European Monitoring Centre for Drugs and Drug Addiction

Centre of Health ECONOMICS

2009 NATIONAL REPORT (2008 data) TO THE EMCDDA by the Reitox National Focal Point

„LATVIA”

New developments, trends and in – depth information on selected issues

REITOX

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BST	Buprenorphine Substitution Treatment
CA	Court Administration
CCDE	Curriculum Development and Examinations
CM	Latvian Cabinet of Ministers
CRPI	Children's Rights Protection Inspectorate
DAST	Drug Abuse Screening Test
DHPP	Department of Health Promotion and Prevention
DRID	Drug-related Infectious Diseases
EC	European Commission
ECAD	European Cities against Drugs
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European school survey project on alcohol and other drugs
EU	European Union
GMR	General Mortality Register
GPS	General Population Survey
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immuno-deficiency Virus
HSD	Health Statistics Department
HSMTSA	Health Statistics and Medical Technologies State Agency
IDU	Injecting drug use
ICD-10	International Classification of Diseases (10^{th} revision)
ICL	Infectology Center of Latvia
INCB	International Narcotics Control Board
LaSPAD	National School Survey on Alcohol and other Drugs
LNFP	Latvian National Focal Point
LPA	Latvian Prison Administration
MCA	Monitoring Centre for Addiction
MI	Ministry of the Interior
MMT	Methadone maintenance therapy
NAF	National Armed Forces
NGO	Non Governmental Organisation
PDU	Problem Drug use
PHA	Public Health Agency
PREDA	Patient REgister DAta
RAPC	Riga Addiction Prevention Centre
RPAC	Riga Psychiatry and Addiction Centre
RRCA	Riga Rehabilitation Centre for Addicts
SAA	State Addiction Agency
SAHP	State Agency of Health Promotion
SATLD	State Agency of Tuberculosis and Lung Diseases
SBDC	State Blood Donors Centre
SEA	State Employment Agency
SFMC	State Forensic Medicine Centre
SPS	State Probation Service
STD	Sexually transmitted diseases
STSDA	Sexually Transmitted and Skin Diseases State Agency
TDI	Treatment Demand Indicator
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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Summary

2008 was the final year of operation for the *National Drug Programme 2005–2008*. Evaluation of the Program took place in 2009, together with development of a new Drug Programme 2010-2012. The Ministry of Interior undertook the evaluation of the former State programme, based on the results of research done during the Programme, trends in statistical indicators for drug supply and demand, and information and expert opinion provided by participating institutions and organizations. The action plan for 2009 developed by the Ministry of Interior was not approved by the Cabinet of Ministers, due to insufficient time being available to perform certain tasks.

In 2008, several important amendments relating to drugs were adopted and came into force in Latvia's legislation. One of the most important amendments, which came into force on 9 August 2008, provides an opportunity for expanding the pharmacological treatment of opioid addiction with methadone, which was previously only possible in one treatment centre. Similarly, significant amendments to the *Children's Rights Protection Law* were adopted, stipulating that compulsory treatment and social rehabilitation were to be provided to any child suffering from mental or behavioural disorders due to using alcoholic beverages, narcotic, psychotropic, toxic or other intoxicating substances. More information is available about *National Drug Programme 2005-2008* evaluation methodology and legislative changes in Chapter 1.

In 2008, a local study in the framework of *ECAD (European Cities Against Drug*s) was conducted as part of the inter-State 5-year project *Youth in Europe*. One of the main aims of the project was to compare various strategies and gather information on examples of best practice in drug prevention in several European cities. Moreover, a study among children in social correction institutions, orphanages and boarding schools was carried out by the Institute of Sociological Research. Qualitative and quantitative methods were aimed at assessing the target groups as well as their substance use habits and prevalence. More information regarding study methodologies and results is compiled in Chapter 2.

Prevention measures in Latvia are mainly focused on the capital Riga and the Riga district. Most of the measures are campaign-like in nature and frequently activities in the field of addiction have been integrated into broader health promotion activities. The main reason why prevention programs based on scientific principles have not been developed is the funding model. At present, prevention activities in Latvia are undertaken in a decentralized manner, i.e. each municipal government carries out its preventive work within the limits of its own capacity and funding. Selective prevention is poorly implemented in Latvia's regions as a whole, and still lacks a consistent approach to the implementation of universal and selective prevention, and only rarely is evaluation undertaken into the effectiveness of prevention interventions, mainly due to lack of funding and capacity. More information on universal and selective prevention activities is compiled in Chapter 3.

Within the 2009 cohort study, problem drug use estimates by applying the Police multiplier method were carried out. The multiplier used in the study was according to self-reports of being brought for drug testing among interviewed drug users, while the data source used was positive drug tests carried out at the Riga Psychiatry and Addiction Centre. Additionally in 2009, the EMCDDA and UNODC consultancy work by Dr.Gordon Hay (Glasgow University) on obtaining estimates by applying capture-recapture models. Within the project available individual level, data were analysed and various statistical models were applied to data. More information on the calculations is summarized in Chapter 4.

In 2008, the new treatment data recording system PREDA (Patient REgister DAta) have been put into developing. With the introduction of the new system changes in the treatment data reporting form took place with inclusion of additional TDI items – living status, family status, injecting, additional answer categories for frequency of use, and treatment modality – which were missing in the previously used TDI reporting form.

Within the UNODC project, the "*Evaluation Pharmacological treatment of opioid addiction in Latvia*" was produced, using as a model the pharmacotherapeutic evaluation undertaken by the Netherlands Institute of Mental Health and Addiction, and the University of Ljubljana Faculty for Social Work in Slovenia. Two main objectives were proposed from within the framework of evaluation of pharmacological treatment: to assess the situation in the area of pharmacotherapy in Latvia, and provide recommendations for improving and expanding pharmacotherapy services. More about evaluation methodology as well as characteristics of treated clients and treatment system may be found in clients Chapter 5.

Since 2008, intravenous drug use is no longer the most common transmission route for HIV infection. In 2008, there was a significant increase in heterosexual transmission, namely 55.6% of all new HIV infections, while 34% were infected using drugs intravenously. Of 140 registered hepatitis B patients, 22% were identified as intravenous drug users. Of 116 patients registered with hepatitis C, 18% were identified as intravenous drug users. There are still concerns that the country has many "hidden" patients, both B and hepatitis C. In 2009, the results of ENCAP project study *"Prevalence of HIV and other infections and risk behaviour among injection drug users in Latvia, Lithuania and Estonia in 2007"* were published.

The calculation of drug-related deaths utilises both the *General Mortality Register* and the *Special Mortality Register*. In 2008, 24 drug-related deaths were recorded in Latvia, four cases more than in 2007. In general, it must be borne in mind that the actual number of deaths directly attributable to drugs could be higher, as a post-mortem is not always conducted, and the true cause of death is not always shown. Because of the difficult economic situation (fewer autopsies are performed), the number of deaths recorded due to drug overdose is expected to decline in 2009, but this may not reflect the real situation. More information on infectious diseases and drug-related deaths may be found in Chapter 6.

Unfortunately, practically no discussion takes place on issues related to the reduction of deaths in this State. In 2008 a booklet was published for drug users, which gives a detailed description of the symptoms and appropriate first aid in overdose cases. Syringe exchange advisory points contribute significantly to reducing drug-related deaths and in preventing infection. More information about prevention and treatment of infectious diseases is summarized in the Chapter 7.

Due to lack of data, social exclusion in relation to drug use continues to be analyzed only in terms of the basic indicators of education level and employment status. It is considered important in the future to make a separate study of social exclusion among users or to incorporate certain parameters into annual studies. Although a number of social exclusion programs and plans have been developed and adopted in Latvia, drug users are not isolated as a distinct group at risk of social exclusion. Further complicating this issue is the current economic situation in the State, whereby it is virtually impossible to allocate funds for socially excluded groups such as drug users. More about social exclusion and reintegration is complied in Chapter 8.

Starting with the second half of 2008, offending trends (including in the trafficking of illegal drugs), and the response reactions from law enforcement agencies (including anti-drug cooperation) in Latvia have to some extent been determined by the economic crisis. In order compile the information on drug-related crime and prevention, a cooperation agreement was entered into with the experts of Ministry of Interior Information Centre, which is the manager or holder of many criminal registration systems in which data in relation to offences/offenders in the field of drugs is collected. More about the results of this cooperation may be found in Chapter 9.

In 2008, amphetamine-type stimulants and substances from the cannabis group remain the most popular in Latvia's illicit drug market. Also *Spice* products and herbal smoking mixes becoming widespread in Latvia. These products with wide range of brand names can be acquired in small trading outlets in various city districts or via Internet – local websites. As of the

economic situation in the country, law enforcement authorities estimate that potential exists for new actors to enter the drug market the future, and for a possible violent individual drug market reallocation between distributors, and increased interest being shown by local drug dealers in undertaking the transit of drugs for sale in other countries. More about trends in drug market is summarized in Chapter 10.

To compile information on the cannabis market and production in Latvia, a study was conducted in which the State situation regarding availability of cannabis was described, utilising analysis of qualitative research methods-normative documents, literature analysis, analysis of available statistical data, focus group discussions with cannabis users, and in-depth interviews with experts in the field. To date, no larger-scale study on the availability of cannabis has been undertaken at the State level, with the aim of understanding the structure of the cannabis market and production trends. However, with Latvia's accession to the Schengen Zone, the illegal importation of drugs, including cannabis, across internal borders has undoubtedly increased, as has production at the State level. Over the past five years, illegal, professionally equipped marijuana farms are discovered increasingly often. The large quantity of high quality cultivating equipment is indicative of the fact that marijuana is increasingly being produced at the State level, not only for the local market but also for export to the nearest neighbouring countries. More information regarding study methodologies and results is compiled in Chapter 11.

Selected Issue on (meth)amphetamine includes information on the most used substance among Problem Drug Users in Latvia. It describes historical data on seizures of a few amphetamine-producing facilities in the early 90s. Since late 90s amphetamine use in most of the drug-related indicators suggests increase of its use. Data from the last few years suggests that most of the amphetamine seized in the country is methamphetamine, which might lead to increased health problems among drug users in Latvia in the coming years. More detailed information about amphetamine use can be found in Chapter 12.

Part A: New Developments and Trends

1. National policy and context

1.1. Legal framework

In 2008 a number of amendments were adopted to Latvia's regulatory enactments, as were several new Cabinet of Ministers' Regulations regarding distribution of narcotic and psychotropic medications, treatment of addicted persons (including children), as well as in other fields related to narcotic and psychotropic substances.

Cabinet of Ministers Regulations issued in 2008

On 17 June 2008, Cabinet Regulation No. 441 *"Procedures for the Purchase, Receipt, Storage, Distribution, Dispensation, Accounting and Destruction of Narcotic and Psychotropic Substances and Medicinal Products in Manufacturing of Medicinal Products and Veterinary Medicinal Products, at Drug and Veterinary Drug Wholesalers and Pharmacies"*[1]. This Regulation came into force on 21 June 2008, and stipulates the procedure by which substances, medicinal products and veterinary medicinal products included in Schedule II and III of narcotic substances, psychotropic substances and precursorscontrolled in Latvia, are received, purchased, distributed, dispensed, stored, accounted for and destroyed, at a drug or veterinary drug wholesaler and a pharmacy (except general-type or open-type pharmacies and closed-type pharmacies or a merchant of veterinary medical care).

Adopted on 2 June 2008, and coming into force five days later was Cabinet Regulation No. 394 on *"Procedure for testing the influence of alcohol, narcotic, psychotropic or toxic substances"*[2]. This regulation stipulates the procedure for testing conducted to determine the influence of alcohol, narcotic, psychotropic or toxic substances in treatment institutions, as well as the procdure by which personnel of the State police, Municipal police, State Border Guard Service or State Probation Service may check persons, using portable measuring devices, to determine the concentration of alcohol present in their exhalations, and thereby conclude whether such persons have consumed alcohol.

Adopted on 21 April last year was Cabinet Regulation No 293 *"Procedures by which a Permit for the Utilisation of Plants, Substances and Medicinal Products Included in Schedules I, II or III of Narcotic Substances, Psychotropic Substances and Precursors Controlled in Latvia for Medical and Veterinary Medical Scientific Research, Specification of Physical and Chemical Properties or for Educational Purposes is Issued, Suspended and Revoked"*[3].

Coming into force on 15 November 2008 was Cabinet Regulation No 930 *"Regulations on the Licensing of Security Guards"*[4].

One of the most important amendments was adopted on 4 August 2008 – Cabinet Regulation No 640 *"Amendments to Cabinet Regulation No. 429 of 24 September 2002: "Procedures for the Treatment of Patients Addicted to Alcohol, Narcotics, Psychotropic and Toxic Substances""*[5]. The amendment came into force on 9 August 2008 and in fact provides the

[1]Ministru kabineta noteikumi Nr.441 „Narkotisko un psihotropo vielu un zāļu iepirkšanas, saņemšanas, uzglabāšanas, izplatīšanas, izsniegšanas, uzskaites un iznīcināšanas kārtība zāļu un veterināro zāļu ražošanā, zāļu un veterināro zāļu lieltirgotavās un aptiekās".
[2] Ministru kabineta noteikumi Nr.394 „Alkohola, narkotisko, psihotropo vai toksisko vielu ietekmes pārbaudes kārtība".
[3] Ministru kabineta noteikumi Nr.293 „Kārtība, kādā izsniedz, aptur un anulē atļauju Latvijā kontrolējamo narkotisko vielu, psihotropo vielu un prekursoru I, II un III sarakstā iekļauto augu, vielu un zāļu izmantošanai medicīniskiem un veterinārmedicīniskiem zinātniskiem pētījumiem, fizikālo un ķīmisko īpašību noteikšanai vai apmācībai".
[4]Ministru kabineta noteikumi Nr.930 „Apsardzes darbības licencēšanas noteikumi".
[5]Ministru kabineta noteikumi Nr.640 „Grozījumi ministru kabineta 2002.gada 24.septembra noteikumos Nr.429 „Alkohola, narkotisko, psihotropo un toksisko vielu atkarības slimnieku ārstēšanas kārtība"".

possibility of broadening the treatment of addiction to pharmacological opioids with methadone. Previously, methadone treatment was possible only at one treatment institution: Riga Centre of Psychiatry and Addiction Disorders.

Adopted on 15 April 2008 (with effect from 19 April) was Cabinet Regulation No 268 *"Amendments to Cabinet Regulation No 15 of 11 January 2005: "Procedure to determine the concentration of alcohol in the blood and exhaled air, and to determine the effect of narcotic or other intoxicating substance""*[6].

Legislation adopted in 2008

Coming into force on 12 January 2008 were the amendments to the *"Law on the Handling of Weapons"*[7], in which Section 20, Paragraph four: *"Restrictions on Natural Persons Regarding Acquisition, Possession and Carrying of Weapons and Munitions Thereof"* was updated, and now applies to a person

> *"... to whom during the last two years administrative sanctions have been applied for violations related to the use of alcohol, narcotic, psychotropic or toxic substances or for petty hooliganism, or malicious disobedience of a police officer, border guard or member of the Home Guard, or disobedience of a lawful order or request given by military personnel while performing duties of protecting public order or while on active service, earlier than the date after which such person shall be regarded as no longer punishable administratively",*

thus giving a new formulation under which a person wishing to obtain a permit for the acquisition, possession or carrying of firearms or munitions was not subject to the restrictions applicable to physical persons.

Likewise, coming into force on 12 January 2008 were the *"Amendments to the Criminal Law"*[8], in which Section 177, Paragraph three stipulates:

> *"For a person who commits fraud, if it has been committed on a large scale, or has been committed in an organised group, or it has been committed, acquiring narcotic, psychotropic, powerfully acting, poisonous or radioactive substances or explosive substances, firearms or ammunition, the applicable sentence is deprivation of liberty for a term of not less than five years and not exceeding thirteen years, or a fine not exceeding one hundred and fifty times the minimum monthly wage, with or without confiscation of property, and with or without police supervision for a term not exceeding three years."*

Coming into force on 27 November were *"Amendments to the Criminal Law"*[9], in which Section 61, Paragraph two, Clause 6 stipulates that conditional early release prior to completion of their sentence may be permitted if the convicted person consents to being treated for drug addiction, if the offence has been committted due to drug addiction.

Coming into force on 9 April 2008 were the *"Amendments to the Border Guard Law"*[10]. The amendments stipulate, inter alia, that members of the Border Guard Service have the right to prevent a person from operating a recreational or other craft of small dimension, if there is reason to suspect such person is under the influence of alcohol, drugs, or psychotropic or other intoxicating substances.

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[6] Ministru kabineta noteikumi Nr.268 „Grozījumi Ministru kabineta 2005.gada 11.janvāra noteikumos Nr.15 „Kārtība, kādā nosakāma alkohola koncentrācija asinīs un izelpotajā gaisā un konstatējams narkotisko vai citu apreibinošo vielu iespaids".

[7] 2008.gada 12. janvāra grozījumi ieroču aprites likumā.

[8] 2008.gada 12. janvāra grozījumi Krimināllikumā.

[9] 2008.gada 27. novembra grozījumi Krimināllikumā.

[10] 2008. gada 9. aprīļa grozījumi Robežsardzes likumā.

Adopted on 7 August 2008 were the *"Amendments to the Latvian Administrative Violations Code"*[11], in which, inter alia, culpability is provided for operating a marine craft while under the influence of alcoholic beverages, drugs, or psychotropic substances, and for refusing to be tested, as well as procedures for the loss of licence to operate a marine craft, in cases where the consumption of alcohol or drugs is suspected.

Coming into force in July last year were the *"Amendments to the Protection of the Rights of the Child Law"*[12]. The final sentence of Paragraph five of Section 48 of the Law comes into force on 1 January 2010. Section 48, Paragraph five, provides that:

> *"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. In any case where the child or his parents does not consent to mandatory treatment, it shall be undertaken if the approval of the child's local Orphan's Court has been obtained".*

Section 49, Paragraph three is also expressed in a new formulation:

> *"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. In any case where the child or his parents does not consent to mandatory treatment, it shall be undertaken if the approval of the child's local Orphan's Court has been obtained".*

In this case also, the final sentence of Section 49, Paragraph three, comes into force on 1 January 2010.

1.2 National action plan, strategy, evaluation and coordination

National action plan and strategy

With Latvia's accession to the European Union, the European Union's policy-planning documents for the reduction of drug abuse and prevalence became politically binding on Latvia. Currently these include the *EU Drugs Strategy (2005-2012)* and its subordinate *EU Drugs Action Plan (2009-2012)*.

At the national level, a planned strategic policy approach to reduce the prevalence and addiction to drugs in Latvia began in 1998 when the *Latvian Drug Control and Drug Abuse Prevention Strategy for 1999–2003* was developed with the help of the United Nations International Drug Control Program.

National Drug Programme 2005–2008 was adopted by the Cabinet of Ministers on 17 August 2005. 2008 was the last year in which the *National Drug Programme 2005–2008* operated. In 2009 evaluation of the National Drug Programme *2005–2008* was undertaken and a new government program was developed.

The action plan developed by the Ministry of Interior was for one year, 2009, during which the evaluation of the *National Drug Programme 2005–2008* was undertaken and a new program was developed, but this was withdrawn in the Cabinet of Ministers, or rather, it was not adopted. This was due to the ongoing coordination of action plans between various ministries, and

[11] 2008. gada 7. augusta grozījumi Latvijas Administratīvo pārkāpumu kodeksā.
[12] 2008.gada 29. jūlija grozījumi bērnu tiesību aizsardzības likumā.

resulted in insufficient time remaining for the completion of the tasks in the said action plan, and it lost its topicality.

Implementation and evaluation of national action plan and strategy

2008 year was the last operational year of the *National Drug Programme 2005–2008*. Consequently, the Drug Control and Drug Addiction Restriction Coordination Council (hereinafter "the Council"), in considering the question of future government policy and planning to reduce the prevalence of drug addiction and of illegal drugs, acknowledged that the next medium-term policy planning document in the field of reducing drug addiction and of illegal drugs must be based on a total and comprehensive State policy, including the evaluation of the National Drug Programme *2005–2008*. As a result, 2009 was a transition period during which the evaluation of the former Programme was undertaken and a new program was developed.

Based on a decision by the Council, evaluation of the National Drug Programme *2005–2008* was undertaken by the Ministry of Interior. Several sources of information were utilised in the evaluation, namely:

- information provided by the 29 public institutions and organizations having direct or joint responsibility for performance of the tasks stipulated in the State Programme;
- information held by the Secretariat of the Council;
- the results of several studies undertaken in the field of drug addiction while the Program was in operation;
- information systems and aggregated statistical indicators maintained by various institutions;
- a panel of experts' discussion on the results of implementing the State Programme.

It should be noted that information on performance of the National Drug Program's tasks was based directly on information provided by the institutions and organizations involved, which mostly reflected quantitative indicators, rather than the results of action taken and policy outcomes. Consequently, the National Drug Program's level of achievement of its aims was mainly characterized by the results of research into drug use prevalence in different groups in society and trends reflected in statistical indicators, which characterize the areas of drug supply and demand throughout the country during the Program's operation *(Ministry of Interior Informative Report, 2009)*.

The final evaluation of the *National Drug Programme 2005–2008*, and its results, will be taken into account in drafting the new National Drug Programme for 2010–2012. The 2009 results will be presented to the Council and will be available on the Ministry of Interior website.

The evaluation results for the *National Drug Programme 2005–2008* will be available in more detail in the 2010 State Report.

Other drug policy develompments

In accordance with the *Development Planning System Law*, the hierarchically highest medium-term development planning document stipulating the State's political priorities for reducing the prevalence of drug addiction and drugs is the "Latvian National Development Plan for 2007–2013", in which objectives are defined for this area to improve and modernize systems in the fight against the prevalence of drugs and involve the public in the fight against diseases of addiction, including addiction to drugs.

The policy framework also reflects government declarations, in which the fight against drug abuse and drug prevention have always been a priority for the Government, regardless of the composition of the government, the state's socio-economic status and other factors. Similarly, several other State policy planning documents were also previously in force during the currency of the State Program, oriented towards achieving the aims of the Program; with content closely

related to reducing drug abuse and drug prevalence, such as the "Action Programme on Implementation of Public Health Strategy for 2004–2010"; the "Program for Reduction of Alcohol. Consumption and Restriction of Alcohol. Addiction for 2005–2008"; the "Human Immunodeficiency Virus (HIV) and AIDS Control Program 2003–2007"; and the "State Program for the Prevention, Combating and Reducing of Organized Crime in 2006–2010" *(Ministry of Interior Informative Report, 2009)*.

Coordination arrangements

The Council is the coordinating State body whose primary role is to coordinate the operations of government agencies, municipalities and non-governmental organizations in controlling the legal movement of drugs and precursors, and in preventing and restricting their illegal circulation, and addiction to drugs. The Council is also responsible for development, implementation and evaluation of the National Drug Programme *2005–2008*. Council sittings are convened between two and four times a year. National Drug Programme *2005–2008* evaluation results were discussed at a sitting of the Drug Control and Drug Addiction Restriction Coordination Council, leading to a recommendation being adopted to refer the recommendations reflected in the final evaluation report to the responsible authorities for development and implementation in the National Drug Programme for 2010–2012

1.3 Economic analysis

Public expenditures

In 2007 the *National Drug Programme 2005–2008* received additional supplementary funding for the implementation of activities that needed additional funding besides base expenditures for the first time in its three-year history. The budgetary situation in 2008 did not allow to allocate additional funding to reach the aims in the National Drug Programme.

In 2009, the National Drug Coordinator at the Ministry of Interior initiated data collection on expenditures for the activities in the National Drug Programme, by using similar methodology as in the previous year. All ministries and involved partner institutions were asked to state the amount of actual expenditures according to two kinds of expenses: 1) funding allocated through the budget for specific activities in the *National Drug Programme 2005–2008* and 2) funding allocated for some other tasks that are somehow related with the activities in the *National Drug Programme 2005–2008*. These expenses were reported according to two dimensions: 1) allocated supplementary funding for activities and 2) base funding. As mentioned by the Ministry of Interior data obtained has to be used with caution, as some of the ministries of agencies involved in the drug-related activities due to various reasons were not able to estimate the amount of resources invested.

The data was summarized according to 1) expenditures for a specific ministry (e.g. expenditures of the Ministry of Health, Ministry of Interior, etc.) and 2) expenditures for specific directions[13] as set out in the *National Drug Programme 2005-2008*.

According to data collected **4.91 million LVL** (6.99 million EUR) were allocated for various activities that are fully or partly[14] drug-related in 2008. Of the expenditures, 1.51 million LVL (2.15 million EUR) were allocated for expenditures directly related with the activities set out in the National Drug Programme, while 3.4 million LVL (4.84 million EUR) were related with some other tasks (which are partly related with the National Drug Programme activities (more than half of these expenditures are in the drug supply field in long-term investments in equipment or surveillance systems) *(for details see Tables 1.1 and 1.2 below)*.

[13] Four main directions are set out in the National Drug Programme: 1) Coordination, 2) Demand Reduction, 3) Supply Reduction, and 4) Information Analysis, which has been described in detail in previous National Reports.
[14] Partly in a sense that long-term investments in equipment according to some methodologies should not be taken into account when estimating public expenditures. This data collection did not take this consideration into acocunt.

Table 1.1. Expenditures in 2008 for various ministries involved in activities of the National Drug Programme (in LVL; 1 EUR=0.7028 LVL)

		Expenditures for specific NDP activities	Expenditures for other drug-related tasks	Total
Ministry of Interior	Allocated supplementary funding	0	0	
	Base expenditures	21831.97	1616028.16	1637860.13
Ministry of Health	Allocated supplementary funding	0	0	
	Base expenditures	1432393.99	0	1432393.99
Ministry of Welfare	Allocated supplementary funding	0	0	
	Base expenditures	0	505121.25	505121.25
Ministry of Finance	Allocated supplementary funding	0	0	
	Base expenditures	34973.00	1152537.00	1187510.00
Ministry of Justice	Allocated supplementary funding	0	0	
	Base expenditures	8191.00	121680.00	129871.00
Ministry for Children and Family Affairs	Allocated supplementary funding	0	0	
	Base expenditures	0	6825.00	6825.00
Ministry of Defence	Allocated supplementary funding	0	0	
	Base expenditures	950.00	0	950.00
Ministry of Education and Science	Allocated supplementary funding	0	0	
	Base expenditures	7500.00	0	7500.00
	Allocated supplementary funding	**0**	**0**	
Total	**Base expenditures**	**1505839.96**	**3402191.41**	**4908031.37**

Source: Ministry of Interior 2009

Table 1.2. Expenditures in 2008 according to four main directions of the National Drug Programme 2005-2008 (in LVL; 1 EUR=0.7028 LVL)

	Allocated supplementary funding	Base expenditures	Total
1. Coordination	0	32207.13	32207.13
2. Demand reduction	0	1873150.24	1873150.24
3. Supply reduction	0	3103034.00	3103034.00
4. Information analysis	0	62105.70	62105.70
Total	0	4908031.37	4908031.37

Source: Ministry of Interior 2009

Social costs

In 2009 the National Focal Point initiated a study on social costs as well as more detailed analysis of public expenditures in the drug field. Results will be published in 2010 and reportred in the next NR.

2. Drug use in the general population and specific targeted groups

2.1. Drug Use in the general population

In Latvia until now two general population surveys aimed specifically at assessing illegal drug use among 15–64–year-old population have been carried out. The first study was conducted in 2003, while the second one – in 2007. The sample sizes for the survey were 4534 and 4500, respectively. Both surveys followed similar methodology and sampling thus are comparable in terms of comparison between cross-sectional surveys (*Koroleva et al. 2003 and Koroleva, Goldmanis et al. 2008)*. Data from both studies were reported in 2008 via EMCDDA standard tables and are available in Fonte[15].

Prevalence rates of any illegal drug use[16] by major age groups and gender are shown in Table 2.1 and 2.2 below *(see Table 2.1. and Table 2.2.)*.

Table 2.1. Lifetime (LTP), last year (LYP) and last month (LMP) prevalence of any illegal drugs in 2003 and 2007 surveys (%)

		LTP	LYP	LMP
15–64				
	2007	16.1	6.1	2.2
	2003	12.3	4.6	2.2
15-34				
	2007	27.9	11.9	4.2
	2003	21.9	9.7	4.7
35-64				
	2007	6.8	1.6	0.7
	2003	5.3	0.9	0.5
Males				
	2007	22.8	9.2	3.8
	2003	19.9	7.7	3.9
Females				
	2007	9.8	3.2	0.8
	2003	6.4	2.2	0.9

Source: Koroleva et al. 2003; Koroleva, Goldmanis et al. 2008

Table 2.2. Lifetime prevalence of various illegal substances by age and gender in 2007 (%)

	15–64			15–34			35–64		
	M	F	T	M	F	T	M	F	T
Any illegal substances	22.8	9.8	16.1	37.5	18.1	27.9	10.3	3.8	6.8
Any illegal substances except cannabis	13.2	4.9	9.0	21.7	8.6	15.2	6.0	2.3	4.0
Cannabis	17.2	7.3	12.1	28.9	14.3	21.7	7.2	2.2	4.6
Ecstasy	7.2	2.3	4.7	12.3	4.6	8.5	2.9	0.6	1.7
Amphetamines	5.4	1.3	3.3	9.2	2.9	6.1	2.2	0.1	1.1
Cocaine	3.1	1.5	2.3	5.4	2.5	4.0	1.2	0.7	0.9
Heroin	0.8	0.3	0.5	1.5	0.4	1.0	0.2	0.2	0.2
Other opioids	4.7	1.1	2.9	5.7	1.6	3.7	3.9	0.8	2.2
LSD	2.1	0.8	1.4	3.6	1.0	2.3	0.8	0.6	0.7
Other hallucinogens	2.6	0.9	1.7	4.4	1.2	2.8	1.0	0.6	0.8

Source: Koroleva, Goldmanis et al. 2008

[15] ST1_2008_LV_01; ST1_2003_LV_01
[16] Cannabis, ecstasy (MDMA), amphetamines, cocaine, heroin and/or other opioids, LSD and/or other hallucinogens

2.2. Drug Use in the school and youth population

ECAD study

In 2008, a local study in the framework of European Cities Against Drugs (ECAD) was conducted as part of the international 5-year project Youth in Europe[17]*, see Koroleva, Mierina, Snikere et al. (2009*). One of the main aims of the project was to compare various strategies and gather information on examples of best practice in drug prevention in several European cities. The 2008 as well as a study conducted in 2006 was financed by the Riga Addiction Prevention Centre, the field work and analysis of results was carried out by the Institute of Sociological Research. The similar methodology employed in 2006 and 2008 studies allows analysing risk and protective factors for substance abuse as well as estimating lifetime prevalence rates for illegal as well as legal substances. Additionally, in 2008 the study following the same methodology was conducted in Jurmala city and Cesis; in those two cities the sampling employed was total population sample of those 15–16–year-olds. For sample sizes and methodology, see ST30 in Fonte[18].

Results

According to results of the 2008 study, one in four (24.6%) 9th and 10th grade pupils in Riga have tried some form of illegal substance. The proportion of experimenters observed is lower among 9th grade students than the proportion of pupils from the 10th grade (respectively 22% and 28%). Statistically significant differences are observable among both the 9th grade boys and girls (26% of boys and 18% of girls had tried of illegal substances,) and among 10th grade pupils (35% boys and 23% girls).

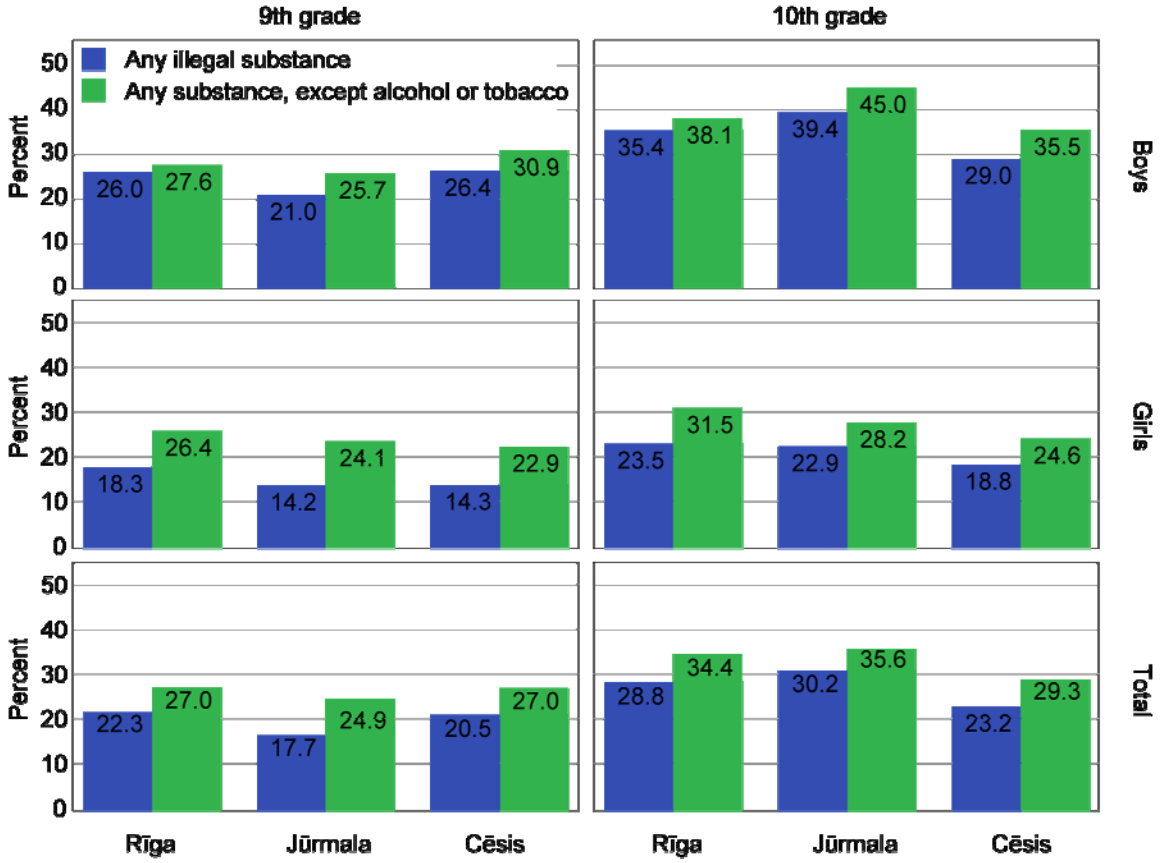
Among the 9th and 10th grade students at Jurmala, slightly more than one in five pupils (23.0%) had tried an illegal drug. The proportion of 9th grade students who tried illegal substances is lower than 10th grade students – cannabis, amphetamines, ecstasy (MDMA), heroin, cocaine or LSD, had been tried by almost every fifth (17.7%) 9th grade pupil, and almost every third (30.2%) 10th grade pupil. Statistically significant differences were observed by gender and grade level. The proportion of boys trying illegal substances is significantly higher than among girls in 9th grade, as well as 10th grade students. In Jurmala, 21.0% of boys and 14.2% girls at the 9th grade had tried illegal substances, while at the 10th grade, 39.4% of boys and 22.9% of girls had tried one of these substances.

Among 9th and 10th grade pupils at Cesis, about one in five pupils (21.8%) had tried an illegal drug. The proportion of 9th grade pupils who had tried illegal substances was lower than among 10th grade students - marijuana or hashish, amphetamines, ecstasy (MDMA), heroin, cocaine or LSD had been tried by 21.3% of 9th grade pupils and 23.2% of 10th grade pupils (see Table 1). Statistically significant differences were observed by gender and grade level. The proportion of boys trying illegal substances is significantly higher than among girls in 9th grade, as well as among 10th grade students. In Cesis, 26.4% of boys and 14.3% girls at the 9th grade had tried illegal substances, while at the 10th grade, 29.0% of boys and 18.8% of girls had tried one of these substances.

Compared with a study undertaken at the same time in Riga, minor differences were observed in the prevalence of trying illegal drugs. Overall, the surveyed students in Riga admitted using illegal drugs slightly more often (25.2%) than students in Jurmala (23.0%) and Cesis (21.8%), but these differences are not statistically significant. *(see Figure 2.1.)*.

[17] For more information see http://www.ecad.net or http://www.youthineurope.org
[18] ST30_2009_LV_01; ST30_2009_LV_02; ST30_2009_LV_03

Figure 2.1. Lifetime substance use by 9th and 10th grade students in Riga, Jurmala, and Cesis, %



Source: Koroleva, Mierina, Snikere et al. 2009

The most commonly used illicit substance among Riga students is marijuana or hashish, which had been used by 22% of 9th and 10th grade pupils. As in the 2006 study *(Koroleva, Senkane, Snikere et al. 2007)* and in ESPAD studies *(Koroleva, Mierina et al. 2007 and Koroleva, Trapencieris, 2003)*, a higher prevalence of use was observed among 10th grade students as compared with 9th grade students, as well as among boys compared with girls. Overall, experience of cannabis use was indicated by 22% of pupils in the 2008 study (18% of pupils in 9th grade, and 25% of pupils in the 10th grade). As already mentioned, the proportion trying this substance is higher among boys in comparison with girls (27% boys and 17% girls).

Compared to the study data from the 2006 in Riga, an increase of about four percentage points in the number of lifetime cannabis users was observed, almost sufficient to be regarded as an increase in lifetime cannabis use among schoolchildren in Riga during the past two years.

The most common illegal drug tried by pupils is cannabis, which in Jurmala has been tried by approximately one in five (20.4%) 9th and 10th grade pupils. Among boys, the ratio trying marijuana or hashish is nearly double that observed among girls (respectively 26.3% and 14.8%), and 10th grade pupils, compared with 9th grade pupils (respectively 26.8% and 15.7%).

The most commonly tried illegal drug among pupils is in marijuana or hashish, which in Cesis has been tried by approximately one in five (20.1%) 9th and 10th grade pupils. The ratio of boys trying marijuana or hashish is nearly double that observed among girls (respectively 26.8% and 14.2%), while being only slightly higher for 10th grade pupils, than 9th grade pupils (respectively 21.8% and 18.7%).

Table 2.3. Lifetime cannabis prevalence rate among 15–16–year-old students in Riga, Jurmala, and Cesis, %

			Prevalence
Riga	Boys	9th grade	22.7
		10th grade	33.4
		Total	27.1
	Girls	9th grade	14.8
		10th grade	19.0
		Total	16.9
	Total	9th grade	18.9
		10th grade	25.3
		Total	21.8
Jurmala	Boys	9th grade	19.9
		10th grade	36.7
		Total	26.3
	Girls	9th grade	11.1
		10th grade	19.1
		Total	14.8
	Total	9th grade	15.7
		10th grade	26.8
		Total	20.4
Cesis	Boys	9th grade	25.5
		10th grade	28.6
		Total	26.8
	Girls	9th grade	11.4
		10th grade	16.7
		Total	14.2
	Total	9th grade	18.7
		10th grade	21.8
		Total	20.1
Three-city average	Boys	9th grade	22.6
		10th grade	33.2
		Total	26.9
	Girls	9th grade	13.8
		10th grade	18.7
		Total	16.2
	Total	9th grade	18.4
		10th grade	25.0
		Total	21.4

Source: Koroleva, Mierina, Snikere et al. 2009

Analysis of the influence of risk and protective factors (ECAD study)

This chapter presents an analysis of the use of (and initial experimentation with) addictive substances among youth in Latvia, utilizing data collected in 2008 during the comparative survey ECAD, which is realized within the project „Youth in Europe: Youth and Well-being." This is the second time that the survey was carried out in Latvia (the first wave was in 2006). The lifetime prevalence rates from the study were reported in ST30 in Fonte[19] and overview of risk and protective factors is described in this chapter.

[19] ST30_2009_LV_01; ST30_2009_LV_02; ST30_2009_LV_03

The research team at the Institute of Philosophy and Sociology, University of Latvia conducted both study waves. At present analysis are ongoing and future plans include conducting analysis on the data file including data from more participating cities. More in-depth analysis is published in Latvian – *see Koroleva, Mierina, Snikere (2009)*.

Individual-level factors

Overall, 25 individual-level factors were identified. The subsequent analysis focused on the influence of these factors on the use of illicit addictive substances. The dependent variable in these analyses was the indicator variable of use of such substances during one's lifetime (including one-time use or „trying out" the drug).

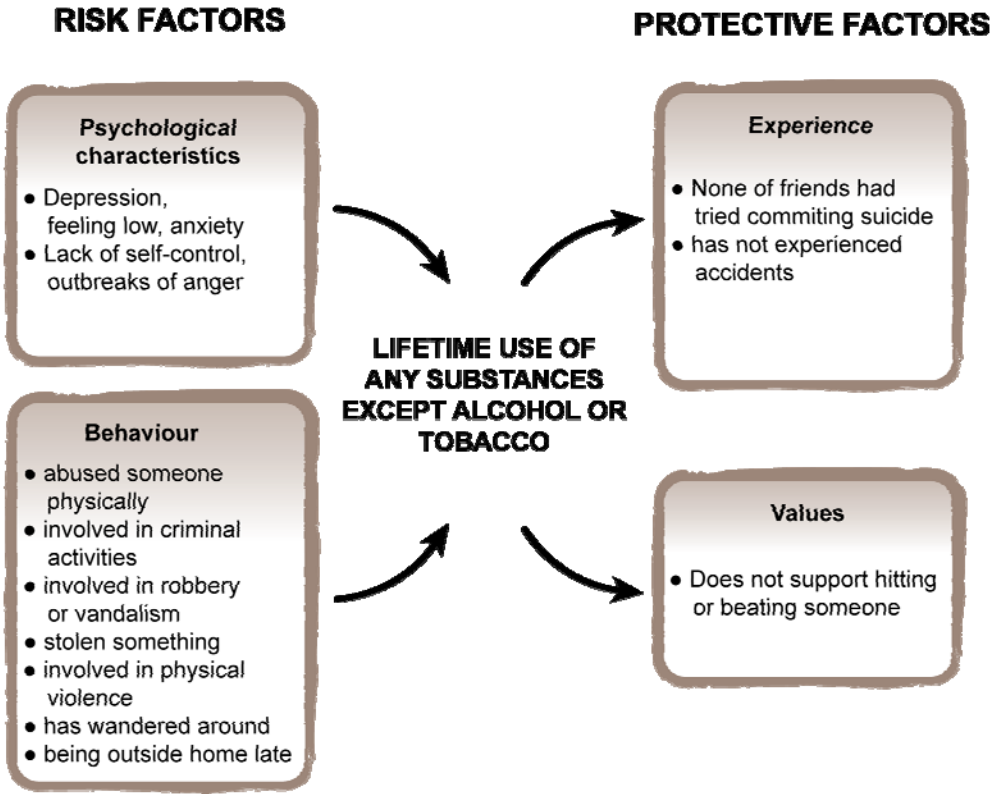
Factors that pose the most important risk factors for the use and trying of legal and illegal addictive substances are own criminal activity (such as stealing), own use of physical violence, lack of self-control and outbreaks of anger, as well as staying out late at night and loitering. Less important factors that increase the use/trying of psychoactive substances are own disrespect towards laws or rules, own justification of aggression, past interaction with individuals who later committed or attempted suicide, own illness, and severe past accidents.

Regarding the use of medications, inhalants, and illegal drugs in particular, the most susceptible individuals are the ones who have a tendency to deviant behaviour and aggressiveness or violence, and/or have a lack of self-control and respect towards existing rules and laws.

Another risk factor meriting close attention is one's having had suicidal thoughts or having interacted with someone who has considered or discussed suicide. Each of these powerful negative experiences significantly increases a youth's likelihood of trying drugs.

The data show that youths who have tried medications, inhalants and illegal drugs are more likely to stay out late at night, to wander around, and to spend time on the town. The use of aforementioned substances is strongly associated with various forms of deviant, violent, and criminal behaviour.

Figure 2.2. Individual level factors leading to lifetime substance use



Source: Koroleva, Mierina, Snikere, 2009

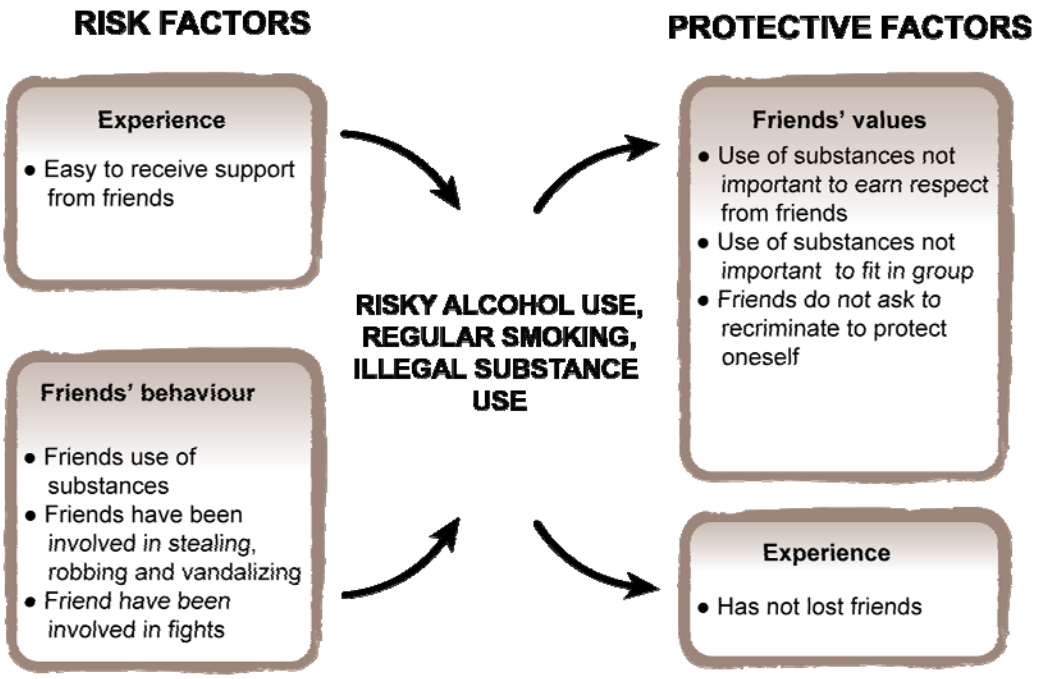
Peer factors

Relationship and attitudes towards peers were characterized by 38 variables, from which 9 peer factors were derived. The most important single risk factor for MII (medications, inhalants, and illegal substances) substance use is peer pressure. Youths who have tried inhalants and illegal drugs often have friends who also take drugs. Friends whose attitude and behavior supports the use of addictive substances or who use such substances themselves create a high-risk environment.

Youths who have tried inhalants and illegal substances, on the other hand, are more likely to believe that their status can be raised by drug use and that the use of illicit substances is sometimes necessary to fit in with one's peers. This result shows that one of the key risk factors is popularity of these substances among youths—the belief that is „cool."

The risk of illegal drug use is particularly high among youths who are involved in groups characterized by aggressive and deviant behaviour, i.e., groups whose values do not support obeying laws and rules.

Figure 2.3. Peer factors leading to lifetime substance use



Source: Koroleva, Mierina, Snikere, 2009

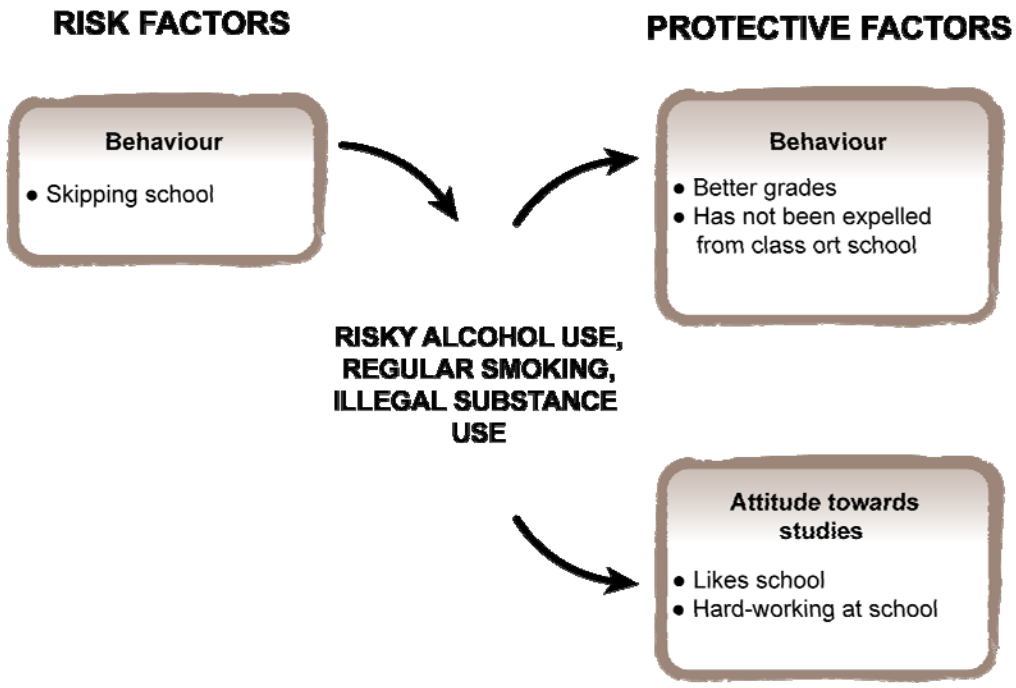
School environment factors

Factor analysis of 20 variables pertaining to the school environment identified seven underlying factors. Regression analysis shows that the most important school-level risk factor for trying MII substances is the adolescent's lack of interest in studies and poor preparation for class, which often also leads to lower grades. Lack of interest in and difficulties with studies increase the risk of trying addictive substances. Adolescents who have a serious attitude toward studies are more protected, while those whose interest is not engaged by the process of studying and who spend little time on homework have a higher tendency to start taking addictive substances.

A lack of interest in schoolwork can manifest itself in absenteeism and dislike for school. Youths who have tried addictive substances are more likely to skip class, and to neglect their homework. Their dislike for school also tends to manifest itself in conflicts with teachers and school staff, and a desire to change the school order.

Another risk factor is an adolescent's problem behaviour at school. Youths who have tried inhalants, illegal addictive substances are more likely to have been suspended or expelled from school or banished from a classroom. Behaviour leading to suspension or expulsion can be an indicator of a youth's propensity for deviant behaviour, including drug use. On the other hand, such a situation can in itself encourage the youth to try addictive substances: either as a result of the emotional distress, or to further demonstrate one's disobedience and defiance.

Figure 2.4. School-level factors leading to lifetime substance use



Source: Koroleva, Mierina, Snikere, 2009

Family factors

Factor analysis of 39 variables pertaining to the respondents' characterizations of their parents' family, family relationships and their own attachment to the family identified 11 underlying factors. The results show that MII users and non-users differ significantly in their levels of attachment to their families and the strength of family relationships. This observation supports the hypothesis that the closeness of family ties and the level of attachment to one's family influence the likelihood of trying and/or using MII substances. The results show that while family-level factors are important for the use of both legal and illegal psychoactive substances, their effect is more prominent for the *legal* substances—alcohol and tobacco. Family relationships, parental example, and parental control constitute extremely important risk and protective factors for smoking cigarettes and drinking alcohol. This result is unsurprising, because, unlike the use of illicit psychoactive substances, the use of alcohol and tobacco is not only widespread, but also considered an integral part of our everyday life and celebrations, and the attitude of parents is tolerating and often even motivating.

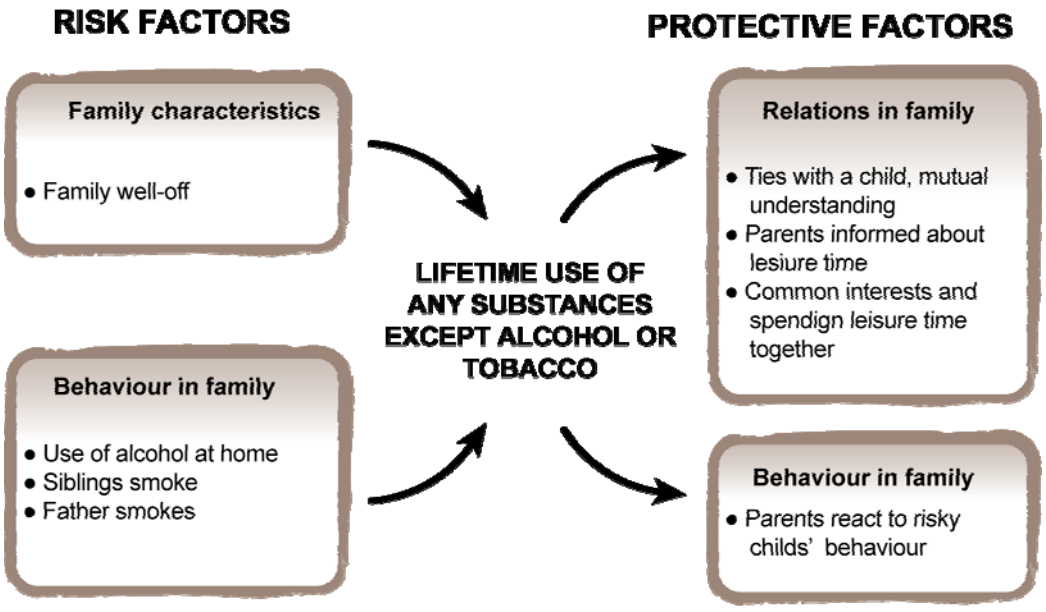
Another important protective or risk factor is the parents' attitude towards the child's risk behaviour, in this case, towards the use of addictive substances. Parental indifference or lack of interest regarding the child's behaviour can be a serious risk factor. The likelihood of trying addictive substances is higher in those families where the child thinks that his or her parents would not care if they found out that their child drinks alcohol or smokes cigarettes or cannabis.

Similarly to binge drinking and regular smoking, the likelihood of MII use is also increased by a tolerating or indifferent attitude on the part of the parents. In addition, smoking by parents and, even more importantly, siblings further adds to that likelihood.

An important factor that affects medications, inhalants, and illegal substances use, but not alcohol or tobacco use, is household income. On the average, the probability of having tried an MII substance is higher for adolescents from higher-income families. However, the relationship between substance use and income is non-monotonic: the highest risk is encountered at the extremes of the income spectrum, i.e., for the lowest- and highest-income families.

In families with closer and more intimate parent-child relationships, where parents spend more time with their children and are more prone to discuss personal matters and provide guidance to them, the probability that the child will try an MII substance is lower. The probability is also decreased in families where parents are well informed about their children's free time activities. Parental education and occupational status has no significant effect on the child's substance use likelihood.

Figure 2.5. Family factors leading to lifetime substance use



Source: Koroleva, Mierina, Snikere, 2009

Environment factors

The final group of factors that can potentially affect the risk of illicit substance use consists of the so-called environmental factors, which characterize safety and security in the community that the individual lives in. Security is affected not only by the presence or absence of physical threats, but also by the youth's own perception of security. An individual's sense of security is affected both by individual traits of character and by external structural characteristics.

Factor analysis of 30 environmental variables identified eight underlying factors. Statistically significant differences between those who have tried MII substances and those who have not were found on the following factors: feeling safe late at night in one's neighbourhood and in one's town at large, having moved from one neighbourhood and/or school to another, and being well acquainted with other youths in the neighbourhood.

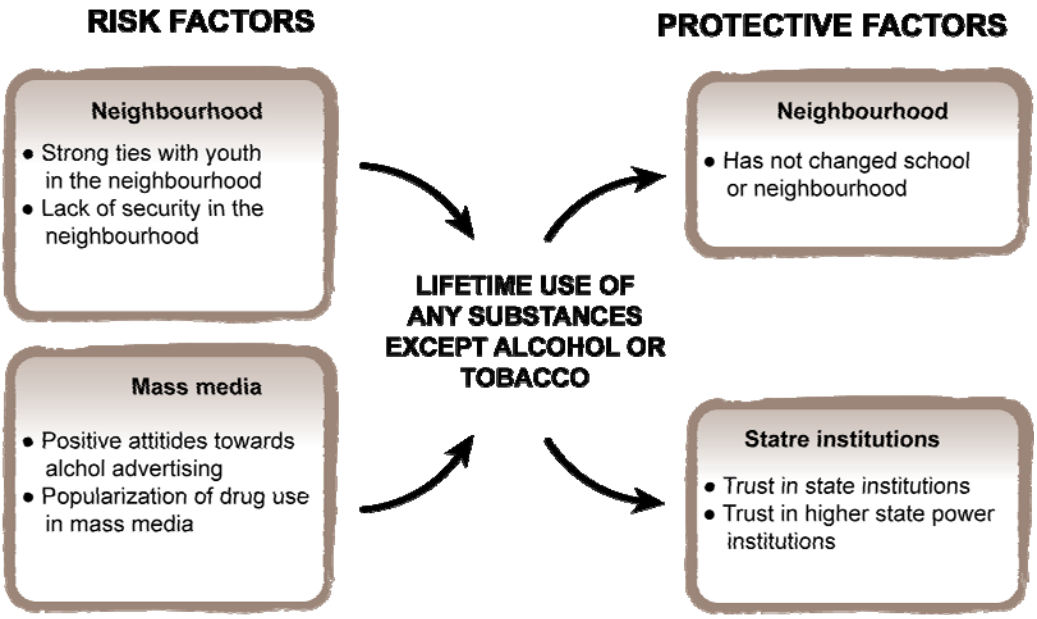
It is interesting to observe that the youths who have used MII substances, the youths who smoke, and those who binge drink all have a higher sense of security in one's neighbourhood. This could be both because they are better acquainted with youths from their neighbourhood and because both drug use and high sense of security are influenced by such common traits of character as recklessness and adventurousness.

The risk of trying MII substances is higher for the youths who have changed schools or moved from one neighbourhood to another, particularly if they have moved or switched schools multiple

times. This risk is likely to be caused not only by the youth's perceived need to adapt to new circumstances and to establish one's status among new peers, but also by the emotional stress caused by the separation from old friends and by the changing of one's environment. If school is located far from home and classmates do not live nearby, youths tend to spend time with non-school friends or neighbourhood youths. Contacts and time spent with neighbourhood youths can be a significant risk factor for addictive substance use.

A significant factor influencing the use of addictive substances is the level of trust in various institutions and authorities (including police and the courts). If trust in the authorities is low, youths also tend to have low respect for the authorities, to disapprove of their activities, and to question the fairness and infallibility of the law. Youths who have tried MII substances have a lower degree of trust in the police, the parliament, the government, and the judicial system, as well as in educational institutions and churches. MII substance use is not statistically significantly associated with one's satisfaction with one's place of residence and with the strength of ties with one's immediate neighbours.

Figure 2.6. Environmental (including neighbourhood) factors leading to lifetime substance use



Source: Koroleva, Mierina, Snikere 2009

Joint analysis of all factors and their relative importance

To isolate the direct effects of each factor and to determine the relative importance of various factors, we conducted multiple logistic regression, with MII (medication/ inhalant/ illicit) substance use as dependent variable and aforementioned factors.

It should be noted that the classification of the factors above is not completely rigid. Individual-level traits overlap and are correlated with peer- and school-level factors, which in turn overlap and are correlated with each other and with environmental factors. Upbringing and family relationships strongly influence the formation of a child's personality, and personality in turn influences the child's choice of friends.

Similarly to 2006 (*Koroleva, Senkane, Snikere et al. 2007)*, the main factors influencing **MII (medications, inhalants, and illegal substances)** use now are personal traits and peer networks. The importance of the school environment has declined since 2006, while the importance of parents has increased. It could be possible that schools are now taking a less active role in the war on drugs, leaving it up to the parents.

The importance of peer pressure in trying MII substances has increased markedly since 2006. The use of these substances among one's friends is now the single most important determinant of one's own substance use. Furthermore, if one's peer network is characterized by norms and attitudes tolerating or encouraging deviant behaviours, such as stealing, robbery, and vandalism, as well as drug use, the youth's likelihood of having tried an MII substance increases substantially. According to the 2008 survey *(Koroleva, Mierina, Snikere, 2009),* important personal factors that increase the risk of substance use are depression, dejection, and general psychological discomfort, particularly if they relate to suicide attempts by friends or acquaintances. The risk to try an addictive substance is particularly high at times of personal crisis and depression. It is therefore imperative that parents pay attention to their children's mood swings, making sure they do not feel lonely and abandoned at such critical moments. It is important that the adolescent be able to talk to a close friend or family member at such critical moments.

Already in 2006 we observed that trying addictive substances is associated with deviant behaviours, such as stealing. Interestingly, the 2008 study identifies lack of self-control as a particularly important factor.

Just as in 2006 and similarly to the cases of alcohol and tobacco, parent-child relationships and parental attitudes are found to be important in determining MII use. If the youth knows that his or her parents would strongly object to such behaviours, the likelihood of trying substances decreases. The risk diminishes further if the adolescents spend their free time with their parents, which gives the parents more information and a higher degree of control.

General environmental factors are less important that the factors mentioned above. However, some of these factors do merit special attention: in particular, a change of residence and a change of school. A final, somewhat curious risk factor for substance use is distrust toward governmental and non-governmental institutions, including churches and the mass media. This appears to be a spurious correlate: both drug use and general distrust toward the world are likely to be caused by the same personality traits, such as frustrated youthful idealism and scepticism toward the current world order in general.

2.3. Drug Use among targeted groups/ settings at national and local level

In 2008 a study among children in social correction institutions, orphanages and boarding schools was carried out by the Institute of Sociological Research *(Sebre, Koroleva, Karklina et al. 2008)*. Qualitative and quantitative methods aimed at assessing the target groups as well as their substance use habits and prevalence were employed: 1) secondary data analysis of previously conducted study within the target group, 2) interviews with key stakeholders at health and social services (n=15), 3) a study among specialists working in the field (n=50), 4) a study among children in social correction institutions, orphanages and boarding schools (n=100). The latter included quantitative study among vulnerable children and apart from drug use prevalence questions included several scales, namely, Achenbach Youth self-report *(Achenbach 2001)*, Trauma Symptom Checklist for Children *(Briere, 1995),* Parental Bonding Instrument *(Parker, Tupling and Brown, 1979)*.

Some of the analysis as suggested by the researchers is presented in the chapter below.

The use of drugs

An important aspect of the using and trying of drugs among young people, is the availability of drugs. Survey respondents - residents at orphanages, correctional institutions and students at boarding schools, more often than others in this age group (13-16 years), have noted that it would be impossible for them to obtain drugs. However, the total number of students for whom it would be easy or very easy to obtain drugs is not less than among students at comprehensive

schools: for 26% it would be easy to obtain marijuana, 23% ecstasy and 21%, amphetamines. This suggests that for many young people the obtaining of drugs of their choice would be easy.

As is known, drug distributors and dealers are well aware that a habit can develop, and they therefore often initially offer drugs for free. Research data show that about half (51%) of a target group of teenagers have encountered the situation where they have been offered drugs without them making any request. For nearly one in three of the respondents this situation had occurred several times. Most frequently, drugs were offered in an open public place (25%, but not infrequently, an offer was also received in a private area, such as another person's home or at a private event at someone's home or apartment.

Studies show that the offering of drugs is now very efficient and significantly increases the risk of young people trying these substances – for 76% of those who had tried marijuana, the drugs had been offered, and therefore external encouragement had been received. Overall, 60% of teenagers who had thought it impossible to obtain marijuana had tried it, but of the teenagers who had at some time been offered drugs, 51% had tried marijuana. So the barriers against the trying of these substances among young people are not great – if there is an opportunity, a large proportion of young people would not refuse it.

Drugs are easier to get for those who have used them previously – they probably know someone who distributes these substances. Drugs are also offered to these students significantly more often. There is therefore an increased risk that a young person with such experience will try drugs again.

The availability of drugs largely determines the drug selected. As in previous studies on drug use among young people, these results again confirm that the drug most often tried is marijuana – one third of young people surveyed had tried it.

Overall, during the past year, 17% of young persons had used marijuana, while one in ten young people has used amphetamines or inhalants. Almost one in five young people have tried inhalants, alcohol with tablets, or amphetamines. Slightly less popular are tranquilizers, sedatives and ecstasy. Comparing the data obtained with other survey results, it can be concluded that the residents of orphanages and boarding schools, and students of institutions of social adjustment have used drugs, other than marijuana, during their lifetime more often than comprehensive school pupils in the relevant age group.

Socio-psychological description of adolescents in the study target group

Adolescence is a special stage in human development, when diverse changes take place in physiology, hormone levels, and emotional aspects, as well as in personal development as a whole.

Adolescents often encounter very strong emotions, ranging from very positive to very negative; furthermore, particularly with the study target group's adolescents, early childhood experiences have been shaped in an often unfavourable family environment, where they sometimes have been subjected to trauma, or may have encountered losses, or emotional, physical or even sexual violence. Unquestionably, traumatic experienced in the family or elsewhere can become a specific risk factor in commencing the use of drugs.

From the results of psychological surveys undertaken during the study, it may be concluded that different types of psychological problems and adjustment difficulties are more characteristic of adolescents who have used drugs ("users"), than of adolescents from non-user groups; adolescents from user groups significantly more often feel anger and sexual frustration, and far more frequently than respondents from the non-user group use non-adaptive forms of behaviour such as aggressive behaviour or rule violations. The study data indicate a close relationship between adolescents' behavioural problems and symptoms of emotional trauma. Helping drug users to effectively cope with negative emotions, anger and stress, paying more attention to the

development of their coping skills, may reduce adjustment difficulties, and with that, the use of drugs.

The study results also indicate that the use of drugs by adolescents is strongly influenced by relationships with close, significant persons. In the context of relationship characteristics, it should be emphasized that one of the risk factors for adolescent behaviour problems, and hence the use of drugs, is the lack of support from adult persons - parents or other relatives, or persons outside the family circle of adults such as a teacher. Analysis of the study data vividly indicates that adolescent drug use is closely associated with drug use by close persons. Therefore, special attention should be paid to adolescents from risk groups in order to provide an opportunity to build relationships with positive, trusted visiting adults. If the adolescent's own parents are unable to provide such positive support, then it is necessary to encourage the formation of such relationships with some other relative, teacher, teacher, social educator or other person. It is also advisable to think about a variety of alternative ways of empowering the adolescent from a risk group to get positive support – such as the Latvian development of the "Big Brothers and Big Sisters" assistance program, which is based on the voluntary principle.

Assessing adolescents' responses regarding causes of alcohol consumption, it can be concluded that adolescent user groups have often mentioned different types of emotions and emotional experiences, namely, that alcohol is used to enhance positive emotions and minimize negative ones. It also an attempt to cope with stress, to forget one's problems, to not think about "bad" things, and to relax. Among the expressions of adolescents who used alcohol frequently, alcohol is frequently described as a way of dealing with negative feelings.

Adolescents in the users' group demonstrated more negative emotions, and implicitly expressed in interview responses that they were trying to reduce these negative emotions with the help of alcohol or drugs.

It must be concluded that helping drug users to cope effectively with negative emotions, anger and stress, paying more attention to the skill development of anger and stress management among these adolescents, can reduce the difficulties of adaptation and hence reduce the use of drugs.

Interviews with adolescents revealed very clearly the effect peers and other people of significance to them can have on adolescent behaviour. Firstly, when describing the reasons for alcohol and drug use, adolescents often mentioned membership of the group, the desire to emulate their friends and be accepted into the group, and acknowledged that it was typically friends who invited them to try a drug for the first time. The significance of peers in forming adolescents' attitudes is highly characteristic of the user group of study participants. This study's target group of adolescents spend almost all their free time with friends. It would appear that among the user groups' adolescent friends, there is a big proportion of alcohol and drug users, and as a result, they have a negative impact on one another and also support each other in this negative behaviour.

The data obtained show that substance abuse among close people, parents, peers, is associated with the adolescents' own drug use. Overall, adolescents from the user group more often than non-users noted that people they are close to, consumed alcohol excessively. Adolescents who use drugs lacked positive experiences of overcoming various obstacles and stress. Instead, they followed the "using" model, utilised by one of the close people - parents, other relatives, or friends. Approximately half of the user group's adolescents indicated that at least one parent is among their four most significant people, but unfortunately, that parent is unable to provide the support, care and the positive example that would be necessary for the adolescent.

Examining adolescent awareness indicators, it can be concluded that teenagers are better informed about the effects of alcohol than about the consequences of drug use. Furthermore, it was observed during the study that adolescents, especially younger adolescents, were

characterized by a very simplified representation of alcohol use and consequences of use, as well as a lack of information about the effects of drugs on the human organism. It is also significant that adolescents from the user group tended to distance themselves from the use of drugs, arguing that it did not apply to them. In addition, characteristic among several adolescents was the view that "If you do not know anything about drugs, then it is easier not to use them, there is no temptation". At the same time, the awareness among adolescents of the negative consequences of drug use may be an important protective factor.

Analyzing the views expressed by the adolescents in interviews, it may be concluded that alcohol and drugs are readily available to teenagers. Thus, both the availability of drugs and public acceptance (vendors sell to adolescents, adults buy for teenagers) can be added to the risk factors for the prevalence of drug use among adolescents.

Adolescents' attitude to school appears as a factor that could influence the use of drugs - the user group adolescents more often than non-users expressed the view that they had a negative attitude towards school, and poor relationships with teachers. For those teenagers from the group of users who expressed a negative attitude, strained relationships at school may result in additional stress and become an aggravating factor in the use of alcohol and drugs. Special attention should therefore be paid to research these adolescents' cognitive abilities to encourage a more positive outcome, and individualized teaching approaches must be considered that would promote positive attitudes and relationships with teachers. It is worth noting that the majority of survey participants expressed a positive attitude towards school and teachers. As is known, such a positive attitude and positive relationship the school environment may be a protective factor for children who come from disadvantaged family backgrounds.

Based on the views of adolescents expressed during interviews, it must be concluded that preventive programs for reducing the use of alcohol and drugs must be such as to attract the adolescents' interest. The study participants expressed the view that such informative programs should include real life examples; with stories from actual drug users and examples of the devastating effects of addiction, that would remain in memory. During the informative process, one of the most important aspects would be motivating adolescents' attention to this information. The expression of adolescents' personal experience and their active participation in the information presentation process can be utilised in developing programs for the prevention of drug use.

It is apparent that the study participants from institutions of social adjustment showed the highest indicators in relation to different emotions and behavioural parameters - anger, anxiety, depression, and aggressive behaviour or rule violations. In turn, these emotions and behaviour are also associated with increased alcohol and/or drug use. Therefore, it can be indirectly concluded that adolescents resident in social correction institutions are more likely to be involved in alcohol and drug use.

3. Prevention

Currently in Latvia there are several institutions, which carry out prevention activities in the field of drugs, but they mainly cover the capital city Riga and the Riga district, most of the activities are campaign-like in nature, and often addiction-related measures are integrated into broader health promotion activities. Similarly, prevention activities in Latvia have not been developed for specific target groups, based on "best practice" principles. The main reason why prevention programs based on scientific principles have not been developed – is the funding. Currently in Latvia, prevention activities are decentralized, i.e. each municipality performs its preventive work within its own capacity and financial limits. In Latvia's regions as a whole, selective prevention is poorly implemented and still lacks a unified approach to the implementation of universal and selective preventive measures, and only rarely is assessment undertaken of the effectiveness of preventive interventions, mainly due to lack[20] of funding and capacity.

3.1. Universal prevention

School-based prevention

One of the directions for action in the National Drug Programme 2005-2008 proposes the integration and implementation of drug prevention in the mandatory themes during the life skills and "teacher's hours" at educational institutions. The Ministry of Education and Ministry of Science are responsible for the integration of prevention into the general education standards. The teaching process in schools is organized so that the student develops social and interpersonal skills. By contrast, issues relating to health are included in curricular standards for a number of primary school subjects, and general secondary education subjects - biology, chemistry, domestic science, sport and social sciences. To strengthen the knowledge and skills acquired by students, health topics are also discussed daily in subject lessons and class lessons and at thematic events.

Apart from the activities organised for schools, professionals from other institutions (police, psychologists, public health professionals) as well as the most active young people are invited to participate in leading various activities. Young people often implement their activities via foundations, associations and centres, organizing various thematic activities on health in schools and groups, in which one of the activities also provides education about drugs. The peer education approach is implemented in a number of Latvian cities, with the main objective of involvement of trained young people in the health education of their peers, increasing the knowledge and skills of the target audience to help take charge of their own health and choose a drug-free lifestyle. To maximise retention in memory of the acquired information, the young people prepared informational materials for distribution to students at both primary and secondary schools.

The work of educators with children and young people affected by addiction problems and their parents has a major role in the further implementation of prevention in schools. Several seminars were held in 2008 to increase the knowledge, skills and development of teachers.

Informative lecture cycles for parents took place at several schools in Riga and Latvian regions on psychoactive substance use and strengthening of mutual child–parent relationship building.

Besides the implementation of health promotion and prevention work, the creation of a safe environment for schools is also important. A "secure environment" is understood to mean

[20]For compilation of information on prevention activities undertaken in 2008, as well as official information provided by Riga institutions and associations the data obtained from an online questionnaire completed by municipalities was analyzed. To obtain comprehensive information, online questionnaires were sent for completion in to the 18 largest municipalities and 25 regional coordinators. Aggregate data suggest that the major prevention activities to restrict dependence on drugs were at the universal or general level.

monitoring of compliance with a school's internal policy rules, CCTV installation, the provision of security, as well as stipulating the action to be taken in the event of discovering a case of drug use, distribution or acquisition. In some schools in several municipalities (due to lack of funding, not all schools) have installed video-surveillance equipment. Police monitoring is provided in many schools in the major cities.

3.2. Selective prevention

In Latvia, because of inadequacies in the statistical data collection program, precise information is unavailable on how many students drop out every year in primary school and do not continue studies. Similarly, there is no statistical evidence that the school drop-out problem is tending to grow *(Bebrisa, Ievina et al. 2007)*. In schools, pupils who miss some lessons or do not attend school at all are the concern of the class teacher and school social pedagogue. Discussions are held with these children and their parents to motivate the students to return to school and parents to strengthen the supervision of the child's school attendance and leisure time. Major prevention work was undertaken in Riga and the Riga District by the Riga Addiction Prevention Centre. In collaboration with school social teachers, both children in risk groups and parents sought assistance in the Riga Addiction Prevention Centre. In accordance with developed programs, specialists undertook interviews and discussions in the counselling rooms with children from risk groups on the negative consequences of drug use, and work is also undertaken with the family, educating parents about addiction issues and actions in resolving complex relationship issues with teenagers. In 2008, the Riga Addiction Prevention Centre continued to implement the project launched in 2006 "Reintegration of adolescents with social behaviour deviations and addiction problems into society." This project aims to promote an addiction-free lifestyle choice, changing teen behaviour and attitudes towards themselves, their health and the environment. This project is also included in the EDDRA database.

In Riga, a special department has been established to work with children in crime prevention- the Riga municipal police child delinquency prevention department. Staff from this department has undertaken informative educational work in schools, explaining to pupils the adverse impact of drugs and the culpability provided by law for the use of these substances. One type of selective prevention is to check places where youth gather and recreational areas to establish the presence of minors away from home late at night, smoking or being intoxicated in a public place. Apart from regular inspections by the State Police, such activities were also undertaken in 2008 by the State Inspectorate for the Protection of Children's Rights and the Parents' Association in cooperation with the staff of state and local government bodies.

To check the availability of drugs and the situation in the prevalence of use among persons attending recreational areas, in 2008 a study was conducted "Drug use in Recreational Settings" *(Koroleva, Karklina et al. 2008)*. Based on this study, recommendations were developed "Recommendations of the Narcotic Drugs and Psychotropic Substances, for the creation of a free and secure environment at recreational settings." The main aim of these recommendations is to limit the bringing in of drugs and their distribution and the possibility of use in leisure facilities, creating a safe environment and reducing drug-related health problems and accidents to visitors in all recreational venues.

At regional level, activities, aimed at specific target or risk groups are not particularly organized or planned. Local governments offer opportunities for support, discussion or leisure in established day-care centres, crisis support centres or support groups. In most of the Latvian municipal, low-threshold centres, work to reduce the spread of drug addiction was also implemented alongside HIV prevention work. At these centres, interviews were conducted, discussions were held, with children from risk groups; counselling and educational seminars were provided for interested parties, and various awareness-raising activities for pupils were organized in collaboration with schools.

3.3. National and local Media campaigns

In Latvia, no major information campaigns took place during 2008. Increasingly, information is circulated via the Internet environment. During lessons, interactive discussions took place among public health professionals and pupils from primary and secondary schools. Various topical issues and opinions on drugs and the negative consequences of their use were expressed and debated on various Internet sites, and specially created websites continued to operate, aimed specifically at a reduction in the prevalence of smoking and motivating giving it up.

Regional newspapers are used to inform residents of municipalities, in which information is published several times a year on educational issues related to drugs, and information about topical issues for young people related to smoking, alcohol, drugs and drug use is published and updated on several city websites.

Generating a large response among inhabitants is the Helpline, a service provided by two institutions in Riga. Most of the callers asked questions about smoking; the second-largest number of questions was related to domestic and psychological problems caused by alcohol and other drugs.

4. Problem Drug Use

4.1. Prevelence and incidence estimates of PDU

Indirect estimates of problem drug users

Within the 2009 cohort study, problem drug use estimates by applying Police multiplier method were carried out. The multiplier used in the study was according to self-reports of being brought for drug testing among interviewed drug users, while the data source used was positive drug tests carried out at the Riga Addiction and Psychiatry Centre. According to the cohort data, the police had brought 25.2% of interviewed drug users to the drug tests at least once in the previous 12 months; while Riga Addiction and Psychiatry Centre data suggests 1879 individuals were tested positive for heroin or other opiates, cocaine and/or amphetamines. Thus according to the Police multiplier the estimated number of problem drug users in Riga and surrounding areas was 7456. These estimates are also reported via Fonte ST7[21].

Additionally in 2009, the EMCDDA and UNODC consultancy work by Dr.Gordon Hay (Glasgow University) on obtaining estimates by applying capture-recapture models. Within the project available individual level, data were analysed and various statistical models were fit to data. As of writing this chapter, work is in progress and it seems some of the data sources are showing good and consistent results. More information on estimates and its problems will be described in the next National Report.

Estimates of incidence of problem drug use

No problem drug use incidence estimates have been carried out in Latvia.

4.2. Data on PDUs from non-treatment sources

Data from the drug users' cohort study has been described in previous national reports. The fourth wave of the study was conducted in 2009 and will described in next National Report.

In 2009, the Public Health Agency, as part of its ENCAP[22] project published a study: "Prevalence of HIV and other infections and risk behaviour among injection drug users in Latvia, Lithuania and Estonia in 2007" *(National Institute of Health Development 2009)*. For the results of this study, see Chapter 6 on Infectious Diseases.

[21] ST7_2009_LV_01

[22] European Commission funded Project Expending Network for Comprehensive and Coordination Action on HIV/AIDS prevention among IDUs and Bridging Population Nr 2005305

5. Drug-related treatment: treatment demand and treatment availability

5.1. Strategy/policy

The treatment of patients addicted to drugs in Latvia is basically directed towards the idea of treatment in its narrowest sense, more so than it is accepted in other EU member states[23]. According to this definition, treatment involves a structured intervention in society, using specific medical and/or psychosocial techniques, which aim to reduce or stop illicit drug use. According to this definition, for example, the low-threshold centres, planned consultations for care, for example, in the social and probation services, and counselling of HIV/AIDS patients in the treatment system is a medical service, but data regarding this type of treatment for drug addicts is available in Latvia only to a limited extent.

In Latvia, the treatment of drug abuse patients/drug users is determined by the *Medical Treatment Law* and a specific procedure for treatment of alcohol, narcotic, psychotropic and toxic substances. It is based on a treatment system provided by medically-educated treating personnel (drug addiction specialists), who have the right to make a diagnosis in accordance with the ICD-10 classification. Also involved in the treatment process are medical nurses, and in recent years, medical support personnel such as psychologists and social workers, thus forming a multi-disciplinary treatment team.

Although operating as a political document in Latvia until 2008, the *National Drug Programme 2005–2008*, in which in relation to reduced demand, including for treatment, were stipulated aims and specific measures were planned for achieving these aims; however, a priority policy planning document (in relation to the entire treatment system, also including the treatment of addicted patients) is the "*Plan for introducing a development program for providers of health care to inpatients and outpatients 2005–2010*" in which development of the drug addiction service is not noted.

Until 4 August 2008, when amendments were adopted to Cabinet Regulation No. 429 of 24 September 2002 *"Procedure for treatment of patients addicted to alcohol, narcotic psychotropic and toxic substances"* and changes were made to specific procedures in the treatment of alcohol, narcotic, psychotropic and toxic substances, patients had very limited access to methadone replacement therapy, as well as very strict procedures by which patients could commence treatment within a buprenorphine replacement therapy program. In amending the legislation, the Ministry of Health introduced proposals to implement broadening of the replacement therapy programs: the possibility of receiving methadone replacement therapy was liberalised and broadened, not just at a single drug treatment institution – Riga Psychiatry and Addiction Centre, but in all treatment institutions, which had agreements with the Latvian Health Compulsory Insurance State Agency (since 1 October 2009 the Health Payment Center). Also simplified was the opportunity for opioid-dependent patients to receive buprenorphine replacement therapy: to receive it before 2008 a patient had to visit specified drug treatment institutions daily for a month which were far from where they lived to receive there a dose of buprenorphine set by the Council for 30 days. Only at the conclusion of the observation period would the addiction specialist write a prescription giving the patient the opportunity of obtaining the medication from a pharmacy. At the moment, in accordance with a Council decision giving the patient the opportunity to use buprenorphine, the patient receives it within 30 days from his addiction specialist (whom he visits every day) and subsequently a prescription is written, reducing the number of visits and improving access. Another important amendment to the

[23] Classifications of drug treatment and social reintegration and their availability in EU Member States plus Norway" (EMCDDA, 2002): „Treatment comprises all structured interventions in the community with specific medical and/or psychosocial techniques aiming at reducing or abstaining from the use of illegal drugs". This drug treatment definition refers to all drug specific interventions beyond open access services (such as needle exchange, information and advice). Therefore, the provision of information and advice is consequently not regarded as treatment, but for example care planned counselling is.

legislation is Cabinet Regulation No.780, which was adopted on 22 September 2008: "Amendment to Cabinet Regulation No.899 of 31 October 2006: "Proposed arrangements for reimbursement of expenditure associated with purchasing medication and medical equipment intended for the treatment of outpatients", which stipulates that the State shall include in the list of compensatable diagnoses those medications used to treat children with addiction problems.

In the informative report adopted by the Cabinet of Ministers on "*Implementation of the National Drug Programme 2005–2008*" in relation to measures for reducing demand, including measures directed towards improving the treatment system, it is noted that as a result of operation of the program, one of its main objectives had not been reached: "A consistent/significant decrease in cases of death due to diagnosed drug addiction, intoxication or use of harmful substances, and in the number of patients registered for the first time, particularly among thos below the age of 25 years". Among the measures not implemented in the area of treatment, it must be noted that during the operation of the program, both because of unallocated funding and as a result of reorganisation of various institutions, a specialised children's treatment facility was not established, nor was a daily outpatient clinic established for drug users, nor a special program developed for patients with double diagnoses (psychiciatric comorbidity).

5.2. Treatment systems

Treatment policy, coordination, and supervision is organised and provided by the Ministry of Health at the national level, but the State funding model, according to the agreements, is implemented by the Health Payment Center[24].

According to Paragraph 76.2.2. of Cabinet Regulation No. 1046 of 19 December 2006 *"The organization and financing arrangements for health care"*, an inpatient drug addiction specialist is a direct access specialist. Applied to the salary of a direct access specialist is a monthly fixed payment (estimated funding), consisting of payment for work and expenditure relating to maintaining of consulting rooms. That means that the most important factor in payment for this service is not the number of treatment episodes conducted by the specialist, but rather access to specialist services in an agreement signed with the Health Payment Center, in a stipulated place and amount of visits. The patients' contributory payment to visit an addiction therapist is LVL 2 (around 3 EUR), except for children.

In Latvia, also involved in treatment addiction patients are private bodies/private medical practices with addiction specialists on staff. In such cases, the patient pays all the costs associated with the treatment; various shortcomings exist in the legislation, and private medical institutions do not provide information about their patients.

The State also pays for treatment at in-patient facilities, where the patient contribution is LVL 1 (1,5 EUR) per day, except for children; but for long-term treatment in rehabilitation programs (therapeutic communities) the patient's maximum contribution limit is LVL 80 (115 EUR) per year. Children's long-term in-patient treatment is funded by the Ministry of Welfare via the administration of funds through the Social Assistance Fund.

In Latvia, as a small country: there are limited resources, and from the historical establishment of the treatment system, a peculiarity of the system is the lack of a treatment network for drug addiction patients having a stated aim, a treatment protocol, qualified specialists, a treatment plan, and a monitoring system, and there is no supervision provided which includes specialist certification and the regular upgrading of their skills.

Treatment of drug-addicted patients takes place together with patients with alcohol addiction, and gambling addicted patients, with the exception of rehabilitation programs (therapeutic

[24] More information also in SQ27P1_2008_LV_01

communities), which have been formed for adult patients separately from the alcohol-dependent patients. Overall, the treatment system has not changed significantly over the past five years.

With the number of newly-registered patients increasing, as was the case in 1999–2000, in order to receive assistance in acute detoxification programs within the treatment system, drug users need to wait in lines, as priority is given to patients being treated for the first time.

Specific treatment programs have not been developed in the country that focus on specific target groups such as women, pregnant women, ethnic minorities, patients with psychiatric co-morbidity, and sex-workers. In Riga, children and their parents can participate in special activities, receive family therapy, addiction specialists work individually with children, children have the right to receive compensatable medication throughout the country. HIV/AIDS patients – drug users receive some outpatient psychosocial intervention approach elements (in the form of counselling from an addiction specialist) while being treated at the Infectology Centre of Latvia.

To further describe the treatment system, in accordance with the EMCDDA definition of the intended drug-users therapeutic network, we shall differentiate between the following treatment approaches *(Centre for Interdisciplinary Addiction Research 2008):*

Outpatient psychosocial interventions, which include counselling, motivational therapy, brief interventions, referral to day centres and case management. *(Centre for Interdisciplinary Addiction Research 2008).* In Latvia, inpatient psychosocial intervention is available in all areas.

The amendments adopted by the Cabinet of Ministers on 9 April 2007 to Cabinet Regulation No.1046 of 19 November 2006: "The organization and financing arrangements for health care" also provide payment options for the work of psychologists, and therefore in some areas, a multidisciplinary team works with patients: a drug addiction specialist, psychologist, and a nurse, providing psycho-social intervention. The treatment system is dominated by systematic consultations, which are also known as "dynamic prevention"; when a patient visits a particular doctor, a treatment plan is developed and regular meetings are scheduled. Motivational intervention is utilised during therapy *(Miller, Rollnick 1991),* cognitive behavioural therapy, which reinforced by symptomatic pharmacotherapy, prescribing new-generation antidepressants for patients in (particularly amphetamine users), short-term sedatives, while also providing relapse prevention therapy with an opioid antagonist *naltrexone*; patients are encouraged to attend self-help groups. Case management, which is a client-oriented approach to complex problems such as drug use disorders and simultaneously resolving common problems, such as cases of infectious diseases, is routine practice in Latvia, when addiction specialists contact other medical specialists, and are familiar with the treatment system for infectious diseases and may make recommendations where to seek assistance in cases of co-morbid somatic diseases. Brief interventions are rarely used in the early identification and further treatment of drug users, since the institution of the family physician, who could provide this service, is relatively new, overloaded, and not oriented to working with drug users.

Outpatient drug addiction support services funded from State budget funds were delivered by 36 medical institutions (37 specialists) in 2007, costing LVL 569 593 (810 462 EUR). These state funded specialists work in specialized psychiatric-addiction/addiction outpatient departments, outpatient wards in the general hospital network, municipal outpatient surgeries, and addiction specialist practices.

In-patient psychosocial intervention includes treatment in hospital-type facilities ranging from short-term inpatient programs to therapeutic communities. In late 2008, the short-term (structured motivational program (treatment time to 12 days), and the *Minnesota*, or 12-step treatment program in which the treatment time is 28 days) drug addiction inpatient care was provided in Latvia by three medical institutions (two State and one private institution), together

providing around 50 beds, in which patients were treated for both alcohol and drug dependence, as well as children in the motivation program.

Latvia has 2 (30 beds) rehabilitation programs for adults, and 50 beds for children, which operate on the therapeutic community principle. Adult patient rehabilitation institutions are specialized for drug addiction patients (both are public institutions), but in the rehabilitation facilities intended for children (one public and one private), children are also treated with alcohol abuse problems. Treatment time is from 6 months to 18 months.

Detoxification

Medically this is the initial stage of treatment, which can be described as a process in which patients are given medical assistance by pharmacological means to improve their physical and mental state. In late 2008, detoxification was being offered in Latvia by 11 medical institutions (including 3 private institutions, as well as the Central Prison Hospital under the auspices of the Ministry of Justice). But basically focusing on detoxification assistance were four State specialized Addiction Disorders/psychiatric institutions and 2 private institutions.

Pharmacological treatment of patients with opioid dependence

This treatment approach, i.e. using methadone for the long-term pharmacological treatment of patients with opioid addiction has been operating in Latvia since 1996; buprenorphine substitution has been used since 2005.

Table 5.1. Number of clients in substitution treatment in 2008

		Patients accepted into program during year				Patients who ceased treatment during year			Patients in program at end of year		
			First time in lifetime								
		Total	Total	Female	Male	Total	Female	Male	Total	Female	Male
Methadone	2008	69	44	13	31	41	14	27	103	27	76
	2007	55	45	11	34	29	8	21	75	21	54
Buprenorphine	2008	35	28	3	25	33	4	29	61	10	51
	2007	45	42	8	34	71[25]	16	55	59	11	48
Total	2008	104	72	16	56	74	18	56	164	37	127
	2007	100	87	19	68	100	24	76	134	32	102

Source: Riga Psychiatry and Addiction Centre 2009

Evaluation of SMT

In 2008 the project "*HIV/AIDS Prevention and Care among Injecting Drug Users and in Prison Settings in Estonia, Latvia and Lithuania 2006 to 2010*", grants competitions were announced in Latvia, which provided an opportunity for the drug addiction treatment institutions and local government social services, after preparing grant applications and submitting them to project administrators – Office of the UNODC in the Baltic, to receive funding to establish methadone program consulting rooms (renovation and equipping of premises etc). One of the project measures is the provision of training to addiction specialist doctors, psychologists and nurses. Within the ambit of this project, the "*Evaluation Pharmacological treatment of opioid addiction in Latvia*" *(Sile, Pugule 2008)* was produced, using as a model the pharmacotherapeutic evaluation undertaken by the Netherlands Institute of Mental Health and Addiction, and the University of Ljubljana Faculty for Social Work in Slovenia. Two main objectives were proposed from within the framework of evaluation of pharmacological treatment: to assess the situation in the area of pharmacotherapy in Latvia, and provide recommendations for improving and expanding pharmacotherapy services.

[25] Of these, 53 Finnish patients (11 females and 42 males) were removed from the programme.

The KIPP model was used for the evaluation, providing evaluation for projects, programs, staff, products, institutions and systems *(Stufflebeam 2003; Trautmann 2007).*

in-depth interviews with experts in the field, interviews with Centre personnel, and interviews with drug users who were not in pharmacotherapy were comduncted and supplemented by 70 interviews with clients in substitution treatment.

Until August 2008, Latvian opioid dependence patients were able to receive methadone from only one government institution – the Riga Psychiatry and Addiction Centre (hereinafter "Centre"). Psychosocial intervention by a drug addiction specialist and a psychologist is also provided as part of methadone replacement therapy. Methadone is received, and consumed in the presence of a nurse. In late 2008, taking into account the operation of simplified replacement therapy and amending Cabinet Regulation No. 429 "Procedures for treatment of Alcohol, drugs, psychotropic substances and toxic addiction patients", a second methadone replacement therapy program was established. In the methadone program, there are no waiting lines, although in some cases, it is necessary to wait for up to one week. Also helping to make the methadone program available to patients is the fact that the patient's contribution for attending drug addiction outpatient psychosocial intervention programs is LVL 2 (EUR 2.8), but the patient only pays this amount each visit only until he is included in the program. The main problem precluding the broadening [of pharmacotherapy is considered to be the lack of drug addiction specialists, who would be ready to commence pharmacotherapy in regional areas. The experts also expressed concern about the possibility of securing the services of a multi-disciplinary team to work with pharmacotherapy patients if pharmacotherapy programs were set up outside the major treatment institutions and Latvian prisons (Sile, Pugule 2008).

During the evaluation, the weak and strong points of pharmacotherapy were identified.

Strong points

- Changes in legislation: After amendment of Cabinet Regulations No 429, methadone pharmacotherapy is now available in the regions of Latvia, which is a positive fact.

- Good medical technologies: According to narcologists, medical technologies are used on a continuous basis and they are considered to be well-developed, extensive and comprehensive.

- Very good and strong understanding about the need for a multidisciplinary team. The staff is experienced and highly qualified.

- The Centre does not have waiting time for entering pharmacotherapy

- There is a lot of focus on safety issues concerning both the use of medication and the equipment of premises.

- The Centre offers different support and treatment options, also pharmacotherapy clients are supported by a multidisciplinary team.

- A good understanding about the necessity of pharmacotherapy among professionals: Leading experts support the opinion that pharmacotherapy should be available not only in the regions, but also in prisons and isolation cells for short-term imprisonment.

- Positive client attitude towards pharmacotherapy: Overall client attitude towards pharmacotherapy is very positive. When comparing various aspects of life before entering the program, during the program and the situation one year after, the period one year after is always scored higher and the use of illegal drugs is evaluated as much lower.

Weak points

- Lack of harmonisation of legislation/guidelines/medical technologies and nonconformity with the actual situation: Though the present legislation allows for more extensive availability of pharmacotherapy, other changes are also necessary. As stated by narcologists, in practice the most extensively used tools are medical technologies, they are good and broad (much broader than guidelines). Therefore, there is a lack of understanding of the need for guidelines, which moreover are not harmonised with medical technologies.

- Tight enrolment/exclusion criteria: The tight enrolment criteria allow inclusion only of very "severe" cases, not only making the system cumbersome, but also creating a negative image of pharmacotherapy. This is also true of the exclusion criteria, envisaging exclusion of a client in the case of parallel use of other drugs. This, in fact, means that the client's participation has to be terminated without warning from the very first time when parallel use has been disclosed. At the same time nothing precludes the client from joining the program again on the next day. The presently approved criteria do not comply with the WHO/UNODC guidelines *(WHO/UNODC/UNAIDS 2004),* on the application of pharmacotherapy to the treatment of opioid addictions.

- Insufficient information on pharmacotherapy among addicts: Interviews with addicts who do not undergo pharmacotherapy showed that among addicts there is little to no knowledge and understanding about the aims of pharmacotherapy, its effects and expected results.

- No pharmacotherapy in isolation cells for short-term imprisonment or in prisons: This is one of the reasons keeping clients back from starting therapy.

- Shortage of staff (in the Centre/countrywide): The interviews carried out at the Centre lead to conclude that there was shortage of staff, particularly paramedical staff.

- Lack of a specialised client registration system: At present clients are registered in an Excel program and, in parallel, in the Register of Drug Addicts. Experience shows that in many cases, the Register data are outdated and the dose received by the client is not recorded.

- Lack of premises and equipment: Premises are of insufficient size, they need renovation; the glass partitioning creates a negative attitude and clients feel excluded.

- Poor treatment of the clients by the staff (according to the clients): This shows that there are certain problems, which may partly be associated with pharmacotherapy clients being particularly "difficult" clients.

- Lack of knowledge among clients about additional services: Most of the clients indicated that no additional services at all were available at the Centre; some only mentioned that it was possible to consult a doctor.

- Lack of co-operation with other organisations: the Centre mostly co-operates only with hospitals, mental health centres and pharmacies, while co-operation with other organisations (probation service, syringe exchange points, rehabilitation institutions, etc.) would be essential.

- Lack of understanding of the positive aspects of pharmacotherapy on the part of the policy-makers and the public.

5.3. Characteristics of treated clients

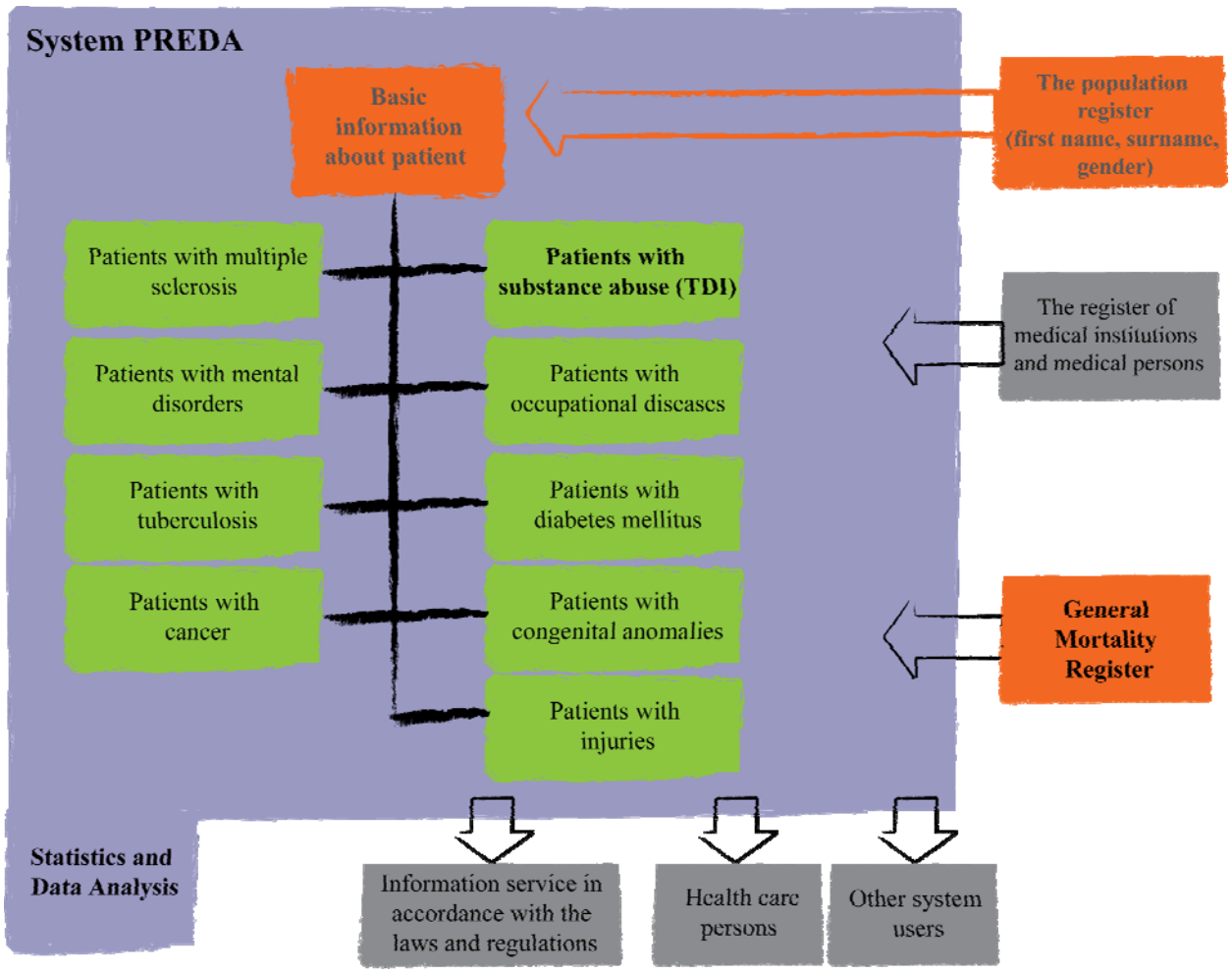
Treatment data recording system

Over the last years huge efforts at the Health Statistics and Mdecial Technologies State Agency (as of October 1, 2009 – Department within the Centre for Health Economics) have been put into developing the new treatment data recording system PREDA (Patient REgister DAta). The system that is fully functional as of September 2008.

The data collection system is web-based and uses secure data transmission channel (SSL). It consists of the PREDA database itself, which is a MSSQL data base, Data input system, systems' public interface (XML Web service-access layer), PREDA Security, PREDA import program, and PREDA analysis system. Within the PREDA system data is collected not only about drug use but also about various diseases or conditions, e.g. mental health, cancer, diabetes mellitus, tuberculosis, injuries, congenital anomalies, occupational diseases; morover PREDA system is directly linked with the General Mortality Register (or Death Causes Database), which provides ICD-10 mortality codes automatically into the system for deceased persons. In Figure below the system is displayed graphically.

With the introduction of the new system changes in the treatment data reporting form took place with inclusion of additional TDI items – living status, family status, injecting, additional answer categories for frequency of use, and treatment modality – which were missing in the previously used TDI reporting form.

Figure 5.1. Patient Register Data components and links with other data sources



Source: PREDA 2009

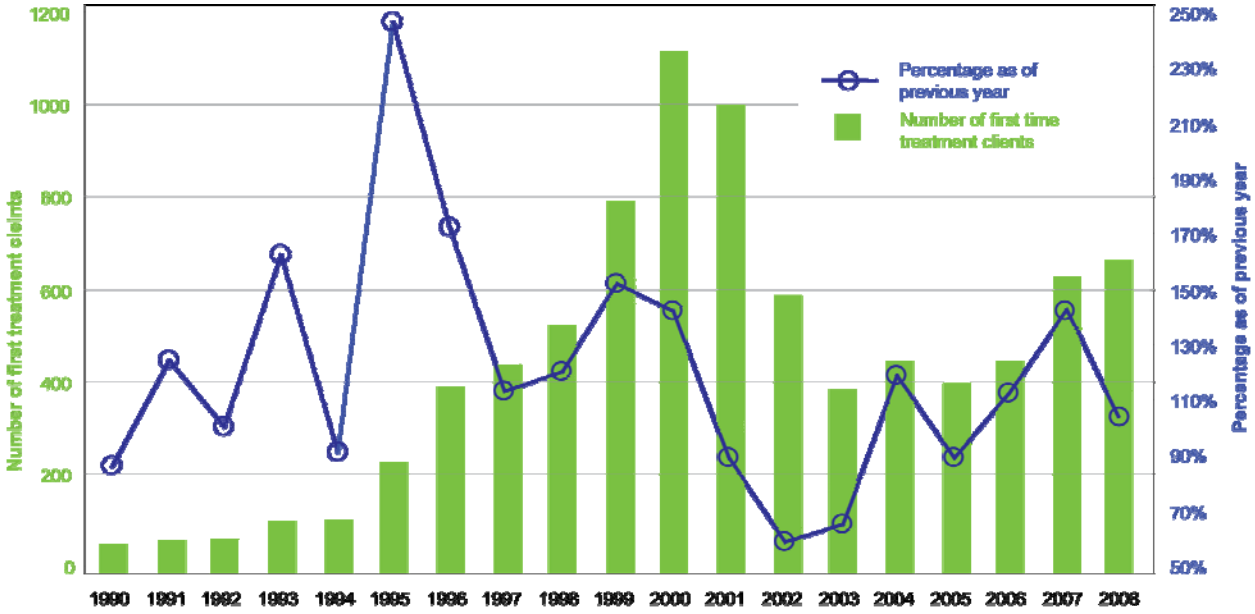
Out-patient treatment

Mainly utilised in this subsection will be data from the Register which, within the framework of the existing systems for patients' record- keeping in Latvia, possibly also includes patients treated at inpatient treatment centres who have not been treated at out-patient centres. For sources of referral and other TDI analysis not described here see Selected Issue on Amphetamine use.

Since the first patient was registered in Latvia in 1976, until December 31, 2008, 8 589 patients[26] had been treated to problems due to psychoactive substances other than alcohol and tobacco.

Beginning in 1993/1994, the situation regarding registered patients changed fundamentally in comparison to previous years regarding the low numbers of patients observed in previous years, and each year thereafter a significant increase was observed in the number of patients treated for the first time. The number of patients treated for the first time reached its maximum in 2000 and decreased until 2003, while during the period from 2004 until 2006 it stabilised at the level of approximately 400 patients treated for the first time each year. In 2008, the number of first-time patients registered in comparison to 2007 had increased by five per cent[27] *(see Figure 5.2)*.

Figure 5.2. Number of first time treated patients at outpatient treatment centres and percentage as of previous year



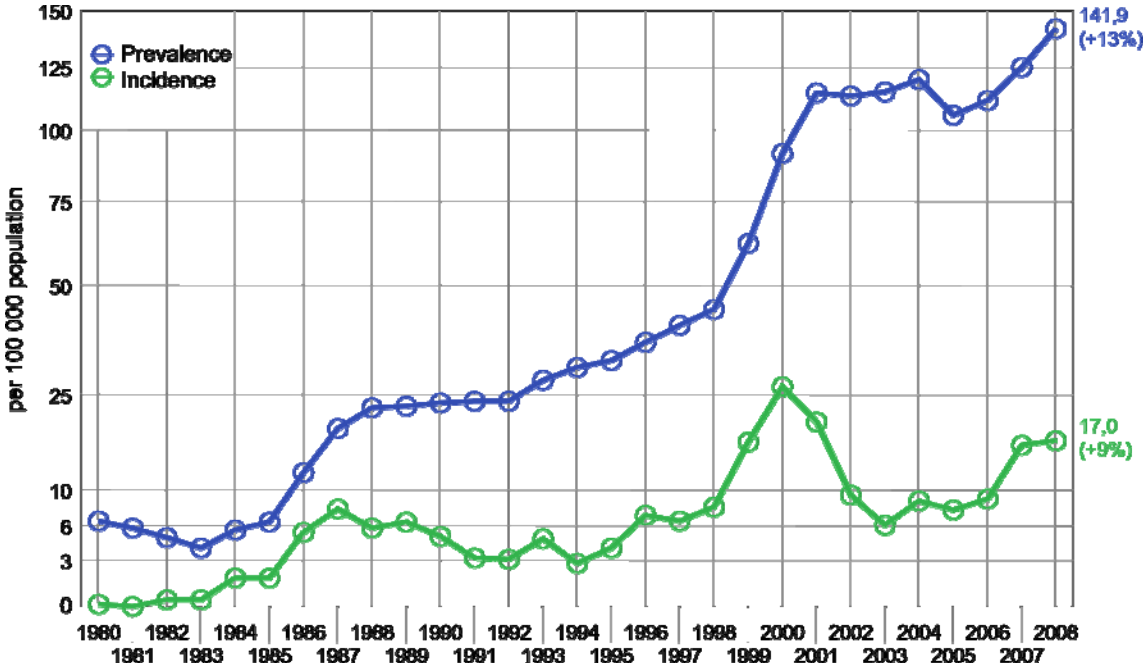
Source: PREDA 2009

According to data from the National statistical report[28], 645 new cases were registered in 2008 that were related with dependence, intoxication or harmful use of narcotic and psychotropic substances; of these 399 were with a first-time diagnosis of dependence; while the prevalence of dependence syndrome diagnosis at the end of 2008 was 3 236 *(see Figure 5.3)*. The prevalence rate decrease as seen in the Figure 5.3 in 2005 is related to improvements in data

[26] There are slight discrepancies with previously reported data as new data collection system, which was described earlier in this chapter, is in place and a huge effort has been put into quality control of historic data, e.g. double counting.
[27] According to TDI out-patient data.
[28] There are differences in number of patients who are reported in the statistical report and those calculated for TDI tables, e.g. in 2007 there are 627 first treatments according to TDI, while 611 are reported via statistical report. These differences are observed because for the national statistical report first treatment episode is according to treatment personnel (usually based on registration system at centre level or according to patient – whether one has been treated or not) ,while for TDI unique personal identifier is used for all reporting treatment centres and it is checked whether there have been previous treatment before or not, based on individual-level data reported.

quality, as a result of which several hundred patients registered, but who had not sought assistance for a long time, were "removed" from the Register.

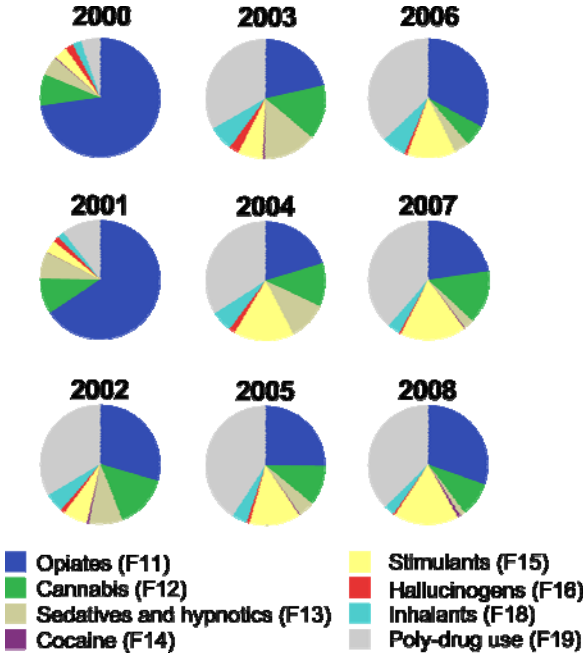
Figure 5.3. Incidence and prevalence of ICD-10 dependence syndrome diagnosis (F11–F19) 1980–2008, per 100 000 inhabitants



Source: PREDA 2009

According to the ICD-10 diagnosis since 2000 there has been a significant increase of proportion of poly-drug related (ICD–10 F19) and stimulant-related (ICD–10 F15), while those related with opiate use (ICD–10 F11) has been on the decrease. Since 2004/2005 the situation has stabilized and in 2008 38% of diagnoses were poly-drug related, 30% – opiate-related and 17% – related with stimulants, which practically has not changed as compared with 2007 data *(see Figure 5.4)*.

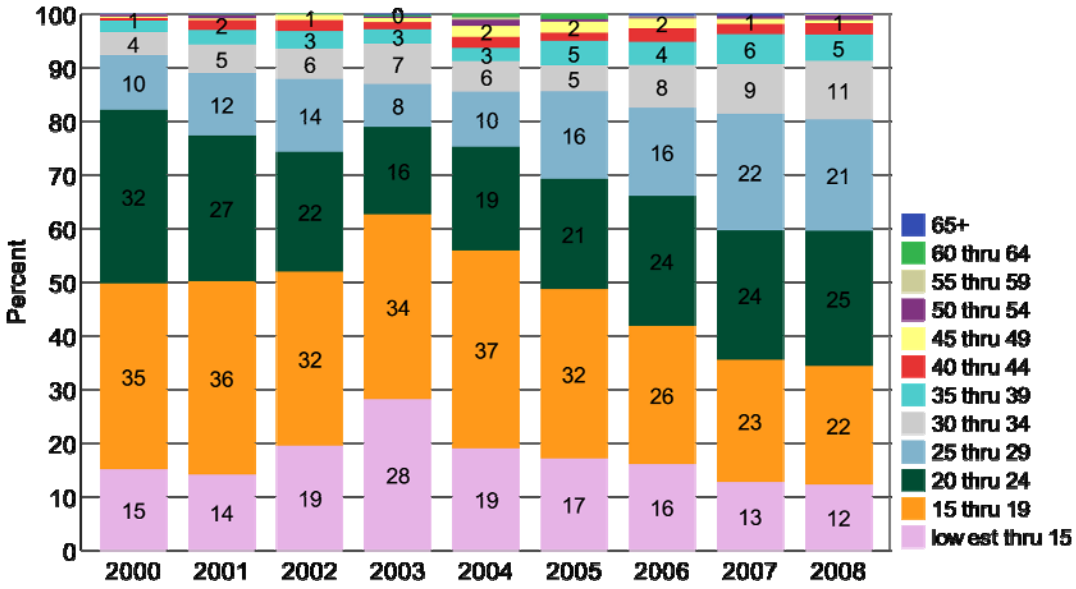
Figure 5.4. Proportion of various ICD-10 diagnoses (F11–F19) among first-time treated clients 1999–2008 (%)



Source: PREDA 2009

2008 out-patient TDI data suggests the number of first-time clients with intoxication, harmful use and/or dependece has slightly increased (by around five per cent) as compared to 2007 data – 659 and 626 clients, respectively. Among first-time treated clients about one-fifth (19%) were females, which has remained at about the same level as in previously reported data. The mean age for first-in-2008-treated females is slightly lower than for males, 23.9 years and 22.5 years respectively *(see Fonte TDI out-patient[29])*. Since 2003 when two thirds of clients (66%) entering out-patient treatment were younger than 20, there has been a gradual decrease over the years and in 2008 only about one-third (34%) were younger than 20. In 2008, 25% of clients were aged 20 to 24, 21% – 25 to 29, 11% – 30 to 34, while less than ten percent of first-time clients in 2008 were older than 35 *(see Figure 5.5)*.

Figure 5.5. Age of first-time patients entering public out-patient treatment, 2000–2008

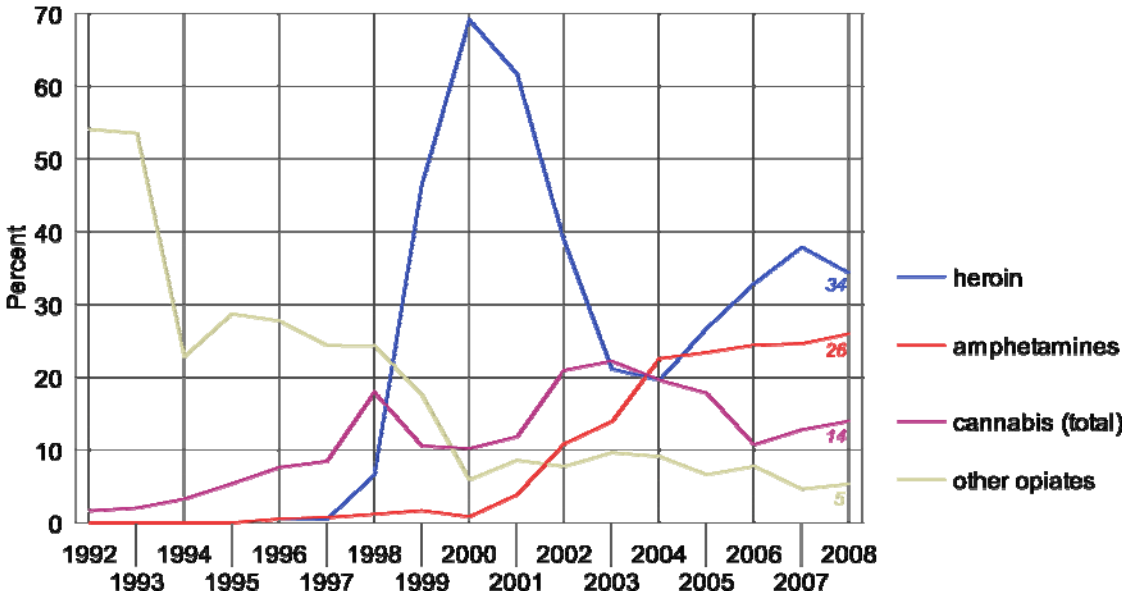


Source: PREDA 2009

Since 2005 the most commonly used primary substance by first-time clients is heroin (226 clients or 34%) followed by amphetamines (171 clients or 26%), cannabis (92 clients or 14%), and other opiates (35 clients or 5%) *(see Figure 5.6)*. For 35 clients (or 5%) primary substance is unknown. Inhalants, barbiturates, benzodiazepines, hallucinogens, other susbtances were mentioned in less than five per cent of first time out-patient clients *(see Fonte TDI out-patient[30])*. The lowest number and precentage of primary first-time heroin clients was lowest in 2004, while since then it has only increased – the reasons for decrease in the percentage of heroin clients in 2008 as compared with 2007 data is not very clear. As reagards amphetamines – the numbers of cleints had significantly increased until 2004 while since then it has remained at about the same level, while the absolute numbers keep increasing every year.

Figure 5.6. Percentage of first-time clients at public out-patient treatment centres, 1992–2008

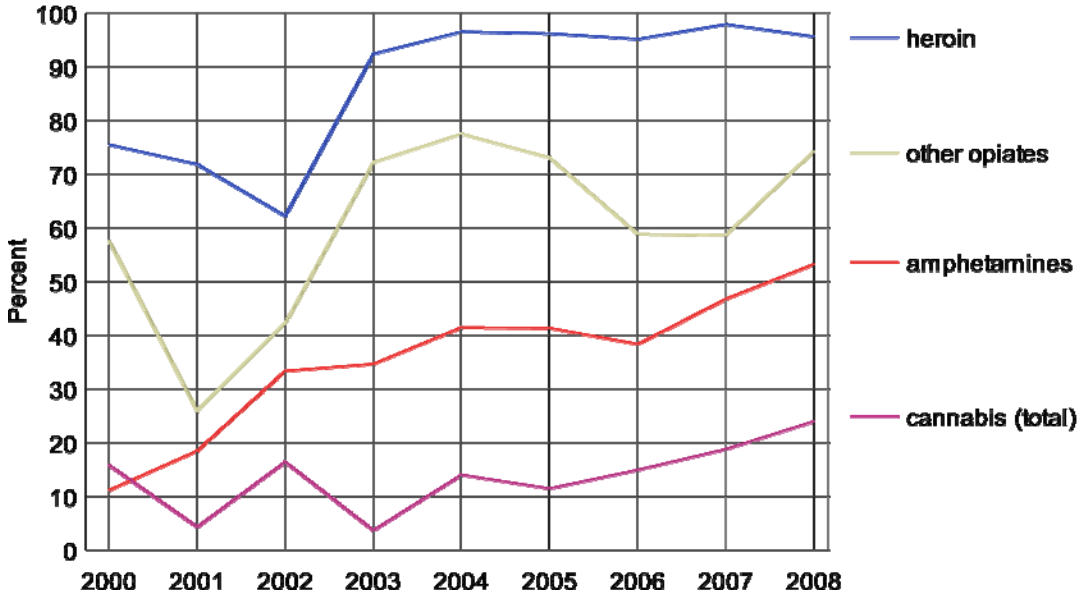
[29] TDI_2009_LV_01
[30] TDI_2009_LV_01



Source: PREDA 2009

Of all first time clients in 2008 60% were diagnosed with ICD-10 diagnosis related to dependence, withdrawal or psychosis (F11-F19.2-9), while 40% – with intoxication or harmful use (F11-F19.0-1). More than 90% of heroin users seeking treatment for the first time in their lifetaime are diagnosed with dependence or withdrawal diagnosis; among clients with primary other opiate use the proportion is somewhat lower. Interestingly, there is a rather steady increasing trend for promary amphetamine users, e.g. if in 2000 only 10% of amphetamine users were diagnosed with diagnosis related to dependence or psychosis, while in 2008 – more than every other. Besides, primary cannabis clients also seem to increase as regards proportion who are first-time diagnosed with dependence-related diagnoses *(see Figure 5.7)*. Such observations would mean that the clients are getting more hard to treat and probably suggests that more effective ways in getting clients into treatment before they develop more serious problems have to be sought after.

Figure 5.7. Percentage of clients diagnosed with dependence according to their primary drug at public out-patient treatment centres, 2000–2008

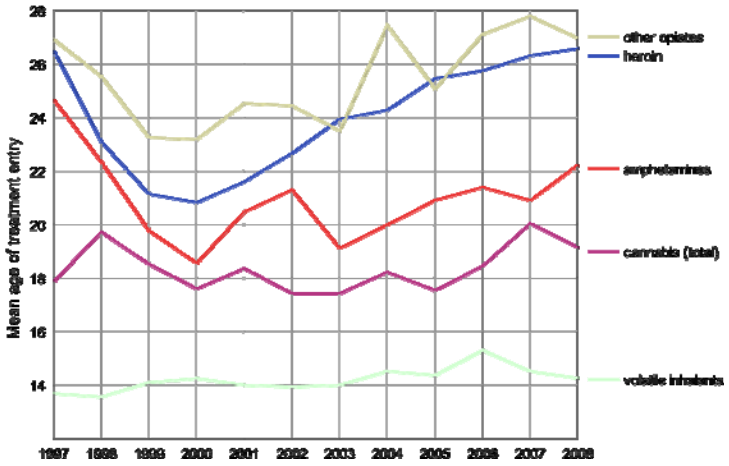


Source: PREDA 2009

Amphetamine users seeking treatment for the first time are generally younger than heroin users and on the other hand, they are older than cannabis clients are, e.g. in 2008, the mean age for primary amphetamine users was 22 years, 26 years for heroin users and 19 years for cannabis

users *(see Figure 5.8)*. As seen in the data the mean age for primary heroin users has increased steadily since 2000 (from 21 in 2000 to 26 years in 2008), while among primary amphetamine it has increased rather steadily since 2003 (from 19 years in 2003 to 22 years in 2008).

Figure 5.8. Mean age of first-time treated clients, outpatient treatment centres 1997-2008, by primary substance



Source: PREDA 2009

Comparing information regarding first-time treated patients in 2007 with earlier observations, no significant changes in trends are seen, and accordingly, below trends mentioned in the 2007 National Report are reported.

- After a rapid increase in the number of patients treated for the first time with problems due to amphetamine between 2000–2004, during the past year this has stabilised and at the moment comprises approximately one quarter of first-time treatment;

- concurrently with an increase in amphetamine treatment demand, by 2004 the number of first-time treated heroin patients decreased, and in 2004, patients treated with amphetamine problems exceeded the number of patients for whom the primarily-used substance was heroin. Since 2005, the number of patients with problems due to heroin continues to increase, and in 2007 comprised 2/5 of first-time patients;

- the number and proportion of patients with problems due to primary cannabinoids is significantly lower in comparison to 2003, but in comparison with 2006 has remained at an unchanged level;

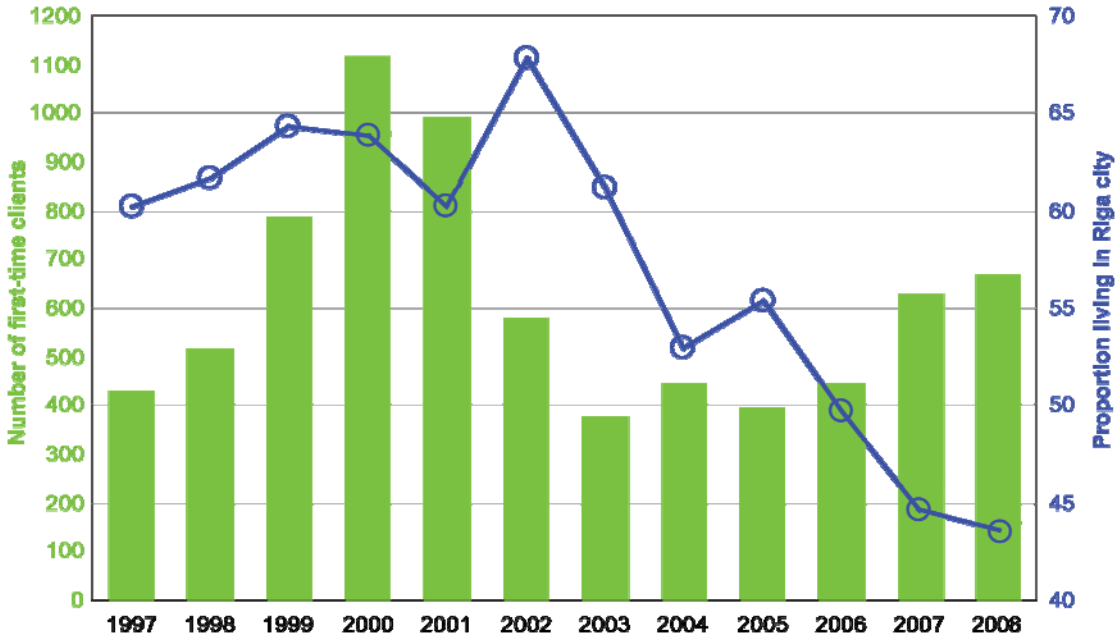
- such substances as hanka and ephedrine, which were popular in the 1990s nowadays are mentioned only in rare cases as the primarily used substance, which could be related to an expansion of the drug market, reductions in drug prices and increased purchasing power of inhabitants, and with that, heroin and industrially manufactured stimulants (amphetamine, methamphetamine) have "pushed out" of the drug market substances that are prepared in domestic conditions (for example, ephedrine or *"hanka"*);

- a significant proportion of young first-time patients (to age 15) mentioned inhalants as the primarily used substance.

Information on the age and substances used indicates that 1) heroin is mostly indicated as the primary-use substance by two age groups or approximately two thirds of patients aged 20–29 and 30–34 years, 2) amphetamines are used more often by 15–19–year-olds, and 3) for those who are younger than 15 years; inhalants are indicated as the primary-use substance. As the number of patients treated for the first time in individual substance groups by various age groups is small, this must be borne in mind when interpreting the results.

Treatment data for the 2008 continue indicating a trend that every year, increasingly more first-time patients come from outside capital city Riga, for example, in 2002, 63% of patients treated for the first time lived in Riga, while in 2008, only 44% did so (in 2007 – 45%) *(see Figure 5.9)*. Such data are evidence of the fact that drug use has spread significantly outside Riga, a conclusion also reached by others *(Dialogs 2008).*

Figure 5.9. Number and proportion of first-time clients living in Riga city



Source: PREDA 2009

The employment status and education of first-time patients are examined in the chapter on Social Exclusion, for, as with education, employment prospects are also affected by the drug user's integration into society, the employment market etc. *(See chapter on Social Exclusion)*.

In-patient treatment

Inpatient data collection peculiarities does not allow very good comparison of comparing trends data on the most recent year of reporting with the previously reported figures because data from the treatment centres is submitted only after discharge. Thus patients in long-term residential treatement programmes are underestimated for 2008 data, and similarly number of long-term clients in 2007 were underrepresented in 2008 NR, as well as the figures reported in Fonte. After receiving a database update in March 2009 long-term patients in the residential programmes have been included and the figures have been recalculated and re-submitted. Such a reporting system does not fully comply with the UNODC and EMCDDA definitions, and does not provide precise information regarding the number of treated patients for the relevant year.

Still as long-term residential programmes for adolescents are funded by the Ministry of Welfare, data on children is not reported to the central database held by the Riga Psychiatry and Addiction Centre. Annually around 100 adolescents participate in these programmes. Additionally, private in-patient drug treatment centres as well as prison hospital do not provide individual level data on their clients.

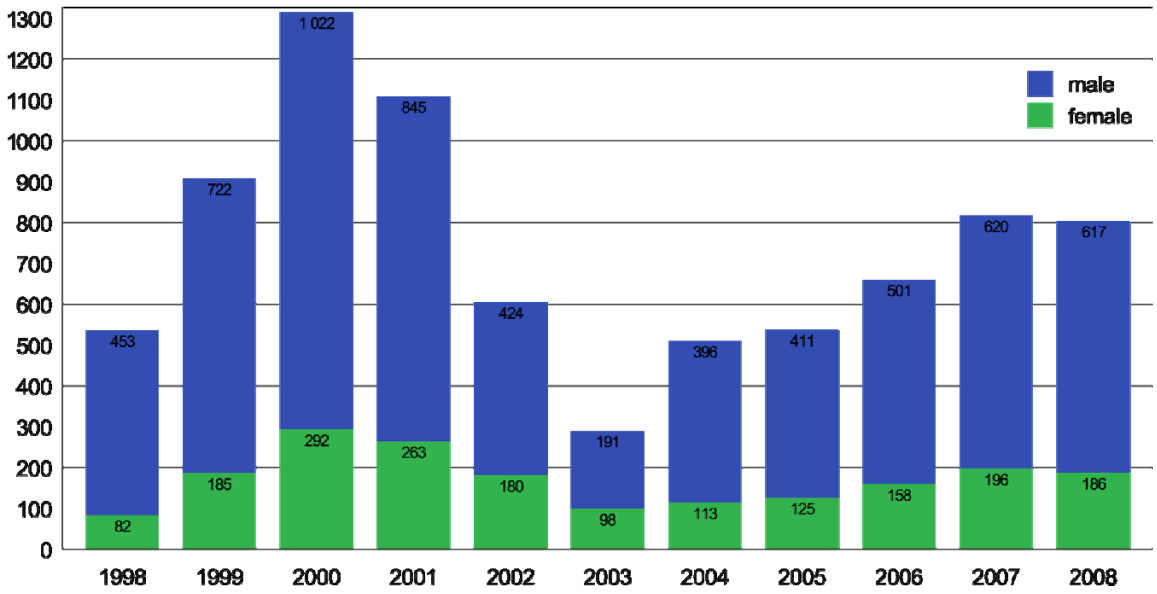
Information regarding specialised drug addiction inpatient clinics is collected by the Riga Psychiatry and Addiction Centre using an approved form on which, in addition to personal information, information on patient's education, employment, primary and secondary diagnosis (according to ICD–10 criteria), and primary and secondary substances used is included, which is partly compliant with the TDI protocol.

Apart from the difficulties in the data collection, data suggests that in 2008 803 patients have been treated at public inpatient treatment programmes, while recalculated data for 2007 suggests there were 816, and it seems that after including those who are in long term residential treatment programmes the number of clients as compared with 2007 had increased *(see Figure 5.10)*.

Among all treated clients at in-patient treatment centres in 2008, 186 (or 23%) were females, which, as compared with 2006 data, have remained at about the same level *(see TDI in-patient in Fonte[31])*.

The mean age for all treated clients in 2007 was 26.6 years, slightly higher for females (27.1) then for females (26.5).

Figure 5.10. Number of all treated clients at inpatient treatment centres, absolute numbers by gender

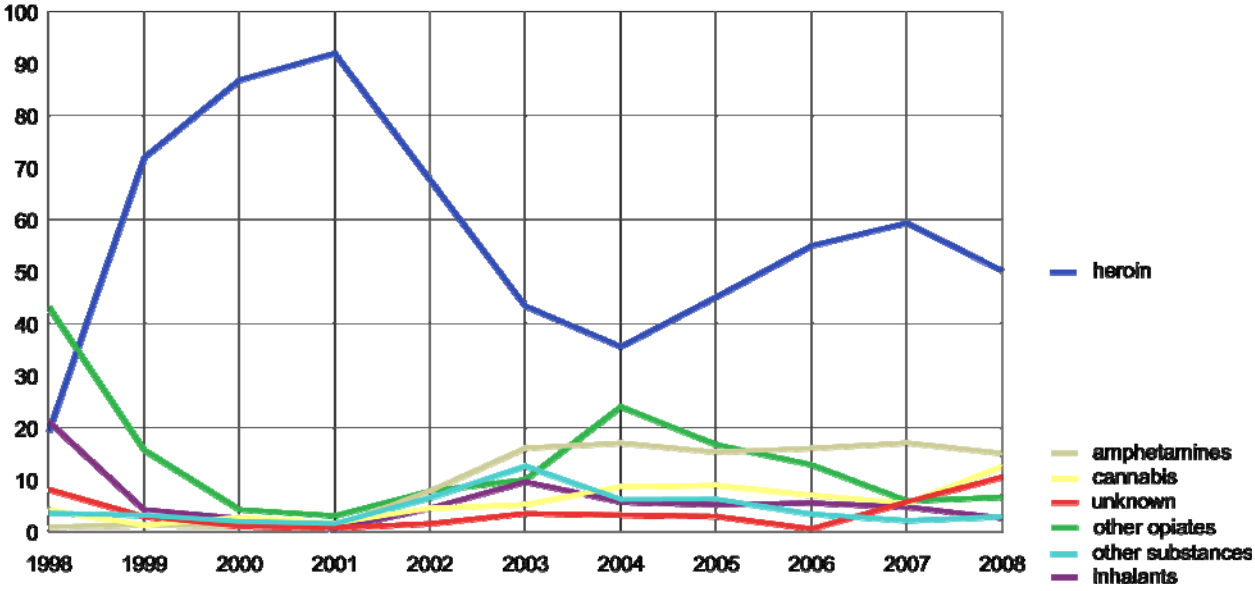


Source: Riga Psychiatry and Addiction Centre/ The Centre of Health Economics 2009

In 2008 the last treatment episode in 50% cases was related with the use of heroin), while for 15% – primarily with the use of amphetamines *(see Figure 5.11 and TDI in-patient table in Fonte[32])*. As compared with the data from previous years and as compared with outpatient data – the most common substance among patients is heroin.

[31] TDI_2009_LV_02
[32] TDI_2009_LV_02

Figure 5.11. Selected primary substances used by inpatient treatment clients 1998–2008 (%)



Source: Riga Psychiatry and Addiction Centre/ The Centre of Health Economics 2009

5.4. Trends of clients in treatment

See Chapeter 5.3. Characteristics of treated clients

6. Health correlated and consequences

Indicators on drug-related infectious diseases and drug- related deaths and mortality among drug users are two important indicators that give the most part of all data related to drugs and drug use. For the period of last three years, there have not been significant changes in numbers of newly registered HIV cases. This can be explained by the important role of work of syringe exchange counselling points. Now the main problem is the change of HIV infection transmission route from injecting drug users to heterosexual transmission.

What relates to hepatitis B and C, there are still a lot of so-called hidden cases and the real number of infected persons – drug addicts – is much higher. Unfortunately, there are no data on other drug-related infectious diseases available.

For analysis of drug-related deaths two data sources are used – General mortality register and Special mortality register.

6.1. Drug-related infectious diseases

Notifications data

HIV/AIDS

In Latvia, data on the morbidity of HIV/AIDS is collected and analysed by the Infectology Centre of Latvia (previously Public Health Agency). In 2008, a total of 152,010 blood samples were examined, which is 3,391 samples more than in 2007, but 1,183 samples less than in 2006 (included in the total number of samples are state funded tests, privately undertaken tests, and samples from blood donors). 863 tests were undertaken in 2008 to confirm the diagnosis of HIV, which is 71 tests less than in 2007, and 171 tests less than in 2006.

To the end of 2008, 4,339 cases of HIV infection had been registered in the State, 656 persons were registered with AIDS, and 212 persons had died while in the AIDS phase. By the end of 2007, 3,981 cases of HIV infection had been registered, while 485 persons were in the AIDS phase. During the past year, 358 new cases of HIV infection were registered in the State, eight cases more than in 2007. The number of persons in the AIDS phase is increasing each year.

In 2008, compared with previous years, the distribution of transmission routes has significantly changed, that is, in the past year, the majority of persons diagnosed with HIV has acquired the virus by heterosexual contact (163); intravenously using drugs (100 persons); in 65 cases, the route of infection is unknown; there were 22 cases of homosexual contact, and eight cases of a mother infecting her child. Previously, the major risk group were intravenous drug users; however, at present there is a significant increase in the proportion of sexually transmitted infections *(see Table 6.1)*.

The increased incidence of sexual transmission may be explained by the fact, that the majority infected were sexual partners of intravenous drug users. The numerical stabilisation in the level of infection by means of using injected drugs, as well as its proportional reduction, is determined by access to services for reduction in harm (including the needle exchange program), and the enlargement of this network since 2003.

In 2008, a total of 628 HIV positive persons were registered in Latvia's places of incarceration, which is 58 inmates more than in 2007. 72 new cases of HIV infection were registered within prisons as compared with 70 incident cases in 2007. In 2002 and 2003 the HIV prevalence indicators were slightly higher, at 766 and 803 respectively.

In 2008, there were 103 incarcerated persons in the AIDS phase – a slight increase as compared with 2007 when 97 in AIDS phases were serving their sentence. By comparison, there were only 23 inmates registered in the AIDS phase in 2002, but by 2003, the total had already risen to 59 *(Fedosejeva 2009).*

Table 6.1. HIV incidence, absolute numbers and percentage of known cases by transmission groups 2005–2008

	2005		2006		2007		2008	
	n	%	n	%	n	%	n	%
Intravenous drug use	114	50,4	108	50,2	141	48,6	100	34,1
Heterosexual contact	96	42,5	87	40,5	126	43,4	163	55,6
Homosexual contact	14	6,2	15	7,0	15	5,2	22	7,5
Mother–child	2	0,9	5	2,3	8	2,8	8	2,7
Total known route of transmission	**226**	**100**	**215**	**100**	**290**	**100**	**293**	**100**
Unknown route of transmission	73		84		60		65	
Total	**299**		**299**		**350**		**358**	

Source: Infectology Centre of Latvia 2009

Hepatitis A/B/C

A rapid increase in cases of hepatitis was observed as from November 2007. Between 20th November 2007 and 31th December 2008, 2817 cases of hepatitis A had been confirmed, with a further 419 cases being in the category of "suspicious". The infected individuals were aged between five months and 86 years (mean age 31.7 years).

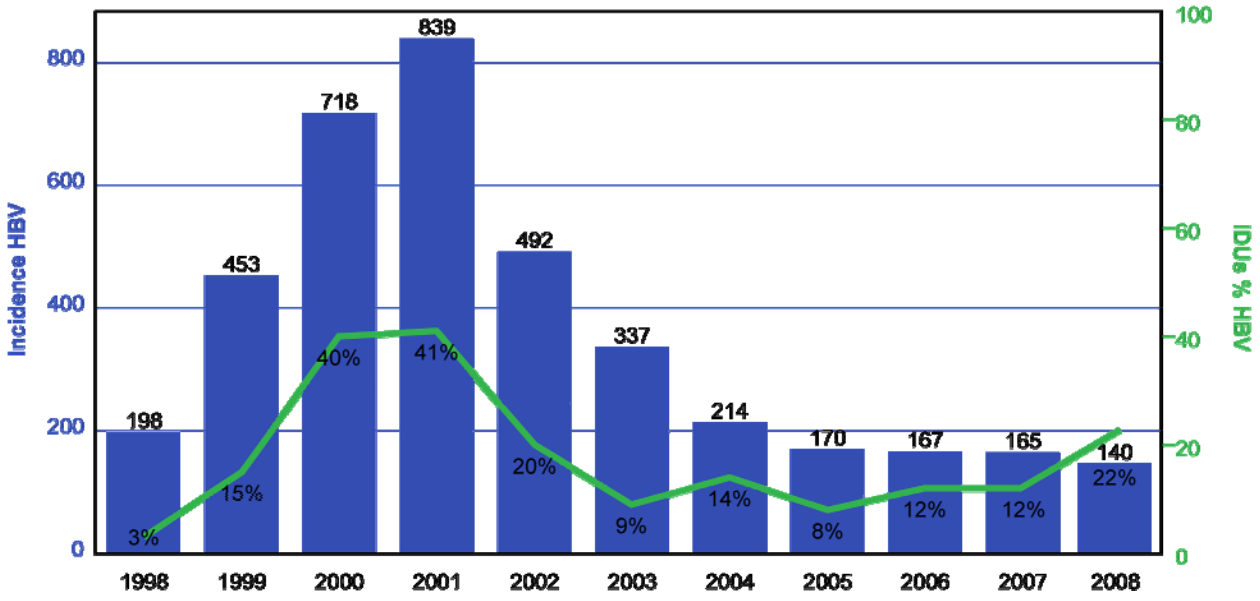
A similar epidemic had been previously observed in the period 1988–1990, when almost 20 thousand people had contracted hepatitis A. In the 2007–2008 epidemic, the majority of those afflicted were men (72% in the first six months), but during the remaining period (May-December 2008), 52% were men. This is partly explainable by the fact that a significant number of the afflicted were identified as intravenous drug users. During this period, 191 drug users were identified among hepatitis A patients; of those, 90% were intravenous drug users. In September 2008, the incidence of hepatitis A among drug users decreased. One possible explanation of this fact could be that the infection had already spread among users earlier, reached its highest point, and subsequently reduced more quickly than in the remaining population.

The majority of infected were registered in Riga and the Riga district. During the epidemic, 17 persons died from hepatitis, however, all the deceased had registered related illnesses or other increased risk factors, including the use of alcohol and/or drugs *(Perevoscikovs, Lucenko et al. 2008)*.

Since 2001, stabilisation is observable in the morbidity of hepatitis B and C; however, an increase in the incidence of intravenous drug users has been observable since 2005. For the moment this trend is difficult to explain unequivocally, as this the first time such an increase has been observable since 2001. One explanation could be the fact that opportunities for testing for hepatitis B/C are increasing; and users, thanks to the operation of harm reduction programs and information available in the mass media are possibly undertaking testing for these infections more frequently.

In Latvia in 2008, acute hepatitis B was registered for 140 persons (103 men and 37 women). Of the 140 persons, 31 persons (29 men and 2 women) were identified as drug users, comprising 22.1% of the total. The total number of persons infected with acute hepatitis B has slightly reduced in comparison with 2007; however, the number of drug users has increased by 10% *(see Figure 6.1)*.

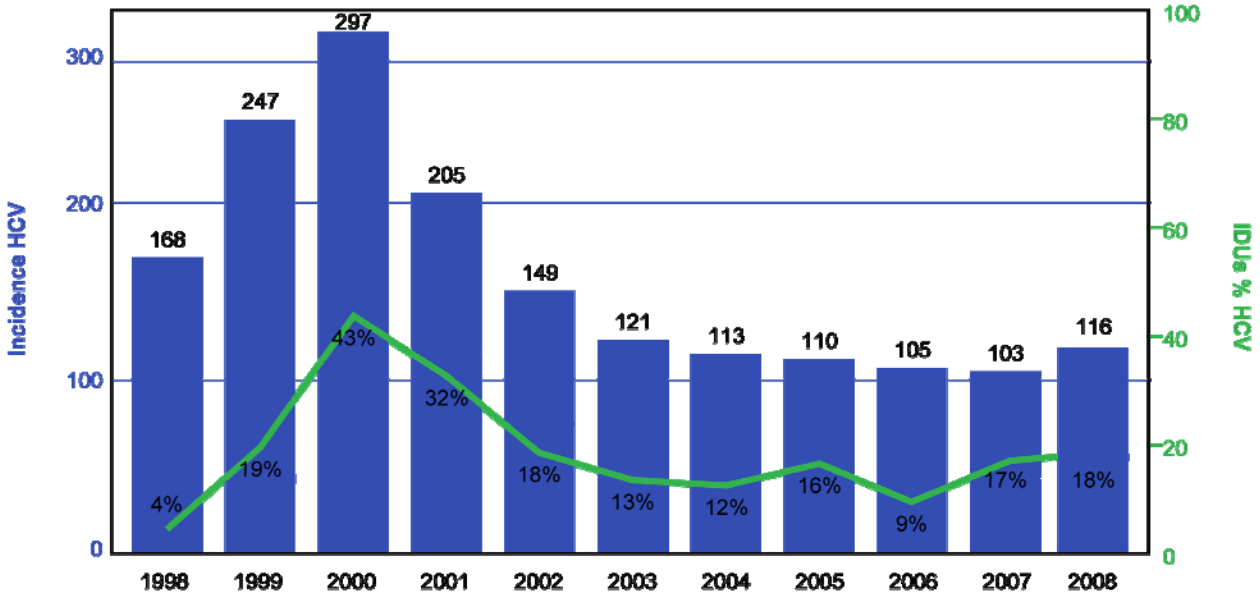
Figure 6.1. Incidence of acute hepatitis B and percentage of intravenous drug users among known cases, 1998–2008[33]



Source: Infectology Centre of Latvia 2009.

Acute hepatitis C was registered for 116 persons (64 men and 52 women). Of these, 21 persons (all men) were identified as drug users, comprising 18.1% of those infected. The incidence of acute hepatitis C in 2008 has increased by 13 cases as compared to 2007, while among drug users it has remained rather stable (see *Figure 6.2.)*.

Figure 6.1. Incidence of acute hepatitis C and percentage of intravenous drug users among known cases, 1998–2008[34]



Source: Infectology Centre of Latvia 2009

[33] See also Fonte ST9P4_2009_LV_02
[34] See also Fonte ST9P4_2009_LV_02

STIs and Tuberculosis

Data on the morbidity of tuberculosis is collected and analysed at the national level by the State Agency for Tuberculosis and Lung Diseases. The operational objective of the Agency is the prevention of tuberculosis and lung diseases, and reduction in morbidity of tuberculosis nationally.

In recent years, incidence of tuberculosis has reduced nationally, as has mortality from that cause; however, it is still a topical problem, among both drug users and persons suffering from HIV/AIDS.

Table 6.2. Incidence of tuberculosis per 100,000 inhabitants, 2000–2008

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Incidence per 100,000 inhabitants	70,5	72,9	65,4	63,3	59	53,5	49,7	47,2	40,3

Source: State Agency for Tuberculosis and Lung Diseases 2009

The State Agency for Tuberculosis and Lung Diseases also counts those patients having a dual diagnosis, namely, tuberculosis and HIV/AIDS. The number of patients suffering from both TBC, and HIV/AIDS has been increasing since 2000.

Table 6.3. The number of persons co-infected with tuberculosis and HIV/AIDS in Latvia, absolute figures

	2000	2001	2002	2003	2004	2005	2006	2007	2008
absolute figures	14	27	25	40	40	53	46	56	72

Source: State Agency for Tuberculosis and Lung Diseases 2009

Of all patients, 42% were unemployed at the moment of contracting the illness, 31% had misused alcohol, 26% had had close contact with a tuberculosis patient, 5% were identified as drug users, 6% were infected with HIV, 4% were incarcerated, and a further 4% were identified as homeless (*State Agency for Tuberculosis and Lung Diseases 2009).*

The Infectology Centre of Latvia gathers and compiles information not only on HIV/AIDS and hepatitis B/C, but also on other sexually transmitted infections. However, this information is not presently being analysed in relation to the use of drugs.

Compared with 2007, morbidity from sexually transmitted infections (syphilis, gonorrhoea, chlamydia, and genital herpes simplex infections) has reduced in 2008.

Table 6.3. Morbidity of sexually transmitted infections, 2001–2008 (in absolute figures)

	Syphilis	Gonorrhoea	Chlamydia	HSV
2001	594	551	589	51
2002	679	555	582	49
2003	784	481	502	52
2004	584	537	528	59
2005	443	694	729	90
2006	483	746	820	67
2007	301	669	711	98
2008	235	487	704	94

Source: Infectology Centre of Latvia 2009

Prevalence data

Research in the fields of HIV/AIDS and other STDs

In 2009, the Public Health Agency, as part of its ENCAP[35] project published a study: "Prevalence of HIV and other infections and risk behaviour among injection drug users in Latvia, Lithuania and Estonia in 2007" *(National Institute of Health Development 2009)*. The research was funded by the European Commission, with co-financing from the Public Health Agency, the Infectology Centre of Latvia, and the State Agency for Tuberculosis and Lung Diseases. The research was conducted in parallel in Lithuania and Estonia.

In Latvia during the 2005–2006 year, there were 130.3 new cases of HIV detected per one million inhabitants. In comparison, there were 504.2 cases detected in Estonia and 29.2 cases detected in Lithuania during the same period.

The aim of the study was to determine the prevalence and associated risky behaviour for HIV, hepatitis B/C, syphilis and tuberculosis infections among intravenous drug users in Riga, Vilnius and Tallinn. The study proposed such tasks as:

- to evaluate the prevalence of HIV, hepatitis B, C and syphilis among intravenous drug users;
- to determine the risk factors associated with HIV infection (sexual behaviour, knowledge of HIV transmission, drug use habits, socio-economic situations etc);
- to obtain data from intravenous drug users as to whether they had become involved in harm-reduction programs, whether they received treatment and other health care services, and also about incarceration;
- to determine the prevalence of tuberculosis markers among intravenous drug users.

In Riga, data were collected during the period September–December 2007. Information regarding behaviour was gathered with the assistance of a structured survey form. Samples of intravenous blood were taken from all respondents to detect HIV, hepatitis B, C, syphilis and tuberculosis infection markers.

Of the 407 respondents, 286 were men, 121 were women; the average age of respondents was 29.9 years. The majority of those surveyed were Russian nationals (217); 31 were of other nationality. The majority (167) of respondents had secondary level education, or primary level education (136). Only 16 respondents had highest (tertiary) level education. At time of interview, 156 respondents had temporary work, 140 had permanent work, 37 admitted being supported by the income of their partner/spouse or friend, 29 subsisted on state support benefits, 19 respondents' source of income was theft and robbery, 14 respondents were supported by their parents, six persons admitted being self-employed, while two people supported themselves by begging. The majority surveyed (200) had never been married, 109 lived with a partner, 44 were married but separated, 39 were officially married, five were widowed, and a further five were divorced.

In Riga, the average starting age for injecting drugs among this group of respondents was 20.2 years; average period of use (injecting) was 9.7 years. The average period between injections during the previous four weeks was 12.7 days, while 27.1% of respondents had injected every day during the previous four weeks. The average number of injections per day among those who injected every day was 1.8 times. In Riga, heroin and amphetamines were most often injected (45% and 44% respectively). 53.8% of respondents had used shared injection paraphernalia during the past four weeks. During the past year, 42% of respondents had had

[35] European Commission funded Project Expending Network for Comprehensive and Coordination Action on HIV/AIDS prevention among IDUs and Bridging Population Nr 2005305

two or more permanent sexual partners. In these contacts, 19.5% had used a condom on each occasion, while 55% of respondents had never used a condom. During the previous six months, 77.1% of respondents (n=105) had engaged in contact with two or more partners. 47.6% had used a condom on each occasion, while 32% had never done so. 60 persons admitted that they had shared injecting paraphernalia with their sexual partners.

By their self-report, 8.1% had suffered or were suffering from tuberculosis, 3.9% from syphilis, 8.4% from gonorrhoea, 3.4% from the genital herpes virus, 4.2% from Chlamydia, 31.9% from some form of hepatitis, and 15.1% from HIV. Almost all respondents admitted that they had undertaken testing for HIV and hepatitis B/C on at least one occasion during their lifetime. The table below reflects the serological test results from respondents.

Table 6.4. Serological test results (%) for all respondents (n=407)[36]

Result	HIV	HCV	HBV	HIV+HCV+HBV	Syphilis	Tuberculosis (n=387)
Positive	22.6	74.2	55.7	15.6	4	23
Negative	77.4	25.6	44.0	21	96	71.3

Source: National Institute of Health Development 2009

In Riga, the prevalence of latent tuberculosis among HIV-positive respondents was 17%; among HIV-negative patients, it was 23%.

Table 6.5. Detailed serological test results, number of cases

	Number of cases
B	10
C	53
B+C	90
HIV	1
HIV+B	1
HIV+C	19
HIV+B+C	46
TB	17
TB+B	2
TB+C	11
TB+B+C	39
TB+HIV+B	1
TB+HIV+C	3
TB+HIV+C+B	11
Sifil	1
Sifil+C	2
Sifil+B+C	5
Sifil+HIV+C	1
Sifil+HIV+B+C	4
Sifil+TB+B	1
Sifil+TB+C+B	3
Sifil+TB+HIV+C	1
Total	386
Missing	21
Total	407

[36] See Fonte ST9P2_2009_LV_01 (HIV), ST9P2_2009_LV_02 (HBV), and ST9P3_2009_LV_03 (HCV)

Behavioural data

With the financial support from the aforementioned project, a qualitative study among current injectors was conducted (Trapencieris, Snikere 2009). The main aim of qualitative interviews with drug users was to look for possible explanations of three areas of drug use that remained unclear after quantitative study conducted in Latvia. These were: 1) risk behaviour (syringe sharing or re-use), 2) use of low threshold centres, outreach workers and mobile units by IDUs and possible solution to improve these services and 3) use of pharmacies as the main source of new syringes and possible targets towards better coverage.

Within the project interviews with 10 IDUs were conducted using a set of previously defined questions. Apart from background information (e.g. age, nationality, family status, employment, etc.) the questions included formed several topics: 1) drug use (and injecting drug use) initiation and current use, 2) syringe sharing (current and past) as well as opinions on syringe sharing and re-use of syringes, 3) availability of syringes (low threshold centres, outreach workers and pharmacies), 4) use of services at low threshold centres/outreach workers and possible solution to improve those services, 5) drug treatment history, especially, use and opinions about pharmacotherapy (methadone or buprenorphine treatment programmes), 6) drug overdose (personal experiences and knowledge) and 7) tuberculosis (knowledge of treatment options). Apart from these themes existence (or non-existence) of drug taking and initiation rituals as well as recent developments in drug use 'on the street' (e.g. new substances, new users' groups) were discussed during interviews.

Out of ten people interviewed six were males and four were females. Age range of respondents was from 24 up to 42, while the length of (regular) drug use of respondents ranged from three to 18 years. Interviews with five people were conducted in Latvian, while the rest were held in Russian. All interviews were held in Riga (on two locations) with respondents coming from different areas of the city. Interviews were conducted by two interviewers who were native speakers of Latvian with good knowledge of Russian and with a high level of expertise of drug situation in the country.

Syringe sharing and re-use of own syringes

Out of ten respondents everyone but one has used syringes by sharing sometime in the past. There are differences in the present situation and most respondents try not to share at the moment, e.g.

> *"No, I don't [share] anymore but it has happened before. When you have the urge to shoot up I've taken somebody's syringe..." (FK25).*

Some respondents claim that they do not share syringes at the moment (or over the last year), some share with their partners only, some others – with people they know they can trust. Among respondents there were none who would share with strangers.

Among respondents and according to the information they provided on their friends syringe re-use is very prevalent - almost everybody mentioned re-use of personal syringes recently. e.g.

> *"I do not throw it away afterwards. I keep it because I know that it is mine. I would rather shoot up with a blunt one than to take from somebody else." (FK25) or*

> *"well, one syringe can be used for four or five days until the needle gets blunt. It [syringe reuse] happens because at pharmacies syringes are expensive..." (FA28).*

One respondent has a hepatitis C and according to him he tries to be honest with others by not giving his previously used syringe to other people. He would also expect others also to be honest about their infections.

"There were several situations that I take a syringe after somebody. ...Yes, it happens... it has happened only several times a year" (MA27)

"If there was such a situation that somebody would be willing to use a syringe after I have used it – I would throw it away and would not give because I am infected with hepatitis" (MA27)

When talking about syringe sharing in the past, one respondent stresses out there was a time in the past when he did not care about anything in the world and then shared with others.

" … I even know the person I got infected from... I knew that this person was sick but there was such a period [in my life] for several months that I wanted to spit on everything in the world, I don't know, from one person..." (MA27)

One respondent mentioned that he is not sharing syringes since 2002 because he has got all possible infections and thus is not sharing with others.

"You know, over the last years - no [I do not share]. The last time I used one [syringe] somebody else has used before was in 2002. I know it for sure. The biggest plus for me is that I am alone. I don't like being with others. And in cases of I am together with somebody I give him a new syringe. But, I have everything one could get by sharing syringes..." (MM42)

Several reasons for syringe sharing can be pointed out:

- once one gets his dose it has to be used rather quickly and there is no time for considerations about health.

  "... when one gets that powder he gets unrest to find some staircase or some other place to inject, where he could perform that operation. And then it does not matter whether that syringe is infected or clean. I can remember for sure, I have been in such situation and this is why I try to escape those hangouts." (MM42)

  "...well, when you have the urge to inject, when everything is mixed in one spoon... if there is no other [syringe], you cannot walk down to the pharmacy... You inject and then only later start thinking about the consequences, about it – that it is dangerous." (FK25)

  "It is because when you have drugs , nobody actually thinks – just to inject as quick as possible, then you don't care. In general they do not think that something can happen. Something like – as was ordained by fate. They think only after they have got some shit." (MR32)

  "... maybe there is not enough patience because... for example, to buy [a syringe] in pharmacy one needs to go somewhere, maybe there is no patience... just [to inject] quicker and quicker." (MA32)

- drug users involved in syringe sharing know they are infected with the same infection, e.g. hepatitis C or HIV.

  "I know two persons who, well, both have that hepatitis C; both are sick and then they, in principle, don't care. Even if they have several syringes available, they do not sort which is which – they just take one and then inject one after another..." (MD24)

- at night time when pharmacies are closed or some other times when a clean syringe is not available.

"... when there is no other syringe and it is night time and pharmacy is closed then, of course, yes [my friends would share]" (FK25)

- sharing of other equipment

"it [syringe sharing] has happened in companies when there are other people... usually there is only one water. Well, even if everybody has got own syringe, the water only... there is only one bottle where to wash that syringe. And then sometimes maybe that friend gives you telling it being new." (FI32)

- sharing only with partner

"well, I shoot up with my boyfriend. Lately each of us kinda has own syringe but, of course, they exchange because of mistakes all the time..." (FA28)

"...usually it is me and my boyfriend and we do not let others close to us. I don't know, but then it's always swearing, so we don't let others close. We just don't like contacting others." (FA28)

Availability of syringes and pharmacies

Among respondents in general there were two kinds of drug users. A few of those interviewed can be classified as being 'smart' and are getting the necessary number of syringes for injections either from outreach workers or at pharmacies. One of the main reasons for getting syringes at pharmacies is the location or proximity, e.g.

"I think the reason is because in Riga there are only two exchange points and I haven't seen those people on the streets, you know those social workers. And the pharmacy is every five blocks. Just go in and buy." (MM42)

"well... I guess because it [the pharmacy] is closer. They [syringes] are not that expensive and you cannot buy anywhere else but at pharmacy. And those exchange points, as long as I know, are two – Dzirnavu street and here... and they are not open at anytime, for example they are not open during night time, when you need that syringe." (FI32)

"it is more convenient. It seems the pharmacy is closer. Well, and he would go there... and... buy that syringe" (MA35)

On the other hand the majority are either re-using old syringes or are sharing them. Sometimes also because of the high price they have pay IDUs would prefer re-using old one. The prices that were mentioned for a syringe ranged from 0.09 Lats to 0.40 Lats (0,13-0,57 EUR). According to the respondents the price depends on where the pharmacy is located, e.g. in Mezciems syringes are cheaper than in Jugla or Teika. Drug users mentioned that when buying syringes during the night time one has to pay additional service fee thus sometimes price also plays role in choosing to use a new syringe or use the old one. For some others price is not a factor, e.g.

"No, it is not that I don't like those working here or that syringes are bad. To put it simple – they are not that expensive. For example, if I break the old one I can buy it at pharmacy. It costs 10 or 15 santimes." (FI32)

Additionally drug users stressed that not all pharmacies are selling syringes to drug users – pharmacists then usually are saying that they do not have syringes at all for sale.

Sometimes choice between sharing and re-using of old syringes and using a new syringe is made towards the first option because of lack of 'good' syringes either at pharmacy or from low-threshold services.

"For example, this girl I know – she injects something expensive. Those syringes that are available at DIA+LOGS are too thick because she cannot hit [the vein]. She kinda takes them but gives them away ... and buys [syringes] for herself at pharmacy because those are thinner. I kinda don't care [as regards what kind of syringe he uses]." (MA27)

It was mentioned that several times a year low-threshold centres as well as some pharmacies lack insulin syringes, which most IDUs prefer.

"... it was because you [the centre] were closed for seven days... just because of that. We would come and here... But anyway it is that... that you have these... um... well these syringes you have here ... they are not good!"

6.2. Other drug-related health correlates and consequences

Advances in data collection

In 2009, as a result of negotiations that started in 2007, between the National Focal Point and the Health Payment Centre, a large dataset with around one million out- and in-patient treatment episodes was obtained. The aim of this data collection is to estimate the burden of patients with alcohol and/or drug-related disorders on the health system, thus all primary and specialist treatment episodes for the alcohol and drug clients has been collected. As the data was obtained in late 2009 there was insufficient time to conduct analysis for inclusion in this years' national report but it will be further analysed reported in 2010.

Co-morbodity

Another way at looking at health correlated and consequences is the analysis of comorbidity based on the PREDA data on mental health patients. This dataset includes patients from general psychiatry services across the country, and annually around five thousand incident cases with ICD-10 F-codes are recorded in the database; it excludes persons with primary diagnosis of substance use (F10-F19). The dataset allows estimating simultanously diagnosed comorbidity with primary psychopathology other than substance use.

As data reveals the level of under-reporting (or under-diagnosing) is very high, e.g. among 5021 incident cases of patients with primary mental health problem, only 68 (or 1.4%) have co-occuring substance use problem, of which in most cases alcohol harmful use or dependence-related is reported. Other substance use or dependence is diagnosed in even less cases *(see Table 6.6)*.

As the new PREDA data collection (for description of new system see chapter on treatment) system allows linking of individual-level data between various registries. In 2009 an exercise linking TDI data and database on mental health patients was carried out. Preliminary analysis of comorbidity among clients in substance abuse treatment suggests that around every fifth drug user (19%) who had been treated for their drug problem between 2001 and 2008 has been diagnosed with mental health problems before or after first treatment for substance use disorders; the most common firstly diagnosed mental health problem for SUD clients is behavioural and emotional disorders with onset usually occurring in childhood and adolescence, followed by organix mental disorders, and neurotic/stress-related disorders *(see Table 6.7)*.

Table 6.6. Simultaneously diagnosed primary psychopathology with substance use, number and percentage of incident cases 2003-2008

	2003	2004	2005	2006	2007	2008
Opiates (F11)	3	4	3	0	3	3
Cannabis (F12)	0	3	1	0	0	2
Sedatives (F13)	6	4	1	1	3	1
Cocaine (F14)	0	1	0	0	0	0
Stimulants (F15)	1	2	1	1	4	1
Hallucinogens (F16)	0	0	0	0	0	0
Solvents (F18)	0	1	2	2	0	3
Poly-drug (F19)	5	4	7	1	6	2
Alcohol (harmful use – F10.0-1)	25	18	19	22	16	10
Alcohol (dependence – F10.2-9)	75	65	51	56	57	46
Total	**115**	**102**	**85**	**83**	**89**	**68**
	6292	**5938**	**5700**	**5234**	**4989**	**5021**
Incidence of psychopathology	**1,8%**	**1,7%**	**1,5%**	**1,6%**	**1,8%**	**1,4%**

Source: PREDA/NFP estimates 2009

Table 6.7. Prevalence of mental health problems among primary drug treatment clients, percentage of first treatment clients 2001-2008

	2001	2002	2003	2004	2005	2006	2007	2008
Any mental health problems *(F00-F98, excluding F10-F19)*	14,6	20,8	21,4	24,8	21,1	21,5	16,5	19,0
Of these:								
Organic, including symptomatic, mental disorders *(F00-F09)*	30	30	21	27	27	23	23	21
Schizophrenia, schizotypal and delusional disorders *(F20-F29)*	8	10	15	8	5	11	9	8
Mood (affective) disorders *(F30-F39)*	6	3	5	2	4	3	3	2
Neurotic, stress-related and somatoform disorders *(F40-F48)*	19	17	11	11	16	15	22	15
Behavioural syndromes associated with physiological disturbances and physical factors *(F50-F59)*	0	2	0	1	0	1	1	0
Disorders of adult personality and behaviour *(F60-F69)*	8	7	3	3	4	4	3	3
Mental retardation *(F70-F79)*	9	6	13	15	8	10	11	9
Disorders of psychological development *(F80-F89)*	2	2	6	6	5	15	8	10
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence *(F90-F98)*	18	22	26	28	33	18	20	33
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: PREDA/NFP estimates 2009

Further work on analyzing this dataset is planned for 2010 and will be reported in next National Report.

6.3. Drug related deaths and mortality of drug users

Deaths associated with drug use are a complex phenomenon and comprise a significant percentage of all deaths among young people in many European countries. The European Monitoring Centre for Drugs and Drug Addiction in cooperation with national experts from

member states has defined an epidemiological indicator having two components: deaths directly caused by illegal drugs, and overdosing and deaths among problem drug users.

In Latvia, information on cases of death associated with the use of drugs is compiled and analysed by two institutions – the Centre of Health Economics[37] (CHE) is responsible for the data contained in the national *General Mortality Register (GMR)* and the *Causes of Death* database, and the Latvian State Centre for Forensic Medical Examination (LSCFME) is responsible for the data in the *Special Mortality Register (SMR)*). The *Causes of Death* database administered by the CHE includes information on the whole state and is based on death certificates which are initially forwarded from all parts of the country to the Central Statistical Bureau of Latvia and subsequently, on a monthly basis, to the CHE, where the received data is encoded, entered into the database and analysed.

The chief operational function of the Latvian State Centre for Forensic Medical Examination is conducting autopsies.

Both institutions cooperate, and throughout the year compare data bases of deceased persons, as initially the data held by both institutions are different, because when a person dies, a death certificate showing a possible cause of death is written immediately, but the result of a subsequent autopsy is received later. If the diagnoses (initially written and subsequently revealed) do not correspond, they are referred for amendment. For this reason, the databases of both institutions are regularly compared and essential amendments are effected to the very end of the current year.

Statistical information

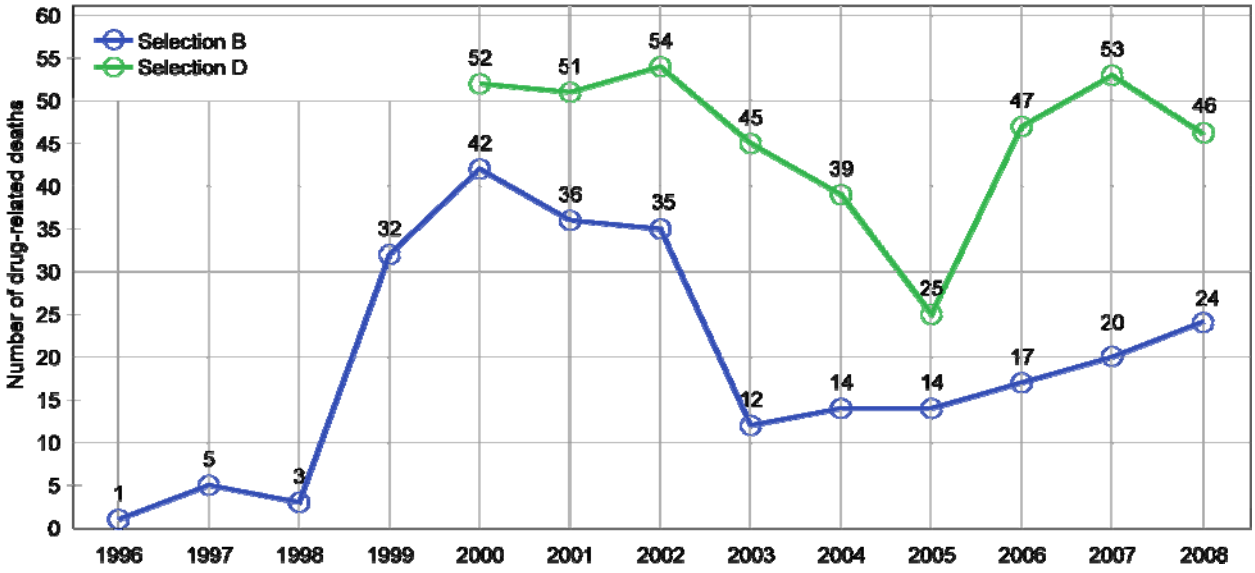
According to GMR data, in 2008 there were 24 deaths registered associated with the use of drugs, which is four cases more than in 2007 and 7 cases more than in 2006 *(see also Selected Issue on amphetamines)*. Of the cases registered as drug-related deaths, the mean age of deceased persons was 29.5 years; youngest person was 19 years old, while the oldest – 57 years old. The majority were men (17 men, 7 women). Of all drug-related deaths intentional poisoning (X61 and X62) was registered in one case, in two other cases – by poisoning undetermined intent (Y11 and Y12), while the majority of cases were accidental poisoning (X41 and X42) by various substances.

In 13 deaths (out of 24) morphine (T40.2) was determined to be the substance leading to death, of which in five morphine-related deaths also ethanol was involved. In total in 2008 four deaths were caused by stimulants (T43.6) – two cases with methamphetamine deaths, one case – amphetamine, and in another case – MDMA. One fentanyl-related death was registered in 2008. Unspecified other narcotics (T40.6) were mentioned in six deaths.

Another nine deaths in 2008 had occurred involving psychotropic medicines (T42), of which three deaths were barbiturate-related (T42.3) and four deaths involving benzodiazepines (T42.4) as the leading cause of death.

[37] Established in accordance with Cabinet Order 509 of 29 July 2009. "On The Reorganisation of State Administration Institutions Subordinate to the Ministry of Health", assuming certain functions from the Public Health Agency, Medical Professional Education Centre, Health Compulsory Insurance State Agency, Health Statistics and Medical Technologies State Agency, which had until then maintained the GMR.

Figure 6.4. Cases of death involving the use of drugs 1996–2008[38]



Source: GMR and SMR 2009.

According to SMR data, in 2008 46 deaths were registered in respect of persons who had used drugs or psychotropic substances (37 men, 9 women). Compared with 2007, according to SMR data, a reduction was observed in the number of deaths for persons whose biological environment revealed drugs, practically identical to the situation in 2006, when 47 persons were registered.

It must be acknowledged that the number of deceased persons associated with the use of drugs could actually be much greater; firstly for the reason that toxicological analyses were not undertaken for all the deceased, and secondly, it is possible that the existing equipment is unable to detect the presence of some new substance, and thirdly, the possibility exists that some substances evaporate more rapidly.

Autopsies are undertaken at the LSCFME; the need for an autopsy is determined by the police or a family physician. During 2008, 846 autopsies were conducted at the LSCFME, 1060 autopsies were conducted in the previous year. Cabinet Regulation No. 215 "Procedures for determining brain death and biological death, and for referring a deceased person for interment", which came into force on 12 April 2007, stipulates that a person's death shall be determined by a family physician, who shall also complete and issue a Death Certificate in the event of a "normal" death. In the case of an unnatural or violent death, the decedent's corpse is referred by the police for autopsy. In the case of an unnatural or violent death, the cost of the autopsy is funded by the State. The main problem and explanation for the fact that during the past year in particular, the number of autopsies conducted has sharply decreased, is the previously-mentioned Cabinet Regulation. There are concerns that not always does a family physician refer a corpse for autopsy and toxicological analysis, but instead registers some other cause of death. This could lead to a situation where the number of deaths attributed to drug overdosing in future periods could be "inexplicably" reduced.

Research

In 2008, in collaboration with the EMCDDA, NFP specialists and experts from the Czech Republic National Focal Point, an evaluation was undertaken of the mortality among persons treated to drug use during their lifetime in Latvia, combining individual-level data from the *State Register of Persons with Drug Dependence and Substance Misuse* (as of 2009 – PREDA) and the *General Mortality Register*. The results obtained established that:

[38] See also Fonte ST5_2009_LV_01 (Selection B), ST5_2009_LV_02 (Selection D), ST6_2009_LV_01

- of 5323 surveyed drug users during the period 1999–2006, 279 (or 5.2%) had died;
- the majority (70%) of decedents had indicated heroin use during their final treatment episode;
- the average age at death of treated drug users was 27.08 years;
- the most frequently indicated cause of death was "external cause of death" (176 cases), including drug overdosing (48 cases). A large number of decedents indicated as cause of death various diseases of the cardiac or pulmonary systems;
- mortality among drug users in comparison with inhabitants of the same age group who did not use drugs was observed to be 7.5 times higher; 5 times higher among men and 13 times higher among women.

7. Responses to health correlates and consequences

7.1. Prevention of drug related emergencies and reduction drug-related deaths

Emergency medical assistance provided in Latvia is free of charge to all its citizens, but as yet the Reitox Latvian National Focal point does not have data from the ambulance services. In the near future, it is planned to commence work with those services, as well as the largest of hospital emergency departments in the country, to identify persons who have received assistance in drug overdose cases.

An important role in preventing drug overdose is played by the pharmacological treatment programs for opioid-dependent patients. Major legislative amendments were adopted in Latvia in 2008 to provide opportunities for expansion of methadone programs (to date, treatment with methadone has been possible only in Riga, at the Riga Psychiatry and Addiction Centre).

Similarly, a significant role in reducing overdose is performed by low threshold centres, where staff informs users about safe use and what to do in the event of a suspected overdose. Unfortunately, due to reduced funding there has been a sharp reduction in the number of street social workers.

Thanks to the European project "Expanding Network for Comprehensive and Coordinated Action on HIV / AIDS Prevention among IDUs and Bridging Population, ENCAP", a booklet was issued entitled *"Overdose. Information for drug users"* in Latvian and Russian. The booklet provides detailed information about the symptoms of overdosing with opiates and stimulants, first aid, etc. The booklets, as well as free advice, are available at all needle exchange counselling points.

7.2. Prevention and treatment of drug-related infectious diseases

The prevention and treatment of infectious disease related to the use of drugs

Pursuant to Ministry of Health Order No 105 of 18 June 2008, a coordination commission to limit the prevalence of HIV, tuberculosis, and sexually transmitted infections began operating in Latvia. The commission's aim is to achieve for the public a reduction in the prevalence of dangerous illnesses, and the submission of mutually co-ordinated measures and proposals for the implementation of health policy. The commission is comprised of specialists in this field and policy planners. Participating in the commission are representatives from the Ministry of Health, the State Agency for Tuberculosis and Lung Diseases, the Infectology Centre of Latvia, the World Health Organisation, the Ministries of Education and Science, the Riga Psychiatry and Addiction Centre, the national armed forces, Latvian Prison Administration, The Latvian Association of Local and Regional Governments, Ministry of Children, Family and Integration Affairs, and from other non-governmental organisations.

Prevention

According to data from the *Human Immunodeficiency Virus HIV Infection Control Program for 2009-2013*, by 1 December 2008, 14 HIV prevention points had been established in 13 municipalities, which contribute to limiting the spread of HIV infection among injecting drug users. From July 1999 until the end of 2007, these locations assisted 11770 injecting drug users. Consultations with social workers and psychologists also are available at these points; clean syringes and disinfectants are issued, contraceptives and informative materials are distributed. Testing for HIV and hepatitis C is available free of charge. The centre also

administers and coordinates the work of several street social workers who undertake consultative work on the street or in places where drug users gather, and issues/exchanges clean syringes for used ones, and issues disinfectants and contraceptives. In several districts a special bus travels a designated route.

Bearing in mind the rapid spread of hepatitis A in 2007 and 2008, there was a rapid increase in the number of vaccinations against this disease. So, for example, while 1815 people had been vaccinated in 2006, 2912 in 2007, and in 2008, 8880 people were vaccinated against hepatitis A. It must however be noted that in Latvia, a fee is charged for vaccination against hepatitis A and during this period, the Public Health Agency together with Ministry of Health invite inhabitants to observe hygiene and to report indications of hepatitis A spreading or symptoms of becoming ill with this disease *(Perevoscikovs 2008)*.

Treatment

One of the largest treatment institutions for infectious diseases is the Infectology Centre of Latvia, which is subordinate to the Ministry of Health. The aim of the Centre is to provide informative support to state administration institutions and the public, and methodological and organisational support to the Ministry of Health in the formation implementation of infectology policy, and to provide highly qualified and high-quality specialised outpatient and inpatient secondary and tertiary level medicinal assistance to persons suffering from infectious diseases (including rare diseases, HIV/AIDS, sufferers from sexually transmitted or parasitic diseases), and to also undertake the specific prevention of, and research into infectious diseases.

According to data from the ENCAP study *(National Institute of Health Development 2009)* 23% of respondents (10 persons) received antiretroviral therapy *(for more information see chapter 6.1)*

Prevention and treatment in places of incarceration

All newly incarcerated persons voluntarily provided blood samples for the diagnosis of HIV infection; pre-and post-test consultations were provided. Testing for HIV was repeated at the request of the prisoner, or in accordance with medical indications, but was compulsory for all prisoners being treated for tuberculosis. Monitoring of their immunological status was undertaken 3-4 times per year for HIV infected prisoners; they received consultations 3-4 times a year from Latvian infectology medical specialists. Treatment for AIDS patients was provided where necessary *(Fedosejeva 2009).*

8. Social correlates and social reintegration

In Latvia, social exclusion has been studied within the framework based on the poverty issue, although it is a multidimensional phenomenon that may include many inter-related factors. Two data sources for reflecting social exclusion associated with drug use are used in the framework of the National Report: treatment demand indicator data, and data from the study undertaken every year on problematic drug users. Neither data source for reflecting social exclusion is complete, so in the future there is a need for a separate study or to add certain indicators to the annual cohort study.

In of the majority of cases the social reintegration of drug users is associated with social rehabilitation, but substantial differences exist between these concepts. Rehabilitation may be regarded as one of the stages of reintegration. In recent years in Latvia, several programs were developed to reduce social exclusion, but a separate document, which would directly stipulate the reducing of social exclusion or their social reintegration for drugs users, does not exist.

8.1. Social exclusion and drug use

The issue of drug-related social exclusion is multifaceted and complex and, although we previously indicated in last year's National Report that data available in Latvia do not permit a proper analysis of social exclusion, it is however possible to reflect basic information on this issue using data from treatment demand indicators and studies.

Since there has been no study undertaken in Latvia that directly reflects social exclusion in connection with drug use, two standard dimensions or indicators are used as the basis: employment and education level.

At the end of 2008, there were 76 435 unemployed persons registered in Latvia, which is 24 114 more unemployed than a year ago. As previously, most of the unemployed were women between the ages of 45 to 59 years. Most of the unemployed people had general education, while 1 417 persons had lower than primary education level. In 2008, of the 76 435 unemployed, most could be defined as "problem group" unemployed. For example, of 8 466 registered long-term unemployed[39] persons, 4 458 were disabled, 10 404 were young people aged 15–24, 2 853 were on parental leave, 227 were persons released from prisons and 8 354 were persons of pre-retirement age. Following a deterioration of the economic situation in the country, in September 2009 there were 147 754 registered unemployed (more than two-fold increase) persons in total (*State Employment Agency 2009).*

In 2008, there were 803 hospital-treated patients (617 men and 186 women). Among both men and women were included a relatively large number of unemployed persons. For example, among men only 16% of patients were in regular official work; among women - 10%. At the same time, a large number of patients exists whose occupation is not specifically defined or is unknown. Compared with 2007, it must be concluded that no major changes have occurred. In 2007, 816 persons were treated as inpatients - about 13 people more than a year later. Gender distribution and employment status largely remained unchanged.

A year earlier, in 2007, 16% of all in-patient male clients (n=620) were in regular employment; 22% were unemployed. It can be concluded that the unemployment rate for male in-patients has increased by 5%, which is probably related to the overall increase in unemployment throughout the country. In 2007, 12% of female in-patients (n=152) were in regular employment, while 35% of female in-patients were unemployed.

[39] Unemployed for more than one year.

The available data, because of its poor collection and compilation, does not reflect the real situation, because, firstly, the definition of "unemployed" would refer to a person who has acquired the status of unemployment, but this information is unavailable. Secondly, it not possible to comprehend the large number of patients with occupational status defined as "other", and finally, thirdly, a high proportion of persons remains for whom the occupational status is unknown. Similar problems can be observed in the data on patients' level of education, where the educational level is not specified for a significant number of patients.

Most of the in-patients treated in 2008 had completed primary or secondary education. Only 0.3% of men and 3% of women[40] had higher (tertiary) education. A similar division was observable in 2007.

Although the treatment demand indicator is an important provider of data, the indicators do not give a complete view of social exclusion; and it is therefore necessary in the future to undertake a separate study or to improve existing data collection systems, incorporating social exclusion indicators.

In subsequent years it is planned to include additional issues regarding problem drug users in the cohort study. The data acquired during cohort study stages has already provided a relatively wide range of information on drug users.

Cohort studies were commenced in 2006, when the survey questionnaires from 553 users were accepted as valid, 618 a year later, and 634 in 2008. In 2008, 64% of respondents were male, 36% were women (Trapencieris, Snikere *et al*. 2008). The mean age of respondents in 2008 was 29.8 years. The majority of respondents (68%) were Russian by nationality; 22% were Latvians, and 10% were of other nationalities (mostly Roma people).

Table 8.1. Nationality of drug users, %

	2006	2007	2008	2009	Official data[41]
Latvian	33	27	22	22	59
Russian	56	63	68	68	28
Other ethnic minorities	11	10	10	10	13
Total	**100**	**100**	**100**	**100**	**100**

Source: Trapencieris, Snikere et al. 2009

In assessing the level of education, it can be concluded that most respondents had secondary or primary education, 33% and 22% respectively. 8% have incomplete primary education, 14% had incomplete secondary education or vocational education without secondary; 19% had secondary special/professional education; 3% had incomplete higher (tertiary) education and only 1% of the respondents had higher (tertiary) education. If we compare all three stages of the cohort study, it must be concluded that no major changes in education levels have been observed and the distribution is approximately equal.

Employment opportunities closely follow education levels. 27% of the respondents indicated that they neither worked nor studied. Only 3% of users were officially registered as unemployed with the State Employment Agency. 25% had an official job, 28% worked under a verbal agreement, 5% were studying, while 24% indicated other employment status. As in society in general, here too the majority of unemployed were women. 61% of drug users surveyed indicated their current profession. As previously, slightly less that a third of employed persons (30%) noted that they worked in the construction industry; the proportion of drug users is considerably lower among workers in other sectors. The most popular professions are loaders (7%); sales (6%), guards or security personnel (5%); unskilled labourers (3%), and prostitutes (3%). 10% indicated working in various jobs.

[40] Primary education = completed 9 classes; secondary education = completed grade 12.
[41] According to the official data from Statistics Latvia, 2007

The majority of problem drug users lived with a partner or with their parents. Men more often than females live with their parents. More than half of the respondents lived with someone who abused alcohol and/or drugs. This phenomenon is especially widespread among women. This greatly hampers the giving up of drugs by these individuals.

Social exclusion is largely, also associated with the severity of a person's addiction. In the 2007 and 2008 stages of the cohort study, respondents were asked to answer five questions, which describe their own evaluation of their addiction problem. For example, in response to the question of whether the respondent is not controlled by his amphetamine or heroin use, most replied that this happens occasionally or even frequently. Use is always not controlled by 7% of amphetamine users and 15% of heroin users. Similar responses can be observed on the issue of whether the respondent would feel alarmed if the administered dosage of the substance would not be available. Accordingly, the 14% of amphetamine users always felt anxiety as did 29% of heroin users, 23% and 37% often felt anxiety, while 18% of amphetamine users never worried about it, as did 7% of heroin. 70% of amphetamine users and 73% of heroin users sometimes or often felt anxious; always concerned about substance use were 10% of amphetamine users and 19% of heroin users. Unfortunately, a relatively high proportion still had never wished to quit drug use: relevantly 9% and 19%, which also complicates their potential socio-integration back into society. At present, 17% of amphetamine users and 32% of heroin users wished to terminate their use. 7% of amphetamine users and 25% of heroin users noted it would be impossible to discontinue using the substance, but 29% and 6% respectively indicated that giving up their drug use completely would cause no problems. 64% amphetamine users and 69% of heroin users said it would be difficult or very difficult *(Trapencieris, Sniķere et al 2008)*.

8.2. Social reintegration

The issue of social reintegration, as opposed to social exclusion, is equally broad and complex, particularly at the moment, when Latvia and other EU member states have encountered serious economic difficulties. It is therefore particularly important to identify socially excluded groups and help them to rejoin society, diverting available funds to suitable objectives. In Latvia, drug users have never been a group whose social inclusion or reintegration has been the primary objective among other socially excluded groups, and, of course, particularly in the current period when there is a shortage of funds for many socially significant areas. Regardless of the foregoing, several programmes aimed at reducing social exclusion have been developed in Latvia.

On 4 July 2006, the Cabinet of Ministers adopted the *Latvian National Development Plan for 2007–2013*, which, *inter alia*, also includes objectives related to restricting the prevalence of drugs. So, for example, the ensuring of internal security proposes as an objective the improvement and modernisation of systems in the fight against the illegal distribution of narcotic and psychotropic substances, human trafficking, and other crimes of an economic nature. The aim: human health as a value anticipates the balancing of responsibility between state and individual regarding the preservation and improvement of health, forming an awareness in society of a healthy lifestyle and food, and involving the public in the fight against illnesses of dependency (addiction to alcohol or narcotic, psychotropic, or toxic substances, gambling, or computer games) (*Latvian National Development Plan for 2007-2013*).

In 2008, the "*National Strategy Report on Social Protection and Social Inclusion 2008–2010*" was developed, taking into account several policy planning documents at the national and European Union levels: the *Latvian National Development Plan for 2007–2013*, operational strategies of relevant ministries, the *National Lisbon Programme of Latvia for 2005–2008*, and other documents related to social inclusion.

Defined in the aforementioned report as specific groups of inhabitants at risk in relation to the risk of poverty and social exclusion are: disabled persons and persons with functional disorders,

unemployed persons (particularly long-term unemployed), the homeless, prisoners and recently released prisoners, Roma people, victims of trafficking in humans, persons addicted to psychoactive substances (alcohol, narcotic, toxic, or other intoxicating substances, persons with knowledge and skills which are inadequate, low, or inappropriate to the employment market, and the poor. It is vital to remember that social exclusion is a multi-dimensional phenomenon, and several social exclusion risk factors may be combined in any single individual. The three major tasks for the period are:

- to facilitate more effective participation and integration in the employment market,
- to improve income support systems;
- to facilitate access to better-quality services (*National Strategy Report on Social Protection and Social Inclusion 2008 - 2010*).

Social reintegration in Latvia is closely related to social rehabilitation, by defining, that social rehabilitation from psychoactive substances in addicted children and adults is directed towards the aim of people giving up the use of psychoactive substances, thereby improving their physical and mental health, as well as facilitating their return to a wholesome lifestyle. According to data from the Republic of Latvia Ministry of Welfare, in 2009, rehabilitation was provided to children at two rehabilitation centres and also for adults at two rehabilitation centres. The rehabilitation period is from 3 to 18 months for children, and from 3 to 12 months for adults (*Ministry of Welfare 2009*).

9. Drug-related crime, prevention of drug related crime and, prison

9.1. Drug-related Crime

Starting with the second half of 2008, offending trends (including in the trafficking of illegal drugs), and the response reactions from law enforcement agencies (including anti-drug cooperation) in Latvia have to some extent been determined by the economic crisis, which is primarily associated with two main factors: a decline in the welfare level of the population resulting in drugs becoming less available to occasional users, and a reduction in resources available to law enforcement agencies (both logistical and personnel), resulting in fewer measures being undertaken by the authorities to reduce the supply of drugs. Also, with Latvia's accession to the Schengen area, the importation of illegal drugs across the European Union's internal borders has significantly increased, as adequate compensatory mechanisms have not been introduced within the country (largely due to lack of resources). In fact, a situation has now developed in which the enhanced protection of external borders has resulted in much less attention being paid to the flow of drugs across the internal borders, and therefore the flow of banned substances from neighbouring countries within the European Union will intensify (e.g. in 2007 and 2008, attempts to bring in drugs were averted only at the internal borders (10 cases at the Latvia–Lithuania border, and one case at the Latvia–Estonia border).

Drug law offences

Details of the descriptions of a crime (place, time, motive, whether the offence was committed in a state of intoxication, or under the influence of any substance) are compiled in the IS "Register of Criminal Offences", whereas in the IS "Persons Who Have Committed Criminal Offences", information is compiled about the penalties imposed on persons and does not provide a separate category to identify persons who have driven a motor vehicle while under the influence of drugs. Therefore, the information on persons convicted of driving under the influence of drugs is derived from the IS "Persons Who Have Committed Criminal Offences" partly by manual means[42].

Convictions involving the use and possession of drugs[43]

The total number of criminal offences and administrative violations registered in 2008 was 5896. It included 1032 criminal offences registered pursuant to the Criminal Law Section 253[44], 1652 offences registered pursuant to the Criminal Law Section 253.[2] [45] Paragraph one, and 3212 administrative violations registered pursuant to Administrative Violations Code Section 46[46].

In 2008, criminal and administrative proceedings for the use and possession of drugs were instituted against 3683 persons. This included criminal proceedings pursuant to CL Section 253 against 373 persons; pursuant to CL Section 253.[2] Paragraph one against 631 persons; and administrative proceedings pursuant to AVC Section 46 against 2679 persons.

Pursuant to CL Section 253, in 2008, 279 persons (or 75% of the total number of persons against whom criminal proceedings had been instituted) were charged with offences committed

[42] More information about the available databases and Sections of the Criminal Law and Administrative Violations Code is available in the National Report for 2008 expanded theme "Sentencing Statistics".
[43] Criminal Law Sections 253, 253.[2], Paragraph one; Administrative Violations Code Section 46
[44] CL Section 253. Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances.
[45] CL Section 253.[2] Unauthorised Manufacture, Acquisition, Storage, and Sale of Narcotic and Psychotropic Substances in Small Amounts and Use of Narcotic and Psychotropic Substances without a Physician's Designation.
[46] AVC Section 46. Illegal Acquisition or Storage in a Small Amount of Narcotic and Psychotropic Substances and Medicinal Products, as well as Substances, which May Be Used for the Illegal Production of Narcotic and Psychotropic Substances (Precursors), or the Use of Narcotic and Psychotropic Substances without Prescription by a Doctor.

in that year. Of those, 107 persons received custodial sentences (from 6 months to 8 years), including 69 persons who received an additional penalty of police supervision (between one and three years). 160 persons received sentences of imprisonment, conditionally suspended (from 6 months to 6 years), including 159 people against whom an additional penalty of probation was imposed (between 6 months and 5 years). Sentences of community service were imposed against six persons (from 80 hours to 200 hours). Fines were imposed as a base penalty against six persons (between LVL 1440 and 8000). An additional penalty of property confiscation was imposed against six persons. An additional penalty of driving disqualification was imposed against eight persons (between 2 months - 4 years). Fines were imposed as a base penalty against three persons (between LVL 360 - 3200).

In 2008, for offences pursuant to CL Section 253, conditionally suspended custodial sentences comprised the primary base penalty imposed (57.3% of cases); and in 99.4% of cases, an additional period of probation was also imposed. Imprisonment was imposed in 38.4% of cases, and in addition, 64.5% of the cases were subject to police supervision on probation. A fine and community service was imposed in 2.1% of cases.

One person was ordered to undergo medical treatment (to attend a medical treatment institution as an outpatient); one person was ordered to participate in a probation program for treatment.

Of 373 persons against whom criminal proceedings were instigated pursuant to CL Section 253, 315 (or 84.5%) were men and 58 (or 15.5%) were women. 31 persons were aged 15–19 years, 107 persons were aged 20–24 years, 101 persons were aged 25–29 years, 75 persons were aged 30–34 years, 33 persons were aged 35-39 years, and 26 persons were older than 40.

In 2008, of 631 persons against whom criminal proceedings were instigated pursuant to CL Section 253.[2], Paragraph one, 449 persons (71.2%) were convicted. Of those, 217 persons or 48.3% of cases received a custodial sentence. Periods of imprisonment ranged between four months to 8 years and 9 months. Police supervision (probation) was imposed on a further 33 persons. Conditional suspension of imprisonment was imposed as a base penalty against 76 persons (or 16.9% of cases). Police supervision (probation) was imposed on a further 76 persons (between 1 year - 3 years). Sentences of community service were imposed as a base penalty on 142 persons (or 31.6%). Fines were imposed as a base penalty on 14 people and ranged between 100 and 800 LVL.

Of 631 persons charged, 519 (or 82.3%) were men and 112 (or 17.7%) were women. Charged with criminal offences were 48 persons aged 15–19 years; 173 persons aged 20–24 years; 235 persons aged 25–29 years; 109 persons aged 30–34 years; 40 persons aged 35–39 years; 26 persons were older than 40 years of age.

In 2008, pursuant to AVC Section 46, administrative proceedings were instituted against 2679 persons, of whom 24 persons were cautioned; fines were imposed against 2478 persons (in the total amount of LVL 106 584, of which LVL 25 317.89 was collected); administrative detention was imposed against 177 persons; compulsory corrective measures were not imposed against any person.

Convictions involving the trafficking, smuggling or production of drugs[47]

In 2008, the total number of criminal offences recorded was 1194. This included 131 offences registered pursuant to CL Section 190.[1] [48]; 1032 offences registered pursuant to CL Section

[47] Criminal Law Sections 190.[1], 253.[1], 253.[2], Paragraph two, 256

[48] CL Section 190.[1] Movement of goods and Substances the circulation of which is Prohibited or specially Regulated across the State Border of the Republic of Latvia.

253.[1] [49]; 30 offences registered pursuant to CL Section 253.[2], Paragraph 2, and one offence registered pursuant to CL Section 256[50].

Pursuant to CL Section 190.[1], criminal proceedings were instituted against 23 persons, of whom 17 persons were convicted, initiated criminal proceedings were sent for trial in relation to 3 persons.

Of the 17 persons convicted, fines were imposed as a base penalty against 7 persons (between LVL 120 and 1440); community service was imposed as a base penalty against 1 person (100 hours); 8 persons were sentenced to suspended terms of imprisonment (between 1 year - 5 years), with probation (between 6 months - 2 years); 1 person was sentenced to imprisonment for 5 years with an additional penalty of confiscation of property; 3 persons received fines as additional penalties (between LVL 360 - 3200).

In 2008, 299 persons were charged under CL Section 253.[1]. 172 persons (or 57.5% of all criminally charged persons) were convicted, of which custodial sentences were imposed on 98 persons (from 7 months to 11 years), with an additional penalty of being subject to police supervision was imposed on 93 persons (from 1 year to 3 years); imprisonment conditionally suspended in respect of 64 persons (from 6 months to 6 years), with an additional probationary period imposed against 62 persons (from 6 months to 5 years); sentences of community service were imposed on 8 persons (from 200 hours to 280 hours); a fine as a base penalty was imposed on 2 persons (from LVL 640 to 1600). Driving disqualifications were imposed as additional penalties against 4 persons (from 6 months to 4 years 5 months). A fine as an additional penalty was imposed against 1 person (LVL 480).

23 persons were charged pursuant to CL Section 253.[2], Paragraph two. 14 persons were convicted, with imprisonment imposed on 7 persons (between 1 year 1 month - 5 years 6 months); with an additional penalty of being subject to police control imposed on 5 people (between 1 year 6 months - 2 years); 1 person received an additional penalty of disqualification from driving for 5 years; imprisonment was suspended in respect of 3 persons (from 2 years to 5 years 2 months); an additional penalty of disqualification from driving for imposed against 2 people (from 2 years to 3 years); 1 person received an additional fine of LVL 320. Community service was imposed as a base penalty against 3 persons (168–200 hours). A fine was imposed as a base penalty against 1 person (LVL 640).

Convictions for other drug-related offences[51]

In 2008, the total number of criminal offences and administrative violations registered was 905.

Pursuant to CL Section 249[52], no criminal offences were registered in 2008, but criminal proceedings were instigated against 1 person (in respect of a 2007 offence), and the person was convicted and sentenced to imprisonment for 6 months with 6 months' conditional probation.

154 offences were registered pursuant to CL Section 250[53]; (criminal proceedings were commenced in respect of 2 offences; one criminal process comprised 152 episodes); criminal proceedings were commenced against 1 person.

13 criminal offenses were registered pursuant to CL Section 251[54]; criminal proceedings were instigated against 3 persons (3 men, 1 person aged 15–20 years; 1 person aged 20–25 years, 1

[49] CL Section 253.[1] Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances for the Purpose of Sale and Unauthorised Sale.
[50] CL Section 256. Unauthorised Sowing and Growing of Plants Containing Narcotic Substances.
[51] Criminal Law Sections 249, 250, 251, 252, 255, 262, 309; Administrative Violations Code Sections 46.[1], 149.[15], Paragraphs five, and seven.
[52] CL Section 249. Violation of Provisions Regarding the Production, Acquisition, Storage, Registration, Dispensation, Transportation and Conveyance of Narcotic and Psychotropic Substances.
[53] CL Section 250. Unauthorised Dispensation of Narcotic and Psychotropic Substances.
[54] CL Section 251. Inducement to Use Narcotic and Psychotropic Substances.

person aged 30–35 years). Of those, 2 persons were convicted and sentenced to imprisonment for 5–8 years), with police supervision (probation) for 1 year and confiscation of property to apply to both persons.

Three offences were registered pursuant to CL Section 252[55], but no criminal proceedings were instituted against any person.

One offence registered pursuant to CL Section 255[56], but no criminal proceedings were instituted against any person.

131 offences registered pursuant to CL Section 262[57]; criminal proceedings instituted against 68 persons; of those, 50 persons were convicted. In 2008, of the 68 persons charged with operating a vehicle while under the influence of drugs, 50 persons were convicted. Of those, 16 persons were sentenced to imprisonment (between 6 months - 3 years); 3 persons were sentenced to imprisonment suspended with a probationary period applied (probationary period set between 1 - 2 years); a fine was imposed against 4 persons (fines between LVL 280 - 3200); enforced labour (community service) was imposed against 25 persons (between 20 - 280 hours); police supervision was imposed on 1 person (for 1 year); as an additional penalty, driving disqualifications were imposed on 50 people (between 1 - 5 years).

238 offences were registered pursuant to CL Section 309[58]; criminal proceedings were instituted against 10 persons; of those, 9 persons were convicted (including 6 men or 60 %, and 4 women, or 40%; 1 person aged 15 - 20 years, 3 persons aged 20 - 25 years; 2 persons aged 25 - 30 years; 1 person aged 30 - 35 years; 1 person aged 40 - 45 years, 1 person aged 50 - 55 years; and 1 person aged 70 - 75 years).

14 administrative violations were registered pursuant to AVC Section 46.[1] [59]; 204 administrative violations were registered pursuant to AVC Section 149.[15] [60], Paragraph 5; 147 administrative violations were registered pursuant to AVC Section 149.[15], Paragraph 7.

Pursuant to AVC Section 46.[1], administrative proceedings were instituted against 12 persons, and all 12 were punished administratively. Fines were imposed against 9 persons (in the total amount of LVL 2550, of which LVL 2300 was collected); administrative detention was imposed against 3 persons. In accordance with AVC Section 239[61], action against 2 people was discontinued.

Pursuant to AVC 149.[15], Paragraph 5, administrative proceedings were instituted against 205 persons, of whom 201 persons were punished administratively. Fines were imposed against all 201 persons (in the total amount of LVL 98 300, of which LVL 49 455.98 was collected). 193 persons were disqualified from driving; administrative detention was imposed against 195 persons; two persons were prohibited from obtaining a driving license.

Pursuant to AVC Section 149.[15], Paragraph 7, administrative proceedings were instituted against 147 persons, of whom 147 persons were punished administratively. Fines were imposed against 150 persons (in the total amount of LVL 62 450, of which LVL 37 882.29 was collected); 123 persons were disqualified from driving; administrative detention was imposed against 138 persons; 23 persons were prohibited from obtaining a driving license.

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[55] CL Section 252. Administering of Narcotic and Psychotropic Substances Against a Person's Will.
[56] CL Section 255. Manufacture, Acquisition, Storage, Transportation, Conveyance and Sale of Equipment and Substances (Precursors) Intended for Unauthorised Manufacture of Narcotic and Psychotropic Substances.
[57] CL Section 262. Operating a Vehicle while Under the Influence of Alcohol or Narcotic, Psychotropic, Toxic or Other Intoxicating Substances.
[58] CL Section 309. Unlawful Providing of Substances and Objects to Persons who are Confined in Places of Detention and Imprisonment, and Unlawful Receiving of Substances and Objects from Such Persons.
[59] AVC Section 46.[1] Violation of Specified Procedures in Pharmaceutical Activity.
[60] AVC Section 149.[15] Driving of a Vehicle under the Influence of Alcohol or Narcotic or other Intoxicating Substances.
[61] AVC Section 239. Circumstances which do not Allow Record-keeping in an Administrative Violation Matter.

Pursuant to AVC Section 46.[1], administrative proceedings were instituted against 12 persons; of whom fines were imposed against nine persons (in the total amount of LVL 2550, of which LVL 2300 was collected); administrative detention was imposed against three persons.

	Criminal proceedings	Charged	Convicted/ punished	Sentenced imprisonment	Suspended sentence	Fine	Community service	Administrative detention
Use and posession								
CL 253	373	279		107	160	6	6	
CL 253.[2] Par.1		631	449	217	76	14	142	
AVC 46		2679				2478		177
Trafficking, smuggling or production of drugs								
CL 190.[1]	131	23	17	1	8	7	1	
CL 253.[1]	299		172	98	64	2	8	
CL 253.[2], Par.2	23		14	7	3	1	3	
CL 256	2							
Other drug offences								
CL 251	13	3		2				
CL 249		1		1				
CL 250	2	1						
CL 252	3							
CL 255	1							
CL 262	131	68	50	16	3	4	25	
CL 309	238	10	9					
AVC 46[1]	12	12				9		3
AVC 149[1] Par.5		205	201			201		195
AVC 149[1] Par.7		147	147			150		138

Source: Ministry of Interior Information Centre 2009

Other drug related crime

The relationship of prostitution with the illegal circulation of drugs

Individual prostitution is permitted in Latvia and regulated by Cabinet Regulation No. 32 of 22 January 2008: "*Regulations to Limit Prostitution*". Administrative culpability is provided for individual violations of the Regulation, but repeated violations during a single year are subject to criminal sanctions.

Data on the administrative penalties imposed for violations of the prostitution regulations are entered into the "Register of Persons Who Have Committed Administrative Violations"; criminal penalties are entered into the Integrated Information System Interior Subsystem "Register of Persons Who Have Committed Criminal Offences".

Table 9.1. Administrative protocols issued for violation of regulations limiting prostitution

	Total Protocols	Issued by State Police	Issued by Municipal Police	Increase	
				+/-	%
2007	44	44	0		
2008	146	84	62	142	231

Source: Ministry of Interior Information Centre 2009

Specific statistical reports on the relationship of prostitution with the illegal circulation of drugs (e.g. whether the same person committed offences both related to regulations limiting prostitution, and in connection with the illegal circulation of drugs) are not produced automatically, so the interrelationship of the data is currently determined manually. Statistical data show that more than 40% of persons punished administratively for violations of regulations

limiting prostitution have also been punished for offences related to the illegal circulation of drugs.

Table 9.2. Breaches by the same person in connection with violation of the regulations limiting prostitution and the illegal circulation of drugs

	Persons punished administratively for violation of regulations limiting prostitution	Of those: Persons punished administratively in relation to the illegal circulation of drugs	Of those: Persons punished criminally in relation to the illegal circulation of drugs	Proportion of persons punished for violations in relation to the illegal circulation of drugs
2007	44	14	5	43.2%
2008	129	50	14	49.6%

Source: Ministry of Interior Information Centre 2009

It should be noted that the number of prostitutes that have not been administratively penalised for violation of the restrictive regulations limiting prostitution and who were not punished for offences related to illegal circulation of drugs, is unknown.

Juvenile offenders

The majority of juvenile drug users have a direct connection with the breaches of the law since the purchase of drugs requires funds which are generally not available to juveniles. Statistical data indicate a slight increase in juvenile offending, but at the same time a reduction (about 17%) in the number of juvenile offenders (in fact it appears that a smaller number of offenders is committing more criminal offences; the number of criminal offences has increased from 543 cases in 2007 to 568 cases in 2008). Significantly (above 20%), there is an increase in the number of juveniles who commit criminal offences and who are not working or studying anywhere.

Table 9.3. Juvenile offences

	Year		Increase	
	2007	2008	+/-	%
Total number of offences committed	1350	1397	47	3
including under the influence of drugs	10	18	8	80
including theft under the influence of drugs	3	2	-1	-33
including robbery under the influence of drugs	0	0	0	
including under the influence of alcohol	354	318	-36	-10
including under the influence of psychotropic substances	5	5	0	0
including under the influence of toxic substances	0	2	2	
Number of juvenile offenders	2191	1812	-379	-17
including under the influence of drugs	0	14	14	
including theft under the influence of drugs	1	5	4	400
including robbery under the influence of drugs	0	0	0	
including juveniles, not working or studying	284	344	60	21

Source: Ministry of Interior Information Centres 2009

Crimes committed under the influence of drugs

In the Integrated Information Systems Subsystem "Register of Persons Who Have Committed Administrative Violations" and the subsystem "Register of Criminal Offences", it is possible to add a reference to the fact that the person committed the offences while under the influence of drugs, but as the adding of these references is not mandatory, it is generally not done.

Table 9.4. Offences committed under the influence of drugs

	Year		Increase	
	2007	2008	+/-	%
Total number of offences committed under the influence of drugs	554	756	202	36
including theft under the influence of drugs	69	66	-3	-4
including theft under the influence of drugs	9	13	4	44

Source: Ministry of Interior Information Centre 2009

Statistical data, regardless of possible data quality problems, confirm a substantial increase (over 36%) in relation to the total offences committed under the influence of drugs, but most likely the increase was directly affected by extensive raids in entertainment venues made by the State Police in 2008, which led to the detention and prosecution of a significant number of people (a large proportion of the offenders were arrested and held criminally liable in connection with repeated use of drugs without a doctor's prescription during a year).

Unauthorized supply of drugs

Criminal proceedings were initiated in 2007 (in 2008 repeat offences were detected) in connection with unauthorized supplying[62] (i.e. no medical necessity) of drugs (buprenorphine (4322 tablets) and trihexyphenidyl (48 tablets). A total of 153 offences had been committed by one and the same person since 2004.

9.2. Prevention of drug-related crime

Reduction of supply is directed towards reducing the supply of any illegal drug. The State Police, Customs and the State Border Guard Criminal Board are the main bodies operating in the area of reducing the supply of drugs, including cannabis. These institutions carry out their assigned measures, activities, and operational work in their fields, in collaboration with other relevant national authorities and among themselves, in cooperation with Europol and Interpol, as well as carrying out intelligence work, and involving dog handlers. Plans relating to the reduction of drug supply are developed on the basis of problems in individual countries and the availability of intelligence information (Kairišs 2009).

State police measures

The State Police undertake a broad spectrum of preventive (mostly involving the relevant police departments (e.g. the Prevention Department), and combating operations in the anti-drug field. The State Police unit primarily engaged in anti-drug activities is the Drug Enforcement Bureau of the Organized Crime Enforcement Bureau of the of the Central Criminal Police Department of the State Police.

The Drug Enforcement Bureau undertakes the role of monitoring and information gathering in respect of the general situation in the drugs field in all State Police institutions, as well as the methodical management functions for the State Police territorial institutions (at regional level) for established anti-drug units.

The illegal circulation of drugs is detected and eliminated:

- during the course of intelligence operations and targeted information gathering and analysis;
- collaboration with other national authorities (territorial institutions of the State Police, Customs Criminal Board, State Prison Administration Board and the State Border Guard);

[62] LR Criminal Law, Section 250. Unauthorised Dispensation of Narcotic and Psychotropic Substances.

- collaboration with other State services; often utilised in the exchange of information are the international communications facilities of the State Police, e.g. Interpol and Europol channels.

The State Police - main operational directions of the fight against circulation of drugs:

- Implement measures to achieve objectives and targets proposed in the *National Drug Programme 2005–2008*, to participate in the work of the Drug Monitoring and Addiction Restriction Coordination Board;

- Participate in UN, NATO and EU projects, programs, and other initiatives and activities in the development of cooperation with the Russian Federation, other Eastern European countries, the Asian region and the European Union to combat the illegal circulation of drugs;

- Continue cooperation with the State Border Guard, Customs Criminal Board and other Latvian and foreign law enforcement authorities to take emergency action and investigations and joint operations to identify, verify, record and put an end to smuggling drugs, and transit-related activities of international criminal groups;

- Undertake regular training of State police units in topicalities of combating drugs and legislative innovation;

- Improve the work of identifying, documenting and investigating money laundering cases related to the illegal circulation of drugs, by cooperating both with Money Laundering Prevention Service, and with other law enforcement authorities in combating money laundering;

- Activate the work and take preventive measures in relation to limiting the spread of drugs in all age groups;

- Implement organizational measures to identify potential problems and their causes in the recording and circulation of information regarding administrative violations in the field of drugs.

Customs Criminal Board activities

The State Revenue and Customs Services have developed a number of internal planning and prioritization documents relating to the combating and prevention of the illicit circulation of drugs, the *State Revenue Service Customs Service Operational Strategy for 2005–2009*[63], the *State Revenue Service Customs Strategy for Prevention and Fighting of Smuggling 2005-2009*, and the Annual Strategy document describe the tactical objectives. Every quarter, progress reports are prepared relating to performance of the tasks defined in the State Revenue Service customs authorities smuggling and fraud prevention strategies 2005– 2009 (including tactical objectives). Given the above, it must be concluded that the Customs Criminal Board regularly undertakes monitoring of the situation and the Agency reports regularly on measures taken and is aware of its performance efficiency and achievements.

The illegal transport of drugs is identified and eliminated:

- during the course of intelligence operations and targeted information gathering and analysis; the Customs Criminal Board was established in the awareness of the need for intelligence work

[63] State Revenue Service Customs Service Operational Strategy for 2005–2009, approved by Order No. 570 of the Director-General of the State Revenue Service.

- collaboration with other national departments (mostly the State Police Administration for Combating Organized Crime, State Prison Administration Board and the State Border Guard)

- cooperation with services of other countries (mostly neighbours); (mainly Sweden (e.g. the Swedish Customs Liaison Officer is stationed in the of the Customs Criminal Board building), and customs authorities of Lithuania, Estonia, Belarus and Russia; there is also active cooperation with agents of the U.S. Drug Enforcement Agency); the exchanges of information often utilise the international communications facilities of the State Police, e.g. and Interpol and Europol channels

- while conducting customs control (especially with the assistance dog handlers).

State Border Guard Service activities

The jurisdiction of the State Border Guard Service in the prevention of illegal circulation of drugs is primarily stipulated in the *Border Guard Law*. The characteristic feature of the State Border Guard in limiting the illegal circulation of drugs is the transfer to other institutions of criminal proceedings that have been initiated; as the State Border Guard Service has no jurisdiction in progressing of criminal cases in this field, and seized substances are also transferred to relevant authorities. This fact also serves to explain why data on the State Border Guard participation in the anti-drug activities are not always included in relevant reports and statistical overviews.

Illegal trafficking in drugs is identified and eliminated:

- in the course of operational activities (receiving relevant information about a planned shipment) – about 70% of information on planned illegal trafficking is sourced within the country;

- collaboration with other State authorities (mostly the State Police Administration for Combating Organized Crime, Customs Criminal Board and the State Prison Administration Board);

- cooperation with other countries' agencies (mostly – neighbours, mainly Lithuania, Belarus and Russia; occasionally the Estonian Border Guard);

- undertaking immigration control (in particular, with the assistance dog handlers).

9.4. Drug use and problem drug use in prisons

There is an annual increase in the illicit circulation of drugs in places of incarceration. According to data from the Latvian Prison Administration, to 31 December 2008 there were 6872 inmates held in Prison Administration prisons, of whom 836 (at 1 January 2008 – 731) had been convicted of a criminal offence in connection with the illegal circulation of drugs. Of the total number of prison inmates, 784 were officially registered as drug addicts (1 January 2008 – 529). In accordance with existing law, convicted persons who seek treatment for addiction can be treated at their own expense.

Drug use and problem drug use in prisons

The most common means by which drugs enter prisons are shipments (letters, mail), addressed to prisoners; furthermore, such criminal acts show a growing trend each year: 2008 - 119, 2007 - 92, and 2006 - 83. Prison administration officials regard the most important operations for the effective combating/prevention of the illicit circulation of drugs as:

- Transition to newly built prisons (reducing the number of prisoners in cells, the introduction of digital control systems, maximising isolation of the prison from the outside world in order to exclude drugs being thrown over the walls etc);

- It should be noted that with the transition to newly built prisons, utilisation of modern technology (e.g. video surveillance etc.) will permit reductions in the number of staff;

- Amendments to relevant legislation (e.g. restricting packages, permitting physicians-psychiatrists to diagnosis drug-related diseases);

- improving the qualifications of personnel of the Prison Administration Board and its subordinate units (e.g. training of prison staff to recognise drug use among inmates);

- introducing substitution therapy to reduce the harm from drug addiction and commencing drug addiction treatment in prisons.

One of the main performance indicators of the State Prison Administration Board is the amount of drugs seized (in fact the amount of substance found with prisoners).

Table 9.5. Drugs seized in 2008 by the State Prison Administration

Substance	grams	tablets	unit
Alpralozam	3.3409	68	
Amphetamine	36.8102		
Amphetamine/methamphetamine	9.9926		
Cyclobarbital /diazepam	0.8303	57	
Cyclobarbital /diazepam/clonazepam	2.734		
Diazepam	193.0608	55	
Dihydrocodeine	1.7088		
Fenazepam	82.5154	118	
Fenazepam/clonazepam	1.5107		
Phenobarbital		1	
Fentanyl	0.0144		
Hashish	27.6546		
Heroin	10.6265		
Heroin / Phenobarbital	0.731		
Clonazepam	570.2503	977	
Cocaine	0.6004		
LSD			1
Marijuana (dried)	182.1864		
MDMA	29.2128	28	
Methamphetamine	762.6844		
Morphine		18	
Nitrazepam	5.2797	44	
Nitrazepam /trihexyphenidyl	0.9815		
Total	**1922.7257**	**1366**	**1**

Source: State Police Forensic Department 2009

In 2008, the Latvian Prison Administration commenced 222 criminal proceedings for criminal offences related to illicit circulation of drugs (2007 – 259, in 2006 – 210). Of the criminal proceedings initiated:

- 119 cases related to the transfer of drugs to persons in detention centres, consignments, parcels, and correspondence (about 23% more than in 2007);

- 66 cases related to drugs seized from "throw- overs", searches of cells and territories(about 46% less than in 2007);

- 37 cases related to detecting and seizing drugs from prisoners and other persons in prisons (during long prison visits), and using drugs without a doctor's prescription if done repeatedly during the year (about 20% less than in 2007).

9.5. Responses to drug-related health issues in prisons

Unfortunately, treatment for drug addiction in is practically non-existent in Latvian prisons. Similarly, opioid substitution treatment is still not available in Latvian prisons. Thus, it is possible that the actual term of imprisonment for convicted drug users in prisoners only intensifies the drug addiction. These problems arise from imbalances (i.e. an investment in one area must be consistent with investment in related areas), effective exchanges of information and lack of coordination.

Despite the increased number of prisoners with drug dependence in places of detention, drug dependence treatment in prisons legal does not take place due to legal (and the related financial) factors (other than for prisoners-drug users in detoxification):

- a prisoner has the right to refuse a drug test,

- prison doctors-psychiatrists are not entitled to make a diagnosis of drug-related illness.

Regardless of the repeated attempts by the State Prison Administration Board (also referring to other European Union Member States' experiences and available solutions) to highlight these issues and make relevant amendments to legislation (e.g. by providing that if a prisoner refuses to take the test, the test results can be considered positive, or permit the Prison Administration to conduct the test by force; to permit psychologists (not drug addiction specialists) working in prisons to make a diagnosis of drug-related illness), the legislation was never supported. One of the counter-arguments used is that diagnosis of an addiction-related disease can be made only by a certified drug addiction specialist[64], and that the drug test taken by force would be a contravention of human rights. In Latvian prisons, a prisoner refusing to take a drug test may face disciplinary action. In practice, the issue of disarray in legislation leads to a drug user being identified solely by the prisoner's own statement i.e. if the prisoner acknowledges himself as a regular/long term drug/user during the initial inspection (upon first arriving in prison) or subsequently, when reviewing complaints about his health,. Prisoners rarely admit being drug users, possibly alarmed by the prospect of closer supervision by the Prison Administration. Thus it must be accepted that in reality the number of drug users in prisons is several times higher than is shown in the official statistics.

Various preventive interventions are undertaken in places of detention, including lectures and awareness campaigns for prisoners, and religious activities. Prisoners are involved in various re-socialisation programs. With co-participation by the NGO and the Prison Administration, a handbook was adapted for places of detention entitled: "*Risk reduction among drug users in prisons*."

Counselling and psychological care are provided for prisoners by social workers and psychologists. Many convicted persons are employed in working places set up by merchants and as part of the domestic staff.

[64] Cabinet Regulation No 429 of 24 September 2002: "Procedures for the treatment of patients dependent on drugs and other toxic substance", Paragraph 5.

10. Drug Markets

10.1. Availability and supply

In 2008, according to a State Police report *(State Police 2009),* amphetamine-type stimulants and cannabis group substances still remain the most popular drugs in the Latvian illicit drugs market. Compared with 2007, there is an increase in volumes of methamphetamine and hashish seized, indicating the stable position of this substance in the illicit drug business. Also observed is an increase in the prevalence of heroin and natrium-oxybutirate (GHB).

Compared with 2007, no significant changes have been observed in drug distribution mechanisms. A trend remains of reducing direct contact between dealers and customers, resulting in drug distribution taking place via telephone contacts, couriers and various hiding places.

Because of its favourable geographical position, Latvia is often used as a transit country for transporting drugs and precursors to its neighbouring countries. Supply channels have been set up by criminal groups to bring drugs into the country. Foreign organized crime groups also use Latvia as a transit country for the transport of illegal drugs, since following the Schengen Agreement virtually no border control exists, permitting freedom of movement, not only for citizens and permanent residents, but also for criminal groups.

The drug distribution centre within the country is the Latvian capital of Riga, from where drugs reach other Latvian cities and rural areas. In Latvia's smaller cities and rural areas drug movement is of a recurrent nature. They are mostly used in recreational activities, or during holidays when young students return home from the largest Latvian cities. Small quantities of drugs are also brought into Latvia by persons returning from working abroad.

According to information held by law enforcement institutions, it can be concluded that synthetic drugs are imported mainly from European Union countries such as Lithuania, the Netherlands, Estonia, Germany and Poland; usually via overland land border control points by road transport, and through ports, using ferry lines.

Cannabis is imported from the Netherlands, Spain and Lithuania. Of the quantity of marijuana seized in 2008, most was Latvian-grown, which was seized when an extensive and technologically advanced marijuana farm[65] was discovered in Talsi district in October 2008.

Cocaine is imported mainly from Latin American countries (Ecuador, Colombia) by using sea routes through Russia and Ukraine. Latvian territory is also used for the transit of cocaine from South America and Russia, and Scandinavia.

Heroin is mainly imported from the Central Asian region through Russia.

Law enforcement agencies predict that in the future, the involvement of new players in drug retailing is possible, who had previously been linked to other forms of criminal activity. It is possible that a violent redistribution could take place between distributors, and an increased interest could be shown by local drug dealers in carrying out the transit of drugs for sale in other countries.

Becoming widespread in Latvia at present are so-called herbal smoking mixes or Spice products. These products with wide range of brand names (e.g., *Spice gold, Spice silver, Spice diamond, Spice arctyc, GOA mix, GOA spirit, Yucatan, Alarma, Sencation vanilla, Sencation*

[65] For more information see the expanded topic "Cannabis Market".

blackberry, Sence, Tropical synergy, King B, Smoke, Clover, Forest humus etc.) can be acquired in small trading outlets in various city districts or via Internet – local websites. The mixtures are sold in packets of 500mg, 2g, 3g and 6g as scented substances and incense, and their price ranges from LVL 5 (per 500 mg packet) to LVL 36 per 6g packet. Some local websites offer price cuts in cases when you purchase larger amount of herbal mixes. Most part of all Internet websites offer to purchase products by ordinary mail or to order them by phone. When ordering by phone, delivery of herbal mixes is provided just in couple of hours and it is possible to order even during night period. Free delivery may be offered within Riga city for products purchased for more than LVL 10. Some Internet websites also offer to purchase products on wholesale trade.

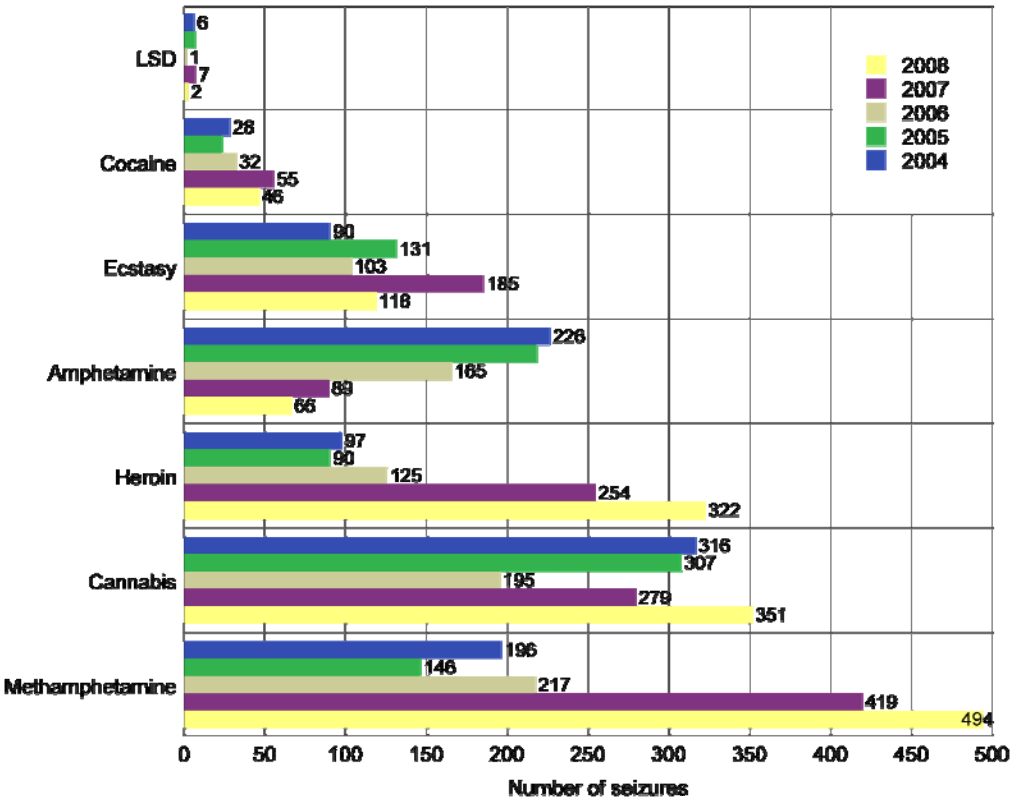
Most popular local Internet websites are www.bongs.lv, www.dumupipes.lv, www.spais.lv but there are a lot more. It is planned to put under control synthetic cannabinoids found in herbal mixtures as also some psychedelic plants in the nearest future. For more information please see chapter on Selected issue – Cannabis Markets and Production.

10.2. Seizures

The number of drug seizures is one of the indicators for evaluation of the illicit drug market (State Police, 2009), and indicates the drug prevalence rate in the country.

According to the State Police Forensic Department in 2008 there were **1399** seizures related with illegal substances, which has slightly increased as compared with the data reported in 2007 (see Figure 10.1 and Fonte ST13[66]). The largest number of seizures was for methamphetamine, followed by a significantly lower number of seizures for cannabis and heroin.

Figure 10.1. Number of seizures in Latvia, 2004-2008



Source: State Police Forensic Department 2009

[66] ST13_2009_LV_01

In comparison with 2007, the number of seizures in respect of heroin, cannabis, methamphetamine has increased. However, there has been a significant decrease in the number of seizures for amphetamine and ecstasy tablets. Consequently, a significant trend noted was that the number of heroin seizures increased by around one-fifth, which might indicate an increase in this substance's share of the illicit circulation.

Another significant trend indicates that with the decrease of ecstasy tablets and amphetamine proportion of the illicit trade, there is a proportional increase in the number of methamphetamine seizures and the seized quantity of the substance, which in 2008 was three times higher than in 2007.

Noted as a third important trend was an increase in the number of hashish seizures. The number of hashish seizures compared with 2007 has increased by 48%; with a 27-fold increase in total annual weight of seizures it reached the largest quantity of hashish seized since 2003. However, it should be noted that 94.7% of seized hashish was seized in four large (over 100g) seizures, which, however, cannot yet indicate a significant increase in the presence of hashish in the total volume in the drug market. However, a decline in the number of cocaine seizures, and quantity seized may partly be explained by the impact of the overall economic situation, given that cocaine is one of the most expensive drugs, and most of the total quantity imported into the country is intended for transit to other countries.

Table 10.1. Quantity of seized illegal drugs, comparison by years

	2005	2006	2007	2008
Heroin kg	0.004	0.157	1.75	1.75
Herbal cannabis kg	25.92	5.9	17.84	42.44
Cannabis plants kg	N/A	N/A	34.48	157.52
Cannabis resin kg	1.55	0.358	0.254	6.88
Amphetamine kg	3.79	11.03	5.78	4.80
Methamphetamine kg	3.42	8.12	11.83	32.27
Ecstasy tab	21937	4600	94753	3945
Cocaine kg	0.68	1.12	11.9	5.15
LSD stamps	2190	3	146	2

Source: State Police Forensic Department 2009

Additionally, in 2008 1.8878 g of methadone, 7.7706 g hallucinogenic mushrooms, 0.0622 g raw opium, 3.3098 g of partially acetylated opium, 1.033 litres of poppy straw extract, 22.54 kg of poppy straws and 5.1 kg (and 7858 tablets) of psychotropic medicines.

2345 ml of a precursor gamma-butyrolactone was seized in Latvia in 2008, and additional 600 litres of BMK was seized as a result of successful international collaboration between Latvia, Lithuania and Belarus.

During 2008, the total value of drugs seized in the country was about LVL 1 780 000 (aprox. 2 532 726 EUR) while abroad, as the result of international co-operation, cocaine worth approximately LVL 2 500 000 (aprox. 3 557 199 EUR) was seized, and amphetamine worth about LVL 370 000 (aprox. 526 465 EUR) was seized according to prices on the Latvian black market *(State Police 2009).*

10.3. Price and purity

Comparing changes in the price of drugs during the year, it appears that, overall, not much has changed. In 2008 compared with 2007, the minimum price has increased, but the maximum and average price of heroin has decreased, which could be explained by an increase in the heroin available in the market. However, the price of cocaine has increased in comparison to previous

years, which can be explained by the fact that the seized cocaine is generally intended for sale in neighbouring countries. The listed prices for other substances have not significantly changed, compared with previous years. However, it must be remembered that currently the prices of drugs are summarized in accordance with a single methodology, but are compiled using operational information from the State police. Consequently, the prices shown are more informative than systematically analytical in nature.

Table 10.2. Price of 1 g drugs in 2006-2008

	2006			2007			2008		
Name of illegal drug	Min	Max	Mode	Min	Max	Mode	Min	Max	Mode
Marijuana	10	17.1	14.2	5.7	14	10	14	17	14
Heroin	113.8	213.4	135.2	64.2	185.7	157	100	142.9	100
Cocaine	49.8	71.1	71.1	43	86	71	85.7	128.6	100
Amphetamine	11.4	19.9	14.2	7	14	14	10	14	14
Ecstasy 1tab	4.3	7.1	5.7	4.2	10	5.8	5.7	7	5.7

Source: State Police Forensic Department 2009

The purity of each of the seizures of illegal substances is determined in Latvia by the Chemical Examinations Unit of the State Police Forensic Department. In 2008, the minimum composition of heroin identified was 2% and the maximum was 65%. On average, heroin purity has increased by 4% since 2007. However, the average purity of cocaine has decreased slightly. Purity of amphetamine in 2008 compared with 2007 has almost doubled. The same applies to the average purity indicator for methamphetamine. The purity of ecstasy tablets has increased slightly.

The purity level of cannabis products, namely, the level of delta-9-tetrahydrocannabinol is not determined. The Chemical Examinations Department, by examining cannabis products, determines whether the product contains delta-9-tetrahydrocannabinol or not. If it is found to be present, then the substance is classified either as marijuana or hashish, which are both illegal substances in Latvia.

Part B: Selected Issues

11. Cannabis markets

The situation in Europe in relation to cannabis[67] has changed significantly during the past decade. In the early 1990s there were few countries in which the indicators of cannabis prevalence were high. However, during the late 1990s and early 21st century, these indicators increased in all countries, as a result of which at the moment cannabis is the most widely prevalent (most widely used) prohibited narcotic substance in the European Union, including Latvia. (EMCDDA, 2008). In Latvia, 12% of inhabitants have tried marijuana during their lifetime, and 2% use it regularly (*Koroleva, Mierina 2008)*.

Until now, no large-scale studies have been undertaken at the national level regarding the availability of cannabis (marijuana and hashish), with the aim of understanding the cannabis market structure and manufacturing trends. The research undertaken to date has focused on the prevalence of use of marijuana and hashish among various groups in society. However, with Latvia joining the European Union, and subsequently the Schengen zone, there has undoubtedly been an increase both in the illegal importing of drugs including cannabis across the internal borders of the European Union and production at the national level. During the past five years, professionally equipped illegal indoor cannabis plantations are discovered increasingly often. According to experts, the necessary equipment is ordered from the Netherlands; while a wide range of instructional materials on how to grow high-quality cannabis is available on the Internet. Perfect nursery equipment and its large quantity are evidence of the fact that marijuana is increasingly often produced at the national level, not only for the local market but also to export to our near neighbours and Scandinavian countries where cannabis prices are higher than in Latvia.

The study, "*Cannabis market and production in Latvia*" (is the first such study in Latvia in which the national situation regarding availability of cannabis is described, utilising advanced research methods: analysis of normative documents, analysis of literature, analysis of available statistical information, focus group discussions with cannabis users, and in-depth interviews with experts in the field.

During the study, a total of four focus group discussions took place in which 32 participants participated aged between 18–54 years, who regularly (at least once a week) used cannabis. Participants in two groups were identified as problem drug users, who, in addition to cannabis, also used other drugs. However, participants in the other two groups were marijuana users who usually did not use other drugs. In the first two groups, discussion took place in the Russian language; in the second two groups in the Latvian language. For the focus group discussions, a form containing basic questions was developed, which included information regarding personal experience of cannabis use, description of the acquisition process (dealers/traders, acquisition points, acquisition process), growing experience, use of slang and coded information.

In-depth interviews were conducted with 10 experts in the field, who worked in various law enforcement institutions, and whose activities are directly or indirectly related to the reduction of availability of drugs, including cannabis. The interviews with experts took place in accordance with a unified specially developed questionnaire, which incorporated six question "blocks": the cannabis market, home production, typology of growers, conditions for cultivating cannabis, consequences of cultivation, together with the flow and pathways of its distribution. The information acquired during the interviews was utilised to reflect the cannabis market and production structures.

[67] *Cannabis- Indian cannabis (Cannabis sativa) containing products and articles whose active ingredienst are various tetrahydrocannabinols*

11.1. Markets

Contextual information

History and prevalence of homegrown cannabis production

The homegrown production of cannabis has a comparatively recent history in Latvia. If overall the prevalence of any drug in Latvia began in the 1980s, then the deliberate cultivation of cannabis began considerably later. The first local cannabis farm of any significance was only discovered in 2005. Until then, large-scale cannabis cultivation had not been registered; however, the use of cannabis for purposes of intoxication in Latvia, as in Lithuania and Estonia, began during the Soviet years when military personnel serving as conscripts in the Central Asian republics, acquired cannabis and used it and occasionally also brought it home. However, the information available on the prevalence of cannabis use is historically scarce, and therefore the bulk of data on the prevalence of cannabis use is only available from the time the *European school survey project on alcohol and other drugs* (hereinafter *ESPAD*) commenced. This project was implemented in Latvia for the first time in 1995 *(EMCDDA 2008)*.

At present in Latvia, as elsewhere in Europe, cannabis is the most widely used drug among inhabitants. As evidenced by results from the 2008 inhabitants' survey "*The prevalence of drug use among inhabitants*" (*Koroleva, Mierina et al. 2008),* marijuana is the most widely used drug, and has been tried during their lifetime by 12% of inhabitants. 5% have used it during the past year, and 2% during the past month. The 2007 *ESPAD* study "*Habits and trends of drug use among school pupils*" *(Koroleva, Mierina et al. 2007)* confirms that marijuana is also the most widely used drug among school pupils. 22% of pupils have used marijuana during their lifetime, 11% had used it on three or more occasions. During the past year 14% of surveyed pupils have used marijuana or hashish, while 5% have done so during the past month.

Marijuana and hashish are also dominant as the most prevalent drug in entertainment venues. Almost every other club visitor has used cannabis during his or her lifetime. During the last 12 months, 24% of club visitors had used cannabis, while 12% had used it over the last month. Of the persons who had used cannabis during the past month, 31% of respondents had done so on five or more occasions, 6% on 4 occasions, 7% on 3 occasions, 28% on 2 occasions, and 28% had used marijuana or hashish on one occasion *(Koroleva, Karklina et.al 2008)*.

The marijuana farms discovered until now for the cultivation of illegal marijuana have only been indoors, where marijuana has been grown in the soil or also by using hydroponic cultivation methods. Likewise, the majority of marijuana farms have specialised only in marijuana cultivation, where the marijuana plants are removed and/or the marijuana is dried. According to the experts, marijuana resin (hash) is not produced in Latvia but is only imported.

In Latvia there are no known specialised shops *(grow shops),* specialising in equipment necessary for cultivating cannabis or trading in marijuana seeds. However, the experts indicate that very frequently, standard horticultural equipment available in gardening shops is utilised for the cultivation of marijuana. Only in the largest identified marijuana farms, according to the experts, has equipment used for cultivation been transported from the Netherlands.

Becoming widespread in Latvia at present is the so-called "legal marijuana", which can be acquired in small trading outlets in various city districts. The term "legal marijuana" refers to Spice products available in other European Union member states and Latvia. In Latvia, these products can be obtained via the Internet or from the previously mentioned trading outlets. Smoking mixtures are available with various names (e.g., *Spice gold, Spice silver, Spice diamond, Spice arctyc, GOA mix, GOA spirit, Yucatan, Alarma* etc). The mixtures are sold in packets of 500mg, 2g, 3g and 6g as scented substances and incense, and their price ranges from LVL 5 (7 EUR) (per 500 mg packet) to LVL 36 (51 EUR) per 6g packet. In these trading places it is also possible to acquire paraphernalia for smoking – various pipes and bongs.

Legislation

Cannabis, cannabis resin, hashish, cannabis extracts and tinctures, dronabinol (delta-9-Tetrahydrocannabinol (and its stereo chemical variants) are substances prohibited in Latvia and are included in the Republic of Latvia Cabinet Regulation No. 847 of 8 November 2005 "*Regulations regarding Narcotic Substances, Psychotropic Substances and Precursors to be Controlled in Latvia*" Schedule I – prohibited particularly dangerous narcotic substances including psychotropic substances and plants. (Cabinet Regulation No. 847 of 8 November 2005 "*Regulations regarding Narcotic Substances, Psychotropic Substances and Precursors to be controlled in Latvia*")

The law "*On the time and arrangements for coming into force of the Criminal Law*" (in force from 27 November 2002) defines the amount of substances, less than which is regarded as small and the amount as from which a quantity is regarded as large *(see Table 11.1)*.

Table 11.1. Amounts of cannabis products deemed as small or large in the Criminal Law

Name of product	Quantity less than which is deemed to be small	Quantity above which is deemed to be large
Marijuana,	5 g	1 kg
Marijuana, dried	1 g	100 g
Hashish	0.1 g	50 g
Cannabis resin, Oil	0.05 g	20 g
Tetrahydrocannabinol	0.003 g	1 g
Dronabinol	0.2 g	10 g

Source: the law "On the time and arrangements for coming into force of the Criminal Law"

The Criminal Law provides culpability for various criminal acts associated with drugs, however, the most important in this context are two sections of the *Criminal Law*, firstly, Section 253[68], which provides culpability for the unlawful preparation, acquisition, possession transporting and sending of drugs and secondly, Section 256[69], which provides culpability for the unlawful sowing and cultivation of plants containing narcotic substances[70].

Like the *Criminal Law*, the A*dministrative Violations Code* provides culpability for the use of drugs, however, while the *Criminal Law* stipulates that the use of drugs without a medical prescription more than once within a single year may be punished by imprisonment or a period of up to two years and/or enforced labour, and/or a fine of up to 50 times the minimum monthly wage, such an offence, if committed on one occasion (during a single year) and administration culpability shall be applied to the offender. The administrative penalty for such an offence is a fine of up to LVL 75 (approximately EUR 107) or administrative arrest for a period not exceeding 15 days. An identical principle operates in relation to the unlawful acquisition or keeping in small quantities without intending to sell narcotic or psychotropic substances or medication or substances which may be used for the unlawful preparation of narcotic or psychotropic substances (precursors), i.e., an offender may initially be punished administratively, however, if the offence is repeated within a year, criminal culpability shall apply.

Responsibility is also provided in the *Administrative Violations Code* for acts leading to the sowing of plants containing drugs, failing to ensure a storage and processing place for such crops in specified secure facilities and for failing to take action to destroy residue and dispose of waste containing drugs after harvest and processing. Breaches attract fines for officials of up to LVL 100 (EUR 142). Likewise, culpability is provided or the unlawful sowing or cultivation of

[68] CL Section 253. Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances.
[69] CL Section 256. Unauthorised Sowing and Growing of Plants Containing Narcotic Substances.
[70] *Additional information regarding sections of the Criminal Law and their distribution according to EMCDDA Offence type may be found in the National Report for 2008 at page 124 124 Table 1 "Comparative table: Republic of Latvia Criminal Law or Administrative Violations Code "drug-related" sections v. EMCDDA Offence type*".

plants containing drugs. For this offence (first offence or an offence committed once during a relevant year) a caution may be issued, or a fine imposed of up to LVL 200 (EUR 285).

Coming into force on 6 June 1996 was the law "*On Procedures for the Legal Trade of Narcotic and Psychotropic Substances and Medicinal Products*". Chapter III, Section 5 of the Law stipulates that it is prohibited to cultivate, produce, prepare, import, export, distribute, advertise, transport, store, transfer for a charge or free of charge, acquire and use, as well as to send through the territory of Latvia, the plants, substances and medicinal products included in Schedule I. Cannabis, as mentioned above, is included on Schedule 1 of the narcotic and psychotropic substances and precursors controllable in Latvia. *Inter alia*, Section 6 of the Law stipulates a prohibition on the growing in Latvia of the so-called "Indian cannabis" *(cannabis sativa* subsp.*indica)*. The growing of crop cannabis *(cannabis sativa* subsp.*sativa)* for harvesting fibres and seeds and for horticultural purposes is permitted. A crop may only be established in an open field (crop cannabis may not be cultivated in rooms and enclosed areas, hot houses or under plastic sheeting). It is the duty of the property owner or the lawful occupant to destroy cannabis growing on their property.

In cases where plants, substances and medications listed on Schedules I, II and III are essential for medical and/or veterinary medical scientific studies, to determine physical and chemical properties, or for training, persons may obtain permission from the State Agency of Medicines for the growing of plants listed in Schedules I, II and III or the distribution of substances and medications listed in Schedules I, (*law* "*On Procedures for the Legal Trade of Narcotic and Psychotropic Substances and Medicinal Products*"). Cabinet Regulation No. 663 of 18 August 2008 "*Requirements for food quality schemes, their implementation, operation, monitoring and control arrangements*" stipulates that the concentration of tetrahydrocannabinol in crop cannabis is not to exceed 0.2 (*Cabinet Regulation No.663 "Requirements for food quality schemes, their implementation, operation, monitoring and control arrangements"*).

Consumer market shares of different cannabis products

In Latvia's illegal drug market, available for the most part is marijuana and in rare cases, marijuana resin (hashish). Cannabis oil has rarely been encountered in Latvia. According to experts, approximately 80–90% of the cannabis market consists of marijuana, and 10–20% consists of cannabis resin or hashish. A similar proportion is also observable among consumers, since hashish is rarely available in Latvia to users and therefore the majority of consumers of cannabis products smoke marijuana.

It is not possible to chemically determine the country of origin of cannabis products available for sale in Latvia, and it is therefore also not possible to determine the market proportions of home-grown or imported marijuana. However, experts indicate that in recent years, with the discovery of several large marijuana plantations, there has been an increase in the market share of locally grown marijuana, which at the moment could comprise around 10-20%. The marijuana in the majority of plantations is cultivated from imported seeds or plants, and this is probably the reason why it is almost impossible to determine the country of origin of seized marijuana.

Cannabis users also indicate that recently for the most part only marijuana is available in Latvia, while hashish is practically unavailable. Several users mentioned *"avganka"* (marijuana imported from Afghanistan, which is practically no longer available in Latvia) as a very good cannabis product. Also identified as "good" marijuana is that imported from the Netherlands, where according to users marijuana production is very highly developed, as well as that marijuana which is imported from foreign countries where the climate is warm and suitable for growing marijuana.

Users are generally in agreement that imported marijuana is considerably better than the locally grown product and this is always given preference, with, of course, the exception of cases where the marijuana grown in Latvia is well cultivated and the necessary watering and illumination of plants has been ensured. At the same time, users indicate that determination of

the origin of marijuana is practically impossible. The word of traders or dealers must be accepted, although very often lower-level traders have no information about the origin of the product.

Distribution of cannabis at national level

Distribution of cannabis at the national level takes place on the "pyramid" principle, whereby distributors at various levels are often unknown to each other. The operators of major marijuana plantations are usually men who often operate several other legal or illegal "businesses" in parallel. Usually these persons have previous convictions. According to experts, between 10-20% of locally grown marijuana reaches the local market; the remainder is exported mainly to Scandinavia where drugs attract high prices, or to neighbouring countries Lithuania and Estonia.

Drug users emphasise that the drug business, like any other business, operates to a plan whereby there is one major supplier or distributor and other smaller distributors or dealers, which means that a network structure is characteristic of drug trafficking.

Views regarding marijuana distributors are divided among its users. Some hold the view that the majority of dealers are of Roma background, and often women, and not infrequently, dealing represents the family business. However, a second group noted that the perception that marijuana is more often sold by Roma persons is outdated, and that marijuana in most cases is sold by persons of Russian and Latvian origin, and also by young people, usually males. One explanation for such differing views could be that those who regard dealers as mostly being of Roma origin are long-term users, and furthermore these users also use heroin, amphetamines, and other drugs in parallel, and their range of acquaintances and places where they most often spent time is different from those groups of users who identified themselves only as marijuana smokers.

Experts indicated that sellers of marijuana as well as growers are mostly men aged over 30 years who have previously been convicted or who have previously been arrested for various breaches of the law. If marijuana is grown, then sometimes the grower himself is also a user and the marijuana is grown for his own use or with the aim of selling it at a profit. Growing may occur in isolation or with the involvement of an organised group. A large number of marijuana growers are always in organised groups.

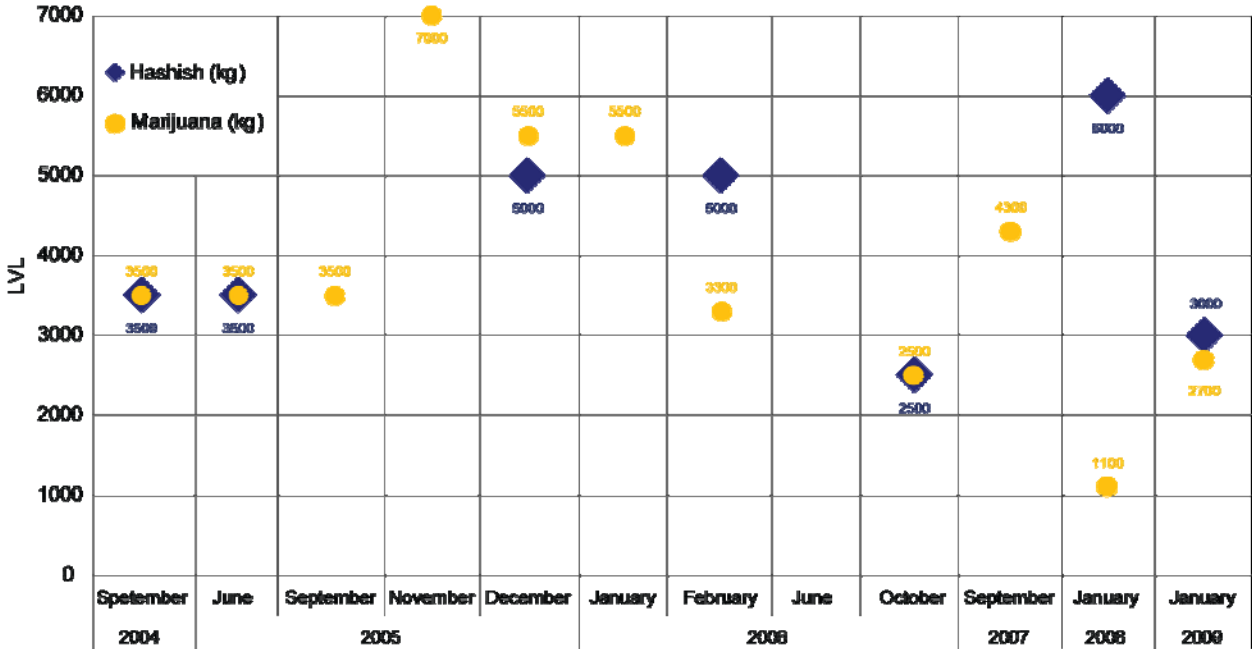
Cannabis wholesale prices

According to operational data from the State police on marijuana and hashish wholesale prices (data available from 2004), in January 2009 a kilogram of hashish cost LVL 3 000 or around EUR 4 270[71], while marijuana cost LVL 2 700 or around EUR 3 842. In January 2008, the price of hashish was LVL 6 000 per kilogram, while the price of marijuana was LVL 1 100 (in June of the same year it was LVL 4 000, but in November it was LVL 1 700). In February 2006, the registered price of hashish per kilogram was LVL 5 000, but by October it had reduced by half to LVL 2 500. In January 2006 the price of marijuana was LVL 5 500, a month later LVL 3 300, but by October, LVL 2 500. In July 2005 the price of hashish per kilogram was LVL 3 500; in December, LVL 5 000, while the price of marijuana in November was LVL 7 000; in December, LVL 5 500. However, in June 2004 and in September both marijuana and hashish cost LVL 3 500 per 1 kg.

Overall, it is possible to conclude that during the period 2004-2009, the highest wholesale price of hashish was LVL 6 000 (January 2008), while its lowest price was LVL 2 500 (October 2006). During this period the highest known wholesale price of marijuana was registered in November 2005 at LVL 7 000, lowest in January 2008 at LVL 1 100 per kilogram. However, bearing in mind the fact that at the moment drug prices are not compiled in accordance with a unified methodology, it is difficult to explain the frequent rises and falls in prices.

[71] 1EUR=0.7028LVL

Figure 11.1. Wholesale prices of cannabis, LVL



Source: State Police 2009

Typology of retail outlets for cannabis sale

As marijuana and hashish are prohibited substances in Latvia, they are included on Schedule 1 of narcotic, psychotropic substances and precursors controllable in Latvia, and any form of activity with these substances is prohibited, the sale of these substances most often takes place in secret with collaboration between the seller or dealer and the buyer, occasionally utilising previously agreed coded phrases and signs.

Retail sites

In the late 1990s, retail outlets selling marijuana and other substances operated in Riga district and these were known as places "on the string". This usually meant that the dealer lived on the second floor or higher, and for the purposes of lowering the "goods" and to receive money, a string was let down from a window with a purse tied to the end. Initially, a purchaser would place an appropriate sum of money in the purse, and the dealer would lower the purse, now containing the desired product, back down to the purchaser. Such places are no longer known in Riga as they are easily discovered and eliminated. Nowadays buying and selling is most often organised "by phone", or in some rare cases (especially among young people), via the Internet (e.g., Skype or e-mail).

Marijuana is mostly obtained from people who are known to the purchaser. Wishing to obtain marijuana, a purchaser initially contacts a dealer by telephone. Using the phone, the purchaser and dealer agree on a meeting place; for example, the purchaser may visit the dealer at home; the dealer may deliver the marijuana to the purchaser at his place of residence, or some other neutral meeting place might be arranged. Of course, it is also possible to obtain marijuana "from the hand" which can happen anywhere. According to users, marijuana is freely offered on the street. However, as pointed out by users, even in such places it is important to know the seller, otherwise it is impossible to know, firstly, whether the product offered really is marijuana, and secondly, the quality of the marijuana, as in such places, marijuana bought from an unknown dealer may be mixed with heroin or other substances.

The majority of dealers know each other, particularly dealers who operate within a single district. Undoubtedly, they are "single level" dealers. According to users, there have been cases when conflict has arisen between dealers fighting to attract clients. However, for the most part a purchaser is free to choose the dealer who in his opinion offers the highest quality marijuana.

The majority of persons who sell or grow marijuana only sell one of its products and it is rare for the range of drugs on offer to be wider.

Similar facts were also acknowledged by experts regarding the issue of marijuana growers, emphasising that in the majority of cases, cannabis growers are concerned only with cannabis, but the possibility of committing other crimes such as money laundering for example, is not ruled out.

Retail outlets for "legal marijuana" or Spice products

Attracting great popularity in recent times is the acquisition and use of the so-called "legal marijuana" or various Spice products. During the past year, the availability of various smokable mixtures in Latvia has grown rapidly; these are offered both on the Internet on local websites, and at so-called "kiosks" - small shops which among other things also offer various smoking paraphernalia (pipes, bongs, souvenirs). It is suggested that in Latvia at the moment there are around 15 such shops, and many more websites. The most widely available smoking mixtures which are defined as various incenses and aromatic substances, are: *Spice gold, Spice silver, Spice diamond, Spice diamond spirit, Spice arctyc, GOA mix, GOA spirit, Yucatan, Yucatan fire, Alarma, Sencation vanilla, Sencation blackberry, Sence, Tropical synergy, King B, Smoke, Clover, Forest humus* etc). The mixtures are sold in packets of 500 mg, 2 g, 3 g and 6 g, and their price ranges from LVL 5 (for a 500 mg packet) to LVL 36 for a 6 g packet. It is not uncommon on the websites offering the said products for discounts to be offered in respect of the products themselves as well as for their home delivery (e.g., free delivery is offered within Riga city for products purchased for more than LVL 10). Smoking mixtures are also available for purchase in bulk. The websites feature various types of forum where users exchange experiences about various products they have tried.

It is of concern that these products, currently legal in Latvia, are being increasingly often tried, not only by young people who wish to experiment, but also by experienced drug users, indicating that these products are more easily obtainable, and they are absolutely legal and there is no need to fear the police and possible punishment.

Even though the typology of illegal marijuana retail outlets is not so readily described, it is easier to fight against the sale of the substances as well as other illegal activities because they are clearly defined in the legislation of the Republic of Latvia. Presently, while the legal smoking mixtures are not subject to control, it is practically impossible to fight against their distributors, which, as indicated by information obtained during focus group discussions, users utilise to their benefit.

Cannabis sources and transaction sizes

Marijuana and hashish are imported into Latvia from the Netherlands, Spain and Lithuania (State police, 2007), although in recent years there has also been an increase in marijuana trading at the local level, and it is also possible that marijuana is being grown for export to Latvia's close neighbours Lithuania and Estonia, and the Scandinavian countries where the price of marijuana is higher than in Latvia. As indicated by experts, the main transit countries for import are Germany, Poland, and Lithuania, and for export, Sweden and Estonia. Marijuana is most frequently imported into and exported from Latvia by overland routes using specially concealed places in car bodies (tyres, body panels, the floor cavity, fuel tank etc). And also, of course, using public transport buses, marijuana is concealed within personal effects. At airports, people most frequently hide marijuana in their shoes and within other personal effects. At present, there are increasing problems with the distribution of drugs due to the free migration of people within the Schengen sign zone.

For the time being, the plantations discovered in Latvian territory are relatively insignificant compared to those discovered in other countries, however, with the worsening economic

situation, it is likely that increasingly more people will choose such illegal means of deriving income.

For the most part, users buy or grow marijuana for their own use. Marijuana growing for own use takes place indoors and is fairly easily done as firstly it is very easy to obtain the equipment necessary for marijuana growing, and not only from the Netherlands or by ordering it from the Internet, but also from within Latvia, utilising common horticultural or building construction equipment retailers, and secondly, it is equally easy to obtain seeds via the Internet. According to users, it is possible to grow good marijuana in Latvia, provided the necessary equipment is available (watering and lighting systems have been installed), and if the appropriate seeds have been obtained. Also available on the Internet is a wide selection of instructional material for growing marijuana, both in printed form and in the form of video instruction.

However, the THC level in the cannabis plants that grow in the wild in Latvia is excessively small. These cannabis plants are therefore practically useless for the purpose of intoxication. However, it is possible to boil an extract from the Latvian wild cannabis plants (the so-called "milk"), and to bake cakes.

The 2007 study "*Drug use in entertainment venues*" *(Koroleva, Karklina et al. 2008)* revealed that 31% of respondents thought it very easy to acquire marijuana/hashish within 24 hours; 32% thought it was fairly easy; 27% thought it was fairly or very difficult; and 10% thought it was impossible. Those respondents who had used drugs during the past year much more often thought it would be easy to obtain hashish or marijuana.

Of respondents who used marijuana during the previous month (12%), 25% had obtained it at another person's home, 24% in their own home, 23% at an event in a private home or apartment, 11% in an open public place, 7% at a club or disco, 2% each at work, at school/college/university or a bar or restaurant, 1% at a musical concert or festival, and 3% had obtained it elsewhere. Marijuana, like other illegal drugs, is most often obtained from friends or acquaintances. Most visitors to clubs believe that drugs are most easily obtained from nightclubs and friends (41% and 40%); 29% think drugs could most easily be bought at discos; 19% - from neighbours, acquaintances; 18% – at large dance music events; equally many respondents think it is easier to buy from street dealers; 7% at the station; 5% - at school; while 2% thought that drugs could most easily be purchased at a hotel.

14% of respondents know of one, and 16% know of a number of drug outlets near their residence. 35% indicate that they know such a place exists, but not exactly where, while another 35% indicate that they have not heard of drug outlets around their place of residence.

"Street" names for cannabis

In Latvia, most names or slang used for marijuana is in the Russian language, but there are also several words in Latvian that used when referring to cannabis. The most common are:

- *Ганджа, шмаль, чопер, шоколадка, ганджубасс, хаш, гаш, анаша, дрянь, головки, дурь, зелёная, сено, подкур, пышка, зелёный табак (in Russian);*

- *Zāle, zālīte, plāns, zaļais, stabs, maziņais, gandžons, laimīte, saulīte, krapālītis, gurķis (in Latvian).*

Often the conversation between the buyer and the dealer is encrypted using specific terms, slang or the above previously agreed phrases. In this way, and by ordering the required quantity of marijuana on the phone or agreeing a certain meeting place, the acquisition of marihuana is better concealed.

Cannabis packaging and transaction size

Marijuana is mostly either pre-packaged in small bags or wrapped in foil, in a paper or newspaper. Experts also found that marijuana is typically pre-packaged in foil, newspaper or small polyethylene bags by quarter gram, the price of which varies from two to three Lats[72]. Users' statements on this differed from those of the experts.

According to users, there are mostly two standard units of measurement they use when purchasing - half a gram and one gram. The stated price per gram of marijuana ranges between LVL 8–12, and for hashish between LVL 12–14 (21 EUR). In some cases, it is possible to receive discounts or purchase at lower prices e.g. LVL 6 per gram, by purchasing marijuana in bulk or from good acquaintances or friends.

Users indicate that they never know the origin of purchased marijuana, except in those cases where friends have brought in marijuana from a specific country or it has been grown here for their own use or that of close friends, but concede that in most cases, marijuana is imported from the Netherlands or grown locally in Latvia. Respondents also mentioned that this issue is of virtually no interest to them; what is important is the quality of the marijuana purchased. Moreover, there is no point in asking one's dealer, who is just as likely not to know the marijuana's country of origin.

11.2. Seizures

Contextual information

It is not possible to separate law enforcement agencies' special and specific strategies, activities, tactics or techniques that are applied directly to reducing the supply marijuana and/or hashish. Reduction of supply is focused on reducing the supply of any illegal drug. The State Police, Customs Criminal Board and the State Border Guard are the main bodies working to reduce the availability of drugs, including cannabis. These institutions carry out their assigned activities, and operational work in their fields, in collaboration with other relevant national authorities and among themselves, in cooperation with Europol and Interpol, as well as carrying out intelligence work, involving dog handlers (see Chapter 9.2 for more information about supply reduction activities)

Seizures of plantations, 2005–2009

In recent years, increasingly more cannabis-growing plantations are being discovered. Overall, during the past four years, seven relatively large farms and several smaller scale properties have been discovered. Data on the plantations has been compiled using data from both the State Police and information reflected in the Latvian mass media. Most of the farm owners were well informed regarding cannabis-growing technology and the equipment needed. In some locations, in addition to seizing cannabis and cultivation equipment, personal records regarding the pace of marijuana-growing, watering schedules etc. were also seized.

The first large-scale plantation was discovered in 2005 in Jelgava city, when 17 kg of marihuana plants (grown in soil) were seized. The plants were grown on the second floor of a home, where rooms had been specially adapted for the purpose with ventilation, heating and lighting. Also seized was a special liquid fertilizer to facilitate the cannabis-growing process. Three persons were arrested for the unlawful activities. (State police 2008).

Two years later - in 2007, three cannabis farms were discovered in the Kuldiga and Ogre districts and in the Riga suburb of Pardaugava. In the Pudure parish of Kuldiga district, an illegal plantation had been established in an underground hangar on an estate near the Nabe Lake,

[72] 1LVL= 0.7028EUR

occupying an area of 120 square metres. During a search of the hangar, 618 marijuana plants (33 kg) were seized and 3 kg of dried marijuana was found. Also found were a special press and bags for the vacuum press of the marijuana. The cannabis was grown in pots, using hydroponics, and it is known that the marijuana was intended for sale on the Russian market. At the second plantation discovered in 2007, in the Ogre district, 13 kg of cannabis plants (grown in soil) was seized, while in Riga, marijuana was being grown in a high-rise apartment on the seventh floor. The apartment was fitted with special lighting, humidity and heat in the room were controlled electrically; a ventilation system with odour filtration had outlets outside the apartment; there was an automatic watering system, and a special fertilizer. (State Police 2008).

One of the largest farms was discovered in Talsi district in 2008. The street value of drugs seized was over LVL 500 000, (EUR 714 285). The marijuana was grown in the Lauciene parish in the Talsi District in a rural farmstead, occupying an area of about 100 square metres. Three men were detained on suspicion of growing marijuana and preparation of drugs for the purpose of sale. One was a previously convicted male in born in 1970, a male born in 1968, and a male born in 1975. During the search, police officers found and seized 5.3 kg of hashish, 18 kg of marijuana and 1905 marijuana plants (which in undried form is the equivalent of 150 kg of marijuana). The plants were being grown hydroponically. It was found that the arrested men had built a marijuana farm and hothouse at the rural farmstead and outbuildings, equipping them with additional lighting, heating and ventilation equipment. Two generators provided uninterrupted electricity supply for the buildings; water pumps provided water supply plants (a tube was attached to each pot). Overall, approximately LVL 60 000, or EUR 86 000 had been invested in hardware and equipment on the marijuana farms. Also seized was special fertilizer (marked in German) for the cultivation of marijuana. As three people worked on the farm, a schedule had been created of who would care for the plants and when. The "farm" was located on two floors: on the first floor were the so-called "mother plants", from which twigs were cut, to be transplanted into newly equipped pots and grown on the second or attic floor. Also ascertained during the investigation was the fact that the marijuana farm had been operating for a considerable period of time and that the drugs were intended for sale outside Latvia (State Police, 2009).

Similarly, two cannabis farms were discovered in the Valmiera district. In the first case, 30 plants grown in soil were seized, while in the second, 100 plants or 1.4 kg of marijuana were seized. As previously, in this case, the marijuana was being grown on a private rural farmstead, in a room specially equipped with apparatus for marijuana cultivation. (*Neatkarīgā Rīta Avīze* newspaper, 6 November 2008).

In addition, a further three farms were discovered in 2008 at Daugavpils (five plants grown in soil were seized); at Aluksne (three plants grown in soil were seized). A young man had been cultivating the three plants in his wardrobe, in which favourable growing conditions had been created – the cupboard wall was lined with foil and several lamps had been attached; and at Cesis (6 kg of plants that were being hydroponically grown were seized, as well as other special equipment such as an irrigation system and lighting).

During eight months of 2009, three cannabis farms were discovered – at Valmiera, Liepaja and at the Cenu parish in the Jelgava District. Seized at Liepaja and Valmiera, were 3 and 14 plants respectively, while 194 plants were seized in the Jelgava district. In this case also, the marijuana had been grown in a private house, using special equipment. Police officers arrested a group of people - men born in 1984, 1976, and 1980, who were Riga residents, of whom two had been previously convicted (*Diena* newspaper, 21 August).

It is anticipated that in the current economic conditions, the number of illegal cannabis farms can only increase. Since 2005, 13 marijuana farms have been discovered, most of which were discovered in 2008 in the Talsi district. Summarized in the following table is the number of cannabis seizures, the seizure sites, amount seized; and the cannabis-growing conditions are indicated.

Table 11.2. Cannabis farms in enclosed areas January 2005 – August 2009

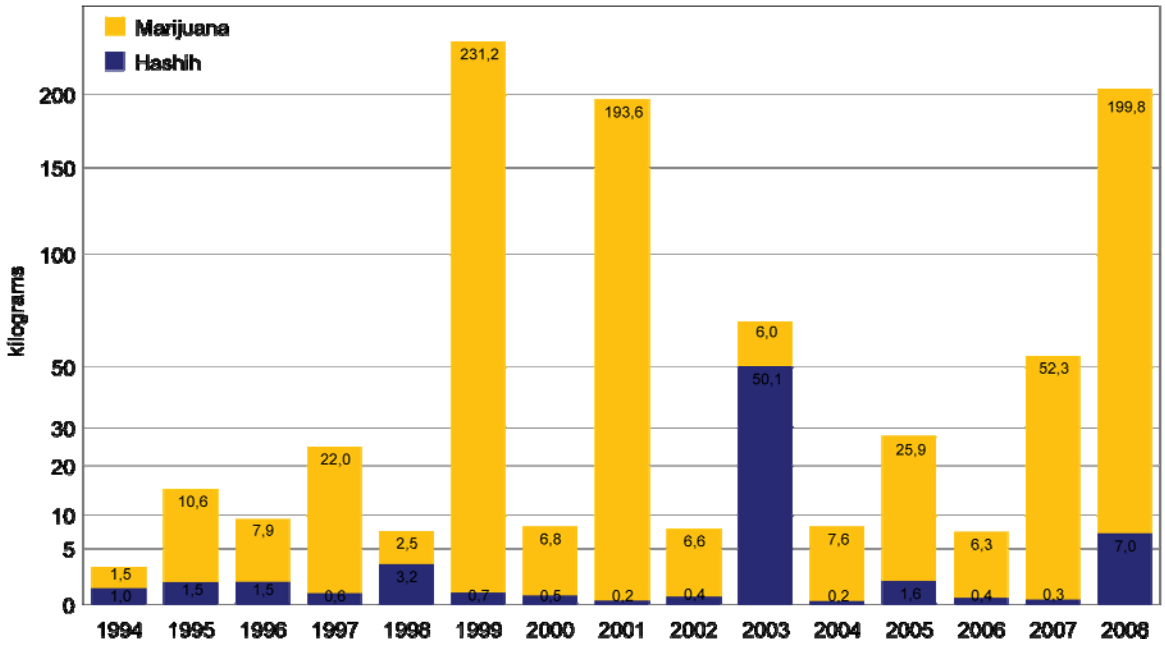
Place	Year	Undried plant weight/ number of plants (if available)	Growing Conditions		
			Soil	Hydroponics	Other
Jelgava	2005	17 kg	X		
Kuldiga district	2007	33 kg/618 plants		X	
Ogre district	2007	13 kg	X		
Riga	2007	6 kg/31 plants	n/a	n/a	n/a
Talsu district	2008	150 kg		X	
Daugavpils	2008	5 plants	X		
Aluksne	2008	3 plants	X		
Valmiera district	2008	30 plants	X		
Cesis	2008	6 kg		X	
Valmiera district	2008	1,4 kg/100 plants	n/a	n/a	n/a
Valmiera	2009	3 plants	X	X	
Liepaja	2009	14 plants			Granules
Jelgava district	2009	194 plants	X		

Source: State Police Forensic Department, 2009.

Breakdown of cannabis seizures by product and by amount seized,1994–2008

The earliest available published information in Latvian on seizures of marijuana and hashish dates from 1994, when the State Police Central Criminal Police Department Drug Enforcement Bureau seized 1.45 kg of marijuana, and 1005.8 g of hashish. A year later the amount seized had increased for both marijuana and hashish: 10.59 kg of marijuana, and 1487.2 g of hashish. The quantity of marijuana seized fell again in 1996, doubled in 1997 and fell again in 1998. The quantities of hashish seized were equally variable. A similar trend is observable in the period 1999-2003, when the largest quantity of marijuana seized was 231.19 kg; the lowest 6.02 kg, while the largest quantity of hashish seized during the same period was around 50 kilograms, and the least was 191,48 grams (State Police 2002) *(see Figure 11.2)*. In later years, increases and decreases were also recorded in quantity seized; the fall in the case of marijuana can be explained by the identification of plantations.

Figure 11.2. Quantities of hashish and marijuana seized nationally, 1994–2008



Source: State police 2009

According to State police data, which includes the entire country, in 2008 there were 34 seizures of cannabis resin or hashish registered in Latvia, 12 cases more than in 2007; 309 seizures of marijuana leaf (2007 - 253 cases); and eight seizures of cannabis plants, four cases more than in 2007.

Overall, 6.88 kg (6880 g) of hashish was seized in 2008 (2007, 254 g), 42.44 kg of marijuana leaf (in 2007 – 17.84 kg) and 157.52 kg of marijuana plants (in 2007 – 34.48 kg). Such an increase in the number of seizures and volume of cannabis products seized is largely explained by the marijuana plantations discovered in 2008 (see also ST13[73]). Such a distribution of marijuana - by leaves and plants - is available only in the EMCDDA standard tables. Mostly data is collected in respect of hashish and marijuana, without distinguishing between leaves or plants.

11.3. Offences

Information on nationally available data for cannabis related-offences is available from the databases accessible to the Ministry of the Interior Information Centre in respect of 2007 and 2008. In 2007, 113 offences were recorded for drug use/possession for personal use, while 28 such offences were recorded during 2008. 120 offences of drug trafficking and production were recorded in 2007, while 133 such crimes[74] were recorded in 2008.

In addition to the above-mentioned cannabis supply offences, in 2007, there was one additional cannabis-related offence recorded pursuant to Section 262 of the *Criminal Law*: "Operating a Vehicle While Under the Influence of Alcoholic Beverages or Narcotic, Psychotropic and Other Intoxicating Substances " and 51offences were registered pursuant to Section 309 of the *Criminal Law*": Unlawful Providing of Substances and Objects to Persons who are Confined in Places of Detention and Imprisonment, and Unlawful Receiving of Substances and Objects from Such Persons." In 2008, 1 and 35 criminal offences were respectively registered under those sections of the *Criminal Law*, as well as one offence pursuant to Section 251 of the *Criminal Law*: "Inducement to Use Narcotic and Psychotropic Substances", and 3 offences pursuant to Section 255 of the *Criminal Law* "Manufacture, Acquisition, Storage, Transportation, Conveyance and Sale of Equipment and Substances (Precursors) Intended for Unauthorised Manufacture of Narcotic and Psychotropic Substances."

Table 11.3. Number of cannabis-related offences

	Drug-related use/possession for personal use			Drug-related dealing/trafficking/production			Other types of offence		
	Section 253[75]	Section 253.[2] [76], Par.1	Section 190.[1] [77]	Section 253.[1] [78]	253.[2]p. Par.2	Section 251	Section 255	Section 262	Section 309
2007	102	11	9	108	3			1	51
2008	21	7	17	110	6	1	3	1	35

Source: Barbala 2009

[73] ST13_2009_LV_01; ST13_2009_LV_02; ST13_2009_LV_03; ST13

[74] More information about sections of the Criminal Law and their conformity with the EMCDDA Offence types may be found in the 2008 National Report in the expanded theme "Sentencing Statistics".

[75] CL Section 253. Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances.

[76] CL Section 253.[2] Unauthorised Manufacture, Acquisition, Storage, and Sale of Narcotic and Psychotropic Substances in Small Amounts and Use of Narcotic and Psychotropic Substances without a Physician's Designation.

[77] CL Section 190.[1] Movement of goods and Substances the circulation of which is Prohibited or specially Regulated across the State Border of the Republic of Latvia.

[78] CL Section 253.[1] Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances for the Purpose of Sale and Unauthorised Sale.

12. Problem amphetamine and methamphetamine use, related consequences and responses

12.1. Epidemiology of amphetamine and methamphetamine use

History of (meth)amphetamine use

The first and publicly much discussed illegal drug case soon after regaining independence was in 1992, which was related with the illegal production of MDA at one of the major pharmaceutical factories Latbiofarm. The tablets containing MDA were exported to Germany under the brand name DOFA. In total around 8 kilograms of MDA tablets and 1 kg of MDA powder substance was seized within the case. In 1998 in the same factory around 200 grams of amphetamine was seized.

Trends and patterns of (meth)amphetamine use

As regards distinguishing methamphetamine and amphetamine use as Trapencieris (2008) tries to explain is that over the years the drug users have developed slang for amphetamines/probably methamphetamines and would refer to 'vitamīni'79. When asked to distinguish between amphetamine and methamphetamine use, only a very few drug users would mention differences in the effects (*"the rush of 'vint' is different and the effects would last longer"*) but in general the feeling is that *"[stimulant] drug users do not know what they are taking"*; among drug users methamphetamine sometimes would be referred as *'vint'* (Trapencieris 2008).

Treatment demand for (meth)amphetamine use

The treatment data collection system in Latvia does not distinguish between methamphetamine or amphetamine use. Although, while developing the treatment data collection forms and system the drug classification includes amphetamine, dexamphetamine, methamphetamine, MDMA, and unspecified amphetamines the data would in most cases include unspecified amphetamines. For example, over the ten years of treatment data registration methamphetamine as primary substance is mentioned 10 data collection forms, while as secondary substance – in nine forms *(see Table 12.1)*. Such a distribution is not compliant with data from other sources, e.g. police seizures, where methamphetamine over the last years is seized in larger quantities as compared to amphetamine or drug testing facilities that in significantly higher number of biological samples would find methamphetamine rather than amphetamines (National Focal Point unpublished data).

Apart from the fact that treatment data does not distinguish between methamphetamines or amphetamines, the number of clients in treatment for ATS that since 1997 has increased dramatically, shows some stabilization over the last few years. Treatment data sources used in this subchapter are:

- Data on **first outpatient** treatment from the Patient Register Data (PREDA) that is maintained by the Health Statistics and Medical Technologies State Agency (as of October 1, 2009 – Health Economics Centre). This subset of data is reported to the EMCDDA as outpatient data.

- Data on **first and all inpatient** treatment that is collected at the Riga Centre of Psychiatry and Addiction Disorders (State Addiction Agency – until 2007).

79 or 'витамин' (in Russian)

Table 12.1. Number of data collection forms[80] or correction notes submitted mentioning ATS use, 1997-2008

	Primary substance	Secondary substance
Amphetamines (unspecified)	1024	741
Amphetamine sulphate	2	4
Dexamphetamine	0	0
Methamphetamine	10	8
Methamphetamine (for smoking)	0	0
Unspecified amphetamines	0	0
Unspecified stimulants (excluding cocaine)	1	4
Methylphenidate	0	0
Phenmatrazine	0	0
Ephedrine, norephedrine, pseudoephedrine	115	57
Ephedrone	393	186
MDMA	29	68
Other specified stimulants (excluding cocaine)	4	2

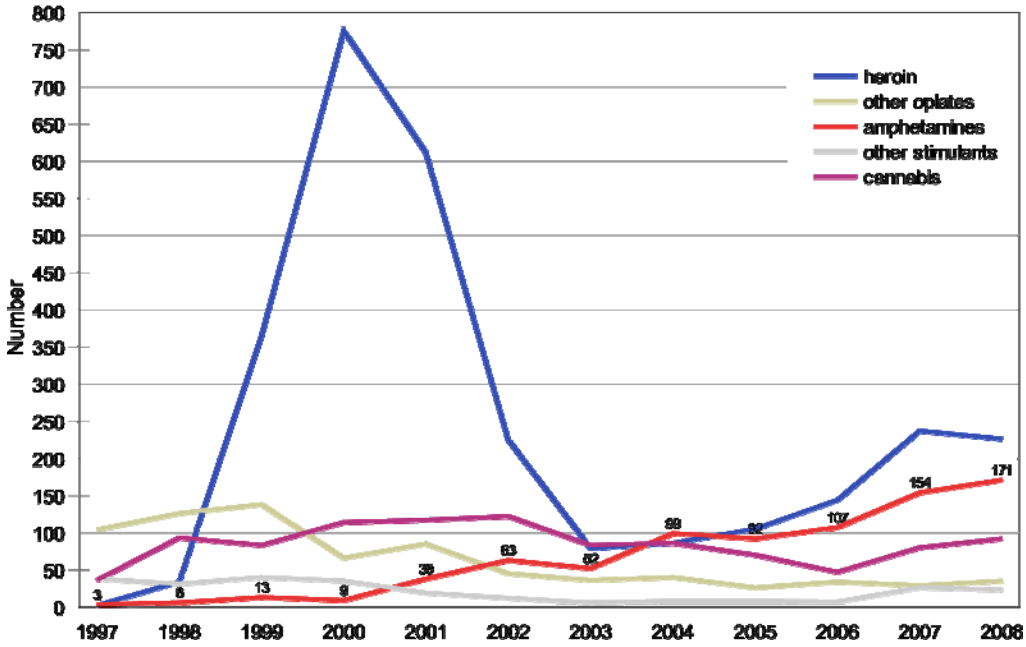
Source: PREDA 2009

Outpatient treatment

Data on first out-patient treatment suggests that since the first cases with primary (meth)amphetamine use in 1996 the situation has changed dramatically since 2001 over the last years and in 2008 constitute 26% (or 171) of first-time treated clients at public out-patient treatment centres *(see Figure 12.1)*.

Since 2004, the percentage of first time treated amphetamine clients have remained at about the same level (23–26 percent) but the number of patients tends to increase each year. Moreover, in 2004 the number of primary (meth)amphetamine treatment clients was higher than that of traditionally more prevalent treatment demands for heroin, while since then it is the second most often mentioned primary substance treatment is sought for.

Figure 12.1. Number of first-time treated (meth)amphetamine clients, outpatient treatment centres 1997–2008



Source: PREDA 2009

80 Does not refer to the number of patients or treatment episodes

Among first-time out-patient amphetamine clients about every fourth client (23.6% for the period of 2001-2008) is female, which is slightly higher than the proportion for other primary substances, especially cannabis *(see Table 12.2)*.

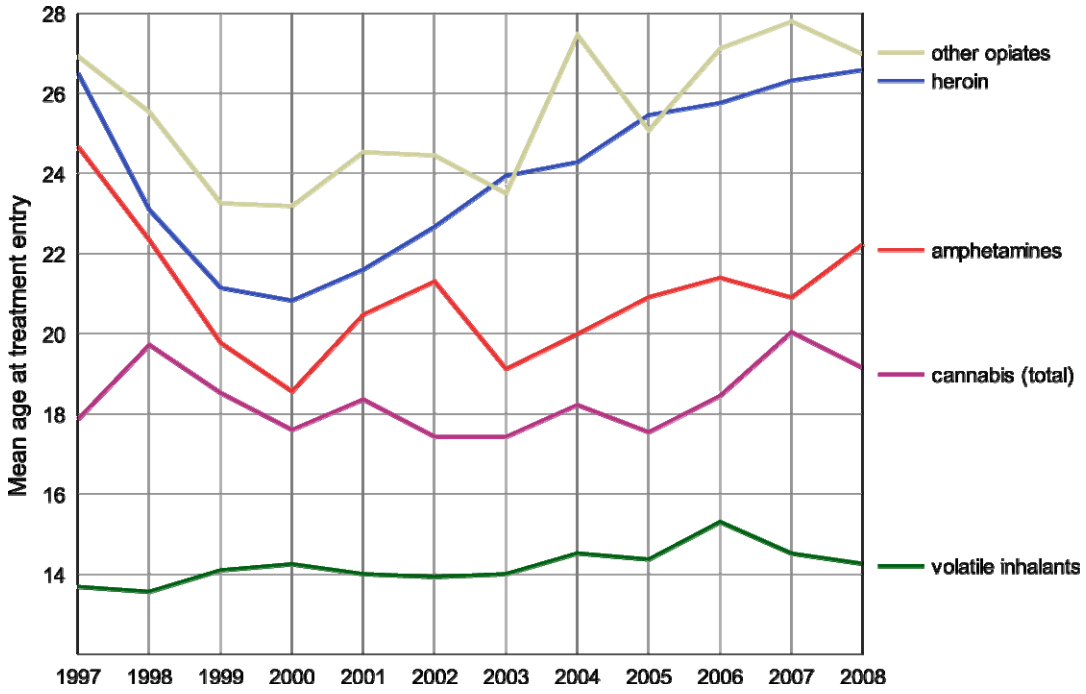
Table 12.2. Proportion of females among first time treated clients, outpatient treatment centres 2001-2008, percentage by primary substance

	2001	2002	2003	2004	2005	2006	2007	2008
Amphetamines	15.8	25.4	32.7	24.2	23.9	20.6	24.0	22.8
Heroin	18.7	25.8	26.6	26.7	21.0	21.5	19.4	21.7
Cannabis	19.7	12.3	16.9	15.1	14.3	17.0	12.5	6.5
Any substance	20.3	22.0	24.1	24.8	23.7	20.3	21.4	19.0

Source: PREDA 2009

Amphetamine users seeking treatment for the first time are generally younger than heroin users and on the other hand, amphetamine users are older than cannabis clients, e.g. in 2008 the mean age for primary amphetamine users was 22 years, 26 years for heroin users and 19 years for cannabis users *(see Figure 12.2)*. As seen in the data the mean age for primary heroin users has increased steadily since 2000 (from 21 in 2000 to 26 years in 2008), while among primary amphetamine it has increased rather steadily since 2003 (from 19 years in 2003 to 22 years in 2008).

Figure 12.2. Mean age of first-time treated clients, outpatient treatment centres 1997–2008, by primary substance



Source: PHA/HEC, 2009

According to the 2008 data more than a half (54%) of the first-time treated primary amphetamine clients according to the ICD-10 are diagnosed as poly-drug users (F19), while intoxication, harmful use or dependence caused by stimulant use (F15) is diagnosed in 38% of clients; there is a small minority of clients who are diagnosed with diagnosis related to opioids (F11 – 7%), cannabis (F12 – 1%) or cocaine (F14 – 2%). Since 2005 the trend of poly-drug diagnosed clients seems to be decreasing but there is no good explanation of the fact, e.g. in 2005 65% of clients were diagnosed with F19, in 2006 and 2007 – 58%.

Data suggest that among amphetamine users seeking treatment for the first time in their lives that the clients are more 'problematic' as compared with first clients in previous years, e.g.

having developed dependence syndrome with or without psychosis or have withdrawal symptom; if in 2001 16% of first treatment cases were related with dependence, it had increased to 40% in 2004, while in 2007 and 2008 there were 47% and 51% of such cases, respectively *(see Table 12.3)*.

Table 12.3. Proportion of diagnostic criteria among first time treated amphetamine users, outpatient treatment centres 2001-2008, (%)

	2001	2002	2003	2004	2005	2006	2007	2008
Intoxication	18	0	4	5	1	7	3	4
Harmful use	63	67	62	54	58	53	49	43
Dependence syndrome, withdrawal	16	33	35	40	41	38	47	51
Total	100	100	100	100	100	100	100	100

Source: PREDA 2009

Out-patient data on first-time treated clients with amphetamines as primary substance suggest that by far most often mentioned secondary substance was cannabis. Benzodiazepines, alcohol, other opiates, MDMA, heroin and other stimulants as secondary substance were mentioned by far fewer number of clients *(see Table 12.4)*.

Table 12.4. Most often mentioned secondary substances by primary amphetamine clients, outpatient treatment 2001–2008, (%)

	2001	2002	2003	2004	2005	2006	2007	2008
Cannabis	9	28	17	35	40	33	38	41
Benzodiazepines	1	7	6	6	4	6	4	5
Alcohol	2	0	0	4	6	11	8	8
Other opiates	1	3	3	3	9	3	4	5
MDMA or other derivates	6	1	1	4	7	3	7	2
Heroin	4	2	4	1	2	2	5	8
Other stimulants	0	4	4	0	4	3	3	5

Only most often mentioned substances (10+ cases between 2001 and 2007) included in the table. A client can have more than one secondary substance.

Source: PREDA 2009

In 2008 amphetamines as secondary substance was mentioned in about every tenth patient (11.5%) asking for out-patient treatment for the first during their lifetime. Table xx shows data on amphetamines as secondary substance as percentage of respective primary substance since 2001. The most often primary used substance by secondary amphetamine clients since 2001 is heroin, while cannabis and other opiates had been mentioned in significantly less cases. There is no clear trend as regards treatment demand for amphetamines as secondary substance over the years – although as compared with 2001 there is more two fold increase in the proportion as of primary clients.

Table 12.5. Primary substance among persons reporting secondary amphetamine use, outpatient treatment 2001-2007, % of secondary amphetamine clients

	2001	2002	2003	2004	2005	2006	2007	2008
Heroin	61	66	58	47	38	61	71	65
Other opiates	16	10	7	18	5	21	5	13
Cannabis	14	21	29	22	25	11	16	11
Number	49	61	31	51	40	38	87	76
Percentage of clients of any primary substance	4,9	10,5	8,3	11,6	10,2	8,7	13,9	11,5

Only most often mentioned primary substances included in the table.

Source: PREDA 2009

Among first-time treated amphetamine clients the most common referral is medical sources (e.g. hospitals, drug treatment centres or other medical sources), while the second most important source of referral is self-referrals. Since 2001, the proportion of clients referred to outpatient treatment from medical sources is steadily decreasing, while referral by family or self-referrals is on the increase. The proportion of clients referred by the law enforcement is rather stable over the years. In comparison – for heroin users the most important source of referral is self-referrals (about three out of four clients), for cannabis users – about half are referred by medical sources and about every fourth – by law enforcement agencies. Detailed comparison of referral by most often mentioned primary substances since 2001 is shown in the Table below.

Table 12.6. Source of referral by clients of primary use of heroin, amphetamine and cannabis clients, outpatient treatment, % of referrals in a given year

		Self referred	Family or friends	Medical sources	Social services	Law enforcement
Heroin	2001	36	28	19	1	16
	2002	22	9	65	0	1
	2003	33	13	49	0	5
	2004	53	15	27	1	3
	2005	64	11	19	0	6
	2006	72	11	14	1	0
	2007	75	11	10	0	3
	2008	73	13	12	0	1
Amphetamines	2001	8	3	58	5	26
	2002	13	6	67	0	14
	2003	17	8	67	0	2
	2004	17	17	52	2	11
	2005	17	16	51	1	12
	2006	20	13	45	3	19
	2007	31	16	37	1	14
	2008	26	19	35	1	15
Cannabis	2001	10	12	33	3	31
	2002	7	13	62	2	8
	2003	4	12	64	5	11
	2004	15	8	64	5	7
	2005	11	10	63	1	9
	2006	9	23	47	0	21
	2007	14	16	39	1	28
	2008	16	11	50	1	16

Only most often mentioned primary substances and referral sources included in the table.

Source: PREDA 2009

There is no clear trend on referral for amphetamine users by gender over time although it seems that males are more likely than females to be referred for treatment by the police (16% males as compared with 9% females since 2001) and self-referred (23% and 17%), while females are more often referred by family or friends (23% and 12%).

Data from the largest specialized drug-treatment provider (Riga Centre of Psychiatry and Addiction Disorders) in country suggest that out of 1504 clients with primary diagnosis of illegal substance use (ICD-10 F11-F19, excluding tobacco F17) for 236 (or 16%) clients diagnosis was related with stimulant use disorders (F15) (Trapencieris, 2009 conference presentation). There are limitations of these data as it is not possible to distinguish primary substance but previous data analyses on other sources suggest that over 80% of ICD-10 F15 clients are primary amphetamine users. Moreover, a substantial proportion of all F11-F19 diagnosis is related with

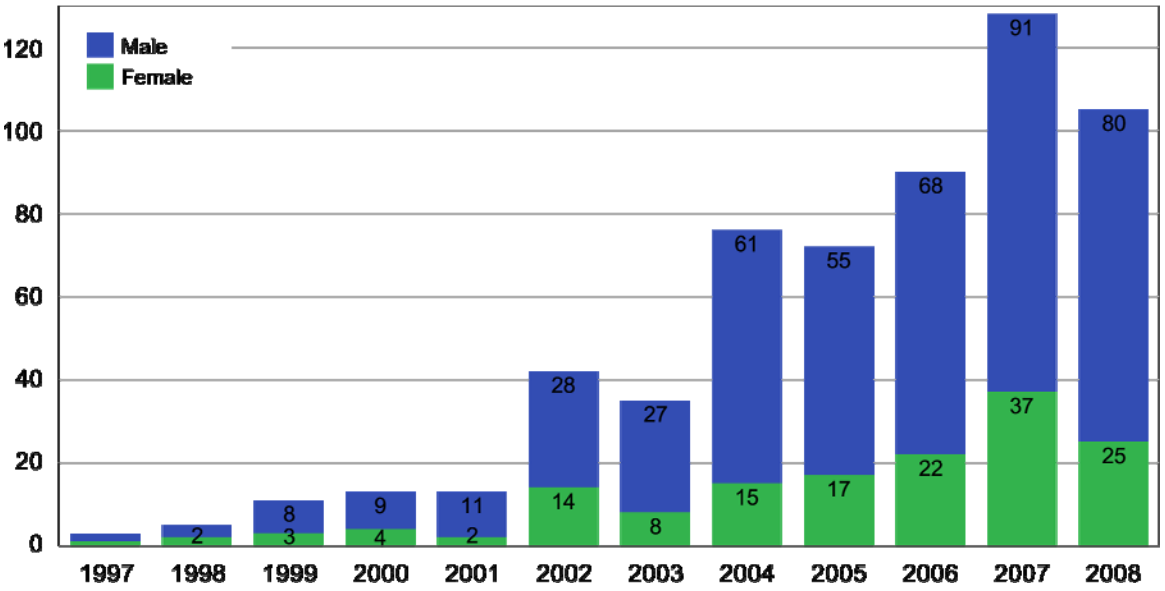
poly-drug use and amphetamines as one the major primary substance. Thus taken into account these consideration the number (or proportion) of amphetamine users in treatment is much higher than 16% shown in actual data.

There is no information about treatment type these clients received rather than data on number of episodes or number of client contacts during the year. Based on the information available it seems that most of the treatment is unstructured, e.g. for 50% clients there had been only one client contact a year, for 20% – 2-3 contacts, fro 15% – 4-10 contacts, and for 15% there were more than ten client contacts within 2008.

In-patient treatment

According to public inpatient treatment data between 1997 and 2008 there were 593 unique individuals[81] treated for primary amphetamine use. As seen in Figure 12.3 below since beginning of data collection in 1997 there has been a steady increase in the number of first time clients entering for amphetamine treatment (see Figure 12.3)[82].

Figure 12.3. Number of amphetamine clients treated for the first time, in-patient treatment centres 1997-2008, by gender



Source: PREDA 2009

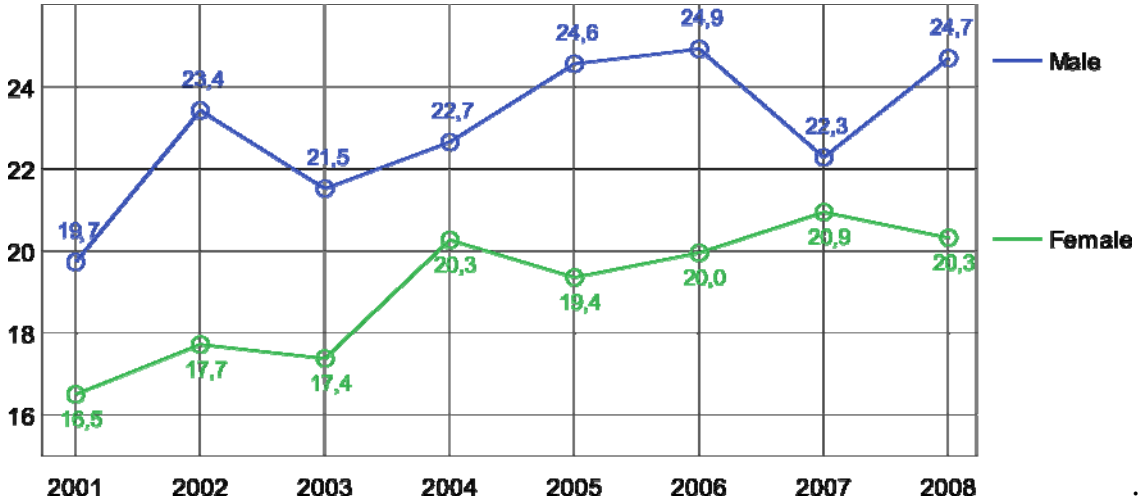
Out of clients entering in-patient treatment for primary amphetamine use between 2000 and 2008 for 22% of all amphetamine clients' first treatment was for other substances than amphetamines.

The mean age for female amphetamine clients is lower than that for males *(see Figure 12.4)*.

[81] Those with at least one in-patient treatment episode with primary amphetamine use; clients could have been treated for some other primary substances before or after treatment for problems related with amphetamines. Since in-patient data is reported only after discharge figures for the most current year (2008) might be underestimated.

[82] Decrease in 2008 is related with data collection methodology as patients are registered only after discharge and proportion of those in long-term treatment are reported during 2009. If compared with similar data in previous years – it is very likely that number of primary amphetamine users is either at the level of 2007 or has slightly increased.

Figure 12.4. Number of amphetamine clients treated for the first time, inpatient treatment centres 1997-2008, by gender



Source: PREDA 2009

Out-of-treatment populations of (meth)amphetamine users

Riga Drug Users' Cohort Study

The Riga Drug Users' Cohort Study (RCS) had been carried out annually since 2006, and in 2009 fourth wave of data collection was carried out. Altogether, in four waves interviews with 1282 individual drug users were carried out at least once. The study design has been reported somewhere else (Trapencieris et al, 2008; National Focal Point, 2007). Data in this section is based on the three waves of the study.

According to the data amphetamines as the first substance was tried by every fifth drug user (21%). Similarly as seen in studies among school children (see e.g. Hibell et al, 2000; Koroleva & Trapencieris, 2005) the most common reason for trying amphetamines was because of interest or curiosity (50%), while 21% were influenced by the peer pressure.

According to the RCS data amphetamines and heroin nowadays constitute most problem drug use in Latvia, e.g. over the last 30 days amphetamines and/or heroin were used by nearly two-thirds (74%) of cohort participants in 2008. Preliminary analysis of 2009 data suggests that over the last 30 days amphetamines were used by 65% of respondents and heroin – by 57%. Among the cohort participants, amphetamines are used mostly by injection (98%).

There is age effect if compared amphetamine and heroin users, e.g. over the last 12 months amphetamines were used by almost all (95%) drug users under age of 24; as comparison only 81% of this age group have used heroin. Among 35–44-year-olds, only two-thirds (65%) had used amphetamine and 82% had used heroin *(see Table 12.7)*. Similar trend can be seen if looked at last 30 days use *(see Table 12.8)*.

Table 12.7. Use of amphetamines, heroin, and *hanka* in 2008 over the last 12 months, percent by age group

	Under 24	25-29	30-34	35-44	45 and older	Total
Amphetamines*	95.2	79.5	75.4	62.8	35.1	77.3
Heroin	81.0	71.6	73.8	82.3	70.3	76.3
Hanka*	26.8	38.4	42.1	61.1	62.2	41.5

Statistically significant differences, p<0.05

Source: Trapencieris, Snikere et al. 2008

Table 12.8. Use of amphetamines, heroin, and *hanka* in 2008 over the last 30 days, percent by age group

	Under 24	25-29	30-34	35-44	45 and older	Total
Amphetamines*	92.9	75.8	74.6	57.5	32.4	74.3
Heroin*	77.4	66.8	71.4	81.4	73.0	73.5
Hanka*	22.6	33.2	35.7	51.3	56.8	35.5

Statistically significant differences, p<0.05

Source: Trapencieris, Snikere et al. 2008

The most consumed substance over the past 12 months among cohort participants in 2007 and 2008 were amphetamines followed by heroin. 2009 data suggests that the gap between amphetamine and heroin users has widened – 48% used mostly amphetamines, while 38% – heroin (see Table 12.9).

Table 12.9. Most commonly used substance over the last 12 months, percent by age group

	Under 24	25-29	30-34	35-44	45 and older	Total
2007						
Amphetamines	59.9	46.4	50.0	20.8	8.5	42.2
Heroin	29.0	39.2	33.0	40.0	29.8	35.0
2008						
Amphetamines	55.4	50.0	46.0	31.0	2.7	44.5
Heroin	38.7	41.6	41.3	46.0	51.4	42.1
2009						
Amphetamines	62.1	54.9	60.2	32.7	8.5	48.2
Heroin	32.3	34.7	33.0	47.5	52.5	38.2

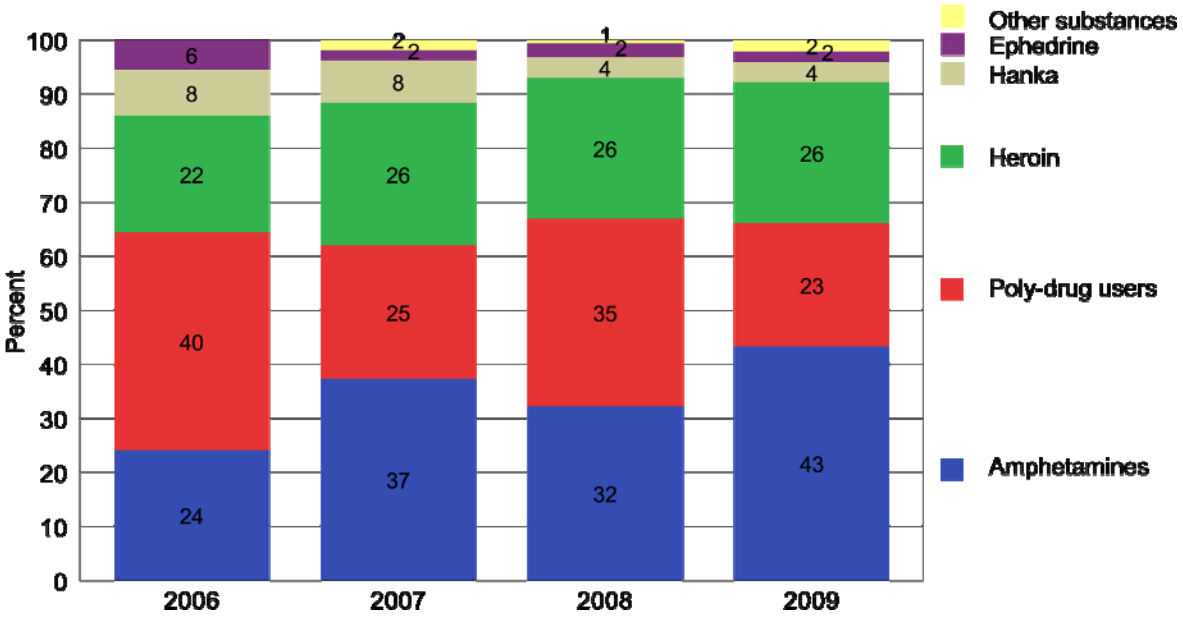
Source: Trapencieris, Snikere et al. 2008

Data from the cohort study suggest that amphetamine users switch their drug of preference less often than heroin users.

Of the amphetamine users in 2007, 78% were still using amphetamines in 2008 and 2009; of the heroin users in 2007, 76% were still using heroin in 2008 and 65% in 2009. Most of amphetamine users who had switched their drug of preference between 2008 and 2009 switched to heroin and small proportion – to *hanka*, 15.5% and 0.9%, respectively; among heroin users 16.9% had switched to amphetamines and 6.3% to *hanka*.

In relation to questions about the most commonly used substances injected during the past six months, it may be concluded that about 77% of the cohort participants used only one substance, and their choice did not change, while one-third used either whatever was most readily available, or sought to achieve various effects caused by their drug use, e.g. heroin-induced intoxication is used to "calm down" or fall asleep after amphetamine (or methamphetamine) intoxication. According to the most recent (2009) data, 43% of the entire cohort used amphetamines exclusively, and 26% only used heroin *(see Figure 12.5)*. There were very few who only used *hanka* or ephedrine (relevantly four and three percent). Among those who indicated that they had used more than one substance in the last six months, the combination most often mentioned was amphetamines and heroin.

Figure 12.5. Ratio of users of only one substance in four waves of the cohort study (%)



Source: Trapencieris, Snikere et al. 2008

Drug users from the police data

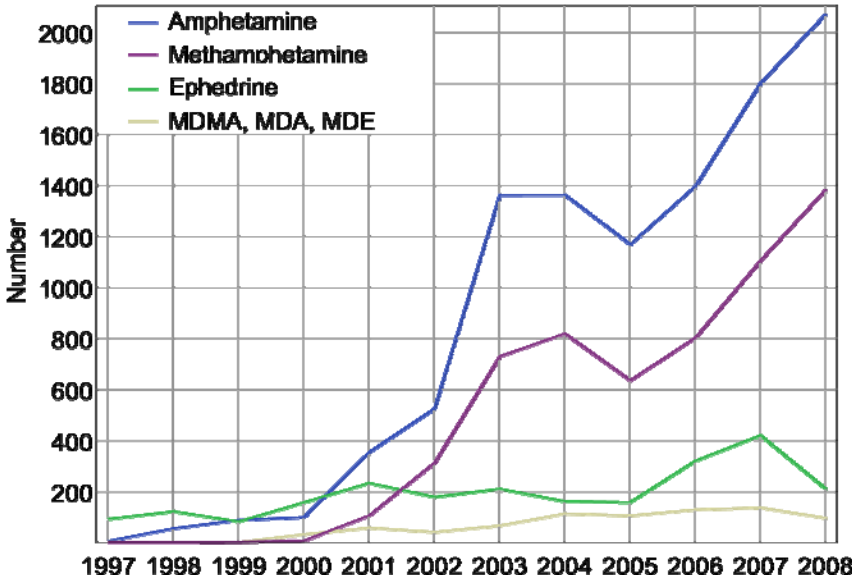
According to the existing legislation in Latvia police is allowed to send people under suspicion (e.g. drivers, people on the street, dealers, etc.) for drug testing. The institution responsible for these tests is Riga Psychiatry and Addiction Centre (before 2007 – State Addiction Agency) that carries out two kinds of tests: 1) assessment of people police has brought for testing and these could be drug users on the streets, drivers under suspicion, and 2) testing biological samples, which are sent from certified drug testing facilities (31 treatment centres) across country.

RPAC holds a database with results of people tested at RPAC premises, which is constantly updated and as of 2009 includes more than 38 thousand records (more than 29 thousand records with positive results) including persons sent mostly by the police for drug testing[83]. The oldest records in the database are dated back to 1986 but since 1998 it includes all records for positive tests. The data includes information on substances that were found using GC (gas chromatography) within biological samples (urine, blood, saliva or swabs from hands). The data collected within the system represents Riga city and surrounding regions.

According to the database the first record with a positive test for amphetamines[84] was in 1991 but it has started to increase since 1998 onwards – in 1997 there 6 positive tests for amphetamines (6 persons), in 1998 – 55 positive tests (53 persons), in 1999 – 88 positive tests (84 persons), in 2000 – 99 tests (92 persons), while it had tripled in 2001 as compared with 2000 – 354 tests (328 persons). Similar situation can be seen with methamphetamine – first positive test where methamphetamine was found was in 1999, and as with amphetamines – it has increased very rapidly since then. In the most recent data reporting year (2008) 2071 positive tests (1377 persons) for amphetamine and 1383 tests (922 persons) for methamphetamine were reported *(see Figure 12.6)*.

[83] According to experts' opinion almost all clients (98-99%) are brought by the police.
[84] In this section by amphetamine we refer to amphetamines or its derivates, for methamphetamine –methamphetamine or its derivates. If MDMA, MDA, or MDE mentioned in the laboratory results there are coded as one of these substances and not as derivates of amphetamine.

Figure 12.6. Number of positive tests for ATS, 1997–2008, by substance[85]



Source: RPAC data, HEC calculations, 2009

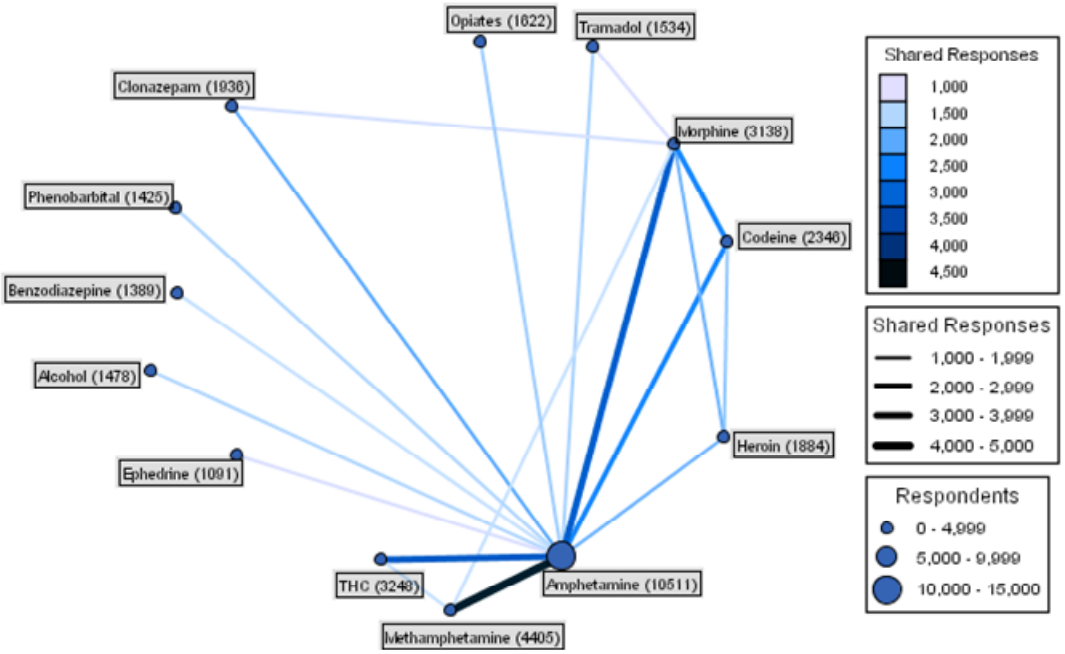
Of 35 697 tests between 1998 and 2008 14 315 were positive with at least one substance of amphetamine-type stimulants (amphetamine, methamphetamine, ephedrine or MDMA/MDA/MDE) were recorded at RCPAD. Nearly two-thirds of positive tests (62.5%) mentioned only one substance of amphetamine-type stimulants, one-third (33.1%) – two stimulants and 4.3% – three or more stimulants at the same time. Of the drug tests since 1998 where only one ATS substance was found – in 64.6% of positive tests only amphetamine was found, in 18.3% – only methamphetamine, 12.2% – only ephedrine/ephedrine/pseudo ephedrine, while in 5% – only MDMA/MDA/MDE.

All records analyzed between 1998 and 2008 suggests that in 20.8% of tests with signs of amphetamine and/or methamphetamine use only one substance was found, while in the rest – at least one other substance was found.

As seen in the figure below of the poly-drug users there are three main types of poly drug users: 1) amphetamine/methamphetamine users who simultaneously use also heroin or other opioids, 2) amphetamine/methamphetamine users who use cannabis, and 3) amphetamine/ methamphetamine users who use benzodiazepines and/or barbiturates *(see Figure 12.7)*.

[85] A positive test can include more than one substance.

Figure 12.7. Number of positive tests for ATS, 1997-2008, by substance[86]



Source: RCPAD data, HEC calculations, 2009

Production sites and laboratories, origin of products and trafficking routes, precursors seizures

According to the data from the law enforcement agencies Latvia is not (meth)amphetamine producing country. As mentioned at the beginning of the Selected Issue there were a few production laboratories closed in the mid-90ies but since then no laboratories have been found in Latvia.

12.2. Overview of health and social correlates of chronic amphetamine and methamphetamine use

Health and social correlates of chronic (meth)amphetamine use

Severity of dependence

As in 2007, the results of the cohort study 2008 show statistically significant differences at SDS score, primarily among amphetamine and heroin users: heroin users have mentioned problems associated with its use significantly more often than amphetamine users (see Table 12), which indicates that heroin use causes significantly more severe consequences (e.g. harder to give up, there is less control over its use, etc.) than amphetamines, which also accords with observations in global practice in the severity of heroin and amphetamine-induced symptoms.

[86] A positive test can include more than one substance.

Table 12.10. Amphetamine and heroin users' answers to SDS questions

		Amphetamine		Heroin	
		2008	against 2007[87]	2008	against 2007
1. Do you think you do not control the use of [name of substance]?	Never or almost never	20	-8	9	-6
	Sometimes	48	+4	32	-5
	Often	25	+4	44	+7
	Always or almost always	7	0	15	+4
2. When thinking about the possibility that dosage or kick of [name of substance] will not be available, do you feel anxious or worried?	Never or almost never	18	-6	7	-6
	Sometimes	46	+2	27	-3
	Often	23	+2	37	+2
	Always or almost always	14	+7	29	+7
3. Are you concerned about using [name of substance]?	Never or almost never	20	-6	7	-6
	Sometimes	42	0	29	-7
	Often	28	+3	44	+11
	Always or almost always	10	+3	19	+2
4. Have you wished to stop using [name of substances]	Never or almost never	19	-2	9	-1
	Sometimes	42	+1	27	-5
	Often	23	-7	32	-5
	Always or almost always	17	+8	32	+11
5. How difficult do you think it would be for you to suspend or give up the use of [name of substance]?	Not at all difficult	29	-1	6	-9
	Fairly difficult	33	-1	23	-3
	Very difficult	31	+7	46	+7
	Impossible	7	-5	25	+5

Source: Trapencieris, Snikere et al. 2008

Infections – HIV, HCV, HBV, other

Notifications data for HIV, HCV or HBV does not allow analysing results by substance. In this section prevalence rates of HIV, HCV and HBV among amphetamine users from the ENCAP study, will be described (see also Chapter on drug-related infectious diseases).

Data from the ENCAP study suggest HIV rates are lower among users of amphetamines than users of opioids, 19.5% and 26.1% respectively. HCV and HBV rates among amphetamine users are 62.0% for HCV and 47.2% for HBV[88]. As with HIV data, prevalence rates of HCV and HBV among amphetamine users were lower than those of opioid users *(see Table 12.11)*. For HIV status by drug (amphetamines and heroin) only age was found to be statistically significant (OR 1.73; p=0.043) while length of injecting or syringe sharing was not *(Karnite et al., in press)*.

 Compared with all surveyed participants in the 2007 cohort, and not only those who were re-interviewed in 2008.

[88] see also ST9P2_2009_LV_01, ST9P2_2009_LV_02, ST9P2_2009_LV_03 in Fonte

Table 12.11. Prevalence rates of HIV, HBV, and HCV among amphetamine users, percent

	Under 24	25-34	34 and older	Total
Amphetamines				
HIV	4.9	26.5	18.9	17.0
HCV	39.3	64.7	64.9	55.8
HBV	23.0	55.9	48.6	42.4
Dual/triple infections	16.4	55.2	54.1	40.6
N (sample size)	*61*	*67*	*37*	*165*
Opioids				
HIV	27.8	26.9	22.7	26.2
HCV	81.5	93.5	79.1	86.8
HBV	38.9	79.6	62.8	64.2
Dual/triple infections	51.9	81.7	67.4	70.0
N (sample size)	*54*	*93*	*44*	*191*
Total				
HIV	15.6	26.1	24.8	22.6
HCV	59.0	82.6	78.0	74.4
HBV	32.0	69.6	60.0	55.9
Dual/triple infections	33.6	70.0	67.0	58.4
N (sample size)	*122*	*184*	*101*	*407*

Source: ENCAP study; Riga Stradins University calculations 2009

Deaths related to amphetamines

Data from the General Mortality Register suggests that between 2002 and 2008 in 42 persons psycho-stimulants (T43.6) were found in post-mortem analyses; of the 42 persons who died 11 (or 26.2%) were females.

About half of the cases (20 of 42 cases) are drug-related deaths (X41 – 13 cases, X42 – 7 cases), in additional two cases accidental poisoning with sedatives had been recorded. In drug-related deaths psycho-stimulants as the main underlying substance was recorded in 13 cases, while in the rest as the secondary substance. Among other main reasons for death V-codes were recorded in 5 cases, cardiomyopathy (I42) – in 4 cases, W-codes – in 2 cases, other X and Y codes – in 6 cases, and one case with B and G code.

Within the mortality cohort study, which was carried out in 2008, 551 persons entered treatment for amphetamine use between 1999 and 2006 (Trapencieris, unpublished data). Out of these persons nine drug users had died during follow-up. The crude mortality rate was calculated and for the whole follow-up it was 5.69 per 1000 person years (PY); directly standardized mortality rate was 3.28 per 1000 PY. These rates have to be used with caution because of very low numbers of people died over the follow-up.

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Part D: Standard Tables and Questionnaires

Standard table	Title	Comments/ uploaded in
Standard Table 01	Basic results and methodology of population surveys on drug use	Fonte/ NNDA
Standard Table 02	Methodology and results of school surveys on drug use	Fonte/ NNDA
Standard Table 03	Characteristics of persons starting treatment for drugs	Fonte
Standard Table 05	Acute/direct drug related deaths	Fonte
Standard Table 06	Evolution of acute/direct drug related deaths	Fonte
Standard Table 07/08	Problem Drug Use	Fonte
Standard Table 09 (P1;P2;P3;P4)	Prevalence of hepatitis B/C and HIV infection among injecting drug users	Fonte
Standard Table 11	Arrests/reports for drug law offences	Fonte
Standard Table 12	Drug use among prisoners	Fonte/ NNDA
Standard Table 13	Number and quantity of seizures of illicit drugs	Fonte
Standard Table 14	Purity at street level of illicit drugs	Fonte
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Standard Table 18	Overall mortality and causes of deaths among drug users	Fonte/ NNDA
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Standard Table 30	Methods and Results of youth surveys	Fonte

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