2006 NATIONAL REPORT (2005 data) TO THE EMCDDA by the Reitox National Focal Point

„LATVIA”
New development, trends and in-depth information on selected issues
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Summary

Latvian National Focal Point is one of the units of the State Addiction Agency which is supervised by the Ministry of Health of Republic of Latvia. The State Addiction Agency is the main institution in Latvia working in the field of drugs and drug policy providing in- and out-patient services; systems of alcohol, tobacco and drug monitoring and other activities.

For the first time since August 2005 Republic of Latvia has its national drug strategy/ programme and action plan. Both documents were adopted in Latvia on August 17th, 2005 by the Cabinet of Ministers of Republic of Latvia. The State Programme for Restriction and Control of Addiction and Spread of Narcotic and Psychotropic Substances 2005–2008 involves four fields of action whereas the general objective of the programme is to promote reduction of drug demand and supply as also to reduce drug–related infectious diseases, drug–related mortality and drug–related crime. In order to ensure implementation of the general objective set of sub objectives are settled. The implementation of the programme requires multidisciplinary approach and close cooperation among involved institutions.

Until the end of 2005 no budgetary resources were allocated for the implementation of the programme (except for the activities which are planned to be implemented in the frame of assigned finance resources to each of the involved institutions). This situation makes difficulties and does not allow implementing the general objectives of the Latvia’s drug policy whereas it is very important. Besides the adopted programme during 2005 several important laws and regulations and amendments of the laws and regulations were adopted in Latvia in the field of drugs, alcohol, tobacco and gambling as well.

National Report 2006 includes ten chapters and three additional chapters of selected issues on “Drug use and related problems among very young people”, “Cocaine and crack – situation and responses” and “Drugs and driving”. Chapter 2 – Drug use in the population is not reflected because of no new information is available at this period.

Report provides information on prevention activities in Latvia in 2005. Main areas covered by prevention are schools, community, recreational settings and risk groups. It has to be mentioned that still in some areas prevention acts on a weak base by activities limited only on publishing and distributing posters and brochures.

Analyzed data shows that there is a large need to improve prevention activities and also treatment availability (in– and out-patient) as in 2005 there has
been an increase in first treatment demand for heroin and has remained much about the same for cannabis and amphetamines as compared with previous years. There have been slight improvements in the patient registration since electronic data entry on all treatments at out-patient services at State Addiction Agency started, but more development of the Treatment Demand Indicator needs to be done to be fully compatible with the EMCDDA definition and guidelines.

There is also only one Methadone maintenance therapy (MMT) program and Buprenorphine substitution treatment centres in Latvia.

In 2005 there were registered 14 drug–related deaths in Latvia (the same number was registered in 2004). Since 2000 (42) there was a large decrease in the number drug related deaths, which may be explained by changes of trends in drug use and registration systems.

Until the end of 2005 there were 3 332 HIV infected persons (299 new cases), 394 persons were in phase of AIDS which is for 72 cases more than in 2004. Number of newly reported HIV cases is on the decrease since 2002, which may also be explained by the changes of mode of use and spread of work of syringe exchange points in Latvia. The same relates to hepatitis B and C whereas during last years numbers of new cases is decreasing.

Latvia needs serious improvements in many systems and provided activities. In 2005 there were major problems with the data of the State Police, since legislation has changed and new improvements and changes in the compilation methods – registers are taking place, the police does not have available statistics about crime under the influence of drugs for all year (only for the first nine months).

Although data (for example numbers of prevalence of addiction, diseases, crime and deaths) provided in the National Report in the scale of Europe does not seem large or high, they are important in the scale of Latvia with population of 2 294 590 inhabitants, including 1 477 108 in the age group of 15–64.

At the end of 2005 survey on problem drug users was carried out. More detailed information is going to be available in the next report of Latvian National Focal Point. Besides that, general population survey and European school survey project on alcohol and other drugs (ESPAD) are planned to be carried out in 2007.
PART A – NEW DEVELOPMENTS AND TRENDS

1. National policies and context

1.1. Legal framework

Over the year 2005 important legislation and amendments in the legislation related to alcoholic beverages, narcotic and psychotropic substances and tobacco were adopted.

A lot of important regulations and laws or law amendments were adopted regarding excise tax. On October 1st 2005, the Cabinet Regulations N 638 “Regulations on Excise Tax Guarantees for Alcoholic Beverages, Tobacco and Petrol Products” were adopted. They provide order for the procedure of submitting, administration, deletion and identification of excise tax guarantees for alcohol and petrol, which lead to the reduction of the amount of the security.

The Law “On Excise Tax” regulates the procedure whereby excise goods are levied with excise tax. Since 1st of January, 2006 the law provides that excise tax should be marked up for alcoholic beverages, especially for beer. The law “On Excise Tax” provides for a gradual annual increase of the excise tax on tobacco products. The amendment of the law “On Excise Tax” of April 25 envisages a decrease of the excise tax to independent small beer breweries.

On December 25, 2005 the Cabinet of Ministers adopted Regulations N 956 “The Procedure of Approval of the Status of a Small Brewery and the Procedure of Adoption of the Rate of Excise Tax on the Beer Produced at Independent Small Breweries” which define the status of a small brewery and the application of the calculation of excise tax rates to them.

Important amendments have been adapted to the law of 2005 on the “Restriction of the Sales, Advertising and Use of Tobacco Products”. The Amendments of February 24th, 2005 to the law on the “Restriction of the Sales, Advertising and Use of Tobacco Products” include the definitions of public activities, public buildings, territory, separate premises for smoking. The law prohibits (from July 1st, 2007) to smoke at medical establishments, higher educational establishments, public buildings, discos, whereas smoking is allowed in cafes, restaurants and casinos at particular premises designated for smoking. Since January 1st, 2006, the law prohibits to smoke nearer than 10 meters from the
buildings housing state and municipal institutions. Control of the prohibitions and restrictions on smoking is carried out by the State and Municipal Police. The municipalities may place other bans upon smoking within the framework of the binding regulations. The amendment to the law “Restriction of the Sales, Advertising and Use of Tobacco Products” adopted by the Saeima on July 6th, 2006 restricts not only direct advertising, but also indirect advertising, sponsoring radio and TV broadcasts, if production or sales of tobacco is the company’s main line of activity. The amendments to the law prohibit advertising tobacco products in cinemas, in the press and in other publications, except in publications which are published in states which are not EU Member States.

On December 25th Cabinet Regulations N 978 “Regulations on the Procedure of Placing Notices or Symbols Forbidding to Smoke or Permission to Smoke, and Examples of Such Notices and Symbols” were issued.

On December 7th, 2005, Saeima (the Parliament) with the view to protect public interest and the interests of gamblers adopted a new “Law on Lotteries and Gambling”. This law lays down the procedure for organising gambling games and lotteries, regulates the activities, responsibility and control of the organisers of gambling games and lotteries and sets down the rights, obligations and responsibilities of persons within the scope of the law.

In 2005 the Cabinet of Ministers adopted several Cabinet Regulations, regulating the handling of legal drugs, including narcotic and psychotropic drugs:

In the May 17th, 2005 “Regulations on the Advertisement of Medicines” lays down the procedure of advertising drugs and prohibits advertising medicines containing narcotic and psychotropic substances.

From December 1st, 2005 the Cabinet Regulations N 803 “Regulations on the Principles of the Price Formation of Medicines” came into force.

Since November 26th, 2005 the Cabinet Regulations N 885 on the “Procedure of Classification of Medicines” came into force, stating the procedure whereby medicines are included into the group of prescription medicines.

In the March 8th, 2005 regulations N 175 “On the Production and Storage of Prescription Blanks and the Regulations for Writing out Prescriptions” lay down the procedure of storing prescriptions, the procedure of prescribing medicines, and state that medicines containing Buprenorphine may be prescribed only by addiction specialists to patients who have obtained the substitution therapy card.
Other regulations of March 8th, 2005 N 168 “The Procedure of the Purchase, Delivery, Storage, Distribution, Handing out and Inventory of Medicines at Production Units, Pharmaceutical Wholesalers and Pharmacies” were adopted laying down the procedure whereby the substances, included in the lists of narcotic, psychotropic substances and precursors are delivered, purchased, distributed, handed out, stored and inventoried at production units, wholesalers and pharmacies. The Regulations lay down the procedure of handing out medicines containing Buprenorphine at pharmacies.

Cabinet Regulations N 847 of November 8th, 2005 “Regulations on Narcotic, Psychotropic Substances and Precursors Monitored in Latvia” lay down the list of substances which are under control in Latvia.

An important document pertaining to the restriction of addiction to narcotic, psychotropic substances was “The State Program for the Reduction of Addiction to Narcotic and Psychotropic Substances for 2005 – 2008” adopted on August 17th, 2005.

On May 18th, 2005 the Saeima adopted “Amendments to the Criminal Law” which came into force on June 1st. The Amendments lay down criminal responsibility for smuggling, introducing into the Republic of Latvia of goods and substances prohibited or regulated in Latvia, prohibited activities with customs goods, laundering.

The amended Criminal Law adopted on October 6th amends Subsection 3 of Section 42 as follows “Property owned by a convicted person, whom he or she has transferred to another natural or legal person, may also be confiscated. Partial confiscation of property in case of an offence against road traffic safety is applicable to the vehicle”. Subsection 3 of Section 260 states that “the applicable sentence is deprivation of liberty for a term of not less than three and not exceeding fifteen years, with deprivation of the right to operate a vehicle for a term not exceeding five years with or without confiscation of property” which is applicable to the vehicle. In section 262 “Operating a Vehicle While under the Influence of Alcoholic Beverages or Narcotic, Psychotropic and Other Intoxicating Substances” the maximum length of the sentence has been increased with or without the confiscation of property (the vehicle). The amendment adds Subsection 262.1 “Refusal from undergoing examination for determining the influence of alcohol, narcotic, psychotropic and other intoxicating substances” which, if the offence is repeatedly committed within a year, may lead to imprisonment. The amendments were enforced on October 14th, 2005.
In January 26, 2006 the “Administrative Offences Code” was enforced with a new wording of Section 149.15 "On the driving of vehicles in the state of alcohol intoxication or under the influence of drugs or other intoxicating substances", providing for larger penalty amounts and for administrative arrest.

“Amendments of the Administrative Offence Code” coming in force on April 15, 2005 Section 42.1 “Incompliance with the restrictions on smoking” has been reworded, indicating that the penalty for the offence is up to 10 LVL; the penalty for allotting unsuitable premises for smoking is 150–250 LVL, payable by the legal person. Section 153.3 has been reworded as “Sales of alcoholic beverages and tobacco products in places prohibited”, which is penalised with a penalty not less than 150 LVL, administrative arrest up to 15 days, with the confiscation of the alcoholic beverages and/or tobacco products found on site. Section 160.20 has also been rewarded to “Breach of the regulations for the sales of tobacco”.

Relevant amendments have been made to the law “On Police”. Subsections 17, 18, 20 have been rewarded. Thus Subsection 17 states that “in order to make sure whether a person has used alcohol, narcotic, psychotropic or toxic substances, an examination shall be performed as prescribed by the Cabinet regulations with portable devices (Alco meters) for alcohol control or the person shall be transferred to a medical establishment for the conduction of such an examination, if it is necessary to obtain proof in order to confirm or refute the offence”. Section 18 is about “stopping vehicles and carrying out their inspection (with the exception of the vehicles of diplomatic or consulate representatives) during planned activities by order of the Head of the State Police in order to detain persons and vehicles in search”. Section 20 is about “stopping and examining a vehicle, if there is ground to believe that the driver has breached the road transport safety regulations, suspending persons who are under the influence of alcohol, drugs or other intoxicating substances from driving.”

On April 2005 the “Amendments to the Law on the Protection of Children’s Rights” were adopted and subsection 1 of section 40 was reworded as follows: “If the head of the children’s care institution, the custodian or the foster family have valid suspicion that the child is carrying alcohol, narcotic, psychotropic or toxic substances or appliances for their use, as well as objects and substances which may endanger the life of the child or other persons, the child may be searched”. Subsection 1 of Section 48 has been elaborated in the wording “A child shall not smoke and use alcoholic beverages”, Subsection 3 has been worded as follows: “In accordance with the Law “On the Handling of Alcohol” and with the Law “Restriction of the Sales,
Advertising and Use of Tobacco Products”, alcoholic beverages and tobacco products may not be sold to a child”; Subsection 4 “A person is responsible for involving a child in the use of alcoholic beverages or smoking. If alcoholic beverages and tobacco products are handed at a child’s disposal, a person may be found guilty of involvement of a child in the use of alcoholic beverages and smoking”. The title of Section 49 has been reworded as follows: “Protection of a child against the usage of narcotic, psychotropic, toxic and other intoxicating substances”, and Subsection 2 has been reworded as follows “The guilty persons for handing narcotic, psychotropic, toxic or other intoxicating substances at the child’s disposal or creating circumstances whereby these substances are freely available to the child or encouraging the child to use narcotic, psychotropic, toxic or other intoxicating substances and involvement of a child in the use of such substances are charged with criminal offence”.

In 2005 four new Cabinet regulations on the procedure of the examination of the influence of alcohol, narcotic, psychotropic or toxic substances were adopted:


Cabinet Regulations N 625 of August 23, 2005 “On the Procedure of the Examining the Influence of Alcohol, Narcotic, Psychotropic or Toxic Substances” on the procedure of medical examinations at medical institutions and the procedure of taking breath tests by the police. These Regulations do not refer to drivers.

Cabinet Regulations N 918 of December 6, 2005 “The Procedure of Inspection of Arrested Persons and Prisoners in Prisons for Finding out whether they have used Alcohol, Narcotic or Psychotropic Substances”.

Cabinet Regulations N 977 of December 20, 2005 “On the Requirements of Appliances Designated for Measuring Breath Alcohol Concentration”.

On October 21st, 2005 the Law “On the Keeping of Detained Persons” came into force, regulating the detention of people on premises designed for these purposes.

An important legislative document for the addiction service was adopted on October 4th, 2005, which amends the Cabinet Regulations N 429 of September 24th, 2002 on “The Procedure of the Treatment of Addicts of Alcohol, Narcotic,
Psychotropic and Toxic Substances” and regulates in detail the medically assisted treatment (methadone maintenance therapy and Buprenorphine substitution treatment). According to the regulation Buprenorphine can be prescribed for one week to patients who are enrolled in the program. This, however, is partly in conflict with the regulations from the March 8th, 2005 stating that prescriptions can be valid for up to two weeks.

On November 18th, 2005 the Cabinet Regulations N 864 on the “Pricelist of the Public Services provided by the State Addiction Agency” came into force.

During 2005 Latvia concluded agreements of cooperation against terrorism, illegal handling of narcotic, psychotropic substances and precursors and organised crime with the following countries – Azerbaijan, Cyprus, Slovenia, and an agreement of mutual assistance in criminal matters with Norway.

1.2. Institutional framework, strategies and policies

1.2.1. Coordination arrangements

Drug Control and Drug Addiction Restriction Coordination Council was set up in 2004 in order to raise drug and addiction problems at political level. Coordination Council is an inter-ministerial institution and its action is regulated by Drug Control and Drug Addiction Restriction Coordination Council statute. Seven ministers (minister of interior, education and science, children and family affairs, welfare, regional development and local government, justice, health) and several national experts (secretary of state of the Ministry of Finance, chief of stuff of National Armed Forces, director of the Pharmacy Department of the Ministry of Health, director of the State Addiction Agency, responsible officer for the drug and psychotropic substance illegal turnover combating of the Central Criminal Police Department of the State Police and rector of the Policy Academy) are involved in the work of the Coordination Council, which is chaired by the Prime minister.

Main functions of the Coordination Council are:

- to review national drug control and drug abuse reduction policy planning document projects on drug and psychotropic substance control, monitoring and drug demand and supply reduction;

- to coordinate state institutions in production, sale, registration, possession, control of legal turnover and prevention of illegal turnover of drugs and psychotropic substances, as also to promote collaboration of involved institutions in mentioned area;
• to review suggestions on development of international agreements, laws and other normative documents in area of drug, psychotropic substance and precursor production, distribution, sale and other ways of legal and illegal turnover, on drug prevention and combating;
• to review action priorities in order to promote drug prevention and combating;
• to promote information availability on drug and psychotropic substance use prevalence in Latvia;
• to coordinate action of state institutions, municipal institutions and NGO’s in order to ensure accomplishment of policy planning documents of national drug control and drug abuse combating;
• to promote scientific surveys in area of drug and psychotropic substance illegal turnover and drug abuse combating;
• to give suggestions on budget application for implementation of different activities related to drug field.

Coordination Council supervises four ad hoc groups:

1. Supply reduction ad hoc group;
2. Demand reduction ad hoc group;
3. Legal turnover ad hoc group;
4. Information analysis ad hoc group.

Head of Latvian National Focal Point is also head of Information analysis ad hoc group. Ad hoc groups meet once or twice a year, discussing important issues and problems regarding drugs, drug addiction and necessary improvements in the drug’s field.

Drug Control and Drug Addiction Restriction Coordination Council is the responsible body in evaluation of the State Programme for Restriction and Control of Addiction and Spread of Narcotic and Psychotropic Substances 2005–2008.

1.2.2. National plan and strategies

The first national drug strategy and action plan were adopted in Latvia on August 17\textsuperscript{th}, 2005. The programme involves four fields of action:

1. international collaboration and strengthening of legal basis;
2. demand reduction;
3. supply reduction;
4. data collection, analysis and evaluation of information.
The general objective of the State Programme for Restriction and Control of Addiction and Spread of Narcotic and Psychotropic Substances 2005–2008 is to promote reduction of drug demand and supply as also to reduce drug-related infectious diseases, drug-related mortality and drug-related crime. Sub objectives state necessity to guarantee effective coordination and collaboration between involved institutions, to ensure development of prevention programs, their coordination, budget and division of competences, to improve rehabilitation programs and their availability, to improve treatment and to develop different alternatives, to improve coordination, collaboration and information exchange mechanisms between institutions involved in drug supply reduction, to make integrated information system, to strengthen legal base, structure and resources, to ensure work of Latvian National Focal Point according to EMCDDA requirements, to develop educational programs for experts and to draw up evaluation criteria for different activities as also to provide systematic and regular drug prevalence and consequence evaluation (for more information see SQ 32).

The implementation of the programme requires multidisciplinary approach and close cooperation among involved institutions.

There also exist other state programmes/strategies and plans which are indirectly related to drug issues, such as:

- Public Health Strategy,
- Mother and Child Care Health Strategy,
- Health Care Development Strategy,
- HIV and AIDS Prevalence Reduction Programme 2003–2007,
- Programme for Alcohol Consumption Reduction and Reduction of Alcoholism 2005–2008 (for more information see SQ 32).

1.2.3. Implementation of policies and strategies

There are needed allocations of sufficient funds although it is planned to do part of activities within the budget of involved institutions for the implementation of the State Programme for Restriction and Control of Addiction and Spread of Narcotic and Psychotropic Substances 2005–2008. Until October 2006 no budget resources were allocated for the implementation of the Programme (for more information see SQ 32) hence the major activities planned in 2005 (and partly for 2006) of the program have not been implemented.
1.2.4. Impact of policies and strategies

As mentioned in the section above there is no budget allocated for the implementation of the national programme which leads to the fact that impact of drug policy is weak. Activities which are feasible under the allocated budget are implemented according to competences of involved institutions (for more information see SQ 32).

1.3. Budget and public expenditure

Estimations and analyses of public expenditures of drug phenomena have not been carried out in Latvia, therefore information available about funds according to drugs are limited. Information on funds allocated for drugs and alcohol issues are available only for treatment centres and the State Addiction Agency under the supervision of Ministry of Health. Other institutions working in the drug field, such as, AIDS Prevention Centre, Health Promotion State Agency, the State Police and others involved, have no funding specifically allocated for drug issues.

According to the study on prevention in Latvia (see Chapter 3 on Prevention), six municipalities have allocated budget ranging from 3 000 LVL to 75 000 for prevention purposes. As compared to the previous year the budgetary allocations for prevention at municipalities have grown on the average by 10-20%. In addiction at some municipalities sources are attracted to prevention measures through a number of projects via allocation of premises or project co-financing. It is essential to mention that these funds are allocated at the largest cities in Latvia, which are also more active to respond addiction problems at local level. However, for majority municipalities there are no specially funds for addiction problems.

The State Program for Drug and Psychotropic substance addiction prevalence reduction and control 2005–2008 must be implement within the budget of involved institutions and also additional funding for activities must be provided by the State budget. However, in 2005 no budgetary funds were allocated to the State Program.

1.4. Social and cultural context

1.4.1. Attitudes to drugs and drug users

According to the last General Population Survey conducted in 2003 slightly more of Latvian population (52%) regards drug dependent people as patient than as criminals; a quarter (25%) perceives both dimensions equally. Only 7% see drug
addicts more as criminals than as patients, and 8% of the respondents have no opinion. Another 8% perceive drug addicts as neither criminals nor patients. Variability across socio-demographic categories reveals a slightly stronger tendency among women to perceive drug addicts as patients (56% to 46%). Men seem to perceive them as criminals more frequently (9% to 6%). The proportions of men and women who see both dimensions are nearly identical (25% and 26% respectively). There are no considerable differences among the different age groups. Overall, the public opinion seems to emphasize the dimension of the patient in the perception of a drug addict. An immediate consequence of this is that drug abuse should also be perceived as a kind of illness, though presumably a social and not a merely medical one.

Respondents were also asked to evaluate their knowledge on the consequences of drug abuse. 36% of the respondents think they are very well informed; a similar proportion (40%) think they are informed, but would like to know more. The proportion of those insufficiently and very insufficiently informed is 19% and 5%, respectively. The respondents on the whole seem to evaluate their knowledge as good, but 40% are willing to learn more. This could imply that the information is not sufficient, or that it is too general.

The personal evaluations and attitudes towards drug use are manifested in the approval or disapproval of certain drug-related behavioural patterns among people. The least disapproved behaviours are drinking alcoholic beverages several times a week (61% of the respondents “do not disapprove” of this behaviour) and smoking ten or more cigarettes a day (54%). The proportions of respondents who strongly disapprove of these behaviours are 4% and 7%, respectively. This could most probably be explained by the high prevalence of these behaviours in society, despite the publicity stressing the harmful effects of the use of alcohol and tobacco. Experimentation with illicit drugs is perceived as a more undesirable behaviour than even frequent use of alcohol and tobacco. Only one-third (33%) of the respondents would not disapprove of people trying ecstasy once or twice, and about one-fifth (20%) would not disapprove of smoking marijuana occasionally. However, the answers regarding experimentation with ecstasy and occasional use of marijuana are quite equally distributed across the evaluation categories, tending only slightly towards disapproval. Even though cannabis is perceived as having a somewhat special position among illicit drugs, it has received a lot of mass media attention with the message trying to deprive it of the special status as the least harmful drug, which
could explain the fact that occasional use of cannabis is more frowned upon than experimentation with ecstasy.

In general, no single opinion is clearly dominant for any of the behaviours (even though the use of alcohol and cigarettes is slightly less disapproved, and the use of drugs tends to be more disapproved). It seems that there is a rather high degree of tolerance towards drug users in general.

When discussing the acceptability of the use of a certain drug, there is a marked difference between the answers of those who have had personal experiences with that drug and those who have not. Regarding both cannabis and heroin, the proportion of those disapproving strongly is higher among those that have had no personal experience with these drugs. Only 3% of those who have smoked marijuana or hashish themselves disapprove strongly of other people doing so, and only 16% of users ever of heroin disapprove strongly of the use of that drug by others. Among those who have not taken cannabis and heroin themselves, the frequencies of disapproving of taking these drugs are 24% and 32%, respectively. Similarly, those who have friends who use cannabis or heroin are also less likely to disapprove of the use of these drugs than are those who have no friends taking the drugs.

Respondents were asked to evaluate the risks pertaining to regular use of alcohol, tobacco and cannabis, and to trying ecstasy and cocaine or crack once or twice. Regular smoking of marijuana or hashish is perceived as causing great risk by the highest proportion of respondents (78%). Furthermore, only 2% perceive the risk as nonexistent. The proportions are about the same for experimentation with cocaine or crack (72% and 4%, respectively).

1.4.2. Media representation

For several years the State Addiction Agency monitors the published press and Internet portals for articles regarding to alcohol, drugs and tobacco. The following press publications (seven altogether) and the following Internet portals (three altogether) are reviewed:

- daily newspaper “Diena”,
- daily newspaper “Neatkarīgā Rīta Avīze”,
- daily newspaper “Latvijas Avīze”,
- daily newspaper “Zemgales Zīņas”,
- daily newspaper “Kurzemnieks”,
- daily newspaper “Latgales Laiks”.

Like during the previous years, this year, too, most of the attention was devoted to the amendments of legislation and to new regulation from the Cabinet of Ministers, different activities (especially activities related to hepatitis C, anti-smoking campaigns and other), statistical information (incidence and prevalence of hepatitis C, HIV/AIDS, incidence and prevalence of alcohol, drug and/or psychotropic substance addiction), information on crime (smuggling, dealing), as well as stories about people, information about globally accepted regulations and different scandals related to the use of alcohol and/or drugs. For several years running similar information appears at particular time periods (especially in the months with important dates – midsummer festival in June and the start of school in September). The information has been split into two categories: drug related information in the press and in the Internet, and other topics.

Drug related topics in the press and in the Internet, year 2005

In January mass media published information on the basis of the EMCDDA annual report for 2004. The information emphasized overdose, which is the main cause of loss of life among young people in Europe.

A month later the press reflected information on Miriam Stopard’s book “What children ask” published by the publishers "Zvaigzne ABC", where marijuana is regarded as a light dope which does not lead to addiction. The book also carries inaccurate information on LSD and ecstasy. Several representative of the Saeima, addiction specialists and other persons were against the book and demanded that it should be taken out from circulation. Such scandal proves that it is important to check all the literature published (especially literature published for children and young people) and, possibly, to consult specialists in certain areas to avoid publishing information that is not true and may lead to hazardous circumstances.

In March media raised the problem of Finnish “drug tourists” who came to Latvia to purchase Subutex (Buprenorphine). According to the legislation if a person has met entrance criteria (more in detail described elsewhere in this report) to the program prescribe Subutex. The Finnish embassy in Tallinn has given information of approximately 600 citizens of Finland regularly visiting Latvia to purchase Subutex.
The number of visitors from Finland leads to suspicion that Subutex is further dealt on the Finnish black market.

In April Latvia found out that an illegal methadone production facility had been operating in Gulbene for seven years, producing methadone 8-10 times a year. Estimated amount of produced methadone since establishment of the “laboratory” was more than 80 kilograms.

When after 11.00 p.m. young people with drugs were detained in one of the Riga clubs, this lead to the renewal of the discussion on the necessity to control clubs, through involving the police, the attendant staff and the club management, as well as prevention workers. In October the Riga Prevention Centre started to patrol the Riga clubs in order to identify people who use addictive substances in order to form an action plan.

Last December the State Addiction Agency presented analysis of national results from the ESPAD’03 study. In connection to the presentation of ESPAD, mass media carried statistic information about the prevalence of alcohol, drugs and smoking against schoolchildren.

Regularly mass media carries so called criminal information – amounts of substances removed from circulation, people detained, smuggling, etc., as well as statistical information (recorded number of cases in a particular period) and other information on drugs (usage, main risks and consequences of usage).

Other important topics in the press and in the Internet

One of the most prevalent topics in 2005 is related to the problem of hepatitis C in Latvia. The state pays for treatment with Interferon which is ineffective. Better medication for hepatitis C treatment cost about 7 800 LVL for six months, which is a very large amount, taking in account the circumstances and the average salaries in Latvia. On a regular basis the public of Latvia is informed about different activities and people are asked to donate for the patients with hepatitis C, however, this should not be practiced on a daily basis. People were invited for free check-ups for hepatitis C. Information on hepatitis C appears frequently, as well as information about the symptoms and treatment possibilities.

The situation is similar with HIV/AIDS. The public has regular information about the prevalence of the disease.
Mass media carries also “life stories” about protagonists – former drug addicts, alcohol users, HIV infected persons telling about their experience and warning young people or other individuals.

Mass media also attracts attention to the issues connected to gambling (new legislation has been passed and new prohibitions are implemented).

2. Drug Use in the Population

No new information available. Next general population survey (GPS) is planned in 2007. More information on GPS can be found out in the National Reports 2005 and 2004.

3. Prevention

3.1. Universal prevention

There are several institutions acting in the field of drug prevention in Latvia. These institutions cover different areas of drug – related topics but work of these institutions may be considered to be interrelated.

3.1.1. School

In 2005 State Health Promotion Agency (SHPA) carried out an EU project called “Non-smoking class” which was implemented with the aim of detaining the commencement of smoking and promoting abandonment of smoking among young people who have started to smoke. The target audience of the project was 7 – 8 graders, who were invited not to smoke from November 1\textsuperscript{st} 2005 to April 30, 2006. By November 1\textsuperscript{st} 535 applications were submitted for the project.

Another institution working in the area of drug prevention questions is Centre for Curriculum Development and Examinations (CCDE). Over the last year CCDE has taken a number of measures with the aim to include health issues in the curriculum, the tutorials and to promote other activities in health studies. The most important CCDE activities are as follows.

The implementation of the reform of elementary education started on September 1\textsuperscript{st} 2005. The new standards of the curriculum include topics on healthy lifestyle, own health protection and the protection of the health of other people. Changes in the curriculum are aimed at developing the children’s knowledge and
skills, as well as at changing attitudes in correspondence to the quality of contemporary education.

The curriculum integrates issues related to health – physical and mental safety, healthy lifestyle, addictions, intoxicating substances, smoking, the effects of tobacco, alcohol and drugs on health and capacity. Special attention to these topics is devoted in the broader areas “Man and the community” and “The basis of technology and science” (social science, natural science, information, physics, biology, chemistry, geography, housekeeping (handicraft) and sport).

In the framework of the curriculum reform a new subject was introduced: “Social sciences” for 1st to 9th grades at primary education. The subject of social sciences includes such divisions as “Health and awareness of the importance of life”, “Personal safety”, where children study according to a curriculum including topics of health education, such as, prevention of intoxicating substances, smoking, the health effects of alcohol and drugs, as well as their influence on the labour capacity of a person.

CCDE has started to work on a new conception of the curriculum of secondary education. With regard to the situation in Latvia and globally, issues of health and safety will be included in secondary education. In working on these issues CCDE collaborates with a number of organisations and institutions in Latvia.

A work group founded by the State Youth Initiative Centre (SYIC) of the Ministry of Education and Science has developed a sample program for the tutors for 1–12th graders, including topics of health and safety. CCDE specialists have taken part in the development of the program.

According to the model elementary school program, the basic topics of tutorials include information on the basis of healthy living, addiction prevention, addictive substances and their health effects.

Over 2005/2006 the curriculum has been tried out at more than 20 schools by over than 200 teachers in all Latvia (Rīga, Daugavpils, Liepāja, the Preiļi region, Riga region, etc.) in both elementary and secondary schools. The results of the pilot, the comments of the teachers and their suggestions were received in March, 2006. The work group will further adjust the program to prepare it for introduction in all schools.

SYIC on a regular basis informs the educational boards and teachers about current issues in educational work and invites tutors to pay more attention to health and safety in their everyday work.
One of the largest school projects in Latvia is the network of Health Promoting Schools (HPS). Since 2000 there are more than 170 schools in Latvia who have joined the network as well as four regional HPS centres. The key positive trends in the HPS are as follows: 1) a growing number of children gain a deeper knowledge of health issues, 2) there is a growth of the competence of teachers in the area of health, 3) the co-operational skills of the pupils, their creative skills and decision making abilities are developed, 4) work organization at the HPS is developed, etc. The children gain a broad spectrum of theoretical knowledge on health issues, the attitudes and skills and decision making capacities of the pupils are consolidated during out-of-class activities. The framework of HPS is important for popularising healthy lifestyle.

In the framework of the project young people – leaders – are trained for peer prevention and leading peer discussions. The school health teams organize different activities in their schools on a regular basis.

Regional centres coordinate work in the regions and they are accessible to schoolchildren, teachers and other interested people as centres of information and knowledge. These centres organise further education for teachers on health issues.

Between December 2004 and May 2005, CCDE in collaboration with UNICEF, carried out the survey “Life skills’ based sexual and reproductive education and HIV/AIDS prevention”. In order to gain more awareness and feedback about sexual and reproductive health classes at schools, a survey was carried out among 9th formers and among teachers. The aim of the survey was not only to assess the knowledge and skills of the children but also the opinion and skills of the teachers who teach different health subjects.

By developing the material “Health issues in the curriculum of elementary school education” (CCDE, 2005) the aim of CCDE is to give an overview to all health workers and other interested persons on issues included into the elementary education program. It gives an overview of the mandatory requirements on the standards of the curriculum in the sphere of health topics at elementary schools.

In 2005 CCDE organised courses for the enhancement of skills’ training of educational professionals. The program included integration of health education topics in the social sciences program, models of integration of health education, life-skills’ education, health promotion and other topics. The courses included topics on both physical and mental and social health, for example HIV/AIDS prevention, smoking, the effects of alcohol and drugs on health, different other addictions.
Further education training courses developed by other institutions, e.g. Department of Education, Health Promotion State Agency, Education Development Centre, Latvian Municipal Education Centre, Adult Education Training Centre of the University of Latvia etc. have also been coordinated with the Ministry of Education and Science.

The target audiences of health education topics are teachers of social sciences, natural sciences, biology, sport, health education, housekeeping, class tutors, school management and their deputies.

3.1.2. Family

No new information available

3.1.3. Community

There are two main organisations in Latvia working on prevention – Riga Addiction Prevention Centre (RAPC) and the State Health Promotion Agency (SHPA) and this section will mostly cover information on these two.

**Riga Addiction Prevention Centre**

Community is considered to be the largest group for which different preventive activities are provided in Latvia. Riga Addiction Prevention Centre (RAPC) in 2005 continued to carry out specialist education through a number of programs. In 2005 the number of specialists trained was 533. Between 2000 and 2005 1 047 young school leaders, 789 teachers, 113 medical workers, 40 general practitioners, 245 police officers have undergone the programs of the RAPC and received certificates. 389 specialists (teachers, social workers, social pedagogues, psychologists, educators of children’s homes) have received methodological training to work independently on the programs developed by the RAPC.

In 2005 RAPC developed and published a number of methodological and informative materials on prevention (pamphlets, posters, advertising material and logos of particular programs, etc.). On a regular basis RAPC submits information about its activities to the mass media, organises press conferences, develops TV and radio programs.

Part of the work of RAPC is related to counselling. The specialists of the telephone hotline have answered 7 579 telephone calls and 786 e-mails; the latter being by 160 more than in 2004 and twice as many as in 2003. It must be mentioned that one of the note of warnings on the cigarette packages is with the telephone number of the RAPC hotline, thus the main group of callers (40%) are smokers who
share their experience about how to quit smoking, how to be cured from the addiction to smoking. Alcohol addicts rank second. The rest of the issues concerned treatment of dependencies, different addictive substances, addiction to computer games and gambling.

Most of the questions posted by e-mail were about drugs, their influence, the reduction of addiction, the signs of drug use, assistance (28%). The second largest group of questions was on smoking (13%).

RAPC continues carrying out alternative prevention measures. On the city centre square “Esplanade” the activity “Do not allow yourself to get lost in the maze” was carried out with the aim of strengthening the ability to resist the temptation to use addictive substances. In the framework of the activity “Against per mills” a cycling tour took place, stopping at places of healthy leisure activities. The main aim of the anti-drugs' week “Free zone” was to popularise the UNO international anti-drugs' day and to raise public awareness. Besides in 2005 RAPC organised three “survival camps” for 49 children of risk groups as well as a summer camp for adolescents of the risk group.

Over 2005 the workers of the RAPC have taken part in various national and international seminars and conferences.

State Health Promotion Agency (SHPA)

The State Health Promotion Agency (SHPA) has carried out a number of activities in the framework of different programs over 2005. In the framework of the program "Prevention of addiction to psychoactive substances and gambling" in 2005 in collaboration with the World Health Organization (WHO), the Ministry of Health of the Republic of Latvia and the Doctors' Association of Latvia a press conference was organised devoted to the International anti-smoking day (May 31st). The final conference on the results of the 2004 program for prevention of the use of psychoactive substances and gambling and regional projects was held. On June 30, 2005 a seminar on tobacco control and quitting of smoking for health care specialists with the aim to train doctors, health promotion professionals, nurses and other people working in health care to render training in their region, institution or professional association was held. In 2005 a follow up survey was carried out for the 2004 participants of the international anti-smoking campaign “Quit and win”, and the primary prevention training material for school age children “Xoteric” “the Underworld” was adapted.
In 2005 WHO publication “The role of health professionals in tobacco control” was translated and published in Latvian. A national overview of the project “Health professionals and quitting of smoking in Europe” has been developed and a lecture for the Baltic General Practitioners’ conference on the involvement of family doctors in the treatment of tobacco addiction was prepared.

In the framework of the program “Prevention of the use of psychoactive substances and prevention of gambling”, representatives of the SHPA have taken part in the International Seminar of Northern and Baltic countries on the development of a common alcohol policy, and have taken part in a ministerial work group on developing the “Regulations for distribution of computer games”.

In the framework of the program “Prevention of cardiac and coronary heart diseases” in 2005 a letter signed by the Anti-Smokers’ Coalition of Latvia and the Doctors’ Association of Latvia, containing an invitation to take definite and rapid action (in three priority areas) with the aim of reducing the harm of smoking has been prepared and submitted to the Prime Minister. In 2005 representatives of the SHPA have taken part in the preparation of the report on the legislative amendments proposed by the Health Ministry of the Republic of Latvia and on the results of tobacco control at the government meeting “Europe free of tobacco smoke 2005”. They have also participated in the spring school “Young people and tobacco” in Helsinki. The topic of the training course was prevention of smoking and treatment of young people.

In 2005 there was a public awareness campaign against the health effects of smoking and its relation to heart and coronary conditions. In the framework of the activity postcards were disseminated with four different pictures, information material and slogans “Smoking – what your heart likes best”, “Sedentary lifestyle – what your heart likes best”, “Workaholic – what your heart likes best”, “Obesity – what your heart likes best”. Large scale posters were printed and placed in the larger towns of Latvia; 4 informative video clips were produced on heart and coronary risk factors.

In 2005 the European Anti-smokers’ Union held the European Commission’s anti-smokers’ campaign in Latvia: “Help: life without tobacco”.

In the framework of the family health promotion program in 2005 a future parents school of the duration of 40 hours was held on different topics, including smoking and pregnancy. There was also a life skills’ training in STS/HIV/AIDS prevention for vocational schools’ educators and trainees aimed at improving the
understanding of educators from vocational school, boarding school and children’s homes (orphanages) about the prevention of STD and HIV/AIDS in young women.

In 2005, two international projects were implemented. Latvia participated in the project “Social exclusion and public health in the EU” with a presentation on the integration of HIV/AIDS patients into society. In the framework of the project “Restriction of smoking and health care specialists in the EU” a work group has been formed for the development of a tobacco monitoring strategy in Latvia. The first presentation of the primary assessment report has taken place. The objective of this project is to strengthen the co-operation of Member States and Candidate States in securing abandonment of smoking, to promote the involvement of health promoters in the service for abandonment of smoking by strengthening an internal network in tobacco control.

In 2005 SHPA gained the right to develop a further training program for educators and schoolchildren on the health habits of schoolchildren, their attitude to health and behaviour influencing health habits. A training course has taken place in the framework of this program: health in elementary school and health as a component of social science. A further training program has been prepared for educators on the topic “Prevention of the use of alcohol in vocational educational establishments”.

In 2005 SHPA analysed the data of the year 2004 survey of the health habits of the population of Latvia (FINBALT) and published issues of this program; it has also conducted preliminary work on the survey of the health habits of schoolchildren in Latvia (HBSC) planned for 2005/2006.

In 2005 SHPA continued to coordinate the radio broadcasted health program “Your health”, acted in health committees and took part at international meetings, seminars and conferences.

Other organizations

There are several NGO’s acting in the field related to addiction and addiction prevention. Still their activities are mostly very weak and limit only on production of informative materials (posters). Some NGO’s also provide educational lectures (viewing movies on addiction problems) for different groups, for example for army soldiers.
3.2. Selective/indicated prevention

3.2.1. Recreational settings

Implementing the activity plan developed by the Riga City council, RAPC workers patrolled a number of Internet cafes and city night clubs. 12 Internet café’s working at night-time were visited and the conclusion was that adolescents were rarely present at the halls after 23:00 since the premises are regularly inspected by the police. On the other hand patrolling of the night clubs showed that there is insufficient door control and that cigarettes and alcohol were traded freely without demanding any age-certifying documents. Smoking and non-smoking premises were not separated at the nightclubs, and that the management of the clubs did not prohibit people under the influence of alcohol and drugs into the clubs. It should, however, be noted that the patrolling of the night clubs was not done on a regular basis, so the results may be subjective, as no analysis of potential drug use was carried out.

3.2.2. At risk groups

RAPC is the largest institution in Latvia and is Riga–based; its scope of work during five years of operation is not only on the prevention of addiction, but also on the prevention of alcohol, smoking, and gambling and computer games.

In 2005 the number of individual clients consulted was 403 people with different addiction problems and 209 families with addiction problems. The main problems of the clients in 2005 concerned addiction to drugs and medicine – 160 cases, alcohol – 127 cases, behavioural problems – 123 cases, tobacco – 64 cases and addiction to computer games and gambling – respectively 76 and five cases.

RAPC continues to be active in psychosocial correction and support groups. In 2005 the number of participants of the groups was 433. 197 children of primary and elementary schools participated in the program “Strange adventures of the dwarfs”. 141 participant took part in the support group "For children under risk" targeted to carry out prevention for children of high risk groups. 45 participants took part in the support group of the Iļģuciema (women’s prison) and the Matīsa prisons. 20 and five persons respectively took part in the program “I smoked awhile, but then I quit” and in the program “I played awhile, but then I quit”. 25 participants took part in the co-addict group.
The AIDS Prevention Centre (APC) is the largest organisation in Latvia monitoring and analysing the epidemiology of HIV/AIDS, and its aim is to implement the policy of restriction of the prevalence of HIV/AIDS in the country.

Every year the AIDS Prevention Centre carries out a number of important activities for the reduction of the prevalence of HIV/AIDS. One of the largest campaigns in 2005 was "I too, if you do" which aimed at enhancing public understanding about the risk of young women to be infected with HIV and other sexually transmitted diseases through sexual contacts. The AIDS Prevention Centre regularly organises press conferences, seminars and lectures, as well as training, advises private persons over the telephone and in person. Over 2005 the Centre developed and published a number pamphlets and posters. They also conducted a project “Information and education activities for the restriction of the prevalence of HIV among young women” with the aim of enhancing the understanding of the right for safe sex aimed at young women. Over the previous year APC submitted a number of new project proposals.

3.2.3. At risk families

No significant information available.

3.3. Prevention measures in municipalities of Latvia

The State Addiction Agency, Latvian National Focal Point continued to monitor existence of official and unofficial prevention strategies and their scope via structured questionnaire at municipality level in Latvia.

76 questionnaires were sent out to municipalities and district councils requesting to point out the programs, strategies and action plans for prevention, the areas involved, aims and objectives, the responsible institutions for the implementation of the programs, strategies or action plans, the budget and sources of financing as well as assessment of efficiency of these policies.

As a result of the survey, 47 questionnaires were received from 23 districts, including Riga, and major cities – Jelgava, Jūrmala, Ventspils, Liepāja and Daugavpils, as well as from 15 district centres, six district municipalities and 13 town municipalities representing seven districts and from several smaller municipalities.

The summarised survey data leads to the conclusion that there are prevention programmes, strategies or action plans in 12 districts only (Alūksne, Daugavpils, Gulbene, Jelgava, Jūrmala, Kuldīga, Liepāja, Ogre, Riga, Talsi, Tukums,
Valmiera, Ventspils). In comparison to previous year existing programs or strategies in the area of prevention were mentioned at the following municipalities – Alūksne, Balvi, Bauska, Gulbene, Jelgava, Jurmala, Kuldīga, Liepāja, Ogre, Rīga, Tukums, Ventspils). Several municipalities have mentioned the district’s Public Health Strategy forming the framework of the prevention activities. The questionnaires mention the town of Liepāja where strategy is underway.

Separate municipalities have mentioned collaboration with AIDS Prevention Centre on setting up and participating in the Unified Secondary Prevention Network for injecting drug users. According to the data of the AIDS Prevention Centre there are ten municipalities involved in the project– Bauska, Jelgava, Jēkabpils, Jūrmala, Kuldīga, Liepāja, Olaine, Rīga, Talsi and Tukums – in total there are 12 low-threshold agencies. Some preventive measures take place also at the municipalities which have not stated their own prevention programs, but have signed agreements on joining the secondary prevention network.

According to the information provided six municipalities have allocated special budget ranging from 3 000 Lats to 75 000 Lats. In comparison to the previous year the budgetary allocations for prevention at municipalities have increased on the average for 10 to 20%. Additionally some municipalities’ financial sources are attracted to prevention measures through a number of projects by provision of premises or project co-financing.

The main target groups of the prevention measures practically have not changed – like in 2004 municipalities are mentioning schoolchildren, children from negligent families, families as such, unemployed, juvenile delinquents, former prisoners, street children (see Table 3.1).

**Table 3.1 Prevention measures at municipalities by target group, in absolute figures**

<table>
<thead>
<tr>
<th>Target Group</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>School children</td>
<td>49</td>
<td>39</td>
</tr>
<tr>
<td>Children from negligent families</td>
<td>44</td>
<td>30</td>
</tr>
<tr>
<td>Families</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>Unemployed</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>Juvenile delinquents</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Former prisoners</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>“Street&quot; children</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Others</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Mentally retarded children</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Homeless people</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Addicts</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

*Source: State Addiction Agency 2006*
The main objectives of the programs, strategies or action plans are public awareness, work with young people, their protection from addiction problems, education of parents and teachers on addiction problems/questions *(see Table 3.2)*. In 2005 activities aimed at motivation for treatment against addiction, assistance to addicts, as well as educational work in particular groups were mentioned more frequently as compared to 2004 figures.

**Table 3.2 Main objectives of the implemented addiction prevention programmes, strategies and/or action plans in absolute figures**

<table>
<thead>
<tr>
<th>Objective</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention measures in general</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Motivation of addicts to take treatment, assistance, treatment</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Raising of public awareness</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Development and implementation of a system (action plan, legislation, regulations)</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Prevention work, restriction of the prevalence of addiction</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Work with young people</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Work with parents, educators and specialists</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Reduction of harm, demand</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Organising educational work</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Development of alternatives</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prevention measures of HIV/AIDS</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Health promotion</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

*Source: State Addiction Agency 2006*

As in 2004, in 2005 the majority of the implemented prevention measures were measures directed against smoking, lectures and discussions on addiction topics, health days or health weeks at schools, measures against the prevalence of drug addiction, against the prevalence of HIV and AIDS, use of alcohol, seminars and conferences, the development of pamphlets and other information materials, work of advisory centres, patrolling by the police etc.

In the sphere of prevention the municipalities have mostly mentioned that a welfare service or a social worker (in the smaller municipalities) was active in their territories; in some municipalities there are day or support centres for children and young people, e.g. for children, their parents or co-addicts; in the larger municipalities there are advisory centres acting within the framework of social services or day care centres, as well as a trust hotline *(see Table 3.3)*. Notably a large part of the prevention measures are in the form of training, lectures or seminars.
Table 3.3  Prevention measures and possibilities offered by municipalities in absolute figures

<table>
<thead>
<tr>
<th>Service</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social services</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Support groups</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Syringe exchange/low threshold centre</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Social worker</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Advisory centre on addiction</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Day centre</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Telephone hot-line</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Support centre</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Parish courts</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Addiction treatment centre</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Crisis centre</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Psychologists’ consultations</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>AA/NA groups</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Street work</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Motivation programs</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Camps</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: State Addiction Agency 2006

When a local municipality did not indicate the existence of a developed program, strategy or action plan, they were requested to indicate the three main reasons for it. Similarly to the previous year, analysis revealed that the main problem why prevention programs were not implemented was lack of specialists/experts. Other causes are also mentioned – addiction problems are not identified or not existing in their territory, therefore there is no need to implement measures, absence of financing, specialists have high work load and other important factors (see table 3.4). In 2005 several representatives from municipalities have mentioned that the elaboration of prevention programs is not part of the municipal/district council competence, and that each municipality (in the case of district councils) has to develop its own program, or the other way round.
Table 3.4 Reasons mentioned by municipalities for failure to develop a prevention programme, in absolute figures

<table>
<thead>
<tr>
<th>Reason</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of specialists/experts</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Addictions are not identified as a problem in the territory of the municipality (or the district)</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>No information about the problem</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Lack of financing</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>There is a program or strategy on the district level</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>Prevention is carried out at educational establishments</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>High work load</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>No coordinating institution</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Lack of experience</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Individual work is carried out</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Lack of co-operation (co-ordination) among institutions</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>No government support</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>The municipality is not aware of the problem</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Non-government organisations take part in tenders and search for financing</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Clients visit treatment centres in Riga, Jelgava and other places</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Have not thought about the program</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Has not been formalised</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Not in the competence of municipalities</td>
<td>-</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: State Addiction Agency 2006

Speaking about the near future or the future perspectives of implementing addiction prevention programs, most of the representatives of the municipalities with no program have not thought about the development or implementation of such a program. It should be additionally mentioned that most of the representatives who think so come from the lesser municipalities where a separate strategy is not necessary. In these cases it is important that there should be a strategy or a program at a higher level - within the district or the region. A similar number of municipalities see the problem as important and think that certain activities should be started in the future, whereas they fail to answer when exactly things are going to happen. A small part of municipalities are presently working on draft programs and think about their implementation in the near future, e.g. in 2006. Some representatives from the municipalities believe that certain prevention work is carried out in the framework of other projects and at schools, so they do not mention implementation in the future. At separate municipalities there is no information about an implementation plan or they have not thought about the necessity of one (see Table 3.5).
Table 3.5 Future plans for the implementation of prevention strategies related to addiction, in absolute figures

<table>
<thead>
<tr>
<th>Status</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has not been planned</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Work is carried out on draft programs/plan to implement in the near future</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>It is in the municipalities working plans to implement the program (timeline – unknown)</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Aware of the existence of the program, but cannot state when program will be implemented</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Different prevention measures are carried out in the framework of other projects, at schools</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>No information, have not thought about the necessity of the program</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

*Source: State Addiction Agency 2006*
4. Problem Drug Use

Overview

This chapter provides information on new developments and main trends of problem drug use in Latvia during 2005 and early 2006. It covers information on problem drug use as defined by the EMCDDA as ‘injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines’ (EMCDDA 2004), information on clients in treatment according to the Treatment Demand Indicator (TDI), as well as some information on a cohort study of drug users that started in 2006.

4.1 Prevalence and incidence estimates

No new estimates on prevalence and incidence have been carried out in 2005 for problem drug use (PDU) or injecting drug use (IDU). At the end of 2005 planning and preparation for a study of drug users in Latvia started, with the actual data collection carried out from May to August 2006. It is planned to include data from this study in the PDU/IDU estimates for 2006 at local and national level. More descriptive information on the study is in the section Main characteristics and patterns of use from non-treatment sources.

4.2. Profile of clients in treatment

This section deals with data obtained from the treatment system. As discussed into detail in 2005 National Report limitations of the data coverage, quality and changes in legislation should be taken into account when interpreting reported figures. There have been some improvements in the overall data quality and coverage; and as of now several indicators of the drug treatment system can be distinguished that will be used in this section such as:

- First treatment demand according to the EMCDDA definition at in- or out-patient treatment settings;
- data on All treatments is only available at in-patient treatment settings;
- Treatment prevalence data should be interpreted with much care because of possible overestimation of people in treatment due to registration issues;
• at national level since 1997 data is analysed and reported according to two main indicators based on the WHO ICD-10 criteria of 1) dependence syndrome/withdrawal state with or without delirium/psychotic disorder\(^1\) and 2) acute intoxication/harmful use\(^2\);

### 4.2.1. First treatment demand

The State Register of Persons with Drug Dependence and Substance Misuse includes people treated back to 1970s with a few cases every year. In this section some data starting from 1987 will be included, when first treatment demands exceeded 50 cases. The majority of analyses will be based on data from 1997/1998 onwards when heroin “epidemic” in Latvia started. To give an overview of the drug situation when Latvia was as a part of the Soviet Union, table below shows the drug problem from back in the 1980s (see Figure 4.1).

**Figure 4.1 Development of first treatment demands**

![Graph showing development of first treatment demands](image)

Source: State Addiction Agency 2006

According to the data number of first treatment demands since its peak in 2000 (1114 at out-patient facilities and 931 at in-patient facilities) has gradually decreased until 2003 (373 and 135, respectively) (see Figure 4.1).

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\(^1\) F11-19.2-5

\(^2\) F11-19.0-1
This figure also shows a rather stable increasing trend in females treated at out-patient treatment centres (from 18% in 1997 to 24% in 2005), but not so clear trends regarding in-patient treatment facilities. Data on ICD-10 diagnosis shows that there are more women who are asking for treatment are diagnosed with dependence syndrome as compared with the female ratio of treatment demand, which might suggest that women are asking for treatment with more chronic condition of substance use.

Figure below shows first treatment demand at out-patient treatment centres in Latvia from 1998 to 2004 by age and gender (see Figure 4.3). It suggests that about one-half of first treatment demands are under age 20 (50,5% for females and 46,1% for males in 2005) since 2003 and the proportion of the youngest age groups (under 15 years of age and 15–19) is rather stable 2003. On the other hand since 2003 there is increase in proportion of males aged 25-29 asking for treatment. Generally it seems that females are starting their treatment at earlier age as compared with their male counterparts. One of the limitations of these data is that it is difficult to assess whether these figures are in line with real treatment demand because of the changes
in reporting guidelines in 2002, following underreporting of treated persons over age of 18.

Figure 4.3 Profile of first treatment demands, by gender and age groups (in percent)

Data suggest that in 2004 there has been relatively large increase in the number of treated persons both at out- and in-patient treatment facilities (438 and 265, respectively) as compared with data from previous year. In 2005 the number of people asking for the treatment for the first time in their lifetime has slightly decreased at out-patient treatment centres (401), but it has increased at in-patient facilities (261) as compared with data from 2004. These figures, however, since 2002 do not include majority of adults (over 18) who have been into drug treatment for reasons of intoxication or harmful use (according to ICD-10) and should be interpreted with caution. Since the data does not allow estimating the number of

---

3 Because of registration peculiarities data from in-patient treatment facilities is sent for data entry only after discharge, thus information on people who are in the long-term treatment programmes (12-18 months) will be collected later.
persons not reported to the State Register it is difficult to estimate the real trend in drug treatment from 2002 onwards when new regulations in the reporting took place.

Since 2000 there has been a sharp decrease in the number of people treated for heroin and other opiates as primary drug and in the same time an increase in treatment for amphetamines (see Figure 4.4). This might suggest that 1) there has been a shift in the substance use in Latvia, and, taken into account decreasing numbers of people asking for treatment for the first time in their lifetime, 2) need for more stimulant-type-drug oriented treatment programmes both for adolescents and adults.

**Figure 4.4 Profile of first treatment demands, by primary drug (in percent)**

![Profile of first treatment demands, by primary drug](image)

Source: State Addiction Agency 2006

Over the last years there has been a sharp increase in first treatment demands with diagnosis related with poly-drug use (F19.0-5 according to ICD-10) and stimulant use (F15.0-5), which mainly includes amphetamines) – from five per cent in 2000 to 41% in 2005 and from four percent in 2000 to 13% in 2005, respectively. At the same time persons with diagnosis related to opiate use (F11.0-5) has decreased sharply – from its peak of 73% of first treatment demands in 2000 to 20% in 2004 followed by a slight increase in 2005 (see Figure 4.5).
Figure 4.6 above shows data on selected secondary drugs. The most commonly mentioned secondary substances are cannabis, followed by amphetamines, alcohol. Figure covers data from 1998 to 2005. Before 1998 the most commonly mentioned secondary substance was alcohol, followed by other stimulants like ephedrine, but since 1998 cannabis is being mentioned in about every third case; slightly less than cannabis amphetamines are mentioned as secondary...
substance. There is no clear trend regarding various medications, such as barbiturates, benzodiazepines or other prescribed psychotropic substances, but it seems that it is following the decrease in the treatment demand for heroin as it has been more used as secondary substance by heroin users.

Figure 4.6 shows use of first time treated patients irrespective of primary or secondary drugs. Back in the beginning of 90s the most “popular” drugs from the point of treatment demand were stimulants – mostly ephedrine, home-made opiates “hanka” made from poppy straws and concentrate, which was mostly produced in former Soviet Union countries as well as in Latvia, and inhalants, which were mostly used by adolescents. Starting 1994 first cases of treatment demand were found related with cannabis use, which started to increase every year, while at the same time treatment demand for the “old times’ popular substances” started to decrease.

Starting 1997/1998 until 2000 there has been sharp increase in the number of heroin addicts asking for treatment and in the same time but at less slower pace for other drugs like cannabis and amphetamines. Since then number of first treatment demands for heroin has decreased but the rise of treatment demand for amphetamines and cannabis is increasing. There are very few cases where cocaine is mentioned either as primary or secondary substance, as are hallucinogens and ecstasy. Data from 2005 suggests that there has been an increase in treatment demand for heroin and slight decrease for amphetamines as compared with 2004.

Figure 4.7 Profile of first treatment demands, by selected substances (in percent)

Source: State Addiction Agency 2006
4.2.2. All treatments

Currently there are no national data available on All treatments at out-patient treatment centres, however, national data is available from in-patient treatment facilities, and since 2005 data collection has been started at major out-patient treatment centre in Riga.

Figure 4.8 shows data on ‘All treatment’ demands at in-patient treatment facilities. In line with of heroin “epidemic” in Latvia treatment demands at in-patient facilities has increased until 2000 (1291 treated persons) after which it started to decrease until 2003 (266). In 2004 and 2005 treatment demand at in-patient centres increased again – to 474 in 2004 and 497 in 2005.

Figure 4.8 All treatment demands at in-patient treatment facilities in Latvia

![Graph showing treatment demands from 1997 to 2005.]

Source: State Addiction Agency 2006

Majority of treatments at in-patient centres are related with heroin and other opiates, but since 2002 there has been increase for treatment demands for amphetamines as primary drug.

4.2.3. Treatment prevalence

At the end of 2005 according to the data from the State Register of Persons with Drug Dependence and Substance Misuse, there were 3 766 patients in treatment. Among people in treatment 3001 or 80% were males and 765 or 20% were females. Females in treatment are slightly older – mean age 27.44 as compared with 26.8 for males. It might be explained by the relatively large proportion
of women over 40 years of age who are treated for hypnotics and sedatives as compared with men in the same age.

Figure 4.9 Treatment prevalence at the of 2005 by age and gender (in percent)

4.3. Main characteristics and patterns of use from non-treatment sources

This section will provide brief information on a cohort study which started in 2006 in several cities in Latvia. Data collection for the study finished in September 2006 and it expected that the results will be published in 2007 and reported in the National Report 2007. The main objectives of the study were:

- to estimate the number of injecting drug users in national level;
- to obtain the main characteristics/profile of injecting drug users who are out of scope of treatment system;
- to obtain the information on new trends in patterns of drug use.

The funding for the study was allocated from the funds of National Focal Point according to the Grant Agreement for an Action No. CT.06.RTX.166.1.0 and it was conducted in close collaboration and co-ordination by AIDS Prevention Centre. The map below shows geographical coverage of the sites for interviewing.
The study is planned to be a prospective open cohort study – following people in the cohort every 12 months or if additional funding is available – every six months. The study was approved by the Central Ethical Committee. Respondents were recruited by specially trained outreach workers, whom drug users find more trustworthy. Sampling method used for the study was modified snowball sampling that allowed for interviewing every contact in the respondents’ contact “chain”, thus drug users’ social networks can be analysed.

Interviews were conducted on basis of structured questionnaire, which included questions on several domains in part with the EMCDDA newly developed questionnaire for DRID (Drug-related Infectious Diseases) indicator:

- personal identifier (initials, date of birth, mothers’ first name initial) for using to compare with other sources and to estimate the IDU population,
- Socio-demographical information (gender, age, nationality, education, family status),
- risk behaviour (sharing of needles, sex contacts),
- self-reported status of HIV and hepatitis,
- lifetime drug use, age of first use,
- last month drug use and frequency,
- episodes of treatment and abstinence from drug use,
- contacts with police and imprisonment,
- use of low-threshold facilities.
Altogether 555 drug users were contacted and baseline information has been collected. Some demographic information on respondents:

- 68% were males and 32% females;
- Youngest respondent – 13 years, oldest – 57, mean age of respondents – 29.8 years;
- Nationality – 56% Russians, 33% Latvians and 11% other nationalities;
- Education – 40% primary or lower, 38% secondary education and 16% vocational education;
- Self-reported HIV+ 14%, self-reported hepatitis – 36%.

Currently data analyses are being done and the results from the study will be published in 2007. The main domains analysis will be aimed at:

- Profile of the drug users,
- Chain and social network analyses,
- Data analysis by using GIS.

5. Drug-related Treatment

Data from medical institutions treating addicts shows an important insight into the key trends of the consumption and prevalence of narcotic and psychotropic substances. It is important, however, to follow up on the trends and the newest developments to keep the data up to date.

This chapter provides information on development of the treatment system in the country. Since the last national report provided more in-depth analysis of the treatment system this chapter includes general information and new developments in 2005.

5.1. Treatment systems

5.1.1. Overview

Treatment of alcoholics and drug addicts in the Latvian addiction clinics is voluntary. Addiction services are available in the out-patient and in-patient clinics, and in the addiction units at general medical treatment institutions either public or privately funded.

Information about patients addicted to drugs and psychotropic substances, intoxication and excessive harmful use is submitted to the State Addiction Service database by those publicly funded out-patient clinics, in-patient institutions, which
includes rehabilitation centres. Paper forms on persons with addictive disorders are sent to the State Addiction Agency (holder of the State Register of Persons with Drug Dependence and Substance Misuse) according to the Regulations of the Cabinet of Ministers as approved in 1998. At national level there is no clear definition of a treatment episode – when a treatment episode is reported or when an episode ends.

In order to gain a more accurate and deeper insight in the sphere of addiction, the methods of registration of the patients should be improved and up-dated (e.g. electronic compilation of data, data exchange between institutions and/or specialists) and the registry card should be up-dated, too.

Since 2002 most of the information in the data base comes from patients addicted to narcotic psychotropic drugs and seeking assistance (according to the ICD-10 criteria), however, addiction specialists are also aware of people who suffer from intoxication with such substances and their harmful excessive use. Changes in legislation give a vivid picture of how external factors may influence statistic data. Thus, according to the Cabinet regulations No 429 “The procedure of treating patients addicted to alcohol, narcotic, psychotropic and toxic substances” since 2002 no information is collected on adult patients with signs of intoxication and harmfully excessive use; which is one of the explanations for the relative stability in the incidence of drug-related conditions.

Since October 2004 at the State Addiction Agency in Riga work has been started on the electronic data recording of out-patients, which in future may provide one more source for assessing treatment demand. This source will make it possible to reflect patient information in line with the EMCDDA requirements on ‘All treatments’. Presently data are collected only on the patients undergoing treatment in the State Addiction Agency. In the future there will be a need to access the Health Compulsory Insurance State Agency data bases, so that information from all in-patient vouchers might be accessed on patients taking treatment from addiction specialists.

Early in 2006 a thorough check-up of the data of the State Register of Addicted Patients and Users of Addictive Substances was carried out. As a result of this check-up data on more than 500 persons were reassessed, because of the following causes: 1) one and the same individual had seen several addiction specialists, who had submitted registration cards and diagnosed the patient; 2) many inaccuracies in the personal data were identified, which allowed to eliminate multiple registrations of the same patient.
Information on recorded prevalence reflects the situation in the country at the end of the year. However, when interpreting this information, the following should be taken into account: 1) sometimes the information in the Register holds data about patients who have not been taken off the record by the addiction specialists for several reasons ("ghost cases"); 2) because of inaccuracies in the data, deceased people have not been taken off the record; 3) the Register does not always have updated information about the change of substance or change of the status of the individual (e.g. whether the individual has obtained higher education, has started to use different substances, or has changed his/her employment status). Therefore, we believe that the drug treatment prevalence figures are overestimated. It should be noted, however, that only those patients have been reflected who have sought assistance at the State treatment institutions and about whom the physician in charge has submitted the registration card.

5.1.2. Out-patient treatment

Out-patient assistance in Latvia is offered by the out-patient unit of the State Addiction Agency, out-patient units at hospitals, addiction units at municipal medical treatment institutions, privately practicing addiction specialists, and other institutions employing addiction specialists.

There are no specialised in-patient treatment centres dealing only with treating drug users but rather all dependencies in general.

An addiction specialist with an outpatient practice performs the diagnosis of the addictive condition (alcoholism, drug addiction, addiction to gambling or tobacco), carries out treatment and prevention of set-backs, as well as identifies addicts. The addiction specialists consults co-addicted family members, consults patients in general hospitals (including minors) with psychoses, acute intoxications, as well as excessive harmful use.

Outpatient assistance includes also medically assisted treatment, such as buprenorphine and methadone replacement therapy programs (see section on Medically assisted treatment). The objective of these programs is to decrease the prevalence of HIV, hepatitis B/C, to promote the social inclusion of the patients, and to reduce crime.
5.1.3. In-patient treatment

At the end of 2005, in-patient services were available at 13 institutions over the country:

- **Four specialised addiction clinics and rehabilitation institutions:**
  - the State Addiction Agency (100 beds),
  - the Straupe Addiction Hospital (70 beds, including 20 beds for adolescents addicted to psychoactive substances for rehabilitation),
  - the Riga Rehabilitation Centre for Addicts (15 beds),
  - the Rindzele Rehabilitation Centre for Addicts (20 beds)

- **Four addiction departments in general hospitals:**
  - the hospital „Gintermuiza” (50 beds),
  - the Liepaja Central Municipal Hospital (30 beds),
  - the Daugava hospital (40 beds),
  - the Rezekne hospital (11 beds).

- **Five other institutions:**
  - „Akrona”, ltd. (15 beds),
  - Medical company „ARS“ (15 beds),
  - Medical company, private entrepreneurship of B. Cjackis „Līdzjūtība” (11 beds),
  - the Narcological and Psychoneurological Recovery Centre „Ķemerī” (16 beds),
  - the Republican Hospital of the Prison Department (5 beds).

There is a social rehabilitation program for children addicted to psychoactive substances “Dzives energija” in Jaunpiebalga.

There have been no changes in the number of institution since 2004, though there has been a change in the accountability and the titles of two institutions. Two specialised addiction hospitals have been turned into addiction departments of other hospitals. The Daugavpils addiction hospital (with 50 beds) was incorporated in the Daugavpils general hospital with 40 beds for addiction patients. The Jelgava addiction hospital (with 60 beds) was incorporated in the hospital “Gintermuiza” with 50 beds for addicts.
5.2. Drug free treatment

No specific information available, see Chapter 4.

5.3. Medically assisted treatment

There are two types of medically assisted treatment in Latvia – methadone maintenance therapy (MMT) and buprenorphine substitution treatment (BST). The rules for entry into these programs are rather strict and the numbers of those in the programs are rather small. The criteria one has to meet for entry are:

- minimum age – 21,
- minimal duration of drug (opiate) use – 5 years,
- number of unsuccessful treatments in the past – 2,
- if a person is pregnant or is infected with HIV/AIDS, hepatitis B/C or with other chronic illnesses, e.g. STD, some of the criteria above can be skipped.

Additionally, there are rules when a person is dropped from the program:

- during regular biological tests there is presence of other drugs that are not prescribed by the doctor,
- there are complications related with either methadone or buprenorphine use,
- has not contacted doctor for five consecutive days,
- or is or is selling these substance or using them not as prescribed by the doctor

There is only one methadone maintenance therapy program in Latvia, which is run at the State Addiction Agency in Riga, and is government financed. Methadone is handed out by a nurse and medical doctor consults patients two times a week. Patients can have a consultation from a psychologist and a social worker.

Buprenorphine (Subutex) is approved as an effective medicine for maintenance therapy, which forms a framework for the medical, psychological and social treatment of people addicted to opiates. Buprenorphine has been used in Latvia since July 2003.

Methadone maintenance therapy

The methadone maintenance therapy model in Latvia in more detail is discussed elsewhere (WHO 2004, Subata 2000). The program in Latvia has been operating since 1996. The MMT is run at the State Addiction Agency, which is financed by the government.
The methadone distribution point is open from 7.30 to 14.30 on week days and from 8.30 to 12.00 on Saturdays, Sundays and State holidays. Methadone is handed out by a trained nurse. The average dose for methadone is from 60 to 100 mg a day. Doctors consult the patients twice a week. Patients may also visit the psychologist or seek advice from a social worker.

At the end of 2005, 53 patients (for comparison with other years see Table 5.1), i.e. 14 women and 39 men were in the program.

Table 5.1. Characteristics of clients in methadone maintenance treatment

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients</td>
<td>107</td>
<td>88</td>
<td>67</td>
<td>69</td>
<td>54</td>
<td>53</td>
</tr>
<tr>
<td>Number of new clients</td>
<td>17</td>
<td>11</td>
<td>8</td>
<td>21</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Number of clients removed from the program</td>
<td>35</td>
<td>29</td>
<td>29</td>
<td>23</td>
<td>32</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: State Addiction Agency 2006

In 2005, 15 first-time patients were admitted to the MMT program and another 6 persons were re-admitted to the program. 20 patients were removed from the methadone treatment because of various reasons – seven persons were taken into custody, six persons gradually decreased the dosage and stopped the program at own will, three people were removed from the program because of use of other illegal drugs, one person died, and the rest for other reasons. Three additional patients are currently decreasing the dosage to quit the program in 2006.

Out of 53 persons in treatment 25 have more or less regular job; out of these six persons are working as outreach workers. Out of 53 patients in MMT at the end of 2005 9 persons have children. In 2005 one person in the program was from Spain.

Since the rules for being in the program are rather strict and because of changes in the drug use in the country, as of 2000 the number of persons in the program is decreasing.

**Buprenorphine substitution therapy**

Buprenorphine (Subutex) has been approved as an effective medicine for substitution (maintenance) therapy, which is used for medical, psychological and social treatment of opioids addicts. In Latvia Buprenorphine has been used in therapy since July 2003 and it has to be paid by the patients undergoing treatment. The average dose for buprenorphine is from 8 to 16 mg a day.

In October 2005 new regulations on buprenorphine substitution therapy came into force with a set of rules that makes very difficult for new patients living outside
Riga (or relatively far from other approved hospitals) for entry into program. The model for substation treatment is as follows – first a patient has to visit addiction specialist for seven days at the State Addiction Agency in Riga on a daily basis; for the next 30 days one has to visit addiction specialist at the State Addiction Agency in Riga or other four licensed treatment centres in the country. Only after 37 days buprenorphine (Subutex) can be prescribed by the addiction specialist on a weekly basis. Before these regulation one could skip the first two phases of the treatment, thus making it easy for foreign “drug tourists” to get prescriptions for buprenorphine.

In 2005 119 people were treated in Buprenorphine maintenance therapy; among them 38 patients were from Latvia but the majority (81) – from Finland. The female ratio among patients from is lower, as compared with those from Finland, respectively 18 and 26 per cent. In 2005 a total of eight persons (including one died) have dropped out of the program.

Because of new regulation in buprenorphine prescription it is estimated that the number of persons in the program is going to decrease in 2006 as compared with 2005.

For development of the program and for effective monitoring, advisory committee has been formed with the main task to create a database of all patients in the buprenorphine substitution therapy.

6. Health Correlates and Consequences

6.1. Drug related deaths and mortality of drug users

Health Statistics and Medical Technologies State Agencies (HSMTSA) Health Statistics Department (HSD) administrates Death Causes Database as well as other data bases (Health Care Statistics National Programme Database, Database of Hospital Beds, Health Care Indicators Database, Newborns State Register, Medical Persons’ Register, Register of Medical Institutions and Practices, Register of Patients of Certain diseases as well as updates information of the databases.

Department audits the disease registers, develops common criteria and normative documentation for disease registers’ establishment and maintenance.

Death Causes Databases records are based on details from death certificates but drug related death cases are also received from the State Forensic Medicine Agency.

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4 Data from the Health Statistics and Medicine Technology State Agency
Expertise Centre (SFMEC). For completion of standard tables data from HSD is used.

For the last years drug related mortality remains quite low (14 death cases in 2005 and 14 death cases in 2004, 12 cases in 2003). According to the official data more death cases were registered in years 1999 – 32 cases, 2000 – 42 cases, 2001 – 36 cases and in 2002 – 35 cases. In 2005 11 of died persons were men and 3 were women. The same division was registered in 2004.

Figure 6.1 Evolution of drug related deaths 1996–2005

![Graph showing trend of drug-related deaths 1996-2005](source: Health Statistics and Medical Technologies State Agencies 2006)

However data must be evaluated critically as for some persons intoxication of drugs is not carried out. Besides that sometimes because of substance fast vaporise it is impossible to determine that a person’s death cause is overdose or intoxication with drug or psychoactive substances. This leads to necessity for more powerful technologies in the State Forensic Medicine Expertise Centre. Also expert training should be provided.

According to the State Forensic Medicine Expertise Centre there were 11 drug related death cases in 2005, still the data of HSD is considered to be more precise as they do the final checking. SFMEC at the beginning of the year also reported on 25 people who have died and who are known as being drug users. Of those 25 persons, 11, as mentioned above, had intoxication, in 4 cases death was related to accidents (road traffic accidents, drowning, gas poisoning), there was 1 case of suicide, 1 murder and in one case it was impossible to fix cause of death.
From 11 SFMAC reported intoxication cases in approximately 80% deaths were related to overdose of opiates by combination with other synthetic drugs, psychotropic drugs and alcohol.\(^5\)

6.2. Drug related infectious diseases

6.2.1. HIV/AIDS

Main institution which administrates and supervises prevalence of HIV/AIDS in Latvia is AIDS Prevention Centre (APC). APC was established in 1993 and it has three structural units:

1. department of epidemiological supervision and analysis;
2. department of information and education;
3. Consultation cabinet.

Centre’s main aim is to carry out HIV/AIDS prevalence restriction policy in Latvia. There are 22 laboratories which guarantee epidemiological supervision of HIV in Latvia. These laboratories provide primary testing on HIV infection. In case the test is positive it is sent to the State Agency “Infectology Centre of Latvia” for affirmation or deny of the result.

In 2005 119 627 blood samples on HIV were examined, 56 795 of them were samples from donors (data provided by State Blood Donors Centre (SBDC) and its Latgale branch.

134 809 primary HIV tests were used for detection of HIV, 58 520 of those were used to test donors. 839 tests were used for confirmatory diagnostics. 22 706 blood samples were examined for a valuable consideration which is for 18% more than in 2004. Total amount of examined blood samples (in public and private sectors) not taking into account donors in 2005 was 85 538 which is by 1,7% more than in 2005.

Since 1987 when the first HIV infected person was detected until the end of 2005 there were 3 332 HIV infected persons in Latvia, which makes the HIV prevalence per 100 000 inhabitants 144.

In 2004 the cumulative index was 3 033, which means that during 2005 there were 299 new HIV cases in the country. At the end of 2005 394 persons were in AIDS phase, which is by 72 more as compared to 2004. There is a tendency that a

numbers of newly reported HIV cases are decreasing since 2002 due to the changes of mode of transmission. At the same time the number of those persons in AIDS phase is increasing every year.

**Figure 6.2 HIV incidence in Latvia 2002–2005**

Still majority of infected persons are injecting drug users (IDU’s) – 68% infected by using common syringes for intravenous drug use, but the trend is that this way of transmission is decreasing. At the same time heterosexual transmission is becoming more common every year – 13,8%; 4% of HIV infected persons infected during homosexual contacts and in 13,6% way of transmission is not known.

**Table 6.1 Total number of HIV infections by mode of transmission in Latvia during the period of 1987–2005**

<table>
<thead>
<tr>
<th>Mode of Transmission</th>
<th>Men</th>
<th>%</th>
<th>Women</th>
<th>%</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexual</td>
<td>139</td>
<td>5,8</td>
<td>0</td>
<td>0</td>
<td>139</td>
<td>4,2</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>222</td>
<td>9,2</td>
<td>238</td>
<td>26</td>
<td>460</td>
<td>13,8</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>1750</td>
<td>72,4</td>
<td>516</td>
<td>56,4</td>
<td>2266</td>
<td>68,0</td>
</tr>
<tr>
<td>Mother - child</td>
<td>4</td>
<td>0,1</td>
<td>8</td>
<td>1</td>
<td>12</td>
<td>0,4</td>
</tr>
<tr>
<td>Not known</td>
<td>304</td>
<td>12,5</td>
<td>151</td>
<td>16,5</td>
<td>455</td>
<td>13,7</td>
</tr>
<tr>
<td>Total</td>
<td>2417</td>
<td>100</td>
<td>915</td>
<td>100</td>
<td>3332</td>
<td>100</td>
</tr>
</tbody>
</table>

**Source: AIDS Prevention Centre 2006**

Majority of all infected persons are men (except for heterosexual and mother–child mode of transmission) 73% and 27% accordingly. There also appears tendency since 2002 that more women get infection in heterosexual contacts (especially young women).
In 2005 the number of cases of mother–child transmission has increased; Until December 1st, 2005 6% of children born with HIV infection (from 183 children who were given birth by HIV infected mothers). In total there are 182 HIV infected children in Latvia which forms about 5% of all HIV infected persons. 75% of these children got HIV by sharing syringes, 8% got HIV in heterosexual contacts.

In 2005 the mean age of discovering HIV for women was 29.5 – about 18 months earlier than for men (31.3). Since 2001 mean age of discovering HIV infection for both genders has been growing. 

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In 2005 AIDS Prevention Centre carried out a survey “Prevalence study on HIV epidemiological supervision among intravenous drug users. The results from the survey are not published yet.

The aim of the survey was to clarify HIV prevalence and drug use habits among intravenous drug users, clients of HIV prevention points (syringe exchange points) as also to compare these results with the data of previously carried out prevalence studies.

At the moment HIV prevention programme acts in 12 municipalities, providing drug users with clean syringes, informative brochures on HIV/AIDS, counselling on different questions about HIV/AIDS, hepatitis, other sexually transmitted diseases, social help possibilities, harm caused by drug use, safer use, detoxification and rehabilitation programmes, also psychological support is provided and possibility to make free HIV tests.

The survey was carried out form March till May 2005. The method of the survey was linked to anonymous test on HIV with person’s agreement. It means that for blood sample and questionnaire one number was allocated. Such method allows comparing result of the test with respondent’s behaviour and at the same time it does not provide possibility to identify respondents.

From all tested persons (325) there were 70% (228) men and 30% (97) women. The mean age of all persons was 29.5 years. Majority were Russians (53.5%), Latvians (31.7%), Gypsies (5.8%) and other nationalities – 8.9%.

In blood samples of 22% (71) respondents antibody on HIV was found. Of them 13% (9) HIV was diagnosed for the first time but other 89% (62) knew that they are HIV infected. There were 28% (27) women with HIV positive test and 19% (44) men with HIV positive test.

Survey showed that there exists relation between drug use duration and higher HIV risk still larger research is needed for entire affirmation.

Mostly used drugs according to questionnaires are amphetamines and heroin. Often these substances are used together. Still a lot of drug users use common syringes (during last month) – 26%. 80% of them reported that they always clean syringes before use with cold water (68%), hot water (20%). 4% (2) had never cleaned syringes before use.

Respondents were also asked to answer questions on safe sexual contacts during last month. 68% reported that they have used condoms at least once but
20% – never. Women use condoms rarer then men. This may also be related to growth of heterosexual transmission among young women.

It might be deduced that HIV prevalence among intravenous drug users will stay more or less stable and feasibly if the drug market and drug use habits will stay the same as now\(^7\).

### 6.2.2. Hepatitis B and C

Public Health Agency is a state administrative institution. Its main task is implementation of public health policy in Latvia. Other objectives of the Public Health Agency are:

- epidemiological supervision of infectious diseases;
- supervision of environmental health risk factors;
- epidemiological supervision of non-infectious diseases;
- monitoring of Public Health Strategy;
- administration and coordination of exceptional public health situations;
- supervision, coordination and planning of Immunization State Programme.

To ensure accomplishment of the set objectives Public Health Agency carries out different functions\(^8\).

Data on hepatitis B and C related to drug use is reported by the Public Health Agency. Agency reports that until 2001 there was a large growth of hepatitis B infection but since 2002 there is a decrease registered.

The same goes for hepatitis C infection. Decreases of number of infection may be explained by increase of different harm reduction measures, for example, syringe exchange points as also by changes of mode of transmission and trends in drug and psychotropic substance use. In 2005 there were 8.2% drug users of all hepatitis B infected persons (in 2004 – 14.5%)\(^9\).

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What relates to hepatitis C the problem still is very serious. One of the main reasons for this problem is that state does not cover expenses of treatment for hepatitis C (except for Interferon, of which successful treatment is very rare). Another aspect is that many people do not know about their infection. Now for several years there are campaigns for prevention of hepatitis C implemented, whereas the main goal is to encourage people to make tests and then – to go for the results and to act accordingly.

The number of cases of hepatitis C has decreased since 2000, too.

### 6.3. Psychiatric- Co- Morbidity (Dual Diagnosis)

No new information available.

### 6.4. Other drug-related health correlates and consequences

No new information available.
7. Responses to Health Correlates and Consequences

7.1. Prevention of drug related deaths

There are no specific prevention programmes to reduce number of death cases among drug users. However informative messages that drug use can cause death are given to society and risk groups whenever discussion on drug issues take place. Overdose prevention mainly addresses opiate drug users and they can receive information on safer use of intravenous drugs at syringe exchange points and AIDS prevention Centre’s counselling cabinets. At the moment there are 12 syringe exchange and counselling cabinets in Latvia. Besides that there are social street workers who meet drug users every day and provide them with new syringes, condoms and information on possible help.

7.2. Prevention and treatment of drug related infectious diseases

7.2.1. Prevention

AIDS Prevention Centre is one of the main institutions which provides different preventive activities related to infectious diseases, especially to HIV/AIDS, STD and hepatitis.

AIDS Prevention Centre (APC) on regular basis provides public information campaigns, public educational and informative materials, spread information in mass media and internet and provide counselling for private persons, organize seminars, conferences and lectures as also cooperates with other organizations in projects regarding HIV/AIDS, STD, hepatitis and prevention of these diseases.

Main public campaigns organized by APC in 2005 were:

- public informative campaign “I do if you do too”. The purpose of the campaign was to promote comprehension of public on issues regarding young women and HIV and other STD risk in sexual contacts. During the campaign 100 posters were located in 17 cities of Latvia, 226 posters were located in WC’s of night clubs, bowling centres and other entertainment places, relay of informative video clips on national TV channels and location of informative advertisement banners on popular internet portals.

- in December 1st in APC counselling cabinet open door day was arranged. In nearest pharmacies informative brochures on World AIDS day were spread.
• special actions were provided for clients of counselling cabinet in St. Valentines day and on Christmas whereas discussions were provided as also movies on themes of HIV/AIDS were demonstrated.

One project was realized by APC in 2005 in collaboration with UNDP and Health Promotion State Agency “Informative and educational activities for HIV prevalence reduction among young women”. During the project different activities were taken – mass media campaigns, provision and spread of informative materials as also conferences and other educational activities. New project applications were drafted\(^\text{10}\).

APC also supervises and realizes HIV prevention counselling programme for intravenous drug users which operates in Latvia since 1999. APC is responsible for the guidance of the programme and for the supply of needle materials (syringes, HIV tests, disinfectants and condoms). Up to now programme operates in 12 municipalities. In counselling cabinets or points it is possible to make a free HIV and hepatitis tests.

The other institution providing different drug related prevention activities is Riga Addiction Prevention Centre (RAPC). RAPC main task is to provide drug addiction prevention (mostly primary prevention). The attention is not specially paid for prevention of drug related infectious diseases. The same relates to the Health Promotion State Agency (more information on these organizations and their projects see in chapter 3).

7.2.2. Treatment

State Agency “Latvia Infectology Centre” (LIC) is main institution dealing with drug related infectious diseases and other infectious diseases. LIC main purpose is to provide patients of infectious diseases, including patients of HIV and other STD with high quality in – patient and out – patient treatment as also to provide prevention and studies of infectious diseases\(^\text{11}\).

The other institution providing help regarding drug related (as also not related) infectious diseases is Sexually Transmitted and Skin Disease State Agency (STSDSA) which administers special register in order to provide epidemiological supervision of infectious diseases.


\(^{11}\) Data of the State Agency “Infectology Centre”.
STSDSA has created a special paid service for prostitutes where consultations and tests are provided and where Health cards are handed out\textsuperscript{12}.

7.3. Interventions related to psychiatric co-morbidity

No new information available

7.4. Interventions related to other health correlates and consequences

No new information available

8. Social Correlates and Consequences

8.1. Social exclusion

In 2005 there were 78 482 unemployed persons registered in Latvia (31 477 men and 47 995 women) which is for 12318 less than in 2004\textsuperscript{13}.

Latvia has also adopted some important documents for reduction of social exclusion. One of the most important documents is Joint Inclusion Memorandum (adopted in 2003) whereas attention is also paid to drug related problems. The other document regarding reduction of social exclusion is Report on social protection and social inclusion strategy 2006. – 2008 which is based on other important local and international documents and strategies\textsuperscript{14}.

Currently in Latvia there are large-scale studies undergoing on social exclusion and labour market; the employment issue is one of the key priorities in Latvia Development Plan for 2007-2013. These studies are financed by the European Social Fund and some of them are also aimed at dependent people (on alcohol, drugs and other dependencies). More information of the studies will be included in the further National Reports when data is available.

It is generally established that use of narcotic and psychotropic substances has a negative impact on health and other aspects of every day life. Besides different aspects of one’s life quality are very closely interrelated, e.g. drug use, education, health, employment, family problems, income etc. are bounded with level of person’s social exclusion or inclusion and vice versa.

\textsuperscript{12} Data of the State Agency “Sexually Transmitted and Skin Disease Centre”.
\textsuperscript{13} Data of the State Employment Agency.
\textsuperscript{14} National report on social protection and social inclusion strategy 2006. – 2008.
It is very important to reduce overall level of unemployment as well as to guarantee secondary education for all persons, including drug users.

The State Register of Persons with Drug Dependence and Substance Misuse at the State Addiction Agency according to TDI indicator guidelines collects data on patients’ level of education and employment. According to this data for all persons in treatment at the end of 2005 more than half (54%) out of 3766 people in the database were without specific employment; according to the First treatment demand indicator there were 34% without specific employment (see Figure 8.1). Such differences might be possible that not always information is updated, especially on changes in substance use, labour status and education. For comparison – only 8% in treatment prevalence data and 15% of First treatment demand were engaged in regular employment. About one-fourth of those in treatment and 39% of those at first treatment during their life are still at school, which can be explained by relatively young age of people in treatment and, especially for first treatments, changes in legislation in 2002 that have been described elsewhere in this report and more into detail in National Report 2005.

**Figure 8.1  Labour status of people in treatment and first-time treated in 2005**

![Pie charts showing labour status](source: State Addiction Agency 2006)

Such figures on labour status for drug users may lead to conclusion that there is a strong need to further improve the multidisciplinary approach of treatment, like there is need to adopt or develop new tools for assessing client needs and with the provision of funding to State Programme for Restriction and Control of Addiction and Spread of Narcotic and Psychotropic Substances 2005–2008 for activities related to
research in the field, development of new and widening the scope of available treatment programs that currently are more focused on medical treatment rather than social inclusion.

Another dimension of social exclusion that is being monitored in the treatment system is level of education. According to the treatment data the most typical level of obtained education of Latvian drug users is the primary level of education. This could be partly explained by a high proportion of those in treatment of relatively young age.

**Figure 8.2 Level of education of people in treatment and first-time treated in 2005**

![Pie charts showing level of education](image)

Other sources, such as drug cohort study conducted in 2006, suggest that the level of education for drug users is higher as compared with the treatment data, but still much lower than for the general population at certain age. About two-thirds (62%) of those under age of 20, while at the same time the majority of young people who are not using drugs have reached secondary level of education and have entered university, have reached primary level of education or even have not completed primary level of education (respectively 39% and 23%), 16% – secondary education, and another 16% – vocational education. With age the level of education
starts to increase, which might be partly explained by first successful treatments followed after by raising level of education.

**Figure 8.3 Level of education of drug cohort study in 2006**

There are other dimensions of social exclusion, which will be more discussed in the next National Report.

### 8.2 Drug related Crime

Sales, purchase and storage of illegal drugs is an offence, and the use of drugs leads to intentional crime. In Latvia the trends in the prevalence of narcotic and psychotropic substances resemble the global trends and the trends in the European countries. The mechanism of drug supply is constantly changing.

Since legislation has changed and new improvements and changes in the data compilation methods (e.g. Registers) are taking place, some of the police data might be underreported, especially on the number of arrested persons. This situation can not be justified, and we hope that the work of the Registers will continue and data will be available in the near future. The police data available for the whole 2005 includes number of crimes, number and quantity of seizures, and drug purity.

In 2005, 1141 drug-related crimes were registered in Latvia – as compared with the situation in 2004 has remained about the same (1148 crimes). About one-third or 35% of all drug-related crimes were related with intention to distribute (dealing), about 30 per cent – without intention to distribute (for personal use), and
another 35% were related to disposal of drugs and psychotropic substances in small amount or repeated use of scheduled psychotropic substances without prescription during one year.

**Figure 8.4 Development of drug-related crimes by crime type, in absolute numbers**

![Graph showing the development of drug-related crimes by crime type from 2001 to 2005.]

Overall, as compared with data from 2004 and as seen in Figure 8.4, the number of crimes related to drug dealing has increased by 11 per cent (347 in 2004 and 387 in 2005); crimes related to drug trafficking has increased almost three-fold (11 in 2004 and 27 in 2005). At the same time the number of crimes related with personal use and/or possession is on the decrease – as compared to 2004 in 2005 number of aforementioned crimes has decreased by 7%. These trends are in close compliance with the police activities – over the last few years they are more aimed towards the fight with drug dealing and taking apart of dealing and trafficking networks.
In 2005, more than 25 criminal groups were arrested, which were engaged in illegal drugs and psychotropic substances circulation and 2 illegal drugs production units were revealed in 2005\textsuperscript{15}.

8.3 Drug Use in Prison

No new information available.

8.4. Social Costs

No new information available

9. Responses to social correlates and consequences

9.1. Social reintegration

No new information available

9.2. Prevention of drug related crime

No new information available.

10. Drug markets

10.1. Availability and supply

10.1.2. Data from Law enforcement bodies

Maps 10.1 and 10.2 (see below) main trafficking routes via Latvia and main routes of drug supply are reported.

Map 10.1 Main trafficking routes via Latvia

- Scandinavian countries
- Estonia
- Russia
- Latin America
- Western Europe

- Cannabis
- Synthetic drugs

Source: Map from the Organized Crime Enforcement Bureau

Map 10.2 Main routes of drug supply to Latvia

- Estonia
- Amphetamines
- Ecstasy
- Russia
- Heroin
- (from Central Asia)
- Cocaine
- (from South America)
- Poland
- Amphetamines
- Ecstasy
- Lithuania
- Amphetamines
- Ecstasy
- Pappy straws
- Methamphetamine

Source: Map from the Organized Crime Enforcement Bureau
According to the information from Organized Crime Enforcement Bureau Latvia is on the trafficking route from Western and Central Europe to Scandinavian countries and Russia and from Russia to Europe and Scandinavian countries. Main routes and means of drug supply and trafficking are discussed here:

- Synthetic drugs are supplied from Poland, Lithuania, Estonia, the Netherlands and Germany mostly by means of road transportation, including public transportation;
- Cannabis is mostly supplied from the Netherlands, Spain and Lithuania; in 2005 for the first time from Bulgaria, as well as first case when industrially manufactured cannabis packages from the Netherlands;
- Latvia is used as cocaine transit route from South America to Russia and Scandinavian countries by air and sea, including use of sea containers;
- Out of all drug trafficking only a small part is for Latvian drug market since it is not a country where large quantities of drug are being sold.

In 2005 two large production facilities were found – 1) methadone production laboratory in Gulbene region (North Eastern part of Latvia), which has been operating for about seven years and has produced about 80 kg of methadone that was smuggled to Russia, Germany and other European countries; and 2) cannabis growing facility based in a private house that was equipped with necessary ventilation and lighting for the purposes of growing cannabis.

10.2. Seizures

Synthetic drugs still prevail in illegal circulation, especially amphetamine and methamphetamine. There is also increase of the illegal circulation of ecstasy. The most popular drugs among users remain cannabis. The main criterion in the prevalence of drugs in Latvia is low prices and the profits of the vendors. There have been no significant changes concerning illegal circulation of heroin in Latvia. It may, however, be seen that there will be a growth in the prevalence of heroin, since there is a growth of legal offences among drug users connected to the distribution of heroin.

Data of the State Police of the Republic of Latvia shows that certain drugs are confiscated more frequently (cannabis resin and leaves, ecstasy and LSD, certain quantities of cocaine and amphetamine) whereas the quantity of confiscated heroin and methamphetamine has decreased.
Table 10.1 Drugs and psychotropic substances removed from illegal circulation in Latvia

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis resin, kg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herbal cannabis, kg</td>
<td>193.58</td>
<td>6.64</td>
<td>6.02</td>
<td>7.58</td>
<td>25.92</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1.02</td>
<td>0.40</td>
<td>0.78</td>
<td>0.64</td>
<td>0.68</td>
</tr>
<tr>
<td>Heroin, kg</td>
<td>0.46</td>
<td>6.08</td>
<td>0.60</td>
<td>0.52</td>
<td>0.04</td>
</tr>
<tr>
<td>Amphetamine, kg</td>
<td>3.55</td>
<td>4.62</td>
<td>3.05</td>
<td>3.55</td>
<td>3.79</td>
</tr>
<tr>
<td>Methamphetamine, kg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecstasy, pills</td>
<td>1620</td>
<td>18298</td>
<td>9239</td>
<td>9460</td>
<td>21937</td>
</tr>
<tr>
<td>LSD (doses)</td>
<td>16</td>
<td>30</td>
<td>20</td>
<td>79.50</td>
<td>2190</td>
</tr>
<tr>
<td>Poppy straws (kg)</td>
<td>182.90</td>
<td>83.46</td>
<td>57.72</td>
<td>107.23</td>
<td>64.26</td>
</tr>
<tr>
<td>Ephedrine</td>
<td>0.57</td>
<td>0.11</td>
<td>0.85</td>
<td>0.66</td>
<td>0.02</td>
</tr>
<tr>
<td>Psychotropic substances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g</td>
<td>16900</td>
<td>570</td>
<td>1571</td>
<td>3045</td>
<td>434</td>
</tr>
<tr>
<td>ml</td>
<td>538492</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tablets</td>
<td>9011</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data of the Organized Crime Enforcement Bureau

10.3. Price/Purity

10.3.1. Prices

Since September 2004 specialists working at the Organized Crime Enforcement Bureau have started monitoring drug prices. The methodology used now is rather simple and does not allow for estimating deviations and coverage since it is not done on monthly basis. It is planned to develop the methodology in 2007 to get more reliable picture on the price increases and decreases.

As of now data on drug prices in retail trade show dynamics of the prices in 2004, 2005 and 2006. In 2005 price of heroin per gram during June–September has increased form 80 to 120 LVL. At the end of the year 2005 and in the beginning of 2006 there was a decrease of heroin price. For other substances there have not been significant changes in the prices (Figure 10.1)16.

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16 For ease of reading the changes in prices, price for heroin and cocaine are calculated for 0.1 grams.
10.3.1. Purity

The State Forensic Research Department is testing drugs on the level of purity according to approved methodology on heroin, cocaine and synthetic substances on all seizures where a person involved in the case\textsuperscript{17}. Currently no analysis on THC levels in cannabis is being done in Latvia.

The range for heroin purity is from two to 87 per cent, with the mean purity being 44%; for cocaine – 22 to 68 per cent (mean 39%); for amphetamines – two to 76 per cent (mean 32%); for methamphetamines – 14 to 84 per cent (mean 43%); and for MDMA – 8 to 94 per cent (mean 35%).

There is not enough data on possible sampling biases or other factors that might influence the results thus it is not possible to make conclusion if the level of purity at street level or wholesales is decreasing or increasing.

\textsuperscript{17} If drugs are sent by regular mail and sender is unknown or drugs are found without knowing the persons who owns them – drugs are not tested for purity.
PART B – SELECTED ISSUES

11. Drug use and related problems among very young people

Children and adolescents are a risk group when it concerns the use of psychoactive substances. In Latvia, at this age part of the adolescents try out of legal addictive substances – tobacco and alcohol as well as illegal narcotic and psychotropic substances for the first time.

Information in selected issue on very young people will be based on several data sources:

- National School Survey, which was carried out in 2003 by expanding the standard ESPAD (European School Survey Project on Alcohol and Other Drugs) age group of 15-16, and includes respondents from age 11,
- Treatment data (both out- and in-patient),
- Legislation analysis.

11.1. Drug use and problematic drug use among very young people (<15 years old) (from special studies)

11.1.1. Drug use among school children

In 2003 first national drug abuse prevalence study was carried out and published (Koroļeva et al. 2003). A chapter in the publication is dedicated to the national school survey. The target population for the school survey consisted of all students in the 5th through 12th grades of comprehensive primary and secondary schools, as well as all 1st through 3rd year students in vocational schools (corresponding to the 9th through 12th grades of comprehensive secondary schools). The questionnaire used in the study was the same that was used for ESPAD study, with only difference that for younger students an abbreviated version of the questionnaire was used. The questionnaire included questions on lifetime, last year and last month prevalence for tobacco, alcohol and other drugs. It is planned to repeat the study early spring in 2007 at the same time with ESPAD’07.

Figure 10.1 shows prevalence figures for some of the main indicators used in the ESPAD study according to age of respondents – for legal drugs, though illegal up to age 18, like alcohol lifetime prevalence for alcohol and tobacco 40 or more times. If gateway theory (Kandel 1975) works this could lead to use of illegal drugs later in
their life. Another indicator for alcohol used in the figure is drinking 10 or more times and being drunk 3 or more times during the last month – these students might be even more “problematic” as they represent about five percent of those aged 13-14 and about eight percent aged 15-16.

**Figure 11.1** Selected indicators of use of legal and illegal substances among 11-20 year olds in Latvia, in percent

Use of illegal drugs at age 11-12 is very rare in Latvia (lifetime prevalence in 2003 for any illegal drugs was 0.8% for boys and 0.7 for girls), but it starts increasing at age 13-14 (respectively 5.4% and 4.4%) and even more at age 15-16 (respectively 17.2% and 11.2%).

There are only two illegal substances mentioned by 11-12-year-olds – cannabis (0.4% lifetime prevalence) and ecstasy (0.4%). Of those at school at age 11 and 12 nobody has mentioned use of illegal drugs during last year or last month, which leads to conclusion that those who have tried the drugs have used them at more than a year ago. The most tried substance for 11-12-year-olds is solvents (used at least once in their lifetime by 15% boys and 12% girls), which is not illegal per se but could lead to problems such as intoxication or dependence. According to the survey data 4.2% 11-12-year-olds boys and 1.4% girls have tried various medications such as benzodiazepines or barbiturates.

Among 13-14-year-olds the prevalence rates for all drugs tend to increase as compared to those aged 11-12, except for solvents, which are used less by those aged 13-14 or 15-16. The fact that solvent usage decreases rather than increases
with age strongly suggests that today's very young people are much likely to abuse solvents than today's older cohorts have ever been. There, of course, might be some underreporting by older cohort and some over-reporting of solvent use by younger students but that only partially explains the strong decrease with age. It seems that solvent usage is an increasing problem and more attention should be paid towards prevention and education of this issue.

Lifetime prevalence rates for 13-14-year-olds for illegal drugs are not alarmingly high (below 5%) (see Figure 11.2) – the most commonly tried is cannabis (4% for boys and 3% for girls), followed by hallucinogens and ecstasy. Hypnotics and sedatives are used more by girls than boys, respectively 2.1% and 4.3%; and solvents by 13% boys and 10% girls.

Figure 11.2 Prevalence of various drugs among 11-20-year-olds, in percent

Source: School Survey 2003
11.1.2. Problem drug use

There have been no special studies aimed at young problematic drug users, but data from the cohort study described in chapter on Problem Drug Use shows that there is need for special approach to young problem drug users – out of 555 interviewed drug users only two were under age of 15. One of the explanation and a suggestion for need of special approach could be that very young drug users with a short history of drug use are often very well hidden and unknown to the older drug using population and since users in cohort were recruited via chain referral are not mentioned by older drug users.

Another data source on problematic drug users (including young people) is the database of persons positively tested drugs at the State Addiction Agency Department of Alcohol and Drug Intoxication Test. Since 2002/2003 all positively tested persons are entered into electronic database; at the beginning of 2005 all positive records from paper forms were entered into database now covering more than 10 500 people dating back to 1990s. It is estimated that more than 95% of the persons in the database are brought for testing by the police thus in this section the data will be called as Police data. There are some limitations with this data, mainly related with geographical coverage, since it does not cover all the country but rather Riga and vicinity.

The proportion of those under among tested in 2005 was 0.5% (14 persons out of 2937 with found drugs) and the proportion of children under 15 among those aged under 20 2.9%. There are no significant changes in the proportion over the years (see Table 10.1).

<table>
<thead>
<tr>
<th>Year</th>
<th>Under 15</th>
<th>15-19</th>
<th>Proportion of &lt;15 among persons &lt;20</th>
<th>Total number of positive drug tests</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>1994</td>
<td>1</td>
<td>0.6</td>
<td>18</td>
<td>10.2</td>
</tr>
<tr>
<td>1995</td>
<td>0</td>
<td>0</td>
<td>29</td>
<td>13.6</td>
</tr>
<tr>
<td>1996</td>
<td>5</td>
<td>1.8</td>
<td>44</td>
<td>15.7</td>
</tr>
<tr>
<td>1997</td>
<td>1</td>
<td>0.3</td>
<td>63</td>
<td>17.1</td>
</tr>
<tr>
<td>1998</td>
<td>2</td>
<td>0.4</td>
<td>117</td>
<td>20.9</td>
</tr>
<tr>
<td>1999</td>
<td>4</td>
<td>0.5</td>
<td>208</td>
<td>26.8</td>
</tr>
<tr>
<td>2000</td>
<td>20</td>
<td>1.6</td>
<td>318</td>
<td>25.6</td>
</tr>
<tr>
<td>2001</td>
<td>17</td>
<td>1.1</td>
<td>383</td>
<td>24.3</td>
</tr>
<tr>
<td>2002</td>
<td>9</td>
<td>0.6</td>
<td>315</td>
<td>19.7</td>
</tr>
<tr>
<td>2003</td>
<td>10</td>
<td>0.4</td>
<td>413</td>
<td>18.3</td>
</tr>
<tr>
<td>2004</td>
<td>18</td>
<td>0.5</td>
<td>632</td>
<td>18.8</td>
</tr>
<tr>
<td>2005</td>
<td>14</td>
<td>0.5</td>
<td>461</td>
<td>15.7</td>
</tr>
</tbody>
</table>
Figure 11.3 shows number of persons under 15 who were tested positive for drugs by gender. As seen in the figure majority of those in the database are aged 14 with a few exceptions every year.

Figure 11.3  Number of persons under 15 tested positive for drugs by age and gender

Source: State Addiction Agency 2006

Figure 11.4  Types of drugs found in biological samples of <15 year old children, 1994-2005

Source: State Addiction Agency 2006
Figure 10.4 above shows drugs found in the tested biological samples (blood, urine, hand and mouth wash) according to the methodology used in the laboratory. The most frequently found drug is cannabis, followed by benzodiazepines, opiates (home-made “hanka”), amphetamines and heroin or combinations of the drugs with alcohol.

11.2. Policy and legal development

There are several laws and regulations which determine different addiction related topics involving young people. In this chapter attention is going to be paid to those laws and regulations which determine treatment and rehabilitation circumstances for young people and children.

Firstly one of the main laws determined order of children rights and responsibilities is Protection of the Rights of the Child Law. The purpose of the law is to set out the rights and freedoms of a child and the protection therefore, taking into account that a child as a physically and mentally immature person has the need for special protection and care. The law also regulates the criteria by which the behaviour of a child shall be controlled and the liability of a child shall be determined, regulates the rights, obligations and liabilities of parents and other natural persons and legal persons and the State and local governments in regard to ensuring the rights of the child, and determines the system for the protection of the rights of the child and the legal principles regarding its operation.

What directly relates to addiction or use of drugs, besides determined cases of separation of child from family (article 27) it is said that a child may be separated from his or her family in case the child is seriously threatening his or her health or development by using alcohol, narcotic or toxic substances (section two). What relates to preventive measures, there is an article on social correction educational and prophylactic institutions, where it is said that (1) Social correction educational institutions are institutions, in which children with socially deviant behaviour are placed and in which, if necessary, compulsory measures of a medical treatment nature are applied. A child shall be placed in a social correction educational institution if social correction of the behaviour of the child while located at his or her place of residence has not been successful or also the child has committed a criminal offence before attaining 14 years of age and (2) A child may be placed in the institutions referred to in this Section pursuant to a court order in accordance with procedures prescribed by a separate law. Besides that in article 40 – Sanctions and
limitations it is determined that (1) If the manager of a childcare institution, the
manager of a social correction educational institution, the guardian or foster family
has reasonable cause for suspicion that a child has alcohol, narcotic, psychotropic or
toxic substances or the devices necessary for the use thereof, as well as items and
substances, which may endanger the life or health of the child himself or herself or
another person, they may search the child and (2) If there is cause for suspicion that
in correspondence or other mail addressed to a child there is alcohol, narcotic,
psychotropic or toxic substances or equipment necessary for their use, pornographic
material or something else as may be harmful or dangerous to the child, the manager
of the care and instructional institution, the guardian or the foster family may examine
the correspondence or mail addressed to the child. Furthermore, article 41 – Special
limitations determines that (1) For a prescribed period a child may be prohibited from
leaving his or her home, or his or her freedom of movement may be restricted, if it is
necessary for the care of the child or in conformity with the interests of the welfare of
the child in cases where: a) extra-familial care has been provided for a child because
the child is seriously threatening his or her health or development by using alcohol,
narcotic, psychotropic or toxic substances, or has committed a criminal offence, or
due to other similar behaviour.

Articles 48 and 49 strictly determine that a child has to be protected form
possible use of alcoholic beverages, narcotic, psychotropic, toxic and other addictive
substances as well as form smoking. Section 48. Protection of the Child from
Smoking and the Influence of Alcoholic Beverages – (1) A child may not smoke and
use alcoholic beverages. A child shall be protected from smoking and the influence of
alcoholic beverages. (2) A negative attitude towards smoking and the use of alcoholic
beverages shall be instilled in a child. A child shall not be permitted to work at jobs
that are associated with alcoholic beverage or tobacco product manufacturing, sale
or advertising. (3) In accordance with the Handling of Alcoholic Beverages Law and
the Law On Restrictions Regarding Manufacture, Sale, Advertising and Smoking of
Tobacco Products, alcoholic beverages and tobacco products may not be sold to a
child. (4) For inducing a child to use alcoholic beverages or to smoke, the persons at
fault shall be held liable as prescribed by law. The giving of alcoholic beverages and
tobacco products at the disposal of the child shall also be deemed to be inducing a
child to use alcoholic beverages or to smoke. (5) A child to whom has been caused
mental or behavioural problems as a result of the use of alcoholic beverages shall be
ensured mandatory medical treatment and social rehabilitation according to the
procedures specified by the Cabinet. Resources shall be allocated in the State
budget for this. Section 49. Protection of the Child from the Use of Narcotic, Psychotropic, Toxic and other Intoxicating Substances – (1) A child may not use narcotic, psychotropic, toxic or other intoxicating substances. A child shall be protected from the use of narcotic, psychotropic, toxic and other such intoxicating substances as have a negative influence on the organism and from the manufacture, sale and any form of distribution of such substances. (2) For the giving of narcotic, psychotropic, toxic or other intoxicating substances at the disposal of a child or the creation of such circumstances that such substances are freely accessible to the child, the encouraging of a child to use narcotic, psychotropic, toxic or other intoxicating substances, or the inducing of a child to use or distribute such substances, the persons at fault shall be held criminally liable. (3) A child to whom has been caused mental or behavioural problems as a result of the use of narcotic, psychotropic, toxic or other intoxicating substances shall be ensured mandatory medical treatment and social rehabilitation according to the procedures specified by the Cabinet. Resources shall be allocated in the State budget for this.\(^\text{18}\)

The other important regulation determined order of children treatment is Order in which Compulsory Treatment for Children is Provided Whereas There are Derangement or Behavioural Disorders Because of Alcohol Use, Drug, Psychotropic or Other Addictive Substance Use and Order in which in Social Correction Educational Institutions Compulsory Treatment from Alcohol, Drug and Psychotropic Substance Addiction is Provided. The regulation has five parts (part one – general questions, part two – out – patient addiction help, part three – in patient addiction help, part four – addiction help in social correction educational institutions and part five – end questions. The most important issues in part one are (2) defining that addiction help for children are provided by addiction specialist in collaboration with general practitioner, social worker and social educator. (5) Help regarding addiction is provided only with agreement of a child and at least with an agreement of one parent, guardian or family (parish) court. (6) Help regarding addiction may be provided without an agreement of a child, one parent, guardian or family (parish) court only in cases of heavy addiction form alcohol and/or drugs, intoxication and if the child's life is unsafe or he/she exposes danger to himself/herself or other people. (7) Expenses regarding treatment for children are covered by state. In second and third part order of in – patient and out – patient treatment is determined.\(^\text{19}\)

\(^{18}\) Protection of the Rights of the Child Law. Translation and Terminology Centre – www.ttc.lv

\(^{19}\) Latvia Legislation Data Base – http://www.likumi.lv/doc.php?mode=DOC&id=82455
Regulation Nr.246 – Order in which Children with an Addiction Receive Social Rehabilitation Services and Requirements for Social Rehabilitation Service Providers is also an important document regarding drug treatment and rehabilitation for children and young people. This regulation is divided into four parts (part one – general questions, part two – service receipt, part three – requirements for service providers and part four – end questions).

One more important law, adopted in 2002 is Law on provision of compulsory educational measures for children. Law determines forms of measures and order of provision. In section 14 (1) it is defined that a court (judge), administrative commission with the agreement of a child and agreement of his/her parents (guardians) or with an agreement of family court may obligate a child to undergo treatment form alcohol, drug, psychotropic, toxic or other addictive substances if the addiction has caused an offence. In the child is institutionalized into social correction educational institution, he/she has to be provided with addiction treatment.

There also are some important articles in Criminal Law and in Administrative Law regarding children rights protection.

Unfortunately for many activities budgetary resources are not allocated which makes impossible to notice and to use order provided by laws and regulations. There still exist two rehabilitation institutions for children and adolescents under 18 and no special treatment institutions but children are rather treated in the same units with adults.

12. Cocaine and Crack - situation and responses

The cocaine and crack use is not widely spread in Latvia. The price of cocaine is relatively high, and this drug is mostly used in population with a high income level, therefore the prevalence of cocaine among drug users in Latvia is low. Cocaine and crack users also are not separately subgrounded in the application of measures of prevention, treatment and rehabilitation. There are only few cases of cocaine use among the treated drug users who have sought assistance within the state addiction service, and it is estimated that the numbers seeking treatment at private specialists involved in treatment of cocaine users (addiction specialists, psychologists and psychotherapists) is much higher.

12.1. Prevalence, patterns and trends of cocaine and crack use

12.1.1. Cocaine use among the general population

A general population survey conducted in 2003 found that 12.3 percent of Latvian population have used any illegal drugs at least once in their lifetimes and only 1.2 percent of adult population aged 15–64 have used cocaine (see Table 12.1) at least once in their lifetime. 0.2 percent have used any illegal drugs at least once in the last year and only 0.1 percent has used cocaine at least once in the last month. The cocaine use rates are higher among young adults and men in general.

Typically, people in Latvia have their first experiences with drugs in their late teens or early twenties. For each type of illegal drug, less than a quarter of users-ever of that drug have tried it before the age of 15. Similarly, less than 25 percent have tried any illegal drug for the first time after the age of 25.

The average age of cocaine users is 20 years, the minimum – 17 years and the maximum – 23 years. In comparison with the average starting age of other drugs, people starts to use cocaine at quite late age, e.g. the drugs that people seem to use the earliest are hallucinogens other than LSD. The average starting age of hallucinogens users is 17 (minimum – 15).

The majority of people think that using cocaine and crack once or twice could cause high or medium risk to health (see Table 12.2).
Table: 12.1. Prevalence of cocaine among general population

<table>
<thead>
<tr>
<th></th>
<th>Any illegal drugs</th>
<th></th>
<th></th>
<th></th>
<th>Cocaine</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LTP</td>
<td>LYP</td>
<td>LMP</td>
<td></td>
<td>LTP</td>
<td>LYP</td>
<td>LMP</td>
</tr>
<tr>
<td>15-64</td>
<td>Male</td>
<td>19.9</td>
<td>7.7</td>
<td>3.9</td>
<td>2.0</td>
<td>0.4</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>6.4</td>
<td>2.2</td>
<td>0.9</td>
<td>0.5</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>12.3</td>
<td>4.6</td>
<td>2.2</td>
<td>1.2</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>15-34</td>
<td>Male</td>
<td>30.4</td>
<td>14.5</td>
<td>1.9</td>
<td>2.5</td>
<td>0.6</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>13.8</td>
<td>5.2</td>
<td>4.7</td>
<td>1.3</td>
<td>0.3</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>21.9</td>
<td>9.7</td>
<td>0.6</td>
<td>1.9</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>35-64</td>
<td>Male</td>
<td>10.6</td>
<td>1.7</td>
<td>0.3</td>
<td>1.5</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1.9</td>
<td>0.5</td>
<td>0.4</td>
<td>0.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5.3</td>
<td>0.9</td>
<td>9.7</td>
<td>0.7</td>
<td>0.1</td>
<td>0.1</td>
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<tr>
<td>15-24</td>
<td>Male</td>
<td>35.7</td>
<td>21.6</td>
<td>6.0</td>
<td>2.2</td>
<td>0.9</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>17.1</td>
<td>8.3</td>
<td>5.5</td>
<td>0.7</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>26.2</td>
<td>14.8</td>
<td>1.4</td>
<td>1.4</td>
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<td>0.2</td>
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<tr>
<td>25-34</td>
<td>Male</td>
<td>24.8</td>
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<td>3.4</td>
<td>2.9</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>10.4</td>
<td>2.0</td>
<td>1.3</td>
<td>1.9</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>17.3</td>
<td>4.3</td>
<td>0.5</td>
<td>2.3</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>35-44</td>
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<td>18.0</td>
<td>2.8</td>
<td>0.8</td>
<td>3.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.9</td>
<td>0.8</td>
<td>0.5</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>9.6</td>
<td>1.6</td>
<td>0.3</td>
<td>1.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-54</td>
<td>Male</td>
<td>5.2</td>
<td>1.1</td>
<td>0.4</td>
<td>0.5</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>0.9</td>
<td>0.3</td>
<td></td>
<td>0.2</td>
<td>0.2</td>
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<tr>
<td></td>
<td>Total</td>
<td>2.5</td>
<td>0.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55-64</td>
<td>Male</td>
<td>6.7</td>
<td>0.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>0.5</td>
<td>0.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3.0</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: General population survey: Drug Abuse Prevalence in Latvia 2003

Table: 12.2 Assessment of risks caused by the use of substance (percent)

<table>
<thead>
<tr>
<th></th>
<th>No risk</th>
<th>Slight risk</th>
<th>Moderate risk</th>
<th>Great risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking marijuana or hashish regularly</td>
<td>2</td>
<td>5</td>
<td>15</td>
<td>78</td>
</tr>
<tr>
<td>Try cocaine or crack once or twice</td>
<td>4</td>
<td>9</td>
<td>15</td>
<td>72</td>
</tr>
<tr>
<td>Try ecstasy once or twice</td>
<td>7</td>
<td>16</td>
<td>24</td>
<td>53</td>
</tr>
</tbody>
</table>

Source: General population survey: Drug Abuse Prevalence in Latvia 2003

12.1.2. Cocaine use among young people

In the subgroup aged 19 to 20 with the highest cocaine use rate 2.4 percent reported cocaine use at least once in lifetime and 1.1 percent cocaine use at least once in the last year. The results of the latest ESPAD study from 2003 shows, that cocaine and crack prevalence is low also in this subgroup, as only 0.6 percent of schoolchildren have used cocaine at least once in the last year and 0.4 percent at least once in the last 30 days. Crack prevalence among schoolchildren is even more lower – 0.2 percent of schoolchildren have used crack at least once in the last year and only 0.1 percent in the last 30 days. Thereby it shows, that among young people cocaine and crack prevalence is quite low.
### Table: 12.3 Lifetime prevalence of cocaine use among 11–20-year-olds

<table>
<thead>
<tr>
<th></th>
<th>11-20</th>
<th>11-12</th>
<th>13-14</th>
<th>15-16</th>
<th>17-18</th>
<th>19-20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>T</td>
<td>M</td>
<td>F</td>
<td>T</td>
</tr>
<tr>
<td>Any illegal drugs</td>
<td>18</td>
<td>11</td>
<td>14</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Any illegal drugs other than cannabis</td>
<td>7.3</td>
<td>5.1</td>
<td>6.2</td>
<td>0.0</td>
<td>0.7</td>
<td>0.4</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.9</td>
<td>0.6</td>
<td>0.8</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Crack cocaine</td>
<td>0.4</td>
<td>0.1</td>
<td>0.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Source: General population survey: Drug Abuse Prevalence in Latvia 2003

### 12.2. Problems related to cocaine and crack use

#### 12.2.1. Treatment demand for cocaine

Treatment demand for cocaine and crack is very low in Latvia – annually first treatment demands at publicly financed treatment centres are up to 2-3 cases. It is not possible to make any further analysis on such small figures.

### 12.3. Responses and intervention to cocaine and crack use

No specific information available.

### 12.4. Cocaine-related crime and cocaine and crack market

Though the cocaine market is quite small in Latvia, the territory of Latvia mostly is used as a transit place for cocaine smuggling. In Latvia cocaine is transit form South America to Russia and Scandinavia. Mostly cocaine is transit through skyways or sea routs. However, there are also cases when cocaine is smuggled from Russia through railroad. The State Police has information that the Baltic States is the transit centre for cocaine smuggling, however only small part of the transit drags are trafficked in Latvia, as the drug market her is very small and unprofitable.

A high cocaine price in comparison to other drugs is one of the reasons of low demand for cocaine among drug users and general population as such. Cocaine is detected in the streets rather occasionally. In 2005, there were 23 seizures with 0.68 kg total quantity seized.

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13. Drugs and driving

13.1. Policy

There are several laws and regulations acting in the field of reduction of driving under the influence of alcohol and/or drugs in Latvia. It has to be mentioned that mostly attention is paid to drivers being under influence of alcohol as this is seen as a larger problem than driving under influence of drugs.

Most important laws determining responsibility for driving under influence of drugs and alcohol and being implemented in order to reduce this growing tendency in Latvia are: Criminal Law, Administrative Law, Road Traffic Law, and Regulation Nr. 625 – Order in which tests on influence of alcohol, psychotropic or toxic drugs are taken.

Criminal Law (with an amendments of November 2006) – Section 260. Violation of Traffic Provisions and Provisions Regarding Vehicle Operation. (1) For a person who commits violation of traffic provisions or provisions regarding vehicle operation, if commission thereof is by a person operating the vehicle, and as a result thereof slight bodily injury with trauma to health, or moderate bodily injury, has been caused to the victim, the applicable sentence is deprivation of liberty for a term not exceeding two years, or a fine not exceeding sixty times the minimum monthly wage, with or without deprivation of the right to operate a vehicle for a term not exceeding five years. (2) For a person who commits violation of the provisions set out in Paragraph one of this Section, if commission thereof is by a person operating a vehicle and as a result thereof serious bodily injury has been occasioned to the victim or the death of a human being has been caused thereby, the applicable sentence is deprivation of liberty for a term not exceeding ten years, with or without deprivation of the right to operate a vehicle for a term not exceeding five years. (3) For a person who commits an offence provided for in Paragraphs one or two of this Section, if such has been committed while under the influence of alcoholic beverages, or narcotic, psychotropic or other intoxicating substances, the applicable sentence is deprivation of liberty for a term of not less than three and not exceeding fifteen years, with deprivation of the right to operate a vehicle for a term not exceeding five years.

Section 262. Operating a Vehicle While Under the Influence of Alcoholic Beverages or Narcotic, Psychotropic and Other Intoxicating Substances. (1) For a person who commits operating a vehicle, or commits giving instruction regarding
practical operation of a vehicle, while under the influence of alcoholic beverages, or narcotic, psychotropic or other intoxicating substances, if commission thereof is repeated within a one year period, the applicable sentence is deprivation of liberty for a term not exceeding two years, or custodial arrest, or community service, or a fine not exceeding fifty times the minimum monthly wage, with deprivation of the right to operate a vehicle for a term not exceeding five years and with or without confiscation of property. (2) For a person who commits operating a vehicle, or commits giving instruction regarding practical operation of a vehicle without having a drivers license and while under the influence of alcoholic beverages, or narcotic, psychotropic or other intoxicating substances, the applicable sentence is deprivation of liberty for a term not exceeding two years, or custodial arrest, or community service, or a fine not exceeding fifty times the minimum monthly wage, with deprivation of the right to operate a vehicle for a term not exceeding five years and with or without confiscation of property.

Section 262.1. Refusal from Alcohol, Drug, Psychotropic, Toxic and Other Intoxicated Substance Influence Tests. In case the driver of the vehicle refuses to make a test for diagnosis of the influence of alcohol, drug, psychotropic, toxic and other intoxicated substances, the applicable sentence is deprivation of liberty for a term not exceeding one year, or custodial arrest, or community service, or a fine not exceeding fifty times the minimum monthly wage, with deprivation of the right to operate a vehicle for a term three to five years and with or without confiscation of property.

Section 264. Allowing the Operation of a Vehicle by a Person Under the Influence of Alcoholic Beverages, Narcotic, Psychotropic and Other Intoxicating Substances. For a person who, being responsible for the technical state or the operation of a vehicle, commits allowing a person under the influence of alcoholic beverages, or narcotic, psychotropic or other intoxicating substances, to operate the vehicle, if the consequences set out in Section 260 of this Law are caused thereby, the applicable sentence is deprivation of liberty for a term not exceeding five years, or custodial arrest, or community service, or a fine not exceeding one hundred and twenty times the minimum monthly wage, with or without deprivation of the right to engage in specific employment for a term not exceeding five years.23

Administrative Law (with an amendments of August 2006) – Section 149.15. Operating a Vehicle While Under the Influence of Alcoholic Beverages or Narcotic,

Psychotropic and Other Intoxicating Substances. (1) For a person who commits operating a vehicle, if the concentration of alcohol in the expired air or blood exceeds 0.2 per mille but does not exceed 0.5 per mills, the applicable sentence for a person whose standing of driving is less than two years is a fine from 100–200 Lats, with deprivation of the right to operate a vehicle not exceeding three months. (2) For a person who commits operating a vehicle, or commits giving instruction regarding practical operation of a vehicle, if the concentration of alcohol in the expired air or blood exceeds 0.5 per mille but does not exceed 1.0 per mills, the applicable sentence is a fine from 200–300 LVL, with deprivation of the right to operate a vehicle not exceeding six months. But for drivers driving buses, the applicable sentence is a fine from 200–300 LVL, with deprivation of the right to operate a vehicle (category D) not exceeding three years and other driving licenses – not exceeding six months. (3) For a person who commits operating a vehicle, or commits giving instruction regarding practical operation of a vehicle, if the concentration of alcohol in the expired air or blood exceeds 1.0 per mille but does not exceed 1.5 per mills, the applicable sentence for drivers of bicycle and moped is a fine not exceeding 20 LVL, but for drivers driving buses, the applicable sentence is an administrative arrest form five to ten twenty four hours, fine not exceeding 400 LVL, with deprivation of the right to operate a vehicle (category D) not exceeding five years and other driving licenses – not exceeding one year. For other drivers the applicable sentence is an administrative arrest form five to ten twenty four hours, fine not exceeding 400 LVL, with deprivation of the right to operate a vehicle not exceeding one year. (4) For a person who commits operating a vehicle, or commits giving instruction regarding practical operation of a vehicle, if the concentration of alcohol in the expired air or blood exceeds 1.5 per mille, the applicable sentence for drivers of bicycle and moped is a fine not exceeding 30 LVL, but for drivers driving buses, the applicable sentence is an administrative arrest form ten to fifteen twenty four hours, fine not exceeding 500 LVL, with deprivation of the right to operate a vehicle (category D) not exceeding five years and other driving licenses – not exceeding two years. For other drivers the applicable sentence is an administrative arrest form ten to fifteen twenty four hours, fine not exceeding 500 LVL, with deprivation of the right to operate a vehicle not exceeding two years. (5) For a person who commits operating a vehicle, or commits giving instruction regarding practical operation of a vehicle being under the influence of drugs, psychotropic, toxic or other intoxicating substances, the applicable sentence for drivers of bicycle and moped is a fine not exceeding 30 LVL, but for drivers driving buses, the applicable sentence is an administrative arrest form ten to fifteen twenty four hours, fine not exceeding 500
Lats, with deprivation of the right to operate a vehicle (category D) not exceeding five years and other driving licenses – not exceeding two years. For other drivers the applicable sentence is an administrative arrest form ten to fifteen twenty four hours, fine not exceeding 500 LVL, with deprivation of the right to operate a vehicle not exceeding two years.

Section 258. Discharge of driving vehicle and small ships and tests of alcoholic beverages, drug or other substance influence. (1) Drivers or other persons driving vehicle or small ship whereas there are suspicion that they have used alcoholic beverages, drugs or psychotropic substances, have to be discharged form the driving and tests of influence has to be provided.

Road Traffic Law (with an amendments of July 2006) – Sentence 2. Purpose of the Law. (1) To establish base of safe road traffic in Latvia in order to protect humans life, health, environment and property of persons. This sentence does not mention directly drugs and driving still it is very important and in fact includes all of the safety principles of the road traffic. What relates directly to road traffic, driving and drugs, is Sentence 20 – Duties and rights of the owner of the vehicle. (2) Owner or driver of the vehicle may not give permission to drive vehicle by a person being under the influence of alcohol, drugs, psychotropic or other addictive substances.

Sentence 28 – Prohibition to drive vehicle, establishes that it is prohibited to drive vehicle: (1) for those drivers whose standing is less than two years – if the concentration of alcohol in blood is more than 0.2 per mills and for those whose standing is more than two years as also drivers of bikes and mopeds – if the concentration of alcohol in blood is more than 0.5 per mills. (2) being under the influence of drugs, psychotropic, toxic and other addictive substances as also being under medicine which may cause slower reaction and diminished level of attention.

This law also determines order of establishing alcohol influence, drug and other addictive substance influence tests 24.

Still as mentioned above in most part of all laws and regulations attention is more paid to alcohol problems as this is considered to be more serious problem for driving. At the moment this situation is in the period of change as the problem of drugs and driving grows.

Every year drivers under the influence of narcotic and/or psychotropic substances cause road traffic safety hazards. In 2005 the number of detained

drivers under the influence of narcotic and/or psychotropic drugs was 383, an increase as compared with 2004.

Figure 13.1 shows that since 1996 the number of drivers being detained under the influence of drugs and/or psychotropic substances has grown for more than 30 times.25

Figure 13.1 Number of detained drivers under the influence of narcotic and/or psychotropic substances

![Graph showing the number of drivers under the influence of narcotics and psychotropic substances from 1996 to 2005.]

Source: State Addiction Agency 2006

13.2. Prevalence and epidemiological methodology

In the State Addiction Agency Department of Alcohol and Drug Intoxication Test and Chemical and Toxicological Laboratory are located. In total amount there are 34 medical treatment institutions in Latvia, facilities for testing the presence of alcohol, drugs and psychotropic substances.

In total amount in Latvia in 2005, 11 411 medical tests were carried out (in 2004 – 12 978). Out of them 7 346 tests were made to establish the presence of alcohol (in 2004 – 6 352) and 4 065 were made to establish the presence of drugs and psychotropic substances (in 2004 – 6 626).

The Department of Alcohol and Drug Intoxication Test of the State Addiction Agency runs a 24 hours medical service for testing the presence of alcohol and narcotic or psychotropic substances. Medical tests are performed in the following cases:

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• by a warrant from the law enforcement institutions (the Prosecution, Court, State or Municipal Police), government institutions, municipal institutions or company management;

• if a request is submitted by a private person.

Medical tests are performed by addiction specialist, who evaluates the person’s clinical condition. A laboratory assistant collects biological samples (blood, urine, hand and mouth wash). Biological samples (blood, urine) are tested for ethylene concentration by the gas chromatography method. For qualitative detection of drugs and psychotropic substances in biological samples (blood, urine and wash) chemical toxicological methods are used in compliance with the UNO Drug Control Program methodology. Exhaled air is tested by Alco-meters meters.

In 2005 the Department of Alcohol and Drug Intoxication Test has carried out 7 350 medical tests (in 2004 – 10 197 tests), including 3 782 tests for determining the presence of alcohol (in 2004 – 4 293 tests) and 3 568 tests for determining the presence of drugs and psychotropic substances (in 2004 – 5 904 tests). It has also made 4 172 tests for persons directed to the Department by other institutions. As compared to 2004, the number of medical tests performed has decreased.

Out of all the 3 782 clients who had to be tested for the presence of alcohol (concentration of ethyl alcohol in the biological samples (blood, urine)), 3 426 (90.6%) including 3 018 men and 408 women agreed to give samples. For persons who did not agree to give samples, the presence of alcohol was determined with a control device in the exhaled air. Testing of the biological samples (urine, blood) showed a negative result (0 per mills) in 8.4% of cases; alcohol concentration up to 0.5 per mills was discovered in 9.2% of the tested cases. Higher alcohol concentrations - 0.5-3 per mills were identified in 2 514 (72.7%) of the cases; in 9.8% of the cases the concentration was above 3 per mills.

| Table 13.1 Persons tested at the department of Alcohol and Drug Intoxication Test |
|-------------------|-----------------|-----------------|-----------------|
|                   | Total           | For the presence of alcohol | For the presence of drugs |
| 2000              | 5039            | 2963             | 2076            |
| 2001              | 5722            | 3416             | 2306            |
| 2002              | 7359            | 5033             | 2326            |
| 2003              | 8719            | 4706             | 4013            |
| 2004              | 10197           | 4293             | 5904            |
| 2005              | 7350            | 3782             | 3568            |

Source: State Addiction Agency 2006

The Chemical and Toxicological Laboratory is a structural unit of the Department of Alcohol and Drug Intoxication Test of the State Addiction Agency. It is
the only laboratory in Latvia, which examines biological materials and material evidence related to illegal use of alcohol, drugs and psychotropic substances. The laboratory has been certified with regard to the mandatory requirements for medical institutions and divisions. The samples for chemical and toxicological testing are human discharge (urine, saliva), blood, wash from hands and mouth, etc.

Chemical and toxicological tests are officially appointed by doctors, the prosecution, criminal investigation, police decisions, as well as via written applications or concluded agreements with private persons, companies and other organizations.

During 2005 the Chemical and Toxicological Laboratory of the Expert Testing Department of the State Addiction Agency examined 6,489 persons for the presence of narcotic and psychotropic substances. The largest number of tested persons (53.6%) belonged to the age group from 20 to 29 years. In comparison to the previous year the number of persons in this group has increased by 9.1%. During the last two years there has been a decrease in the age group below 15 years and in the age group between 15 and 19 years. The number of persons in the age group between 40 and 49 years has decreased by 1.4%.

Table 13.2  Persons tested for the presence of drugs and psychotropic substances by age group (2002 – 2005) in absolute figures

<table>
<thead>
<tr>
<th>Age group</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 15</td>
<td>98</td>
<td>407</td>
<td>146</td>
<td>111</td>
</tr>
<tr>
<td>15 – 19</td>
<td>1270</td>
<td>1735</td>
<td>1614</td>
<td>1180</td>
</tr>
<tr>
<td>20 – 29</td>
<td>1877</td>
<td>2094</td>
<td>2815</td>
<td>3477</td>
</tr>
<tr>
<td>30 – 39</td>
<td>663</td>
<td>1148</td>
<td>1202</td>
<td>1254</td>
</tr>
<tr>
<td>40 – 49</td>
<td>178</td>
<td>712</td>
<td>446</td>
<td>363</td>
</tr>
<tr>
<td>50 years and older</td>
<td>58</td>
<td>84</td>
<td>109</td>
<td>104</td>
</tr>
<tr>
<td>Age unknown</td>
<td>195</td>
<td>52</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4339</strong></td>
<td><strong>6232</strong></td>
<td><strong>6332</strong></td>
<td><strong>6489</strong></td>
</tr>
</tbody>
</table>

Source: State Addiction Agency 2006

Table 13.4. Distribution of biological samples tested in 2005 in absolute figures

<table>
<thead>
<tr>
<th>Objects tested</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine</td>
<td>3369</td>
<td>2642</td>
</tr>
<tr>
<td>Blood</td>
<td>544</td>
<td>638</td>
</tr>
<tr>
<td>Saliva</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Hand wash</td>
<td>485</td>
<td>160</td>
</tr>
<tr>
<td>Mouth wash</td>
<td>318</td>
<td>318</td>
</tr>
</tbody>
</table>

Source: State Addiction Agency 2006
During the last few years there is a significant growth of cases when multiple substances are detected during analysis (most frequently combinations of 2 to 10 substances in a single test). Drivers detained for driving under the influence of addictive substances (383 cases during 2005) usually show a combination of drugs (a single drug is rarely identified).

The most frequent combinations are:

- amphetamines + cannabis;
- barbiturates + tranquilizers + cannabis;
- cannabis + benzodiazepines;
- amphetamines + cannabis + opiates;
- amphetamines + opiates + barbiturates + benzodiazepines;
- amphetamines + cocaine + cannabis\(^{26}\).

Department of Alcohol and Drug Intoxication Test has special form of protocol whereas results of the testing and demographic information is included.

Drivers of the vehicles are detained on the base of suspicion of the police (state or municipal) or border guard in the area of frontier. The same relates to the drivers caused road traffic accidents and drivers who have died in the road traffic accidents. Only in the case of suspicion tests are provided (also in the Forensic Medicine Expertise Centre). So it means that no mandatory testing exists for drivers even in cases of accidents. This is because of the lack of needed budgetary resources (tests and analysis are very expensive).

13.3. Detection, measurement and law enforcement

A right to detect drivers has only police (state and municipal) and border guard in the area of frontier. Tests for drugs are provided only in case of existing suspicion that a driver is under the influence of drugs and/or psychotropic substances. Police officers are trained by the experts of the State Addiction Agency to recognize persons who are under the influence of drugs. If the suspicion has persisted police officers deliver the person to a medical treatment institution for provision of the test. Every provided test arrives to the Chemical and Toxicological Laboratory.

The level of the drug being present in the body of the person has no any importance. It is just important has there been found or has not been found any drug in the organism of the detained person.

13.4. Prevention

No special preventive measures exist to prevent driving under influence of cannabis or benzodiazepines. Mostly the attention is paid to reduction of driving under any kind of illegal drugs and alcohol as well. No information is available on existing trainings for pharmacists or provision of alternative transports at nightclubs.

All the campaigns provided in Latvia mostly target driving under influence of alcohol. These campaigns usually arise in period of summer whereas there is a Midsummer night festival Ligo in Latvia which is a national celebration. During this festival people have holidays and mostly it turns to united use of alcohol and a lot of detained persons driving vehicles under influence of alcohol.
14. Bibliography


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14. Data of the Health Statistics and Medicine Technology State Agency


23. The practices and context of pharmacotherapy of opioid dependence in Central and Eastern Europe. WHO, 2004


26. The State Agency “Translation and Terminology Centre”- www.ttc.lv,
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APC</td>
<td>AIDS Prevention Centre</td>
</tr>
<tr>
<td>BST</td>
<td>Buprenorphine Substitution Treatment</td>
</tr>
<tr>
<td>CCDE</td>
<td>Centre for Curriculum Development and Examinations</td>
</tr>
<tr>
<td>DRID</td>
<td>Drug-related Infectious Diseases</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EMCDDDA</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
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<tr>
<td>ESPAD</td>
<td>European School Survey Project on Alcohol and Other Drugs</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GMR</td>
<td>General Mortality Register</td>
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<td>GPS</td>
<td>General Population Survey</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B virus</td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C virus</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPS</td>
<td>Health Promoting Schools</td>
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<td>HSD</td>
<td>Health Statistics Department</td>
</tr>
<tr>
<td>HSMTSA</td>
<td>Health Statistics and Medical Technologies State Agency</td>
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<tr>
<td>ICD-10</td>
<td>International Classification of Diseases rev.10</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting drug use</td>
</tr>
<tr>
<td>LIC</td>
<td>Latvia Infectology Centre</td>
</tr>
<tr>
<td>JMSIL</td>
<td>Joint Memorandum on Social Inclusion of Latvia</td>
</tr>
<tr>
<td>MMT</td>
<td>Methadone maintenance therapy</td>
</tr>
<tr>
<td>NFP</td>
<td>National Focal Point</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organisation</td>
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<tr>
<td>PDU</td>
<td>Problem Drug Use</td>
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<tr>
<td>PHA</td>
<td>Public Health Agency</td>
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<td>PG</td>
<td>Pompidou Group</td>
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<td>RAPC</td>
<td>Riga Addiction Prevention Centre</td>
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<td>SAA</td>
<td>State Addiction Agency</td>
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<td>SBDC</td>
<td>State Blood Donors Centre</td>
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<td>SFMEC</td>
<td>State Forensic Medicine Expertise Centre</td>
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<td>SHPA</td>
<td>State Health Promotion Agency</td>
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<td>SFMEC</td>
<td>State Forensic Medicine Expertise Centre</td>
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<td>STD</td>
<td>Sexually transmitted diseases</td>
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<td>STSDSA</td>
<td>Sexually Transmitted and Skin Disease State Agency</td>
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<tr>
<td>SYIC</td>
<td>State Youth Initiative Centre</td>
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<tr>
<td>TDI</td>
<td>Treatment demand indicator</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>WHO</td>
<td>World Health Organization</td>
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PART D – Standard Tables and Structured Questionnaires

STANDARD TABLES AND STRUCTURED QUESTIONNAIRES 2006

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