers, respectively, was examined in a toxicological laboratory (Zaoral and Weinberger, 2010). Positive tests for any of the drugs under study, including alcohol, were recorded in 108 samples (88 males

[30] The results are available from http://www.vyzkum-mladez.cz/zpravy/1265711667.pdf.
[31] Driving under the Influence of Drugs, Alcohol, and Medicine

and 20 females), which contained 138 instances of drugs, both legal and illegal. The research study was voluntary; drivers had a chance to refuse to participate. Presumably, participation was more likely to be refused by impaired drivers. The *Transport Research Centre* estimates that, out of a total of 500 refusals, approximately one third of the drivers had used a substance impairing their capacity to drive. The total prevalence level of driving under the influence of psychoactive substances is estimated to be 10-15%. Out of 108 positive samples, the active metabolite of cannabis (delta-9-THC) was detected in 33 cases, alcohol in 23 cases, methamphetamine in 12 cases, cocaine once, and benzoylecgonine (the primary metabolite of cocaine) was found in two cases. As far as legal drugs (pills) are concerned, citalopram was identified the most frequently (18 cases), followed by nordiazepam, bromazepam, alprazolam, and tramadol in 9, 8, 7, and 6 cases, respectively. In total, illegal drugs, or combinations thereof, were detected in 41 cases, medicines with negative effects on the ability to drive were identified in 47 cases, and alcohol was present in 23 cases. The most common combination of illegal drugs was methamphetamine and THC, which were detected concurrently in 8 samples. Even if the drivers who refused to participate in research showed a higher level of the presence of alcohol, the results suggest, nevertheless, that the level of use of non-alcohol drugs, including illicit ones, among road users is comparable to that of alcohol use. The detection of psychoactive substances in traffic accidents and in drivers killed on the road is covered by the chapter on Drugs and Road Accidents (p. 72).

2.3.3 Drug Use in the Nightlife Setting

The year 2009 saw the continuation of the data collection process as part of the evaluation of the *2009 Safer Party Tour* project, following up on a similar initiative carried out in 2008, which provided preventive and harm reduction services at 14 summer festivals (for more details see the chapter Selective Prevention on page 39). The questionnaire survey among the project's clients included 381 respondents from 16 to 54 years old, the average age of the entire sample being 24.2. Males comprised two thirds (69.7%), and the average ages of the male and female respondents were 24.8 and 22.8 years, respectively. During the survey, less than one third (30.5%) of the project's clients were students, 62.5% were in employment or were carrying on a business. One fifth (20.1%) of the respondents reported having university/college education, while secondary school graduates with the "maturita" school-leaving exam accounted for 53.5%.

At least one experience with any of the drugs under study (with the exception of alcohol and the so-called "syrup"[32]) was reported by the vast majority of clients (92%) who completed the questionnaire. Three quarters (75.9%) and 44.9% of the sample had used at least one of the drugs under study in the past twelve months and the past 30 days, respectively. The prevalence rates of the use of the substances under scrutiny during the specific recall period are summarised in Table 2-5.

Cannabis, alcohol, and ecstasy, followed by magic mushrooms, LSD, pervitin, poppers, and cocaine, enjoyed the greatest popularity with the clients of the project. Alcohol, cannabis, and ecstasy were also the most likely to be reported by the respondents as the drugs which they had used, or planned to use, at the festival where they completed the questionnaire; in all three cases, the proportion of such people was even larger than that of the people who had used drugs in the past thirty days. In gender terms, with the exception of 12-month and lifetime cannabis use, men were more likely to have greater experience with most of the substances under study.

Table 2-5: Proportions of 2009 Safer Party clients who reported experience with drugs in their lifetime, in the past 12 months, and the past 30 days, and/or planned to use them at the event where they completed the questionnaire (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2010a)

Drug	Lifetime (%)	12 months (%)	30 days (%)	This event (%)
Alcohol	61.7	40.2	33.1	62.5
Cannabis	71.1	47.1	31.8	36.6
Ecstasy	60.3	37.4	14.7	29.2
Pervitin/amphetamine	43.8	21.6	7.7	7.1
LSD	44.7	23.8	7.1	5.0
Magic mushrooms	52.9	21.3	4.2	1.8
Poppers	44.6	15.4	5.3	2.9
Opiates/heroin	10.3	1.3	0.5	0.5
Cocaine	41.6	22.6	8.7	5.3
GHB	13.2	3.9	1.8	0.8
Ketamine	10.8	2.9	0.3	0.3
Syrup (dextromethorphan)	7.7	1.1	0.7	0.4

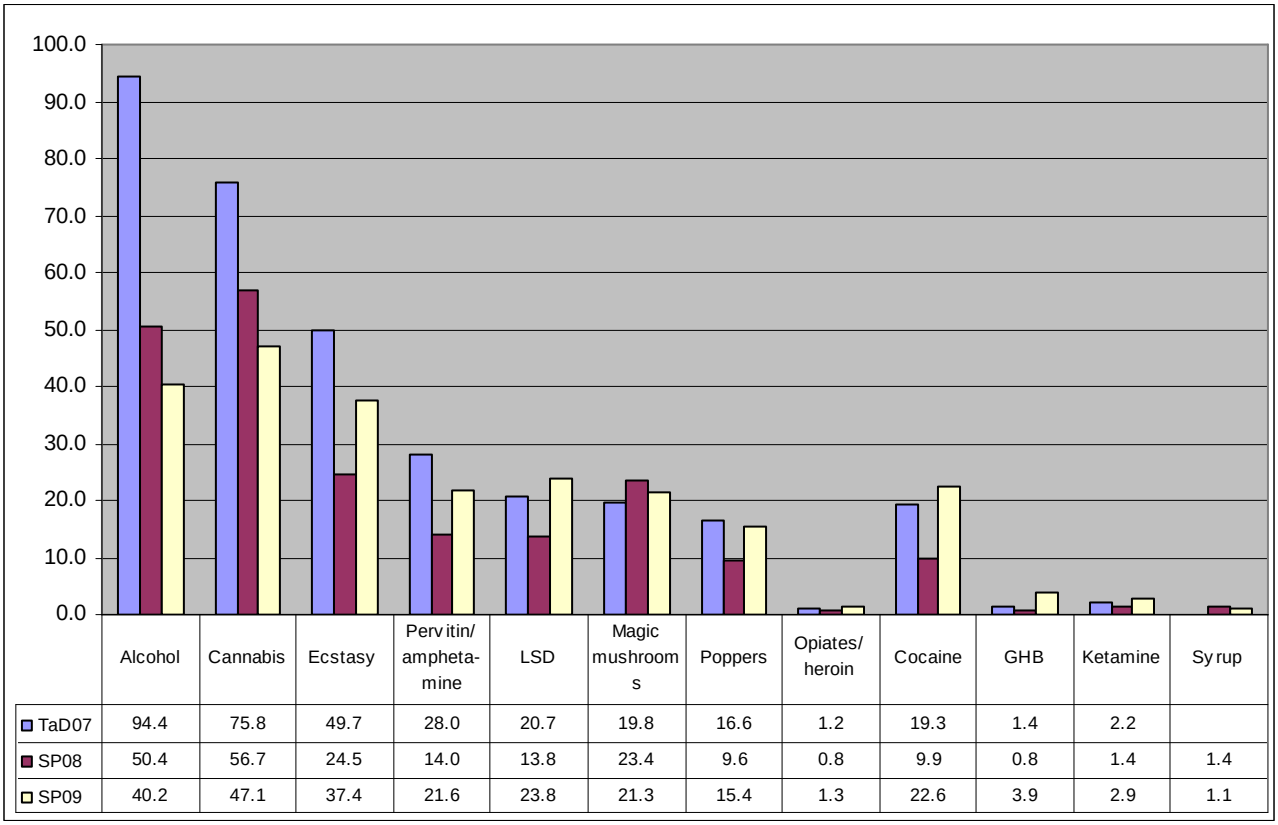
The process of data collection for the *2010 Dance and Drugs* research project concerned with the recreational use of drugs in the nightlife setting, conducted by the *National Monitoring Centre for Drugs and Drug Addiction* in

[32] Cough syrup with a content of dextromethorphan (the relevant products with a marketing authorisation for the Czech Republic include Robitussin® and Humex, dry cough syrup), which hip-hop fans, in particular, tend to abuse.

association with the *Rave.cz* and *Techno.cz* internet magazines and the *Metropolis* magazine, was initiated in June 2010. The project involves an online questionnaire survey on a self-nominated sample of electronic dance music fans which follows up on similar studies carried out in the years 2000, 2003, and 2007. The main objective of the research project is to explore, using a comparable methodology, trends in the use of both legal and illegal drugs and the prevalence of risk behaviours among young people who attend dance events. Data will be collected until late September 2010. The preliminary results should be available by the end of the same year.

A comparison of the degree of the use of drugs identified by the *2007 Dance and Drugs* study and the 2008 and 2009 *Safer Party Tour* projects, respectively, is provided in Figure 2-7. In view of the methodological differences between the studies and the fact that none of the studies worked with representative samples of the population of dance partygoers, the trend data need to be interpreted with caution.

Figure 2-7: Prevalence of use of specific drugs in the past 12 months among the clients of the 2008 and 2009 Safer Party Tour projects and among recreational drug users interviewed as part of the 2007 Dance and Drugs survey (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2008a)



	Alcohol	Cannabis	Ecstasy	Pervitin/ amphetamine	LSD	Magic mushrooms	Poppers	Opiates/ heroin	Cocaine	GHB	Ketamine	Syrup
TaD07	94.4	75.8	49.7	28.0	20.7	19.8	16.6	1.2	19.3	1.4	2.2	
SP08	50.4	56.7	24.5	14.0	13.8	23.4	9.6	0.8	9.9	0.8	1.4	1.4
SP09	40.2	47.1	37.4	21.6	23.8	21.3	15.4	1.3	22.6	3.9	2.9	1.1

Note: Experience with alcohol use reported for the purposes of the Safer Party Tour project is most probably under-represented because of the way the answers to the alcohol-related questions were recorded.

The year 2009 also experienced a few surveys carried out through the *vyplnto.cz*[33] public portal. The issues in question included drug prevalence, the effects of drugs on life, and opinions about the legalisation of marijuana. In view of the fact that the samples comprise internet users and are not representative, the evidence these research efforts provide is very limited.

[33] See http://www.vyplnto.cz/.

3 Prevention

In the Czech Republic, the co-ordination of primary prevention of high-risk behaviour and addictive substance use is in the competence of the *Czech Ministry of Education, Youth, and Sports (*the *Ministry of Education)*. The main documents in this area are the Strategy for the Prevention of Risk Behaviour among Children and Young People in the Jurisdiction of the Ministry of Education in the Period 2009-2012 and the methodological guidelines of the *Ministry of Education* concerning the prevention of social pathologies in children, pupils, and students in schools and educational facilities. The *Standards of Primary Prevention* and the process for certifying primary prevention programmes are major quality control tools in the field of prevention; the latter was temporarily halted in mid-2009 due to the transformation of the system.

In 2009 the *Ministry of Education's* subsidy programmes were used to support 278 projects carried out by schools and educational facilities and 18 projects implemented by non-governmental non-profit organisations. The *GCDPC* supported 11 preventive projects in 2009 – mainly with regards to specialised NGO preventive programmes.

Specific and indicated prevention programmes are focused on working with at-risk groups, individuals, and families. A significant topic is the prevention of addictive substance use among children and adolescents from ethnic minorities in the Czech Republic.

In the field of early diagnosis and intervention, tools such as the *Substance Use Risk Profile Scale* (*SURPS*) diagnosis method, *PREVenture* intervention tool and the *CRAFFT* questionnaire with an intervention manual for paediatricians have been implemented in practice.

Besides the Czech equivalents to the *Pay attention – or pay the price!* and *Designated Driver* campaigns that are partially or even entirely focused on preventing drug use among drivers, no campaign focused on drug use was held at a national level in 2009. In the Czech Republic, several good websites and online applications offer information and counselling in the field of preventing drug use and the impacts of drug use.

3.1 System and Framework of Drug Prevention

Primary prevention has traditionally been one of the four pillars of the Czech anti-drug policy strategy. In the Czech Republic, the development of a plan, the contents, and the coordination of primary prevention of high-risk behaviour in children and adolescents are in the competence of the *Czech Ministry of Education, Youth, and Sports*; specifically, the area of prevention is in the competence of the department responsible for prevention and institutional education. The use of addictive substances is one type of high-risk behaviour.

The *Ministry of Education* co-ordinates the prevention of high-risk behaviour and the prevention of addictive substance use on the horizontal level, where its task is to actively work with topically relevant departments (*Ministries of Health*, *Interior*, *Labour and Social Affairs*, *Defence* and others). Such collaboration includes interdepartmental bodies and structures such as the *GCDPC and the* National Committee for Crime Prevention). In addition, the *Ministry of Education* works with local governments (regions and municipalities), providers of counselling, education and methodological services in primary prevention (other organisations directly managed by the *Ministry of Education*, non-governmental organisations, colleges and universities, regional counselling facilities). In 2009, the *Committee for Primary Prevention Coordination*, an advisory body to the *Ministry of Education*, was set up with the main goal of coordinating activities on interdepartmental, region-based and district levels, unifying processes and models in the area of preventing high-risk behaviour.

On the vertical level, the *Ministry of Education* leads the methodology and co-ordinates regional prevention co-ordinators at schools (employees of the regional authorities), local prevention workers (employees at educational and psychological counselling centres) and school prevention workers (selected teaching staff at schools and educational facilities).

The *Ministry of Education* Methodological Guidelines No. 20 006/2007-51 on primary prevention of social pathologies in children, pupils, and students at schools and educational facilities: (1) defines the terminology and the integration of prevention into school education programmes; (2) describes individual institutions in the prevention system and the role of the teaching staff member; (3) defines the Minimum Prevention Programme; (4) recommends procedures to be followed by schools and educational facilities ("schools") in the event that specific forms of high-risk behaviour arise in children and adolescents. In January 2009, the *GCDPC* instructed the Minister of Education to amend these methodological guidelines, particularly in relation to the performance of drug tests on pupils' bodily fluids, school procedures and cooperation with external subjects in resolving addictive substance-related problems among pupils (for more details see the 2008 Annual Report)[34].

In five sections, the document *Strategy for the Prevention of Risk Behaviour among Children and Young People in the Jurisdiction of the Ministry of Education in the Period 2009-2012* presents an evaluation of the past strategy for

[34] The Ministry of Education, Youth, and Sports has announced that it would issue the updated methodological guidelines in the autumn of 2010.

the 2005-2008 period, defines target groups and terms, and presents a system for organising primary prevention and strategic goals for the 2009-2012 period. These long-term goals should be detailed in action plans which are always drawn up for two-year periods. The strategy is also beneficial in that it introduces the term "risk behaviour" in place of the previous outdated and inaccurate terms "social pathology" or “socially pathological phenomenon”.

Addictive substance use primary prevention programmes in the Czech Republic which apply for government funding from the *Ministry of Education* and the *GCDPC* must be certified[35]. The reason for certification is based in ensuring that the preventive programmes provided meet at least a minimum level of quality and ensuring that public funding is spent efficiently. Certification regarding the professional competence of the provider of the addictive substance use primary prevention programme offers proof that the programme corresponds to set quality and comprehensiveness standards. The certification process is based in the Professional Qualification Standards for Providers of Addictive Substance Use Primary Prevention Programmes (Ministerstvo školství, mládeže a tělovýchovy, 2005) and the certification system in the field of prevention was launched in 2006 – for more information see the 2006, 2007, and 2008 annual reports. The *Certification Agency* established at the *Institute for Pedagogical and Psychological Counselling* verified whether the programme meets the criteria for professional competence (certification process). On the basis of an order by the Minister of Education, the activities of the *Certification Agency* were discontinued as of 16 July 2009 due to an announced transformation of the certification system; as a result, all certification processes were halted. Certification for addictive substance use primary prevention programmes is planned to be renewed from 1 August 2010.

The *Ministry of Education* supports primary prevention programmes in subsidy proceedings which are divided into: Programme I for schools and educational facilities (the *Ministry of Education* up until and including 2009 provided financing in the form of subsidies for individual regions which then distributed the funds to schools and educational facilities); Programme II for national and regional projects implemented primarily by NGOs; and Programme III addressing educational facilities for young people in institutional care and educational establishments for preventive care. In 2009, a total of 278 projects were supported in Programme I, with 166 projects being at primary schools. The greatest number of projects supported was from the Ústí nad Labem region (37); on average, the most resources per project (CZK 57,400) (€ 2,171) were received by projects in the South Moravian region (MŠMT, 2010b). As part of Programme II, non-governmental non-profit organisations were given subsidies for 18 projects in 2009 (MŠMT, 2010c). Based on the *Ministry of Education's* methodological guidelines concerning the provision of government subsidies to implement activities in the area of preventing risk behaviours for the 2010-2012 period, subsidy proceedings for 2010 were announced in September 2009. A new feature is that subsidy programmes were merged. The sole provider of subsidies will be the *Ministry of Education* (projects will not be supported through subsidies given to the regions as was done earlier in Programme I); for projects lasting several years, applications can be submitted to receive subsidies for up to three years, but subsidies will be provided for the corresponding calendar year (MŠMT, 2010d). For more on the *Ministry of Education's* expenditures and subsidies earmarked for drug policy, also see the section on Economic Analysis (p. 18).

The school prevention worker coordinates the development and implementation of the school's prevention programmes, and controls and evaluates prevention activities[36]. Working with the school administrators and other educational staff, the school prevention worker creates a Minimum Prevention Programme which presents the basic strategy (short-term for a single school year or long-term over several years) for preventing social pathologies at the school or educational facility. The minimum prevention programme is part of the school's educational programme.

In a survey of school prevention workers in the Ústí nad Labem region carried out in the 2009-2010 school year, a profile of the typical school prevention worker was created: female aged 41-50 years, has worked in education for 21-25 years, has been working as the school prevention worker for one year, in addition is a homeroom teacher who has not completed an accredited study programme in school prevention work, has not built a prevention team at the school, and her most frequent activities include direct work with pupils, work with the class, and consultations with parents (Šťastná et al. 2010b).

A total of 42 school prevention workers (37 women and 5 men) and five prevention workers based at pedagogical and psychological counselling centres in the Olomouc region participated in a study focused on school prevention workers and their role in school prevention carried out in the region of Olomouc. The results found that most of the time, school prevention workers in the region resolve disciplinary and relationship problems, or problems connected with smoking. The time allocated to perform prescribed school prevention activities and no or low financial remuneration represent a significant problem (Dolejš, 2009).

Ministry of Education Decree No. 317/2005 Coll., on the further education of teaching staff, accreditation commissions and the career system of teaching staff, Section 9 (Education to perform specialised activities) requires that, in order to perform the post of a school prevention worker, a person must complete at least 250 lessons of

[35] By virtue of Government Resolution No. 693 from 7 June 2006, on the introduction of a certification system in the field of primary drug prevention and on the basis of the rules for financing drug policy approved by Government Resolution No. 1071, dated 19 September 2007.

[36] The activities of the school prevention workers are defined in Annex 3/II to Decree No. 72/2005 Coll., on the provision of counselling services in schools and educational counselling facilities.

specialised training. According to the methodological guidelines on the primary prevention of social pathologies in children, pupils, and students in schools and educational facilities (see above), the school education staff member who, in addition to direct educational activities, also performs specialised activities to prevent risk behaviour, receives a bonus of CZK 1,000 to 2,000 (€ 38 to 76) per month, i.e. 5-10% of their monthly salary. A survey among school prevention workers in the Ústí nad Labem region found that 22% of the prevention workers at basic schools and 33% at secondary schools who were questioned completed a specialisation course; nevertheless, in connection with the performance of their prevention-related responsibilities, school prevention workers complete training courses with a fewer number of lesson hours (Šťastná et al. 2010b).

In 2009, the *Ministry of Education* supported implementing the project *Development of a modular training system in the prevention of social pathologies for teaching and counselling staff at schools and educational facilities on a nationwide level* (Reg. No. CZ.1.07/1.3.00/08.0205). This is focused on creating systematic training in the prevention of risk behaviour for teaching staff at schools and on an initial, pilot verification of the proposed changes in five Czech regions. The resulting output will be a proposed system for life-long education in this field on a national level. Emphasis is placed on its applicability in preparing the Minimum Prevention Programme and regional education strategies. The goal of the project is to resolve the existing absence of systematic training for this target group in preventing risk behaviour and solving problems with differing qualities of education among the Czech regions[37].

With co-operation from the *Municipality Authority of the City of Prague* and *Charles University* in Prague (1st Faculty of Medicine), in reaction to the need to co-ordinate primary prevention activities, the pilot phase of the operations of the *Prague Centre for Primary Prevention (Pražské centrum primární prevence o.p.s.*) and unified record-keeping and data collection pertaining to prevention in Prague was launched in June 2009. At the same time, this will be compatible with the planned national prevention (coordination) system. The *Prague Centre for Primary Prevention* was established as a professional service and coordination facility in the primary prevention of risk behaviours and as the expert supervisor of the prevention system in the City of Prague. In 2009, the preparatory phase was launched for the next pilot project for a regional primary prevention centre in the region of South Moravia.

As part of the development of a modular training system in the field of prevention mentioned above, in co-operation with the *Centre for Addictology* and *SANANIM, a civic association,* preparatory work was started in 2009 on a Czech localisation and pilot release of an online training programme for parents entitled *Prevention-Smart Parents*[38]. The course, created by the British organisation *The Mentor Foundation*, will be available free of charge.

In November 2009, the sixth annual conference on the primary prevention of risk behaviour, entitled *Primary Prevention: Options and Paths Forward*[39], was held. As part of the selected topic of the conference, the current situation was reflected on and visions were presented for the primary prevention of a wide range of risk behaviours in the Czech Republic.

3.2 Universal Prevention

Universal prevention programmes are mainly implemented in schools and educational facilities. The Minimum Prevention Programme (MPP), which is compulsory for every school, is a document containing the school's plan for supporting healthy lifestyles and preventing all forms of risk behaviour. Created by the school prevention worker, the minimum prevention programme is subject to being checked by the Czech School Inspectorate. Schools can implement preventive activities on their own or in cooperation with external subjects (such as NGOs or the Police of the Czech Republic). According to the evaluation of individual regions, the shortage of funds to implement preventive activities, low support for the school prevention workers from the school administration and other colleagues, and the perfunctory nature of the minimum prevention plan can be considered the most frequent reported shortcomings of such plans in 2009.

An evaluation of the international preventive programme *Unplugged* (part of the *EU-Dap 2* project) entered its final phase in the Czech Republic. The programme is focused on preventing addictive substance use among pupils in the 6th grade, i.e. children aged 12-14. The research project is being implemented at 70 schools (experimental group of 966 pupils from 37 schools; control group of 888 pupils from 33 schools). The final, sixth round of data collection was carried out in June 2010 (Miovská et al. 2009; Jurystová et al. 2009; Adámková et al. 2009).

In 2009, the *GCDPC* supported 11 specialised preventive projects implemented by NGOs in Brno, Jindřichův Hradec, Mladá Boleslav, Olomouc, Ostrava, Pilsen, Prague (3), Slavičín, and Tišnov (a total of 149 projects of various types of services were supported by the *GCDPC* in 2009). During the school days, a total of 24,208 prevention interventions were carried out (blocks, meetings, interactive seminars, consultations, interventions, overnight trips, etc.) and contact was made with 102,985 people. Outside of school, a total of 13,579 prevention interventions were carried out and contact made with 5,598 people as part of indicated prevention, educational activities, and information service (Národní monitorovací středisko pro drogy a drogové závislosti, 2010d).

[37] For more information see http://www.adiktologie.cz/articles/cz/220/1592/Tvorba-systemu-modularniho-vzdelavani-v-oblasti-prevence-socialne-patologickych-jevu-pro-pedagogicke-a-poradenske-pracovniky-skol-a-skolskych-zarizeni-na-celostatni-urovni.html?acc=enb.
[38] See http://prevention-smart.org/.
[39] For more information see http://www.pprch.cz.

3.3 Selective Prevention in At-risk Groups and Settings

Selective prevention programmes are focused on at-risk groups in the population with a higher risk of addictive substance use. From a long-term perspective, the use of addictive substances among children and adolescents from ethnic minorities in the Czech Republic is a serious problem which has not been managed sufficiently. The *Centre for Addictology* has implemented a project aimed at evaluating preventive measures, researching and proposing solutions in relation to early diagnosis and interventions (see below) used when working with children and adolescents from ethnic minorities who are at risk of social exclusion and the consequences of addictive substance use (Šťastná, 2010; Šťastná et al. 2010a).

Over the long term, the activities of *Prev-Centrum*, a civic association, which implements the Early Intervention Programme for at-risk classroom groups between the 5th and 9th grades at basic schools is presented as an example of good practice in the area of selective (and indicated) prevention (for more information see the 2008 Annual Report). The activities of *Anima*, a civic association, which operates a Children's Club for children from families at risk due to dependency or from otherwise difficult environments, can also be presented as an example (Anima, 2010).

In cooperation with other providers of drug services, the civic association *Chilli.org* has implemented the second year of its project *2009 Safer Party Tour*, focused on drug prevention and harm reduction interventions at large summer dance and music festivals. A total of 5,507 contacts were recorded at 14 festivals. It is difficult to draw a clear line between primary prevention and harm reduction intervention in projects of this type. An evaluation of the *2009 Safer Party Tour* project was co-ordinated by the *National Focal Point*. In addition to other areas, information was evaluated regarding how the safety of the people attending music events was organised and managed. Although music festivals vary in how they ensure the safety and health of their participants, the lack of drinking water, poor sanitation facilities and the fact that security confiscates soft drinks at the entrance can all be considered fundamental inadequacies. Nevertheless, as opposed to the previous year, the organisers' accommodating approach to work with the *2009 Safer Party Tour* implementation team was evaluated positively. The presence of medical personnel at festivals is standard (National Monitoring Centre for Drugs and Drug Addiction, 2010a) – for more results of the 2009 *Safer Party Tour* project see the chapter on Drug Use in the Nightlife Setting (p. 34).

3.4 Indicated Prevention

Indicated primary prevention works individually with at-risk individuals, their families, and the community. The first signs of addictive substance use are present in these individuals, but the criteria for problem drug use and dependency are not met. In the Czech Republic, indicated prevention is carried out by institutions established by the national, regional or local municipal government (including pedagogical and psychological counselling centres and child and family counselling centres) as well as non-governmental organisations (i.e. low-threshold clubs for children and adolescents which can be classified as non-specific prevention, as well as selective and indicated prevention).

3.4.1 Early Diagnosis and Intervention

A screening psychodiagnostic method called *Substance Use Risk Profile Scale* (*SURPS*) has been tested on and adapted to the Czech student population. The *SURPS* assessment tool is designated for pupils and students between 14 and 17 years of age (approximately 8th grade at basic school until the 2nd year of secondary school). Individuals who achieve the highest level of risk on the *SURPS* scale are offered *PREVenture* intervention (see below). In the field of early diagnosis, Czech population norms were also created for the *High School Personality Questionnaire* (*HSPQ*)[40] (Šucha, 2010a).

PREVenture (Conrod et al. 2006; Conrod et al. 2008) is a methodology for indicated primary prevention of addictive substance use and early diagnosis and intervention which was adapted to the Czech population by the *Centre for Addictology*. The *PREVenture* methodology is based on the principle of brief intervention related to corresponding specific high-risk personality characteristics and lasting 2 x 90 minutes or 4 x 45 minutes for each of the risk factors. *PREVenture* used cognitive behavioural techniques, elements of motivational interviewing, and education[41] (Šucha, 2010b).

The adapted and recently also tested *CRAFFT* (Knight et al. 1999) questionnaire has been available in the Czech Republic since 2006, as has the early intervention methodology in the form of the *Drug Prevention Manual in Paediatric Practice* (Starostová et al. 2007). The six-item *CRAFFT* screening questionnaire is used to identify individuals at increased risk of the use of alcohol and other drugs. On the basis of the results of the screening, the physician provides the individual with brief advice or intervention. Physicians were informed of the results of the project and the pilot implementation of the tool was carried out in 2009 (Csémy et al. 2010; Kabíček and Csémy, 2010).

[40] For more information: http://www.adiktologie.cz/articles/cz/218/1644/Prevod-a-standardizace-psychodiagnosticke-metody-Substance-Use-Risk-Profile-Scale-SURPS-a-tvorba-norem-u-Osobnostniho-dotazniku-pro-mladez-HSPQ-vysledky.html.

[41] For more information: http://www.adiktologie.cz/articles/cz/218/1681/Metodika-indikovane-primarni-prevence-PREVenture-zakladni-informace.html.

3.5 National and Local Media Campaigns

The nationwide road-safety campaign “Pay Attention or Pay the Price!”[42] continued in 2009 – for more information see the 2008 Annual Report. Another Czech Government Council for Road Safety (BESIP) project that continued to be implemented in 2009 was the “Designated Driver”[43] campaign – for more information see the 2007 Annual Report.

Since 2005, the internet and text message service "Promile INFO" operated by *SANANIM* has been in place in the Czech Republic. The service is focused on preventing driving under the influence of alcohol. This is a simple application that helps users ascertain their approximate blood alcohol level and about how long it will take for them to sober up and they would be able to drive again. As part of an extensive information campaign, the service was promoted on beer coasters in 2009 and experienced exponential growth in requests. From the time it started functioning in September 2005 until the end of 2009, a total of 69,839 requests were received, with 42,373 (61%) of these occurring in 2009 alone. The Promile INFO service was used repeatedly by 4,670 telephone numbers. The overwhelming majority of clients in 2009 were men, who sent in 83% of all requests; their average age was 29 years old, while women were an average 27 years old. Nearly a third of requests (32%) were sent at a time when, based on the data they entered, the client was sober. With regard to the average amount of alcohol consumed, the highest values were reached for requests stating that consumption had started on Saturday through Monday – men on these days consumed an average of 5 to 10 g of pure alcohol[44] more than women; but women, on the other hand, consumed more alcohol on workdays (Škařupová and Kubů, 2010).

In the Czech Republic there are several good websites which offer information and counselling pertaining to prevention; some of these are provided in a list of drug-related websites at the end of the report.

In 2010, the Prague Centre for Primary Prevention launched its Primary Prevention of High-Risk Behaviour in Prague portal which offers information mainly for parents and professionals (including teachers, educators, district and school prevention workers, school psychologists, and regional drug coordinators). The website includes information support for creating minimum prevention programmes at schools, an overview of primary prevention providers, opportunities for accredited specialised studies in prevention, current information about lectures, seminars, conferences, etc.[45]

[42] For more information see http://www.nemyslis-zaplatis.cz/.
[43] For more information see http://www.ibesip.cz/, http://www.domluvme-se.cz.
[44] This is 2-4 standard servings of alcohol. One standard serving is e.g. 0.5 l of beer, 2 dl of wine or 5 ml of hard alcohol.
[45] For more information: http://www.prevence-praha.cz.

4 Problem Drug Use

According to the *EMCDDA*, problem drug use is defined as injection drug use and/or long-term/regular use of opioids/opiates and/or amphetamine-type drugs and/or cocaine (European Monitoring Centre for Drugs and Drug Addiction, 2009). The Czech definition does not include cocaine use as this is still on a very low level in the Czech Republic. For similar reasons, from the amphetamine group, the number of pervitin (methamphetamine) users is only estimated. Opiates/opioids typically used in the Czech Republic mainly include heroin and Subutex® (opium also appears seasonally).

In 2009, the mean value of the estimated number of problem drug users rose significantly, to approximately 37,400. Pervitin users (approx 25,300) accounted for most of the increase. The number of injecting drug users (approx 35,300) also increased. Opiate users also increased slightly, to 12,100; an estimated 7,100 of these are heroin users and 5,100 Subutex® users. The regions with the greatest numbers of problem drug users, as well as the greatest number of opiate users include Prague and Ústí nad Labem. Of all the regions, Ústí nad Labem also has the highest estimated number of problem pervitin users. While the number of problem drug users in the capital fell for the first time since 2005, the estimated number of problem users increased in the Ústí nad Labem region.

The growth in the mean value of total problem drug users must be considered conservatively due to the fact that there has been overlap in the confidence intervals of estimates from the past years. Nevertheless, there was a statistically significant year-on-year rise in the numbers of problem pervitin users and injecting drug users.

4.1 Prevalence and Incidence Estimates of Problem Drug Use

As in previous years, the multiplication method was used to estimate the number of problem drug users in 2009. In *Multiplier 2010*, a questionnaire survey of clients at low-threshold facilities (see the chapter on Data on Problem Drug Use from Non-treatment Sources, page 44), the value of the *multiplier*[46] was updated. This multiplier is then applied to the recorded number of problem drug users in contact with low-threshold facilities in the Czech Republic. The annual final reports for projects supported in *GCDPC's* subsidy proceedings are the source of data regarding the number of problem drug users in contact. As opposed to previous years, however, extrapolation was not used to estimate the number of problem users from facilities which do not receive support; instead, the data were received directly upon request.

The multiplication method has been used to estimate the number of problem drug users in the Czech Republic since 2002. The *multiplier* value was first obtained through a special questionnaire module as part of a study on the prevalence of HCV among injecting drug users in 2003 (for more information about the study see the 2003 Annual Report) and applied for estimates from the 2002-2005 period. The estimates for 2006 were produced as the sum of the estimates for the entire country outside of Prague calculated using the 2003 multiplier, and the estimate for Prague, where the updated value of the multiplier was obtained as a by-product of the study Sexual Behaviour of Drug Users (see the 2006 Annual Report). For the entire Czech Republic, the multiplier was updated in an independent survey in 2008 (estimates for 2007 and 2008) and once again in 2010 (for the current 2009 estimate).

The multiplier – the proportion of problem drug users who are in contact with a low-threshold facility – was found using the *peer nomination technique* in the studies listed above. The respondent (programme client) was asked to answer the following questions: (1) "How many people you know well are regular users of pervitin and/or opiates (heroin, Subutex or Suboxone)?" and (2) "How many of them have been in contact with any sort of low-threshold centre or outreach programme over the past twelve months?" The multiplier is then expressed as the weighted average of the proportion of both values, adjusted in such a way as to take into account that the respondent is a user in contact. Only those who stated a reasonable number of known drug users[47] were included in the calculation, and the weighting is the size of the population of problem drug users represented by individual respondents (number of the respondent's acquaintances). With regard to the fact that in all surveys to date, peer nomination questions were posed only to users in contact with low-threshold facilities and not to a representative sample of drug users, the assumption can be made that the real proportion of problem drug users in contact will be somewhat lower than is expressed by the *multiplier*. With regard to the methods used, trends in the estimates of problem drug users are sensitive to changes in the input data: there is a positive correlation in regard to the number of low-threshold service clients, while the *multiplier* value impacts estimates in negative correlation. Multiplier values for individual regions obtained in independent Multiplier 2008 and 2010 studies can be found in Table 4-1: The updated value of the multiplier for the entire Czech Republic outside of Prague, expressed as a percentage, is 67% (95% CI[48]: 63-70 %), one percentage point less than in 2008. The value of the multiplier for the capital city, though, is four percentage points higher and is 80% (95% CI: 70-91%).

[46] This is the proportion of problem users who are in contact with low-threshold programmes. The remainder is the hidden part of the problem drug user population.
[47] A "reasonable" number of known drug users was arbitrarily placed at 25 or less so as to exclude non-credible estimates from the analysis.
[48] 95% confidence interval – i.e. the interval in which the value occurs with a 95% probability.

The estimate of the number of problem drug users in the Czech Republic is the sum of estimates for individual regions. The total number of problem drug users in the Czech Republic in 2009 was thus estimated at 37,400 (95% CI: 33,300-41,500), of which 25,300 (24,600-25,900) were pervitin users, 7,100 (6,600-7,600) were heroin users and 5,100 (4700-5400) were Subutex® users. Therefore, opiate users are estimated at 12,100 (11,500-12,800) persons. The number of injecting drug users (IDUs) was estimated at 35,300 (34,200-36,400).

Table 4-1: Multiplier values for individual regions in 2008 and 2010

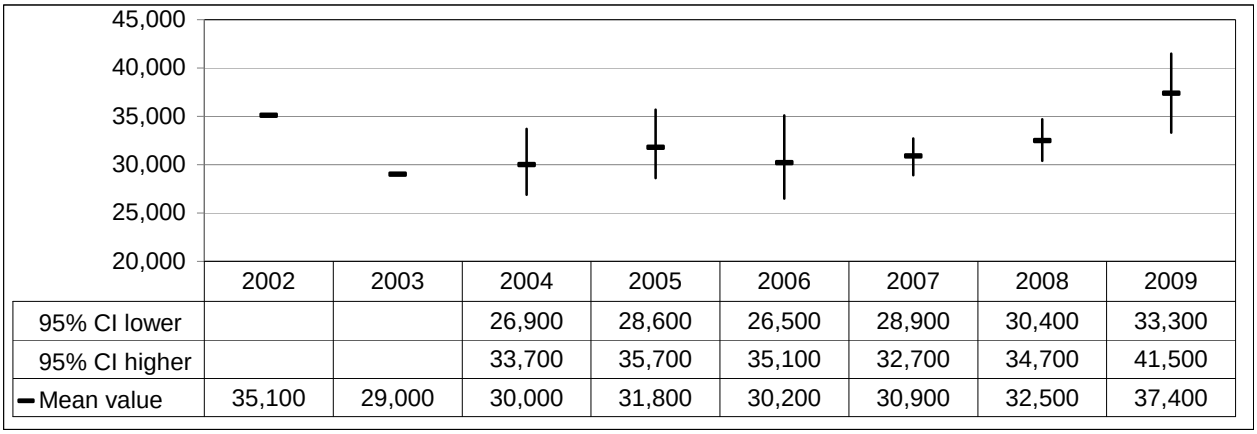
Region	**2008**			**2010**		
	Mean value	95% CI		Mean value	95% CI	
Prague	0.76	0.63	0.90	0.80	0.69	0.91
Central Bohemia	0.81	0.73	0.88	0.69	0.52	0.87
South Bohemia	0.78	0.71	0.86	0.77	0.67	0.86
Pilsen	0.74	0.65	0.83	0.62	0.44	0.79
Karlovy Vary	0.68	0.65	0.71	0.91	0.65	1.17
Ústí nad Labem	0.65	0.58	0.71	0.62	0.56	0.68
Liberec	0.63	0.45	0.80	0.31	-3.68	4.30
Hradec Králové	0.65	0.57	0.74	0.62	0.51	0.73
Pardubice	0.68	0.65	0.71	0.81	0.64	0.97
Vysočina	0.64	0.44	0.84	0.65	0.46	0.84
South Moravia	0.58	0.47	0.70	0.53	0.43	0.64
Olomouc	0.84	0.45	1.22	0.53	0.40	0.66
Zlín	0.68	0.65	0.71	0.48	0.09	0.87
Morava-Silesia	0.65	0.57	0.73	0.77	0.70	0.84
Czech Republic minus Prague	0.68	0.65	0.71	0.67	0.63	0.70
Entire Czech Republic	**0.69**	**0.66**	**0.72**	**0.68**	**0.65**	**0.71**

Estimates of the number of problem drug users from 2002 till 2009 are shown in Table 4-2. In comparison to 2008, there was an increase in the total number of problem drug users. Even while considering the range of the confidence intervals, there was a statistically significant increase in the numbers of problem pervitin users and injecting drug users. The statistical significance of the change in the estimated total number of problem drug users is depicted in Figure 4-1 – there has been overlap in the confidence intervals of estimates from past years, meaning that the trend observed in mean estimate values must be interpreted with caution.

Table 4-2: Mean values of prevalence estimates of problem drug use carried out using the multiplication method with the use of data from low-threshold programmes in 2002-2009 (Mravčík et al. 2009; National Monitoring Centre for Drugs and Drug Addiction, 2010b)

Year	**Total number of problem drug users**		**Problem users of opiates/opioids**				**Problem users of pervitin**		**Injecting drug users**	
	Number	Per 1,000 people aged 15-64	Heroin users	Subutex® users	Total	Per 1,000 people aged 15-64	Number	Per 1,000 people aged 15-64	Number	Per 1,000 people aged 15-64
2002	35,100	4.89	n.a.	n.a.	13,300	1.85	21,800	3.04	31,700	4.41
2003	29,000	4.02	n.a.	n.a.	10,200	1.41	18,800	2.61	27,800	3.86
2004	30,000	4.14	n.a.	n.a.	9,700	1.34	20,300	2.80	27,000	3.73
2005	31,800	4.37	n.a.	n.a.	11,300	1.55	20,500	2.82	29,800	4.10
2006	30,200	4.13	6,200	4,300	10,500	1.44	19,700	2.69	29,000	3.97
2007	30,900	4.20	5,750	4,250	10,000	1.36	20,900	2.84	29,500	4.01
2008	32,500	4.39	6,400	4,900	11,300	1.52	21,200	2.87	31,200	4.21
2009	37,400	5.04	7,100	5,100	12,100	1.63	25,300	3.40	35,300	4.75

Figure 4-1: Mean values and 95% confidence intervals of prevalence estimates of problem drug use carried out using the multiplication method with the use of data from low-threshold programmes in 2002-2009



	2002	2003	2004	2005	2006	2007	2008	2009
95% CI lower			26,900	28,600	26,500	28,900	30,400	33,300
95% CI higher			33,700	35,700	35,100	32,700	34,700	41,500
Mean value	35,100	29,000	30,000	31,800	30,200	30,900	32,500	37,400

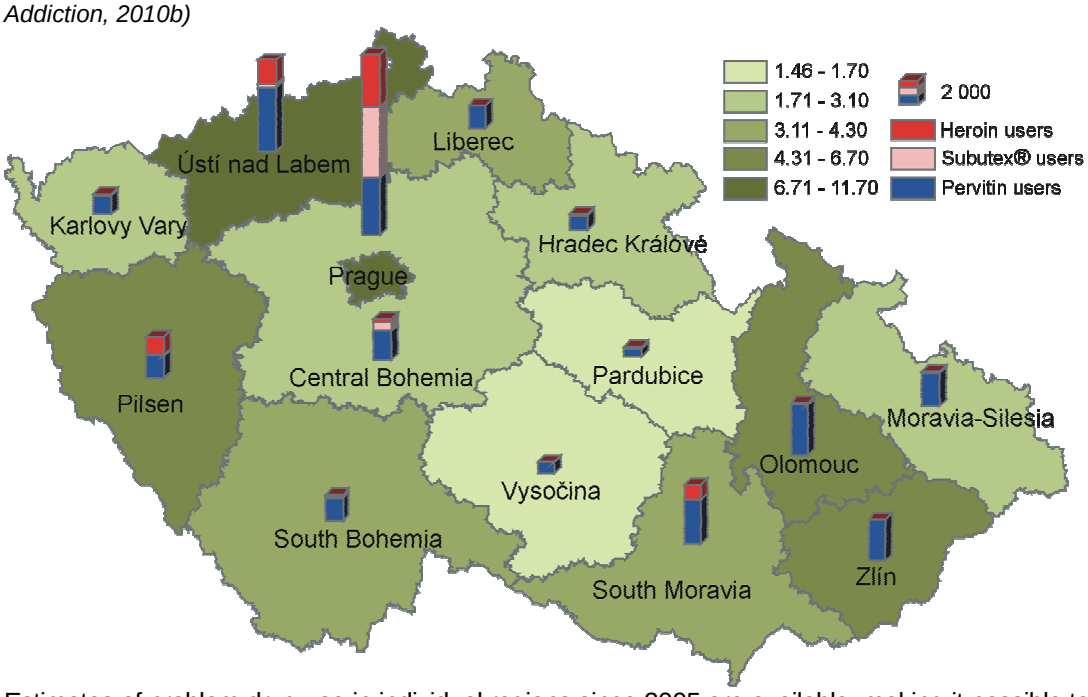
The highest number of problem drug users was traditionally in the City of Prague and the Ústí nad Labem region – areas with the greatest number of opiate users. The Ústí nad Labem region also has the highest estimated number of problem pervitin users. Prevalence estimates of problem drug use by region are shown in Table 4-3 and Map 4-1.

Table 4-3: Prevalence estimates of problem drug users in the Czech Republic in 2009 by region – mean values (Mravčík et al. 2009; National Monitoring Centre for Drugs and Drug Addiction, 2010b)

Region	**Number of problem drug users**	**Number of opioid/opiate users**			**Number of pervitin users**	**IDUs**
		Heroin	**Subutex®**	**Total**		
Prague	10,400	3,000	4,050	7,050	3,300	10,300
Central Bohemia	2,400	200	550	750	1,700	2,300
South Bohemia	1,500	100	100	200	1,350	1,500
Pilsen	2,400	1,050	< 50	1,100	1,300	2,200
Karlovy Vary	1,200	100	< 50	150	1,050	1,100
Ústí nad Labem	5,300	1,350	250	1,600	3,700	5,100
Liberec	1,300	< 50	< 50	< 50	1,300	1,300
Hradec Králové	1,000	100	< 50	100	850	1,000
Pardubice	500	50	< 50	50	450	500
Vysočina	600	< 50	< 50	< 50	600	500
South Moravia	3,400	850	< 50	850	2,500	3,100
Olomouc	3,000	150	< 50	150	2,850	2,500
Zlín	2,400	< 50	< 50	< 50	2,400	2,100
Morava-Silesia	2,000	100	< 50	100	1,900	1,800
Entire Czech Republic	**37,400**	**7,100**	**5,100**	**12,100**	**25,300**	**35,300**

Note: The values in the table are rounded.

Map 4-1: Number of problem drug users per 1,000 inhabitants aged 15-64 and the number of problem users of opiates and pervitin in regions of the Czech Republic in 2009 – mean values (National Monitoring Centre for Drugs and Drug Addiction, 2010b)



Estimates of problem drug use in individual regions since 2005 are available, making it possible to observe trends in drug use on the regional level; see Table 4-4. Continual growth in the number of problem drug users could be seen in Prague since 2008; in 2009, the share of Prague users in contact with low-threshold facilities and the estimated number of problem drug users fell for the first time. On the other hand, a significant increase in the number of problem drug users can be seen in the Olomouc, Ústí nad Labem, Zlín and Moravia-Silesia regions. The situation in the Pardubice, South Moravian, and Vysočina regions has not changed significantly over the past five years.

Table 4-4: Estimates of problem drug use carried out using the multiplication method with the use of data from low-threshold programmes by region in 2005-2009, mean values (Mravčík et al. 2009; National Monitoring Centre for Drugs and Drug Addiction, 2010b)

Region	2005	2006	2007	2008	2009
Prague	9,800	8,400	10,000	11,500	10,400
Central Bohemia	2,500	2,450	1,700	1,750	2,400
South Bohemia	1,700	1,750	1,500	1,550	1,500
Pilsen	1,450	1,350	1,300	1,650	2,400
Karlovy Vary	1,450	1,250	900	1,000	1,200
Ústí nad Labem	4,450	4,450	4,100	4,150	5,300
Liberec	750	500	500	1,500	1,300
Hradec Králové	1,150	1,050	1,750	1,100	1,000
Pardubice	600	350	450	450	500
Vysočina	600	350	700	500	600
South Moravia	2,800	3,150	3,400	3,250	3,400
Olomouc	1,900	2,350	1,650	1,600	3,000
Zlín	1,150	1,300	1,850	1,350	2,400
Morava-Silesia	1,500	1,450	1,100	1,150	2,000
Entire Czech Republic	**31,800**	**30,200**	**30,900**	**32,500**	**37,400**

4.2 Data on Problem Drug Use from Non-treatment Sources

As part of the *Multiplier 2010* project focused primarily on estimating the proportion of problem drug users in contact with low-threshold facilities, using questionnaires, additional information was also collected from clients. A total of 44 programmes (low-threshold centres and outreach programmes) from all regions in the Czech Republic participated in the survey and completed questionnaires with 642 clients who used their services in the period between 10 and 21 May 2010 and agreed to be included in the survey. Men composed 69.3% of the sample and the average age of the respondents was 29.2 (in a similar study from 2008, the low-threshold facility clients were an average 27.7 years old). Men were an average 30.0 years old and women 27.3 years old; the youngest respondent was 15 at the time of the survey, the oldest 69.

Most respondents reported using pervitin (78.7%), followed by Subutex® (15.9%) and heroin users (13.9%). Five clients reported using Suboxone ® (0.8%). There were 121 (18.8%) of respondents who admitted to using other

drugs of choice – most frequently these were cannabis (66.9%), other opiates/opioids (e.g. methadone, opium, tramadol – 14.0%), alcohol (8.2%), inhalants (6.6%), and psychoactive pills (4.1%). Nearly three quarters of the sample (73.7%) reported using one drug of choice; this group comprised 68.1% of pervitin users and 53.9% of heroin users. A total of 159 clients (24.8%) used two primary drugs, while 10 individuals (1.6%) were users of three or more drugs.

Administration of drugs by injection over the past thirty days was reported by 567 clients (88.3%), the vast majority of whom (91.5%) injected drugs repeatedly. The majority (87.5%) of injecting drug users stated that they used a sterile needle and syringe the last time they injected drugs, 5.7% could not remember and 6.8% stated that they did not use clean equipment the last time they injected drugs.

The questionnaire also included questions regarding testing and preventing infectious diseases; for more information see the chapter on Testing for Infectious Diseases (p. 84).

More information about problem drug users in contact with various types of services is provided in chapters Drug-related Treatment: treatment demand and treatment availability (p. 46), Responses to Health Correlates and Consequences (p. 80) and Social Correlates and Social Reintegration (p. 87).

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

No study has been conducted in the Czech Republic so far that investigated the level of the prevalence of problematic forms of drug use which do not fall under the definition of problem use according to the *EMCDDA*. The *2008 General Population Survey* investigated the high-risk consumption of cannabis. The results were summarised in the 2008 Annual Report. Further information about problem forms of recreational (dance) drug use will be provided in the *2010 Dance and Drugs* study. General population studies and other sources of data[49] indicate that, in addition to the problem use of opiates/opioids and pervitin, the relatively high prevalence of health or social problems in the Czech Republic is primarily associated with the use of psychoactive drugs and cannabis.

Students of social sciences often focus their final papers on the use of illicit drugs in the Czech Republic. At the *Faculty of Social Sciences at Charles University in Prague*, two master's theses using semi-structured interviews to collect data and the grounded theory to analyse the data obtained were defended in 2009.

In the first of these, the typology of regular cannabis users was created and detailed. Users of cannabis were divided into four categories according to the frequency and duration of use, and the thesis focuses on two of these groups in more detail: "moderate" short-term users (using 1-3 times per week for a period of less than three years) and "heavy" long-term users (using 4 or more times per week for three or more years). People in the first category use cannabis as a recreational drug, to relax and depending on the opportunity; rarely is there a problem with dependency and cannabis is usually consumed in a group in the evening. Users adhere to their own rules which, together with availability of the drug, regulate the use of the drug. Intensive, long-term users, however, smoke marijuana to relax when they feel stressed and irritated, or in order to get rid of tension. Use while alone is not exceptional; there is often use during the day or in the morning after waking. It is also typical of this group that availability of the drug is stable and there are occasional episodes of loss of control over using it (Erva, 2010).

The second thesis investigated the phenomenon of controlled use of pervitin. The author came to the conclusion that controlled pervitin users can be divided into two categories: users who are 'having fun' and users who are "having problems". According to the author, users having fun are able to maintain a low frequency of pervitin use (usually once or twice per month or less often) over the long term (even for several years), do not feel dependent and never tried to abstain. This user remains anchored in original social relationships and did not become part of the "deviant" drug user community whose attributes include homelessness, unemployment, secondary drug crime, and a major fixation on the drug. As opposed to this, users with problems have reported certain critical periods of use which is described in the text as "periods of hell", when they maintained relationships mainly with other pervitin users. They typically reflect a change of character, psychological problems, and difficulties when they attempt to abstain. Users with problems form an inconsistent group with regard to viewing their relationship towards "deviant" drug users – some have accepted the identity even without accepting the lifestyle, while others rejected it even though they have long figured in the group of deviant users (Markvartová, 2010).

The author also concluded that the transition from controlled forms of drug use to more problematic forms and dependency is influenced by several factors. Besides the respondent's personality and motivation, in particular, these factors included the pattern of use and the group of individuals the respondent spends time with. Although it is not generally applicable, the author considers a frequency of use of once to twice per month to be sustainable over the long term. At the same time, if the user starts (and exceeds) using pervitin as part of a social group that had existed beforehand and has other interests and subjects in common, the group's social norms can protect the user from more serious drug problems. On the contrary, individuals using drugs in groups which formed only on the basis of one common interest – drugs – are more at risk of dependency, the author suggests.

[49] For example, data about drug use treatment – see the chapter on Drug-related Treatment: Treatment Demand and Treatment Availability on p. 47, or data on drug crime – chapter on Drug-related Crime, Prevention of Drug-related Crime, and Prison on p. 93.

5 Drug-related Treatment: treatment demand and treatment availability

The number of outpatient health care facilities providing treatment to drug users did not change in 2009, but the number of live cases registered in the databases of outpatient facilities in connection with non-alcohol drug use disorders did increase. Among the three largest groups, there was a slight increase among users of opiates (heroin), a slight decline among users of stimulants (pervitin) and a significant increase among polydrug users.

In 2009 there was an increase in the number of hospitalisations of illegal drug users at inpatient psychiatric facilities. This was due to an increase in the number of admissions to psychiatric hospitals; the number of hospitalisations in psychiatric departments remained stable. This growth is on account of patients hospitalised for disorders caused by polydrug use; the number of hospitalised opiate and stimulant users fell.

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

There was also an increase in the number of drug users in the *Register of Treatment Demands* of the Public Health Service. In 2009, a total of 8,763 drug users sought treatment services, which is 500 more than in 2008. In comparison with previous years, the trend shows a slight decline and the number of people demanding treatment is reaching 2004-2005 levels.

People demanding treatment are dominated by users of stimulants, who were the most numerous group among all those demanding treatment (59.5%) and among those demanding treatment for the first time (60.9%); the number of pervitin users also shows the greatest year-on-year increase. The second largest group comprises opiate users (23.4%), but cannabis users are in second place among first treatment demands (18.3%). In terms of age structure, a slight aging in the population of those demanding treatment can be seen. Although the year-on-year increase in the average age is small, from a medium-term perspective, the increasing trend is clear. In 2009 the average age of people demanding treatment for the first time was 24.2 years old, and 25.9 years old for all treatment demands. Over the past decade, the average age of those demanding treatment for the first time has increased by over three years, and for all those demanding treatment the increase in age has been 3.5 years.

Over the long term, some of the characteristics of treatment demands copy the structure of problem users in the Czech Republic. Women, for example, stably make up one third of treatment demands, and the greatest relative prevalence and incidence of treatment demands are reported by the Ústí nad Labem region and the City of Prague. These characteristics correspond to the gender and geographic distribution of problem drug users in the Czech Republic.

5.1 Strategy/Policy

In the area of the legislative and strategic definition of treatment, there were no changes in 2009; see the 2008 Annual Report for the latest data summary.

In 2010, the Government adopted the National Drug Policy Strategy for the nine-year period 2010-2018, and the *2010-2012 Action Plan* is prepared (for more information see the chapter on National Action Plan, Strategy, Evaluation, and Coordination, p. 11). Treatment and social reintegration constitute one of the key areas in the strategy.

5.2 Treatment Systems

Treatment programmes for drug users and addicts and their capacity and occupancy in 2009, subject to the availability of data, are summarised in Table 5-1.

Information about treatment and counselling services for drug users is also provided in other chapters. Treatment interventions at prisons are discussed in the chapter on Responses to Drug-related Health Issues in Prisons (p. 101), harm reduction services are described in chapter Responses to Health Correlates and Consequences (p. 80) and after-care programmes in the chapter on Social Correlates and Social Reintegration (p. 87).

Table 5-1: Treatment programmes catering to drug users in 2009

Programme type	Number	Capacity (persons, beds)	Occupancy (number of persons)[1]
Outpatient health care facilities - psychiatry	298	n.a.	16,343[2]
Outpatient (non-health care) facilities operated by NGOs	11	n.a.	1,533
Day care centres	1	10	46
Registered healthcare facilities providing substitution treatment	34	n.a.	1,555
Sobering-up stations	14	137	27,664
Detoxification units	14	116	n.a.
Psychiatric hospitals for adults	17	9,207[3] (1,370[4])	3,578
Psychiatric departments in hospitals	31	1 383[3]	1,709
Psychiatric hospitals for children	3	260[3]	21
Therapeutic communities	15-20	160[5]	394[5]
Specialised departments for children at risk of drug dependency at residential special education facilities	5	74	152
After-care programmes	15-30	134[5]	986[5]
Detoxification units in prisons	4	n.a.	219
Substitution treatment in prisons	9	n.a.	67
Departments for differentiated service of prison sentences (voluntary treatment)	7	294	507
Departments for undertaking compulsory drug/alcohol treatment in prisons	3	120	117

Note: [1]This is the number if illegal drug and inhalant users, except sobering-up stations where the total number of persons is stated, including alcoholics. [2]This is the number of persons in the live case record, i.e. the number of people who have visited the facility at least once per year. [3] Number of all psychiatric beds. [4] Number of beds in departments for treating AT (alcohol/drug dependent) patients. [5] Data from programmes supported in GCDPC subsidy proceedings in 2009: 10 therapeutic communities, 15 after-care programmes and 13 intensive after-care programmes providing sheltered housing.

5.2.1 Professional Competency of Services and Quality Assurance

The system for inspecting registered social services and the system for certifying the professional competency of services for drug users is covered in detail by the previous annual reports, in the chapters dedicated to drug treatment and services. More information about the certification system is provided in the Selected Issue on History, Methods, and Implementation of National Treatment Guidelines (p. 112).

As of June 2010, a total of 141 programmes had valid certificates of professional competency, see Table 5-2.

Table 5-2: Overview of certified programmes according to type as of 25 June 2010

Type of service	Number of programmes
Detoxification	2
Outreach programmes	44
Low-threshold and counselling programmes	45
Outpatient treatment	15
Day care programmes	1
Short- and medium-term residential treatment	2
Inpatient treatment in therapeutic communities	10
Outpatient after-care programmes	15
Substitution treatment	7
Total	**141**

In October 2010, the *Government Council for Drug Policy Coordination* approved the changes to the *Certification Rules* and *On-site Inspection Guidelines* – for more information see the chapter on Coordination Arrangements (p. 16).

As part of the Operational Programme Human Resources and Employment announced by the Ministry of Labour and Social Affairs, the project *Exchanging experiences and disseminating good practice in the field of quality control of services for drug users* started to be implemented. This project is carried out by the *Centre for Quality and Standards in Social Services* (*CEKAS*) at the *National Training Fund,* a public service company, which operates as a certification agency within the service quality assurance system managed by the *GCDPC*. The aim of the project is to support national and international cooperation and develop good practice and share experience in assessing the

quality of drug services on various levels, including quality evaluators (certifiers), drug coordinators, staff at the *GCDPC* secretariat, and staff at the certification agency.

5.2.2 Outpatient Treatment

Outpatient medical treatment is provided by a range of professionals, including psychiatrists, first and foremost, as well as general practitioners for adults, particularly in connection with the more prevalent opiate substitution treatment; see further below). Alcohol abuse counselling centres, which since 1981 have been called AT clinics, have historically played a special role in the treatment of addictions to alcohol and other drugs among psychiatric facilities. The number of these facilities hovered between 165 and 180 in the period from 1963 to 1980. The number of AT clinics also remained very stable from 1981 to 1993 (around 177 clinics). The first greater increase took place in 1993, when outpatient clinics at psychiatric hospitals also started to be counted towards the number of outpatient AT facilities, but particularly because all psychiatric offices that treated at least one patient using addictive substances started to report AT care that year. For this reason, the number of clinics increased from 1993 up until 2005, when it reached its maximum of 403 facilities. In subsequent years, the numbers of clinics have fallen(Nechanská et al. 2010; Mravčík et al. 2010a).

In 2009 a total of 346 outpatient healthcare facilities in psychiatry[50] reported outpatient care of users of legal and illegal drugs, which is three less than in 2008. Of these, 298 clinics treated at least one illegal drug user and 331 clinics treated alcohol users in 2009. Since 2005 there has been a drop in the number of these outpatient facilities, but the numbers of illegal drug users receiving treatment there (except alcohol and tobacco) has changed little. The number of alcohol users in treatment has fallen[51], see Table 5-3. The largest group is composed of clinics that treated between 1-10 patients using illegal drugs in the given year; clinics with 1-50 patients account for nearly 80% of the total. As for alcohol users, the most clinics (38%) had 11-50 patients; see Table 5-4. The highest number of outpatient clinics and the highest number of patients have historically been reported by specialist clinics, i.e. largely at psychiatric facilities and AT clinics (Nechanská et al. 2010; Institute of Health Information and Statistics, 2010a); see Table 5-5.

Table 5-3: Number of clinics and number of addictive substance users treated in 2000-2009 (Nechanská et al. 2010; Institute of Health Information and Statistics, 2010a)

Year	Illegal drugs		Alcohol		Addictive substances, total	
	Number of clinics	Number of clients	Number of clinics	Number of clients	Number of clinics	Number of clients
2000	272	11,423	298	27,021	320	39,721
2001	285	13,050	309	28,582	330	42,955
2002	288	14,203	317	25,400	342	41,136
2003	312	15,786	340	25,017	368	42,881
2004	320	14,040	358	25,235	382	40,625
2005	337	16,394	379	27,440	401	44,971
2006	340	16,392	367	26,966	394	44,887
2007	311	15,684	348	25,342	367	42,196
2008	298	15,711	328	25,293	349	42,612
2009	298	16,343	331	24,206	346	41,419

Table 5-4: Number of outpatient healthcare facilities according to the number of users of addictive substances, alcohol and drugs, treated in 2005-2009 (Nechanská et al. 2010; Institute of Health Information and Statistics, 2010a)

Number of clients	Illegal drugs					Alcohol					Addictive substances, total				
	2005	2006	2007	2008	2009	2005	2006	2007	2008	2009	2005	2006	2007	2008	2009
1-10	157	161	140	124	118	94	85	85	72	69	71	72	63	53	49
11-50	105	110	107	114	119	149	144	133	123	124	123	120	110	101	98
51-100	38	34	30	24	23	61	63	64	69	70	86	83	90	86	81
101-150	11	11	9	10	11	26	30	21	24	21	31	40	31	37	43
151-200	7	4	7	7	4	20	15	17	14	18	32	16	17	16	18
201-300	8	10	7	6	11	16	15	13	11	14	28	29	24	24	23
301-400	3	3	5	4	5	5	5	6	5	8	8	10	11	8	14
401 and more	8	7	6	9	7	8	10	9	10	7	22	24	21	24	20
Total	**337**	**340**	**311**	**298**	**298**	**379**	**367**	**348**	**328**	**331**	**401**	**394**	**367**	**349**	**346**

[50] This number includes also other facilities than IT clinics, i.e. specialised outpatient centres focusing on the treatment of disorders associated with the use of alcohol and other drugs.
[51] This is the number of patients in the live case record, i.e. treated in the given year.

Table 5-5: Number of addictive substance users (including users of alcohol and tobacco) treated at outpatient healthcare facilities in 2005-2009 (Nechanská et al. 2010; Institute of Health Information and Statistics, 2010a)

Type of facility	2005		2006		2007		2008		2009	
	Number of facilities	Number of clients	Number of facilities	Number of clients	Number of facilities	Number of clients	Number of facilities	Number of clients	Number of facilities	Number of clients
Inpatient facilities with outpatient services	58	11,053	60	13,081	54	12,458	53	11,725	55	10,259
Integrated outpatient facilities (formerly outpatient healthcare centres)	30	4,018	27	4,561	26	4,862	23	4,833	24	3,960
Independent general practitioner's offices	1	8	1	12	1	14	1	16	1	14
Independent specialist's – psychiatrist's - offices	305	27,120	300	25,563	279	23,119	265	24,524	259	25,386
Addiction treatment facilities	6	2,601	5	1,498	5	1,513	5	1,334	5	1,604
Other outpatient facilities	1	171	1	172	2	230	2	180	2	196
Total	**401**	**44,971**	**394**	**44,887**	**367**	**42,196**	**349**	**42,612**	**346**	**41,419**

A special type of outpatient facility in the Czech Republic are sobering-up stations – special healthcare facilities for short-term stays (several hours) and detoxification in case of acute intoxication, especially due to alcohol. At present there are 14 sobering-up stations in the country. They are established and operated by the regions. Until 2005, the number of clients at sobering-up stations copied the number and capacity of the stations; but since that year a drop in capacity but increase in client numbers, especially men, can be observed. In 2009 there were 27,664 people treated at the stations, with 23,079 of these being men. Of the total number of these patients, 1,222 were under 20 years of age(Nechanská et al. 2010; Mravčík et al. 2010a).

Outpatient treatment in the Czech Republic is also available through NGOs; some of these programmes are accredited as healthcare facilities, some also provide substitution treatment (these facilities and their clients may also be included in other reporting systems); the common denominator is that the NGOs apply for grants from the state budget to provide their services. In 2009, the *Government Council for Drug Policy Coordination* subsidised 11 outpatient programmes which provided services to a total of 1,533 clients – drug users (National Monitoring Centre for Drugs and Drug Addiction, 2010d); see Table 5-6.

Table 5-6: Outpatient treatment facilities operated by NGOs and their clients in 2003-2009 (National Monitoring Centre for Drugs and Drug Addiction, 2010d)

Year	Number of subsidised facilities	Number of clients – drug users
2003	19	1 590
2004	20	1 493
2005	18	1 743
2006	15	2 428
2007	13	1 642
2008	12	1 923
2009	11	1 533

In addition, an intensive three-month outpatient programme in a day care centre is offered by only one facility in the Czech Republic – *SANANIM* in Prague. It has been in operation since 1996. The programme capacity is approximately 10 people.

P-centrum, a civic association in Olomouc, has carried on with its project based on the adaptation of a British method for a twelve-week "Brief Intervention Programme" (hour sessions once per week for twelve weeks). Originally intended for users of crack and cocaine, the project will be redesigned for pervitin users. It involves several phases, from translating and adapting the original methodology to testing the methodology in practical work with clients (Růžička, 2010).

5.2.2.1 Opiate Substitution Treatment

In the Czech Republic there are three medications for substitution treatment of opiate/opioid addiction – (1) methadone, prepared from an imported generic substance (available in specialised substitution centres); (2) Subutex® with buprenorphine as the active substance, available since 2000; and (3) Suboxone®, a composite preparation containing buprenorphine and naloxone as the active ingredients, available since February 2008. Subutex® and Suboxone®, which are available in pharmacies as mass produced medications, can be prescribed by any physician, regardless of their specialisation. Substitute medications are administered only orally in treatment.

In 2009, other substitute drugs were registered in the Czech Republic – methadone in the form of mass-produced medications, and another medication which contains buprenorphine.

On 18 March 2009, the *State Institute for Drug Control* (*SUKL*) registered the medication Methadon-Zentiva® 5mg/ml in the form of an oral solution in packages of 10, 50 and 1000 ml, but the medication has not yet been launched on the Czech market. Since December 2009 the *State Institute for Drug Control* has been gathering information to set a maximum price, amounts, and conditions for reimbursement of the medication. In addition, on 29 October 2009 the *SUKL* registered the medication Buprenorphine Alkaloid® in strengths of 0.4 mg, 2 mg and 8 mg in the form of sublingual tablets; in this case as well, it has not yet been launched on the market and administrative proceedings are underway regarding the price to be set. Buprenorphine Alkaloid® should be launched on the Czech market in December 2010[52].

On 1 February 2010, a decision of the *State Institute for Drug Control* to the effect that the medication Suboxone® 8mg is partially covered by health insurance went into effect. The partial compensation for one package (seven sublingual tablets) from health insurance is set at CZK 629.72 (€ 23.8). The maximum price in pharmacies was set at CZK 890.76 (€ 33.691) , meaning that the patient's contribution is CZK 231.04 (€ 8.7) plus a CZK 30.00 (€ 1.1) prescription fee. Compensation is conditional upon the physician's speciality (must be prescribed by a psychiatrist or a physician with a specialisation in addictive diseases). Treatment is not paid if the patient does not cooperate (e.g. by not adhering to planned visits). Another condition for compensation of Suboxone® sets out that treatment take place in a specialised (selected) healthcare facility. It is the first time in the history of the Czech Republic that substitution treatment of opiate/opioid addiction is covered by health insurance.

The methodology for substitution treatment in the Czech Republic has been defined in the Standard of Substitution Treatment since 2001 and amended in 2008; for more information see the 2007 Annual Report. In the course of 2010 it was supposed to be reworked, e.g. in the area of defining conditions for specialised substitution centres with regard to compensation from health insurance companies, and in the area of the conditions under which substitution treatment would not have to be reported to the *National Register of Users of Medically Indicated Substitution Substances* (*NRULISL*, *the Substitution Treatment Register*) such as for time-restricted detoxification. A detailed comparison of the Czech Standard of Substitution Treatment with the *WHO* sample standard is provided in Table 11-1 (p. 117).

All physicians administering a substitution preparation are obliged by law to report the patient data to the National Register of Users of Medically Indicated Substitution Substances *NRULISL*, operated by the Institute of Health Information and Statistics of the Czech Republic. An electronic web-based application *NRULISL*[53] has been operating since November 2007.

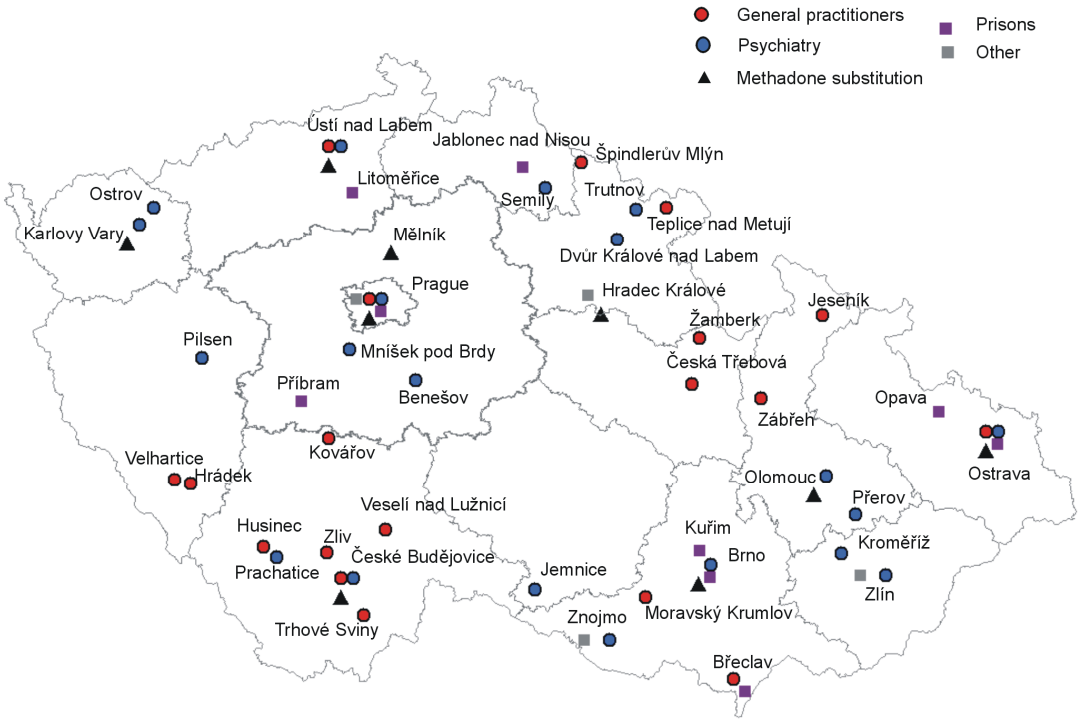
Developments in substitution treatment in the Czech Republic up until 2008 are summarised in the 2008 Annual Report. At the end of 2009, the *Substitution Treatment Register* had listed a total of 72 facilities (16 of these were AT clinics, 20 psychiatric offices, 23 general practitioners of adult medicine, three other departments and 10 prisons), see Map 5-1. In 2009, 34 of these facilities reported patients treated – Table 5-7; these included two general practitioners of adult medicine, five psychiatrists and eight prisons (Institute of Health Information and Statistics, 2009e).

In 2009 the *Substitution Treatment Register* included 1,555 persons in treatment (1,089 men and 466 women) – the trend since 2000 is presented in Table 5-7. The most people in treatment were registered at the substitution centre in Ústí nad Labem, at the *Remedis* facility in Prague (each with 22%), and at *Drop-In* in Prague (slightly under 17%). The regions of Pilsen, Karlovy Vary, Liberec, Pardubice, Vysočina, Olomouc, and Zlín still are practically not covered by substitution treatment (no more than 23 people per region) (Institute of Health Information and Statistics, 2010e; Nechanská et al. 2010).

[52] Personal communication with a representative from Alkaloid AD Skopje on 1 July 2010.

[53] At the site https://snzr.uzis.cz/nrulisl/. Until 2007, the register was maintained as a simple database and reports were collated only from specialised substitution treatment centres accredited by the Ministry of Health. Communication took place through written announcements and over the telephone.

Map 5-1: Network of registered healthcare facilities in the NRULISL electronic application in 2009 (Institute of Health Information and Statistics, 2009e)



In 2009, methadone was used for treatment at 13 facilities and 8 prisons[54] – methadone centres are located in the Karlovy Vary, Liberec, Hradec Králové, Pardubice, and Zlín regions. In Pilsen, a new methadone centre was opened in mid-2009 by *Ulice – Agentura sociální práce,* a civic association, but they did not report clients to the *NRULISL* register; methadone treatment was started there on 1 June 2010[55].

In 2000 only methadone was provided by the substitution centres. Since 2001 there has been a growing proportion of patients using medications which contain buprenorphine – in 2001, Subutex® was prescribed for 4% of clients in treatment, in 2003 there were already more than a third, and in 2009 Subutex® or Suboxone® were prescribed to nearly 56% (631 and 238, respectively, or 869 in all) of all persons registered in the Substitution Treatment Register(Institute of Health Information and Statistics, 2010e; Nechanská et al. 2010).

Table 5-7: Number of registered facilities actively reporting clients and number of people in substitution treatment according to the NRULISL (by substitution drug) in 2000-2009 (Institute of Health Information and Statistics, 2010e; Nechanská et al. 2010)

Year	Number of facilities		Number of clients treated		
	Registered	Active	Total	Of this number	
				Methadone	Buprenorphine
2000*	7	7	245	245	-
2001	8	8	533	510	23
2002	8	8	560	511	49
2003	8	8	789	520	269
2004	8	8	866	546	320
2005	9	9	825	571	254
2006	12	12	938	586	352
2007	14	13	1,038	605	433
2008	38	24	1,356	689	667
2009	72	34	1,555	686	869

*Note: * Facilities started to report clients to the NRULISL register from May 2000.*

The *NRULISL* does not keep a record of all medical facilities prescribing buprenorphine-based products (Subutex® and Suboxone®)[56]; their total number, as well as the total number of patients using buprenorphine preparations, is not known. A survey of physicians in the Czech Republic carried out in 2007 (for more information see the 2007 and 2008 annual reports) and a survey of outpatient psychiatric facilities in 2008-2009 (for more information see the 2008

[54] The Prison Service reports 9 prisons where substitution treatment was carried out in 2009 – see the chapter on Responses to Drug-related Health Issues in Prisons (p. 101). The number of patients in substitution treatment recorded by the prison services is also higher than the number reported to NRULISL.
[55] http://www.ulice-plzen.com/aktuality.html, accessed June 20, 2010.
[56] All facilities (specialised centres) using metadone are registered in NRULISL.

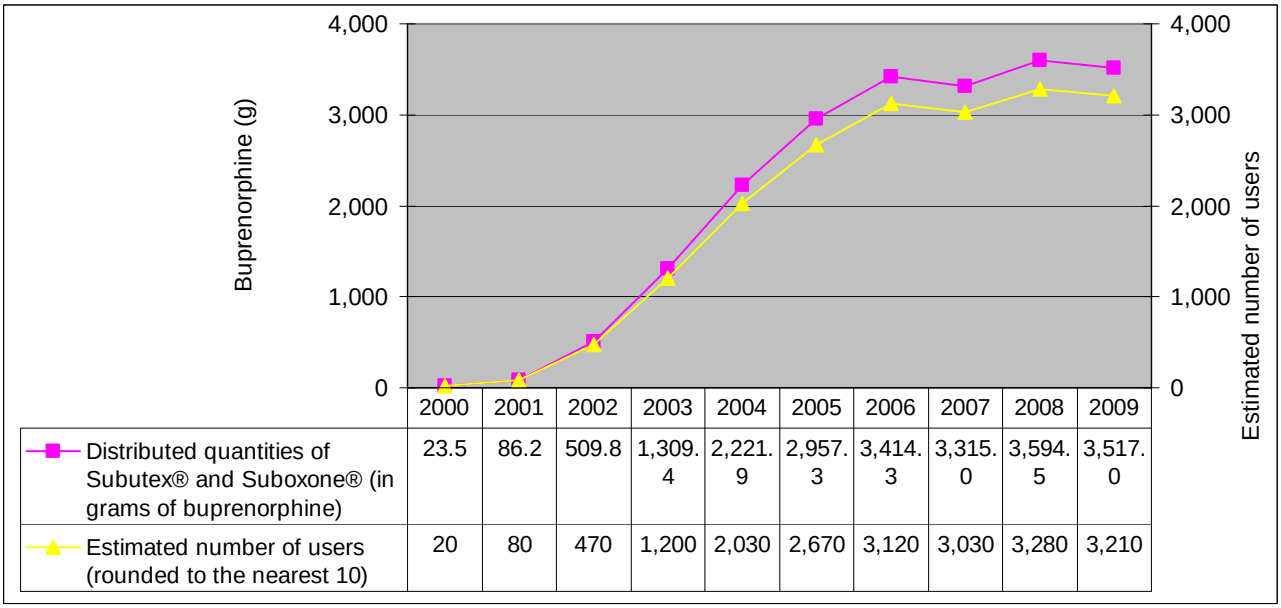
Annual Report) confirmed that there is a large number of physicians (tens or hundreds) and patients (hundreds or thousands) who are not in the *Substitution Treatment Register*. The total number of psychiatrists and general practitioners of adult medicine who prescribe Subutex®, including those who are registered, was estimated in 2007 at 150 to 240, and the number of patients using Subutex® was estimated at a total of 4,300 persons, with approximately 3,000 of these patients receiving prescriptions from psychiatrists and about 1,400 from general practitioners (National Monitoring Centre for Drugs and Drug Addiction Agentura INRES-SONES, 2008).

In 2009, the amount of Subutex® and Suboxone® distributed on the Czech market corresponded to 3517 g of buprenorphine (Ministry of Health of the Czech Republic, IOPL, 2010), which is nearly the same amount as in 2008.

In 2009 a total of 9,910 packages of Suboxone® 7x2mg, 4,993 packages of Suboxone® 7x8mg, 32,201 packages of Subutex® 7x2mg and 47,283 packages of Subutex® 7x8mg were distributed. As compared to 2008, in 2009 there was an increase in the amount of Suboxone® and a decrease in the amount of Subutex® distributed (264.7 g buprenorphine in Suboxone® and 3,329.8 g in Subutex® in 2008, 418.3 g buprenorphine in Suboxone® and 3,098.7 g in Subutex® in 2009) (Ministry of Health of the Czech Republic, IOPL, 2009; Ministry of Health of the Czech Republic, IOPL, 2010).

Given the same conditions as in past years (average daily consumption of 6mg buprenorphine and average frequency of administration every two days[57]), the number of Subutex® and Suboxone® users in 2009 can be estimated at around 3,210 persons; see Figure 5-1.

Figure 5-1: Quantities of Subutex® and Suboxone® (in grams of buprenorphine) distributed and estimated number of users of these medications in 2000-2009 (Ministry of Health of the Czech Republic, IOPL, 2010; National Monitoring Centre for Drugs and Drug Addiction, 2004)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Distributed quantities of Subutex® and Suboxone® (in grams of buprenorphine)	23.5	86.2	509.8	1,309.4	2,221.9	2,957.3	3,414.3	3,315.0	3,594.5	3,517.0
Estimated number of users (rounded to the nearest 10)	20	80	470	1,200	2,030	2,670	3,120	3,030	3,280	3,210

As part of the survey *Multiplier 2010* (for more information see the chapter on Problem Drug Use, p. 41) focused on estimating the proportion of problem drug users in contact with low-threshold facilities, data was also gathered regarding the proportion of problem opiate users involved in substitution programmes. The rationale behind this was to verify whether the peer nomination technique could be used for this purpose.

The multiplier (in-treatment rate) for substitution treatment[58] was calculated as the weighted average of the share of problem drug users or problem opiate users whom the respondent (low-threshold facility client) knows and who are also involved in a substitution programme. The value of the multiplier calculated as the share of all users with no difference in terms of drugs as well as the share of opiate users (heroin, Subutex®, and Suboxone®) whom the respondent knows are provided together with estimated numbers of opiate users in substitution treatment Table 5-8. These values show that 8% (95% CI: 7–10%) of problem drug users and respectively 23% (95% CI: 20–27 %) of problem opiate users are in substitution treatment. In both cases, the estimated number of substitution treatment clients is around 3,000 people, and even though it is somewhat lower, it approximately corresponds with the estimated number of people in substitution treatment stated above.

[57] Information on the average length of treatment (approximately six months) was obtained from a survey of outpatient psychiatrists in 2004 (Národní monitorovací středisko pro drogy a drogové závislosti, 2004), and was recalculated using the average of 1 administration per two days.

[58] This is the proportion of problem users who are participating in substitution treatment.

Table 5-8: Estimated number of substitution treatment clients in 2009 calculated using a multiplier out of all estimated problem drug users

Indicator	Of all problem drug users	Of problem opiate users
Estimated number of problem drug users	37,400	12,100
Multiplier (in-treatment rate)	0.08	0.23
Estimated number of substitution treatment clients	3,100	2,800
95% CI	2,400 – 3,800	2,300 – 3,300

Note: The data in the table are rounded.

Experiences involving oral substitution of pervitin (methamphetamine) with other psychostimulants in the Czech Republic are given in a selected issue chapter of the 2008 Annual Report.

5.2.3 Inpatient treatment

Detoxification units are inpatient medical facilities in psychiatric and addiction treatment departments which serve for short-term (usually up to three weeks) inpatient treatment aimed at managing withdrawal syndrome in the early days of abstinence prior to starting further (usually residential) treatment. In most cases these units are located in psychiatric hospitals and at large regional and university hospitals. At some inpatient care facilities where there is no separate detox unit, detoxification is carried out in standard psychiatric departments or AT departments, and the beds for detoxification are not detached from the ward's total bed capacity.

At present 14 healthcare facilities operate detoxification units. They have 116 beds specially designated for AT patient detoxification; see Table 5-9. There are no detoxification units in the Karlovy Vary, Pardubice, Olomouc, and Zlín regions; the Capital City, Prague and the Vysočina region each have three; the other regions each have one facility with a detoxification unit. Prague is also home to the country's only detoxification unit for children and adolescents – the Detoxification Centre for Children and Adolescents at the Hospital of Sisters of Mercy of St Charles Borromeo (for more information see the 2008 Annual Report). Detoxification also took place at four prisons in 2009 – for more information see Responses to Drug-related Health Issues in Prisons (p. 101).

Table 5-9: Numbers of detoxification units and their bed capacities in individual regions of the Czech Republic as of 1 September 2010 (Institute of Health Information and Statistics, 2010d)

Region	Number of facilities	Number of beds
Prague	3	42
Central Bohemia	1	9
South Bohemia	1	13
Pilsen	1	6
Karlovy Vary	0	0
Ústí nad Labem	1	3
Liberec	1	5
Hradec Králové	1	6
Pardubice	0	0
Vysočina	3	17
South Moravia	1	10
Olomouc	0	0
Zlín	0	0
Morava-Silesia	1	5
Total	**14**	**116**

Psychiatric hospitals for children and adults as well as psychiatric departments of hospitals provide inpatient medical treatment for addicted patients. Psychiatric hospitals in particular organise the treatment by departments specialising in various types of addiction. Over the past years, the network of psychiatric hospitals and psychiatric departments has remained practically unchanged, but there has been a reduction in the total number of beds. In 2009 the number of treatment facilities has increased, but no new facilities were opened – the treatment facility *U Honzíčka* in Písek was detached from the psychiatric hospital for adults in Dobřany. There was a further reduction in the number of beds (by 40) at psychiatric hospitals for children, and the psychiatric ward at the Ostrava City Hospital was closed (Nechanská et al. 2010; Mravčík et al. 2010b; Ústav zdravotnických informací a statistiky, 2010c).

The inpatient psychiatric facilities in 2009 admitted 15,336 patients for hospitalisation due to disorders induced by the use of addictive substances, of which 10,026 were disorders caused by alcohol use (there has been a marked decrease since 2005), and 5,308 were patients with disorders caused by the use of other psychoactive substances, excluding tobacco.

Court-imposed compulsory treatment, including its institutional form, is described in the chapter on Interventions in the Criminal Justice System, page 100).

Table 5-10: Number of inpatient psychiatric facilities, their total bed capacity and occupancy by users of non-alcohol drugs (except tobacco) in 2000-2009 (Nechanská et al. 2010; Institute of Health Information and Statistics, 2010a)

Year	Psychiatric hospitals for children			Psychiatric hospitals for adults				Psychiatric departments in hospitals		
	Number	Total number of beds	Number of patients	Number	Total number of beds	– of which are beds in AT departments	Number of patients	Number	Total number of beds	Number of patients
2002	4	368	13	17	9,677	1,194	2,494	33	1,546	1,200
2003	4	368	17	17	9,609	1,275	2,536	33	1,517	1,480
2004	4	368	27	17	9,583	1,266	2,880	33	1,501	1,762
2005	3	320	27	17	9,538	1,356	3,104	32	1,439	1,584
2006	3	320	29	17	9,442	1,387	3,200	31	1,420	1,846
2007	3	320	16	16	9,307	1,358	3,489	32	1,419	1,834
2008	3	300	25	16	9,240	1,341	3,527	32	1,396	1,708
2009	3	260	21	17	9,207	1,370	3,578	31	1,383	1,709

A therapeutic community is another type of residential treatment programme. The history of therapeutic communities for drug addicts in the Czech Republic is summarised in the chapter on treatment in the 2008 Annual Report. Therapeutic communities in the Czech Republic are associated in the section of therapeutic communities of the Association of Non-governmental Organisations (A.N.O.), which had ten members as of June 2010[59]. According to the *Register of Social Service Providers* maintained by the *Ministry of Labour and Social Affairs*, as of June 2010 there were 14 programmes registered as therapeutic communities in the Czech Republic. They are primarily targeted at people who are at risk of addiction or who are already suffering from substance addictions[60].

The Ministry of Education manages the system of alternative educational care for children at risk. The system comprises educational establishments for young people in institutional care, protective custody, or in preventive care. Four types of institutional facilities and one type of preventive care facility cooperate with each other. They include institutions for juvenile delinquents and children with behavioural disorders ("diagnostic institutions"), children's homes with schools, rehabilitation institutions, and children's homes and educational care centres. The facilities are established by the Ministry of Education, Youth and Sports, Regional Authorities or the private sector. In all there are 272 facilities in the Czech Republic; see Table 5-11. Administered by the Ministry of Education, diagnostic institutions are divided up into children's diagnostic institutions, diagnostic institutions for adolescents, a diagnostic institution for children and adolescents, and a diagnostic institution for the children of foreigners. Children's homes are usually administered by the regional authorities, churches, private entities or the Ministry of Education. Children's homes with schools are administered by the Ministry of Education. Rehabilitation institutions are administered by the Ministry of Education or the private sector; some also specialise in underage mothers with children or adolescents who use drugs. In terms of organisation, educational care centres report to diagnostic institutions or rehabilitation institutions, in which case they are not independent, but they can also be managed by private entities. The number of children in institutional care increases each year. In 2003 there were 7,250 children placed in these facilities, while in 2009 this number had risen to 7,820. Most children have experience with cigarettes, about a third with drugs – particularly alcohol and cannabis[61].

Table 5-11: Educational facilities for young people in institutional care, protective custody, or in preventive care in the Czech Republic

Types of facilities	Number of facilities
Children's homes	155
Children's homes with schools	29
Rehabilitation institutions	34
Diagnostic institutions for children	8
Diagnostic institutions for adolescents	4
Diagnostic institutions for children and adolescents	1
Diagnostic institutions for children of foreigners	1
Educational care centres	40
Total	**272**

Five facilities contain departments specialised in treating children at risk of drug addiction. The total capacity of these departments in 2009 was 74 spaces, and 152 children were placed there.

[59] See http://www.terapeutickekomunity.org/, accessed on 20 June 2010.
[60] See http://iregistr.mpsv.cz/, retrieved on 20 June 2010.
[61] Information provided by the Ministry of Education's Department of Prevention, Special Education, and Institutional Education in September 2010

Table 5-12: Capacity and number of children with drug use problems in specialised departments of facilities providing institutional, protective, and preventive care in the Czech Republic in 2009

Facility	Capacity	Number of children
Dvůr Králové Rehabilitation Institution	24	31
Klíčov Rehabilitation Institution	8	14
Žulová Rehabilitation Institution	8	15
Hostouň Rehabilitation Institution	16	25
Řevnice Educational Care Centre	18	67
Total	**74**	**152**

5.3 Characteristics of Clients in Treatment

5.3.1 Systems for Collection of Data on Drug Users in Treatment

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

The *Register of Treatment Demands*, a national reporting system, has been maintained by the Public Health Service, specifically the *Public Health Office in Prague,* since 1995. Drug users who in any given year sought treatment, counselling, or social services in designated facilities for drug users, either healthcare or non-healthcare (e.g. therapeutic communities, low-threshold centres, etc.) ones, are included in this register. Separate records of first treatment demands are also kept. The data set and its structure and the definitions in use comply with the treatment demands collection standard issued by the *European Monitoring Centre for Drugs and Drug Addiction* (*EMCDDA)*. The register does not effectively cover the treatment provided through general practitioners, substitution treatment centres, and prisons (Studničková, 2009).

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

The data on clients of and services provided by NGOs, or programmes delivered with financial support from the state budget, are mainly available from final reports of projects implemented from grants administered by the *GCDPC*. This information is processed annually by the *National Focal Point*. In particular, the data cover low-threshold harm reduction, as well as other types of services provided by NGOs (outpatient treatment, after-care, and inpatient treatment in therapy communities)[62].

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

In 2010 a historical analysis of treatment data on addictive substance users at healthcare facilities, collected by the *Institute of Health Information and Statistics* in the Czech Republic since 1959, was completed (Nechanská et al. 2010; Mravčík et al. 2010a; Mravčík et al. 2010b).

5.3.2 Treatment Demand Register

The *Treatment Demand Register* received data from 276 centres (72 low-threshold, 146 outpatient, and 58 inpatient facilities) in 2009. The most sought-after type of facility has traditionally been the low-threshold centre; as in the previous years, the clients of these facilities accounted for more than a half of the treatment demands – 54.9% of first treatment demands and 50.3% of all treatment demands. Inpatient facilities were the most widely represented type among the centres; however, their share of the total volume of the reported incidence and prevalence of drug users in treatment was only 23.0% and 24.5%, respectively (Studničková and Petrášová, 2010).

In 2009, a total of 8,763 drug users sought treatment services at these facilities, which is 500 more than in 2008. Of this number, 4,318 represented first-time demands, which is about 400 more than in 2008. In comparison with

[62] Since 2003 the *National Focal Point* has operated *FreeBase*, a software application with a consolidated system for data collection in low-threshold facilities, and from 2008 also *UniData*, an application for all types of services. A similar application in the area of primary prevention – *PrevData* – has been in place since 2008. All these applications are principally intended for capturing data about clients and the services provided to them. They contain a number of other tools making it possible to process reports in compliance with the requirements of the Register of Treatment Demands and with the requirements for regular and final reports in the *GCDPC* subsidy proceedings. The applications can be downloaded for free from http://www.drogovesluzby.cz.

previous years, the trend shows a slight decline, and the number of people demanding treatment is reaching 2004-2005 levels. Women stably make up one third of treatment demands (Studničková and Petrášová, 2010).

The order of drugs used which are the cause for all demands and first treatment demands has remained the same as in previous years. Users of stimulants dominate treatment demands – both overall and in terms of first demands. Stimulant users[63] were the largest group of all treatment demands (59.5%) as well as first treatment demands (60.9%); this is particularly the case for pervitin (59.4%, and 60.8%, respectively). The second largest group of all demands are opiate users (23.4%), while cannabis users predominate among first treatment demands (18.3%). Trends in the numbers of treatment demands according to drug used are given in Figure 5-2 and Figure 5-3.

The prevalence and incidence of treatment demands and the representation of treatment demands by drug type is not the same throughout the Czech Republic. It is evident from the available data that the greatest relative prevalence and incidence of treatment demands are in the region of Ústí nad Labem and in the City of Prague. The most commonly used drug among those demanding treatment, pervitin, is relatively dominant, with stimulant users predominating in all regions across the Czech Republic (from 50% in the City of Prague to 80% in the Zlín region). Opiate users were most markedly represented in treatment demands in Prague (36.9%), Central Bohemia (35.3%) and the Ústí nad Labem region (28.1%). The greatest share of cannabis users among treatment demands is reported by the Pardubice (27.2%), Pilsen (26.1%), and Vysočina (25.7%) regions, see Map 5-2.

In terms of the age structure of treatment demands, a slight aging in the population of those demanding treatment can be seen – Figure 5-4 and Figure 5-5. Although the year-on-year increase in the average age is small, from a medium-term perspective, the increasing trend is apparent. In 2009 the average age of people demanding treatment for the first time was 24.2 years old, and 25.9 years old for all those demanding treatment. Over the past decade, the average age of those demanding treatment for the first time has increased by over three years, and for all those demanding treatment the increase in age has been 3.5 years. People in treatment for heroin use for the first time have aged the most. Since 2000 one can observe an average age increase of over six years, to the current 27.9 years. In 2009 the most commonly represented age group among all treatment demands and among first treatment demands was 25 to 39-year-olds, who accounted for 39% and 49.3%, respectively. Similarly, in addition to the gradual increase in the average age of treatment demands, one can also observe a decrease in the youngest age categories of users in treatment – the number of persons under 19 is gradually dropping among first demands as well as all demands for treatment (Studničková and Petrášová, 2010); see Figure 5-6 and Figure 5-7.

Over the long term, users of heroin and cocaine have been among the oldest and, at the same time, most rapidly aging groups of treatment demands. On the other hand, they youngest demands are users of cannabis (19.7 among first demands and 21 among all demands). The popularity of cannabis, especially among adolescents and young adults, is also confirmed by data from other sources – see, for example, the chapter on Drug Use in the General Population and Specific Targeted Groups (p. 26).

5.3.2.1 Selected Characteristics of Treatment Demands

The gender distribution of treatment demands has not changed over the long term, and reflects the estimated structure of problem drug users in the Czech Republic – i.e. a ratio of two males per female. The greatest proportion of males is among users of inhalants and hallucinogens; the lowest is among users of sedatives and hypnotics, with women accounting for over half of all users. There is a relatively high percentage of females among users of stimulants (approximately 36%), while women make up just 29% of opiate users (Studničková and Petrášová, 2010).

Two-thirds of those demanding treatment administered drugs by injection, or by smoking (15%) or inhaling/snorting (12.8%). Treatment contact most often took place at low-threshold facilities (50.3%), outpatient (24.5%) and residential (25.1%) programmes.

The socioeconomic characteristics of those demanding treatment has changed little over the past years. Out of the total of 8,763 treatment demands in 2009, 11.5% were from homeless people and another 8.5% were from people resident in institutions (e.g. in prisons, institutional care, hostels or sheltered housing); only 47% gave a permanent address of residence. Less than a half of both all and first treatment demands were from drug users who lived with their parents, and 20.4% of all clients in treatment stated they lived alone – men (24.4%) more frequently than women (11.8%); 17.8% of newly registered clients stated that they lived alone. A total of 582 clients (6.6%) receiving treatment indicated they lived in a household with children. The number of people without a permanent home is significantly greater among repeatedly treated and long-term drug users than among those demanding treatment for the first time. The percentage of homeless people has been increasing among all clients and first demands since 2006 (Studničková and Petrášová, 2010).

More than a half of treatment demands were from unemployed people or people with temporary jobs (52.9%). A total of 14.9% of first treatment demands and 17.2% of all treatment demands were from people who stated they had

[63] The *Public Health Service* ranks amphetamine-type drugs, including MDMA, phenmetrazine, and ephedrine, as stimulants; cocaine is recorded separately.

regular employment. Nearly half of treatment demands were from people who had just a basic education; 40% have completed secondary school (Studničková and Petrášová, 2010).

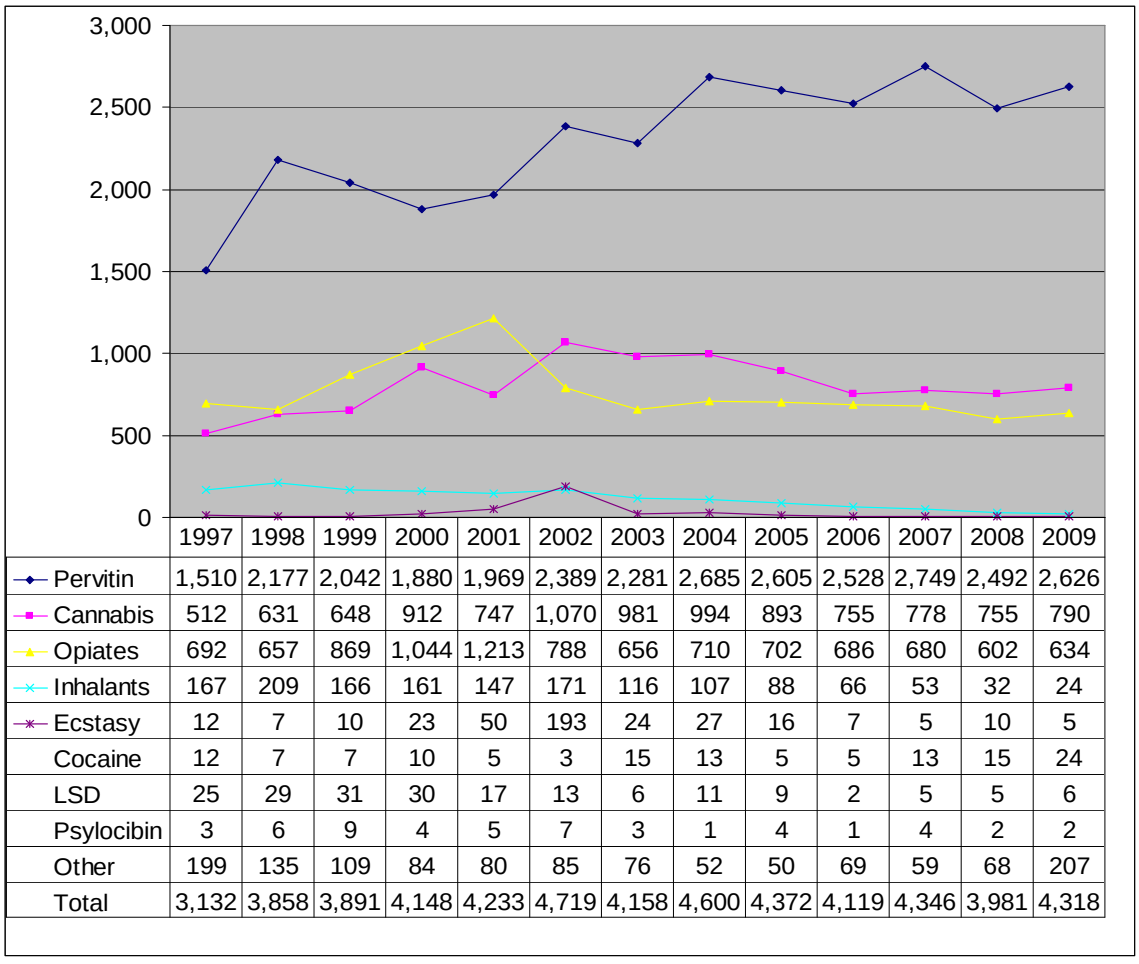
In 2009, first treatment demands reported daily use of drugs in 1,200 cases (27.8%); an additional 1,000 users (23.2%) used the drug 2-6 times per week. Heroin was most frequently used daily by newly recorded users (50.7%), pervitin was used on a daily basis by 22.1% of people demanding treatment for the first time. The most widely reported frequency of use of pervitin was 2-6 times per week (26.7%).

All treatment demands reported the daily use of drugs in 2,652 cases (30.3%); an additional 1,886 users (21.5%) used a drug 2-6 times per week. Among all heroin users in treatment, about half of those demanding treatment reported daily use. Among pervitin users, a lower frequency of use was more common, at several times per week (26.1%) as opposed to daily use (21.8%). At the same time, most users of Subutex® (68.3 %) reported daily drug use in their demand for treatment (Studničková and Petrášová, 2010).

In 2009, problem drug users made up 7,811 of all treatment demands (89.1%) and 3,607 of first treatment demands (83.5%)[64]. A total of 5,840 (66.6%) of all demands stated that they were injecting drug users; this figure for first demands was 2,402 (55.6%) (Studničková and Petrášová, 2010). Trends for selected characteristics among those demanding treatment are shown in Figure 5-6 and Figure 5-7. Further information about injecting drug users among those demanding treatment is provided in the section on Risk Behaviour of Drug Users (p. 70).

The typical profile for a client in treatment in 2009 is an unemployed male of Czech nationality between 25 and 30 years of age, with completed basic education, from Prague or Central Bohemia, with a permanent residence, living with his parents and using stimulants (pervitin). He uses the drug several times per week, mostly by injecting.

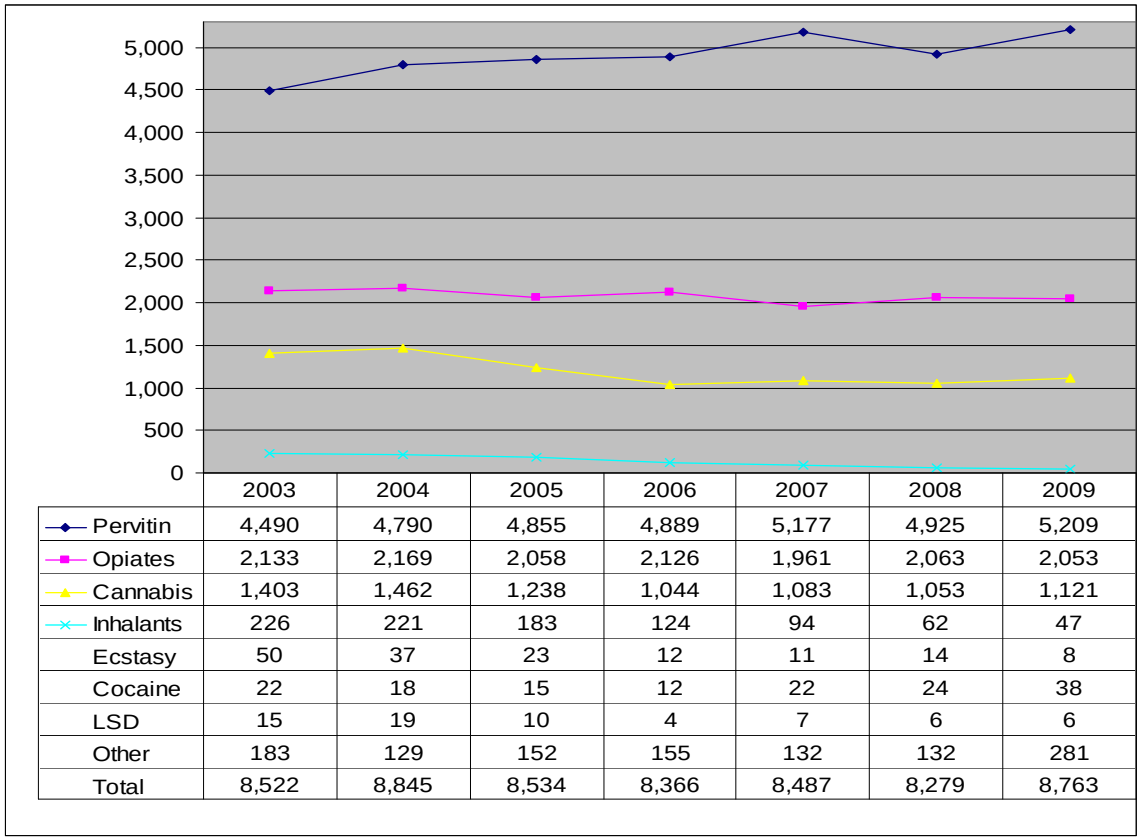
Figure 5-2: Number of first treatment demands according to drug used, 1997-2009 (Studničková and Petrášová, 2010)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Pervitin	1,510	2,177	2,042	1,880	1,969	2,389	2,281	2,685	2,605	2,528	2,749	2,492	2,626
Cannabis	512	631	648	912	747	1,070	981	994	893	755	778	755	790
Opiates	692	657	869	1,044	1,213	788	656	710	702	686	680	602	634
Inhalants	167	209	166	161	147	171	116	107	88	66	53	32	24
Ecstasy	12	7	10	23	50	193	24	27	16	7	5	10	5
Cocaine	12	7	7	10	5	3	15	13	5	5	13	15	24
LSD	25	29	31	30	17	13	6	11	9	2	5	5	6
Psylocibin	3	6	9	4	5	7	3	1	4	1	4	2	2
Other	199	135	109	84	80	85	76	52	50	69	59	68	207
Total	3,132	3,858	3,891	4,148	4,233	4,719	4,158	4,600	4,372	4,119	4,346	3,981	4,318

[64] EMCDDA defines problem drug use as: injecting drug use and/or long-term/regular use of opioids/opiates and/or amphetamine-type drugs and/or cocaine (European Monitoring Centre for Drugs and Drug Addiction, 2009). Cocaine use in the Czech Republic is at a very low level. The prevalence of problem cocaine use has not been estimated.

Figure 5-3: Number of all treatment demands according to drug used, 2002-2009 (Studničková and Petrášová, 2010)



	2003	2004	2005	2006	2007	2008	2009
Pervitin	4,490	4,790	4,855	4,889	5,177	4,925	5,209
Opiates	2,133	2,169	2,058	2,126	1,961	2,063	2,053
Cannabis	1,403	1,462	1,238	1,044	1,083	1,053	1,121
Inhalants	226	221	183	124	94	62	47
Ecstasy	50	37	23	12	11	14	8
Cocaine	22	18	15	12	22	24	38
LSD	15	19	10	4	7	6	6
Other	183	129	152	155	132	132	281
Total	8,522	8,845	8,534	8,366	8,487	8,279	8,763

Map 5-2: Number of all treatment demands according to drug type in regions of the Czech Republic in 2009, per 100,000 inhabitants aged 15-64 (Studničková and Petrášová, 2010)

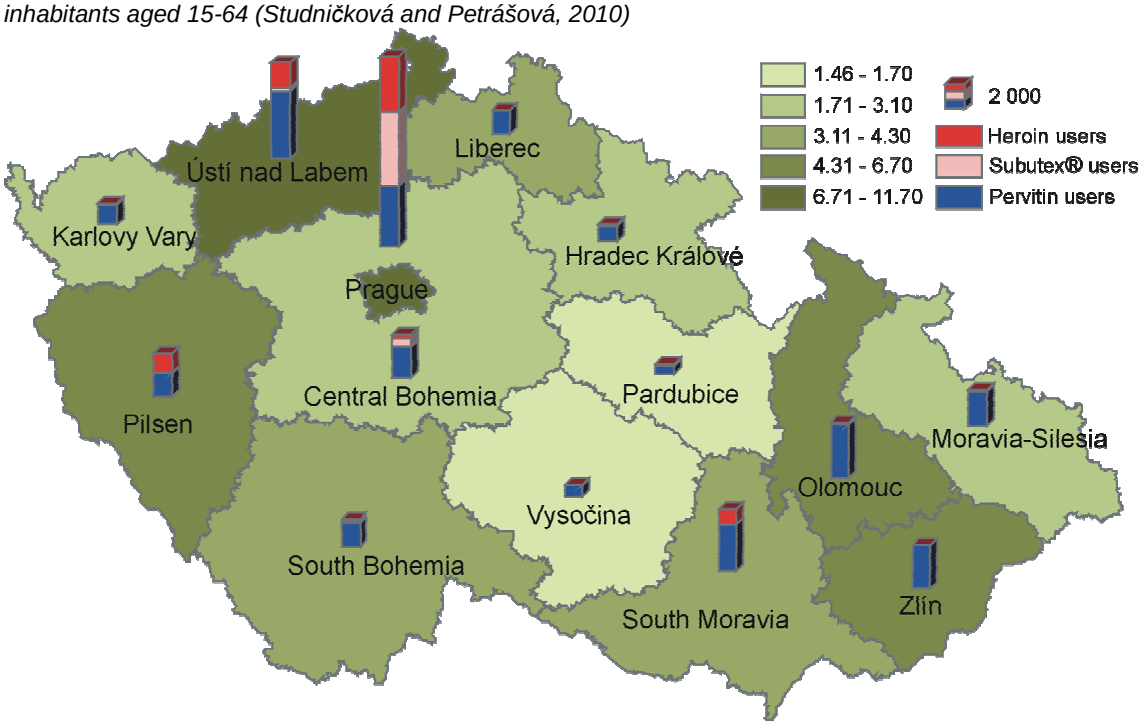
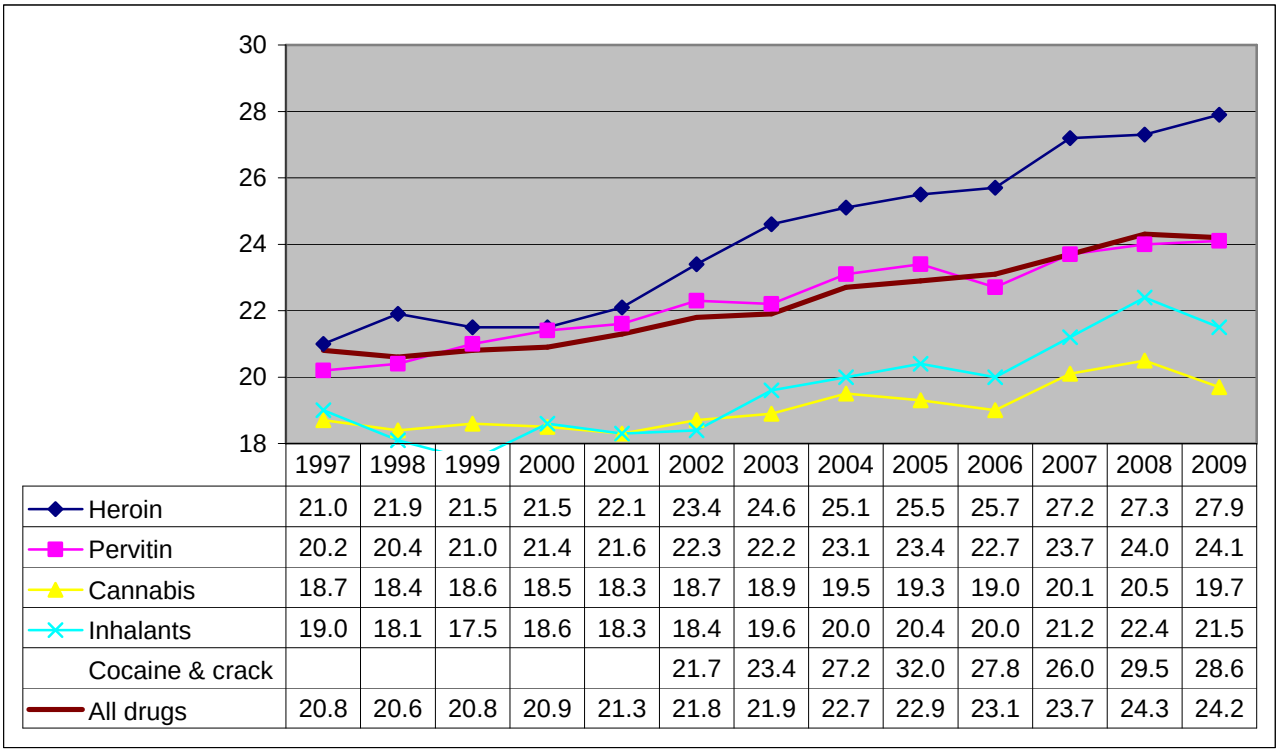
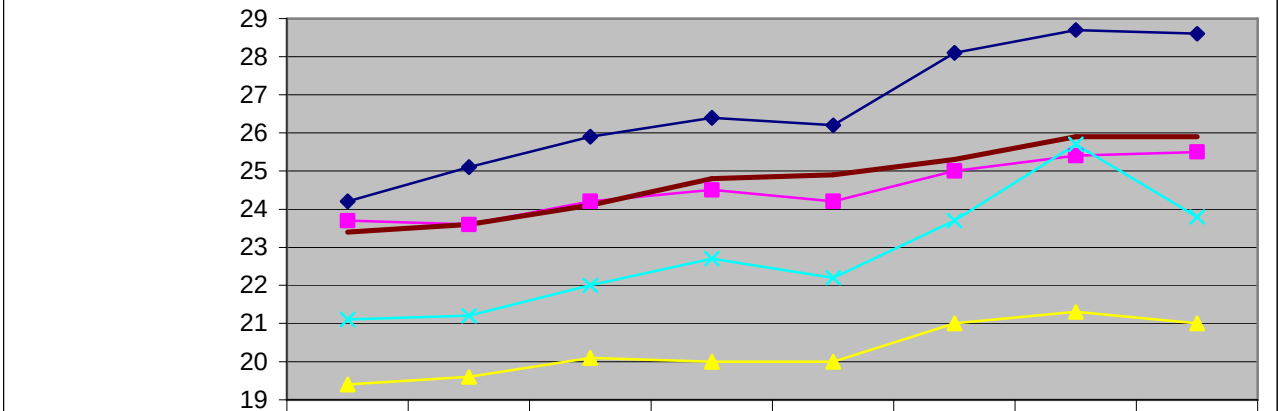


Figure 5-4: Average age of first treatment demands according to specific drugs, 1997-2009 (Studničková and Petrášová, 2010)



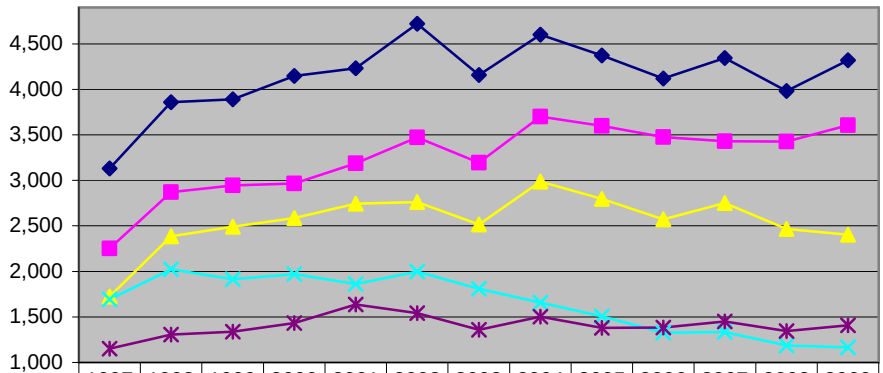
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Heroin	21.0	21.9	21.5	21.5	22.1	23.4	24.6	25.1	25.5	25.7	27.2	27.3	27.9
Pervitin	20.2	20.4	21.0	21.4	21.6	22.3	22.2	23.1	23.4	22.7	23.7	24.0	24.1
Cannabis	18.7	18.4	18.6	18.5	18.3	18.7	18.9	19.5	19.3	19.0	20.1	20.5	19.7
Inhalants	19.0	18.1	17.5	18.6	18.3	18.4	19.6	20.0	20.4	20.0	21.2	22.4	21.5
Cocaine & crack						21.7	23.4	27.2	32.0	27.8	26.0	29.5	28.6
All drugs	20.8	20.6	20.8	20.9	21.3	21.8	21.9	22.7	22.9	23.1	23.7	24.3	24.2

Figure 5-5: Average age of all treatment demands according to specific drugs, 2002-2009 (Studničková and Petrášová, 2010)



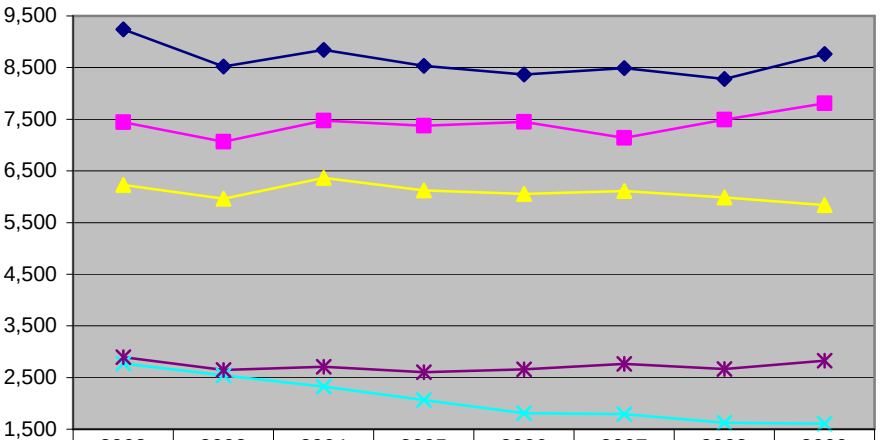
	2002	2003	2004	2005	2006	2007	2008	2009
Heroin	24.2	25.1	25.9	26.4	26.2	28.1	28.7	28.6
Pervitin	23.7	23.6	24.2	24.5	24.2	25.0	25.4	25.5
Cannabis	19.4	19.6	20.1	20.0	20.0	21.0	21.3	21.0
Inhalants	21.1	21.2	22.0	22.7	22.2	23.7	25.7	23.8
Cocaine & crack	25.2	25.7	26.9	29.1	30.1	26.8	29.6	28.1
All drugs	23.4	23.6	24.1	24.8	24.9	25.3	25.9	25.9

Figure 5-6: Selected characteristics of first treatment demands, 1997-2009 (Studničková and Petrášová, 2010)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Number of first treatment demands, total	3,132	3,858	3,891	4,148	4,233	4,719	4,158	4,600	4,372	4,119	4,346	3,981	4,318
- problem users	2,253	2,871	2,943	2,966	3,187	3,472	3,196	3,701	3,600	3,475	3,429	3,428	3,607
- injecting users	1,723	2,385	2,490	2,586	2,745	2,761	2,516	2,986	2,796	2,573	2,753	2,468	2,402
- persons under 19	1,694	2,023	1,914	1,970	1,860	2,000	1,808	1,656	1,506	1,327	1,335	1,186	1,164
- females	1,152	1,307	1,337	1,431	1,637	1,541	1,359	1,503	1,381	1,384	1,449	1,344	1,408

Figure 5-7: Selected characteristics of all treatment demands, 2002-2009 (Studničková and Petrášová, 2010)



	2002	2003	2004	2005	2006	2007	2008	2009
Number of first treatment demands, total	9,237	8,522	8,845	8,534	8,366	8,487	8,279	8,763
- problem users	7,441	7,067	7,473	7,372	7,451	7,137	7,490	7,811
- injecting users	6,228	5,964	6,364	6,125	6,054	6,109	5,986	5,840
- persons under 19	2,773	2,541	2,322	2,064	1,811	1,792	1,625	1,604
- females	2,895	2,646	2,709	2,602	2,656	2,763	2,663	2,829

5.3.3 Clients in Outpatient Treatment

In 2009, 41,419 users of alcohol and drugs were treated in outpatient psychiatric facilities; of these, 17,213 were users of non-alcohol drugs (dg. F11-F19) and 16,343 were users of illicit drugs with the exception of tobacco (dg. F11-F16, F18-F19). In comparison to 2008, there was a slight drop in the number of alcohol/drug patients undergoing outpatient treatment, particularly because of the fall in the number of patients using alcohol. The total number of men in treatment fell, while the number of women increased slightly. The number of children under 15 doubled year-on-year in 2009 (78 children), mainly as a result of cannabis users and problem drug users in this age group. The total number of problem drug users, particularly women, rose. The proportion of patients from higher age groups also grew (Institute of Health Information and Statistics, 2010b).

The users of drugs (excluding tobacco) included 10,924 males (67%) and 5,419 females (33%). The most patients were 20-39 years old (70%); less than 12% of patients were under 20. Disorders caused by the use of opiates (F11), stimulants (F15) and polydrug use (F19) are traditionally the most frequent diagnoses among patients in treatment. Developments in the total number of patients are provided in Table 5-13. Trends in the proportion of injecting users among patients in outpatient psychiatric treatment is provided in Figure6-6 (p. 71).

Table 5-13: Trends in the number of addictive substance users in treatment at outpatient healthcare facilities in 1993-2009 according to addictive substance (groups) (Nechanská et al. 2010; Institute of Health Information and Statistics, 2010b)

Year	**Alcohol**	Opiates and opioids	– heroin	Cannabinoids	Sedatives and hypnotics	– benzodiazepines	Cocaine	Other stimulants	– methamphetamine	Hallucinogens	Tobacco	Inhalants	Polydrug use	Other	**Drugs overall**	**Drugs except tobacco**
1993	**49,102**	816	–	211	2,589	–	8	595	–	62	–	561	260	132	**5,234**	**5,234**
1994	**44,660**	653	–	291	2,561	–	8	706	–	87	–	380	558	367	**5,611**	**5,611**
1995	**32,956**	461	–	383	712	–	14	699	–	69	–	281	473	246	**3,338**	**3,338**
1996	**30,259**	1,619	–	474	761	–	20	1,471	–	84	–	347	685	480	**5,941**	**5,941**
1997	**31,691**	2,183	1,813	659	810	347	33	2,125	979	120	–	347	710	527	**7,514**	**7,514**
1998	**31,955**	2,255	1,823	1,039	1,011	456	95	2,896	2,436	127	–	370	1,148	491	**9,432**	**9,432**
1999	**28,022**	3,368	2,552	1,293	1,613	1,080	42	3,655	3,211	160	1,965	368	1,750	247	**14,461**	**12,496**
2000	**27,021**	3,815	3,176	1,152	1,122	491	52	3,169	2,695	244	1,277	280	1,430	159	**12,700**	**11,423**
2001	**28,582**	4,336	3,464	1,248	1,787	644	57	3,415	2,718	182	1,323	310	1,559	156	**14,373**	**13,050**
2002	**25,400**	4,029	3,171	1,505	2,292	774	63	3,185	2,719	232	1,533	261	2,480	156	**15,736**	**14,203**
2003	**25,017**	4,768	4,035	1,718	2,090	799	129	3,714	3,162	200	2,078	189	2,912	66	**17,864**	**15,786**
2004	**25,235**	4,592	3,644	1,354	2,257	1,014	79	3,025	2,579	170	1,350	180	2,279	104	**15,390**	**14,040**
2005	**27,440**	5,558	3,635	1,634	2,312	1,101	47	4,076	2,662	196	1,137	174	2,275	122	**17,531**	**16,394**
2006	**26,966**	4,640	3,357	1,681	2,190	1,153	45	3,746	3,055	137	1,529	187	3,631	135	**17,921**	**16,392**
2007	**25,342**	4,259	2,614	1,544	1,799	1,057	33	3,979	3,272	198	1,170	140	3,616	116	**16,854**	**15,684**
2008	**25,293**	4,585	3,055	1,620	2,229	1,408	73	4,103	3,330	177	1,608	79	2,489	356	**17,319**	**15,711**
2009	**24,206**	4,797	3,120	1,667	2,377	1,492	36	3,907	3,383	74	870	90	3,071	324	**17,213**	**16,343**

Note: Separate data for heroin, benzodiazepines, and pervitin are not available up to 1996, for tobacco up to 1998.

In 2009, outpatient treatment was also available from 11 NGOs funded by the *Government Council for Drug Policy Coordination*. Services were provided to 1,533 illegal drug users, of whom 783 (51%) were males and 750 (49%) females; their average age was 26.8 years old. A total of 712 clients (46.4%) injected drugs, 700 (45.7%) used pervitin, 173 (11.3%) heroin, 139 (9.1%) cannabis, and 80 (5.2 %) other opiates, mainly illegally obtained buprenorphine. In comparison to 2008, there was a drop in the number of clients, in particular heroin and Subutex® users, and a significant increase in the number of pervitin users. A comparison of the period from 2003 to 2009 is provided in Table 5-14 (National Monitoring Centre for Drugs and Drug Addiction, 2010d).

Table 5-14: Outpatient treatment facilities operated by NGOs and selected characteristics of their clients, 2003-2009 (Mravčík et al. 2009; National Monitoring Centre for Drugs and Drug Addiction, 2010d).

Indicator	2003	2004	2005	2006	2007	2008	2009
Number of subsidised facilities	19	20	18	15	13	12	11
Number of clients	2,820	2,506	3,127	4,301	3,044	3,278	3,060
Number of drug users	1,590	1,493	1,743	2,428	1,642	1,923	1,533
– injecting drug users	848	697	1,034	1,024	708	724	712
– pervitin users	547	540	540	771	511	456	700
– cannabis users	246	339	158	405	101	118	139
– heroin users	310	223	391	240	256	317	173
– Subutex® users	–	–	126	110	116	186	65
Average age of drug users	23.6	25.9	26.8	29.6	26.3	28.9	26.8

Over the long term, only one facility in the Czech Republic offers an intensive three-month outpatient treatment programme in a day care centre – operated by *SANANIM* in Prague and in existence since 1996. The programme capacity is approximately 10 persons. In 2009 services were provided to 46 clients (19 men, 27 women), whose average age was 25.9 years. Altogether, 25 clients (54.3%) were injecting drug users before the treatment; 25 (54.3%) were heroin users and 6 (13%) used pervitin. A total of 54.3% of the clients completed treatment successfully. The average length of treatment per client was two months (National Monitoring Centre for Drugs and Drug Addiction, 2010d).

5.3.4 Clients in Substitution Treatment

In 2009 the *Substitution Treatment Register* included 1,555 persons in treatment (1,089 men and 466 women) aged 17 to 57 years, with males being the oldest patients (Institute of Health Information and Statistics, 2009e) – the trend since 2000 is presented in Table 5-15. In comparison to 2008, the number of patients in treatment recorded in the *Substitution Treatment Register* increased by nearly 15% (up by 199 clients). The greatest increase, by 110 clients, occurred in the City of Prague (+20%) and in the region of Central Bohemia, by 54 clients (+39%). On the contrary, there was a decline in the number of patients in the South Bohemian region, where the sole substitution centre, in the city of Česke Budějovice, cut back on its activities, and in the Karlovy Vary region, where the facility with the greatest number of clients stopped providing substitution treatment.

A total of 755 new treatment cases for 643 recorded persons were registered with the substitution programme in 2009, with men making up 70% of both the cases and the persons; 343 individuals (248 males and 95 females) entered treatment for the first time in their lives in 2009, while 412 of cases involved persons who had already been in treatment. In comparison to 2008, there was a 15% decline in new cases. It is not uncommon for a person to be admitted and re-admitted within one calendar year. Out of the persons who were admitted for treatment in 2009, 6% were attempting for the second time, 2% for the third time, and the maximum number of attempts for treatment by one person was four. The highest number of re-admissions was reported by the University Hospital in Ostrava, Drop-In in Prague, the South Bohemia Substitution Centre and the Mělník Hospital. Re-admissions, or more specifically the terminations of the previous treatment episodes, were most frequently caused by a violation of the treatment regime on the part of the patient; over the long term, the repeated violation of the therapy agreement is the reason behind 70% of all treatment terminations. In 2009 treatment was terminated a total of 508 times (354 and 154 cases of treatment termination involved males and females respectively) by 415 persons (288 males and 127 females), which is approximately 11% less than in 2008 (Institute of Health Information and Statistics, 2009e); see Table 5-15.

Clients from the City of Prague (43%) and the regions of Ústí nad Labem (17%) and Central Bohemia (13%) were most frequently among the newly reported cases. On the other hand, clients from the Pilsen, Karlovy Vary, Liberec, Pardubice, Olomouc, Zlín, and Vysočina regions were rarely represented (Institute of Health Information and Statistics, 2009e).

Table 5-15: Trends in persons in treatment, reported and terminated treatment cases in the NRULISL register by gender, 2000-2009 (Nechanská et al. 2010; Institute of Health Information and Statistics, 2010e)

Year	Number of persons in treatment			Number of new treatment cases			Number of terminated treatment cases		
	Males	Females	**Total**	Males	Females	**Total**	Males	Females	**Total**
2000	173	72	**245**	207	86	**293**	72	30	**102**
2001	369	164	**533**	374	167	**541**	261	107	**368**
2002	393	167	**560**	265	106	**371**	265	110	**375**
2003	557	232	**789**	499	183	**682**	345	115	**460**
2004	605	261	**866**	375	136	**511**	430	159	**589**
2005	578	247	**825**	438	150	**588**	395	135	**530**
2006	652	286	**938**	455	175	**630**	378	145	**523**
2007	719	319	**1,038**	403	157	**560**	378	143	**521**
2008	949	407	**1,356**	621	266	**887**	389	179	**568**
2009	1 089	466	**1,555**	530	225	**755**	354	154	**508**

5.3.5 Clients in Inpatient Treatment

Polydrug use (dg. F19) was again the most common cause (almost half) of hospitalisation of illegal drug users in inpatient psychiatric facilities in 2009. Other causes of hospitalisation included stimulant use (28%) and opioid use (13%). The causes of hospitalisation in psychiatric hospitals for children were polydrug use, the use of inhalants, cannabis, and stimulants. Nearly half of illegal drug users admitted to hospital were aged 20-29, less than a quarter were 30–39 years old, and persons under 20 made up 16% of the total number of hospitalised illicit drug users. In terms of regional distribution, the most patients hospitalised in connection with (non-tobacco) drug use were permanent residents of the Ústí nad Labem region (92 patients per 100,000 people living in the region) and the City of Prague (87). After a gap, this is followed by the Liberec (62), Central Bohemia (55), and Pilsen (54) regions. Numbers of patients according to main diagnoses and types of psychiatric facilities in 2009 are shown in Table 5-16.

Table 5-16: Number of hospitalisations resulting from disorders caused by alcohol and other psychoactive drug use in psychiatric inpatient facilities in 2009 according to type of healthcare facility, gender, and diagnosis (Institute of Health Information and Statistics, 2010c)

Diagnosis	Psychiatric hospitals for children			Psychiatric hospitals for adults			Psychiatric departments in hospitals		
	Males	Females	**Total**	Males	Females	**Total**	Males	Females	**Total**
F11 (opioids)	0	0	**0**	262	108	**370**	209	108	**317**
F12 (cannabis)	5	0	**5**	68	13	**81**	75	13	**88**
F13 (sedatives/hypnotics)	0	0	**0**	51	122	**173**	39	85	**124**
F14 (cocaine)	0	0	**0**	0	3	**3**	1	1	**2**
F15 (other stimulants)	1	2	**3**	627	370	**997**	282	206	**488**
F16 (hallucinogens)	0	0	**0**	4	0	**4**	1	0	**1**
F18 (inhalants)	5	0	**5**	44	2	**46**	11	5	**16**
F19 (polydrug use)	4	4	**8**	1,354	550	**1,904**	443	230	**673**
Drugs in total (F11-19, excl. F17)	**15**	**6**	**21**	**2,410**	**1,168**	**3,578**	**1,061**	**648**	**1,709**
F10 (alcohol)	0	0	**0**	5,348	2,164	**7,512**	1,500	1,014	**2,514**
F17 (tobacco)	0	0	**0**	0	0	**0**	1	1	**2**
Addictive substances in total (F10-F19)	**15**	**6**	**21**	**7,758**	**3,332**	**11,090**	**2,562**	**1 663**	**4,225**

The trend in the number of hospitalised patients by individual drug (groups) varies. In 2001 and 2002 there was a significant decrease in the number of hospitalisations resulting from disorders caused by opioids (F11). With minor fluctuations, this has continued into the following years. The number of admissions to hospital because of polydrug use disorders (F19) has been increasing over the long term (2.6 times higher from 1997 to 2009). The number of hospitalisations resulting from non-cocaine stimulant use (F15) increased in the period 1997-2009 by over two thirds, but there has been a slight decline since 2007. The number of hospitalisations resulting from disorders induced by other drugs is much lower by comparison. In 2009 there was an increase, and hospitalisations declined only as far as hallucinogens are concerned (Nechanská et al. 2010; Mravčík et al. 2010b; Ústav zdravotnických informací a statistiky, 2010c); see Table 5-17.

Table 5-17: Number of hospitalisations resulting from disorders caused by alcohol and other psychoactive substances in psychiatric inpatient facilities in 1997-2009 (Nechanská et al. 2010; Institute of Health Information and Statistics, 2010c)

Year	Number of hospitalisations by diagnosis											
	F10 (alcohol)	F11 (opioids)	F12 (cannabis)	F13 (sedatives/hypnotics)	F14 (cocaine)	F15 (other stimulants)	F16 (hallucinogens)	F17 (tobacco)	F18 (inhalants)	F19 (polydrug use)	**Addictive substances, total**	**Drugs (excl. tobacco)**
1997	10,188	1,170	48	162	7	892	26	6	139	991	**13,629**	**3,435**
1998	9,997	1,624	57	175	6	1,194	64	-	137	1,276	**14,530**	**4,533**
1999	9,511	2,069	60	152	9	1,082	39	-	110	1,222	**14,254**	**4,743**
2000	9,875	2,327	65	153	5	901	41	1	135	1,448	**14,951**	**5,075**
2001	10,176	2,079	79	164	5	814	33	1	106	1,496	**14,953**	**4,776**
2002	10,492	918	91	149	9	925	16	2	128	1,471	**14,201**	**3,707**
2003	11,068	989	112	154	13	986	15	6	153	1,611	**15,107**	**4,033**
2004	11,669	1,068	95	199	3	1,227	21	2	128	1,928	**16,340**	**4,669**
2005	11,691	981	115	223	9	1,222	15	1	92	2,058	**16,407**	**4,715**
2006	10,705	875	147	240	7	1,564	5	2	103	2,134	**15,782**	**5,075**
2007	10,514	889	148	219	3	1,638	12	-	75	2,355	**15,853**	**5,339**
2008	10,360	713	161	270	3	1,524	13	4	48	2,528	**15,624**	**5,260**
2009	10,026	687	174	297	5	1,488	5	2	67	2,585	**15,336**	**5,308**

In 2009 the *Government Council for Drug Policy Coordination* granted subsidies to 10 therapeutic communities. Data about the number of clients and services provided are available from these communities' final reports, see Table 5-18.

The capacity at the ten therapeutic communities was 160 beds. 394 drug users with an average age of 26.6 years entered treatment there. A total of 343 clients (87.1%) were injecting drug users prior to treatment, 276 (70.1%) used pervitin, and 74 (18.8%) used opiates (69 used heroin, 5 used illegally procured buprenorphine). There were 93 clients (26.6%) who successfully completed the programme; the average duration of a successful (completed) treatment was 309 days. A total of 163 clients (41.4%) dropped out, 35% within 3 months of the commencement of treatment. The average duration of the treatment of all patients was 181 days. A comparison of the period from 2003 to 2009 is provided in Table 5-18.

Table 5-18: Therapeutic communities and their clients in 2003-2009 (Mravčík et al. 2009; National Monitoring Centre for Drugs and Drug Addiction, 2010d)

Indicator	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Number of communities	17	14	12	12	11	10	10
Facility capacity	238	218	183	185	169	138	160
Number of clients	510	546	491	451	472	427	394
– injecting drug users	428	429	400	375	347	326	343
– pervitin users	270	306	287	281	291	283	276
– heroin users	187	151	132	93	66	67	69
Average client age	23.4	24.2	24.9	25.1	24.2	23.8	26.6

Since the beginning of 2007, a study entitled *Treatment Outcome Evaluation of Therapeutic Communities for Drug Users* has been conducted at five therapeutic communities associated in the *Therapeutic Communities Section of the Association of NGOs*. The study is planned to be completed in 2010. Analysis of the study sample at the beginning of the research project and other information about the study are provided in more detail in the 2008 Annual Report.

6 Health Correlates and Consequences

The state of affairs in terms of infections among (injecting) drug users remained relatively favourable in 2009 – the HIV infection rate was still far below 1%. In 2009, seven new HIV-positive persons were identified who may have become infected through injecting drug use. This is less than in 2007 and 2008, returning the reported incidence to the positive values from previous years (the overall incidents of HIV in the Czech Republic is rising, however, mainly as a result of the spread of infection among gay men). The number of newly reported HBV and HCV cases among injecting drug users has fallen over the past years. Depending on the characteristics and selection criteria of the sample studied, the prevalence of HCV among drug users ranges from approximately 20% in low-threshold programmes to 40% in prisons. The relatively highest prevalence of infection was reported among imprisoned injecting drug users (for HIV, for example, a prevalence of over 2% was found in 2009), but the results should be interpreted with caution bearing in mind the possibility of a sampling error.

For the first time, data about new cases of sexually transmitted diseases among injecting drug users are available for 2009. In the past years there is an evident growing trend in the presence of syphilis among injecting drug users. In 2009 there were 103 syphilis cases reported among drug users (10% of all reported cases), and prostitution was also found in 17% of these cases (these were mostly females).

The proportion of pervitin and opiate users who administer drugs by injection has been gradually falling over the long term, but this still applies for the majority of users in contact with counselling or treatment institutions.

In 2009 there was a slight year-on-year increase in cases of fatal overdoses on illicit drugs and inhalants (total 49 cases), and over the past two years a slightly increasing trend can be observed. Year-on-year, the number of fatal opiate overdoses increased from 15 cases in 2008 to 20 cases in 2009; the number of cases of lethal pervitin and inhalant overdoses has remained practically at the same level. After several years of zero occurrence, three cases of fatal overdoses on (new) synthetic drugs have been reported. Cocaine was present in two deaths classified as pervitin overdoses. From the mid-term perspective, there is an evident growing number of cases of indirect deaths (i.e. deaths other than by overdose, particularly as a result of accidents or suicide) involving the detection of pervitin and THC, although in 2009 these remained at the same levels as in 2008.

For the first time, the Annual Report presents data on fatal drug overdoses contained in the Czech Republic's general mortality register (*Deaths* information system). Despite the methodological difficulties connected with selecting cases, over the past three years a growing trend in the number of fatal drug overdoses is evident in the general mortality register.

The traffic police records indicate that the number and proportion of accidents caused under the influence of alcohol and drugs, as well as the number of people killed in accidents caused by impaired drivers, continued to grow in 2009. There has also been an increase in both the number and proportion of people killed in accidents caused by drivers under the influence of other drugs, although the numbers of these reported by the police still tend to be much lower in comparison to the results of autopsies on individuals killed in road accidents investigated at forensic medicine departments.

6.1 Drug-related Infectious Diseases

6.1.1 Reported Incidence of HIV/AIDS, Viral Hepatitis, and Sexually Transmitted Diseases

The number of new cases of HIV infection reported each year in the Czech Republic up to 2006 had ranged between two and eight cases among injecting drug users and another one or two cases in the mixed category of injecting drug users and homo-/bisexuals. In 2007 there were 17 cases and the following year 12 cases reported of HIV-positive persons who may have become infected through injecting drug use. In 2009 the situation in the area of new diagnoses of HIV among injecting drug users returned to the values from previous years – a total of seven cases were reported in which infection could have occurred through injecting drug use. Altogether, 1,344 HIV-positive persons with a permanent place of residence in the Czech Republic were registered as of 31 December 2009; 65 of them are injecting drug users and another 25 fall under the mixed category encompassing injecting drug use and homo-/bisexual intercourse (National Institute of Public Health, 2010b); see Table 6-1.

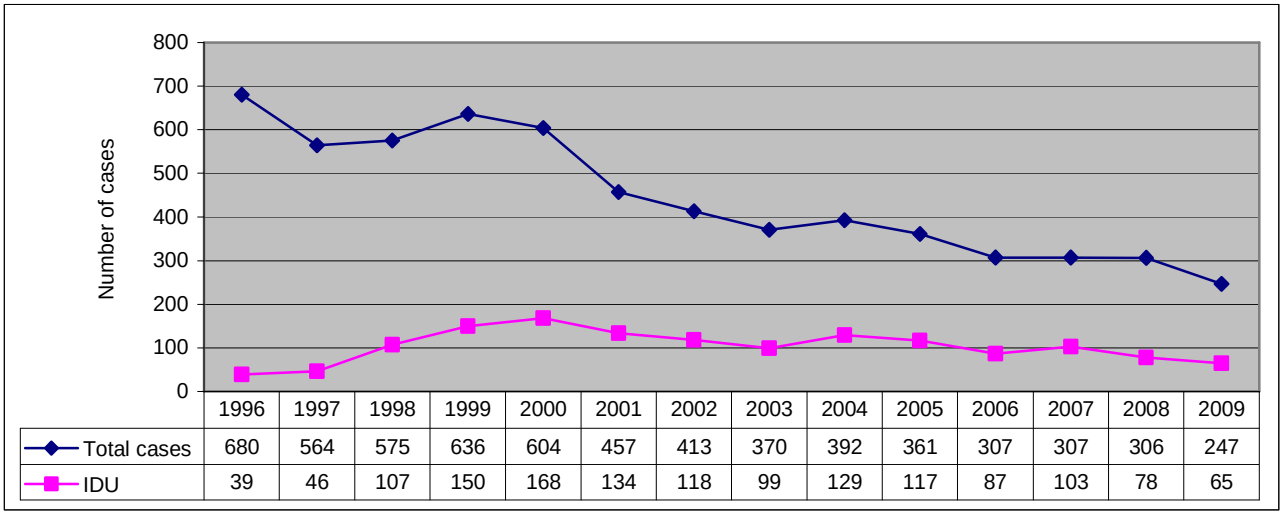
Table 6-1: Number of new HIV cases in the Czech Republic up to 2009 for individual years and according to route of transmission (National Institute of Public Health, 2010b)

Route of transmission (risk group)	1985-2003	2004	2005	2006	2007	2008	2009	Total	
								Number	%
Homo-/bisexual intercourse	356	30	52	54	72	88	102	**754**	**56.1**
Heterosexual intercourse	209	31	29	26	28	45	41	**409**	**30.4**
IDU	26	7	4	4	12	8	4	**65**	**4.8**
IDU and homo-/bisexual intercourse	10	1	1	1	5	4	3	**25**	**1.9**
Other	37	0	0	0	0	0	0	**37**	**2.8**
Not ascertained	27	3	4	6	4	3	7	**54**	**4.0**
Total	**665**	**72**	**90**	**91**	**121**	**148**	**157**	**1,344**	**100.0**

Note: The number of cases is being corrected for previous years – corrections stem from duplicities that were found and from subsequent clarification of information regarding the route of transmission.

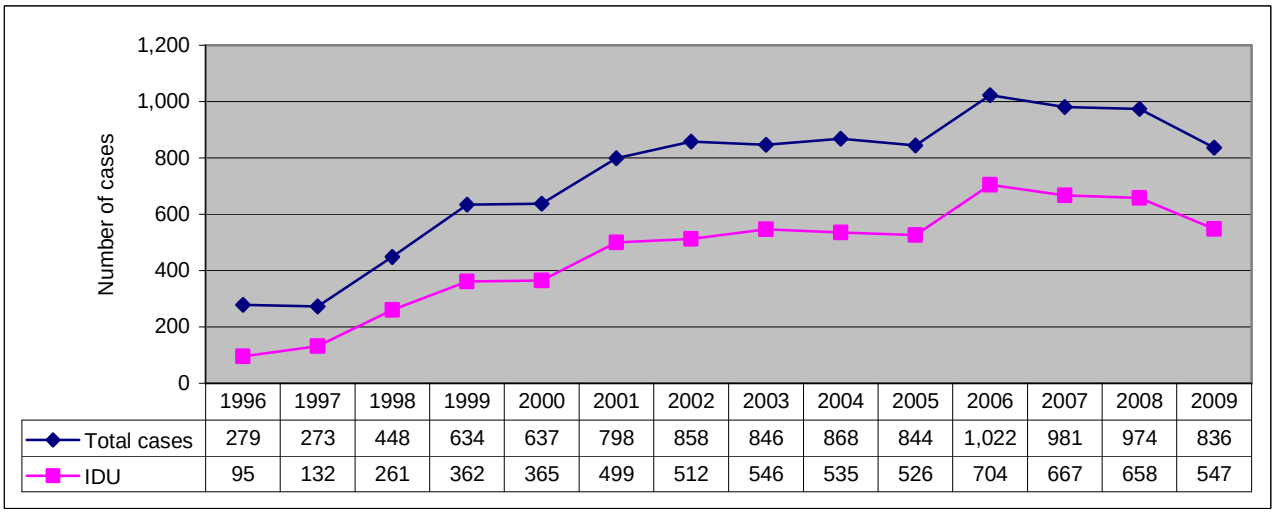
In 2009 the EPIDAT national system of compulsory reporting of infectious diseases recorded another decrease in newly reported cases of acute viral hepatitis B (HBV, dg. B16) and C (HCV, dg. B17.1 and B18.2). Both the total number of cases and cases among injecting drug users declined. (National Institute of Public Health, 2010a); see Figure 6-1 and Figure 6-2.

Figure 6-1: Reported incidence of HBV among all patients and injecting drug users in the Czech Republic in 1996-2009 (National Institute of Public Health, 2010a)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total cases	680	564	575	636	604	457	413	370	392	361	307	307	306	247
IDU	39	46	107	150	168	134	118	99	129	117	87	103	78	65

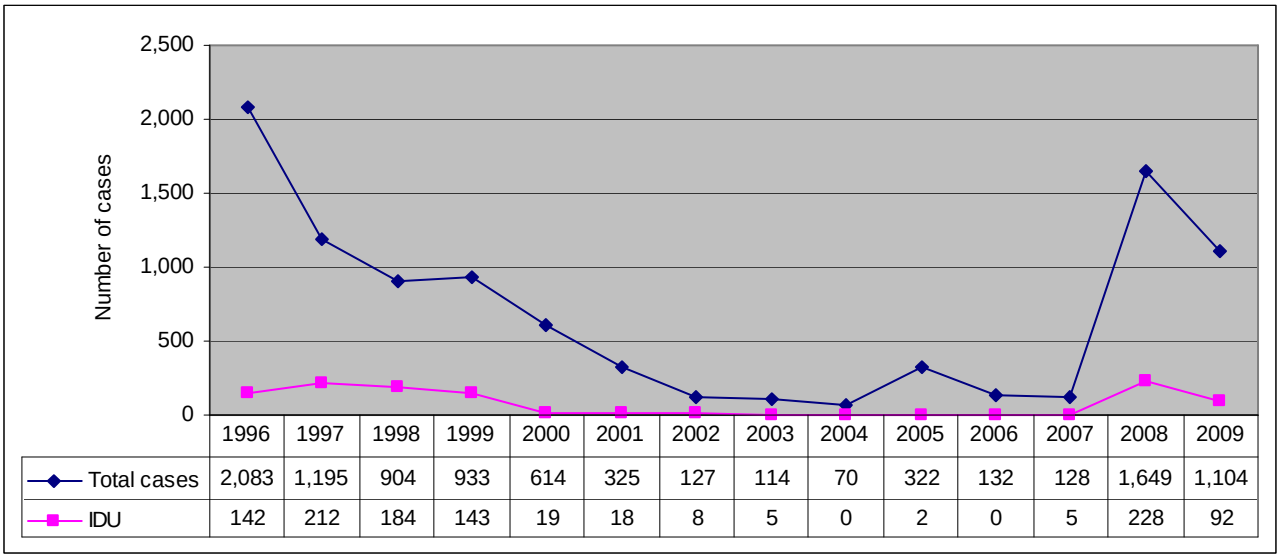
Figure 6-2: Reported incidence of acute and chronic HCV among all patients and injecting drug users in the Czech Republic in 1996-2009 (National Institute of Public Health, 2010a)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total cases	279	273	448	634	637	798	858	846	868	844	1,022	981	974	836
IDU	95	132	261	362	365	499	512	546	535	526	704	667	658	547

Following the epidemic of viral hepatitis A (HAV, dg. B15) which broke out at the end of May 2008 in Prague (initially particularly among injecting drug users) and later spread to Central Bohemia, the increased prevalence of HAV continued in 2009 (National Institute of Public Health, 2010a); see Figure 6-3.

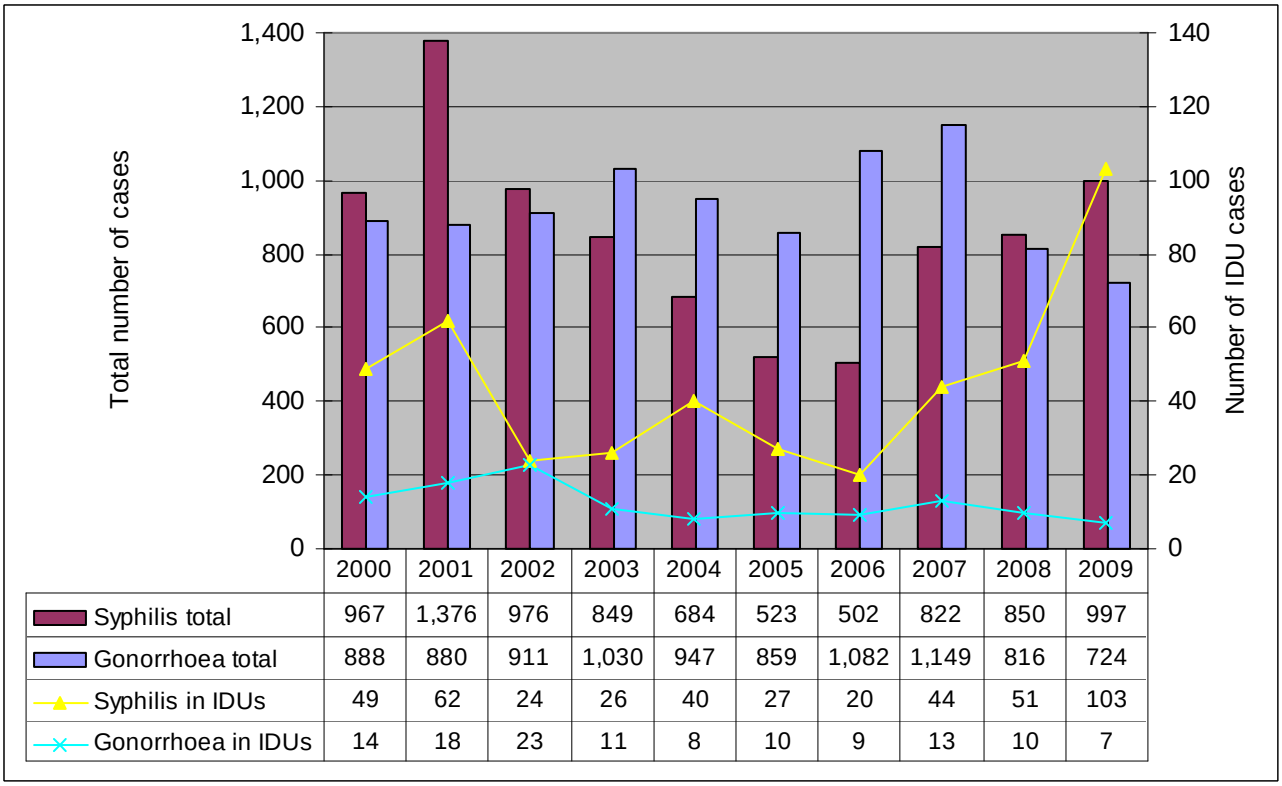
Figure 6-3: Reported incidence of HAV among all patients and injecting drug users in the Czech Republic in 1996-2009 (National Institute of Public Health, 2010a)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total cases	2,083	1,195	904	933	614	325	127	114	70	322	132	128	1,649	1,104
IDU	142	212	184	143	19	18	8	5	0	2	0	5	228	92

For the first time, data from the National Register of Sexually Transmitted Diseases are published in the Annual Report. Compulsory reports are completed for all persons found to have a sexually transmitted disease, who died from such a disease or are suspected to be suffering from or infected with a sexually transmitted disease in the Czech Republic. Syphilis (dg. A50 through A53), gonorrhoea (dg. A54), lymphogranuloma venereum (dg. A55) and chancroid (A57) are subject to reporting from all healthcare facilities. Injecting drug use and prostitution have been found to be risk factors. Developments in the number of reported cases overall and among injecting drug users (IDUs) for syphilis and gonorrhoea are shown in Figure 6-4. Since 2006 there has been an evident increase especially in syphilis cases, which also relates to IDUs. In 2009 injecting drug users accounted for 10.3% of cases of syphilis and 1.0% of cases of gonorrhoea (Institute of Health Information and Statistics, 2010g).

Figure 6-4: Reported incidence of syphilis and gonorrhoea among all patients and among injecting drug users in the Czech Republic, 2000-2009 (Institute of Health Information and Statistics, 2010g)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Syphilis total	967	1,376	976	849	684	523	502	822	850	997
Gonorrhoea total	888	880	911	1,030	947	859	1,082	1,149	816	724
Syphilis in IDUs	49	62	24	26	40	27	20	44	51	103
Gonorrhoea in IDUs	14	18	23	11	8	10	9	13	10	7

In general, sexually transmitted diseases are marked by a significantly higher prevalence among males than females - an average 29% higher for syphilis and over twice as high for gonorrhoea in the period under study. Among IDUs, the number of females infected with syphilis was higher than that of males (by 14%), but gonorrhoea in males was 37% higher than in females. In 2000-2009, early stage syphilis (dg. A51) accounted for over 42% of cases, with over

two thirds of cases involving injecting drug users. As for gonorrhoea, 88% of cases were diagnosed as acute; 81% of acute conditions were associated with IDUs.

Data on the prevalence of high-risk behaviour pertaining to the reported cases of sexually transmitted diseases indicate that concurrent prostitution and injecting drug use is relatively common. In 2000-2009, injecting drug use was found in a total of 14.6% of syphilis and gonorrhoea cases in commercial sex workers, and prostitution was concurrently found in 16.9% of injecting drug users (mainly females); see Table6-2.

Table6-2: Proportion of commercial sex workers (CSW) and injecting drug users (IDU) in reported syphilis and gonorrhoea cases, 2000-2009 (Institute of Health Information and Statistics, 2010g)

Infection	Number of cases reported				Share (%)	
	Total	CSW	IDU	- CSW and IDU	IDU per CSW	CSW per IDU
Syphilis	8,546	449	446	83	18.5	18.6
Gonorrhoea	9,286	207	123	13	6.3	10.6
Total	**17,833**	**656**	**569**	**96**	**14.6**	**16.9**

Anthrax infection among injecting users of heroin was identified in Europe in December 2009[65]. The Czech Republic has recorded no cases of anthrax or other infections caused by bacterial spores (tetanus, botulism or gas gangrene) that could have been contracted through injecting drug use[66].

The chapter on Responses to Drug-related Health Issues in Prisons (p. 101) provides information on HBV, HCV, and HIV and the treatment of the diseases among prisoners, including drug users.

6.1.2 Prevalence of Infections among Drug Users

According to the *National Reference Laboratory for AIDS at the National Institute of Public Health in Prague*, a total of 906,870 laboratory tests for HIV were conducted on Czech citizens and residents in the Czech Republic in 2009, of which 157 were positive (0.17‰); 806 tests were conducted among IDUs[67], with one positive result (1.2‰); the number of tests carried out among IDUs decreased again in 2008, mainly due to the absence of saliva tests, and reached its lowest value in the period under scrutiny (National Institute of Public Health, 2010b); see Table6-3[68].

Table6-3: Testing of injecting drug users for HIV antibodies in 1994-2009 (National Institute of Public Health, 2010b)

Year	Blood tests		Saliva tests		Total	
	Number of tests	Number of positive results	Number of tests	Number of positive results	Number of tests	Number of positive results
1994–1997	1,206	1	895	0	2,101	1
1998	1,034	0	1,124	0	2,158	0
1999	1,101	0	1,219	0	2,320	0
2000	1,090	0	1,001	0	2,091	0
2001	1,208	1	961	0	2,169	1
2002	801	0	735	1	1,536	1
2003	985	1	652	0	1,637	1
2004	1,382	0	227	0	1,609	0
2005	925	1	449	1	1,374	1*
2006	994	1	412	0	1,406	1
2007	845	1	531	1	1,376	2
2008	886	1	477	0	1,363	1
2009	806	1	0	0	806	1
Total	**13,263**	**8**	**8,683**	**3**	**20,540**	**10**

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

The monitoring of testing for infections among IDUs has been ongoing since 2004 in low-threshold programmes; the 2009 results were collected using an online questionnaire in the period from July to August 2010 (National Monitoring Centre for Drugs and Drug Addiction, 2010c). A total of 20 low-threshold programmes responded, of which 13 were low-threshold centres, 5 outreach programmes and 2 were services operating both low-threshold and

[65] On 22 July 2010, a total of 52 cases of anthrax were found among injecting drug users in Scotland, England, and Germany, with 15 of these cases being fatal. For more information see http://www.drogy-info.cz/index.php/o_nas/varovani_nove_drogy/vyskyt_antraxu_u_uzivatelu_heroinu_ve_skotsku_anglii_a_nemecku.

[66] Communication with public health protection authorities (Ministry of Health, National Institute of Public Health in Prague), August 2010.

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

[68] Only tests carried out in Czech laboratories with the explicit description that the reason for the test is injecting drug use are provided in this table. Injecting drug users can also be tested for many other reasons, and in these cases it is made known only afterwards that the subject was an injecting drug user. In 2009 a total of four new HIV positive injecting drug users were found. Three of these cases were found on the basis of clinical symptoms of the disease. Of the three men who are reported homo-/bisexual IDUs in 2009, one was examined at his own request, one in connection with prostitution, and one because of a clinical diagnosis.

outreach programmes. The results are shown in Table 6.4. Because of the very low participation of low-threshold programmes in the questionnaire survey, it is very difficult to make general statements about the results that were obtained. Nevertheless, these results as well show a very low prevalence of HIV and HCV among injecting drug users[69].

Table 6-4: Results of testing among injecting drug users in low-threshold facilities in 2009 (National Monitoring Centre for Drugs and Drug Addiction, 2010c)

Infection	Type of test*	Number of programmes	Number of tests		Number of persons		
			Total	Positive	Total	Positive	Positive (%)
HIV	Saliva test**	–	–	–	–	–	–
	Quick capillary blood test	8	414	1	395	1	0.3
	Quick capillary blood serum test	4	79	0	68	0	0.0
	Laboratory vein blood serum test	1	5	0	5	0	0.0
	Total	12	498	0	468	0	0.0
HCV	Quick capillary blood test	1	5	0	5	0	0.0
	Quick capillary blood serum test	10	387	76	343	76	22.2
	Laboratory vein blood serum test	1	5	3	5	3	60.0
	Total	10	397	0	353	79	22.4
HBV	Laboratory vein blood serum test	1	5	0	5	0	0.0
Syphilis	Quick capillary blood test	3	253	19	244	19	7.8
	Laboratory vein blood serum test	1	4	2	4	2	50.0
	Total	3	257	0	248	21	8.5

*Note: * The results of testing for long-term antibodies are looked for. ** Saliva tests were not available in 2009.*

The trend in the number of low-threshold facilities that test for these infections and the numbers of tests conducted according to the information provided in the final reports of the projects supported in the *GCDPC* subsidy programme are given in Table *7-6* (p. 85), section on Prevention and Treatment of Drug-Related Infectious Diseases.

The data about testing for infections and the results of the tests are also monitored by the *Register of Treatment Demands* (Studničková, 2010). This information is provided by the clients themselves or is obtained from their records; only tests with known results are included; see Table 6-5. Although they provide limited evidence only, the data indicate a stable and, in recent years, falling prevalence of infections among drug users.

Table 6-5: The results of testing for HIV, HAV, HBV, and HCV among users demanding treatment, self-reported, 2003-2009 (Studničková, 2010)

Infection		2003	2004	2005	2006	2007	2008	2009
HIV	Total tested	2,471	2,483	2,253	2,196	1,905	2,332	2,558
	Positive (%)	0.8	0.4	0.2	0.5	0.3	0.6	0.5
HAV	Total tested	2,132	2,059	1,931	1,997	1,774	2,271	2,307
	Positive (%)	7.1	5.5	4.5	3.3	3.3	8.4	6.1
HBV	Total tested	2,504	2,581	2,332	2,290	2,004	2,463	2,553
	Positive (%)	11.2	9.9	10.1	10.0	8.4	8.9	8.3
HCV	Total tested	2,884	2,913	2,577	2,497	2,168	2,636	2,852
	Positive (%)	31.5	33.6	35.0	32.6	31.0	32.0	29.8

For the first six months of 2010, the results of testing of imprisoned injecting drug users are available (Generální ředitelství Vězeňské služby ČR, 2010d). As the selection of prisoners is not representative, care must be taken in making general statements regarding the results. Nevertheless, the results indicate a higher incidence of infection among prisoners in comparison with available results of studies and monitoring systems aimed at drug users in the community-based facilities – particularly the prevalence of HIV (even though the number of persons examined is low) is relatively high; see Table 6-6.

[69] It must be taken into account that the tests are only for general informational purposes and that offers to get tested are mainly taken up by clients who are new – and thus tend to be less frequently infected.

Table 6-6: Results of testing injecting drug users for HIV, HBV, and HCV at prisons in the first six months of 2010 (Generální ředitelství Vězeňské služby ČR, 2010d)

Infection	Tested indicator		Start of serving prison sentence	Start of custody	In course of prison sentence	Total
HIV	anti-HIV	Total tested	24	56	88	**168**
		Positive	2	2	0	**4**
		Positive (%)	8.3	3.6	0.0	**2.4**
HBV	HBsAg*	Total tested	575	392	833	**1,800**
		Positive	87	51	134	**272**
		Positive (%)	15.1	13.0	16.1	**15.1**
	anti-HBc IgG**	Total tested	496	311	603	**1,410**
		Positive	70	30	128	**228**
		Positive (%)	14.1	9.6	21.2	**16.2**
HCV	anti-HCV	Total tested	848	486	812	**2,146**
		Positive	359	214	319	**892**
		Positive (%)	42.3	44.0	39.3	**41.6**

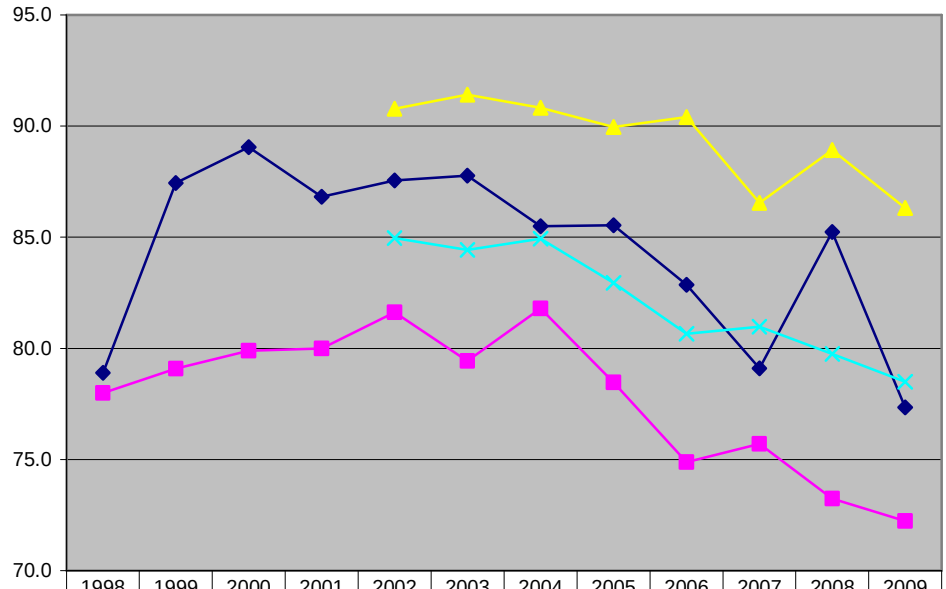
*Note: * An antigen indicating acute or chronic active infection, ** antibodies created in case of an acute HBV infection but lasting even long after recovery.*

As part of a student research project, a group of injecting pervitin and heroin users entering treatment at the Červený Dvůr Psychiatric Hospital in the second half of 2009 were monitored. The sample included a total of 135 people, 84 of whom were males. As far as primary drugs are concerned, 104 cases were pervitin users and 31 were heroin users. The prevalence of anti-HCV antibodies was found in 34.8% of cases (Borská, 2010).

6.1.3 Risk Behaviour of Drug Users

Over the long term there has been a slight decline in the proportion of injecting users among those demanding treatment for the first time in connection with heroin and pervitin use; administration by injection is also the most frequent form of application among users of Subutex® – developments from 1998-2009 can be seen in Figure 6-5. In the Czech Republic, cocaine is used almost exclusively by snorting (four out of the total of 38 cocaine users reported injecting in their demand for treatment); no treatment demands related to crack use were registered in 2009 (Studničková and Petrášová, 2010).

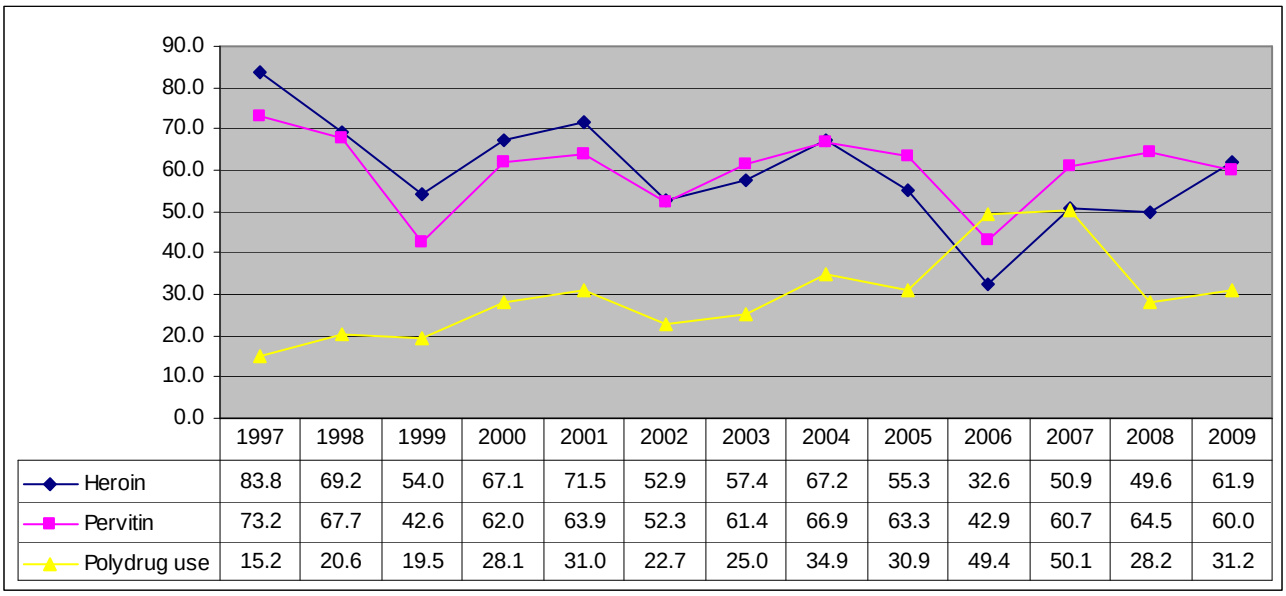
Figure 6-5: Developments in the proportion of injecting drug use in first treatment demands and in all treatment demands in relation to the use of heroin, Subutex®, and pervitin (%) (Studničková and Petrášová, 2010)



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
IDU of heroin - first demands	78.9	87.4	89.1	86.8	87.6	87.8	85.5	85.5	82.9	79.1	85.2	77.3
IDU of pervitin - first demands	78.0	79.1	79.9	80.0	81.6	79.4	81.8	78.5	74.9	75.7	73.2	72.2
IDU of heroin - all demands					90.8	91.4	90.8	90.0	90.4	86.5	88.9	86.3
IDU of pervitin - all demands					85.0	84.4	84.9	82.9	80.7	81.0	79.8	78.5
IDU of Subutex® - first demands							70.7	85.3	73.1	84.9	78.4	85.9
IDU of Subutex® - all demands							57.2	74.7	70.7	82.2	82.1	81.8

Developments in the proportion of injecting users among patients – users of heroin, pervitin, and polydrug users (F19) in the live case records (clients treated at least once in the given year) at outpatient psychiatric facilities is shown in Figure6-6 (Nechanská et al. 2010; Ústav zdravotnických informací a statistiky, 2010b). The proportion of administration by injection among heroin and pervitin users has been decreasing over the long term, and is lower than in the *Register of Treatment Demands* (see Figure 6-5). The growing share of injecting drug users among polydrug users (F19) is likely a reflection of the growth in pervitin and opiate users who combine these two drugs together or with other drugs.

Figure6-6: Developments in the proportion of injecting users among heroin, pervitin, and polydrug users (F19) in the live case records at outpatient psychiatric facilities, 1997-2009 (%) (Nechanská et al. 2010; Institute of Health Information and Statistics, 2010b)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Heroin	83.8	69.2	54.0	67.1	71.5	52.9	57.4	67.2	55.3	32.6	50.9	49.6	61.9
Pervitin	73.2	67.7	42.6	62.0	63.9	52.3	61.4	66.9	63.3	42.9	60.7	64.5	60.0
Polydrug use	15.2	20.6	19.5	28.1	31.0	22.7	25.0	34.9	30.9	49.4	50.1	28.2	31.2

The trend in the proportion of injecting users demanding treatment who report sharing needles and syringes hovers around 40%, see Table 6-7.

Table 6-7: Sharing of needles and syringes at any time in the past reported by IDUs demanding treatment in 2002-2009 (Studničková, 2010)

Year	Number of IDUs	Number of those sharing	Sharing (%)
2002	6,437	2,590	40.2
2003	5,901	2,356	39.9
2004	6,314	2,725	43.2
2005	5,769	2,421	42.0
2006	5,860	2,313	39.5
2007	5,338	2,139	40.1
2008	5,766	2,057	35.7
2009	6,012	2,263	37.6

6.2 Other Drug-related Health Correlates and Consequences

6.2.1 Non-fatal Drug Intoxications

The collection of data about non-fatal intoxications[70] is based on the system operated by the Public Health Service and the data are collected centrally by the Public Health Office in Prague. There are still major differences between the regions in the system of collecting data[71]. Various health facilities, primarily emergency units, provide reports to the system. In 2009 there were 1,018 cases of non-fatal intoxication with drugs. The trend is shown in Table 6-8.

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

[71] The trends of the cases reported are also significantly influenced by changes in the network of the reporting facilities – starting from 2007, for instance, data are available from the emergency medical service of the Central Bohemia region, while there were no cases reported from the South Moravia and Hradec Králové Regions in 2007 and 2008. In 2009, no cases were reported from the South Bohemia, South Moravia, and Vysočina regions; from 30 June 2009, data collection was restricted in Prague.

Table 6-8: Non-fatal drug intoxications in the Czech Republic in 2001-2009 (Studničková and Petrášová, 2010)

Drug	2001	2002	2003	2004	2005	2006	2007	2008	2009
Pervitin	163	191	149	180	222	231	343	364	187
Heroin	285	176	152	179	244	149	190	166	122
Methadone	2	6	3	2	10	7	2	1	1
Subutex®	–	–	2	12	14	18	32	7	0
Other opiates	16	23	22	20	19	21	40	17	42
Benzodiazepines	137	89	157	126	153	124	139	113	180
Other sedatives, hypnotics	195	137	82	103	88	107	125	135	127
Cannabis	63	101	90	84	73	72	127	108	105
Inhalants	75	58	69	64	48	28	31	9	33
Psilocybin	15	7	4	10	6	5	10	9	7
Cocaine, crack	4	2	6	5	7	8	1	7	2
Datura stramonium	4	0	0	0	1	0	1	5	2
LSD	3	2	3	7	3	5	7	4	13
MDMA	15	4	8	3	8	12	12	3	1
Other known drugs and medications	182	179	100	92	111	89	124	140	173
Other, unknown	24	25	34	65	186	78	71	58	23
Total	**1,183**	**1,000**	**881**	**952**	**1,193**	**954**	**1,255**	**1,146**	**1,018**

6.2.2 Psychiatric and Somatic Comorbidity of Drug Users

No new data are available for 2009.

6.2.3 Drugs and Road Accidents

Since 2003, cases where ethanol and other drugs[72] were detected have been analysed in forensic autopsies of road accident fatalities in the Czech Republic; for more information see the chapter on Drug-related Deaths and Mortality of Drug Users (p. 74). Active participants in road accidents (pedestrians, bicyclists, and drivers) are monitored separately[73]. The results for 2008 (for more information see the 2008 Annual Report) have been published in print (Mravčík et al. 2010). The analysed group composed 1,040 victims killed in road accidents, 387 of whom were drivers. The drivers killed on the road were ethanol positive in 29.2% of cases, 12.7% were positive for one or more monitored psychoactive substances – most frequently stimulants (pervitin) and cannabinoids (9.2% and 6.2% of these cases respectively). Among drivers of lorries, vans, and buses (essentially professional drivers), there was zero prevalence of ethanol or other drugs, with the exception of one positive finding of pervitin (6.7% of this subgroup). Positive ethanol results were most frequently found in the male victims aged around 40, while stimulants and cannabis were found in persons aged 30 and 25, respectively, regardless of gender. Out of the entire 2008 sample, a total of 146 active participants in road traffic who were killed tested positive for ethanol (of whom 59 were drivers) and 45 (27 of whom were drivers) tested positive for one of the narcotic and psychotropic substances under scrutiny.

According to the data reported by forensic medicine departments, 914 persons died in traffic accidents or as a result of traffic accidents in 2009, of whom 508 (56%) were subject to toxicological examination[74], which is a similar proportion as in the previous years. The highest proportion of positive tests was detected in the case of ethanol, where there was a year-on-year increase, particularly in drivers. As far as the three most common non-alcohol drugs are concerned, there was a year-on-year drop in the share of positive pervitin and cannabis tests; on the contrary, there was an increase in benzodiazepines; see Table 6-9. There were no cases where cocaine or inhalants were detected in 2009; cases with the presence of barbiturates and opiates did not exceed 2% (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2010). Out of the entire 2009 group, a total of 109 active participants in road traffic who were killed were positive for ethanol (of whom 46 were drivers) and 33 were positive for one of the narcotic and psychotropic substances under monitoring (22 of whom were drivers).

[72] A test is considered to be positive for ethanol if the level of ethanol is higher than 0.2 g/kg (Společnost soudního lékařství a soudní toxikologie, 1999), positive for cannabis if THC or its active metabolite is proven (i.e. not THC-COOH, for instance), and positive for inhalants if the autopsy detects substances which do not develop post mortem or are not indicated in some physiological or pathological conditions (e.g. acetone, acetaldehyde, n-propanol, n-butanol).

[73] The category of other victims comprises mainly passengers in motor vehicles and fatalities who could not be assigned to any of the three previous categories (i.e. victims of non-road accidents, e.g. aircraft accidents, construction site accidents, and public transport accidents).

[74] I.e. tested for ethanol or any drug from the following groups: inhalants, opiates, stimulants, cannabis, cocaine, benzodiazepines, barbiturates.

Table 6-9: Detection of ethanol and other drugs in the bodies of active participants in road accidents who were killed in 2003-2009 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2010)

Drug	**Year**	**Category of active road users who were killed in traffic accidents**							
		Pedestrians		Cyclists		Drivers		**Total**	
		Tested	Positive (%)	Tested	Positive (%)	Tested	Positive (%)	**Tested**	**Positive (%)**
Ethanol	2003	141	51.8	50	40.0	203	32.0	394	40.1
	2004	150	48.7	44	29.5	209	23.9	403	33.7
	2005	148	45.3	35	34.3	198	18.7	381	30.4
	2006	102	55.9	35	37.1	164	26.2	301	37.5
	2007	130	50.8	44	40.9	215	20.9	389	33.2
	2008	139	51.8	40	37.5	202	29.2	381	38.3
	2009	114	50.9	30	16.7	184	25.0	328	33.2
Stimulants (incl. pervitin	2003	91	1.1	27	0.0	152	3.3	270	2.2
	2004	109	1.8	23	0.0	170	1.8	302	1.7
	2005	103	1.9	17	0.0	148	0.7	268	1.1
	2006	79	1.3	15	0.0	125	7.2	219	4.6
	2007	107	0.9	27	0.0	223	5.8	357	3.9
	2008	121	3.3	21	0.0	195	9.2	337	6.5
	2009	84	3.6	18	0.0	175	5.1	277	4.3
Cannabis (active metabolites of THC)	2003	70	2.9	21	0.0	101	4.0	192	3.1
	2004	44	2.3	14	0.0	100	0.0	158	0.6
	2005	54	1.9	11	0.0	94	3.2	159	2.5
	2006	53	11.3	8	12.5	91	4.4	152	7.2
	2007	61	3.3	11	0.0	154	4.5	226	4.0
	2008	60	6.7	13	0.0	130	6.2	203	5.9
	2009	49	4.1	9	0.0	125	1.6	183	2.2
Benzodiazepines	2003	89	3.4	28	7.1	150	2.0	267	3.0
	2004	109	5.5	23	4.3	172	2.9	304	3.9
	2005	103	2.9	17	5.9	147	4.1	267	3.7
	2006	81	2.5	15	0.0	127	3.9	223	3.1
	2007	114	7.0	30	3.3	223	5.8	367	6.0
	2008	135	5.2	24	12.5	204	2.0	363	3.9
	2009	99	6.1	22	13.6	189	4.2	310	5.5
Any drug besides ethanol	2003	108	7.4	35	11.4	171	6.4	314	7.3
	2004	117	9.4	26	7.7	181	5.5	324	7.1
	2005	110	8.2	19	5.3	158	7.0	287	7.3
	2006	84	9.5	18	5.6	133	12.8	235	11.1
	2007	122	9.0	30	6.7	233	13.7	385	11.7
	2008	142	10.6	29	10.3	213	12.7	384	11.7
	2009	100	8.0	22	13.6	191	11.5	313	10.5

Information about the influence of alcohol and other drugs on the rate of road traffic accidents registered by the police is given in Table 6-10. According to this data, in 2009 the number and percentage of accidents occurring under the influence of alcohol and drugs as well as the number of fatalities in drunk driving accidents increased. The number and the percentage of fatalities in accidents where other drugs played a role is also rising, but this number is still much lower than the reported results of forensic autopsies of those who were killed in road accidents (see above).

Table 6-10: Road traffic accident statistics in the Czech Republic in 2003-2009 – influence of alcohol and other drugs (Ředitelství služby dopravní policie Policejního prezidia ČR, 2010)

Year	Accidents					Accident fatalities				
	Total	Under the influence of alcohol		Under the influence of medications and other drugs		Total	Under the influence of alcohol		Under the influence of medications and other drugs	
	Number	Number	%	Number	%	Number	Number	%	Number	%
2003	195,851	9,076	4.9	39	0.02	1,319	111	8.5	0	0.0
2004	196,484	8,445	4.5	53	0.03	1,215	59	4.9	1	0.1
2005	199,262	8,192	4.3	60	0.03	1,127	59	5.2	0	0.0
2006	187,965	6,807	3.8	64	0.03	956	42	4.3	1	0.1
2007	182,736	7,266	4.3	78	0.04	1,123	36	3.2	2	0.2
2008	160,376	7,252	4.8	109	0.07	992	80	8.1	1	0.1
2009*	74,815	5,725	8.1	137	0.18	832	123	14.9	6	0.7

*Note: * Starting from 1 January 2009 the level for mandatory reporting of accidents to the police increased from CZK 50,000 (€ 1,891) to CZK 100,000 (€ 3,781) in damage*

Since 2007 the traffic police has tested for narcotic and psychotropic substances using saliva tests as a general detection tool[75]. If the result of the general test is positive, a specialised medical and subsequent toxicological exam must be carried out. In 2007 a total of 2,758 general tests were carried out, of which 347 returned positive (12.6%). These most frequently involved amphetamines (152 cases), cannabis (81), ecstasy (15), opiates (6), and hallucinogens (1). Several drugs at the same time were found in 77 cases. In 2008 a total of 8,511 general tests were carried out, with 794 of these returning positive (9.3%). Although complete results for 2009 are not available, 1,149 cases of narcotic and psychotropic substance and 13,767 cases of alcohol use were found (Ředitelství služby dopravní policie Policejního prezidia ČR, 2010)

Data about deaths due to other causes (including accidents and injuries in total) under the influence of drugs are provided in the chapter on Deaths with the Presence of Drugs (p. 76); data on the prevalence of drug use among drivers (driving under the influence of drugs) is provided in the chapter on Drug Use among Targeted Groups/Settings at National and Local Level (p. 33).

6.3 Drug-related Deaths and Mortality of Drug Users

6.3.1 Drug Deaths in the Special Mortality Register

In the Czech Republic, a forensic medical examiner carries out a mandatory autopsy in all cases of sudden death in which the examining practitioner could not determine the cause of death and in all cases of violent deaths (all injuries and poisonings). Since 1998 drug-related deaths (fatal overdoses), and since 2003 also indirect fatalities (with the presence of drugs), have been monitored on a routine basis by means of a special register maintained by all departments of forensic medicine, with close collaboration between the *National Focal Point* and the Czech *Society for Forensic Medicine and Toxicology of the J. E. Purkyně Czech Medical Association*. Detailed data for 2009 were obtained from 14 departments[76] that performed a total of 13,276 autopsies. Aggregate reports since 2007 have also been obtained from three pathology departments where forensic medical examiners perform autopsies which are, under Section 115 of the Criminal Procedure Rules, mandatory on an irregular basis (no drug-related deaths were reported by these three facilities for 2009).

6.3.1.1 Fatal drug overdoses

In 2009 there were 225 lethal overdoses on illicit drugs, inhalants, and psychotropic medication (238 in 2008). They included 49 overdoses on street drugs, i.e. illicit drugs and inhalants[77] (44 in 2008), and 176 overdoses on psychotropic pills (194 in 2008). The substances which caused the fatal overdose were successfully identified in all the cases in 2009.

A total of 20 cases of lethal overdoses on (illicit) opiates, mainly heroin (15 confirmed or very probable cases), were identified (15 cases in 2008). In 16 cases the opiates were identified alone or together with ethanol (two cases), one case was likely a fatal overdose on opium, in one case methadone alone was the cause, and in one case there was a combination of methadone and heroin. In four other cases, an opiate was the cause of the lethal overdose in combination with other non-alcohol drugs: two of these were with benzodiazepines, one with benzodiazepines and pervitin, and one with pervitin and THC. Pervitin was the cause of fatal overdose in 18 cases (19 cases in 2008), with two of these being in combination with cocaine, one in combination with THC, one with MDMA, and three with psychoactive medication. In eight cases there was a lethal overdose on inhalants (ten cases in 2008). Three fatal overdoses on synthetic (dance) drugs were reported – in one case this was a methoxy derivative of amphetamine

[75] DrugWipe (http://www.drugwipe.us) tests are used.
[76] Unlike in 2008, data were obtained from the department of forensic medicine in Most (Ústí nad Labem region).
[77] Cases selected according to EMCDDA selection D for drug-related deaths.

trimethoxyamphetamine (TMA)[78], in one 4-methylthioamphetamine (4-MTA)[79] and in the last case a gamma-hydroxybutyric acid (GHB) in combination with diazepam. In 2009, for the first time ever, no lethal overdoses were present where buprenorphine was identified; in addition, no lethal overdoses on hallucinogens, THC or other cannabinoids were reported (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2010); see Table6-11.

Table6-11: Fatal drug overdoses in the Czech Republic in 2009 by groups of drugs, age groups and gender (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2010)

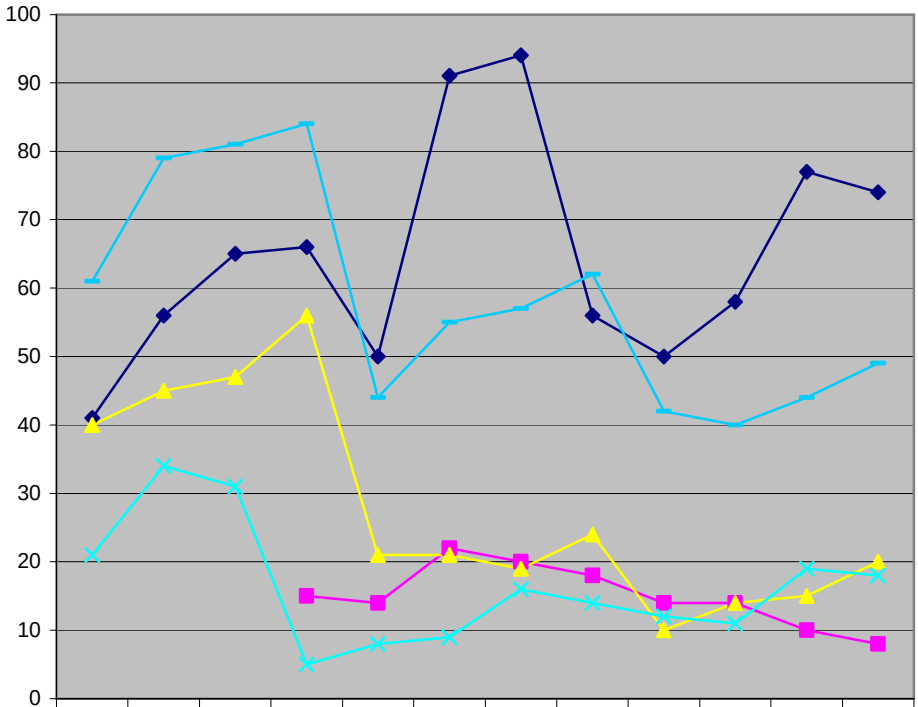
Drug / age group	**<15**	**15–19**	**20–24**	**25–29**	**30–34**	**35–39**	**40–44**	**45–49**	**50–54**	**55–59**	**60–64**	**>64**	**Unknown**	**Total**		
														Males	Females	**Total**
Only opiates/opioids (excluding methadone)	0	0	4	3	3	2	3	0	0	0	0	0	0	13	2	**15**
Only methadone	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	**1**
More substances, including opiates/opioids	0	0	0	3	1	0	0	0	0	0	0	0	0	3	1	**4**
– methadone	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total opiates/opioids	**0**	**0**	**5**	**6**	**4**	**2**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**17**	**3**	**20**
One or more substances, excluding opiates/opioids	**1**	**0**	**5**	**6**	**5**	**4**	**4**	**1**	**0**	**3**	**0**	**0**	**0**	**22**	**7**	**29**
– inhalants	0	0	2	1	1	0	1	0	0	3	0	0	0	8	0	**8**
– pervitin	1	0	3	5	3	3	2	1	0	0	0	0	0	12	6	**18**
– cocaine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
– synthetic (dance) drugs (such as MDMA)	0	0	0	0	1	1	1	0	0	0	0	0	0	2	1	**3**
– hallucinogens	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Unspecified / unknown	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total illegal drugs and inhalants (EMCDDA selection D)	**1**	**0**	**10**	**12**	**9**	**6**	**7**	**1**	**0**	**3**	**0**	**0**	**0**	**39**	**10**	**49**
Psychoactive pills	**2**	**4**	**7**	**5**	**15**	**16**	**20**	**31**	**21**	**20**	**14**	**21**	**0**	**94**	**82**	**176**
– benzodiazepines	0	1	1	3	8	7	9	13	7	10	6	9	0	42	32	**74**
Total	**3**	**4**	**17**	**17**	**24**	**22**	**27**	**32**	**21**	**23**	**14**	**21**	**0**	**133**	**92**	**225**

Fatal overdoses on psychotropic medicaments constitute a very heterogeneous category which would be difficult to evaluate accurately. This is because this category comprises suicidal overdoses, accidental overdoses, and overdoses without any established intention, both from medications that were prescribed *lege artis* and from abused drugs. In total, 176 cases of lethal overdoses on psychotropic medicaments[80] were identified in 2008 (194 cases in 2008), out of which 74 cases involved overdoses on benzodiazepines (77 in 2007) and 24 involved overdoses on opiate-containing medications (37 in 2008).

In 2009 there was a slight year-on-year rise in the number of lethal overdoses on illicit drugs, especially as a result of the increase in fatal opiate overdoses from 15 cases in 2008 to 20 cases in 2009; the number of cases of fatal pervitin and inhalant overdoses remained essentially the same. After several years of zero occurrence, three cases of lethal overdoses on (new) synthetic drugs were reported. Cocaine was present in two deaths classified as pervitin overdoses. The long-term trend is shown in Figure 6-7.

[78] This is a drug that is structurally very similar to mescaline, with effects that tend to be more hallucinogenic than stimulating.
[79] This is a very dangerous substitute for ecstasy, whose use is associated with the risk of developing serotonin syndrome and death.
[80] The vast majority of overdoses on medications are suicidal in nature, most often involving a combination of (several) medications with alcohol.

Figure 6-7: Fatal overdoses on benzodiazepines, illicit drugs, and inhalants, 1998–2009 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2010)



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Benzodiazepines	41	56	65	66	50	91	94	56	50	58	77	74
Illicit drugs and inhalants in total (EMCDDA Selection D)	61	79	81	84	44	55	57	62	42	40	44	49
- inhalants				15	14	22	20	18	14	14	10	8
- opiates/opioids	40	45	47	56	21	21	19	24	10	14	15	20
- amphetamines (pervitin)	21	34	31	5	8	9	16	14	12	11	19	18
- cocaine	0	0	0	0	0	0	1	1	1	1	0	0
- synthetic (dance) drugs	0	0	0	0	0	1	0	2	0	0	0	3
- hallucinogens	0	0	2	0	0	0	0	0	0	0	0	0
- cannabis	0	0	0	0	0	0	0	0	0	0	0	0
- unspecified	0	0	1	8	1	2	1	3	5	0	0	0

Note: Inhalants have been monitored separately since 2001. Since 2002 data from the forensic medicine departments has been available in electronic database form.

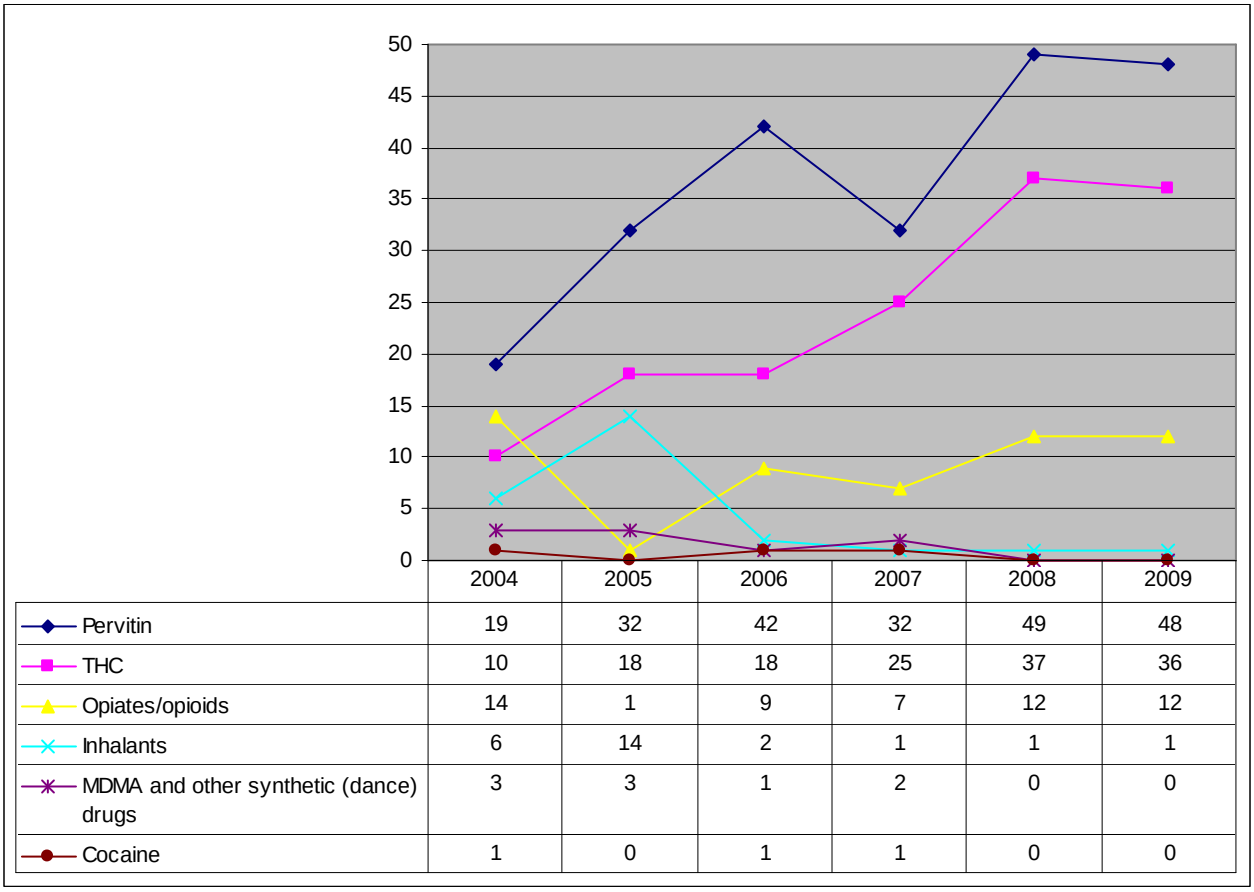
6.3.1.2 Deaths with the Presence of Drugs

A total of 117 deaths with the presence of a drug were identified in 2009 (against 209 in 2008), of which eight cases involved an illness (eight in 2008), 51 cases involved accidents (89 in 2008), 47 involved suicides (108 in 2008), and seven were cases of manslaughter or murder (four in 2008). An overview of the numbers and proportions of selected groups of drugs in the individual groups of deaths in which drugs were present is given in Table 6-12; the trend since 2004 is shown in Figure 6-8 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2010). Over the medium term, a growing number of cases of indirect deaths with pervitin and THC found is particularly evident, even though 2009 levels were the same as 2008. Opioids used in substitution therapy were not found in any cases of drug-related deaths in 2009.

Table 6-12: Deaths with the presence of drugs detected by forensic medicine departments in the Czech Republic in 2009, by selected groups of drugs and causes of death (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2010)

Drug	Illness (n = 12)	Accident (n = 51)	Suicide (n = 47)	Manslaughter/ murder (n = 7)	Other (n = 0)	Total (n = 117)	Proportion (%)
Pervitin	2	29	15	2	0	48	41.0
THC	7	17	10	2	0	36	30.8
Benzodiazepines	1	8	14	1	0	24	20.5
Other psychoactive pills	1	5	13	1	0	20	17.1
Opiates/opioids	1	5	5	1	0	12	10.3
Inhalants	0	0	0	1	0	1	0.9
MDMA and other synthetic (dance) drugs	0	0	0	0	0	0	0.0
Cocaine	0	0	0	0	0	0	0.0

Figure 6-8: Deaths with the presence of selected drugs detected by forensic medicine departments in the Czech Republic, 2004-2009 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2010)



	2004	2005	2006	2007	2008	2009
Pervitin	19	32	42	32	49	48
THC	10	18	18	25	37	36
Opiates/opioids	14	1	9	7	12	12
Inhalants	6	14	2	1	1	1
MDMA and other synthetic (dance) drugs	3	3	1	2	0	0
Cocaine	1	0	1	1	0	0

For information on the detection of drugs in the corpses of road accident victims see the chapter on Other Drug-related Health Correlates and Consequences (p. 71).

6.3.2 Drug-related Deaths in the General Mortality Register

At the beginning of 2010, an *NFP's* working group for drug-related deaths[81] focused on the problem of extracting drug-related death data from the general mortality register (*Deaths* information register) managed by the Czech Statistical Office, which provides the register to the *Institute of Health Information and Statistics* for further processing. In all cases of death in the Czech Republic, the physician diagnosing the death must complete a *Certificate of Post-mortem Examination* which, in case an autopsy is performed, is augmented by an autopsy diagnosis and sent to the register of births and deaths. At the register of births and deaths, data from the *Certificate of Post-mortem Examination* is copied into a Czech Statistical Office form (*Report of Death*). These forms are collected at the Czech Statistical Office in Prague, where data are entered into the database of the *Deaths* information system. *WHO* recommendations for coding causes of death are applied. In the event that the physician

[81] For more information: http://www.drogy-info.cz/index.php/o_nas/pracovni_skupiny.

or forensic medical examination department ascertains new facts regarding the cause of death, a change to the *Certificate of Post-mortem Examination* is reported to the regional office of the *Institute of Health Information and Statistics* in Prague, Hradec Králové, Brno, and Ostrava, which pass these on to the Czech Statistical Office [82].

To extract data about drug-related deaths from the death statistics, *EMCDDA* criteria are used. They are based on selecting corresponding cause of death diagnosis or a combination thereof and the mechanism of death. As a standard, the *EMCDDA* selection B is used. This is based in selecting deaths where the cause of death is mental disorder or behavioural disorder caused by illegal drugs and combinations thereof (dg. F11 through F19, except F13, F17 and F18) or in cases where there was accidental, intentional or unascertained poisoning with illegal drugs, i.e. a combination of diagnoses listed under letters X or Y with diagnoses for poisoning with the given substance – a narcotic of psychodysleptic drug (dg. T40 and T43.6). In 2010, for the first time an alternative selection was made from the death statistics. In the alternative selection, a combination with a T diagnosis for substances is not necessary for accidental, intentional or unascertained poisonings with narcotics and psychodysleptic drugs (X42, X62 and Y12). The disadvantage of alternative selection is that without the substance code, no differentiation can be made between the individual types of drugs which cause the fatal overdose.

The structure of cases of fatal drug overdoses in 2009 according to standard *EMCDDA* selection B by age, gender, and type of drug is shown in Table 6-13. Death trends for standard *EMCDDA* selection B by drug is shown in Table 6-14 (Ústav zdravotnických informací a statistiky, 2010f).

Table 6-13: Fatal drug overdoses in the Czech Republic in 2009 according to selection B in the general death register by groups of drugs, age groups, and gender (Ústav zdravotnických informací a statistiky, 2010f)

Drug	**<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**
Opiates/opioids	0	0	4	3	2	2	3	1	2	1	1	1	0	12	8	**20**
Cannabis	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	**1**
Cocaine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other stimulants	0	0	0	1	1	0	0	0	0	0	0	0	0	2	0	**2**
Hallucinogens	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Drugs not further specified	1	0	1	4	0	1	2	0	0	0	0	1	0	5	5	**10**
Total	**1**	**0**	**5**	**8**	**3**	**3**	**5**	**1**	**2**	**2**	**1**	**2**	**0**	**20**	**13**	**33**

Table 6-14: Fatal drug overdoses in the Czech Republic according to selection B in the general death register by groups of drugs, 1994-2009 (Ústav zdravotnických informací a statistiky, 2010f)

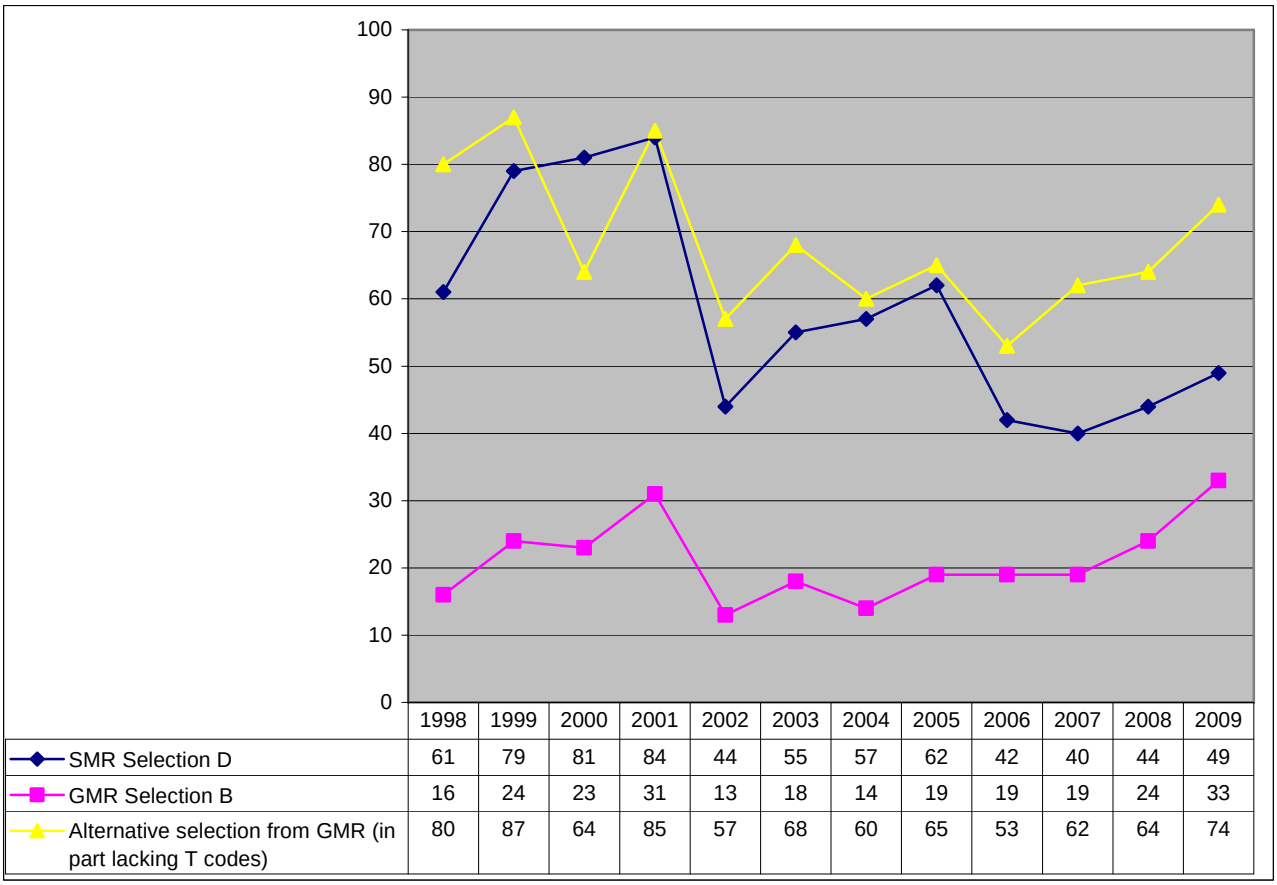
Year	**Opiates/ opioids**	**– methadone**	**Cannabis**	**Cocaine**	**Other stimulants**	**Hallucinogens**	**Drugs not further specified**	**Total**
1994	7	0	0	0	0	0	3	10
1995	0	0	0	0	0	0	3	3
1996	2	0	0	0	0	0	4	6
1997	4	0	0	0	0	0	9	13
1998	7	0	0	0	0	0	9	16
1999	14	1	1	0	1	0	8	24
2000	11	0	0	0	0	0	12	23
2001	18	0	0	0	0	0	13	31
2002	6	0	0	0	3	0	4	13
2003	12	0	0	0	2	0	4	18
2004	2	0	0	0	1	0	11	14
2005	9	0	0	1	2	0	7	19
2006	11	0	1	1	1	0	5	19
2007	6	1	1	0	2	0	10	19
2008	9	0	0	0	7	0	8	24
2009	20	1	1	0	2	0	10	33

Note: In comparison with data according to selection D in the special mortality register, fatal overdoses on inhalants are not included in selection B of the general register. Deaths coded as death from inhalants was recorded just once in the special register, in 2004.

[82] At the present time, an amendment to health care legislation has been prepared which changes the process for sending Dertificates of Post-mortem Examination among and to various institutions (register of births and deaths, Czech Statistical Office, Institute of Health Information and Statistics) and the reporting deadlines, but it also adds various additional data to the Certificate, including the influence of narcotic and psychotropic substances in the death.

Developments in the number of drug-related deaths according to standard *EMCDDA* selection B and alternative selection in comparison with data regarding fatal illegal drug and inhalant overdoses from the special register of drug-related deaths (selection D) is shown in Figure 6-9. It is evident that fatal drug overdose trends in the special death register and the alternative selection from the general mortality register are relatively identical, and the number of fatal overdoses according to selection B is gradually reaching the number of lethal overdoses according to selection D in the special death register.

Figure 6-9: Comparison of trends in the prevalence of fatal drug overdoses extracted from the general (GMR) and special (SMR) mortality registers in 1998-2009 (Ústav zdravotnických informací a statistiky, 2010f; Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2010)



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
SMR Selection D	61	79	81	84	44	55	57	62	42	40	44	49
GMR Selection B	16	24	23	31	13	18	14	19	19	19	24	33
Alternative selection from GMR (in part lacking T codes)	80	87	64	85	57	68	60	65	53	62	64	74

6.3.3 Mortality of Drug Users

See the detailed information provided in the selected issue chapter on Mortality Related to Drug Use (p. 122).

7 Responses to Health Correlates and Consequences

Risk reduction has been one of the main areas of the Czech drug policy since 1993. The measures targeted at the reduction of drug-related health risks are implemented mainly by low-threshold facilities. Approximately 70% of problem drug users (up to 80% in Prague) are estimated to be in contact with these facilities.

The number of low-threshold programmes for drug users varies from year to year. Nevertheless, there has been a marked increase in the number of clients in contact with such facilities. There is also a steady increase in the number of contacts and the quantity of needles, syringes, and other injecting paraphernalia exchanged, although the year-on-year increase in the quantity of the injecting kits distributed was not as high in 2009 as in previous years. A total of nearly 4.9 million needles and syringes were distributed in 2009.

The low availability of testing for infectious diseases and very low level of testing among problem drug users can be described as a long-standing negative trend. However, data from the past two years suggest that the negative trend is gradually being reversed.

In terms of the staff of the low-threshold facilities, there are repeated reports of confrontations between the outreach workers and the police and of difficulties in working with ethnic minorities. With regard to the presence of drug users on the open drug scene and the related public order problems, suggestions have appeared for the establishment of drug consumption rooms and for the installation of needle and syringe vending machines in Prague.

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

In the Czech Republic, the prevention of overdoses is conducted through drug user counselling and as part of the services provided by low-threshold and treatment facilities. For low-threshold programmes see below; treatment is discussed in the chapter on Drug-related Treatment: treatment demand and treatment availability (page 46). The main educational topics include first aid in the event of an overdose, the risks of polydrug use, and the principles of safe drug use. Most low-threshold facilities also provide counselling in this area via email and telephone. The facilities have prepared and have available a range of reference materials, some of which are also provided in other language versions.

The new web portal *eDekontaminace.cz* focuses on sharing information on harm reduction, including safe use and overdose prevention information[83].

In the *Early Warning System* (EWS) for new psychoactive substances, all low-threshold facilities are notified if new drugs or dangerous drugs involving higher health and overdose risks are detected in the Czech Republic (or anywhere across Europe). For example, in 2009 the facilities were notified about the possible penetration of fentanyl[84] into the Czech drug market and also received information regarding the anthrax outbreak among injecting drug users in the United Kingdom.

No other specific activities are being pursued in the Czech Republic with a view to the prevention of overdoses (e.g. the preventive distribution of opiate antagonists such as naloxone to drug users). Information about counselling and other services provided to drug users upon their release from prison is included in the section on Responses to Drug-related Health Issues in Prisons (page 101). Mention should be made of the discussion held in 2010 between the professional public, service providers, the police, and local administration authorities regarding the establishment of an application room for injecting drug users in Prague.

7.2 Prevention and Treatment of Drug-Related Infectious Diseases

7.2.1 Low-Threshold Harm Reduction Programmes

The prevention of infectious diseases is one of the key services provided by the low-threshold facilities. Harm reduction measures are mainly implemented in Czech low-threshold facilities in the form of exchanging needles and syringes, distributing condoms, providing/mediating tests for infectious diseases, and distributing information on the risks related to drug use. The target population of the low-threshold facilities includes problem drug users, experimenters, and their families and friends. In addition, programmes aimed at drug users in the nightlife setting are also being implemented.

The type and volume of the services vary from one low-threshold programme to another. Nevertheless, the programme of quality certification, which is a prerequisite for grants from the state budget and from certain regional budgets, guarantees a certain minimum quality of services – for details see the selected issue chapter on History, Methods, and Implementation of National Treatment Guidelines (page 112).

The network of low-threshold facilities comprises low-threshold centres and outreach (streetwork) programmes. In 2008, there were 95 of them in total; see Table 7-1.

[83] For details see http://www.edekontaminace.cz.
[84] Fentanyl is a high-potency opioid. It was first seized in Slovakia in 2009, which was the immediate reason for notifying the services.

Information about the services provided in the low-threshold facilities and about the recipients of such services is mainly available from the final reports drawn up by the facilities for the purposes of the grant procedures of the *Government Council for Drug Policy Coordination*[85]. The number of users with whom contact was established increased in 2009; this trend has been noted in the long term for all drugs except inhalants[86].

As indicated by Table 7-2, the service most commonly used in low-threshold programmes is the exchange of needles and syringes and distribution of paraphernalia, which is understandable, considering the high number of injecting drug users (IUDs) among HR programme clients. There were 12 contacts per client on average in 2009.

Similarly to the previous years, the low-threshold programmes in Prague, followed by those in the Ústí nad Labem, South Moravia, and Olomouc regions, reported the highest numbers of contacts in 2009. The highest number of individual exchanges in exchange programmes was reported from Prague (approximately 124,000), followed by the Ústí nad Labem (approx. 32,000), Central Bohemia (approx. 23,000), South Moravia (approx. 11,500), and South Bohemia (approx. 11,000) regions (Národní monitorovací středisko pro drogy a drogové závislosti, 2010d). A detailed account of the services reported by the low-threshold programmes in 2009 by region is provided in Table 7-3.

Table 7-1: Clients of Czech low-threshold facilities in the years 2002-2009 (Mravčík et al. 2009; Národní monitorovací středisko pro drogy a drogové závislosti, 2010d)

Indicator	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Number of low-threshold facilities/programmes	92	93	92	92	90	109	100	95
Number of drug users	n.a.	25,200	24,200	27,800	25,900	27,200	28,300	30,000
– injecting drug users	19,000	16,700	16,200	17,900	18,300	20,900	22,300	23,700
– pervitin users	12,900	11,300	12,200	12,300	12,100	14,600	14,900	16,000
– opiate users	8,000	6,100	6,000	6,800	6,900	7,300	8,300	8,300
– opiate users	n.a.	n.a.	n.a.	n.a.	4,000	4,100	4,600	4,950
– Subutex® users among opiate users	n.a.	n.a.	n.a.	n.a.	2,900	3,200	3,700	3,950
– cannabis users	3,400	5,500	4,100	3,600	2,700	2,000	1,700	2,200
– inhalant users	n.a.	705	560	470	450	390	300	250
Average age of drug user (years)	22.0	23.2	23.4	25.0	25.3	26.1	26.4	27.4
Total contacts/visits (in thousands)	290.0	315.0	317.9	403.9	322.9	338.1	329.5	365.6

Table 7-2: Selected services of low-threshold centres in the years 2004-2009 (Mravčík et al. 2009; Národní monitorovací středisko pro drogy a drogové závislosti, 2010d)

Indicator	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Number of needle and syringe exchanges	139,800	249,000	191,000	215,800	217,200	237,848
Food service	94,700	99,500	97,600	94,100	87,800	108,774
Hygiene service	34,500	40,900	41,100	40,000	34,800	44,271
Individual counselling	27,300	25,800	21,900	24,100	21,000	27,825
Medical attendance	13,500	12,500	10,500	9,400	7,700	10,233
Crisis intervention	3,000	2,500	1,800	1,600	1,100	1,577
Group therapy	1,800	1,500	1,500	1,000	1,100	1,261

[85] The number of programmes is influenced by the projects submitted by low-threshold facilities for their activities for grant procedures, and by the formal differentiation of the individual activities. A low-threshold centre or outreach programme may be both operated and conducted by a single entity within a single project and, in other cases or in other years, they can form two or more separate projects. Despite these influences, the offer and availability of low-threshold services in the Czech Republic have remained stable in recent years.
[86] Even though the Ústí nad Labem region shows a higher percentage of inhalant users.

Table 7-3: Selected services provided by low-threshold centres in the individual regions in 2009, extrapolated to the total number of programmes (Mravčík et al. 2009; Národní monitorovací středisko pro drogy a drogové závislosti, 2010d)

Region	Contact	First contact	Exchange	Food service	Hygiene service	Individual counselling	Referral*	Medical attendance	Crisis intervention	Group therapy
Prague	145,891	645	123,971	17,054	5,424	4,075	3,827	2,618	274	223
Central Bohemia	17,229	616	23,121	7,369	2,760	1,617	943	69	131	12
South Bohemia	22,204	660	10,944	10,465	3,498	1,963	1,749	188	220	84
Pilsen	14,565	1,014	5,175	5,474	2,348	2,526	1,964	607	127	107
Karlovy Vary	7,733	535	4,181	4,930	2,923	670	227	2,786	25	11
Ústí nad Labem	48,135	1,859	32,047	11,669	5,440	1,934	2,821	626	166	32
Liberec	6,502	252	2,824	2,576	1,198	613	84	33	64	3
Hradec Králové	8,042	277	3,139	2,559	2,505	573	144	178	25	0
Pardubice	3,134	188	1,058	930	891	83	174	73	21	0
Vysočina	7,782	184	1,613	4,543	2,042	713	895	124	20	1
South Moravia	19,568	770	11,523	7,501	3,538	2,457	609	393	41	64
Olomouc	23,682	1,244	5,669	13,275	3,123	4,782	1,003	1,014	102	59
Zlín	11,326	606	4,280	2,928	1,786	1,009	2,715	434	73	79
Moravia-Silesia	28,627	623	8,303	17,501	6,795	4,810	930	1,090	288	586
Total – Czech Rep.	364,420	9,473	237,848	108,774	44,271	27,825	18,085	10,233	1,577	1,261

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

Data on the clients of low-threshold facilities from other sources are also provided in the chapter on Data on Problem Drug Use from Non-treatment Sources (page 44). The *Centre for Addictology* conducted a qualitative study aimed at the trends on the Czech drug scene for the *National Monitoring Centre for Drugs and Drug Addiction* in 2009. The main objective of the investigation was to find qualitative data on the current situation and new trends on the drug scene in the regions of the Czech Republic by using and subsequently analysing information obtained from the streetworkers and staff of low-threshold facilities for (illicit) drug users through focus groups. On the basis of the research, the authors have identified the following main trends: an increasing number of pregnant active drug users, the concurrent use of pervitin and benzodiazepines among younger drug users, the increasing popularity of heroin, and the increasing prevalence of users with dual diagnoses. The low-threshold facility staff repeatedly reported confrontations between the outreach programmes and police officers and the complicated nature of work with ethnic minorities, and expressed the need for the establishment of drug consumption rooms and needle and syringe vending machines in Prague (Radimecký et al. 2010).

7.2.1.1 Needle and Syringe Exchange Programmes

A needle and syringe exchange component was included in 95 low-threshold programmes in 2009. A comparison of the number of programmes and the number of needles and syringes distributed in the years 1998-2009 is provided in Table 7-4; the number of needles and syringes distributed in the individual regions is shown in Table 7-5.

According to information available from the final reports, each injecting drug user who visited a low-threshold facility made an average of 10 exchanges in 2009 (compared to 9.7 exchanges in 2008) and received a total of 205 sterile needles and syringes (208 in 2008) on average. The number of injecting kits distributed in the individual regions corresponds with the relative number of injecting (problem) drug users; see Map 7-1 (see below) and Map 4-1 (page 44).

Table 7-4: Exchange programmes in the Czech Republic in 1998-2009 (Mravčík et al. 2009; Národní monitorovací středisko pro drogy a drogové závislosti, 2010d)

Year	Number of exchange programmes	Number of needles and syringes exchanged
1998	42	486,600
1999	64	850,285
2000	80	1,152,334
2001	77	1,567,059
2002	88	1,469,224
2003	87	1,777,957
2004	86	2,355,536
2005	88	3,271,624
2006	93	3,868,880
2007	107	4,457,008
2008	98	4,644,314
2009	95	4,859,100

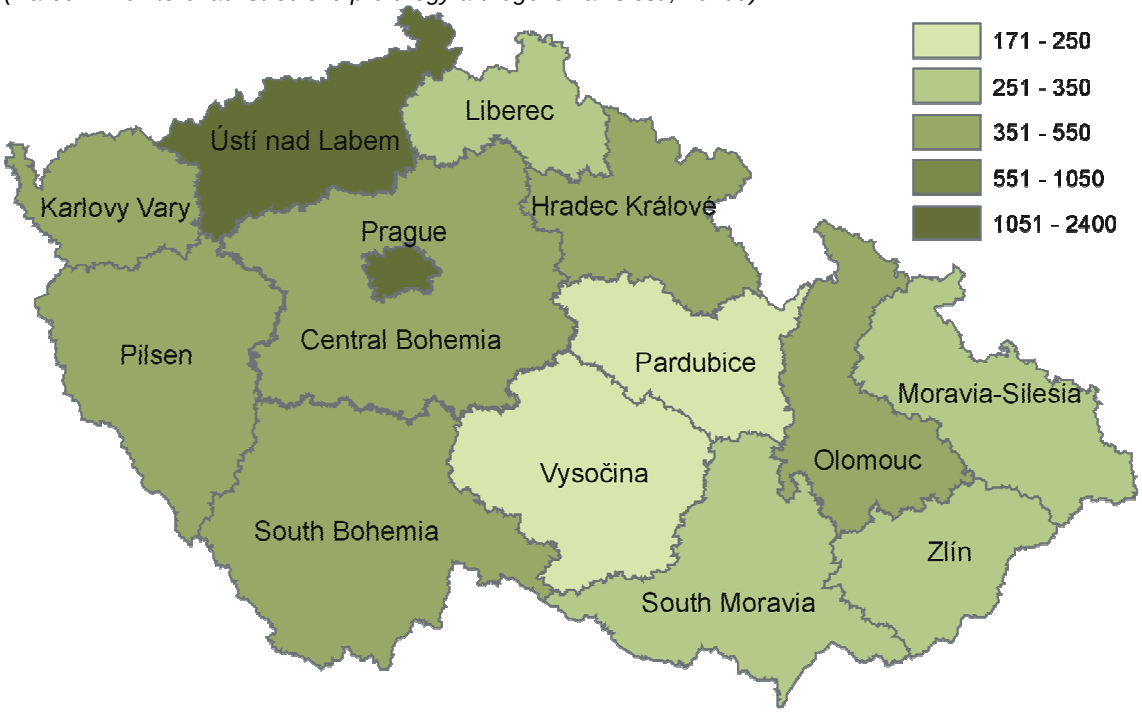
In addition to being caused by the increase in the estimated number of injecting drug users (for details see the chapter on Problem Drug Use on page 41), the rise in the quantity of needles and syringes distributed can be explained by the following factors, which may be generally assumed and whose existence is also supported by qualitative data:

- the drug-using population is ageing and an extended drug career can hence be assumed to cause damage to the users' vascular system, thus increasing the number of needles and syringes they need to consume for the successful application of the drug;
- there is a change in drug users' habits as some injecting users of Subutex® filter the solution for injecting application in one syringe and use another syringe for the application itself;
- the users are more aware of the principles of safe application and use more sterile material (Radimecký et al. 2010).

Table 7-5: Number of needles and syringes distributed in the exchange programmes in 2002-2009, by region – (Mravčík et al. 2009; Národní monitorovací středisko pro drogy a drogové závislosti, 2010d)

Region	2002	2003	2004	2005	2006	2007	2008	2009
Prague	858,507	979,560	1,210,704	1,697,554	1,850,330	2,071,788	2,060,588	2,130,729
Central Bohemia	12,561	31,682	66,600	110,325	168,220	215,640	309,590	345,214
South Bohemia	14,883	69,004	102,621	124,454	141,825	212,791	228,872	239,690
Pilsen	23,221	44,670	88,450	116,611	157,317	189,894	207,938	188,416
Karlovy Vary	16,608	29,299	35,756	58,680	66,382	83,462	79,834	102,467
Ústí nad Labem	256,071	262,418	351,561	479,383	612,259	655,882	637,887	678,007
Liberec	12,273	21,108	33,467	32,800	47,756	63,967	129,903	87,272
Hradec Králové	22,250	45,089	41,021	86,221	98,269	139,075	173,417	183,186
Pardubice	23,622	23,330	36,081	38,725	48,144	29,908	52,690	62,541
Vysočina	11,254	29,363	39,348	61,425	68,682	99,447	65,343	81,127
South Moravia	134,285	122,137	165,846	173,090	227,833	269,236	264,872	252,145
Olomouc	21,809	33,832	85,872	96,416	150,024	134,433	137,321	164,699
Zlín	19,973	11,362	41,977	52,169	69,005	115,744	89,913	111,099
Moravia-Silesia	41,907	75,103	56,232	143,771	162,834	175,741	206,146	232,508
Total	**1,469,224**	**1,777,957**	**2,355,536**	**3,271,624**	**3,868,880**	**4,457,008**	**4,644,314**	**4,859,100**

Map 7-1: Number of needles and syringes distributed in Czech regions in 2009, per 1,000 inhabitants aged 15-64 (Národní monitorovací středisko pro drogy a drogové závislosti, 2010d)



Needle and syringe exchange programmes are complemented by the distribution of aluminium foil for smoking heroin and the distribution of gelatine capsules intended for the oral application of the drug as an alternative to injecting, in particular in the case of pervitin.

The use of the capsules by the respondents was examined under the *Multiplier 2010* project, which was primarily aimed at estimating the proportion of problem drug users in contact with low-threshold facilities (for details see the chapter on Problem Drug Use on page 41 and the chapter on Testing for Infectious Diseases below). 189 out of the total of 642 respondents (29.4%) received capsules for the oral application of the drug last year, with most of them (87.8%) being pervitin users.

An internet survey conducted in 2008 found that gelatine capsules were distributed by 16 of the 50 low-threshold facilities (32%) which responded to the questionnaire (Mravčík et al. 2010). In the monitoring of tests for infections among injecting drug users in low-threshold programmes in 2009 (Národní monitorovací středisko pro drogy a drogové závislosti, 2010c), a total of 20 low-threshold programmes provided their responses (see also the chapter on Drug-related Infectious Diseases on page 65). Fourteen (70%) of these programmes conducted a capsule distribution programme, having issued 28,638 capsules to 719 drug (most commonly pervitin) users.

The results were published of a study conducted from mid-2007 to March 2009 with the pervitin-using clients of the *Charáč* drop-in centre in Uherské Hradiště (a qualitative study analysing 7 semi-structured interviews and a survey in the form of a structured interview with 49 clients) and aimed at the user habits and experience with the use of capsules (Guryčová, 2010). One of the findings was that the handling of the capsule and its application were not considered difficult, especially among the more experienced users. The onset and intensity of the effects are described as lower in the case of oral use in comparison with injection. In addition, the dose used for oral application is higher. There are less frequent reports of overdose sensations, or the overdose was described as less intense in the case of oral application involving the capsules. The passing of the effects of pervitin was also perceived as milder compared to injecting application.

7.2.1.2 Testing for Infectious Diseases

Some low-threshold facilities conducted saliva HIV tests in cooperation with the National Reference Laboratory for AIDS in Prague. However, HIV testing from saliva was suspended in late 2008 because of an interruption to the deliveries of the laboratory materials by the manufacturer. Similarly to the years 2006-2007, there was a persistent problem with the availability of HCV testing in low-threshold facilities, mainly as a result of the absence of a quick test for HCV antibodies from whole blood. In June 2008 a range of quick tests and the related equipment for HCV antibody tests from capillary blood serum were successfully obtained for selected low-threshold facilities, some of which started to conduct the tests during July and August 2008. A new, properly certified HCV test was introduced during 2009 for whole capillary blood testing. However, even the availability of valid tests does not resolve all the problems encountered in conducting tests in low-threshold facilities, i.e. in a non-laboratory environment. The difficulties and pitfalls of testing and counselling for infectious diseases were the topic of a one-day seminar held in November 2009 in cooperation with the National Institute of Public Health. Its outcomes indicate three key areas

preventing the rapid expansion of quick tests: (1) the costs involved in purchasing the tests; (2) the conditions for blood sampling in non-healthcare facilities, and (3) the necessity of high-quality training for the testing staff.

The *National Focal Point* is informed about the extent of testing for infections in low-threshold facilities from the final reports concerning projects supported within the framework of the grant procedure of the *Government Council for Drug Policy Coordination*. The test results are available from the monitoring of the tests in low-threshold programmes; for detailed information see the chapter on Drug-related Infectious Diseases (page 65). In 2009, 47 facilities offered HIV testing, 43 HCV testing, and 23 HBV testing, and 4 low-threshold facilities offered syphilis testing; see Table 7-6.

Table 7-6: Number of tests for infectious diseases and the number of low-threshold facilities providing tests in 2002-2009 (Mravčík et al. 2009; Národní monitorovací středisko pro drogy a drogové závislosti, 2010d)

Year	HIV		HBV		HCV		Syphilis	
	Tests	Facilities	Tests	Facilities	Tests	Facilities	Tests	Facilities
2002	1,158	35	515	26	1,202	33	176	2
2003	2,629	64	739	21	2,499	60	209	4
2004	2,178	58	932	25	2,582	53	84	1
2005	2,425	54	1,370	28	2,664	55	54	2
2006	1,253	46	693	56	1,133	62	209	3
2007	609	53	370	19	401	24	62	4
2008	1,120	50	399	18	862	40	124	3
2009	1,592	47	560	23	1,501	43	143	4

A significant drop was observed in 2005-2007 in the number of tests conducted with IDUs, in particular as far as HIV and HCV tests are concerned, and a decrease in the number of (low-threshold) facilities providing such tests to drug users. The 2007 and 2008 data indicate that this negative trend was reversed and that the number of tests performed is growing. However, the number of tests performed was still low compared to the pre-2006 level.

In their 2009 final reports on projects for the purposes of grant procedures of the *Government Council for Drug Policy Coordination*, low-threshold facilities reported contact with a total of 23,700 injecting drug users. These reports from the low-threshold facilities for the *GCDPC's* grant procedures indicated the performance of 1,592 HIV tests and 1,501 HCV tests (Table 7-6). Assuming that the tests were performed on injecting drug users and that no person was tested repeatedly, it can be estimated that the low-threshold facilities conducted HIV tests on 6.7% of their clients and HCV tests on 6.3% of them. This low level of testing is in striking contrast with the potential for testing and the related counselling, as offered by the network of low-threshold facilities. In 2005, when the number of HCV tests performed by low-threshold facilities peaked, contact was reported with 17,900 injecting drug users, while 2,662 tests were performed, making the level of HCV testing 14.9%.

The low level of testing is confirmed by data obtained from the monitoring of tests for infections among injecting drug users in low-threshold programmes in 2009 (Národní monitorovací středisko pro drogy a drogové závislosti, 2010c), in which 20 low-threshold programmes were involved. The percentage of the injecting drug users tested in 2009 (calculated as the number of tests per the number of injecting drug users in contact with such facilities) reached 6.0% for HIV tests, 4.5% for HCV tests, and 3.2% for syphilis tests.

The information above shows that the availability of tests for infectious diseases for injecting drug users and the level of testing among these users have decreased. It can also be assumed that the number of undetected and untreated cases of infections among injecting drug users, including HIV and HCV infections, has increased, thus also increasing the probability of the further spread of these diseases among both IDUs and the general population. The low level of testing of injecting drug users also limits the awareness of the incidence of infections in this risk population group and the possibility of the timely detection and control of epidemics, if any, including HIV epidemics (Mravčík and Nečas, 2010).

In addition to the testing itself, pre- and post-test counselling is also important as it enables closer contact to be established with the client, the risks of any infection explained, and information provided on safe application (UNAIDS and WHO, 2004; Dolanská Pavla et al. 2004). Higher levels of testing among the risk population are not only beneficial for the clients but also have a clear positive impact on the protection of public health. On the contrary, a low level of testing among the target population leads to a number of adverse consequences. The timely detection of infections increases the probability of efficient therapy and recovery and reduces the possibility of the further spread of the disease. The financial cost of treatment is another important aspect, being lower in cases detected in time. An increased level of testing among the population of problem drug users thus increases the effectiveness of the timely intervention for the infected IDUs and, consequently, the effectiveness of harm reduction services in general (Mravčík and Nečas, 2010).

A survey was also conducted as part of the *Multiplier 2010* project, which was primarily aimed at estimating the proportion of problem drug users in contact with low-threshold facilities (for details see the chapter on Problem Drug Use on page 41), and whether the clients had previously been tested for HIV or HCV. 316 out of the total of 642

respondents (49.2%) stated that they had had an HIV test in the past 12 months and 375 persons (58.4%) reported having had an HCV test in the same period. These testing data suggest a higher level of drug user testing for HIV and HCV compared to that shown by the testing data from the low-threshold facilities provided above. It is, however, a question of where and under what circumstances the testing takes place.

The clients' history of HIV, HBV, and HCV testing is also monitored in the *Register of Treatment Demands.* The information contained in these items is mostly self-reported but may also come from the client's documentation or from reports on infection examination as part of the relevant treatment episode. The percentage of injecting drug users demanding treatment between 2002 and 2009 and prior tests for the individual infections is shown in Table 7-7.

Table 7-7: History of HBV, HCV, and HIV testing of all clients – injecting drug users demanding treatment in 2002-2009, (Studničková, 2010)*

Year (N*)	HBV	HCV	HIV
2002 (N=6225)	39.8	45.6	47.7
2003 (N=5959)	41.3	47.8	48.2
2004 (N=6364)	38.7	44.8	52.8
2005 (N=6125)	39.8	44.1	54.8
2006 (N=6022)	38.4	42.2	55.7
2007 (N=6109)	37.4	40.3	53.4
2008 (N=5986)	42.1	45.0	55.1
2009 (N=6157)	42.9	48.2	57.8

*Note: * The individual years show the number of injecting drug users who had a history of testing and also knew the result of the test.*

7.2.1.3 Programmes Aimed at Drug Use in Recreational Settings

Specific programmes for the reduction of risks in recreational settings were conducted in 2009 by a total of five[87] organisations in seven programmes. These programmes recorded a total of 3,774 contacts (40.5% of them men; average age 22.3) and the most commonly reported illicit drug used was cannabis (31.5%), followed by ecstasy (23.0%) and hallucinogens (14.5%). The quality of 665 tablets was tested (Národní monitorovací středisko pro drogy a drogové závislosti, 2010d). In comparison with the previous year, the number of contacts more than doubled and the number of ecstasy tablets tested increased five-fold. A total of 1,839 clients were contacted in 2008. Compared to 2007, there was a marked increase in the services provided, which reversed the post-2004 declining trend of a significant reduction of preventive activities on the dance scene resulting from the negative political view of ecstasy quality testing (there were 18 active programmes which contacted nearly 5,000 clients in 2003) – for details see the 2007 Annual Report, 2008 Annual Report, and the issue of the "*Zaostřeno na drogy*" ("Focused on Drugs") bulletin dealing with this topic (Mravčík et al. 2008; Mravčík et al. 2009; Mravčík et al. 2008). In June 2010, the Ministry of the Interior and the Police of the Czech Republic repeated their previous negative position regarding ecstasy quality screening tests at dance parties[88], which was followed by a debate in the media in which opinions and standpoints referring to the contribution of this specific work with drug users were also voiced[89].

The *Safer Party Tour* project also focused on recreational settings – for details see the chapter on Selective Prevention (page 39).

7.3 Responses to Other Health Correlates Among Drug Users

The treatment of dual-diagnosis drug users in the Czech Republic usually takes place in the network of treatment facilities in consideration of the drug users' specific needs; see the chapter on Drug-related Treatment: treatment demand and treatment availability (page 46).

[87] *CPPT Pilsen*, *Sdružení Podané ruce*, *Středisko pro prevenci a léčbu Drop-In*, *Občanské sdružení Prevent*, and the *Kappa-Help* civic association.
[88] http://www.mvcr.cz/clanek/stanovisko-mv-a-policie-cr-k-testovani-tablet-extaze-na-tanecni-scene.aspx.
[89] For example, see http://www.tyden.cz/rubriky/zdravi/testovani-extaze-v-klubech-rozdeluje-odborniky_172662.html.

8 Social Correlates and Social Reintegration

The most significant social problems of drug users include family and work problems, unemployment, lower education, and a poor housing situation, which sometimes even lead to homelessness. These problems mainly accumulate among drug users who are members of ethnic minorities and among immigrants (in the Czech Republic, this mainly applies to Roma) and older drug users.

In the Czech Republic, homelessness seems mainly associated with the use of alcohol. It appears that the prevalence of drug use among Roma in the Czech Republic has been stable in recent years, involving mainly legal drugs such as alcohol and tobacco, with marijuana and pervitin representing the most widespread illicit drugs.

The number of aftercare facilities decreased in 2009 but their capacity and the number of clients did not drop. There was a significant decrease in the sheltered housing capacity.

8.1 Social Exclusion and Drug Use

8.1.1 Social Exclusion among Drug Users

The most significant social problems of drug users include family and work problems, unemployment, lower education, and a poor housing situation, which sometimes even lead to homelessness. These problems mainly accumulate among drug users who are members of ethnic minorities and among immigrants and older drug users (see, for example, the relevant selected issue in the 2008 Annual Report).

Information about the social consequences of drug use among drug users, including those who are members of ethnic minorities, comes from two studies conducted in 2008 and is presented in the 2008 Annual Report. The socio-economic characteristics of treatment demands in connection with drug use are provided in the chapter on Selected Characteristics of Treatment Demands (Page 56).

8.1.2 Drug Use among Socially Excluded Groups

8.1.2.1 The Homeless

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

In 2008, the Department of Civic Society Studies of the *Charles University Faculty of Humanities* participated in a 7FP project of the EU named *Combating social exclusion among young homeless populations (CSEYHP): a comparative investigation of homeless paths among local white, local ethnic group, and migrant young men and women and appropriate reinsertion methods*[90]. It is a three-year project focusing on investigating the life trajectories of homeless local white, ethnic, and migrant young men and women. The other three countries involved in the project in addition to the Czech Republic are the UK, Portugal, and the Netherlands. The research report shows that the majority of the homeless population are over 40 years of age; approximately 15% belong to a younger age group, which is dominated by men who have not completed elementary education or had a very low level of education and often with a history of drug use (Disdarevič and Šloufová, 2009).

8.1.2.2 Roma Communities

In the Czech Republic, social exclusion also concerns certain Roma communities. The exclusion is the product of the accumulation of social problems, which mainly include long-term unemployment, low incomes, and either the unavailability or poor quality of housing (Kancelář Rady vlády pro záležitosti romské komunity, 2007a). The 2010-2013 Roma Integration Policy was approved in late 2009. The Policy does not change the basis of the previous approach of the government to resolving the situation of Roma communities and continues to seek cohesion and coordination of the activities of the key entities for the inclusion of Roma at both the national and local levels. The Policy aims at supporting the Roma culture and language and the areas of education, employment, high debt, housing, social protection, and health care. It also seeks to resolve the situation in communities at risk of social exclusion and, finally, also addresses the safety and security aspects of Roma integration (Kocáb, 2010).

Monitoring and evaluation of the situation in Roma communities has been provided in the long term by the Office of the Government Council for Roma Community Affairs within the framework of the Field Social Workers Support Programme. Altogether, 47 municipalities were involved in the Field Social Workers Support Programme and 72 jobs for outreach workers were supported in 2009 (Kancelář Rady vlády pro záležitosti romské komunity, 2010b).

[90] The Czech name is *Boj proti sociálnímu vyloučení mezi mladou bezdomoveckou populací: srovnávací výzkum cest k bezdomovectví mezi lokální bílou populaci, lokálními etnickými skupinami a mezi migranty a migrantkami a adekvátní metody návratu.*

The field social workers provided their services to a total of 13,903 clients, 53% of whom were in the 25-29 age group, with children under the age of 14 and the 15-24 age group accounting for significant proportions (with 21% and 22%, respectively) in 2009. In terms of the structure of the problems addressed, services were most commonly provided in the areas of debt resolution (27%), unemployment (22%), and low housing quality (17%). 291 clients (2%) used the services of the field workers in connection with drug use; see Table 8-1.

A decrease was observed in the number of problems related to usury, even though the number and percentage of interventions related to debt dropped only slightly. There was a marked increase in terms of problems related to unemployment. The number and percentage of problems related to illicit drug use and gambling has remained stable and relatively low in the long term (Kancelář Rady vlády pro záležitosti romské komunity, 2010b).

Table 8-1: Number of clients provided with the services of Roma field workers in 2006-2009 and classified by problem type (Kancelář Rady vlády pro záležitosti romské komunity, 2007b; Kancelář Rady vlády pro záležitosti romské komunity, 2008; Kancelář Rady vlády pro záležitosti romské komunity, 2009; Kancelář Rady vlády pro záležitosti romské komunity, 2010a)

Problem type	2006		2007		2008		2009	
	Number	%	Number	%	Number	%	Number	%
Debt	4,477	34.1	5,314	31.9	3,779	28.7	3,722	26.8
Unemployment	2,672	20.4	2,916	17.5	2,598	19.8	3,070	22.1
Low housing quality	3,362	25.6	3,364	20.2	2,432	18.5	2,408	17.3
Problematic tenant/landlord relations	1,847	14.1	1,522	9.1	1,285	9.8	1,413	10.2
Insufficient sanitation	1,300	9.9	1,204	7.2	1,282	9.7	1,309	9.4
Truancy	907	6.9	716	4.3	1,000	7.6	679	4.9
Usury	277	2.1	320	1.9	696	5.3	218	1.6
Crime	620	4.7	574	3.4	636	4.8	532	3.8
Drug use	457	3.5	391	2.3	344	2.6	291	2.1
Gambling	268	2.0	302	1.8	323	2.5	236	1.7
Prostitution	63	0.5	39	0.2	51	0.4	25	0.2
Total*	**13,116**	**100.0**	**16,662**	**100.0**	**13,144**	**100.0**	**13,903**	**100.0**

*Note: * The aggregate number of clients classified by problem type may exceed the total number of clients because of the accumulation of problems in individual clients and because of the methods of reporting in the individual years.*

In 2007, the government established the Agency for the Elimination of Social Exclusion in Roma Localities. The Agency's main objective is the transformation of Roma ghettos, with a view to improving the quality of life of the residents of such problematic areas; for details see the 2007 Annual Report.

In 2009, the Agency operated in a total of 13 locations (in Brno, Broumov, Břeclav, Holešov, Cheb, the Jeseník area, Most, Přerov, Roudnice nad Labem, and Slezská Ostrava) and cooperated with the town of Litvínov.

In 2009, the Agency participated in the *Long-term Monitoring of Roma Community Status – Locations in Bohemia* project (GAC spol. s r.o., 2009), which follows up on the previous *Long-term Monitoring of Roma Community Status – Locations in Moravia* project (Kašparová et al. 2008). The objective of the project was to monitor the situation in Ústí nad Labem, Most, Cheb, Broumov, and the Šluknov area, mainly with regard to the factors affecting the position of socially excluded Roma (inadequate housing quality, worse access to education, unemployment, and a low level of education). Among other factors, the research also focused on the health condition of the inhabitants of socially excluded communities, including drug use. The most commonly reported drug is pervitin (Ústí nad Labem, Most, the Šluknov area, and Cheb) followed by heroin (Ústí nad Labem, Most, and Cheb), cannabis (Ústí nad Labem, the Šluknov area, and Cheb) and toluene (Most, the Šluknov area, and Broumov). In addition to drug use, other widespread problems include gambling and the related usury and debt (GAC spol. s r.o., 2009).

The Agency also participated in a project of the World Bank and the Government Council for Roma Community Affairs named *Czech Republic: Improving the Employment Chances of the Roma*, and in the *Roma Population and Health* research conducted under the SASTIPEN project. The projects sought to prepare a study focused on the health and social status of the Roma minority and access to social and health resources. The study focused in detail on smoking and the use of alcohol. The results show that 60% of Roma over the age of 16 currently smoke on a daily basis, and another 9% are irregular smokers. The most popular beverages include beer and wine, which are sometimes drunk by one-half (wine) or three-fifths (beer) of Roma admitting the use of alcohol in the past year (Nesvadbová et al. 2009).

In addition to the status analyses, in 2009 the Agency also carried out partial innovative and thematic research studies concerning the needs of the individual locations. For example, research into criminogenic factors was conducted in Přerov for the purposes of the implementation of crime prevention measures, and a methodology for research into the use of addictive substances among young people was prepared in Brno – additional information and the detailed findings of the Brno study regarding drug use are provided in the chapter on Drug Use among Targeted Groups/Settings at National and Local Level (p. 33).

The results of a socio-ethnographic field study conducted in five Roma families and focused on the evaluation of the health effects of substance abuse were published in 2009 (Kajanová and Mrhálek, 2009). Nicotine addiction prevailed among the participants of the study, even among children aged 12 and often also among pregnant women. While the regular use of alcohol was rather rare among the respondents, illicit drug abuse was observed among young Roma; the authors even reported that the community did not consider marijuana a drug. An important part seems to be played by the tolerant attitude of the family and community to substance abuse, which is apparent in the tolerance shown towards young children smoking. According to the authors, the group of relatives is one of the most common initiators of drug use.

8.2 Social Reintegration

In the Czech Republic, aftercare for drug users and their social inclusion are provided for through outpatient aftercare programmes, which may include sheltered housing programmes and sheltered work programmes (sheltered workshops, sheltered employment, and supported employment). The target population of the structured intensive aftercare programmes consists of people with the recommended abstinence period of at least 3 months.

Aftercare was provided by 15 facilities subsidised by the *Government Council for Drug Policy Coordination* in 2009[91], 13 of which offered their clients sheltered housing and 4 also provided protected employment. Altogether, 986 clients (611 of them male) used the aftercare services; 627 (63.6%) of them used to inject drugs before they entered treatment; 585 (59.3%) used to use pervitin and 161 (16.3%) heroin. The total capacity of the facilities offering sheltered housing was 134 places. 29 clients worked in protected workshops (Národní monitorovací středisko pro drogy a drogové závislosti, 2010d); a comparison for the period 2005-2009 is shown in Table 8-2.

Table 8-2: Aftercare programmes subsidised by the Government Council for Drug Policy Coordination in the period 2005-2009 (Mravčík et al. 2009; Národní monitorovací středisko pro drogy a drogové závislosti, 2010d)

Indicator	2005	2006	2007	2008	2009
Number of facilities	20	18	18	18	15
Number of aftercare clients	865	904	883	1,041	986
Sheltered housing places	118	126	126	283	134
Number of clients in sheltered housing	244	235	261	-	-
Number of clients in sheltered workshops	59	40	44	25	29

Outpatient aftercare was offered by 11 facilities, whose services were used by 443 clients (277 of whom were men), which represents a slight decrease against 2008. The average age of the clients has been rising in the long term and reached 30.4 years in 2009. A total of 235 clients (53%) had been injecting drug users prior to the treatment; 246 (55.5%) had used pervitin and 64 (14.4%) opiates (Národní monitorovací středisko pro drogy a drogové závislosti, 2010d). A comparison for the period 2003-2009 is shown in Table 8-3.

Table 8-3: Outpatient aftercare programmes subsidised by the Government Council for Drug Policy Coordination, and their clients in the period 2003-2009 (Mravčík et al. 2009; Národní monitorovací středisko pro drogy a drogové závislosti, 2010d)

Indicator	2003	2004	2005	2006	2007	2008	2009
Number of facilities	8	14	13	10	12	12	11
Number of clients	460	444	336	380	389	487	443
– injecting drug users	320	307	218	230	236	306	235
– pervitin users	210	187	182	216	209	259	246
– opiate users	120	115	58	78	69	71	64
Average age of clients	26.0	26.6	27.4	26.4	29.3	30.3	30.4

Twelve facilities provided intensive aftercare (within a long-term structured programme, typically involving sheltered housing and protected employment); their total capacity of 316 beds was used by 543 clients (334 of whom were men). The average age of the clients was 29.2 years. A total of 392 (72.2%) clients had been injecting drug users prior to the treatment; 329 (60.6%) had used pervitin and 99 (18.2%) opiates (heroin, Subutex® or methadone). The average duration of the stay of a client in an intensive aftercare programme was 6 months. 174 clients (32%) completed the programme, 132 (24.3%) dropped out, and 52 (9.6%) were expelled (Národní monitorovací středisko pro drogy a drogové závislosti, 2010d); see Table 8-4.

[91] A total of 30 providers of aftercare programmes for the target group of *persons at risk of addiction or persons with substance addiction* were included in the Register of Social Service Providers (http://iregistr.mpsv.cz), which is administered by the Ministry of Labour and Social Affairs (retrieved on 5 September 2010). The Ministry of Labour and Social Affairs also operates additional databases collecting and providing information about the social services provided; for details see the 2008 Annual Report.

Table 8-4: Intensive aftercare programmes subsidised by the Government Council for Drug Policy Coordination, and their clients in the period 2003-2009 (Mravčík et al. 2009; Národní monitorovací středisko pro drogy a drogové závislosti, 2010d)

Indicator	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Number of facilities	14	14	15	16	15	15	12
Capacity	321	342	385	365	325	283	316
Number of clients	585	562	526	524	494	554	543
– injecting drug users	463	404	399	364	360	422	392
– pervitin users	245	260	276	304	284	317	329
– opiate users	224	184	143	105	104	105	99
Average age of clients	24.5	27.0	26.4	27.1	26.6	28.7	29.2

In addition to the facilities specified above, aftercare services may be provided by other inpatient or outpatient treatment facilities. However, their number and the scope of the services provided are difficult to determine. Alcoholics Anonymous (AA) groups operate on a self-help basis. There are currently 47 AA groups in 34 towns and cities in the Czech Republic (Anonymní alkoholici - Česká republika, 2010). There is no additional information about the *Fatima* self-help group, which was established in Brno in May 2009 to bring together the users of non-alcohol drugs. There is no information available about any other self-help group aimed at non-alcohol drugs in the Czech Republic.

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

In 2009, the National Drug Headquarters registered a total of 2,340 persons arrested for drug-related offences and the Ministry of the Interior registered 2,415 and the Ministry of Justice 2,553 persons prosecuted for them. The absolute number of those prosecuted is highest in the Moravia-Silesia and Ústí nad Labem regions and in Prague; in relative terms per 100 thousand inhabitants, the figures are highest in the Ústí nad Labem region and in Prague. 2,332 persons were charged with drug-related offences in 2009. In the long term, approximately 90% of the persons arrested and prosecuted for drug-related offences are subsequently indicted.

There is an increase in the number of people prosecuted and charged, with a marked increase in the number of persons prosecuted for and charged with drug possession (Section 187a). On the contrary, the figures for the promotion of drug use (Section 188a) have decreased. Offenders are most typically prosecuted in connection with pervitin, followed by cannabis and heroin, with the percentage of cannabis rising and that of pervitin decreasing.

1,535 individuals were sentenced for drug-related offences in 2009, the highest figure for the past three years. As far as the persons sentenced are concerned, an increase can also be observed in the proportion and number of offences of drug possession according to Section 187a. A total of 489 unsuspended sentences and 869 suspended sentences were imposed in 2009. Institutional or outpatient compulsory treatment was imposed by the courts upon 123 persons; 68 of the cases involved the outpatient form of treatment and 55 the institutional form in 2009. The situation is stable in terms of the structure of sentences – unsuspended imprisonment sentences have accounted for approx. 30% and suspended sentences for 50% in the past three years. The highest number of sentences is imposed in connection with the production and trafficking of drugs (Section 187) and with pervitin.

Starting in 2009, misdemeanours involving drug possession for personal use (and, starting in 2010, also misdemeanours involving the cultivation of plants or mushrooms containing narcotic or psychotropic substances for personal use) are handled by the municipal authorities of municipalities with extended competences and no longer by the Police of the Czech Republic. The 2009 data were not available at the time of the drafting of this Report.

According to expert estimates, drug users account for 71-74 thousand offences per year, approximately a fifth of all the offences reported in the Czech Republic. They most typically involve vehicle burglaries. According to other estimates, approximately 14% of the new clients of the Probation and Mediation Service of the Czech Republic have committed an offence in connection with drugs.

Police records show 22.2 thousand offences committed under the influence of alcohol, represented most frequently by the criminal offence of endangerment under the influence of addictive substances, inebriation, and road traffic accidents caused by negligence. A total of 2.3 thousand offences were reported as having been committed under the influence of non-alcohol substances and again most frequently involved endangerment under the influence of addictive substances, inebriation, and various types of thefts and burglaries. Most offences were committed by non-alcohol drug users under the influence of pervitin and cannabis. When roughly related to the total number of criminal offences reported (345 thousand), the number of offences committed annually under the influence of alcohol can be estimated as approximately 62 thousand (18%) and the number of offences committed under the influence of non-alcohol drugs as 7 thousand (2%).

There were 36 prisons in the Czech Republic in 2009. As in the previous years, there are no results available in 2009 from any representative studies conducted among prisoners which could be used as the basis for the qualified determination of drug use among this population. Various types of services aimed at drug users were available in prisons in 2009. They included drug prevention counselling centres, which are operated in all prisons, detoxification services in four prisons, drug-free zones in 33 prisons, and two types of dedicated departments: voluntary treatment departments in seven prisons and dedicated departments for court-ordered institutional compulsory treatment in three prisons. Methadone substitution therapy was provided in nine prisons in 2009. The care for imprisoned drug users was complemented by the services provided by 15 non-governmental organisations in 30 prisons; six of the organisations, which are members of the *A.N.O.* (Association of Non-Governmental Organisations) Section for Drug Services in Prison, operated in 19 prisons.

9.1 Drug-Related Crime

There are several data sources available in the Czech Republic regarding the so-called "drug-related offences", i.e. offences under the provisions of Sections 187 (Unauthorised production and handling of narcotic and psychotropic substances and poisons), 187a (Unauthorised possession of a narcotic or psychotropic substance or poison), 188 (Manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison), and 188a (Promotion of drug use) of Act No. 140/1961 Coll, the (old) Penal Code[92]. They mainly include the statistics of the *Police of the Czech Republic*, especially the *Criminal Statistics Record System* and the statistics

[92] This old Penal Code was in force until 31 December 2009. On 1 January 2010 Act No. 40/2009, Coll., the (new) Penal Code, became effective. In the new Penal Code, stipulations concerning drug-related offences are included in sections 283 through 287. For more information see the chapter on Legal Framework (p. 6). Comparison of selected sections of the old and the new penal codes is provided in Appendix 14.2 (p. 139).

of the dedicated police unit – the *National Drug Headquarters of the Criminal Investigation Service of the Police of the Czech Republic* – as well as the statistics of the public prosecutors' offices and court statistics prepared by the *Ministry of Justice*. Additional data in this area are collected by the *Probation and Mediation Service of the Czech Republic* and the *Prison Service of the Czech Republic*.

Individuals arrested or prosecuted for drug-related offences are recorded in the system of the *National Drug Headquarters*, which only focuses on drug-related crime, and in the police and Ministry of Justice systems, which cover general, i.e. not only drug-related, crime. The data from the above-mentioned sources differ slightly. The differences in certain details result from the different reporting practices and discipline, as well as from the methodological differences between the individual reporting systems. For example, such differences include the recording of offences and offenders at different stages of criminal proceedings[93], different definitions of the cases reported, and different statistical units (individuals, cases, or offences), and double entries of persons in the recorded data (e.g. if a single person has violated multiple drug-related sections of the Penal Code and/or in connection with multiple drug types). However, the non-existence of a uniform record-keeping system for all the institutions involved in criminal proceedings (i.e. the police, public prosecutors' offices, courts, the *Probation and Mediation Service,* and the *Prison Service*) is a major disadvantage in this context.

9.1.1 Drug Law Offences

Both the police and the Ministry of Justice data confirm the relatively stable situation in the past three years as far as the number of persons arrested, prosecuted, charged, and sentenced for drug-related offences is concerned, whether classified by the drug-related Penal Code section, drug type, or region of the Czech Republic. However, certain changes can be observed in the long term of approximately 10 years as far as the number and structure of drug-related offences are concerned.

2,340 and 2,415 persons were arrested in 2009, according to the *National Drug Headquarters* and the *Criminal Statistics Record System*, respectively, and 2,553 persons were prosecuted for drug-related offences according to the *Ministry of Justice*; the numbers of persons arrested or prosecuted obtained from all three systems are the highest for the past three years (2007-2009); see Table 9-1. The percentage of persons arrested or prosecuted for drug-related offences is shown in Table 9-2, Table 9-3, and Table 9-4, broken down by Penal Code section and main drug type. 2,332 persons were charged with drug-related offences, the highest number in the past three years (compared to 2,042 in 2007 and 2,100 in 2008); the percentage of the people charged is shown in -5, broken down by Penal Code section and main drug type. 1,535 persons were sentenced, the highest figure in the past three years (compared to 1,382 in 2007 and 1,360 in 2008); the percentage of the persons sentenced is shown in Table 9-6, broken down by Penal Code section and main drug type.

Table 9-1: Number of persons arrested (National Drug Headquarters) and prosecuted (Police, Ministry of Justice) for drug-related offences in 2005-2009, according to the individual information sources (Národní protidrogová centrála SKPV Policie ČR, 2010c; Ministerstvo vnitra ČR, 2010a; Ministerstvo spravedlnosti ČR, 2010c)

Source	2005	2006	2007	2008	2009
National Drug Headquarters (arrested)	2,168	2,198	2,031	2,322	2,340
Criminal Statistics Record System (prosecuted)	2,209	2,344	2,023	2,296	2,415
Ministry of Justice (prosecuted)	2,429	2,630	2,282	2,304	2,553

The number of individuals prosecuted for drug-related offences has remained stable in recent years. After the inclusion of the data from all the three record systems specified above, 2,023-2,553 persons (with an average of 2,285) were arrested and prosecuted for drug-related offences in the past three years (2007-2009). According to the statistics of the *Ministry of Justice*, an average of 2,380 persons were prosecuted in the past three years, of whom an average of 1,771 (74%) persons were prosecuted under Section 187, 355 (15%) under Section 187a, 22 (10%) under Section 188, and 32 (1%) under Section 188a. An increase in the number of persons prosecuted under Section 187 can be observed between 2007 and 2009 (1,684 persons in 2007 and 1,970 persons in 2009), and there was also a marked decrease in the number of persons prosecuted under Section 188a in the same period (53 persons in 2007 and 12 persons in 2009) (Ministerstvo spravedlnosti ČR, 2010c). The percentage of the drug types in connection with which the persons were prosecuted for drug-related offences has remained stable during the last three years; the persons were most typically prosecuted in connection with pervitin (approx. 60%), cannabis (approx. 30%), and heroin (approx. 7%) (Ministerstvo spravedlnosti ČR, 2010d). In terms of regions, the highest absolute numbers of persons prosecuted in 2009 were reported from Prague (375 persons) and from the regions of Moravia-Silesia (268) and Central Bohemia (240). In relative terms per 100 thousand inhabitants, the highest numbers of persons were prosecuted in the Karlovy Vary region (50), Ústí nad Labem region (32), and Prague (32) (Ministerstvo

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

vnitra ČR, 2010b). In the past three years, the absolute number of those prosecuted has been highest in the Moravia-Silesia and Ústí nad Labem regions and in Prague; in relative terms per 100 thousand inhabitants, the figures are highest in the Karlovy Vary and Ústí nad Labem regions and in Prague.

Table 9-2: Number of persons arrested and prosecuted for drug-related offences in 2009, classified by Penal Code section (Národní protidrogová centrála SKPV Policie ČR, 2010c; Ministerstvo vnitra ČR, 2010a; Ministerstvo spravedlnosti ČR, 2010c)

Source	**Sections 187+188**		**Section 187a**		**Section 188a**		**Total**	
	Number	%	Number	%	Number	%	Number	%
National Drug Headquarters (arrested)	2,044	87	285	12	11	1	2,340	100
Criminal Statistics Record System (prosecuted)	2,096	87	302	12	17	1	2,415	100
Ministry of Justice (prosecuted)	2,177	85	364	14	12	1	2,553	100

Table 9-3: Number of persons arrested in 2009, classified by main drug type and Penal Code section, according to the National Drug Headquarters (Národní protidrogová centrála SKPV Policie ČR, 2010c)

Drug type	**Sections 187+188**		**Section 187a**		**Total**	
	Number	%	Number	%	Number	%
Cannabis	661	32	125	44	786	34
Pervitin	1,160	57	115	40	1,275	55
Cocaine	41	2	6	2	47	2
Heroin	103	5	33	12	136	6
Other drugs	79	4	6	2	85	3
Total persons	**2,044**	**100**	**285**	**100**	**2 329***	**100**

*Note: * This does not include 11 persons arrested under Section 188a because information about the drug type involved is missing. The total number of persons arrested in 2009 according to the National Drug Headquarters is thus 2,340.*

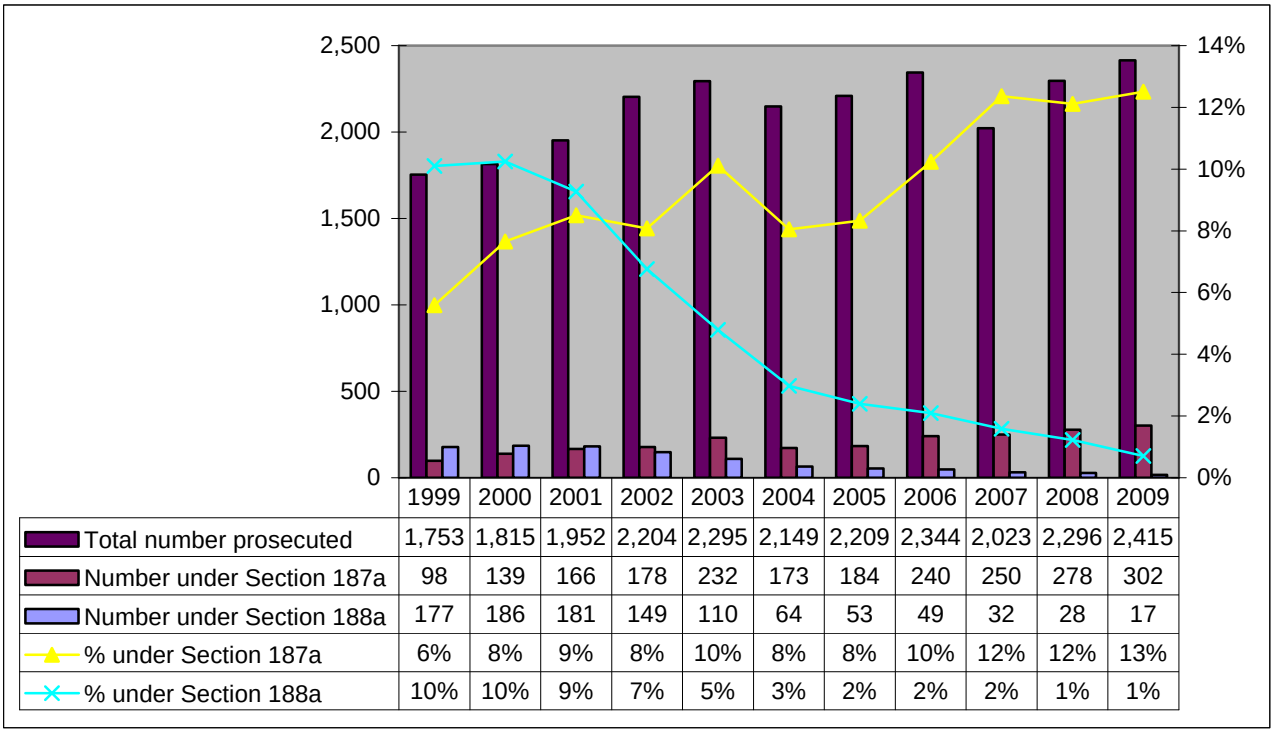
Table 9-4: Number of persons prosecuted, classified by main drug type and drug-related Penal Code section, according to the Ministry of Justice (Ministerstvo spravedlnosti ČR, 2010d; Ministerstvo spravedlnosti ČR, 2010c)

Drug type	**Section 187**		**Section 187a**		**Section 188**		**Section 188a**		**Total**	
	Number	%	Number	%	Number	%	Number	%	Number	%
Cannabis	605	31	154	42	11	5	6	50	776	30
Pervitin	1,237	63	160	44	191	92	3	25	1,591	62
Cocaine	44	2	4	1	0	0	0	0	48	2
Heroin	124	6	45	12	0	0	0	0	169	7
Other drugs	114	6	30	8	17	8	3	25	164	6
Total persons*	**1,970**	**100**	**364**	**100**	**207**	**100**	**12**	**100**	**2,553**	**100**

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

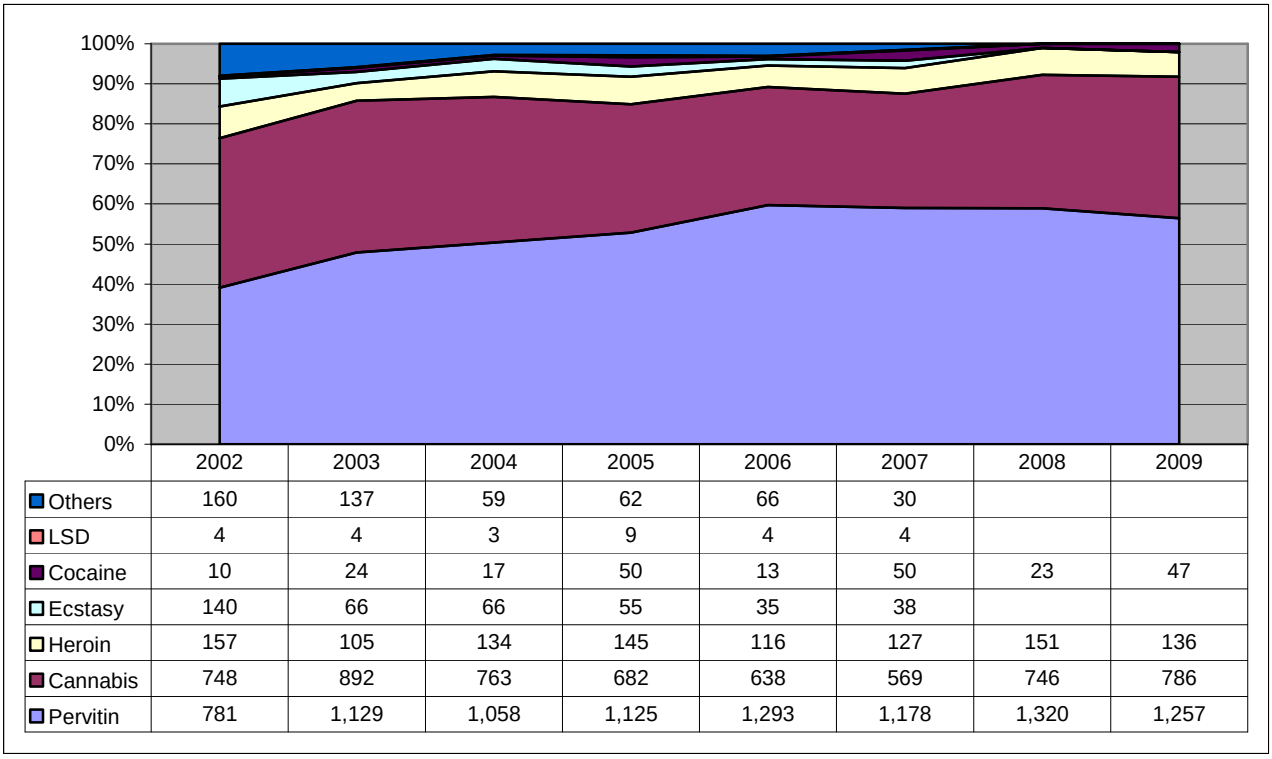
In retrospect, over approximately the past 10 years, an increase can be noted in the total number of persons prosecuted for drug-related offences and in the percentage of persons prosecuted for the possession of drugs (Section 187a), and a decrease can be observed in the number of persons prosecuted for promoting drug use (Section 188a); see Figure 9-1. A consistent long-term development can be observed in the percentage of the individual drug types in the cases of persons prosecuted for drug-related offences and is shown by drug type; see Figure 9-2.

Figure 9-1: Total number of persons prosecuted and the percentage of persons prosecuted under Sections 187a and 188a of the Old Penal Code in the period 1999-2009 (Ministerstvo vnitra ČR, 2010a)



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total number prosecuted	1,753	1,815	1,952	2,204	2,295	2,149	2,209	2,344	2,023	2,296	2,415
Number under Section 187a	98	139	166	178	232	173	184	240	250	278	302
Number under Section 188a	177	186	181	149	110	64	53	49	32	28	17
% under Section 187a	6%	8%	9%	8%	10%	8%	8%	10%	12%	12%	13%
% under Section 188a	10%	10%	9%	7%	5%	3%	2%	2%	2%	1%	1%

Figure 9-2: Long-term development in the percentage of individual drug types for persons arrested for drug-related offences (Národní protidrogová centrála SKPV Policie ČR, 2010c)



	2002	2003	2004	2005	2006	2007	2008	2009
Others	160	137	59	62	66	30		
LSD	4	4	3	9	4	4		
Cocaine	10	24	17	50	13	50	23	47
Ecstasy	140	66	66	55	35	38		
Heroin	157	105	134	145	116	127	151	136
Cannabis	748	892	763	682	638	569	746	786
Pervitin	781	1,129	1,058	1,125	1,293	1,178	1,320	1,257

The number of persons charged with drug-related offences has remained stable in recent years. The statistics of the *Ministry of Justice* reported a total of 2,042-2,332 persons (an average of 2,160) charged with drug-related offences in the past three years (2007-2009). An average of 1,630 persons (75%) were charged under Section 187, approx. 300 (14%) under Section 187a, approx. 200 (10%) under Section 188, and approx. 30 (1%) under Section 188a in the past three years. The trends observed here are similar to those applicable to those prosecuted (see above) – an increase in the number of persons charged under Section 187 (1,526 persons in 2007 and 1,820 persons in 2009) and a decrease in the number of persons charged under Section 188a in the same period (45 persons in 2007 and 11 persons in 2009). The statistics thus show that approximately 90% of the persons arrested for drug-related offences are subsequently charged; the percentages are roughly similar for those arrested, prosecuted, and charged

under the individual drug-related sections of the Penal Code (Ministerstvo spravedlnosti ČR, 2010c). The percentages for drug types in connection with which the persons were charged with drug-related offences has been stable in the past three years; there is, however, a steady increase in the percentage of persons charged in connection with cannabis (16% in 2007 and 28% in 2009) and a slight decrease in the percentage of those charged in connection with pervitin (70% in 2007 and 65% in 2009) (Ministerstvo spravedlnosti ČR, 2010d).

Table 9-5: Number of persons charged, classified by main drug type and drug-related Penal Code section (Ministerstvo spravedlnosti ČR, 2010d; Ministerstvo spravedlnosti ČR, 2010c)

Drug type	Section 187		Section 187a		Section 188		Section 188a		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Cannabis	509	28	116	38	11	6	6	55	642	28
Pervitin	1,192	66	148	48	180	92	2	18	1,522	65
Cocaine	43	2	3	1	0	0	0	0	46	2
Heroin	120	7	41	13	0	0	0	0	161	7
Other drugs	108	6	26	9	0	0	0	0	134	6
Total persons*	**1,820**	**100**	**306**	**100**	**195**	**100**	**11**	**100**	**2,332**	**100**

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

The number of persons sentenced for drug-related offences has remained relatively stable in recent years. The *Ministry of Justice* statistics for the past three years (2007-2009) reported 1,360-1,535 (with the average of 1,426) persons sentenced for drug-related offences. An average of 1,146 persons (80%) were sentenced under Section 187, 167 (12%) under Section 187a, 100 (7%) under Section 188, and 12 (1%) under Section 188a in the past three years. An increase in the percentage and number of persons sentenced under Section 187a can be observed between 2007 and 2009 (138 persons in 2007 compared to 214 in 2009). The statistics therefore show that approximately two-thirds of the persons charged are subsequently sentenced; the proportion is roughly the same for persons charged and those sentenced for the individual drug-related Penal Code sections (Ministerstvo spravedlnosti ČR, 2010a). The percentage of the drug types in connection with which the persons were sentenced for drug-related offences has remained stable in the past three years; the persons were most typically sentenced in connection with pervitin (approx. 47%) followed by cannabis (19%), and heroin (7%) (Ministerstvo spravedlnosti ČR, 2010d).

Table 9-6: Number of persons sentenced, classified by main drug type and drug-related Penal Code section (Ministerstvo spravedlnosti ČR, 2010a; Ministerstvo spravedlnosti ČR, 2010b)

Drug type	Section 187		Section 187a		Section 188		Section 188a		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Cannabis	263	22	56	26	6	5	4	31	329	21
Pervitin	564	48	71	33	77	60	0	0	712	46
Cocaine	25	2	2	1	0	0	0	0	27	2
Heroin	80	7	15	7	0	0	0	0	95	6
Other drugs	155	13	34	16	30	23	8	62	227	15
Total persons*	**1,180**	**100**	**214**	**100**	**128**	**100**	**13**	**100**	**1,535**	**100**

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

9.1.1.1 Sentences for Drug-Related Offences

In the past three years, approximately 1,400 persons were annually reported as having been sentenced for a total of approximately 1,600 drug-related offences. Roughly 30% of the sentences imposed were unsuspended. Suspended sentences accounted for 50%, with other types of sentences accounting for the remaining proportion. The highest number of sentences was imposed in connection with violations of Section 187 and with pervitin. The development in the total number of persons and in the number and percentage of unsuspended and suspended sentences imposed for drug-related offences in 2002-2009 is shown in Figure 9-3.

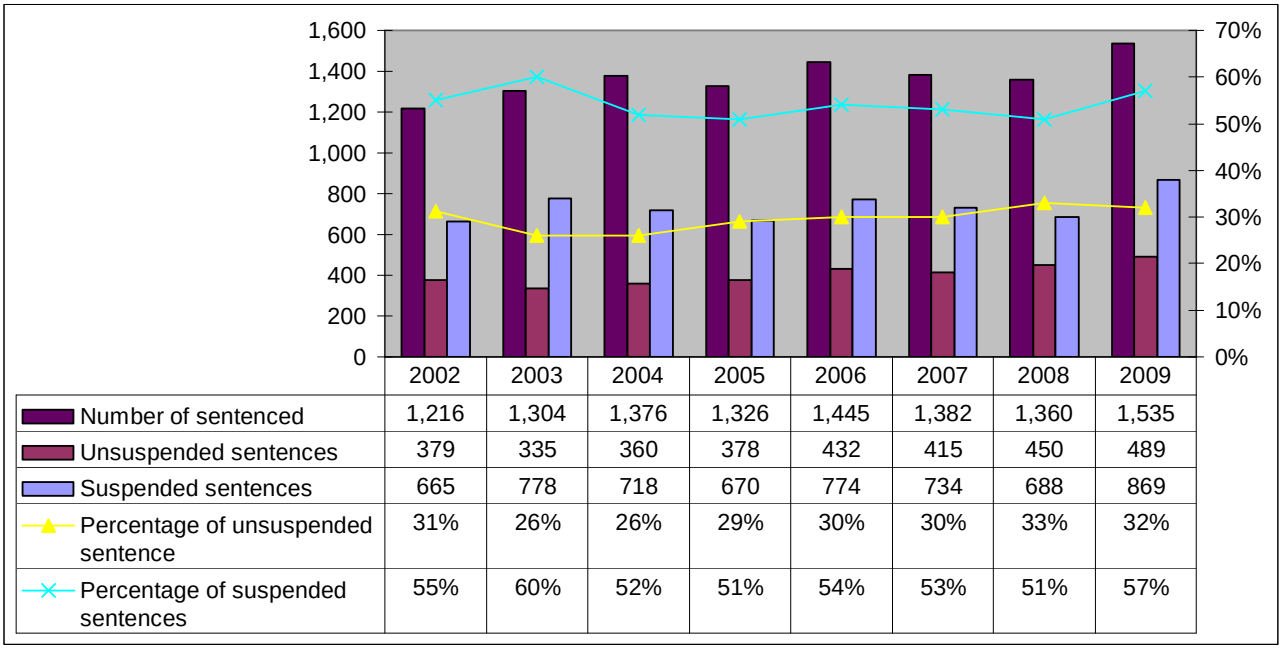
The number and structure of the sentences of persons convicted of drug-related offences in 2009 corresponded with those of the previous years. According to the statistics of the *Ministry of Justice* (Ministerstvo spravedlnosti ČR, 2010b; Ministerstvo spravedlnosti ČR, 2010a), 1,535 persons were sentenced in 2009 for 1,595 drug-related offences (compared to 1,360 persons in 2008 for 1,607 offences and 1,382 persons in 2007 for 1,623 offences). A total of 489 unsuspended sentences (450 sentences in 2008 and 415 sentences in 2007) and 869 suspended sentences (688 sentences in 2008 and 734 sentences in 2007) were imposed. The structure of the sentences in 2009 for Sections 187 and 187a is shown in Table 9-7, by drug type.

Table 9-7: Number of sentences imposed for drug-related offences under specific Penal Code sections in 2009, by selected drug type (Ministerstvo spravedlnosti ČR, 2010b; Ministerstvo spravedlnosti ČR, 2010a)

Sentence type	Total	of which				
		Section 187	Section 187a	Cannabis	Pervitin	Heroin
Unsuspended sentences						
– up to 1 year's imprisonment	75	45	19	5	40	5
– imprisonment for 1-5 years	358	300	31	49	198	43
– imprisonment for 5-15 years	55	52	3	1	14	11
– imprisonment for over 15 years	0	1	0	0	0	0
Total unsuspended sentences	**489**	**398**	**53**	**55**	**252**	**59**
Suspended sentences	**869**	**665**	**127**	**223**	**392**	**33**
Other selected sentences						
community service	87	69	15	35	42	0
penal measure imposed in combination with another sentence*	696	478	150	146	313	57
sentence waived	56	40	11	13	23	2
protective measure**	122	99	12	17	74	13
educational measure***	21	17	2	12	6	1
Total persons sentenced	**1,535**	**1,180**	**214**	**329**	**712**	**95**

*Note: *Includes, e.g., prohibition on undertaking a specific activity, fines, and deportation **Includes, e.g., compulsory treatment *** Includes, e.g., supervision by a probation officer, a probation programme, or warnings.*

Figure 9-3: Development in the number and structure of sentences imposed for drug-related offences in 2002-2009 (Ministerstvo spravedlnosti ČR, 2010a)



	2002	2003	2004	2005	2006	2007	2008	2009
Number of sentenced	1,216	1,304	1,376	1,326	1,445	1,382	1,360	1,535
Unsuspended sentences	379	335	360	378	432	415	450	489
Suspended sentences	665	778	718	670	774	734	688	869
Percentage of unsuspended sentence	31%	26%	26%	29%	30%	30%	33%	32%
Percentage of suspended sentences	55%	60%	52%	51%	54%	53%	51%	57%

9.1.2 Misdemeanours Involving Drug Possession for Personal Use

A total of 970 misdemeanours involving drug possession for personal use were reported in 2006, and 966 misdemeanours were reported in 2007. The incomplete data available for 2008[94] show 450 cases of misdemeanours, in which 473 persons participated. The 2009 data on drug possession for personal use were not available at the time of the drafting of this Report.

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

The amendment[95] to Act No. 200/1990 Coll. on misdemeanours changed the competence for the handling of misdemeanours under Section 30 (1) (j), i.e. the possession of a small quantity of a drug for personal use. Effective from 1 January 2009, the Police of the Czech Republic no longer have that jurisdiction, which instead lies with the municipal authorities of municipalities with extended competences. The provision of Section 30 of the act on misdemeanours falls within the operation of the *Ministry of Health*, which has competence as the higher-instance appeal authority (review of and appeal against the administrative decision) but the data on the misdemeanours handled are provided by the *Ministry of the Interior*. A prescribed form is used to collect aggregate misdemeanour data from municipalities for the entire calendar year. These data are collected by the regional authorities, which consolidate the data and send them to the *Ministry of the Interior* (General Administration Department). The 2009 misdemeanour data according to Section 30 (1) (j) of the act on misdemeanours will be collected retrospectively in cooperation with the *Ministry of the Interior*[96]. For 2010, an extended form will be used to collect misdemeanour data to provide a more detailed picture of misdemeanours concerning Section 30 (j), i.e. the unauthorised possession of a small quantity of drugs for personal use, and Section 30 (k), i.e. the unauthorised cultivation of a small quantity of plants or mushrooms containing narcotic or psychotropic substances for personal use.

9.1.3 Secondary Drug-Related Crime

The *National Drug Headquarters* again collected data to estimate the level of secondary drug-related crime for 2009, using a similar methodology to that applied to estimate secondary crime for 2007 and the first half of 2008 (for details see the 2008 Annual Report). The study was conducted in the form of an expert retrospective estimate by the regional headquarters and territorial departments of the Police of the Czech Republic. This was done for each territorial department for each of the 42 selected[97] criminal offences and the proportion of those committed by drug users for acquiring the wherewithal to purchase drugs for personal use. In the course of the data processing, which was performed by the *National Focal Point*, the estimated percentages were weighed using the actual number of cleared-up criminal offences in the individual districts (Národní protidrogová centrála a Národní monitorovací středisko pro drogy a drogové závislosti, 2010).

The estimated drug-related crime figures are consistent for the years 2007, 2008, and 2009. According to expert estimates, drug users account for 71-74 thousand offences per year. They most typically involve vehicle burglaries, two-thirds of which are attributed to drug users, reaching a total figure of 30 thousand such offences a year. The ten offences most typically committed with the involvement of drug users are shown in Table 9-8.

In the years 2007-2009, a total of 333-357 thousand criminal offences were reported annually in the Czech Republic. Assuming that approximately 345 thousand offences are reported per year and that drug users commit approximately 73 thousand specific offences yearly on average, the involvement of drug users in general crime can be estimated as approximately 21%. This means that a drug user is involved in one in five criminal offences reported.

[95] The amendment was made by Act No. 274/2008 Coll. amending certain acts in connection with the adoption of the Act on the Police of the Czech Republic.

[96] The results of the retrospective collection of the data on misdemeanours involving the possession of drugs for personal use in 2009 should be made available by the *Ministry of the Interior* in the autumn of 2010.

[97] They especially included crimes against property (e.g. theft, fraud), crime with violence (e.g. robbery, bodily harm, arbitrary interference with the home) and others (neglect of compulsory maintenance, extortion, etc.), according to a detailed list from the Criminal Statistics Record System. The selection also included the criminal offences of illicit drug production and trafficking under Section 187 of the Penal Code.

Table 9-8: Estimated proportion and number of selected (reported) offences committed by drug users in 2007-2009, by type of offence (Národní protidrogová centrála a Národní monitorovací středisko pro drogy a drogové závislosti, 2010)

Type of criminal offence	Proportion 2007–2008* (%)	Number in 2007	Number in 2008	Proportion in 2009 (%)	Number in 2009
Vehicle burglary	62.7	32,301	30,993	68.5	31,888
Theft - pickpocketing	34.2	6,560	6,229	33.8	6,289
Other types of burglary	19.4	6,066	5,711	19.9	5,924
Theft on other premises	13.6	3,496	3,351	16.7	3,850
Vehicle theft	21.9	4,271	3,944	24.7	3,452
Theft of bicycles	31.0	1,672	1,629	37.9	2,427
Unauthorised possession of a credit card	27.4	2,220	2,148	29.9	2,420
Other theft committed against persons	17.0	1,524	1,633	22.1	2,143
Illicit drug production and trafficking	70.7	1,567	1,671	81.1	1,980
Other types of theft	19.5	2,340	1,983	14.6	1,076
Other	17.7	12,148	12,157	12.8	12,660
Total offences committed by drug users	**29.4**	**74,143**	**71,451**	**31.4**	**74,109**
Total selected offences reported	**100.0**	**252,547**	**242,852**	**100.0**	**236,116**

*Note: * The study covered a period of 1.5 years from the beginning of 2007 to the end of the first half of 2008. The calculated percentage of involvement of drug users in the selected offences was applied to the total number of those offences in 2007 and 2008.*

The *Criminal Statistics Record System* also processed the 2009 data on offences committed under the influence of alcohol and non-alcohol drugs (Policejní prezidium České republiky, 2010). According to the *Criminal Statistics Record System* data processed for the individual districts, 125 thousand criminal offences were cleared up in the Czech Republic in 2009. 22.2 thousand of them were committed under the influence of alcohol, represented most frequently by the criminal offence of endangerment under the influence of addictive substances, inebriation (11.4 thousand), road traffic accidents caused by negligence (3.9 thousand), voluntary bodily harm, disorderly conduct, damage to property, and assault. A total of 2.3 thousand offences were reported as having been committed under the influence of non-alcohol substances and again most frequently involved endangerment under the influence of addictive substances (1,000) and various types of thefts or burglaries (311), and the unauthorised production of narcotic and psychotropic substances according to Section 187 of the Old Penal Code. Most offences perpetrated by drug users were committed under the influence of pervitin or other amphetamines (1,201) followed by cannabis (272), synthetic drugs (162), and heroin or other opiates (92). When roughly related to the total number of criminal offences reported (345 thousand per year), the number of offences committed yearly under the influence of alcohol can be estimated as approx. 62 thousand and the number of those committed under the influence of non-alcohol drugs as approx. 7 thousand, i.e. approx. 10% of the estimated drug-related offences committed by drug users (see above) and 2% of all the offences reported in the Czech Republic.

A research effort aimed at secondary drug-related crime was completed in 2010. A total of 66 drug users in contact or in treatment (42 men and 24 women, with an average age of 28) participated in the questionnaire survey. Forty-six respondents (70%) had previously committed at least three offences, consisting most frequently of theft (83% of all the offences committed), especially shoplifting (44% of all the thefts), vehicle burglary (24%), or other burglary (11%). There were no instances of rape or murder committed by drug users. 70% of the respondents committed at least one theft; 20% of them possessed a credit card without authorisation, committed a burglary, damaged property, or committed credit fraud. In the clients who reported having committed at least 3 criminal offences (46), crime aspects were investigated in relation to the preference for the drugs used and depending on the acute effect of the drug: the self-reports showed that 17% of these respondents had always, 26% often, 48% sometimes, and 5% never committed an offence under the influence of a drug. Opiate users had committed only financially motivated offences consisting almost exclusively of theft, 66% of the cases of which had been motivated by the immediate need for funds to purchase the drug, followed by offences instigated by a convenient opportunity (18%). Most heroin users (54%) had stolen with deliberation ("Heroin could really calm me down but when I tried pervitin once or twice I was freaked out."). Pervitin users showed a wider range of criminal offences, and offences of violence were more common – burglaries had been committed by nine out of 27 pervitin users, compared to only one out of 13 heroin users. The offence of bodily harm had been committed by six persons using pervitin as their drug of choice and yet by not a single opiate user. Most pervitin users (56%) stole on the basis of a momentary impulse ("Meth users just steal anything they find. At one point we kept stealing plants in flowerpots from corridors in houses. There was no rational reason. We eventually had no room to put them on our balcony."), and their theft is most typically motivated by an immediate need (38%), followed by a convenient opportunity (32%). The study shows that the length of the drug career is not directly related to the frequency of commission of offences. Instead, other effects on committing criminal offences are discussed in this context, such as the personality of the drug user and their social environment (Škuba, 2010).

9.1.4 Clients of the Probation and Mediation Service

Data are available for 2009 about the clients of the *Probation and Mediation Service of the Czech Republic (PMS)* who are drug users. In 2009, the *PMS* recorded a total of 25,851 new clients (25,465 in 2008), 531 (2.1%) of whom were the perpetrators of drug-related criminal offences. According to the *PMS*, "drug-related crime" includes both offences committed under Sections 187, 187a, 188, and 188a of the Old Penal Code (i.e. primary drug-related crime) and property crimes committed for the purpose of acquiring the wherewithal for purchasing drugs (i.e. secondary drug-related crime). The percentage of all the new cases[98] associated with drug-related crime in all the cases of the *Probation and Mediation Service* was between 2.1 and 3.5% per year in the period 2006-2009 (Probační a mediační služba ČR, 2010); see Table 9-9.

Table 9-9: Persons registered by the Probation and Mediation Service (PMS) in connection with drug-related crime in 2006-2009 (Probační a mediační služba ČR, 2010)

Cases registered by PMS	**2006**		**2007**		**2008**		**2009**	
	Number	%	Number	%	Number	%	Number	%
All cases	24,885	100.0	27,648	100.0	25,465	100.0	25,851	100.0
– primary drug-related crime	712	2.9	692	2.5	659	2.6	531	2.1
– offences under Section 187 of the Old Penal Code	506	2.0	566	2.0	501	1.9	475	1.8
– offences under Section 247 of the Old Penal Code*	86	0.3	101	0.4	75	0.3	101	0.4
– other**	69	0.3	138	0.5	134	0.5	n.a.	n.a.

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

Thirty-eight members of the *PMS* staff were approached as part of the *Substance Users in the Care of the PMS* study, which was conducted at the turn of 2010. One of the outcomes is an expert estimate that approx. 14% of the new cases of the *Probation and Mediation Service* in 2009, i.e. an estimated 3,600 persons, were associated with drug-related crime[99]. These persons' drugs of choice mostly included marijuana, pervitin, heroin, and illegally obtained Subutex®. One in five clients of this target group was under the age of 18. By contrast, the official 2009 statistics of the *PMS* only reported 531 cases of drug-related crime. Interviews with six members of the *PMS* staff revealed that the underestimation of the data in this area may be, among other factors, due to the absence of a standardised tool for diagnosing drug users and due to the voluntary nature of reporting the circumstances of drug-related crime in the record system of the *Probation and Mediation Service*. The most frequent problems encountered by the *PMS* staff when working with these clients include the diagnosis of acute intoxication and the absence of the skills needed to motivate these clients towards a change in their habit – the levels of addiction-related knowledge and skills among the *PMS* staff are likely to show significant differences. The analysis of the interviews with 12 drug users who were contacted in low-threshold and aftercare programmes and were/had been in contact with the *PMS* showed that they were predominantly satisfied with the approach and style of work of the probation workers, who were seen as open, supportive, and tolerant. However, experience was also reported with an unreasonably strict and rigid approach on the part of the *PMS* staff. None of the respondents reported any intense cooperation between the *Probation and Mediation Service* and addiction services. The outcomes of the study will be used to initiate expert discussion in order to improve the addictological care for the clients of the *PMS*. Recommendations will also be made to conduct a nationwide survey to identify the actual prevalence of drug crime among the *PMS* clients, introduce a standardised tool for drug user assessment, review the collection and reporting of data in this area, and, finally, propose a structure for the systematic addictological training of the *PMS* staff (Gabrhelíková, 2010).

9.2 Prevention of Drug-Related Crime

In the Czech Republic, crime prevention is within the competence of the Ministry of the Interior, which addresses the issue without distinguishing the prevention of drug-related crime from other types of crime. The information, including the *2008-2011 Crime Prevention Strategy*, is concentrated on the website of the Ministry of the Interior[100]. This Strategy mainly focuses on reducing crimes against property and violent crime and eliminating socially negative phenomena involving criminal risk. The target groups of the Strategy also include persons addicted to alcohol and other substances. The issue of crime prevention also falls within the competence of the *Ministry of Education*, which is in charge of the prevention of risk behaviour among children and young people; for details see the chapter on Prevention (page 36).

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

[99] They included cases associated with primary drug-related crime (i.e. the violation of the drug-related Penal Code sections), secondary drug-related crime (i.e. mainly the commission of offences to acquire the wherewithal for purchasing drugs), and offences committed under the influence of non-alcoholic drugs.

[100] See http://www.mvcr.cz/clanek/programy-prevence-kriminality.aspx.

The specific activities within the framework of the prevention of drug-related crime in 2009 were mainly conducted by the *National Drug Headquarters*. A project named *I Do Not Support Drug Production* was carried out by the *National Drug Headquarters* in cooperation with the Czech Chamber of Pharmacists, with pharmacists and the operators and owners of pharmacies being called upon not to sell larger quantities of medicinal products to persons reasonably suspected of participating in pervitin production. The *National Drug Headquarters* also launched the *STOP Indoor Cannabis Plantations* project, under which it sent a letter of advice to the citizens of the Cheb area, which shows the highest number of illegal large-scale plantations, asking the local residents to cooperate with the police in detecting such growing sites. A similar request was also sent to the town halls of municipalities with extended competences; the results of this project will be available in 2010. In connection with the detection of illegal large-scale plantations of cannabis, the *National Drug Headquarters* also worked together with the representatives of power distribution companies, which can be the first ones to detect suspicious facts such as abnormally high power consumption by a single distribution point or significant losses on the grid in a particular location (Národní protidrogová centrála SKPV Policie ČR, 2010a).

9.3 Interventions in the Criminal Justice System

Compulsory treatment and security detention are so-called "protective measures", which, like sentences, represent penalties under criminal law. Unlike sentences, however, their purpose is to protect society using exclusively the means of special prevention. They therefore do not express condemnation of the offender and of the offence and are not dependent on the degree of the offender's guilt, which means that they can also be imposed upon persons who are not criminally liable (Novotný et al. 2007). Compulsory treatment[101] is imposed in institutional or outpatient form, depending on the nature of the illness and treatment options. Institutional compulsory treatment is performed in healthcare facilities or in prisons if it is imposed in addition to a sentence of imprisonment and if it can be provided in the prison in question. Institutional or outpatient compulsory treatment was imposed by courts on 123 persons in 2009; 68 of the cases involved the outpatient form and 55 the institutional form. Out of the total number of 123 compulsory treatment sentences, 49 concerned offenders sentenced for drug-related offences, 39 of whom had violated Section 187 (production and trafficking of drugs) of Act No. 140/1961 Coll., the (old) Penal Code; another 47 persons were ordered to undergo compulsory treatment for violating Section 247 of the (old) Penal Code (theft). The number of compulsory treatment sentences has remained stable in the long term (Ministerstvo spravedlnosti ČR, 2010a); see Table 9-10.

Table 9-10: Number of persons ordered to undergo outpatient or institutional compulsory drug/alcohol treatment in the period 2004-2009 (Ministerstvo spravedlnosti ČR, 2010a).

Compulsory treatment type	2004	2005	2006	2007	2008	2009
Drug use	161	141	164	139	162	123
Alcohol use	190	193	220	232	217	195
Total	**351**	**334**	**384**	**371**	**379**	**318**

Security detention takes place in a dedicated institution under high security and in connection with therapeutic, psychological, educational, teaching, rehabilitation, and work programmes. It is a precondition for the imposition of security detention that compulsory treatment, which would otherwise be imposed in the given case, cannot be expected to protect the public sufficiently because of the nature of the mental disorder and the potential effect on the offender (who is not willing or able to undergo therapy under compulsory treatment).

Act No. 40/2009 Coll., the (new) Penal Code, which came into force on 1 January 2010, brings one rather significant change compared to the previous Code as far as substance users are concerned. According to the new Penal Code, courts may impose security detention upon an offender in consideration of the offender's history and circumstances, even when an offender who is a substance user has again committed a particularly serious offence (i.e. a premeditated offence punishable by imprisonment for up to 10 or more years) and has been previously been sentenced to unsuspended imprisonment for at least 2 years for a particularly serious offence committed under the influence or in connection with the abuse of an addictive substance. The prerequisite is that sufficient protection of the public cannot be achieved by compulsory treatment, with consideration also being given to the previously demonstrated attitude of the offender to compulsory treatment. As far as compulsory treatment is concerned, it still applies that the court may also impose this sanction on offenders who abuse addictive substances and have committed an offence under the influence or in connection with the abuse of such a substance (Section 99 (2) (b) of the new Penal Code). However, compulsory treatment is not imposed if it is apparent with regard to the offender that the purpose of compulsory treatment cannot be achieved (i.e. that compulsory treatment for the given period of time would probably be ineffective).

In addition to compulsory treatment, other options were also used in 2009 in the case of drug users within the framework of diversion or alternative sentences. This mostly involves the imposition of a reasonable obligation to undergo treatment. For example, this applied to decisions on suspended imprisonment with supervision (Section 60a of the old Penal Code) or to cases of release on parole with supervision (Section 63 of the old Penal Code).

[101] The instrument of compulsory treatment and its exercise was described in more detail in the 2008 Annual Report. The situation remained unchanged in 2009.

The key factor in these cases is a personal motivation to undergo treatment, which significantly affects the decision of the court or (in the course of preliminary proceedings) of the public prosecutor. Although this is not compulsory treatment, the failure to fulfil the obligation to undergo treatment or abstain from substance use may affect the decision of the court on meeting the conditions of the probationary period of a suspended sentence or release on parole. However, unlike in the case of compulsory treatment, the offender cannot face prosecution for obstructing justice.

9.4 Drug Use and Problem Drug Use in Prisons

There were 36 prisons and remand prisons in the Czech Republic in 2009. As of the end of 2009, the *Prison Service of the Czech Republic* reported a total of 21,734 prisoners (18,901 in 2007 and 20,502 in 2008), with 19,374 persons serving prison sentences and 2,360 awaiting trial in custody. On the above date, 1,007 of the persons who had been sentenced were women; most prisoners (21%) were serving prison sentences of 1-2 years; the most common age group among the persons sentenced (36%) was 30-40, and most persons were serving their sentence in medium-security prisons (51%). In relative terms, the prison population rate was 204 persons per 100 thousand inhabitants in the Czech Republic in 2009. By way of illustration, the figure was 753 in the USA, 610 in Russia, and 63 in Japan (Generální ředitelství Vězeňské služby ČR, 2010a). The prison population rate in the EU is 70-100 persons per 100 thousand inhabitants (Valeš, 2009).

As of the end of 2009, a total of 3,899 drug-related offences under Sections 187-188a of the old Penal Code were reported for those in prison, which exceeds the 2008 figure by 135%; see Table 9-11. However, the total number of prisoners could be lower because a single person may have been sentenced for committing multiple drug-related offences.

Table 9-11: Number of drug-related offences under Sections 187-188a of the old Penal Code recorded for prisoners at the end of 2007, 2008, and 2009 (Generální ředitelství Vězeňské služby ČR, 2010a)

Drug-related offences	31 Dec 2007	31 Dec 2008	31 Dec 2009
Section 187	1,314	1,257	3,073
Section 187a	101	127	323
Section 188	144	185	365
Section 188a	69	93	138
Total	**1,628**	**1,662**	**3,899**

As in the previous years, there are no results available in 2009 from any representative (cross-section) studies conducted among prisoners which could be used as the basis for the qualified determination of drug use among this population. The level of drug use in Czech prisons in 2009 can only be generally estimated on the basis of information from the *General Directorate of the Prison Service of the Czech Republic*. These data concern the data of the examinations of the prisoners and treatment measures provided to them, urine toxicology screening tests of those sentenced, and drug seizures in prisons using drug-sniffing dogs (Generální ředitelství Vězeňské služby ČR, 2010b).

As part of the medical and preventive care of inmates awaiting trial or serving a prison sentence, the staff of the Health Service Department conducted examinations or treatment interventions in 316,663 cases in 2009; in this context, 9,802 persons dependent on addictive substances (including alcohol) were reported (compared to 9,390 persons in 2008).

A total of 1,286 urine toxicological screening tests were conducted in 26 prisons (in drug-free zones and treatment departments, respectively) in 2009, with 28 of the tests being confirmed by the laboratory as positive. The detailed results of the toxicological screening are provided below.

Scheduled and random drug searches using trained drug-sniffing dogs were performed in all 36 prisons. They involved searches of the living quarters, common areas, and workplaces, and checks on correspondence, including packages etc. The dogs indicated 150 seizures (cf. 115 in 2008). In most instances (65), it was a case of “positive indication without a find” (i.e. the dog reliably indicated the spot but a physical search was not able to reveal any drugs); marijuana was found in 24 cases, amphetamine or ecstasy in 22 cases, pervitin in 17 cases, and an unknown substance or syringe in 18 cases.

9.5 Responses to Drug-related Health Issues in Prisons

Information about counselling and therapeutic interventions for drug users in prisons is provided by the *General Directorate of the Prison Service* on an annual basis. In November 2007 it adopted the Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2007-2009 which was also the key document in this context in 2009. This plan, which is compatible with the Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2007-2009, focuses on the following seven key areas: (1) primary prevention; (2) treatment and aftercare; (3) harm reduction; (4) supply reduction and law enforcement; (5) information, research, and evaluation; (6) coordination and funding, and (7) international cooperation. In addition to the *National Drug Policy Strategy for the Period 2010-2018* (for details see the chapter on National Action Plan and Strategy on page 11), the

implementation of drug policy measures in the Prison Service of the Czech Republic is regulated by strategic documents, which are mainly represented by the Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2007-2009[102] and the Czech Prison Service Development Policy until 2015, which was drawn up in 2005.[103] (Generální ředitelství Vězeňské služby ČR, 2010b).

9.5.1 Drug Prevention Counselling Centres

Drug prevention counselling centres exist in all prisons and provide drug users with services such as motivational interviews, individual counselling, educational activities, and both group and individual therapy. The objective of these activities is to minimise the medical and social risks arising from drug use and motivate drug users to undergo treatment while serving their prison sentence. 5,504 inmates used these services in 2009 (6,892 in 2008) (Generální ředitelství Vězeňské služby ČR, 2010b).

9.5.2 Detoxification

Detailed data on detoxification for drug users are available for 2009. It was conducted either in outpatient form in the health centre of the relevant prison, utilising mostly psychiatric medication and letting the inmates remain in their cells, or (in the more serious cases and on the basis of a physician's decision), the persons were admitted to specialised departments (e.g. the Psychiatric Department of the Brno Remand Prison). Depending on the indication, mainly opioids (e.g. buprenorphine), benzodiazepines, or neuroleptics are used in detoxification pharmacotherapy. The detoxification period is between 5 and 10 days. Detoxification was performed in four prisons in 2009 (the Prague-Pankrác, Prague-Ruzyně, Brno, and Ostrava prisons). A total of 219 persons underwent detoxification (208 persons in 2008), 196 of whom were men, 200 injecting drug users, 155 opiate users, 56 pervitin users, and five benzodiazepine users (Generální ředitelství Vězeňské služby ČR, 2010b).

9.5.3 Drug-free Zones

The purpose of drug-free zones is to restrict the contact of persons serving their prison sentence with drugs and lead them to abstinence and a healthy lifestyle, both during and after imprisonment. Inmates are accepted in drug-free zones on the basis of a decision of the relevant attending physician or at their own request, reviewed by a committee of prison service professionals. Prisoners may be disqualified from the drug-free zone on the grounds of violating the set rules and monitoring measures (which include, for example, more frequent urine testing for drugs). On the contrary, adherence to the rules brings certain advantages to the prisoners. The structure of the individual drug-free zones follows the criteria of gender, age, and drug problem type. Similarly to 2008, a total of 33 prisons operated drug-free zones in 2009, ten of which were intended for inmates who were not drug users and three for former drug users, and 20 drug-free zones used a combined approach, i.e. served individuals with various drug problems; see Table 9-12. A total of 920 toxicological screening tests were conducted in all the drug-free zones in 2009, with 21 of the tests being confirmed by the laboratory as positive for pervitin (13), benzodiazepines (5), THC (3), morphine (2), and other drugs (3) (Generální ředitelství Vězeňské služby ČR, 2010b).

9.5.4 Specialised Treatment Departments

Similarly to the previous years, there were two types of specialised departments dealing with drug users in operation in prisons in 2009. The first type includes departments for prisoners with personality and behavioural disorders caused by drug use; the treatment is voluntary and the prisoners enter the therapy at their own request, which is assessed by a committee of prison service professionals. These departments were operated in seven prisons in 2009[104], were all intended only for men, and offered a total capacity of 294 places; see Table 9-12. Prison sentences were served in these departments by 507 men in 2009, with 283 individuals completing the treatment. A total of 245 toxicological screening tests were conducted in the above-mentioned seven prisons in 2009, with five of the tests being confirmed by the laboratory as positive for pervitin (3) and benzodiazepines (2).

The other specialised department type is used for serving court-ordered compulsory treatment sentences. They can be found in the Opava, Rýnovice, and Znojmo prisons. They employ group therapy-based regime activities with the features of a therapeutic community. The treatment programme is designed for 6-12 months, but the length of the stay is determined on an individual basis. The total capacity of these departments in 2009 was 120 places and treatment was received by 117 persons (87 of whom successfully completed the treatment; see Table 9-12. 121 toxicological screening tests were performed in the three prisons mentioned above in 2009, with two tests being confirmed by the laboratory as positive for pervitin (Generální ředitelství Vězeňské služby ČR, 2010b).

[102] The validity of this fundamental drug policy document for the Prison Service of the Czech Republic has been extended until 2010.
[103] Other rules applicable to the drug policy of the Prison Service of the Czech Republic are included in the internal regulations governing the rules, organisation, record-keeping, and forms and methods of addressing various stages of addiction at departments specifically dedicated to the relevant type of dealing with the users of addictive substances.
[104] Bělušice, Nové Sedlo, Ostrov, Pilsen, Příbram, Všehrdy, Valdice.

Table 9-12: Number, capacity, and use of drug-free zones and specialised departments in Czech prisons in 2006-2009 (Generální ředitelství Vězeňské služby ČR, 2010b)

Year	Drug-free zones			Voluntary treatment department			Departments for court-ordered treatment		
	Number of departments/ prisons	Capacity	Persons	Number of departments/ prisons	Capacity	Persons	Number of departments/ prisons	Capacity	Persons
2006	31	1,665	3,201	6	286	625	3	105	162
2007	35	1,877	3,524	6	258	419	3	114	200
2008	33	1,998	3,646	6	262	422	3	120	206
2009	33	2,057	4,224	7	294	507	3	120	117

9.5.5 Substitution Therapy

Substitution therapy was available in 2009 in nine out of the ten prisons planned for substitution therapy (compared to seven out of ten in 2008). The substitution therapy was provided by seven psychiatrists, nine other professional physicians, and 18 nurses. The substance administered was methadone, which is fully covered by the Ministry of Health of the Czech Republic. Individuals awaiting trial or serving a prison sentence may be included in substitution therapy at their own request (accompanied by a confirmation of the health facility in which the person underwent therapy prior to being admitted to the prison) or on the basis of a recommendation from the attending physician who performed the initial medical examination of the inmate upon admission. A total of 67 persons underwent substitution therapy in 2009 (76 in 2008), one of whom was disqualified on the grounds of breaching the therapy agreement; see Table 9-13.

Table 9-13: Prisons in which substitution therapy was planned, and the number of persons in treatment in 2009 (Generální ředitelství Vězeňské služby ČR, 2010b)

Prison	Programme implemented	Number of persons
Brno	Yes	9
Břeclav	No	0
Kuřim	Yes	7
Litoměřice	Yes	10
Opava	Yes	3
Ostrava	Yes	1
Prague-Pankrác	Yes	16
Prague-Ruzyně	Yes	1
Příbram	Yes	14
Rýnovice	Yes	6
Total	**–**	**67**

9.5.6 Prevention, Treatment, and Care of Infectious Diseases

At the end of 2009, the *Health Service Department of the General Directorate of the Prison Service* had registered 1,376 persons with chronic hepatitis type B, 1,133 (82%) of whom were drug users; five inmates had received virostatic treatment with interferon as of the same date. There were also 3,123 persons with hepatitis type C, 2,730 (87%) of whom were drug users. A total of 68 persons with HCV had received virostatic treatment with interferon as of the end of 2009. A total of 15 HIV positive inmates were reported in prisons as of the same date[105], seven of whom had undergone antiretroviral therapy. However, the number of HIV positive inmates with a history of drug use was not known (Generální ředitelství Vězeňské služby ČR, 2010c).

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

Care for imprisoned drug users was complemented by the services provided by 15 non-governmental non-profit organisations (NGOs) in 2009. Six of them, together with the *A.N.O. Legal Aid Centre* project, are members of the *A.N.O. (Association of Non-Governmental Organisations) Section for Drug Services in Prison*. These six NGOs provided mainly individual and group counselling and therapy in 19 Czech prisons and remand centres in 2009 (see Table 9-14), with all the programmes paying particular attention to the pre-release stage in order to prepare the clients for their release from prison and link the clients with other outpatient and residential treatment services. The staff of these six programmes conducted over 700 visits to 19 prisons and provided services to 920 persons (with one-third consisting of persons awaiting trial and two-thirds of those serving their prison sentences). Sixty-four

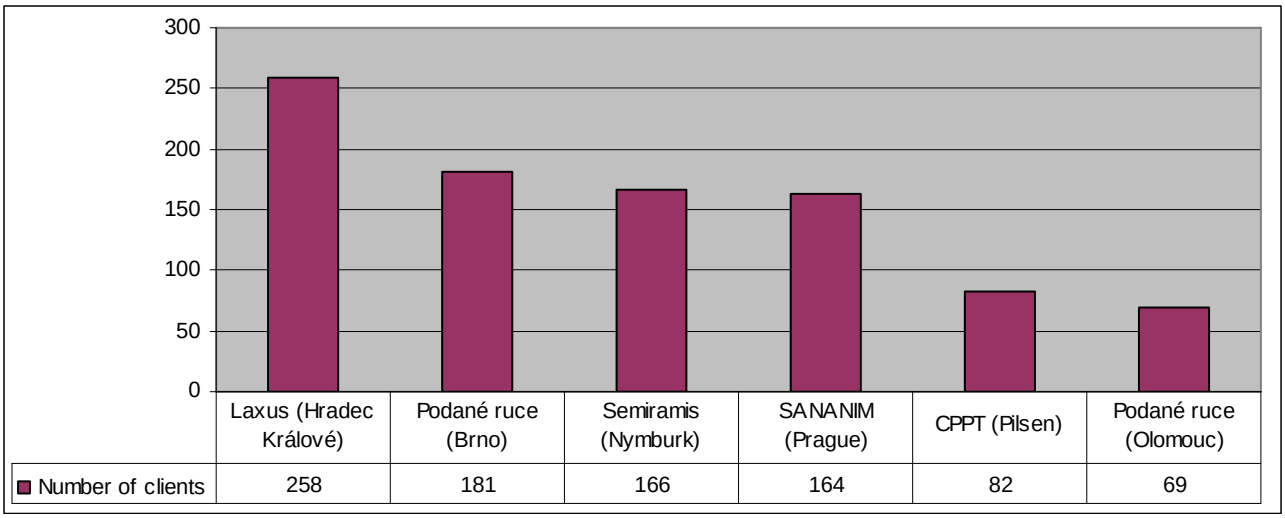
[105] For the entire year 2009, the Prison Service reported 27 HIV positive people (Generální ředitelství Vězeňské služby ČR, 2010a).

inmates participated in group therapy and 925 individuals attended debates and meetings; see Figure 9-4 (Generální ředitelství Vězeňské služby ČR, 2010b; Ženíšková, 2010).

Table 9-14: Drug service providers associated in the A.N.O. Section for Drug Services in Prison, and prisons and remand centres in which their services were provided in 2009 (Generální ředitelství Vězeňské služby ČR, 2010b)

A.N.O. *Section for Drug Services in Prison*	**Prisons and remand centres**
SANANIM (Prague)	Prague-Pankrác, Prague-Ruzyně, Vinařice
Semiramis (Nymburk)	Jiřice, Rýnovice, Stráž pod Ralskem
Podané ruce (Brno)	Brno, Kuřim, Opava, Znojmo, Rapotice
Podané ruce (Olomouc)	Olomouc, Mírov
Laxus (Hradec Králové)	Hradec Králové (including the separate department of Hradec Králové – Pouchov), Pardubice, Světlá nad Sázavou, Valdice, Odolov
CPPT (Pilsen)	Pilsen

Figure 9-4: Number of persons receiving the services provided by the A.N.O. Section for Drug Services in Prison in 2009, as reported by the organisations (Ženíšková, 2010)



Other NGOs also offered various types of drug services. Their provision, however, was mostly irregular and non-systematic. It mostly concerned speeches and discussions about drugs and the introduction of the services provided by the organisations which the prisoners can use after they are released. These NGOs included the *White Light I*. civic association, which operated in the Litoměřice, Nové Sedlo, Teplice, and Všehrdy prisons; the *Renarkon* public service organisation (Heřmanice and Ostrava); the Halfway House – Aftercare Centre of the *Renarkon* public service organisation (Karviná and Heřmanice); the *Rodiče* civic association (Příbram); the *Magdaléna* public service organisation (Příbram); *K-Centrum Karlovy Vary* of the *Světlo Kadaň* civic association (Horní Slavkov); *Teen Challenge Pilsen* (Drahonice); the Aftercare Programme of the *CPPT* public service organisation of Pilsen (Ostrov), and *Archdiocesan Charity Prague* (Příbram). These NGOs operated in a total of 11 Czech prisons, to which the NGO staff made 45 visits. 60 inmates participated in the individual interviews and 125 inmates attended the group activities. There are no NGOs focused on drug services for prisoners operating in six prisons (Bělušice, Břeclav, České Budějovice, Kynšperk nad Ohří, Liberec, and Oráčov) (Generální ředitelství Vězeňské služby ČR, 2010b).

9.5.8 Reintegration of Drug Users after Release from Prison

Overdose prevention programmes are only pursued in the form of providing information to the person concerned on their release from prison. Post-penitentiary care and the reintegration of drug users released from prison are a part of the services provided in the prisons by non-governmental organisations; see above. Only one programme, i.e. that provided by the *Podané ruce* civic association of Brno, was directly concerned with post-release care or rather focused on the target group of persons released from prison in 2009. According to the 2009 annual report of A.N.O., 114 persons used outpatient care immediately after their release. The problems in post-penitentiary care continue to be the lack of services for drug users released from prison, especially in North and West Bohemia, and the generally insufficient cooperation between drug and non-drug social services (Ženíšková, 2010).

10 Drug Markets

Marijuana is the most widely available drug in the Czech Republic. Cannabis is often grown in artificial conditions, which results in a higher THC content. The yearly number of marijuana seizures in the four previous years (2005-2008) was between 550 and 600. In 2009, however, a lower number of seizures was reported (384). A total of 172 kg of marijuana were seized in 2009. In addition, 33,427 cannabis plants were seized in 117 seizures, the highest number since 2006. The number of cannabis plantations detected is also growing (84 plantations in 2009). The number of hashish seizures and the volume of the drug seized were relatively stable in 2006-2009, reaching 30-40 seizures per year.

With 326 seizures in 2009, pervitin is the second most commonly seized drug. Approximately 300-400 seizures annually were reported in the last four years. A total of 3.6 kg of pervitin were seized in 2009, with amounts under 50 g accounting for 96% of the seizures. The number of cooking labs detected was the lowest in the past three years (342 in 2009). Effective from May 2009, the State Institute for Drug Control restricted the dispensation of medicines containing pseudoephedrine in pharmacies as these medicines are used as the main precursors of pervitin. This resulted in a decrease in the sales of these medicines in the Czech Republic. However, an increase in illegal imports of these medicines from Poland was reported.

Cocaine has become an established stimulant, mainly in the recreational and nightlife settings. Twenty-six seizures of a total of 12.9 kg of cocaine were reported, the second-highest volume seized in the past four years. Batches of dozens or hundreds of ecstasy tablets are imported mainly from the Netherlands, Poland, and Slovakia. The number of seizures and the quantity of the ecstasy seized in 2009 were the lowest in the past four years. The percentage of tablets containing mCPP, which is not a controlled drug in the Czech Republic, by far exceeds that of tablets containing MDMA. The number of heroin seizures and the quantity of the heroin seized remain relatively stable, reaching approximately 100 seizures of 20-40 kg annually.

Even though the prices of most basic drugs remained stable in 2009, a slight increase in the average and most common prices of marijuana can be observed at the retail level. In order to understand the development of drug purity/potency and of the related prices, it is advisable to distinguish between the wholesale and the retail levels of the drug market. Pervitin is almost exclusively sold at the retail level and in quantities of under 50 g. Its purity and price have been 70% and CZK 1,000 (€ 38) per gram, respectively, in the past three years. The differences in the purity (15-35%) and price (CZK 1,500-2,500) (€ 57-95) of cocaine between wholesale and street sale are minimal and the drug is probably cut before entering the territory of the Czech Republic. Heroin enters the Czech Republic via the so-called Balkan Route with a purity of 90%, which is, however, often reduced by further cutting. Retail-level heroin thus has a purity of 10-15% and is sold at CZK 1,000-1,400 (€ 38-53) per gram, while at the wholesale level the average purity is 20-30% and the price of 1 kg of heroin with a purity of 30% is estimated to be between CZK 200,000 (€ 7,563) and 800,000 (€ 30,251) .

An increase in the level of interest in the stimulant mephedrone was observed in 2009, especially on the dance scene. The increased demand for new stimulants can be partially explained by the changes on the drug market across Europe (e.g. with regard to the shortage of ecstasy tablets containing MDMA) and the fact that a number of them are not controlled (or banned) in many countries. This is also the case of the Czech Republic, where the handling of mephedrone and other (new) synthetic drugs can be prosecuted in the relevant cases as the offence of promoting drug use according to Section 188a of the old Penal Code or Section 287 of the new Penal Code, respectively. It cannot, however, be prosecuted as the offence of the production and trafficking of drugs.

According to the estimates of the drug market, almost 19 tonnes of cannabis, 4.7 million tablets of ecstasy, and 1 million doses of LSD were consumed in the Czech Republic in 2008. 550 kg of cocaine with a purity of 70% were imported and 1 tonne of cocaine with a purity of 45% was consumed. 4.2 tonnes of pervitin were produced and 4.4 tonnes of pervitin with a purity of 70-80% were consumed. 330 kg of heroin with a purity of 40% were imported and 1.3 tonnes of the drug with a purity of 10% were consumed.

10.1 Availability and Supply

Information provided by the *National Drug Headquarters of the Police of the Czech Republic* and the *General Customs Headquarters* represents the basic data regarding the availability, production, smuggling, and distribution of drugs on the territory of the Czech Republic (Národní protidrogová centrála SKPV Policie ČR, 2010b; Národní protidrogová centrála SKPV Policie ČR, 2010c; Celní protidrogová jednotka , 2010b). Marijuana and methamphetamine were the two most widely available drugs in 2009, and a trend of cocaine becoming increasingly popular and available was noted.

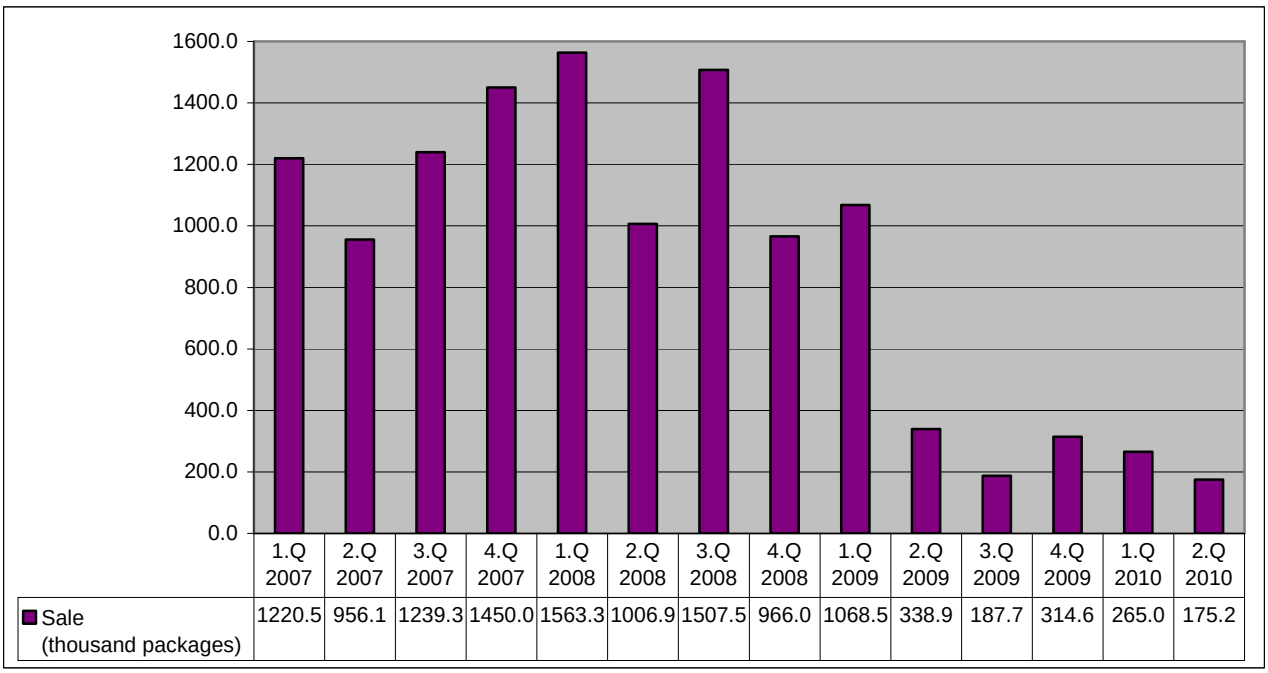
Most marijuana grown in the Czech Republic is intended for the domestic market. However, the large-scale indoor growing of marijuana with a high content of THC (up to 20%) has increased steadily since 2005, with 80% of the plantations detected in 2009 being run by persons of Vietnamese descent and most of their production being exported, especially to Germany, the Netherlands, and the United Kingdom, while a smaller proportion was sold

domestically[106]. A total of 84 illegal marijuana plantations were seized in 2009. In the same year, the Customs Drug Unit reported 92 seizures of marijuana with a total quantity of 79.4 kg. Twenty-two of these seizures concerned 24.7 kg of marijuana intended for export, half of which (13) was to be sent to the United Kingdom by air shipments. The imported hashish mainly originates in North Africa (Morocco). It is smuggled into the Czech Republic, mainly via Spain and the Netherlands, in postal consignments transported by air.

Pervitin is exclusively made by domestic producers (who are usually also pervitin users) and almost exclusively from pseudoephedrine, which is extracted from over-the-counter medicines. Nevertheless, the quantity of ephedrine seized has increased in the past three years (with 6 kg being seized in 2009). Ephedrine was the dominant pervitin precursor in the past and is still preferred to pseudoephedrine, if available; see Table 10-2. While pervitin is mainly intended for the domestic market, a small part of the production is exported, in particular to Slovakia and Germany; in 2009, the Customs Drug Unit reported 16 pervitin seizures with a total quantity of 1.2 kg, with 2 seizures of 312 g and 500 g of pervitin, respectively, being intended for export to Germany.

Effective from May 2009, the *State Institute for Drug Control* restricted the dispensation of medicines containing pseudoephedrine from pharmacies and mandatory registration of the supply of such medicines in the central electronic prescription database was introduced. This restriction was modified in November 2009 on the grounds of the findings of the Office for Personal Data Protection – for details see the chapter on Legal Framework (p. 6). Because of the measures that had been implemented, the sales of medicines containing pseudoephedrine from pharmacies decreased dramatically as early as in May 2009, and the low level of sales was maintained for the rest of the year; see Figure 10-1. Beginning with June 2009, an increase was observed in the illegal imports of medicines containing pseudoephedrine from the neighbouring countries, especially from Poland, where an increase in the sales of these medicines was monitored, in particular in the regions along the border with the Czech Republic (Szymanski, 2010). A higher quantity of medicines containing pseudoephedrine imported from Poland was also reported by the Customs Drug Unit, which seized 42,449 tablets of these medicines in six seizures performed in 2009 and another four seizures of 9,512 by April 2010 (only one inland seizure, of 15 litres of a pseudoephedrine solution, was reported in 2008) – Table 10-3. According to the estimates of the *National Drug Headquarters*, up to 95% of the medicines containing pseudoephedrine used for pervitin production in the first quarter of 2010 originated from Poland. The quantity of pseudoephedrine on the domestic illegal market has therefore not been reduced as the quantity of illegal imports of medicines containing pseudoephedrine from Poland is estimated to cover the drop in the sale of these medicines in the Czech Republic (Pracovní skupina pro metamfetamin, 2010). Despite the efforts described above, medicines containing pseudoephedrine continue to be used for pervitin production in the Czech Republic (see below). The above facts and expert estimates show the need for the implementation of regulated sales of medicines containing pseudoephedrine at the European level, in particular in the neighbouring countries (e.g. Poland, Slovakia, and Germany) and the need to reduce the availability of additional key substances for pervitin production, e.g. red phosphorus, at both the national and international levels.

Figure 10-1: Development of the sales of medicines containing pseudoephedrine in the Czech Republic in 2007-2010 (Státní ústav pro kontrolu léčiv, 2010)



	1.Q 2007	2.Q 2007	3.Q 2007	4.Q 2007	1.Q 2008	2.Q 2008	3.Q 2008	4.Q 2008	1.Q 2009	2.Q 2009	3.Q 2009	4.Q 2009	1.Q 2010	2.Q 2010
Sale (thousand packages)	1220.5	956.1	1239.3	1450.0	1563.3	1006.9	1507.5	966.0	1068.5	338.9	187.7	314.6	265.0	175.2

[106] In August 2010 the Customs Drug Unit and the National Drug Headquarters apprehended 21 suspects of Vietnamese descent who had produced up to 1.4 tonnes of the drug worth approx. CZK 100 million per year in an organised group. The marijuana was sold on the domestic market and exported to Hungary, Austria, and Slovakia.

Cocaine has become an established stimulant, mainly in the recreational and nightlife settings – see also the chapter on Drug Use among Targeted Groups/Settings at National and Local Level (p. 33) – and is no longer the prerogative of the higher levels of society. This fact needs to be seen in the context of growing demand for and supply of cocaine throughout Europe. Its import and distribution are mainly pursued by West Africans (predominantly Nigerians), who often hire couriers from other African countries but also use Czech nationals for this purpose. The couriers import cocaine into the Czech Republic, mainly from Western European countries such as the Netherlands, the United Kingdom, Spain, and France. Cocaine is most typically transported in cars, buses, or trains in quantities between 1 and 3 kg. In 2009, the Customs Drug Unit reported 12 seizures of a total of 8.1 kg of cocaine smuggled in body cavities (by the so-called "swallowers"). Ten of these shipments were being smuggled by Nigerians, mostly on airline services from Spain, the Netherlands, and Belgium. The street distribution of cocaine is mainly pursued by Nigerians and other West Africans, who deal cocaine in the centre of Prague and in Prague night clubs, among other locations. Czech nationals also participate in the street distribution of the drug.

According to the *National Drug Headquarters*, the Czech Republic is both a consumer and (especially) a transit country for heroin. The import of heroin to the Czech Republic is mainly organised by Kosovo and Macedonian Albanians. Mainly nationals of Romania, Bulgaria, Hungary, Slovakia, and the Czech Republic are used as couriers to import and transport heroin from Turkey, usually in quantities of below 10 kg per shipment, via Bulgaria, Romania, Hungary, Slovakia and the Czech Republic into Germany, the Netherlands, and the United Kingdom (via the so-called "Balkan Route"). The Customs Drug Unit reported four seizures of a total quantity of 14.6 kg of heroin in 2009, with the two largest shipments being of 2.7 kg and 11.8 kg, respectively. The first shipment was concealed in a suitcase and was being transported by a Bulgarian national from Turkey by air, while the other shipment was being transported by a Czech national in a passenger car. Roma and persons of Vietnamese descent are also involved in heroin trafficking at the lower level (Národní protidrogová centrála SKPV Policie ČR, 2010a).

Subutex® continues to appear on the black market and competes with heroin. Another substitution preparation, Suboxone®, was introduced onto the Czech market in 2008 but has attracted little attention on the black market in comparison with Subutex®, mainly because the former leads to the development of withdrawal symptoms when injected. A Subutex® tablet containing 8 mg of buprenorphine is sold for CZK 300-800 (€ 11.3-30.3) on the black market and one containing 2 mg of the active substance costs CZK 100-250 (€ 3.8-9.5). See also the chapters on Problem Drug Use (page 41) and Drug-related Treatment: treatment demand and treatment availability (page 46).

According to the available data, ecstasy is not produced in the Czech Republic and is instead imported, mainly from the Netherlands, Poland, and Slovakia. This mainly involves individual imports of dozens (up to hundreds) of tablets by means of public international surface and air transport. In the Czech Republic, ecstasy is subsequently sold at open-air festivals, in music clubs, and at rock concerts and dance parties.

10.1.1 New Drugs on the Czech Drug Scene

In 2009, the *National Drug Headquarters* monitored several online and regular stores (called "smart shops") offering (natural) psychoactive substances, which also offered a mixture of spices called *Spice*, which was sold as a natural aromatic mixture for fumigation. *Spice* is imported to the Czech Republic from Asia (China), among other places of origin. Even though no accurate or actual description of the composition of the mixture is usually provided on the packaging, it often contains synthetic cannabinoids such as JWH-018 and CP 47-498 (the synthetic cannabinoids JWH-073 and JWH-076 were also detected in 2010). The parties selling this mixture may be subject to prosecution for promoting drug use under Section 188a of the old Penal Code and Section 287of the new Penal Code, respectively. It is probably because of the relatively easy availability of cheaper cannabis that no higher level of the use of synthetic cannabinoids has been observed in the Czech Republic.

An increase in the level of interest in the stimulant mephedrone was observed in the Czech Republic in 2009 and in the first half of 2010, in particular on the dance scene. According to estimates by experts of the *EWS* network, there may be thousands of grams of mephedrone in the Czech Republic. The drug appears in powder form and is snorted in doses of 100 or more milligrams, often in combination with alcohol and marijuana. Highly unpleasant sensations ("bad trips") have been described following its application. Mephedrone is sold, for example, as a fertiliser for indoor plants to decelerate the growth of leaves and can be ordered from abroad, mainly via the internet[107]. An application for the import of bath salts containing mephedrone has also been reported in the Czech Republic. Even though this substance has not been included in the list of controlled substances according to Act No. 167/1998 on addictive substances, the handling of mephedrone and other (new) synthetic drugs can be prosecuted in the relevant cases as the offence of promoting drug use according to Section 188a of the old Penal Code or Section 287 of the new Penal Code, respectively. In 2010, the *Customs Drug Unit* also seized 10 kg of ephedrone, a stimulant with a chemical structure similar to that of mephedrone. The seized shipment was intended for domestic consumption.

Tablets named *Head Candy* containing the central stimulant pipradrol have also been seized in the Czech Republic. By March 2010, the Customs Drug Unit had also seized 3 kg of the stimulant MDPV (methylenedioxypyrovalerone)

[107] Especially from China and (before 2010) from the United Kingdom, which, however, included mephedrone in the list of controlled substances in April 2010.

and 1 kg of propiophenone (worth EUR 8,000), which is used to produce ephedrine – a methamphetamine precursor.

The increased demand for these recently detected stimulants can be partially explained by the changes on the drug market across Europe (e.g. with regard to the shortage of ecstasy tablets containing MDMA) and the fact that a number of them are not included in the lists of illicit or controlled substances in many countries.

10.1.2 Drug Consumption and Drug Market Estimates

The drug market in a specific territory inherently combines domestic production, foreign trade (import and export), and consumption. The method used to estimate the volume of the drug market was that estimating the drug market on the demand side, i.e. in terms of drug consumption.

The consumption of the selected drugs for 2008 was estimated on the basis of the outcomes of the *2008 General Population Survey* (Národní monitorovací středisko pro drogy a drogové závislosti, 2009), which measured the level of prevalence of illicit drug use in the country, and on the basis of the prevalence estimates of problem drug users. The consumption was then calculated by multiplying the estimated number of users by the quantity of drugs consumed during the year on the basis of their consumption habits, i.e. using the responses to the questions regarding drug use in the previous 12 months obtained from a questionnaire population study and from the published data on drug consumption by problem drug users.

The number of occasional drug users and their frequency of drug use in the previous year, as obtained from the *2008 General Population Survey*, were related to the mean population in the individual five-year age groups of men and women. The number of problem users of the individual drugs, as well as data on the frequency of use and average dose, were published in the 2008 Annual Report (Petroš et al. 2005). The quantity of the drug used on a single occasion (e.g. 0.26 g for cannabis) is based on the published data (EMCDDA, 2004; Vopravil, 2005). The other data sources used included information about drug seizures – this concerned the number of seizures and quantities seized, as well as information on whether the seizure was performed during import or export or inland. Another aspect that was considered was the purity of the drugs which are commonly diluted (cocaine, pervitin, and heroin) – the different concentrations of the drugs at the production, import, and sale stages are attributed to dealers, who dilute the drugs to achieve a higher profit, for which reason the quantity of certain drugs that is produced or imported is lower than that consumed or that sold to the end users, respectively (Vopravil, 2010); see Table 10-1.

Table 10-1: Estimated consumption of selected drugs in the Czech Republic in 2008 (Vopravil, 2010)

Indicator	Cannabis (kg)	Ecstasy (thousand tablets)	LSD (thousand doses)	Cocaine		Pervitin		Heroin	
				Quantity (kg)	Purity (%)	Quantity (kg)	Purity (%)	Quantity (kg)	Purity (%)
Total drug consumption	18,846	4,715	1,053	957	45	4,436	70-80	1,314	10
– imported	3,769	4,715	1,053	547	70	0	0	329	40
– domestic production	15,228	0	0	0	0	4,226	80	0	0
– domestic production exported	151	0	0	0	0	141	70	0	0

According to these estimates, almost 19 tonnes of cannabis, 4.7 million tablets of ecstasy, and 1 million doses of LSD were consumed in the Czech Republic in 2008. 550 kg of cocaine with an average purity of 70% were imported into the Czech Republic but almost 1 tonne of the drug with an average purity of 45% reached the end users. According to expert estimates, 4.2 tonnes of pervitin with an average purity of 80% were produced but the drug is often cut and its purity for street sale or export is reduced to 70%. A total of 4.4 tonnes of pervitin are estimated to have been consumed in the Czech Republic. 330 kg of heroin with an average purity of 40% were imported to the Czech Republic but the purity on the market was only approximately 10% and 1.3 tonnes of the drug were consumed on the Czech market.

10.2 Seizures

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

Marijuana was the drug that was most frequently seized in 2009. The yearly number of marijuana seizures in the four previous years (2005-2008) was between 550 and 600. In 2009, however, a lower number of seizures was noted (384). A total of 172 kg of marijuana were seized in 2009. In addition, 33,427 cannabis plants were seized in 117 seizures in 2009, the highest number since 2006. There was also an increase in the number of cannabis-growing

plantations, with 84 plantations detected in 2009. The number of hashish seizures was relatively stable in the period 2006-2009, with 30-40 seizures annually. However, at 12.5 kg, the quantity of the hashish seized in 2009 was a multiple of that seized in 2008; see Table 10-4.

Pervitin remains the second most commonly seized drug (326 seizures in 2009). Approximately 300-400 seizures annually were reported in the last four years. The quantity of pervitin seized in 2009 (3.6 kg) was comparable to that in 2008; see Table 10-4. The number of pervitin cooking labs detected was the lowest in the past 3 years (342 in 2009). In addition to medicines containing pseudoephedrine, which has been the main precursor of pervitin in the Czech Republic in recent years, the quantity of ephedrine seized has increased significantly in the past three years (with 6 kg seized in 2009); see Table 10-2.

Table 10-2: Seizures of pervitin precursors, pervitin cooking labs, and pervitin in the period 2007-2009 (Národní protidrogová centrála SKPV Policie ČR, 2010b)

Seizures	2007	2008	2009
Ephedrine (g)	1,185	1,677	6,023
Pseudoephedrine (g)	218	–	–
Modafen® (tablets)	3,480	7,876	840
Nurofen® StopGrip (tablets)	11,948	21,785	876
Panadol® Plus Grip (tablets)	72	17,021	1,224
Paralen® Plus	–	–	1,440
Acatar® (tablets)	–	–	3,508
Cirrus® (tablets)	–	–	6
Ibuprofen® (tablets)	–	–	80
Ibuprom® (tablets)	–	–	22,080
Sudafed® (tablets)	–	–	12,231
Cooking labs	388	434	342
Pervitin (g)	5,978	3,799	3,599

Table 10-3: Seizures of pseudoephedrine in medicinal products imported to the Czech Republic in 2009 (Celní protidrogová jednotka , 2010a)

Seizure location	Quantity (tablets)	Imported from
Aeroplane	17,000	Vietnam
House search	280	-
Passenger car	1,140	Poland
Passenger car	1,192	Poland
Passenger car	22,081	Poland
Passenger car	756	Poland
Total	**42,449**	**-**

Note: Preparations: Decolgen® Forte, Sudafed®, Reactime®, Acatar®, Rhinafen®. Pseudoephedrine content in 1 tablet: 30-120 mg.

Twenty-six seizures of cocaine were reported in 2009, with the total quantity of 12.9 kg being the second-highest volume seized in the past four years. On the contrary, the lowest number of ecstasy seizures and quantity seized in the past four years were reported in 2009. As far as heroin is concerned, the number of seizures and the quantity seized remain relatively stable, reaching approximately 100 seizures of 20-40 kg annually. The situation is also relatively stable in terms of LSD seizures. In the past three years, there were a total of five seizures per year of 100-200 doses of LSD. Again, no crack was seized in the Czech Republic in 2009; see Table 10-4.

Table 10-4: Number of seizures and quantities of main drug types seized in 2006-2009 (Národní protidrogová centrála SKPV Policie ČR, 2010c)

Drug type	2006		2007		2008		2009	
	Number	Quantity	Number	Quantity	Number	Quantity	Number	Quantity
Marijuana (g)	556	108,352	563	122,124	602	392,527	384	171,799
Pervitin (g)	406	5,249	374	5,978	405	3,799	326	3,599
Heroin (g)	86	27,877	96	20,332	105	46,302	73	31,257
Cannabis plants (no.)	44	2,276	46	6,992	69	25,223	117	33,427
Hashish (g)	42	466	25	387	30	696	41	12,499
Ecstasy (tablets)	29	26,259	30	62,226	18	16,610	13	198
Cocaine (g)	11	4,708	38	37,587	24	7,631	26	12,904
LSD (doses)	7	1,748	5	117	5	246	5	142

The breakdown of the seizures for 2009 by weight shows that almost two-thirds of the marijuana seizures involved quantities of less than 100 g, and 7% of the seizures concerned amounts of over 1 kg of the drug (compared to 6% of the seizures concerning quantities of over 1 kg in 2008), of which quantities over 10 kg were seized in three cases.

The largest number of seizures (185) involved quantities in the category of under 15 grams. As far as cannabis plants are concerned, 16% of the seizures involved five plants or fewer; seizures of 6-50 plants accounted for 41% of the seizures; 11% of the seizures concerned quantities of over 1,000 plants, and two seizures involved over 2,000 plants. For hashish, 85% of the seizures were of quantities of less than 50 grams, with most seizures (18, i.e. 44%) being in the category of 6-50 grams; the weight of the largest seizure was 11.2 kg. 96% of the pervitin seizures involved less than 50 grams of the drug, mostly (159 seizures) in the category of under 2 grams; the largest pervitin seizure weighed 0.5 kg. The breakdown of the cocaine seizures was relatively stable across the intervals monitored, i.e. between one and five seizures, with the largest number (five seizures) being in the category of 500-799 grams; four seizures were of a quantity larger than 1 kg, with the largest seizure weighing 1.6 kg. Nearly three-quarters of the heroin seizures were of quantities of under 10 grams; six seizures (8%) were of quantities over 1 kg, with the largest seizure weighing 11 kg. All the seizures of ecstasy (13) were of quantities of 100 tablets or less, with 100 tablets seized being the largest quantity (Národní protidrogová centrála SKPV Policie ČR, 2010b).

10.3 Price/Purity

Information about the prices of the basic types of drugs in the Czech Republic is determined on an annual basis according to estimates provided by the regional headquarters and territorial departments of the Police of the Czech Republic to the *National Drug Headquarters*. The prices of most basic drugs remained stable in 2009; a slight increase can be observed in the average and most common street prices of marijuana – see Table 10-5.

Table 10-5: Average and most commonly reported (modus) prices of drugs in 2006-2009 (€) (Národní protidrogová centrála SKPV Policie ČR, 2010c)

Drug type	2006		2007		2008		2009	
	Average	Modus	Average	Modus	Average	Modus	Average	Modus
Marijuana (g)	7	6	7	4	7	8	8	9
Hashish (g)	10	8	10	8	9	9	10	11
Ecstasy (tablets)	8	6	8	8	8	8	8	9
Pervitin (g)	40	38	43	38	43	38	49	38
Heroin (g)	41	30	42	38	41	38	48	38
Cocaine (g)	84	76	78	76	76	76	73	95
LSD (doses)	6	6	7	8	7	4	8	8

Note: Prices rounded to €. 2009 average exchange rate was used (1€ = CZK 26.445)

Drug purity data are only available for a part of the drugs seized and are mostly obtained from the Departments for Forensic and Technical Analyses of the regional police headquarters and from the Forensic Science Institute in Prague. The data provided below (see Table 10-6) are for reference only because the number of samples from which the purity/potency of the drug is calculated may be low and, in addition, the statistical evaluation merges samples from the seizures of larger quantities with a higher concentration of the active substance with samples obtained from retail-level drugs of lower purity. A detailed analysis of the prices, purity levels, and admixtures of the selected types of drugs is provided below.

Table 10-6: Average drug purity percentage in 2005-2009 (Národní protidrogová centrála SKPV Policie ČR, 2010c)

Drug type	2006		2007		2008		2009	
	Number of samples	Average purity (%)	Number of samples	Average purity (%)	Number of samples	Average purity (%)	Number of samples	Average purity (%)
Marijuana	151	4.5	177	4.7	404	5.5	289	8.1
Hashish	1	11.0	2	8.1	5	5.2	3	15.9
Ecstasy*	54	22.6	31	27.4	20	17.5	6	3.4
Pervitin	58	52.3	123	66.4	145	64.3	144	68.1
Heroin	35	7.9	31	17.4	47	22.6	57	16.6
Cocaine	12	40.2	48	49.1	35	43.5	21	33.1

*Note: * The average purity of ecstasy tablets is expressed as the average quantity of MDMA in milligrams in one tablet containing MDMA.*

10.3.1 Retail and Wholesale Levels of the Drug Market

In order to understand the development of drug purity/potency and of the related prices, it is advisable to distinguish between the wholesale and the retail levels of the illicit drug market and the retail (e.g. under 0.5 kg) and wholesale (over 0.5 kg) quantity of the drugs trafficked, respectively. It is obvious that the threshold between the retail and wholesale quantity is not identical for different drugs.

At the wholesale level of the marijuana market (i.e. as far as quantities of 1.5 kg or more are concerned), a total of 16 seizures were reported in 2009, and the average price is estimated as CZK 100,000 (€ 3,781) per kilogram of the drug. It can be estimated that larger quantities of marijuana are sold for CZK 60-115 thousand (€ 2,269-4,349) per

kilogram. Given the retail price of CZK 250 (€ 9.5) per gram of marijuana (i.e. CZK 250,000 (€ 9,454) per kilogram), the retail-level dealer can make a profit of up to CZK 150,000 (€ 5,672) for each kilogram of the drug.

Pervitin is almost exclusively sold at the retail level and in quantities of under 50 g. Its purity and price have been 70% and CZK 1,000 (€ 37.8) per gram, respectively, in the past 3 years. If pervitin is diluted, piracetam is used for that purpose. As far as larger transactions are concerned, 1 gram of pervitin is sold for EUR 18 (approx. CZK 500 (€ 18.9) and 1 kilogram for approx. CZK 800,000 (€ 30,251).

Heroin mainly enters the Czech Republic via the Balkan Route, with a purity of around 90%. However, further cutting (often with a mixture of paracetamol and caffeine or with the anaesthetics procaine and mesocaine) reduces the purity. The price of the mixture for heroin cutting can be up to CZK 15,000 (€ 567) per kilogram. Heroin is sold at the retail level with a purity of 10-15% for prices between CZK 1,000 (€ 37.8) and 1,400 (€ 52.9) per gram, i.e. CZK 1 million (€ 37,814) per kilogram). The heroin sold at the retail level has an average purity of 20-30% and 1 kg of heroin with a purity of 30% is estimated to sell at CZK 200,000-800,000 (€ 7,563-30,251).

Cocaine appears at street level with a purity of 10-35% and its price has been dropping in recent years – in 2009 it was reported to be CZK 1,500-2,500 (€ 57-95) per gram, with the lowest reported prices being as low as CZK 1,000 (€ 37.8) per gram. Cocaine is often cut with phenacetine (a paracetamol derivative and a substance which used to be administered as a painkiller and fever reducer) or levamisol (a veterinary preparation used against intestinal parasites); levamisol was present in 20% of the cocaine samples analysed in 2008 and in as many as 50% of the samples in 2009, and almost all the cocaine seized in the Czech Republic since May 2009 has been diluted with levamisol. A tendency for the purity of cocaine to decline has been observed in the Czech Republic in the past three years; see Table 10-6. At the retail level of the drug market, the purity of cocaine is in the range of 15-35% and the estimated purchase price of 1 kilogram of approximately 15% cocaine is about CZK 1.5 million (€ 56,000). It can therefore be said that the differences in the purity and price of cocaine between wholesale and street sale are minimal and the drug is probably cut before entering the territory of the Czech Republic.

Fakes containing no MDMA or a similar substance (such as MDEA or MDA) are sometimes sold as ecstasy and sometimes diverse substances and medicinal products (such as paracetamol, benzodiazepines, caffeine, and Ibuprofen) are mixed, pressed, and then sold as ecstasy. Some of these fakes are imported from abroad. An increased presence of ecstasy tablets containing mCPP has been reported; their quantity on the market is significantly higher than that of tablets containing MDMA. The Forensic Science Institute in Prague analysed 25 tablets of ecstasy in 2009. Six tablets contained MDMA together with other substances such as caffeine, amphetamine, and mCCP, one tablet contained MDEA, and one tablet contained MDA. 13 tablets contained mCPP as their main active substance. In 2009, the *Jihočeský streetwork* civic association tested 290 tablets of ecstasy at three dance parties. Only 26 (9%) of the tablets contained MDMA as the active substance (Jihočeský streetwork, 2010).

PART B: SELECTED ISSUES

Selected issues are included in the Annual Report every year. The topics are set by the *EMCDDA* in cooperation with the focal points in the individual Reitox countries with regard to the topics' relevance and the research needs. Since last year all the countries have been required to prepare chapters on at least two selected issues, one of which is mandatory (this year it is the History, Methods, and Implementation of National Treatment Guidelines), and one is selected from two options offered. As last year, the Czech *National Focal Point* has chosen to cover all three selected issues.

11 History, Methods, and Implementation of National Treatment Guidelines

This chapter deals with the treatment guidelines[108] applicable to drug users in the Czech Republic[109]. The *EMCDDA* lists the Czech Republic as a Member State which has implemented and applied treatment guidelines in the area of drug use. However, a closer examination of the documents that have been implemented and their use reveals that this is not entirely certain. It will therefore be useful to begin with a brief excursion into the general topic of guidelines and their typology, purpose, logic, and mutual links.

11.1 History and Overall Framework

11.1.1 Definitions and Typology

Guidelines are instruments used for quality maintenance and assurance. The term "guideline" refers to a set of criteria applied in order to assess whether and to what extent the service in question is provided in a quality manner. However, the view of "quality" is rather broad and, in addition to comprising the correct execution of certain measures whose effectiveness has been verified, it also includes management and organisational support for the service, its availability, client-friendliness, and involvement in a network of other services.

These multidimensional criteria are usually not compiled into a single code. In addition, there are multiple approaches to "quality". The *WHO* (WHO, 1997; Kalina, 2001) distinguishes the following guidelines:

1. training guidelines;
2. guidelines for centres, facilities, and programmes;
3. case or diagnosis-based procedural guidelines;
4. guidelines for methods, and
5. ethical guidelines.

Types 3 and 4 are sometimes referred to as "good practices". They are a valuable link between research and practice. Their main objective is to assist professionals, as well as patients, in their decision making about the appropriate interventions under specific circumstances, e.g. in case of a certain health-related event or its complications. In addition, they also help public officials, administrators, and clinical managers plan the services and create the environment of good practice. Last but not least, teaching materials are also involved because well-prepared guidelines support the training of students, as well as of the more advanced practitioners aspiring for greater expertise. The main requirements for sound good practice guidelines include a broad expert base and scientific evidence (Kalina, 2010).

The "mechanisms" applied to verify the compliance with the criteria represent the second component of quality assurance. These mechanisms include, for example, comprehensive workplace quality management, internal and external supervision, peer reviewing, and formal and "official" mechanisms such as inspection, accreditation, certification, licensing, etc.

11.1.2 Purpose of Guidelines

This section covers the questions regarding whom the standards serve, who needs them, and who uses them and for what purpose.

11.1.2.1 Expert Communities

Historically, guidelines were created in professional communities, in particular the medical ones, which sought to strengthen the quality performance of the profession and achieve external recognition. This is where the terms "good practice" or "lege artis procedure" originated from. Specialised publications, lectures, seminars, and other

[108] Terminology note: The term *standard* rather than *guideline* is more commonly used in the Czech Republic and, as such, is interchangeable with the term *guideline* for the purposes of this document. In accordance with the EMCDDA, the term *treatment* is understood as professional care provided to patients or clients, and goes beyond the term of "treatment" in the medical sense.

[109] The references to the selected sources are provided in the text of the chapter. In addition, this selected issue chapter has been prepared using the following literature: Kalina and Jaroš, 1998; Kalina K. et al., 2001; Kalina, 2000; Kalina, 2003; Kalina, 2007a; Kalina, 2009b; Miovský, 2008; WHO, 2000.

components of the life of professional communities have spread and introduced good practices into the training of those who wish to pursue the profession. The formalisation of good practices, i.e. guidelines as we understand them today, occurred in medicine in the second half of the 20th century, and even earlier in the USA. In the 1950s and 1960s, this model was adopted by the newly formed non-medical profession of social workers, especially in English-speaking countries. It was also during that period that communities of institutions appeared, such as associations of hospitals, adding organisational aspects to the criteria of good practices. Mechanisms such as peer review and supervision began to spread.

A number of communities of care providers sought to achieve a status where the very membership of such communities would indicate and guarantee quality. The so-called accreditation communities subjected the candidates (individuals or institutions) to demanding examinations prior to their acceptance as members. The prestigious *Royal College* in the countries of the British Crown is an example of such an institution.

In the late 20th century, quality assurance ceased to be the exclusive domain of the providers and, instead, the state took on the important role, often to their displeasure. However, the direct providers of services continue to be interested in developing quality, and professional communities are still an irreplaceable source of the professional parameters of good practices.

11.1.2.2 Government and Public Administration

The state interventions in the area of the quality of health and social services arise from the fact that the state guarantees the availability of these services for its citizens in terms of accessibility and affordability. It performs its guarantee by funding these services, whether by redistributing general taxes or using dedicated "taxes" such as public health insurance. In order to ensure the proper use of these financial resources following the "value for money" principle, it also takes charge of quality control, and guarantees quality to its citizens. Especially in the Member States of the *EU*, the extent of these guarantees is enormous.

However, this triple guarantee also represents a trap for the state. Public financial resources are always limited and, as has been shown by social economists, so are private resources. On the other hand, the needs increase without any limit, pushed by the demands of the citizens (with the legitimate demands including, for example, the ageing of the population) and pulled by the professional development of services (the providers continuously improve their quality potential). We can imagine the resulting difficulties for politicians and administrators when assigning the state-guaranteed values of quality, availability, and costs to the apexes of a triangle, which, however, cannot stand on all three apexes at one time. If the base is "quality care – expensive care", it is not likely to be widely available. If the base is "quality care – widely available care", the costs increase. If the "widely available care – cheap care" base is selected, it will be difficult to maintain its quality. Public policies must always balance between the availability, quality, and cost of care but, at the same time, they rely on the saying "We can never have everything at the same time but we always want it" (Acheson, 1994), cited in Kalina (2001).

The state and the providers thus find themselves in a conflicting position. The state promotes the value-for-money principle, requiring quality and availability at the lowest cost possible, while the providers promote the money-for-value principle, requiring the level achieved to be adequately paid for and development to be supported. The current situation in the Czech Republic in the area of services for drug users and persons with an addiction proves that this is not only a textbook description (see also the information on the *We Have Had Enough of This!* in the chapter on Initiatives in Civil Society (p. 15).

11.1.2.3 International and Intergovernmental Organisations

On the global scene, it is mainly the *WHO* that promotes guidelines in order to transfer good practices from the developed countries to the less developed ones to contribute to an improvement in the health of their population. Together with the Council of Europe, it operates in the "European" region of the two organisations, which also covers the entire post-Soviet bloc, including the former Soviet republics in Central Asia. The less developed countries, however, often choose the "available care – cheap care" formula and lack the funding for quality improvement.

The interventions of the European Union in the area of service quality are derived from the central principles of the *EU*: the free movement of services and people. The objective is to ensure a comparable and optimum level of services for the citizens of the *EU* in all Member States. As far as the quality of the services for drug users and persons with an addiction is concerned, it is the topic of several measures in the current Action Plan of the *EU*. The current *EMCDDA* initiative is aimed at their implementation.

11.1.2.4 Users of Services

It is again the *WHO* that promotes "user reviews", which should be carried out by the users of the services, their families and friends, and, in the broader sense, the public stakeholders. This is an important trend in developed Europe, which is supported by the *WHO* Regional Office for Europe. It represents the principle of a patient/client focus of services and a belief that the "user's voice and choice" are as crucial for service provision as the professional and economic aspects. The public administration in most *EU* Member States usually considers the opinions of the users a necessary addition to expert and administrative evaluations. However, service providers,

especially those on the European continent, have not been open to the increased influence of non-professionals until recently.

The participation of the users in quality assurance can be valuable and does not have to impair the professional aspects. In any case, understandable guidelines can contribute to overcoming the information imbalance between the service provider and the service user, even though the resulting deeper insights and their demanding and critical nature may be unusual for the provider.

11.1.3 Internal Correlates of Guidelines

Good practices, in particular type 3 – case or diagnosis-based procedural guidelines – form the core of the guidelines. When designed optimally, they should clearly formulate what needs to be done with an individual – the problem bearer – from their entry into professional care to their exit from it in order to maintain and improve the quality of their life. The type 3 guideline refers to the detailed description of the individual verified references (type 4). It can be used to derive the parameters of facilities competent to perform the good practices (type 2) and the qualifications of the staff capable of such performance (type 1). In addition, it also provides the service user with an understandable idea of their demand and is the basis of the "invoice" *vis-à-vis* public financial resources.

Even though (or perhaps because) the type 3 guidelines are crucial, their design is often not optimal: for example, they may not encompass the entire continuum of the resolution of the problem but instead only concern a certain segment thereof (such as the current status) or they may only consist of a set of methods and interventions that may be considered[110]. Previous attempts show that there are certain concerns, on the part of the providers as well as the public payers, regarding the excessive accuracy (and the resulting excessively binding nature) of such procedures[111].

11.2 Existing Guidelines

This section will attempt to clearly outline the existing guidelines in the Czech Republic, in particular those pertaining to services for drug users and persons with an addiction.

11.2.1 Training Guidelines

As mentioned above, the guidelines of this type specify what qualifications, knowledge, and skills a person competent to perform "good practices" should possess. The standardisation of education and training has been achieved in the greatest detail in medicine through the system of university curricula and the content of the postgraduate specialisations, subspecialisations, and microspecialisations, a system which is embedded in health care legislation. The Czech Republic does not differ from other developed countries in this respect. Where it differs in a positive manner is the inclusion of addiction disorders and their treatment in the curriculum for students of medicine and for beginning physicians. The mandatory content of the graduate and postgraduate studies, which is generally considered insufficient in the Czech Republic, is well above the European average (Vermeulen et al. 2003). The Czech Republic is also one of the few countries in Europe where a medical specialisation in the field of addictive diseases exists, which has been the case since as early as 1980 (for additional information see the 2008 Annual Report). However, the interest in the specialisation is not great, and it is also impossible to guarantee that the specialised physician will master the psychosocial interventions required in practice.

The above-mentioned shortage of specialists should be compensated for by the new profession of an addiction specialist – addictologist (a Bachelor's study programme at the *First Faculty of Medicine of Charles University in Prague* since 2005; a follow-up Master's programme is being prepared from 2010). The curriculum of this major is based on the "bio-psycho-social" concept of the *WHO* and on the integrated interdisciplinary model of training promoted by the Council of Europe at the turn of the century[112]. In this form, i.e. as a non-medical specialisation in health care, addictology is most probably unparalleled anywhere in Europe. The addictologist-physician and the addictologist-non-physician are foreseen as constituting two of the professional pillars of the addiction treatment services in the Czech Republic in the future.

Another profession applicable to services for drug users and persons with an addiction (specifically those falling within the sector of social services) is that of the social worker (for details see the 2008 Annual Report), whose official definition is vague and broad, though. We have no knowledge of any training guidelines qualifying a "social worker" to perform good practices in facilities for drug users.

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[110] These shortcomings also apply to the recently prepared Recommended Procedures for Psychiatry, the section of which on addictive disorders is discussed in detail in Section 11.2.3 (page 115).

[111] The DRG (*Diagnosis-Related Groups*) scheme, applied mainly in the USA for payments to health facilities, is an example of type 3 guidelines. Efforts to introduce a DRG equivalent have been made in the Czech Republic since the 1990s with significant public financial backing but they have not been implemented into practice. A body that is active in the area of the implementation of DRG in the Czech Republic is the National Reference Centre ("Národní referenční centrum") (http://www.nrc.cz), an interest group of legal entities, which also administers the National Sets of Health Service Standards register (https://kvalita.nrc.cz).

[112] European Drug Abuse Treatment Training Programme, Drug Demand Reduction Staff Training Programme. See also Miovský et al., 2009.

11.2.2 Guidelines for Centres, Facilities, and Programmes

These types of guidelines are well-developed in the Czech Republic but their direct impact on good practices in services for drug users and persons with an addiction is difficult to assess because this is where the departmental and interdepartmental approaches meet (and collide).

The Ministry of Health formulates the basic requirements for different forms of health care facilities through legal standards, and its extensive programme for quality and safety in health care also specifies the quality standards for hospitals and treatment facilities, which are assessed by the *Joint Accreditation Commission, a* public service organisation, under the accreditation process (accreditation standards for hospitals, for long-term care, etc.). These quality standards correspond with the internationally recognised accreditation standards for health care quality and safety and with the requirements of the *EU*. They focus on the quality and safety of care in the broader sense[113]. They undoubtedly stimulate quality in departments or separate facilities for addiction treatment.

The Ministry of Labour and Social Affairs has prepared its *Standards for Quality in Social Services*[114], which are binding for most non-health services for drug users and persons with an addiction, which, according to the law[115], fall into the category of social services. However, their impact on quality is not very stimulating because they do not greatly respect the specific professional focus. Nevertheless, the fulfilment of the standards, verified by the audit process, is a prerequisite for funding from the subsidies of the *Ministry of Labour and Social Affairs* (see below).

The Government Council for Drug Policy Coordination has introduced the *Standards of Professional Competency for Facilities and Programmes Providing Professional Services to Problem Substance Users and Persons with a Substance Addiction*, the so-called *Certification Standards* (Kalina K. et al., 2003). The standards are verified through a certification process. They are of an interdepartmental nature, spanning a wide range of health, social health, and social services, and their original ambition was to bridge the interdepartmental interfaces. Even though the *Certification Standards* reflect the professional specifics, as well as the more general areas of quality, they have failed in the competition with the departmental policies and their fulfilment is only a requirement for entry into the grant systems of the *Government Council for Drug Policy Coordination* and of certain regions. The *Certification Standards* are discussed in detail in Section 11.3 (p. 118). However, their justified inclusion in guidelines of this type also indicates that they are not typical treatment guidelines as understood by the *EMCDDA*.

It needs to be stated in this category that the Ministry of Education, Youth, and Sports has prepared guidelines for drug use/abuse primary prevention programmes (Ministerstvo školství, mládeže a tělovýchovy, 2005). These guidelines are formally inspired by the Certification Standards of the *Government Council for Drug Policy Coordination*, and the certification process is also similar. Certification is a precondition (although not the only one) for obtaining a subsidy from the departmental budget.

11.2.3 Case or Diagnosis-Based Treatment Guidelines

As stated above, this is a crucial issue, and therefore a vexed one, in the entire circle of quality assurance. There are not many optimum models. From the professional perspective, the basic requirements for the drafting of the guidelines include: (1) an evidence-based approach; (2) the broad involvement of professionals, and (3) the consensus of the relevant professional community.

In the area of addictions, the guidelines from the United Kingdom or the proposals of the Hamburg team of Professor Haasen drafted for the European Commission can be considered examples of achievable guidelines (Department of Health (England) and the devolved administrations, 2007; Haasen et al., 2008).

The development of these guidelines for professional treatment in the Czech Republic is a long-term process, which requires the necessary active participation of all the institutions involved. The responsibility for these guidelines in the individual areas lies with the professional communities who are members of the *J. E. Purkyně Czech Medical Association*. In order to ensure that a consistent methodology is applied in the preparation of the national guidelines, the *Ministry of Health* has established the *Professional Forum for the Preparation of Treatment Guidelines and the Concentration of Selected Highly Specialised Care*[116]. Over 300 so-called diagnostic and treatment standards have been prepared, covering various acute and sub-acute conditions, in particular those in somatic medicine. As part of these initiatives, the *Psychiatric Association of the J. E. Purkyně Czech Medical Association* has formulated a set of the so-called "recommended procedures" for various diagnostic areas in psychiatry.

The *Recommended Treatment Procedures for Addiction Disorders and Pathological Gambling* (Nešpor, 2010), which follow up on the similar recommended procedures of the *Psychiatric Association* from 2006, form a component of the set (Popov and Nešpor, 2006). The new version of the *Recommended Procedures* was prepared without the knowledge and participation of the *Society for Addictive Diseases* of the *J. E. Purkyně Czech Medical*

[113] Procedures in the area of care and care quality management, in particular care availability and continuity; organisation of patient examinations and treatment; operational rules; qualified staffing; lifelong education; record keeping and other administrative, management, and organisational parameters; sanitary and epidemiological aspects; the security, rights, and safety of patients, etc.
[114] Annex 2 of Decree of the Ministry of Labour and Social Affairs No. 505/2006 Coll.
[115] Act No. 108/2006 Coll. on social services.
[116] See http://www.nrc.cz/cs/odborne-forum-pro-tvorbu-standardu-pece-koncentraci-vybrane-vysoce-specializovane-pece.

Association. Certain members of the Committee of the *Society for Addictive Diseases* have expressed their significant reservations regarding the *Recommended Procedures* (Jeřábek, 2010; Kalina, 2010). The *Society for Addictive Diseases* is preparing its own guidelines based on the prior activities in this field[117].

11.2.4 Guidelines for Methods

An evidence-based approach and the consensus of the professional community again represent the basic requirements. In the area of addiction treatment, good examples include the British set of guidelines for psychosocial interventions or the guidelines for substitution procedures published by the *WHO* (NICE, 2008; WHO, 2009).

In essence, the only guidelines of this type in the area of addictology also concern substitution. The first version of the Substitution Treatment Standard (Ministerstvo zdravotnictví ČR, 2008) of 2001 was prepared at the dawn of the development of substitution programmes in the Czech Republic. A major amendment to the Standard is currently being considered in order to sufficiently reflect upon the current developments in substitution programmes, as well as the "sample" substitution treatment guidelines of the *WHO* (2009). A comparison of the Substitution Treatment Standard with the criteria of the *WHO* guidelines is provided in Table 11-1. However, no matter how good the guidelines, they cannot ensure good practices if there is an absence of control, which is the case in the area of substitution in the Czech Republic – for details see the chapters on Opiate Substitution Treatment (page 50) and Drug Markets (page 105).

11.2.5 Ethical Guidelines

The "good practices" must necessarily include ethics, which, however, appears to be the Cinderella in quality assurance. The guidelines for centres, facilities, and programmes always discuss the rights of the patients in detail but often overlook the fact that each such right must also be based on an ethical obligation on the part of the provider. Ethical issues are often neglected, even in the specific professional guidelines. The codes of ethics of different professions and professional communities and their own control mechanisms (ethics committees etc.) seem to be put aside.

Even though ethical standards of various professions and specialisations operating in the drug services do exist in the Czech Republic, the level of ethical awareness is rather low and sensitivity to ethical problems is increasing only slowly. It is therefore interesting that, as early as in the mid-1990s, a code of ethics was implemented in the Czech Republic in the therapeutic communities for addicts[118] and has spread, with certain modifications, into other services. Even the *Certification Standards* make reference to this code of ethics and require the certified facility to ensure awareness of the code and adherence to it[119] (the Standards classify this item as "required").

[117] For example, the area of dealing with acute conditions has been previously addressed (Dvořáček, 2003), and there is publication and research support available for the area of therapeutic communities for addiction treatment.
[118] It originated from the World Federation of Therapeutic Communities (WFTC).
[119] A-General, Section 5.11.

Table 11-1: The comparison of the Substitution Treatment Standard with the criteria of the WHO guidelines.

WHO guideline recommendation	Included in the Czech guidelines?	Remarks
Choice of treatment		
Most opiate/opioid-dependent patients should be advised to use opioid agonist maintenance treatment as the pharmacological method of choice.	No	Substitution therapy is specified as the method of second choice for patients who are objectively or subjectively incapable of undergoing treatment without opioid agonists.
For patients not commencing opioid agonist maintenance treatment, antagonist pharmacotherapy following the completion of opioid withdrawal should be considered.	No	The Czech guidelines do not address any other types of therapy, i.e. also no opioid antagonist pharmacotherapy.
Opioid agonist maintenance treatment		
For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine.	No	The Czech guidelines do not address this issue.
During methadone induction, the initial daily dose should generally not be more than 20 mg, and certainly not more than 30mg.	No	The initial daily dose is set at 5-10 mg for patients with a lower tolerance and 20-40 mg for patients with a higher tolerance.
On average, methadone maintenance doses should be in the range of 60-120 mg per day.	n. a.	The average dose is not specified. It is determined on an individual basis. The usual dose is 60 to 100 mg per day but the necessity of administering a multiple of the recommended dose has been reported in individual cases or under specific circumstances (e.g. in the case of a concurrent antiretroviral therapy).
Average buprenorphine maintenance doses should be at least 8 mg per day.	No	The lowest therapeutic dose is set at 4 mg per day or 8 mg every other day, respectively.
Methadone and buprenorphine doses should be directly supervised in the early phase of treatment.	Yes	Supervision for at least 2 hours following the administration is required.
Take-away doses may be provided for patients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion, subject to regular review.	No	The continuous review of the patient does not expressly mention this specific aspect.
Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence.	Yes	Four types of substitution therapy are defined, three of which include psychosocial or social support/counselling as standard. Such support is not included only in the short-term emergency administration (hospitalisation for other illnesses, etc.).
Management of opioid withdrawal		
For the management of opioid withdrawal, tapered doses of opioid agonists should generally be used, although alpha-2 adrenergic agonists may also be used.	Yes	Opioid withdrawal schemes using opioid agonists are specified as the method of first choice; alpha-2 adrenergic agonists are not mentioned in the guidelines.
Clinicians should not routinely use the combination of opioid antagonists and minimal sedation in the management of opioid withdrawal.	n. a.	The Czech guidelines only provide the withdrawal (detoxification) schemes and are not specifically a guideline for opioid withdrawal using substitution preparations. They specify the general interactions between the substitution substances and other pharmacological groups, including sedatives.
Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal.	n. a.	The Czech guidelines do not address this issue.
Psychosocial services should be routinely offered in combination with pharmacological treatment of opioid withdrawal.	n. a.	The Czech guidelines do not address this issue.
Pregnancy		
Opioid agonist maintenance treatment should be used for the treatment of opioid dependence in pregnancy.	Yes	Pregnancy is specified as a factor supporting entry into the treatment.
Methadone maintenance should be used in pregnancy in preference to buprenorphine maintenance for the treatment of opioid dependence; although there is less evidence about the safety of buprenorphine, it might also be offered.	No	The Czech guidelines do not address this issue (the authors do not consider such a recommendation appropriate/generalisable/evidence-based).

Note: The authors of the guideline, P. Popov and T. Zábranský, have been consulted regarding the information provided above. "n.a." means that the Czech guidelines either do not address the selected criterion or address it in another manner, which is specified in the Remarks column.

11.3 Development and Implementation Process

The *Standards of Professional Competency for Facilities and Programmes Providing Professional Services to Problem Substance Users and Persons with a Substance Addiction* (*Certification Standards*) were created in the period 1998-2003 on the basis of a previous document, the *Minimum Standards* issued and recommended by the then-existing interdepartmental *National Drug Commission*[120] in 1995. The *Minimum Standards* were prepared by Pavel Bém, who was the Secretary-General of the *National Drug Commission* at the time, on the basis of documents from the *WHO*. They were accepted quite positively by the provider community, and the *Association of Non-Governmental Organisations (A.N.O.)*, which was then established, adopted them with a view to becoming the accrediting association to guarantee the quality of the services of providers who are its members. This plan was never fulfilled because the opinion prevailed that it should be the state that should take over the process of standard certification, and that the verified quality of the service should be considered in the distribution of state grants. Despite many obstacles, the *A.N.O.* and the Secretariat of the *National Drug Commission/Government Council for Drug Policy Coordination* continued to work for a number of years on implementing the plan.

The project regarding the certification system[121] was implemented under the alternating competence of the *National Drug Commission/Government Council for Drug Policy Coordination* and of the *Ministry of Health*, but always by a relatively coherent group of external experts led by Kamil Kalina. The guidelines prepared by this group were tested in pilot studies and discussed by the professional community in order to achieve a clear and widespread consensus and unquestionable compatibility between the certification standards and the simultaneously pursued efforts of the individual ministries, in particular the *Ministry of Health*[122] and the *Ministry of Labour and Social Affairs*. In the last stage,[123] the process for the verification of the standards, i.e. the certification of professional competency, was designed and established. The documents produced included the *Certification Rules*, accompanying manuals, a scoring system[124], and a set of templates for the standards. The first seminar was organised for the future certifying officers – practitioners. In 2005 the Government approved[125] the entire certification system and authorised the *Government Council for Drug Policy Coordination* to award the certificates. The certification programme was launched in 2005. In terms of organisation, the certifications are supported by a third party (an NGO), the so-called certification agency[126]. The on-site audits are conducted by a team of three trained certifiers, and the outcomes are discussed by the *Certification Committee of the Government Council for Drug Policy Coordination,* whose recommendations are used by the *Government Council for Drug Policy Coordination* to grant the certification. In 2005-2009, the certification was awarded for a maximum of 3 years.

An evaluation of the first stage of the evaluation process (2005-2006) was conducted and resulted in a number of suggestions for the modification of the process, standards, and scoring system (Radimecký J. et al. 2008). These suggestions were partially used in the amendment to the *Certification Rules* and to other documents applicable to the certification process. The desired innovation of the standards themselves and of the scoring scheme has not taken place. Neither has the specialised section been extended by additional types (suggestions for the dedicated standards for drug services in prisons and for multipurpose outpatient facilities, respectively, have been considered for many years).

The current version of the standards is described in Table 11-2. Their general part (Part A) provides a comprehensive and detailed idea of "quality". It consists of 12 sections and a total of 136 items, 42 of which are classified as "required". The special standards for the 9 basic types of services, described in Part B, consist of 18-25 items, with 3-8 of them always classified as "required"[127]. According to the scoring system, a facility must score at least 635 out of the available 815 points (80%) in the general part, of which 176 points must be obtained for the "required" items (28% of the minimum score). In the special part, a facility should score at least 125 out of the available 165 points (76%) on average for all the types of services, of which 25 points must be obtained for the "required" items (20% of the minimum score). The required items in the general part include, for example, staff training, independent supervision, and the evaluation of service efficiency.

[120] Now the *Government Council for Drug Policy Coordination (GCDPC)*.
[121] The terms "accreditation" and "accreditation standards" were used during the initial years.
[122] At the time, they concerned the ISQua/JCIA criteria (Kalina K. et al., 2002).
[123] As part of the PHARE Twinning CZ 2000/IB/JH/03 *Strengthening National Drug Policy* project between the Czech Republic and Austria.
[124] The rather complex scoring system was based on the then-existing accreditation scoring sheet of the Joint Accreditation Commission of the Czech Republic (for hospital accreditation).
[125] Government Resolution No. 300 of 16 March 2005 regarding the proposed changes in drug policy funding.
[126] The *Centre for Quality and Standards in Social Services (CEKAS)* of the *National Training Fund* performs the role of the certification agency under a contract with the Office of the Government of the Czech Republic; for additional information see http://www.cekas.cz/.
[127] As far as aftercare programmes are concerned, additional partial standards and scoring systems are also provided for sheltered housing and protected employment, if applicable.

Table 11-2: Content of the Certification Standards of the Government Council for Drug Policy Coordination

A – General	**B – Special ("type" standards)**
1. Availability of professional services	1. Detoxification
2. Patient/client rights	2. Outreach programmes (including syringe and needle exchange programmes)
3. Admission and initial assessment	
4. Range of services and principles of their provision	3. Low-threshold and counselling services (including syringe and needle exchange programmes)
5. Human resources	
6. Professional leadership and development of staff and teams	4. Outpatient treatment
7. Accessibility, external relations	5. Day care programmes
8. Organisational aspects	6. Short-term and medium-term institutional treatment
9. Finance	7. Residential care in therapeutic communities
10. Environment and physical resources	8. Outpatient aftercare programmes (including sheltered housing and protected employment programmes)
11. Minimum safety	
12. Service quality and efficiency evaluation	9. Substitution treatment

Even though the dedicated standards in Part B specify in quite considerable detail what the relevant facility should do to meet the standard (including the application of the required or desired approaches), they cannot be considered "treatment guidelines" as understood by the *EMCDDA*. It was not the objective in the preparation of this set of standards to specify the procedures, and hence this dimension is completely absent. The inadequacy in this respect was shown by a study aimed at Standard B7 – Therapeutic communities (Kalina, 2007b). The study confirmed the pre-existing concern that facilities certified according to Standard B7 may not even be a therapeutic community within the meaning of internationally recognised criteria for a therapeutic community as an evidence-based treatment method. Therefore, an additional standard for B7 has been drafted, verified in a pilot project, and published, but has never seen use in the certification practice (Kalina, 2006). The same may apply to other dedicated standards in the certification dossier.

The original ambition of the certification standards was high: they were to become the actual "national guidelines" for the area of drug services, and meeting them was to be the prerequisite for access to any public funding (i.e. to subsidies from the state or the regions, as well as to payments from health insurance companies). However, their importance and value have been reduced in recent years because the departmental approaches have prevailed over the interdepartmental one. The certification is currently not recognised even by the *Ministry of Health* (it has its own criteria and mechanisms to evaluate quality in the health care sector) or the *Ministry of Labour and Social Affairs* (which has its own standards for quality in social services and for their verification as part of the inspection process). The certification is now only one of the requirements for access to subsidies from the *Government Council for Drug Policy Coordination*. In the distribution of subsidies, it is taken into consideration by Prague and by certain other regions. In the years 2009-2010, the certification system has struggled with a lack of funding and the certification audit process has already been suspended twice for that reason.

A list of the certified programmes by type as of June 2010 is provided in Table 5-2 (page 47).

11.3.1 The Standards for Quality in Social Services and Their Relevance for Addiction Treatment Services

The Standards for Quality in Social Services of the *Ministry of Labour and Social Affairs* were drafted almost simultaneously with the Certification Standards of the *Government Council for Drug Policy Coordination*, with certain experts working in both teams. There was an effort on the part of the creators of the Certification Standards to achieve "tight compatibility", which means that the Certification Standards contain all the fundamental components of the quality standards of the *Ministry of Labour and Social Affairs*. The opposite, however, does not, and perhaps even cannot apply because the ministry and its working groups prepared the standards for all the social services ranging from conventional homes for senior citizens and institutions for persons with physical or mental disabilities or those with sensory impairments to small non-governmental initiatives such as early intervention or crisis centres for children. The ministry made no secret of the fact that it was mainly seeking to improve the quality of the care provided in large institutions, where the quality level was often critical.

In comparison with the Certification Standards, the standards of the *Ministry of Labour and Social Affairs* are professionally less sophisticated, and they are also "only social", which interferes with the required comprehensive and bio-psycho-social approach to services for drug users. A comparison of these two sets of standards using 13 aspects is shown in Table 11-3 (Kalina K. et al., 2002). As far as the dedicated standards for the individual types of social services are concerned, the *Ministry of Labour and Social Affairs* launched its activities in this field but eventually abandoned this large-scale project; the individual types are therefore briefly described in social legislation.

Table 11-3: Comparison of the Certification Standards and the Standards for Quality in Social Services (Kalina K. et al., 2002)

Aspect of the *Certification Standards* of the *Government Council for Drug Policy Coordination*	**Standards for Quality in Social Services of the *Ministry of Labour and Social Affairs***
1. Quality facility	Yes
2. Comprehensive assessment of the client upon admission	Yes – differently
3. Evaluated and documented process of care	Yes
4. Bio-psycho-social approach	No
5. Comprehensiveness of care	No
6. Continuity of care	Yes
7. Confidentiality of information	Yes
8. Minimum safety requirements	Partially
9. Client rights	Yes
10. Adequate team composition	Yes – differently
11. Staff training	Yes
12. Evaluation of efficiency	Partially
13. Mandatory content and scope of care depending on type	No

The standards of the *Government Council for Drug Policy Coordination* were endorsed only by a Government resolution, i.e. in the lowest and least binding legal norm, while the standards for social services are backed by a specific legal regulation[128]. The law also specifies the mechanism for their verification – through the inspection of social services, which is usually conducted by regional officials under the State Audit Act. The providers of services for drug users and the experts in the field have varying views of the impact of the social standards and inspection on the addiction treatment policy and specialisation previously implemented and achieved, respectively, in the area of drug services. Attempts by the *Government Council for Drug Policy Coordination* to achieve interdepartmental harmonisation of the standards have failed as the *Ministry of Labour and Social Affairs* continues to refer to the act on social services.

11.4 Summary of the Development of Certification Standards in the Czech Republic

The development of a series of guidelines and standards for agencies and programmes in the Czech Republic during almost the past 15 years, from the issue of the first *Minimum Standards* to the *Certification Standards*, can be seen as highly valuable for both the services and the professionals. The integrated and detailed description of the services has raised and unified the standard of services, made its way into publications, as well as the curricula of the discipline of addictology, inspired primary prevention standards, and initiated professional activities regarding other types of evaluation criteria, which should introduce additional aspects to the criteria[129], thus encouraging more publication, research, and training efforts.

On the other hand, it is apparent that there are significant gaps and excessive blank spaces in the Czech Republic in the core areas of treatment guidelines, diagnostic and treatment procedures, recommended evidence-based procedures, etc. With regard to the data provided in the preceding sections of this selected issue, there is a risk that even the *Certification Standards*, which are, quite rightly, considered the "family silver" of addictology, will lose their place and importance in the system of drug services.

Table 11-4 attempts to briefly analyse the current status in the area of quality assurance in services for drug users and addicts in the Czech Republic.

[128] Act No. 108/2006 Coll. on social services.

[129] E.g. the list and definitions of the interventions pursued in addictology, the so-called Minimum Evaluation Set (Národní monitorovací středisko pro drogy a drogové závislosti, 2006); the above-mentioned standard for a therapeutic community as a method; the drafting of the main performance indicators (Russel, Hrdina, Kalina, and Kuda, incomplete and unpublished); the cost-effectiveness criteria for the grant procedures of the *Government Council for Drug Policy Coordination*, etc.

Table 11-4: Attempted SWOT analysis of the current status in the area of quality assurance in services for drug users and addicts in the Czech Republic.

Strengths
Both medical and non-medical professional qualifications in the field exist
15 years of the stimulating impact of the Minimum/Certification Standards
Introduction of a professional certification process
Capability and willingness of the professional community to address quality and pursue professional development
Weaknesses
Evidence-based diagnostic and treatment guidelines are absent or inadequate
Uncoordinated initiatives, many existing methodologies and evaluation tools are not utilised
Insufficient funding of research and development
Poor assurance and insufficient control of adherence to procedures, e.g. in substitution
Fragmentation of interdepartmental and departmental approaches; certification standards are pushed aside by departmental schemes
Opportunities
The new Action Plan of the Czech Republic includes the creation of diagnostic and treatment guidelines and other innovative measures
Increasing opportunities for the involvement of addictology students and graduates in projects concerning quality
A programme is being formulated to link research and practice in addictology
Threats
Insufficient funding may reduce service quality
The certification system of the Government Council for Drug Policy Coordination may cease to exist
The specific (drug) specialisation may be weakened in services falling within the social sector

12 Mortality Related to Drug Use

This chapter summarises the mortality (cohort) studies among drug users carried out hitherto in the Czech Republic and related public health implications.

Drug users in the Czech Republic show a higher mortality rate in comparison to their peers in the general population. The available studies suggest that their relative risk of death is at least 10 times higher than is the case for the comparable general population age group. Women and very young adults show the highest risk, given the respective low mortality rates for these demographic groups in the general population. The most common causes of death in the case of drug users (in approximately 75% of cases) include external (violent) causes of death and intoxication. Proportionally, the highest risk of death occurs shortly after the onset of (problem) drug use, which is usually at a very early age.

12.1 Introduction

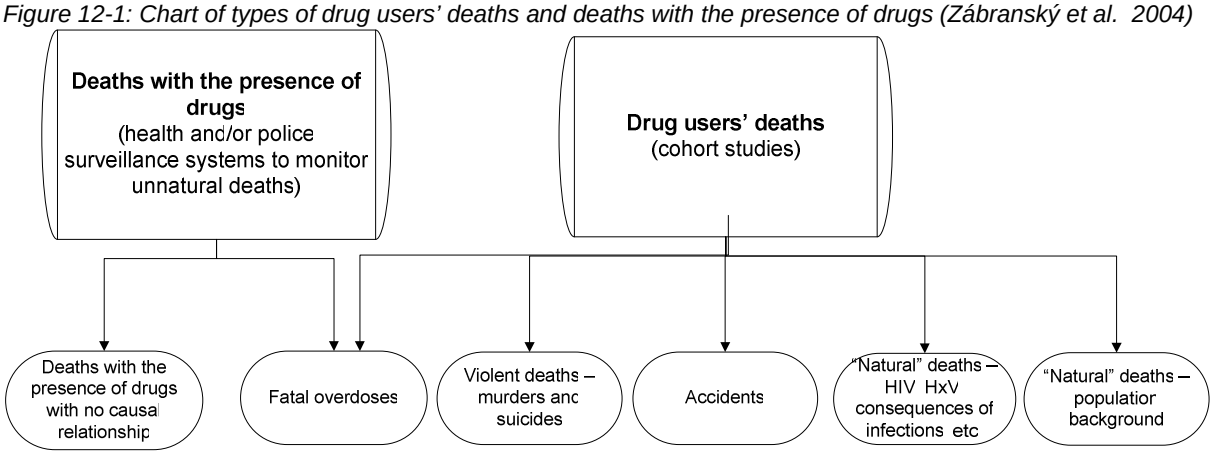
The use of both legal and illegal drugs may lead to a range of serious health problems, some of which may result in (premature) death. In particular, heavy (frequent) drug use and/or high-risk forms of using[130] are extremely dangerous in this respect.

As the most serious and irreversible consequence of illicit drug use, death has received growing international attention in recent years. In the Czech Republic, deaths by overdose or fatal acute poisonings caused by (illegal) drugs are well accounted for by means of a nationwide reporting system (for more details see the chapter Drug-related Deaths and Mortality of Drug Users on page 74). Regarding other types of drug-related deaths, however, the situation is more complicated. As they are related to

- the chronic toxicity of drugs (e.g. circulatory system disorders in stimulant users),
- the consequences of infectious diseases contracted as a result of drug use (including, typically, HIV, liver cirrhosis, endocarditis, myocarditis, and phlebitis),
- the social consequences of drug use and drug users' living conditions and lifestyles (accidents, violent deaths, and suicide),

or have no relationship with drug use and involve deaths similar to those encountered in the general (non-using) population[131], the examining physician may not find the death to be associated with drug use, and, therefore, such deaths are not recorded as "drug-related" in the autopsy report. In addition, the examining practitioner generally has no resources to identify a person whose death resulted from causes other than a fatal overdose as a drug user[132].

Figure 12-1: Chart of types of drug users' deaths and deaths with the presence of drugs (Zábranský et al. 2004)



Therefore, it is not possible to identify the overall mortality of drug users and other related indicators[133] by means of the standard reporting system, as is the case with fatal overdoses on illicit drugs.

In view of the above, the overall mortality of (illegal) drug users is determined, or estimated, using *cohort studies*, where a cohort (a set of a number of individuals who share a certain feature) consists of a defined group of users of

[130] I.e., for example, injecting into veins, arteries, and muscles, combining various illegal drugs, and mixing drugs and alcohol.
[131] For example, both users and non-users of drugs die during flu epidemics. The proportion of the drug users' death rate which equals the death rate of non-users of drugs is then referred to as the "population background" for the drug users' death rate.
[132] Or the relationship between the death and drug use cannot be determined. Neither forensic medicine nor pathology departments possess resources which would make it possible for them to carry out thorough historical investigations. In fact, it is not their responsibility to pursue the epidemiological identification of causes of deaths with a distant aetiology.
[133] Typically, indicators of the (high) risk of death to which drug users are exposed in comparison to the non-using or general "average" population (such as the relative death risk).

illegal drugs, inhalants, and psychotropic pharmaceuticals used for purposes other than medicinal ones[134]. Such a group then serves to determine the death rate, using either a prospective (over time, in the future from the point of identification) or retrospective (backwards, from the point of identification in the past towards the present) approach.

In the Czech Republic, the first type of cohort study, where a cohort of drug users is identified first and then such drug users are followed up periodically in order to establish their health status, has not been conducted in its typical form. A study designed in a similar manner, however, has been in progress. It involves a follow-up (after 10 or more years) on the life, health, and social status of a cohort of problem drug users interviewed in the second half of the 1990s at treatment facilities and low-threshold harm reduction centres in Prague (see below).

Two retrospective cohort studies have been conducted in the Czech Republic. As part of them, historical drug user samples (cohorts) were extracted from the existing registers in order to find, by pairing the data with the general mortality register (*Deaths* information system), which of these (ex-) drug users had died, including the information on the dates and causes of their deaths.[135]

12.2 Summary of Drug-related Mortality Cohort Studies in the Czech Republic

Three cohort studies of mortality among drug users have been carried out in the Czech Republic:

1. Historically, the first Czech study looked into the mortality of 18,772 people aged 15-49 (at the time of the first entry)and identified as drug users in three health registers (Lejčková and Mravčík, 2005; Lejčková and Mravčík, 2007). The study worked with the following four (cohort) subsamples:

   a. 207 people hospitalised in the Czech Republic in 1997-2002 with disorders resulting from the use of illegal psychotropic substances, inhalants, and psychotropic medication as their primary diagnosis (diagnoses F11–F19, excluding F17);
   b. 2824 people with drug use disorders as their secondary diagnosis admitted to Czech hospitals in 1997-2002;
   c. 704 patients in substitution treatment in the Czech Republic from 2000 to 2002;
   d. 3037 individuals with formally diagnosed viral hepatitis reported in the Czech Republic in 1997-2002 and identified as ex-users/users of drugs.

   The data obtained in such a manner were paired (cross-references were identified) with the 1997-2002 general mortality register.

2. Elaborating the methodology of the previous one, the second study employed the same registers as the former research, but worked with sources of data covering a longer period, with the exception of the sample comprising people with viral hepatitis (Zábranský et al. 2009). The sample of 27,475 problem drug users aged 15-39 (at the time of the first entry) consisted of:

   a. 20,068 people hospitalised in the Czech Republic in 1997-2007 with disorders resulting from the use of illegal addictive substances, inhalants, and medication as their primary diagnosis (diagnoses F11–F19, excluding F17);
   b. 5827 people with drug use disorders as their secondary diagnosis admitted to Czech hospitals in 1997-2007;
   c. 1580 patients in substitution treatment in the Czech Republic from 2000 to 2007.

   The general mortality register, with which the data obtained in this way were paired, included individuals who died in the period 1997-2007.

3. The most recent and methodologically different study followed the mortality of a sample of 185 people who were interviewed between April 1996 and December 1998, when they were clients of low-threshold facilities and residential addiction treatment institutions, as part of a study focused on the risk factors of the development of addiction (Csémy, 1999; Zábranský et al. 2010). The data of 151 respondents who consented to being subjected to a follow-up study were compared to the general mortality register for the years 1994-2008, inclusive, as part of the preparatory phase of the *FUP1990s* study. At the time of the finalising of this annual report, a follow-up component of the study is in progress. During this stage, the surviving participants in the 1990s study are contacted and subjected to a thorough quantitative interview, as well as a qualitative interview, including a battery of psychological tests, in order to survey the "natural progress of their illness". The field follow-up stage of the study will be completed in 2010 and the first results of the analysis will be published in 2011.

[134] Typically, users who were in treatment or engaged with any other agency providing specialised services for illicit drug users, or a law enforcement agency, as applicable.

[135] In all three studies, a birth registration number was used as a feature to pair database entries. The birth registration numbers were encoded using a one-way cipher generated by the *EpiCrypt* software which was assessed and approved for the purposes of epidemiological surveys by the *Office for Personal Data Protection*. As a result, the identity of neither the dead nor the survivors contained in the databases employed by the studies was known to any investigators involved in any of the research projects described in the chapter.

12.2.1 Overall Mortality among Problem Drug Users

The earliest study by Lejčková (Chomynová) and Mravčík (2005) looked for the crude mortality rates in all four study groups (subcohorts). The highest level was found among drug users identified thanks to their hospitalisations with disorders resulting from the use of illegal substances, inhalants, and medication (hereinafter "drug use disorders") as the secondary diagnosis. This may have resulted from the type of identification of the study participants in this cohort, i.e. from the fact that, beyond the drug use disorders, the identified drug users had suffered from another serious illness which was the primary cause of their being admitted to hospital.

A summary of the basic characteristics of the 2005 study (sub-) cohorts, including mortality rates (per 1000 person-years[136] – indicated in ‰), is provided in Table 12-1.

More thorough analysis of the oldest study's subcohort, including people who were admitted to hospital primarily for drug use disorders, showed that their mortality grew with the patients' age – from 2.60‰ in the 15-19 age cohort to 29.36‰ in the 45-49 age cohort – and declined with the time that had elapsed since their first hospitalisation.

Table 12-1: Description of cohorts in the 2005 study on drug use-related mortality (Lejčková and Mravčík, 2005)

Cohort of 15-64-year-olds	Years under study	Number of persons in the cohort	Number of deaths in the cohort	Follow-up person-years	Crude mortality rate (‰)
Hospitalised – primary diagnosis F11–F19	1997-2002	12,207	320	37,325.20	8.39
Hospitalised – secondary diagnosis F11–F19	1997-2002	2824	112	7,259.79	15.43
Injecting drug users – viral hepatitis (EPIDAT)	1997-2002	1998	36	4,991.46	7.21
Drug users in substitution treatment	2000-2002	706	8	1,106.51	7.23

In comparison to the first research project, a study by Zábranský et al. (2009) was able to use data from a time period that was twice as long, but the cohort only included people from 15 to 39 years of age, which made it (artificially) significantly younger. This explains the lower crude mortality in this cohort of drug users, particularly in the subgroup featuring drug use disorders as the secondary diagnosis where, necessarily, mortality from serious illnesses having primarily resulted in hospitalisation was recorded to a smaller extent than that observed in the older cohort used as part of the previous study; see Table 12-2.

Table 12-2: Description of cohorts in the 2009 study on drug use-related mortality (Zábranský et al. 2009)

Cohort of 15-39-year-olds	Years under study	Number of persons in the cohort	Number of deaths in the cohort	Follow-up person-years	Crude mortality rate (‰)
Hospitalised – primary diagnosis F11–F19	1997-2007	20,068	771	110,977.81	6.95
Hospitalised – secondary diagnosis F11–F19	1997-2007	5827	232	26,315.79	8.82
Drug users in substitution treatment	2000-2007	1853	42	12,173.80	3.45

The design of the third and latest Czech cohort study concerned with the mortality of drug users differs in both the lower number (by an order of two) of participants and the recruitment procedure: unlike both the retrospective studies, this research project involved an extensive assessment interview with drug users in low-threshold services and in residential treatment. Some characteristics of the users are summarised in Table 12-3.

[136] A person-year (generally person-time) is an epidemiological indicator encompassing the number of persons and the time over which they were observed as part of the study. It is used to follow the incidence of a phenomenon under study (deaths, in our case), as not all the persons are followed for the same amount of time. Typically, this involves people who have developed a condition under study which puts an end to their individual time in observation, or people who enter the process (study) at different points. The incidence, the incidence of deaths in our case, or death rate (mortality), is then expressed as a ratio of the newly developed conditions under study (deaths) to the total person-time of the sample being examined.

Table 12-3: Description of the FUP1990s study (Zábranský et al. 2010)

Variable	Males	Females	Total
Number	65	86	151
Average age at the time of the first contact	18.2 years	17.2 years	17.6 years
Mean age at the time of the first contact	18 years	17 years	18 years
Heroin as a drug of choice	27 (42%)	38 (44%)	65 (43%)
Pervitin as a drug of choice	34 (52%)	43 (50%)	77 (51%)
Drug of choice other than above	4 (6%)	5 (6%)	9 (6%)
Low-threshold centre 1	13 (20%)	14 (16%)	27 (18%)
Low-threshold centre 2	45 (69%)	44 (51%)	89 (59%)
Inpatient addiction treatment department	4 (6%)	15 (17%)	19 (13%)
Institution for juvenile delinquents and children with behavioural disorders	3 (5%)	6 (7%)	9 (6%)
Home for children with special needs (incuding addiction)	0 (0%)	7 (8%)	7 (5%)

The drug user cohorts surveyed by both retrospective studies showed significant gender differences in mortality rates. Both studies also found a statistically significant difference between the crude mortality of polydrug users on one part and users of a single drug (used by injecting); see Table 12-4 and Table 12-5.

Table 12-4: Person-years and mortality rates (‰) - by gender and drug of choice - among individuals hospitalised for drug use disorders as their primary diagnosis (N=12,207), included in the 2005 study (Lejčková and Mravčík, 2005)

Gender	Follow-up person-years				Crude mortality rates			
	Opiate users	Stimulant users	Polydrug use	Total	Opiate users	Stimulant users	Polydrug use (all combinations)	Total
Males	9,209.9	6,081.5	6,873.9	25,313.7	9.88	6.08	12.07*	9.96*
Females	4,114.0	3,666.8	3,138.3	12,817.4	5.59	3.00	6.37	5.31*
Total	**13,323.9**	**9,748.4**	**10,012.2**	**38,131.2**	**8.56**	**4.92**	**10.29**	**8.39**

*Note: * Statistically significant differences (p=0.05).*

Table 12-5: Person-years and mortality rates (‰) - by gender and drug of choice - among individuals hospitalised for drug use disorders as their primary diagnosis (N=20,068), included in the 2009 study (Zábranský et al. 2009)

Gender	Follow-up person-years				Crude mortality rates			
	Opiate users	Stimulant users	Polydrug use	Total	Opiate users	Stimulant users	Polydrug use (opiates + stimulants)	Total
Males	21,898.9	23,371.3	3,255.7	48,525.9	8.49	5.90	2.31*	8.46*
Females	9,761.2	12,687.2	1,766.3	24,214.7	3.89	2.84	0.55	3.69*
Total	**31,660.2**	**36,058.5**	**5,022.0**	**72,740.6**	**7.07**	**4.83**	**1.95**	**6.47**

*Note: * Statistically significant differences (p=0.05).*

The gender difference in mortality was the greatest in the third – prospective – study, as all eight people who had died were men (no woman died in the period under scrutiny); see Table 12-6.

Table 12-6: Person-years and mortality rates (‰) - by gender and drug of choice - in follow-up on 151 clients who were clients of low-threshold and treatment facilities in Prague from 1996 to 1998 (Zábranský et al. 2010)

Gender	Follow-up person-years				Crude mortality rates			
	Opiate users	Stimulant users	Other drugs of choice	Total	Opiate users	Stimulant users	Other drugs of choice	Total
Males	263.98	365.63	46.67	676.28	18.94	8.21	0	11.829
Females	427.98	497.54	57.91	983.43	0	0	0	0
Total	**691.97**	**863.17**	**104.57**	**1659.72**	**7.225**	**3.48**	**0**	**4.82**

12.2.1.1 Standardised Mortality Rate

The *standardised mortality rate*, or *standardised mortality ratio* (SMR), is considered a more objective and illustrative indicator of the death rate in specific cohorts. It shows how many times higher the mortality in the cohort of the identified drug users is than that observed in the reference population with the same age structure. In our case, it indicates the level of the risk of death for an average drug user from the given sample in comparison to an average Czech citizen of the same age.

Table 12-7: Standardised mortality ratios (SMR) in the 2005 study's cohorts (Lejčková and Mravčík, 2005)

Cohort	Total	Males	Females	Opiates	Stimulants	Polydrug use
Hospitalised – primary diagnoses F11-F19	8.149	8.130	8.224	8.960	6.224	8.614
Hospitalised – secondary diagnoses F11-F19	11.106	10.500	13.572	12.491	4.092	11.717
Injecting drug users – viral hepatitis (EPIDAT)	8.441	8.197	9.777	–	–	–
Drug users in substitution treatment	7.180	6.086	15.588	–	–	–

Table 12-8: Standardised mortality ratios (SMR) in the 2009 study's cohorts (Zábranský et al. 2009)

Cohort	Total	Males	Females	Opiates	Stimulants	Polydrug use (opiates + stimulants)
Hospitalised – primary diagnoses F11-F19	8.549	7.658	9.044	9.309	6.349	4.184
Hospitalised – secondary diagnoses F11-F19	11.600	9.072	14.394	13.342	8.150	5.458
Drug users in substitution treatment	4.539	3.405	6.677	4.960	–	1.329

The 2005 study concluded that drug users from the cohort of those admitted to hospital primarily for drug use disorders show a mortality rate approximately eight times higher than their counterparts in the general population. The highest standardised mortality rate (*SMR*) in this subgroup was recorded in female opiate users: their death rate is 11 times higher than that of their counterparts in the general population. The 2009 study, whose sample was followed for a period that was twice as long, found levels similar to those established by the 2005 study, despite the fact that it worked with a younger age cohort; the *SMR* indicator is controlled for the effect of the age structure. A higher *SMR* in the users with "drugs" as their secondary diagnosis has the same explanation as their high crude mortality rate: the presence of a serious illness other than the drug use disorder. On the contrary, polydrug users in the 2009 study show a lower level of risk than the sample as a whole. However, this is caused by a varying definition: in the 2005 study, the F19 diagnosis is applied to all polydrug users, i.e. users of multiple drugs in any combination thereof, including pills, while in 2009 this subgroup only included users identified as concurrent users of opiates and stimulants. Interestingly, the 2005 study recorded a high *SMR* among female drug users in substitution treatment – their mortality rate was more than 15 times higher than that among the general population; the 2010 study indicates that it is currently lower than in the remaining subcohorts.

Table 12-9: Standardised male mortality ratio (SMR) by age group in a study with 151 clients of low-threshold and treatment facilities in Prague from 1996 to 1998 (Zábranský et al. 2010)

Age cohort	Follow-up person-years	Deaths observed	Expected deaths in view of the general population	SMR	95% confidence interval
15-19	83.18754	3	0.049913	60.1	19.4-186.4
20-24	297.77618	3	0.238221	12.6	4.1-39.0
25-29	271.13415	2	0.244021	8.2	2.0-32.8
> 30	24.18412	0	0.024184	0.0	–
Total	**676.282**	**8**	**0.556338**	**14.8**	**7.2-28.8**

The prospective study, which analysed data pertaining to 151 clients of specialised agencies in the period 1996-1998, found the very highest standardised mortality rate among men (while no deaths were recorded among women). The reason is a highly specific study sample (very young problem users whose deaths pertain to age cohorts which show extremely low levels of mortality in the standard population) and probably also its relatively small size.

12.2.1.2 Survival Probability

Analysis of the survival probability in the retrospective cohort study using the 1997-2007 patient data and in the prospective study with 151 clients of specialised services as specified in Table 12-10 shows the highest mortality rate (a survival probability gradient with the steepest downwards tendency) among "novice" problem drug users.

Table 12-10: Survival probability in individual studies (Zábranský et al. 2009; Zábranský et al. 2010)

Study	1 year later	2 years later	3 years later	5 years later	10 years later
1997-2007 retrospective study	0.9919	0.9856	0.9811	0.9721	0.9576
Prospective study with the 1996-1998 clients	0.9934	0.9538	0.9077	0.9077	0.8769

12.2.2 Cause-specific Mortality among Problem Drug Users

Both retrospective cohort studies involved the analysis of specific mortality according to the causes of deaths in the subcohort of people admitted to hospital with a drug use disorder as their primary diagnosis. Both studies generated consistent results, suggesting that the most common causes of death among drug users include injuries, poisonings, and other external factors; these accounted for approximately three quarters of all the cases of deaths identified in both retrospective cohort studies. Other common causes of death in both studies included diseases of the circulatory (approximately 7.5% of deaths) and digestive (approximately 5%) systems. A detailed breakdown of the causes of the deaths of hospitalised drug users from 1997 to 2007 is provided in Table 12-11.

The major role of external causes in terms of drug users' mortality is also confirmed by the structure of the causes of death in the cohort of 151 young injecting drug users contacted from 1996 to 1998 via agencies providing specialised services and treatment. All eight deaths which have hitherto occurred in this cohort can be attributed to the "external cause of death" category. Fatal drug overdoses were the most frequent (4 cases, i.e. 50%). Overdoses on alcohol and cyanide accounted for 1 case each; the latter was probably suicide. Death as the result of an injury occurred on two occasions.

Table 12-11: Structure of causes of death by diagnostic groups of dead drug users – inpatients – in the period 1997-2007 from the 2009 study (Zábranský et al. 2009)

Diagnosis group	Number	%
Infectious and parasitic diseases	10	0.96
Neoplasms	15	1.44
Diseases of the blood and immune systems	15	1.44
Endocrine, nutritional, and metabolic disorders	4	0.38
Mental and behavioural disorders	23	2.20
Diseases of the nervous system	25	2.39
Diseases of the circulatory system	80	7.66
Diseases of the respiratory system	23	2.20
Diseases of the digestive system	52	4.98
Diseases of the musculoskeletal system	2	0.19
Diseases of the genitourinary system	7	0.67
Congenital malformations and deformations	2	0.19
Injury, poisoning, and other external (violent) causes	765	73.21
Symptoms and findings, not specified elsewhere	22	2.11
Total	**1045**	**100.00**

12.2.3 Risk and Protective Factors of Deaths among the Population of Problem Drug Users

None of the cohort studies hitherto carried out in the Czech Republic has included rigorous analysis of prediction factors concerning the risk of death in the population of problem drug users. No prediction model similar to the Cox regression model has been developed either. However, the existing analyses suggest that, among drug users, men show a higher risk of death than women, the highest risk is associated with the youngest age, or a period shortly after the onset of drug use, and the risk decreases as the drug career grows longer. Participation in substitution treatment, particularly among women from the first retrospective study, seemed to be a prediction factor for a very high risk of death; given its decrease observed in the second retrospective study which worked with similar data, although for a period of time that was twice as long, this may result from the inclusion of the most problematic proportion of the population shortly after the substitution treatment programmes had been launched in the Czech Republic. From a longer-term perspective, on the contrary, both men and women in substitution treatment are associated with a lower risk of death than patients in other treatment modalities.

12.3 Complementary Sources with Drug-related Mortality Information

12.3.1 Mortality among HIV/AIDS Cases

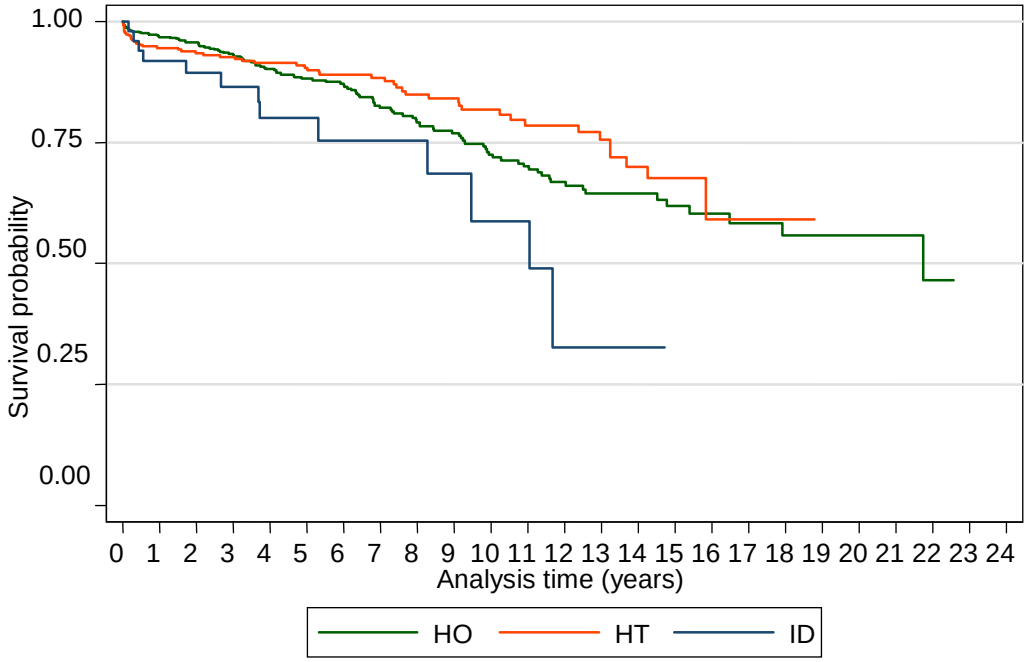
A database of all the diagnosed HIV/AIDS cases, including the specification of the assumed route of transmission, has existed in the Czech Republic since 1987. As of 31 July 2010 the National Reference Laboratory for AIDS at the National Institute of Public Health in Prague had registered a total of 1462 cases of HIV infection among Czech citizens and people residing in the Czech Republic.

A total of 217 deaths of HIV-positive people were recorded from 1987 to 31 July 2010, out of whom 160 were suffering from AIDS symptoms at the time of dying and 57 cases were asymptomatic. The most common causes of death in the asymptomatic HIV-positive category include cardiovascular diseases, suicide, and accidents.

The deaths included 13 HIV-positive individuals who contracted the infection through injecting drug use; intoxication was ascertained as the cause of death in two of them. Another three deaths came under the "injecting drug users + homo-/bisexual men" category; one committed suicide. Another two individuals who died had a history of injecting drug use, but both were likely to have contracted the virus through homosexual intercourse; one of them died of a drug overdose (Malý, 2010).

Analysis prepared for the purposes of this Special Issue concludes that HIV-positive patients assumed to have contracted the infection through injecting drug use show a statistically significant lower level of survival than the heterosexual transmission group ($p<0.01$) and even than the homosexual transmission groups ($p<0,05$); see Figure 12-2. The possible reasons for this may include a lower rate of compliance with treatment and higher susceptibility to infections and other diseases, particularly when patients persist in injecting drug use. Nevertheless, the interpretation must take into account the small number of people in the HIV-positive IDU group.

Figure 12-2: Kaplan-Meier survival curve of three groups of HIV-positive persons in the Czech Republic since 1987 (Malý, 2010)



Note: HO – homosexual transmission; HT – heterosexual transmission; ID – injecting drug use.

12.3.2 Mortality Resulting from Diseases and External Causes of Death

The structure of cause-specific death rates in the mortality studies carried out thus far in the Czech Republic is covered by Section 12.2.2 (p. 127).

The first retrospective cohort study used EPIDAT as a source of data. This database collects information on the reported cases of infectious diseases, including viral hepatitis, also indicating the assumed route of transmission of the infection, including injecting drug use. The results available for this subcohort of drug users in 1997-2002 are summarised in Table 12-1 and Table 12-7.

Regular analyses of road fatalities involving people under the influence of alcohol and other drugs use data from the special death register supplied by the forensic medicine departments; their results are summarised in the chapter on Drug-related Deaths and Mortality of Drug Users (p. 74). The special mortality register, however, does not include data on either previous or present drug use, which makes it only useful for the analysis of data concerning people whose body fluids and/or tissues contained drugs or metabolites thereof at the time of death. As a result, it may not be used to analyse the deaths of drug users for reasons other than overdoses.

12.4 Public Health Implications

Both previous nationwide cohort studies examining the mortality of drug users in treatment concluded in an agreement that external violent deaths and poisoning were among the most common causes of drug users' deaths

(accounting for approximately 75%). This finding was further supported by the non-representative prospective study on young problem drug users who were in contact with a range of treatment services in Prague from 1996 to 1998. All three studies also show that the highest proportional risk of death among injecting drug users occurs shortly after the onset of injecting drug use or drug use in general, usually at a very young age. Other causes of death for drug users include circulatory and digestive diseases which generally develop within a longer time span from the commencement of drug use. Although their crude mortality rate is lower than that among males, female drug users show a significantly higher relative risk of death (i.e. in relation to the non-user population) than men.

Logically, these findings imply the following recommendations for the specific prevention of mortality among this high-risk population group:

- to focus on the development of specific interventions for young and very young drug users, including programmes aimed at reaching out to them at the beginning of their drug careers;
- to develop modules of preventing risk situations (not only in terms of overdoses) for young male drug users. Peer-driven interventions appear particularly promising in this respect (Madray et al. 2000; Hughes, 1999).
- as far as the care of the aging population of problem/injecting users and ex-users of drugs is concerned, to focus on the prevention and early diagnosis of cardiovascular diseases resulting from the damage caused to the system by the frequent injecting of non-sterile solutions with a content of solid particles and the prevention and early diagnosis of diseases of the digestive system, and of the liver in particular, given the high prevalence of viral hepatitis among this population.
- in view of the high prevalence of viral hepatitis (especially HCV) among injecting drug users and the higher level of mortality of HIV-positive drug users in comparison to the remaining HIV-positive high-risk groups, to strive for the enhancement of compliance with virostatic and antiretroviral treatment in the group of infected drug (ex-) users.

13 Cost of Drug-related Treatment

This chapter provides an overview of the costs of drug-related treatment in the Czech Republic in 2007. They are addressed in the context of costs pertaining to other pillars of the drug policy (primary prevention and harm reduction) and divided up according to types of treatment interventions. It covers the costs incurred in relation to addiction and drug use counselling, treatment, and after-care, not those of the treatment of health consequences and complications, such as infectious diseases and injuries, brought about by drug use.

In the Czech Republic, drug addiction treatment is funded using health insurance, public resources (ministries, the *Government Council for Drug Policy Coordination*, regions, and municipalities), services' own resources, and private resources (clients' and patients' fees, contributions, and sponsorship). The data reflect the 2007 situation, as more recent data concerning the expenses of the General Health Insurance Company spent on drug-related treatment were not available for analysis.

The identified costs of prevention, harm reduction, and drug use treatment and aftercare in the Czech Republic in 2007 amounted to CZK 741.1 million (€ 28, 024 thousand); CZK 53.5 million (€ 2,023 thousand), CZK 148.9 million (€ 5,631 thousand), and CZK 505.9 million (€ 19,130 thousand) were spent on prevention, harm reduction, and treatment and aftercare, respectively. The most resources to fund treatment and aftercare, CZK 204.4 million (€ 7,729 thousand), were provided by health insurance. Treatment and aftercare receives less financial support from the budget of the *Government Council for Drug Policy Coordination* than harm reduction programmes, but significantly more than primary prevention.

When different types of programmes covering the domain of treatment and aftercare are compared, the greatest proportion of all the resources is earmarked for institutional treatment. The resources spent on abstinence-oriented outpatient treatment rank second, followed by substitution treatment in third place. The smallest amount of resources is dedicated to treatment in therapeutic communities and aftercare.

An additional comparison of treatment interventions indicates that therapeutic communities and aftercare programmes, which are not covered by health insurance, as they do not have the status of a healthcare facility, have the relatively smallest amount of financial resources to use. When the cost is calculated in relation to the number of clients, therapeutic communities turn out to be the most expensive, although the average period of treatment in a community is much longer than in an institutional setting.

13.1 Funding Sources

Information about treatment costs provided in this chapter was obtained from several sources. The first source of data was the *General Health Insurance Company* (*VZP*), and the data obtained related to the General Health Insurer's payments to psychiatric outpatient and inpatient facilities for health interventions, pharmaceuticals, and medical materials provided for patients with a primary diagnosis of F11–F19[137]. Another public source is subsidies, specifically from the state budget (Office of the Government of the Czech Republic – Government Council for Drug Policy Coordination and individual ministries) and local budgets (regions and municipalities) quantified in the 2007 Annual Report. The next source is internal resources, fees paid by clients for treatment or costs to purchase the substitution drug Subutex® (State Institute for Drug Control, 2008), which in 2007 was not covered by health insurance. Clients' private costs were estimated according to data published by the Institute of Health Information and Statistics[138]. An overview of financial resources and the character of the organisations receiving such funding is given in Table13-1.

Most programmes financed by the state and local budgets through subsidies are operated by NGOs. Healthcare facilities financed from health insurance funds are state, regional or private. Costs for prevention, harm reduction, treatment, and after-care pertaining to drug use in the Czech Republic reached CZK 741.1 million (€ 28,024 thousand) in 2007. The structure by individual resources is provided in Table13-1.

[137] Costs for all health insurance policy holders were calculated from the General Health Insurance Company's data on the basis of its share in the structure of the Czech population, according to five-year age categories (VZP, 2008).

[138] These are the average private costs per patient for outpatient and inpatient/residential treatment, costs for prescribed and non-prescribed medications, and for medical devices in 2007, according to the Czech Statistical Office data published by the Institute of Health Information and Statistics (Ústav zdravotnických informací a statistiky, 2008).

Table13-1: Resources and costs for prevention, harm reduction, treatment, and after-care pertaining to drug use in the Czech Republic in 2007

Funding sources	**Institutions**	**€ thousands**
Health insurance	*General Health Insurance Company* and other health insurers*	7,728.41
State budget – national agency	Government Council for Drug Policy Coordination **	3,783.17
State budget – ministries	*Ministry of Health*, *Ministry of Labour and Social Affairs*, *Ministry of Justice*, Ministry of Education, *Ministry of Defence** *	3,845.44
Local government	Regions, municipalities**	7,208.78
Foreign resources***	European Union, other**	291.42
Internal resources and fees****	Internal activity, client fees, price of medication**	4,469.99
Endowments, sponsors***	Sponsoring, fundraising, endowments**	267.09
Other	–	429.78
Ascertained costs, total	**–**	28,024.07

*Note: * Healthcare facilities (state, regional, private) – cannot be broken down; ** NGOs and organisations administered by the state, region, and municipalities, *** Data available only for organisations financed from the GCDPC budget, **** Data available for organisations financed from the GCDPC budget, the healthcare sector is estimated on the basis of the Institute of Health Information and Statistics data regarding average personal costs to patients in the Czech Republic in 2007 and data on the consumption of Subutex® in the Czech Republic for 2007 published by the State Institute for Drug Control.*

13.2 Costs for Individual Types of Services

The following overview shows the volume of finances from individual sources of financing according to the following characteristics:

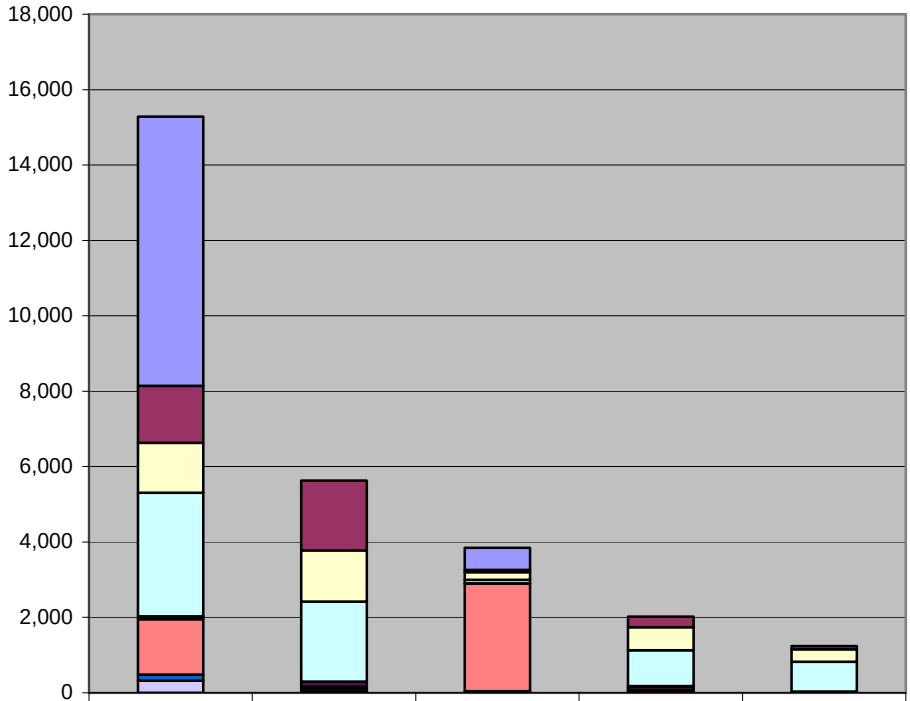
- Costs for individual areas of the drug policy, with the exception of law enforcement (abstinence-oriented treatment, harm reduction, substitution treatment, primary prevention) and type of programme (institutional treatment, outpatient abstinence-oriented treatment, substitution treatment, therapeutic community, low-threshold centre, outreach programme, after-care programme, primary prevention),
- Costs per client in the area of health care and services co-financed using the *GCDPC* funds,
- Costs of treatment according to programme size, expressed by the number of clients (programmes co-financed using *GCDPC* funds).

13.2.1 Total Costs for Individual Types of Services

When comparing the costs ascertained for individual areas of the drug policy, the greatest proportion of public and private funds (a total of CZK 505.9 million (€ 19,130 thousand)) went towards treatment and after-care. Harm reduction was in second place (CZK 148.9 million) (€ 5,631 thousand), followed by primary prevention in third (CZK 53.5 million) (€ 2,023 thousand)[139]. Over a quarter (27.6%) of all identified drug policy costs (except law enforcement), and two fifths (40.4%) of all treatment and after-care costs were covered by health insurance; see Figure13-1.

[139] A number of contact centres whose costs fall under the area of harm reduction also carry out work in the area of primary prevention. These costs were not quantified for the purpose of this analysis.

Figure13-1: Labelled expenditures on drug policy in 2007 by area (except law enforcement) according to sources of funding (€ thousand)



	Abstinence treatment and after-care	Harm reduction	Substitution treatment	Prevention	Other, not specified
Total	15,287.1	5,631.2	3,843.8	2,022.9	1,239.1
Health insurance	7,146.4	0.0	582.0	0.0	0.0
GCDPC	1,505.9	1,852.4	60.8	283.4	80.6
Ministries	1,330.1	1,363.0	207.3	610.8	334.3
Local budgets	3,272.4	2,115.6	86.5	946.4	788.0
Endowments, fundraising and sponsors	80.9	132.2	16.0	29.6	8.4
Internal resources and fees	1,464.0	52.9	2,851.0	76.5	25.6
Foreign resources	161.4	69.5	30.4	30.1	0.0
Other	326.1	45.6	9.7	46.2	2.2

In terms of individual types of treatment interventions, the most money in 2007 went towards residential treatment (institutional treatment and therapeutic communities) – this was a total of CZK 261.8 million (€ 9,900 thousand), of which CZK 192.8 million (€ 7,291 thousand) was spent on institutional dependency treatment at healthcare facilities and CZK 69.0 million in therapeutic communities. A total of CZK 218.1 million (€ 8,247 thousand) was spent on outpatient treatment, with an estimated CZK 116.6 million used for abstinence-oriented treatment and CZK 101.6 million (€ 3,842 thousand) for substitution treatment[140]. Unspecified and other services funded from public resources, such as legal counselling, research projects or projects focused on disseminating information, represented costs amounting to CZK 32.8 million (€ 1,240 thousand). After-care programmes cost CZK 25.8 million in 2007.

The Government Council for Drug Policy Coordination was the largest contributor to services in therapeutic communities and the second largest contributor to harm reduction programmes (low-threshold centres and outreach programmes), covering 34.8% and 33% of their costs, respectively. *GCDPC* earmarked the greatest volume of its funds to harm reduction programmes (CZK 49.0 million) (€ 1,853 thousand), followed by therapeutic communities (CZK 24.0 million) (€ 908 thousand) – services which are not financed from health insurance; see Figure13-2.

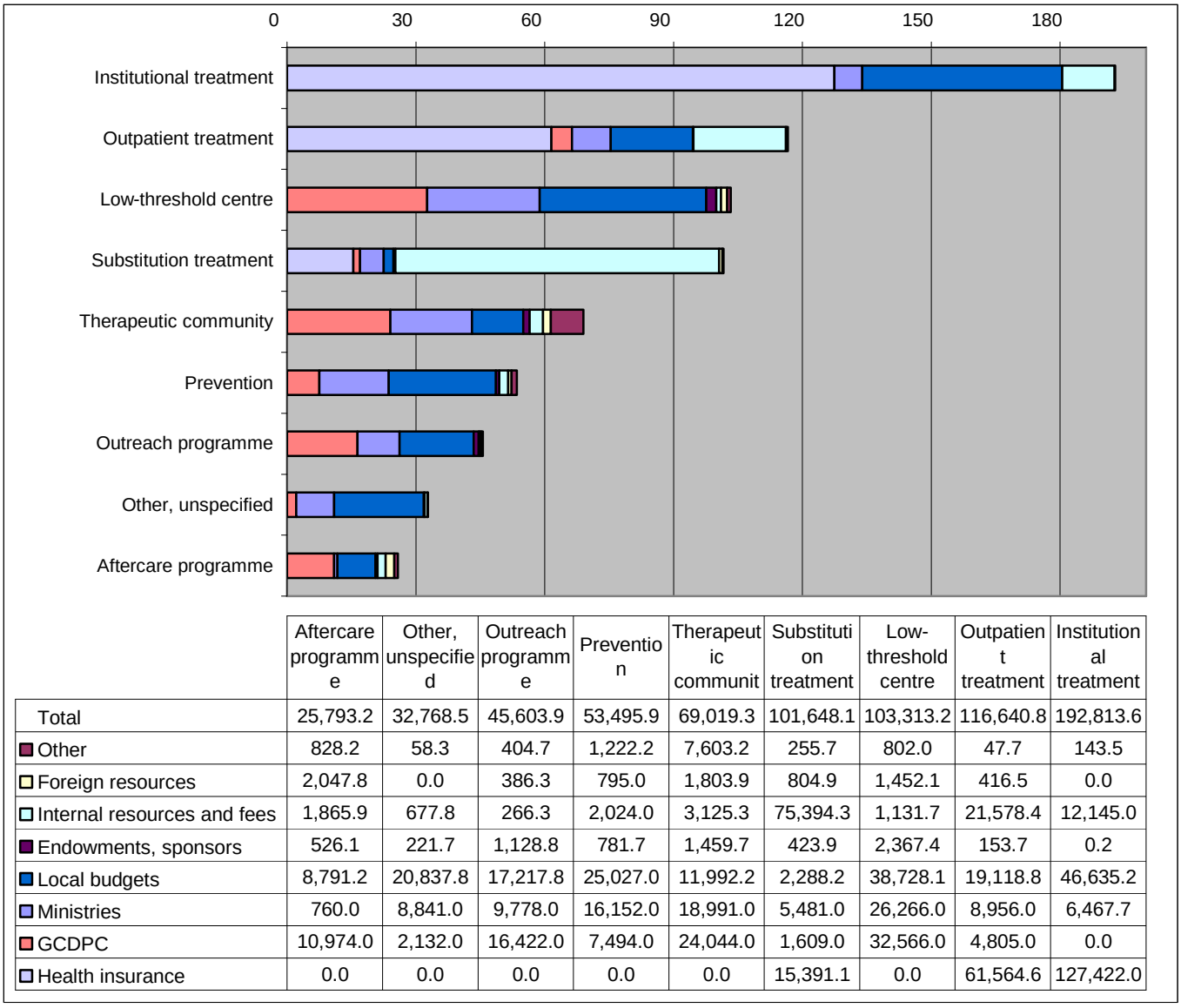
Health insurance[141] was the main resource for financing institutional treatment (66.1% of costs) and outpatient abstinence-oriented treatment (52.8% of costs). In substitution treatment, health insurance represented 15.1% of all

[140] The proportion of substitution treatment patients at healthcare facilities was estimated on the basis of the estimate that the number of patients in substitution treatment and total number of clients in contact with outpatient psychiatric facilities is 20% of all patients in outpatient addiction treatment; substitution treatment was assigned the same proportion of outpatient interventions.

[141] It is compulsory for every citizen of the Czech Republic to contribute to the health insurance system; the government contributes on behalf of persons without an income (unemployed, students, children, etc.). For the purposes of this selected issue, data were obtained from the General Health Insurance Company. These data were subsequently converted according to its policy holders' share in the overall structure of residents of the Czech Republic.

resources; 74.2% of costs were covered by patients who paid for Subutex®, which in 2007 was not covered by health insurance.

Figure13-2: Labelled expenditures on drug policy in 2007 by type of service and sources of funding (€ thousand)



	Aftercare programme	Other, unspecified	Outreach programme	Prevention	Therapeutic communit	Substitution treatment	Low-threshold centre	Outpatient treatment	Institutional treatment
Total	25,793.2	32,768.5	45,603.9	53,495.9	69,019.3	101,648.1	103,313.2	116,640.8	192,813.6
Other	828.2	58.3	404.7	1,222.2	7,603.2	255.7	802.0	47.7	143.5
Foreign resources	2,047.8	0.0	386.3	795.0	1,803.9	804.9	1,452.1	416.5	0.0
Internal resources and fees	1,865.9	677.8	266.3	2,024.0	3,125.3	75,394.3	1,131.7	21,578.4	12,145.0
Endowments, sponsors	526.1	221.7	1,128.8	781.7	1,459.7	423.9	2,367.4	153.7	0.2
Local budgets	8,791.2	20,837.8	17,217.8	25,027.0	11,992.2	2,288.2	38,728.1	19,118.8	46,635.2
Ministries	760.0	8,841.0	9,778.0	16,152.0	18,991.0	5,481.0	26,266.0	8,956.0	6,467.7
GCDPC	10,974.0	2,132.0	16,422.0	7,494.0	24,044.0	1,609.0	32,566.0	4,805.0	0.0
Health insurance	0.0	0.0	0.0	0.0	0.0	15,391.1	0.0	61,564.6	127,422.0

13.2.2 Costs of Services according to the Number of Clients and Interventions

The costs per client at healthcare facilities financed from health insurance (plus other public and private funds made available for this type of care) were compared with services provided outside of the healthcare sector and co-financed by the *Government Council for Drug Policy Coordination* (also supported by ministries, regions, and private entities).[142]

Individual types of programmes differed in terms of the absolute amount of costs as well as in the number of clients and interventions or, if applicable, bed days. More clients (12,100 at outpatient, 3,000 in inpatient and an estimated 3,000 in substitute treatment) were treated at healthcare facilities than at treatment programmes operated by NGOs (1,600 clients in outpatient treatment, 750 in substitution treatment, 470 in communities and 1,150 in after-care programmes)[143].

As a result, the average cost per client in healthcare outpatient treatment was CZK 7,567 (€ 286), while outpatient care provided by NGOs cost CZK 6,974 (€ 264). For institutional care at a healthcare facility, this was CZK 40,597

[142] Data about the number of clients and interventions were not available for programmes financed exclusively by ministries or from regional budgets.

[143] According to data provided by *the General Health Insurance Company* for 2007 and according to final reports on projects implemented using *GCDCP* grants for 2007. The figures are rounded. The number of clients reported at healthcare facilities are in relation with the number of patients in the live case record or number of hospitalisations reported by the Institute of Health Information and Statistics – see the chapter on Drug-related Treatment: treatment demand and treatment availability (p. 46). There is overlap among patients in individual types of care.

(€ 1,535) per client[144]. Therapeutic communities, whose treatment programmes are normally four times longer than institutional care and many times longer than the detoxification programme, had an average cost of CZK 89,794 (€ 3,396) per client[145].

13.2.3 Cost of Drug-related Treatment by Size of the Facility

Costs for treating drug users were further categorised according to sources of financing depending on the size of the programme. This analysis includes only programmes co-financed by the *Government Council for Drug Policy Coordination*, as in case of other (healthcare) facilities, information on health interventions broken down into facilities according to size was not made available. The source of data are final reports of projects supported by *GCDPC* grants in 2007 (National Monitoring Centre for Drugs and Drug Addiction, 2008b). For the purposes of this analysis, all treatment and harm reduction facilities were divided into categories according to a fixed number of clients (Figure 13-3) and all facilities providing outpatient care, inpatient care, and after-care were then also divided into five quintiles according to the number of clients (Figure 13-4).

On average, harm reduction services were marked by their greater capacity and flux of people than treatment services, where most resources were allocated to relatively smaller facilities (83% of resources for residential care were allocated towards inpatient treatment facilities with a capacity of under 125 clients, just like 84% of resources for after-care facilities; at low-threshold services or outpatient care, just 11% of total financing designated for these services went towards facilities with this capacity). The *Government Council for Drug Policy Coordination* financed a greater share of all harm reduction services (37% of resources in programmes with a capacity of over 550 clients, compared to an average 30% in smaller programmes). On the other hand, in the area of inpatient care, there was relatively more support for smaller services under 125 clients (40% of *GCDPC* resources, compared to 19% for the same services with a capacity of over 125 clients).

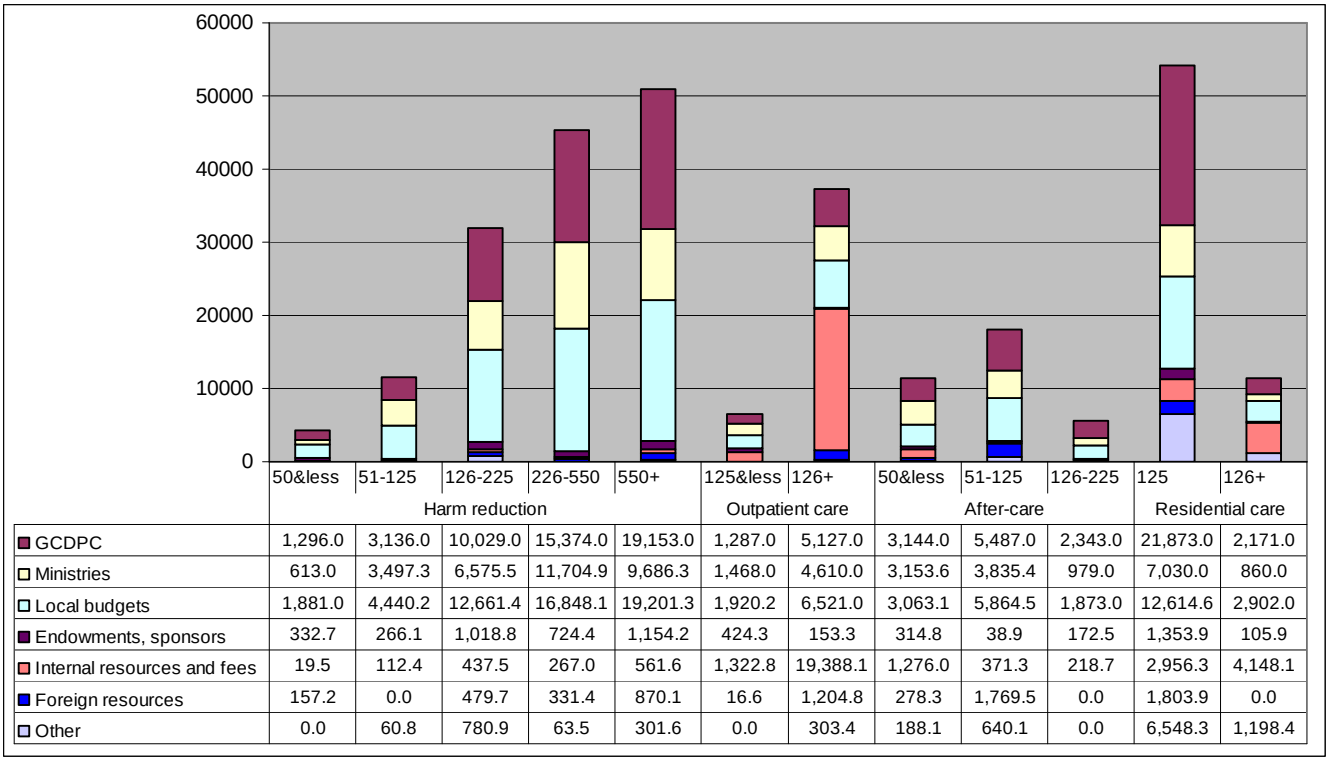
In terms of financing individual treatment services according to their division into quintiles, private costs for Subutex®[146] had a significant share at inpatient treatment facilities in the fifth quintile (over 330 clients, as substitution treatment facilities had an average higher capacity than abstinence-oriented treatment facilities); in absolute terms, public funds were lower. In outpatient care, the most resources went towards large facilities (5th quintile – over 331 clients, 38% of resources); as regards inpatient care, the most resources were spent on rather large facilities (4th quintile, 41-165 clients, 44.5% of resources); and for after-care, medium-sized facilities received the most support (3rd quintile, 41-60 clients, 37% of resources). At present the Secretariat of the GCDPC also uses quintile subsets when evaluating the performance of services in subsidy proceedings.

[144] *GCDPC* funds were used to support one detoxification programme for children at a healthcare facility established by a church organisation, where costs were approximately CZK 27,041 (€ 1,023) per client.

[145] It is difficult to compare the costs of various types of services in terms of the volume of interventions performed because of the varied definitions of the interventions. The absolute number of interventions at facilities which were carried out by NGOs was significantly higher than at healthcare facilities. The costs per outpatient care "intervention" in health care, including materials, reached CZK 4,787 (€ 181); at NGOs this was CZK 348; for institutional care this was CZK 15,743, compared with CZK 2,442 at NGOs or CZK 1,213 in therapeutic communities.

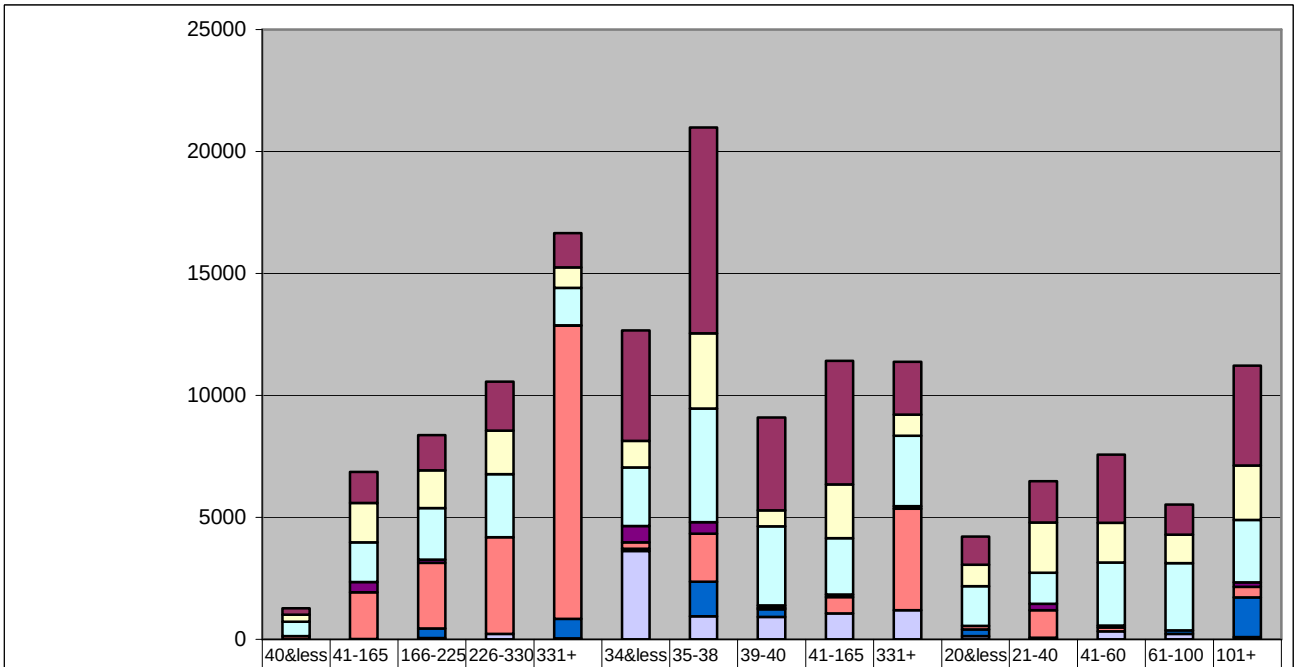
[146] The share of costs incurred by NGO clients for Subutex® in the overall costs of Subutex® was estimated based on average numbers of clients in substitution treatment at NGOs and at healthcare facilities.

Figure 13-3: Sources of funding according to facility size (number of clients according to fixed categories) – treatment and harm reduction programmes subsidised by the GCDPC in 2007 (€ thousand)



	50&less	51-125	126-225	226-550	550+	125&less	126+	50&less	51-125	126-225	125	126+
	Harm reduction					Outpatient care		After-care			Residential care	
GCDPC	1,296.0	3,136.0	10,029.0	15,374.0	19,153.0	1,287.0	5,127.0	3,144.0	5,487.0	2,343.0	21,873.0	2,171.0
Ministries	613.0	3,497.3	6,575.5	11,704.9	9,686.3	1,468.0	4,610.0	3,153.6	3,835.4	979.0	7,030.0	860.0
Local budgets	1,881.0	4,440.2	12,661.4	16,848.1	19,201.3	1,920.2	6,521.0	3,063.1	5,864.5	1,873.0	12,614.6	2,902.0
Endowments, sponsors	332.7	266.1	1,018.8	724.4	1,154.2	424.3	153.3	314.8	38.9	172.5	1,353.9	105.9
Internal resources and fees	19.5	112.4	437.5	267.0	561.6	1,322.8	19,388.1	1,276.0	371.3	218.7	2,956.3	4,148.1
Foreign resources	157.2	0.0	479.7	331.4	870.1	16.6	1,204.8	278.3	1,769.5	0.0	1,803.9	0.0
Other	0.0	60.8	780.9	63.5	301.6	0.0	303.4	188.1	640.1	0.0	6,548.3	1,198.4

Figure 13-4: Sources of funding according to facility size (number of clients according quintiles) – treatment programmes subsidised by the GCDPC in 2007 (€ thousand)



	40&less	41-165	166-225	226-330	331+	34&less	35-38	39-40	41-165	331+	20&less	21-40	41-60	61-100	101+
	Outpatient treatment					Residential care					After-care				
GCDPC	266.0	1,292.0	1,441.0	2,011.0	1,404.0	4,522.0	8,448.0	3,820.0	5,083.0	2,171.0	1,155.0	1,688.0	2,803.0	1,237.0	4,089.0
Ministries	286.0	1,602.0	1,564.0	1,776.0	850.0	1,090.0	3,080.0	660.0	2,200.0	860.0	880.0	2,063.2	1,625.9	1,160.0	2,239.0
Local budgets	591.7	1,624.5	2,099.0	2,597.0	1,529.0	2,407.0	4,664.9	3,231.7	2,311.0	2,902.0	1,621.0	1,275.1	2,586.5	2,758.0	2,560.0
Endowments, sponsors	0.1	424.2	141.6	0.0	11.7	676.2	476.1	101.6	100.0	105.9	5.0	257.6	76.7	1.2	185.7
Internal resources and fees	130.3	1,912.0	2,681.4	3,966.3	12,021.	263.7	1,959.9	61.8	670.8	4,148.1	145.7	1,130.3	160.8	0.0	429.1
Foreign resources	0.0	16.6	400.0	0.0	804.9	88.9	1,411.2	303.9	0.0	0.0	278.3	0.0	0.0	140.5	1,628.9
Other	0.0	0.0	47.7	220.3	35.4	3,618.1	948.9	922.3	1,059.0	1,198.4	125.5	62.6	325.6	225.5	89.0

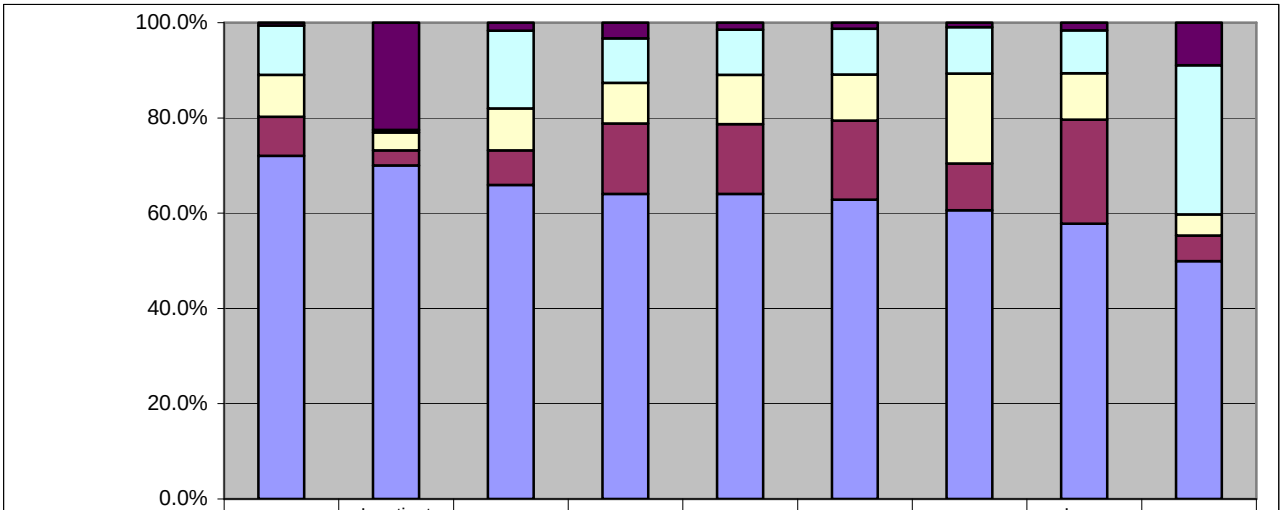
13.3 Cost Structure

No studies have been carried out in the Czech Republic thus far that focused on the structure of costs at individual programmes or compared their efficiency. A study is currently being conducted on the social costs of alcohol, tobacco, and illicit drug use in the Czech Republic in 2007. The results will be available at the end of 2011. No other studies were carried out that would prove the cost effectiveness of drug addiction treatment specifically for the Czech Republic.

Yet non-profit organisations that receive *GCDPC* grants submit detailed accounts for their projects each year. Items were selected from these reports that best correspond to the structure of the Brief DATCAP[147] form which *EMCDDA* requires for presenting types of costs in this selected issue. A summary of the results is provided in Figure 13-5, detailed cost categories are in Table13-2.

The highest costs of the treatment of addiction are human resources costs – costs for salaries and social security deductions, representing two thirds of all costs. The greatest share of human resources costs were in outpatient treatment (72.1%) and detoxification (70.0%); this share declined in substitution treatment and therapeutic communities as material costs rose. Among all the services for drug users, human resources costs make up the relatively lowest proportion of overall costs at low-threshold facilities (57.8%); a fifth of the costs at these centres is for medical materials designated for exchanges. At after-care programmes which are usually connected with sheltered housing, operating expenses (18.8%) represented a significant cost item.

Figure 13-5: Cost structure at drug addition, prevention, and harm reduction treatment programmes subsidised by the GCDPC in 2007



	Outpatient treatment	Inpatient treatment and detox	Prevention	Therapeutic community	Substitution treatment	Outreach programme	Aftercare	Low-threshold centre	Other
Taxes and other	0.6%	22.5%	1.7%	3.3%	1.5%	1.3%	0.9%	1.6%	8.9%
Services	10.3%	0.6%	16.3%	9.3%	9.5%	9.6%	9.8%	9.0%	31.4%
Energy and operation	8.8%	3.7%	8.8%	8.5%	10.3%	9.7%	18.8%	9.7%	4.4%
Material costs	8.1%	3.2%	7.3%	14.8%	14.7%	16.6%	9.8%	21.9%	5.3%
HR costs	72.1%	70.0%	65.9%	64.1%	64.0%	62.9%	60.6%	57.8%	49.9%

Upon closer look at individual cost items, it is evident that human resources costs alone represent half of all addiction treatment programme costs (57.1%), while another fifth of costs (17.7%) go toward social security deductions and insurance. The third most significant item is other services (6.4%), followed by medical material (5.1%), petty items (3.7%) and rent (3.4%).

In terms of comparisons of individual types of therapy interventions, the lowest proportion of salary costs were found in after-care facilities and therapeutic communities (44.6% and 45.3%, respectively) which must cover costs associated with the clients' residences to operate the programme. The highest human resources costs were in outpatient treatment and the detoxification unit[148] (52.9% and 52.0%, respectively). In substitution treatment, material costs connected with treatment represented a major share (11.8%).

[147] Drug Abuse Treatment Cost Analysis Program (http://www.datcap.com/).
[148] As only one detoxification programme was supported from *GCDPC* funds, this is not a representative sample.

Table13-2: Cost structure at drug addiction treatment programmes (without primary prevention and harm reduction) subsidised by GCDPC

Type of cost	**Detailed cost breakdown**	**Therapeutic community**		**After-care programme**		**Outpatient treatment**		**Inpatient treatment and detoxification**		**Substitution treatment**		**Total**	
		€ thousand	%	€ thousand	%	€ thousand	%	€ thousand	%	€ thousand	%	€ thousand	%
Personnel expenses	Salary costs	891.84	45.3	575.09	44.6	320.92	52.9	230.82	52.0	159.89	49.9	2,178.54	47.1
	Social security and costs	369.56	18.8	207.33	16.1	116.26	19.2	79.85	18.0	45.40	14.2	818.40	17.7
	Subtotal	**1,261.39**	**64.1**	**782.42**	**60.7**	**437.18**	**72.1**	**310.66**	**70.0**	**205.29**	**64.1**	**2,996.94**	**64.7**
Material costs	Tangible Fixed Assets	38.79	2.0	52.40	4.1	23.73	3.9	0.54	0.1	6.55	2.0	122.01	2.6
	Medical materials	118.71	6.0	57.21	4.4	16.55	2.7	6.19	1.4	37.76	11.8	236.41	5.1
	Petty materials	133.38	6.8	17.13	1.3	9.15	1.5	7.33	1.7	2.70	0.8	169.68	3.7
	Subtotal	**290.87**	**14.8**	**126.74**	**9.8**	**49.42**	**8.1**	**14.06**	**3.2**	**47.01**	**14.6**	**528.10**	**11.4**
Energy and operations	Electricity	0.48	0.0	38.71	3.0	4.69	0.8	4.26	1.0	2.40	0.7	50.54	1.1
	Petrol	34.93	1.8	4.34	0.3	1.61	0.3	0.00	0.0	0.23	0.1	41.11	0.9
	Gas and other energy	28.65	1.5	35.30	2.7	10.20	1.7	3.85	0.9	5.31	1.7	83.31	1.8
	Water	2.94	0.1	10.04	0.8	1.34	0.2	1.68	0.4	0.54	0.2	16.53	0.4
	Telephone	33.55	1.7	28.63	2.2	13.80	2.3	1.38	0.3	4.44	1.4	81.79	1.8
	Rent	29.53	1.5	99.78	7.7	13.93	2.3	3.75	0.8	11.93	3.7	158.93	3.4
	Repairs and maintenance	38.22	1.9	26.46	2.1	8.10	1.3	1.55	0.3	8.29	2.6	82.62	1.8
	Subtotal	**168.29**	**8.5**	**243.26**	**18.8**	**53.67**	**8.9**	**16.48**	**3.7**	**33.13**	**10.4**	**514.84**	**11.1**
Services	Staff travel expenses	21.41	1.1	13.80	1.1	5.88	1.0	0.00	0.0	1.18	0.4	42.28	0.9
	Client travel expenses	5.98	0.3	1.67	0.1	0.37	0.1	0.00	0.0	0.00	0.0	8.02	0.2
	Staff training	19.70	1.0	19.62	1.5	10.15	1.7	0.23	0.1	8.19	2.6	57.89	1.3
	Other services	136.72	6.9	90.93	7.0	46.22	7.6	2.30	0.5	21.04	6.6	297.21	6.4
	Subtotal	**183.80**	**9.3**	**126.03**	**9.7**	**62.63**	**10.4**	**2.53**	**0.6**	**30.42**	**9.6**	**405.40**	**8.8**
Taxes and other	Taxes and fees	4.38	0.2	3.53	0.3	0.92	0.2	0.00	0.0	0.24	0.1	9.06	0.2
	Other	59.96	3.0	8.55	0.7	2.79	0.5	99.84	22.5	4.48	1.4	175.62	3.8
	Subtotal	**64.34**	**3.2**	**12.08**	**1.0**	**3.70**	**0.7**	**99.84**	**22.5**	**4.72**	**1.5**	**184.68**	**4.0**
Total		**1,968.70**	**100**	**1,290.53**	**100**	**606.60**	**100**	**443.57**	**100**	**320.57**	**100**	**4,629.97**	**100**

14 Appendices

14.1 Objectives of the 2005-2009 National Strategy

Main objectives:

- to combat organised crime involved in drug trafficking and to enforce the law in relation to the distribution of legal drugs
- to reduce the use of all types of drugs and potential risks and damage that can afflict individuals and society as a result of drug use.

Specific objectives:

I. to stabilise or reduce the number of problem drug users;

II. to halt the rising experimental and recreational use of legal and illegal drugs;

III. to stabilise or reduce the consumption of legal and illegal drugs in society, especially among minors;

IV. to reduce the potential risks of all types of drugs and the economic, health, and social impacts of their use on individuals and society;

V. to increase the quality of life of users of all types of drugs, their parents and other persons close to them by assuring the availability of quality treatment and resocialisation services;

VI. to reduce the availability of legal and illegal drugs for the general population, and in particular for minors by means of the proper use of existing legislative and institutional instruments.

Technical and organisational objectives:

VII. Efficient funding – to make the financing of individual drug policy strategies and measures more efficient and more transparent on the basis of identified requirements and their proven efficiency;

VIII. Coordination – to create a sufficient legislative environment for the drug policy, to improve the quality of the current system and to build up a functional, transparent structure based on the efficient coordination of the activities of entities involved at all levels, with clearly defined and distributed responsibilities and competences;

IX. Public awareness – to propose and implement a flexible model of universal communication and to appoint the competence of the entities involved so that the public is provided with comprehensive, objective, reliable, and balanced information about the use of drugs, the impacts of drug use, and the measures implemented;

X. International cooperation – to become fully involved in international cooperation and to ensure the active participation of Czech representatives in the processes of harmonising the drug policy with that of the European Union;

XI. Evaluations of activities – to ensure the consistent application of evidence-based procedures in the evaluation of the effectiveness of measures in all areas of the drug policy and to apply knowledge based on evaluations in practice.

14.2 Comparison of selected sections of Act No. 140/1961, Coll. (the "old" Penal Code) and Act No. 40/2009, Coll. (the "new" Penal Code) pertaining to the unauthorised handling of narcotic or psychotropic substances, poisons, and substances with hormonal effects

Act No. 140/1961, Coll. (the "old" Penal Code) effective until 31 December 2009		**Act No. 40/2009, Coll. (the "new" Penal Code) effective from 1 January 2010**	
Provisions	**Punishment**	**Provisions**	**Punishment**
Section 187 – Unauthorised production and handling of narcotic and psychotropic substances and poisons		**Section 283 – Unauthorised production and other handling of narcotic and psychotropic substances and poisons**	
(1) A person who, without authorisation, produces, imports, exports, transports through the country, offers, traffics in, sells, or otherwise procures or holds in their possession for another person a narcotic or psychotropic substance, a preparation containing a narcotic or psychotropic substance, a drug precursor, or a poison shall be punished by imprisonment for a term of between one and five years.	1-5 years in prison	(1) A person who, without authorisation, produces, imports, exports, transports through the country, offers, traffics in, sells, or otherwise procures or holds in their possession for another person a narcotic or psychotropic substance, a preparation containing a narcotic or psychotropic substance, a drug precursor, or a poison shall be punished by imprisonment for a term of between one and five years, or by a fine.	1-5 years in prison, a fine
(2) An offender under Subsection 1 above shall be punished by imprisonment for a term of between two and ten years a) if they committed a crime under Subsection 1 as a member of an organised group or on a significant scale, b) if they committed such a crime in relation to a person below the age of eighteen.	2-10 years in prison	(2) An offender under Subsection 1 above shall be punished by imprisonment for a term of between two and ten years, or by forfeiture of property, if they committed such a crime a) as a member of an organised group, b) despite having been convicted of or punished for such a crime in the three preceding years, c) on a substantial scale, or d) on a significant scale in relation to a child, or involving a quantity greater than small in relation to a child below the age of fifteen.	2-10 years in prison, forfeiture of property
(3) An offender shall be punished by imprisonment for a term of between eight and twelve years if a) they gained a substantial benefit by a crime under Subsection 1, b) they committed such a crime in relation to a person below the age of fifteen, c) by such a crime they caused grievous bodily harm.	8-12 years in prison	(3) An offender shall be punished by imprisonment for a term of between eight and twelve years, or by forfeiture of property, if a) by a crime under Subsection 1 they caused grievous bodily harm, b) they committed such a crime with the intention of gaining a substantial benefit for themselves or for another person, c) they committed such a crime on a large scale, or d) they committed such a crime on a significant scale in relation to a child below the age of fifteen.	8-12 years in prison, forfeiture of property
(4) An offender shall be punished by imprisonment for a term of between ten and fifteen years if a) by a crime under Subsection 1 they caused grievous bodily harm to more than one person or death, b) they gained a large-scale benefit by such a crime, or c) they committed such a crime in association with an organised group operating in multiple states.	10-15 years in prison	(4) An offender shall be punished by imprisonment for a term of between ten and eighteen years, or by forfeiture of property, if a) by a crime under Subsection 1 they caused grievous bodily harm to at least two persons or death, b) they committed such a crime with the intention of gaining a large-scale benefit for themselves or for another person, or c) they committed such a crime in association with an organised group operating in multiple states.	10-18 years in prison, forfeiture of property

Act No. 140/1961, Coll. (the "old" Penal Code) effective until 31 December 2009		Act No. 40/2009, Coll. (the "new" Penal Code) effective from 1 January 2010	
Section 187a – Possession of a narcotic or psychotropic substance or poison		**Section 284 – Possession of a narcotic or psychotropic substance or poison**	
(1) A person who, without authorisation, possesses a narcotic or psychotropic substance or poison in a quantity greater than small shall be punished by imprisonment for a term of up to two years or a fine.	up to 2 years in prison or a fine	(1) A person who, without authorisation, possesses for their personal use in a quantity greater than small the narcotic substance cannabis, cannabis resin (hashish), or a psychotropic substance containing any form of tetrahydrocannabinol, or an isomer or a stereochemical variant thereof (THC), shall be punished by imprisonment for a term of up to one year, by prohibition on undertaking a specific activity, or by forfeiture of an item of property or another asset.	up to a year's imprisonment, prohibition on undertaking a specific activity or forfeiture of an item of property
–	–	(2) A person who, without authorisation, possesses for their personal use a narcotic or psychotropic substance other than that stated in Subsection 1 or a poison in a quantity greater than small shall be punished by imprisonment for a term of up to two years, by prohibition on undertaking a specific activity, or by forfeiture of an item of property or another asset.	up to 2 years' imprisonment, prohibition on undertaking a specific activity or forfeiture of an item of property
(2) An offender shall be punished by imprisonment for a term of between one and five years if they committed a crime under Subsection 1 on a significant scale.	1-5 years in prison	(3) An offender under Subsections 1 or 2 above shall be punished by imprisonment for a term of between six months and five years, or by a fine, if they committed such a crime on a significant scale.	from 6 months to 5 years in prison or a fine
–	–	(4) An offender under Subsections 1 or 2 above shall be punished by imprisonment for a term of between two and eight years if they committed such a crime on a substantial scale.	2-8 years in prison
Act No. 140/1961, Coll., the old Penal Code, did not specifically provide for the cultivation of plants containing a narcotic or psychotropic substance.[149]		**Section 285 – Unauthorised cultivation of plants containing a narcotic or psychotropic substance (a new offence)**	
–	–	(1) A person who, without authorisation, cultivates, for their personal use and in a quantity greater than small, a cannabis plant shall be punished by imprisonment for a term of up to six months, by a fine, or by forfeiture of an item of property or another asset.	up to 6 months' in prison, a fine, or forfeiture of an item of property
–	–	(2) A person who, without authorisation, cultivates, for their personal use and in a quantity greater than small, a mushroom or a plant other than that stated in Subsection 1 containing a narcotic or psychotropic substance shall be punished by imprisonment for a term of up to one year, by a fine, or by forfeiture of an item of property or another asset.	up to a year in prison, a fine, or forfeiture of an item of property

[149] In the absence of a specific definition of a crime, the unauthorised cultivation of plants containing a narcotic or psychotropic substance for personal use was prosecuted as an offence under Section 187a or Section 187 of the old Penal Code.

Act No. 140/1961, Coll. (the "old" Penal Code) effective until 31 December 2009		Act No. 40/2009, Coll. (the "new" Penal Code) effective from 1 January 2010	
–	–	(3) An offender under Subsections 1 or 2 above shall be punished by imprisonment for a term of up to three years, or by a fine, if they committed such a crime on a significant scale.	up to three years in prison or a fine
–	–	(4) Offenders under Subsections 1 or 2 above shall be punished by imprisonment for a term of between six months and five years if they committed such a crime on a substantial scale.	from 6 months to 5 years in prison
Section 188 – Manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison		**Section 286 – Manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison**	
(1) A person who produces, procures for themselves or another person, or holds in their possession an article designed for the unauthorised production of a narcotic or psychotropic substance, a preparation containing a narcotic or psychotropic substance, or a poison, shall be punished by imprisonment for a term of between one and five years or prohibition on undertaking a specific activity or a fine or forfeiture of an item of property or another asset.	1-5 years' prison term or prohibition on undertaking a specific activity or a fine or forfeiture of an item of property	(1) A person who produces, procures for themselves or another person, or holds in their possession a drug precursor or other article designed for the unauthorised production of a narcotic or psychotropic substance, a preparation containing a narcotic or psychotropic substance, or a poison, shall be punished by imprisonment for a term of up to five years, by a fine, by prohibition on undertaking a specific activity, or by forfeiture of an item of property or another asset.	up to 5 years' prison term, a fine, prohibition on undertaking a specific activity, or forfeiture of property
(2) An offender shall be punished by imprisonment for a term of between two and ten years if a) they committed a crime under Subsection 1 on a significant scale, b) they committed such a crime in relation to a person below the age of eighteen, or c) they gained a substantial benefit by such a crime.	2-10 years in prison	(2) An offender shall be punished by imprisonment for a term of between two and ten years if a) they committed a crime under Subsection 1 as a member of an organised group, b) they committed such a crime on a substantial scale, c) they committed such a crime on a significant scale in relation to a child, or d) they gained a substantial benefit for themselves or another person from such a crime.	2-10 years in prison

Act No. 140/1961, Coll. (the "old" Penal Code) effective until 31 December 2009		Act No. 40/2009, Coll. (the "new" Penal Code) effective from 1 January 2010	
Section 188a – Promotion of drug use		**Section 287 – Promotion of drug use**	
(1) A person who induces another person to abuse an addictive substance other than alcohol, or abets another in so doing, or who otherwise instigates or spreads the abuse of such a substance shall be punished by imprisonment for a term of up to three years, or by prohibition on undertaking a specific activity or a fine.	up to three years' imprisonment or prohibition on undertaking a specific activity or a fine	(1) A person who induces another person to abuse an addictive substance other than alcohol, or abets another in so doing, or who otherwise instigates or spreads the abuse of such a substance shall be punished by imprisonment for a term of up to three years, or by prohibition on undertaking a specific activity.	up to three years' imprisonment or prohibition on undertaking a specific activity
(2) An offender under Subsection 1 above shall be punished by imprisonment for a term of between one and five years if a) they committed a crime under Subsection 1 in relation to a person below the age of eighteen, or b) they committed such a crime via the print media, film, radio, television, a publicly accessible computer network, or in some other manner with a similar effect.	1-5 years in prison	(2) An offender under Subsection 1 above shall be punished by imprisonment for a term of between one and five years, or by a fine, if they committed such a crime a) as a member of an organised group, b) in relation to a child, or c) via the print media, film, radio, television, a publicly accessible computer network, or in some other manner with a similar effect.	1-5 years in prison or a fine
–	–	(3) An offender under Subsection 1 above shall be punished by imprisonment for a term of between two and eight years if they committed such a crime in relation to a child below the age of fifteen.	2-8 years in prison
Act No. 140/1961, Coll., the old Penal Code, did not specifically provide for issues related to the production and other handling of substances with hormonal effects.		**Section 288 – Production and other handling of substances with hormonal effects (a new offence)**	
–	–	(1) A person who, without authorisation, produces, possesses, imports, exports, transports through the country, offers, sells, or provides or administers to another person a greater-than-small quantity of a substance with anabolic and other hormonal effects for purposes other than medicinal ones or whoever subjects another person to a method involving enhanced oxygen transfer in the human body or any other method producing doping effects for purposes other than medicinal ones shall be punished by imprisonment for a term of up to one year.	up to a year's imprisonment

Act No. 140/1961, Coll. (the "old" Penal Code) effective until 31 December 2009		Act No. 40/2009, Coll. (the "new" Penal Code) effective from 1 January 2010	
–	–	(2) An offender shall be punished by imprisonment for a term of between one and three years a) if they committed a crime under Subsection 1 as a member of an organised group, or b) if they committed such a crime on a significant scale in relation to a child, or involving a quantity greater than small in relation to a child below the age of fifteen.	1-3 years in prison
–	–	(3) An offender shall be punished by imprisonment for a term of between two and eight years if a) by a crime under Subsection 1 they caused grievous bodily harm, b) they committed such a crime with the intention of gaining a substantial benefit for themselves or for another person, c) they committed such a crime on a significant scale in relation to a child below the age of fifteen d) they committed such a crime in their role as a physician or another competent health professional.	2-8 years in prison
–	–	(4) An offender shall be punished by imprisonment for a term of between five and twelve years if a) by a crime under Subsection 1 they caused grievous bodily harm to at least two persons or death, b) they committed such a crime with the intention of gaining a large-scale benefit for themselves or for another person, or c) they committed such a crime in association with an organised group operating in multiple states.	5-12 years in prison

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SELECTED DRUG-RELATED WEBSITES ON THE CZECH INTERNET

The following list provides selected official websites of key institutions concerned with drug-related issues. An exhaustive list of helping organisations is provided in the Help Map application available at drogy-info.cz.

Adiktologie – odborný časopis pro prevenci, léčbu a výzkum závislostí (Addictology – a professional journal for the prevention, treatment of, and research into addiction): http://www.adiktologie.cz/Casopis-Adiktologie.html

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

An application used to register drug-related services and their clients: http://www.drogovesluzby.cz

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

Centrum adiktologie VFN a Psychiatrické kliniky 1. LF UK v Praze (Centre for Addictology, Department of Psychiatry, First Faculty of Medicine of Charles University in Prague and General University Hospital in Prague): http://www.adiktologie.cz/

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

Česká asociace streetwork (Czech Outreach Work Association): http://www.streetwork.cz/

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

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

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

Database of social prevention services: https://www.sluzbyprevence.mpsv.cz/

Drug information server (administered by SANANIM, a civic association): http://www.drogy.net/

Drug counselling service (administered by SANANIM, a civic association): http://www.drogovaporadna.cz/

Drug services in prison (administered by *Podané ruce*, a civic association): http://www.wezeni.cz/

EXTC – web counselling – prevention of synthetic drug abuse: http://www.extc.cz/

Hygienická stanice hl. m. Prahy, referát drogové epidemiologie (Public Health Office in Prague, Drug Epidemiology Unit): http://www.hygpraha.cz

Information for the staff and clients of outreach programmes and low-threshold centres (administered by SANANIM, a civic association): http://www.edekontaminace.cz/

UN Information Centre in Prague: http://www.osn.cz/

Primary prevention information portal (administered by SANANIM, a civic association): http://www.odrogach.cz/

"Safer Party" initiative: http://www.saferparty.cz

Institut pedagogicko-psychologického poradenství (Institute for Pedagogical and Psychological Counselling): http://www.ippp.cz/

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

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

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

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

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

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

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

Národní program řešení problematiky HIV/AIDS (National HIV/AIDS Programme): http://www.mzcr.cz/Verejne/Pages/133-narodni-program-reseni-problematiky-hivaids.html; Národní program boje proti AIDS ČR (National Programme for Combating AIDS in the Czech Republic): http://www.aids-hiv.cz/

Národní protidrogová centrála služby kriminální policie a vyšetřování, Policie ČR (Police National Drug Headquarters): http://www.policie.cz/clanek/narodni-protidrogova-centrala-skpv-prezentace-utvaru.aspx

Poslanecká sněmovna Parlamentu ČR, Výbor pro zdravotnictví, Zdravotní výbor (Chamber of Deputies of the Parliament of the Czech Republic, Health Committee): http://www.psp.cz/sqw/fsnem.sqw?f1=8&f2=6&id=963

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

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

Rada vlády pro koordinaci protidrogové politiky (Government Council for Drug Policy Coordination): http://rvkpp.vlada.cz

Register of social service providers: http://www.mpsv.cz/cs/3880

Sekce terapeutických komunit A.N.O. (Therapeutic Communities Section, Association of NGOs): http://www.terapeutickekomunity.org/

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

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

Ústav zdravotnických informací a statistiky (Institute of Health Information and Statistics of the Czech Republic): http://www.uzis.cz/

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

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

ABBREVIATIONS

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

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

2007–2009 Action Plan – Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2007 to 2009

2008 General Population Survey (CS 2008) – General population survey on the use of psychotropic substances in the Czech Republic in 2008

2010-2012 Action Plan – Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2010 to 2012

2010–2018 National Strategy – National Drug Policy Strategy for the Period 2010-2018

Annual Report – Annual Report: The Czech Republic – Drug Situation

AT – Alcohol – Toxicomania (AT clinic – a name for an outpatient medical facility dealing with addiction treatment)

Centre for Addictology - Centre for Addictology, Department of Psychiatry, First Faculty of Medicine of Charles University in Prague and General University Hospital in Prague

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

ESPAD– European School Survey on Alcohol and Other Drugs

EU – European Union

GCDPC – Government Council for Drug Policy Coordination

HAV – hepatitis A virus, viral hepatitis A

HBSC – Health Behaviour in School-aged Children survey

HBV – hepatitis B virus, viral hepatitis B

HCV – hepatitis C virus, viral hepatitis C

ICD-10 – International Classification of Diseases, 10th Revision

IDU(s) – injecting drug user(s)

NFP – National Focal Point (Czech National Monitoring Centre for Drugs and Drug Addiction)

NGO(s) – non-governmental organisation(s)

PMS – Probation and Mediation Service of the Czech Republic

WHO – World Health Organisation

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