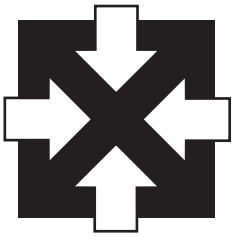
Annual Report

The Czech Republic

2012 Drug Situation

CZECH NATIONAL MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION
NÁRODNÍ MONITOROVACÍ STŘEDISKO PRO DROGY A DROGOVÉ ZÁVISLOSTI



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Prague, September 2013

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SECRETARIAT OF THE GOVERNMENT COUNCIL FOR DRUG POLICY COORDINATION
Commissioned by the Government of the Czech Republic and the European Monitoring Centre for Drugs and Drug Addiction

Annual Report: The Czech Republic – 2012 Drug Situation

Published by: © Office of the Government of the Czech Republic, 2013

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The report was considered by the Advisory Body for Drug Data Collection of the Government Council for Drug Policy Coordination.

For bibliographical citations:

MRAVČÍK, V., CHOMYNOVÁ, P., GROHMANNOVÁ, K., NEČAS, V., GROLMUSOVÁ, L., KIŠŠOVÁ, L., NECHANSKÁ, B., SOPKO, B., FIDESOVÁ, H., VOPRAVIL, J., JURYSTOVÁ, L. 2013. Annual Report: The Czech Republic – 2012 Drug Situation. MRAVČÍK, V. (Ed.). Prague: Office of the Government of the Czech republic.

We would like to acknowledge the support and assistance of all the collaborators, members of working groups, organisations, institutions, and bodies that provided the necessary data and contributed to the interpretation of the data for their help and cooperation during the preparation of this annual report. Their names can be found in the reference list or in the text of the report.

In the previous years the Annual Report included special chapters on selected issues to be addressed by the National Focal Points associated in the Reitox network. The EMCDDA decided not to include such chapters this year.

ISBN 978-80-7440-078-0

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SUMMARY

The development and enforcement of the national drug policy is the responsibility of the Government of the Czech Republic. Its main advisory and coordination body for drug-related issues is the Government Council for Drug Policy Coordination (GCDPC), which met four times in 2012.

The year 2012 was the third year of the operation of the National Drug Policy Strategy for the Period 2010-2018 and the last year of the operation of its first Action Plan for the period 2010-2012. The following Action Plan, for the period from 2013 to 2015, underlines again the principle of integrating legal and illegal drugs into one policy and also addresses other forms of addictive behaviour such as gambling. The evaluation of the 2010-2012 Action Plan showed that out of its 185 activities 109 (59%) were completed. The least success was achieved in the domains of treatment and social reintegration (38.7%) and alcohol and tobacco (25%). No major changes in the drug policy coordination at the regional level occurred.

The year 2012 also recorded no changes in the laws concerning drug-related crime. A debate about the implementing regulation, i.e. Government Regulation No. 467/2009 Coll., specifying for the purposes of the Penal Code what quantities of drugs should be considered greater than small, was under way. Nevertheless, before any legislative changes could be adopted, the regulation, or, strictly speaking, substantial parts thereof, was annulled as of 23 August 2013 on the basis of a decision of the Constitutional Court dated 23 July 2013, which found it contradictory to the constitution. Government Regulation No. 455/2009 Coll., setting out the threshold quantities of plants and mushrooms containing a narcotic or psychotropic substance, remains in effect for the time being, as the Constitutional Court has not dealt with it.

On the basis of Act No. 50/2013 Coll., amending, respectively, the acts on pharmaceuticals, addictive substances, and administrative fees, effective from 1 April 2013, in the Czech Republic it is possible to use cannabis for treating selected diagnoses. Cannabis for medical purposes can only be prescribed by a physician with a specialised qualification under a restricted regime. The process of prescription and supply from pharmacies will be managed using the register of restricted medicinal products, which ensures that the quantity limits are not exceeded. The law also allows licensed producers to cultivate cannabis for medical purposes starting from 1 March 2014. However, a functionality of the system has not been proven so far since the law was not implemented six months after its adoption.

In 2012 the Ministry of Health was preparing an amendment to Act No. 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances. In view of the large number of changes that were proposed, the Ministry of Health finally decided to draw up a new bill dealing with the protection of health against addictive substances. The bill was submitted for an intergovernmental review process in April 2013.

On 30 August 2012 the Czech Republic became the 176th party to the WHO Framework Convention on Tobacco Control.

A professional association approved a draft policy document which outlines a network of specialised addiction treatment services, as well as introducing definitions of various types of health services for drug users and addicts. In addition, a strategy for the reform of psychiatric care for the period 2014-2020, commissioned by the Ministry of Health, has also been under development since September 2012. This reform process will also have a bearing on addictological services. In 2013 six new health interventions linked to the paramedical profession of an addictologist were approved (as a basis for the coverage from health insurance in future). Moreover, addictologists will be eligible to use another two interventions that are already being provided as part of day care.

Public expenditure specifically earmarked for the funding of drug policy amounted to a total of CZK 587.3 million (€ 23,358 thousand) in 2012. This sum included CZK 346.8 million (€ 13,794 thousand) (59.1%) provided from the national budget and CZK 240.5 million (€ 9,564 thousand) made available from local budgets, with regions and municipalities contributing CZK 176.1 million (€ 7,005 thousand) (30.0%) and CZK 64.3 million (€ 2,559 thousand) (11.0%) respectively. In comparison to the previous year, the total expenditure rose by 4.2%; while the resources supplied from the national and regional budgets increased by 1.4% and 12.2% respectively, the municipalities spent 0.8% less money on drug policy. In terms of areas of allocation, the labelled expenditures recorded a rise in all the domains, with the exception of prevention, law enforcement, and coordination-research-evaluation. Resources from the European Social Fund used to support drug policy projects at the local level amount to an estimated CZK 100 million (€ 4 million) annually.

The main source of the funding of substance addiction treatment is health insurance. The cost of such treatment in 2011 (the latest year for which relevant data are available) amounted to a total of CZK 1,563 million (€ 62,168 thousand), with CZK 1,110 million (€ 44,133 thousand) being spent on the treatment of alcohol use disorders (dg. F10) and CZK 453 million (€ 18,035 thousand) incurred in relation to disorders caused by substances other than alcohol (dg. F11-F19). In comparison to 2010, the expenditures on the part of health insurers recorded a 4% decline. Psychiatry and addiction medicine accounted for about 90% of the costs as regards inpatient care and almost 60% as far as outpatient care is concerned.

The attitudes of the Czech public to substance use have remained relatively consistent. While the level of public acceptance of tobacco smoking has shown a slight decrease recently, a growing number of people find it acceptable to use alcohol and cannabis. In addition, there has been a continuous increase in the proportion of the population who oppose the criminalisation of cannabis users, people who use cannabis for medical purposes, and those who cultivate cannabis for their own personal use.

The 2012 National Survey on Substance Use confirmed the sustained level of cannabis use among the general population and the continuing decline in the level of experience with other illegal drugs. The exception is the slight increase in the lifetime prevalence of cocaine use, particularly among men in the 35-44 age group.

The most frequently used drug was cannabis, which had been taken ever in their lifetime by 27.9% of the population (when applied to the population of the given age range, this rate corresponds to an estimated 1.9-2.2 million people). In the last year, cannabis had been used by 9.2% of the respondents, i.e. there are approximately 570-760 thousand current users. According to the Cannabis Abuse Screening Test (CAST), about one third of the current cannabis users fell into the category of moderate or high risk of cannabis-related problems. Extrapolated to the general population, these figures are equivalent to 1.2% and 1.6% of the population being exposed to high and moderate risk because of cannabis use, i.e. approximately 87 and 116 thousand respectively.

While ecstasy was long the second most commonly used illicit drug in the Czech Republic, in 2012 the second place was taken by hallucinogenic mushrooms. Other places belonged to the use of methamphetamine (pervitin) or amphetamines, cocaine, and LSD, with a rather consistently low level of lifetime prevalence (2.3–2.8%), while the Czech population's lifetime experience with heroin has shown low levels in the long term (less than 1%). Very low levels for the use of illegal drugs other than cannabis were recorded for the 12-month and 30-day time frames.

The level of risky alcohol consumption remains high in the Czech Republic. According to the CAGE screening scale, risky drinking pertains to a total of 17.0% of the population, i.e. 1.1-1.4 million individuals, while harmful or problem alcohol use is associated with 8.2% of the population, i.e. 500-690 thousand people.

A representative survey among prisoners conducted in 2012 shows that inmates have much greater experience with all the illegal drugs than the general population. Lifetime illicit drug use was reported by almost 50% of the respondents and more than 21% had used an illegal drug in the last 12 months. The drugs mostly included cannabis, pervitin, amphetamines, and pharmaceuticals with sedative effects obtained without a prescription. 26% of the prisoners can be referred to as problem drug users.

The regional analysis of the 2011 ESPAD survey showed that experience with illegal drugs is more prevalent in Prague and the Ústí nad Labem, Karlovy Vary, Olomouc, and Moravia-Silesia regions, while the Central Bohemia, Pilsen, Hradec Králové, and Pardubice regions show relatively low levels of drug use among students. However, the situation is becoming similar across the country, as the regional differences are diminishing. The situation at the regional level is relatively dynamic, nevertheless: while at the national level the situation concerning the use of certain drugs has remained stable, different trends can be observed in the regions.

In recent years the area of the prevention of risky behaviour, which includes drug use and addiction, has witnessed the development or establishment of a number of structural elements that enhance the competencies of prevention workers, as well as improving the quality and coordination of prevention activities. The year 2012 also abounded in new professional publications and guidelines. Eight programmes specialising in the indicated prevention of substance use were identified in the Czech Republic, with seven of them being certified for professional competency. The Ministry of Education, Youth, and Sports (the Ministry of Education) adopted the new Strategy for the Primary Prevention of Risk Behaviour for 2013-2018 and the regional authorities, for the very first time, drew up their "regional prevention plans". With some exceptions, prevention campaigns in the media focus on the issues related to the cessation of smoking, alcohol being served to minors, or driving under the influence of alcohol and illegal drugs. There are also preventive campaigns aimed at visitors to summer music festivals.

The estimated number of problem drug users recorded a slight increase in 2012. According to the estimates, there were approximately 41.3 thousand problem drug users (the central estimate) in the Czech Republic, including 30.7 thousand pervitin users, 4.3 thousand heroin users, and 6.3 thousand buprenorphine users (i.e. 10.6 thousand opiate/opioid users in total). The number of injecting drug users was estimated at 38.7 thousand. Statistically significant changes can be observed in the number of opiate/opioid users: while the number of heroin users dropped, there were more using buprenorphine. The number of pervitin users decreased slightly. In the past five years the central estimate of the number of problem drug users has risen by approximately one third. In 2012 the prevalence of problem drug use in the Czech Republic reached 0.6% of the population aged 15-64.

In addition to pervitin, heroin, and buprenorphine, some use of raw opium and an increase in the misuse of analgesics containing opiates/opioids, such as fentanyl, codeine, and morphine, have been recorded among problem drug users. Recent years were marked by the emergence of new synthetic drugs of the cathinone or phenetylamine group. The past-year prevalence of their use has been at the 10% level among problem drug users, but only a fraction of problem drug users are currently reporting them as their primary drug, and there are also dramatic regional differences in this respect. In the Czech Republic cocaine users have not been included in

estimates of problem drug users, as their numbers in the data sources used for such estimates are still on very low levels.

Traditionally, the highest rates of problem drug users, as well as of opiate users, are reported from Prague and the Ústí nad Labem region, where, as in other Bohemian regions, the injecting use of buprenorphine is particularly widespread. A prevalence of problem drug users which is far above the average in relation to the number of inhabitants has also been reported by the Karlovy Vary region.

The 2012 data on drug-related deaths from forensic medicine departments were not available at the time of the writing of this annual report. The information on drug overdoses provided by the Deaths Information System shows that there were a total of 45 cases of overdoses on illegal drugs and inhalants (27 cases in 2011), with a year-on-year increase in the number of reported cases of overdoses on opiates/opioids, stimulants (pervitin), and inhalants. There were 317 cases of fatal overdoses on ethanol identified in 2012, which is approximately the same number as in the previous year. Widespread cases of poisoning with methanol present in illegal spirits were recorded in the Czech Republic from September 2012 to mid-July 2013 (in 47 people the poisoning had fatal consequences).

The relatively favourable situation concerning the occurrence of infections among drug users continued in 2012. Five new cases of HIV-positive people who contracted the infection through injecting drug use were identified. HIV seroprevalence among injecting drug users remains below 1% in the Czech Republic. The number of newly reported cases of viral hepatitis C (HCV) among injecting drug users rose slightly in the last year, while that of viral hepatitis B (HBV) remained almost at the same level as in 2011. While the number of reported cases of syphilis among injecting drug users is lower, the cases of gonorrhoea recorded an increase. The number of reported cases of tuberculosis among injecting drug users has not changed to a significant degree.

The prevalence of HCV among injecting drug users ranges from approximately 20-30% in low-threshold programmes and 40-50% in prisons up to 60-70% in substitution treatment. These results, however, need to be interpreted with caution, as they come from routine testing and may not necessarily be representative of the situation within the entire population of injecting drug users.

The Treatment Demand Register has seen a relatively large proportion of injecting drug users in the long term; pervitin and opiate (heroin and buprenorphine) users account for approximately 80% and 90% respectively of injecting drug users seeking treatment. Among the clients of outpatient psychiatric clinics, the percentage of people who use both pervitin and opiates by injecting is lower. The available data suggest a declining trend in needle sharing among people who inject drugs.

Needle and syringe exchange services were provided by 103 low-threshold programmes in 2012. Almost 5.4 million items of injecting equipment were supplied, which means no further year-on-year increase. The available information indicates that there were at least 27 programmes in the Czech Republic in 2012 that distributed gelatine capsules as an oral alternative to hypodermic syringes. More than 46 thousand such capsules were supplied to clients.

The availability of testing of injecting drug users for infectious diseases has been on the rise from the medium-term perspective. Both the programmes performing the tests and the persons being tested are growing in numbers. However, the Czech Republic still lacks formal guidelines for the testing and prevention of infections among drug users that would take into account both the specific needs of this population and the Czech system of low-threshold services.

In the Czech Republic, treatment services and care for people who have been infected with HIV and developed AIDS, including injecting drug users, are provided by seven AIDS centres, which also operate at the regional level. In 2012, 745 former and current injecting drug users (64% of all the patients) received HCV treatment in 38 centres that specialised in the treatment of viral hepatitis (out of the total of 53 centres providing HCV treatment). There is a growing number of patients who enter HCV treatment in prison.

Approximately 250 facilities may be considered as constituting the core of specialised services for drug users and addicts. Alcohol users account for approximately 60% of the patients in both outpatient and inpatient addiction treatment. Stimulant users have long predominated among users of substances other than alcohol in contact with drug services, with pervitin being the primary drugfor most of them. The second largest group comprises users of opiates/opioids and cannabis. Healthcare facilities report high rates of polydrug users; in inpatient psychiatric facilities they represent the most frequent diagnostic group from among the disorders caused by the use of substances other than alcohol. Users of opiates/opioids comprise the largest group in psychiatric outpatient clinics, which may be due to the provision of substitution treatment. An aging of the population demanding treatment is apparent; their average age in 2012 was approximately 28 years. Women continue to account for a little less than one third of treatment demands.

About 50 to 80 facilities in the Czech Republic may be considered as outpatient clinics specialising in addiction treatment (“AT clinics”). Again, there was a slight drop in the number of alcohol/drug patients in outpatient treatment, which was particularly attributed to patients using alcohol. The number of patients recorded in the Substitution Treatment Register remained almost the same. However, the Register does not yet fully account for treatment with buprenorphine-based preparations. Aggregated data about the numbers of patients in substitution treatment

provided by outpatient psychiatrists and general practitioners for adults are monitored. 2,298 people were reported to the Substitution Treatment Register in 2012, which is approximately two thirds of the total number reported by psychiatrists and general practitioners.

As of August 2013 the Register of Social Services included 35 aftercare programmes for drug users. However, a 2012 facility survey, the Drug Services Census, indicates that social work and support services intended to facilitate the social reintegration of drug users are provided by tens to hundreds of addiction treatment facilities and programmes; such services mainly involve assistance with housing, employment, and debts.

In 2013 a questionnaire survey was conducted in socially excluded areas of the Czech Republic in order to assess the situation concerning substance use and gambling. With a year's delay, the 2011 data from the programme of support for field social work in Roma localities were made available. Specific programmes addressing substance use-related problems in socially excluded areas are lacking. Most of the interventions are targeted at the key challenges that socially excluded localities are facing: unemployment, debts, and housing issues. The most common substance used in socially excluded localities in the Czech Republic is alcohol, with cannabis and pervitin being the most frequently used illegal drugs.

Drug-related and alcohol-related criminal offences accounted for 1.3% and 3.2% respectively of all the reported crimes. Prague and the Karlovy Vary and Central Bohemia regions were the regions with the highest rate of drug crime in relative terms per 100 thousand inhabitants in 2012. The number of drug-related criminal offences has been rising since 2007. Over 2.8 thousand individuals were prosecuted for drug-related offences, most commonly for the production, smuggling, and sale of pervitin and cannabis. While offending associated with the production, sale, and smuggling of drugs has long accounted for approximately 80% of drug-related offences, activities constituting the offence of the unauthorised handling of drugs for personal use have made up approximately 15% of drug-related crime. 2,400 people were charged, with 2,100 individuals receiving final court sentences. The most common sanction imposed was a term of suspended imprisonment. 1,285 misdemeanours of the unauthorised handling of narcotic and psychotropic substances were dealt with in the Czech Republic in 2012, which is 10% more than in 2011.

According to the data of the Police of the Czech Republic, 18,400 criminal offences were committed under the influence of addictive substances, i.e. more than 15% of the criminal offences that were cleared up. Out of these offences, 16,100 and 2,300 were committed under the influence of alcohol and drugs other than alcohol respectively.

In 2012 an estimated 11.6 tonnes of cannabis, 5.9 tonnes of pervitin, 0.8 tonnes of heroin, 0.7 tonnes of cocaine, 62,300 tablets of ecstasy, and 75,800 doses of LSD were consumed in the Czech Republic. The domestic production covers all the pervitin and most of the cannabis consumed.

The concentration of THC in the cannabis cultivated indoors that was seized was between 10 and 15%. The Police of the Czech Republic and the Customs Administration of the Czech Republic discovered 199 indoor cultivation sites in 2012. The data on reported offending indicate an increase in the number and share of people of Vietnamese descent involved in the cultivation and distribution of cannabis and in the import of equipment for indoor plantations. The number of marijuana seizures and the quantities seized have been increasing since 2009. 558 seizures involving a total of 653 kg were recorded in 2012. In addition, 90,100 cannabis plants and 21 kg of hashish were seized.

Pervitin is mostly manufactured in low-volume easily movable makeshift laboratories. In 2012 the Police of the Czech Republic and the Customs Administration of the Czech Republic detected 235 such facilities. In particular, pseudoephedrine extracted from over-the-counter medication, imported mainly from Poland, but also from Germany and Hungary, has been used as the precursor of pervitin. 355 seizures of pervitin in a total quantity of 32 kg were reported in the Czech Republic in 2012. In that year, too, law enforcement authorities focused their attention on the drug market in the areas of northwest Bohemia near the border with Germany, which has been stimulated by the growing demand for pervitin and marijuana on the part of German nationals.

8.1 kg of cocaine and 7.6 kg of heroin were seized in 2012. The purity of the diluted heroin distributed among end users was around 5%.

A total of 18 new types of synthetic drugs were intercepted in the Czech Republic in 2012. These are primarily sold via e-shops. The substances seized in the largest quantities included 4-methylethcathinone (126 kg), the synthetic cannabinoid AM-2201 (4 kg), and the tryptamine 5-MeO-AMT (1,5 kg).

PART A: NEW DEVELOPMENTS AND TRENDS

1 Drug Policy: legislation, strategies, and economic analysis

No changes in the laws concerning drug-related crime occurred in 2012. A debate about Government Regulation No. 467/2009 Coll., which lays down for the purposes of the Penal Code what quantities of drugs should be considered greater than small, was under way. Nevertheless, before any amendments to it were adopted, the regulation was pronounced null and void by the Constitutional Court with effect from 23 August 2013, as it was found contradictory to the Constitution of the Czech Republic and the Charter of Fundamental Rights and Freedoms. Government Regulation No. 455/2009 Coll., specifying threshold quantities of plants and mushrooms containing a narcotic or psychotropic substance, remains effective for the time being, as the Constitutional Court has not dealt with it.

In August 2013 the Parliament approved an amendment to Act No. 167/1998 Coll., on addictive substances, which stipulates, among other things, that the list of narcotic and psychotropic substances hitherto included in the schedules to the Act will constitute a part of the Government Regulation.

On the basis of Act No. 50/2013 Coll., amending respectively the acts on pharmaceuticals, addictive substances, and administrative fees, effective from 1 April 2013, it is possible in the Czech Republic to use cannabis for therapeutic purposes.

On 30 August 2012 the Czech Republic became the 176th party to the WHO Framework Convention on Tobacco Control.

In early 2013 the Ministry of Health submitted for a review process a bill on the protection of health against addictive substances. This new piece of legislation is to replace Act. No 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances.

2012 was the third year of the operation of the National Drug Policy Strategy for the Period 2010-2018 and the last year of the operation of the first action plan for the implementation of the Strategy in the period 2010-2012. The following action plan for the period from 2013 to 2015 underlines again the principle of integrating legal and illegal drugs into one policy and also addresses other forms of addictive behaviour such as gambling. The evaluation of the 2010-2012 Action Plan showed that 109 (59%) out of its 185 individual activities were completed. The least success was achieved in the domains of treatment and social reintegration (38.7%) and alcohol and tobacco (25%). No major changes in the drug policy coordination at the regional level occurred.

Public expenditure specifically earmarked for the funding of drug policy amounted to a total of CZK 587.3 million (€ 23,358 thousand) in 2012. This sum included CZK 346.8 million (€ 13,794 thousand) (59.1%) provided from the national budget and CZK 240.5 million (€ 9,564 thousand) made available from local budgets, with regions and municipalities contributing CZK 176.1 million (€ 7,005 thousand) (30.0%) and CZK 64.3 million (€ 2,559 thousand) (11.0%) respectively. In comparison to the previous year, the total expenditures rose by 4.2%; while the resources supplied from the national and regional budgets increased by 1.4% and 12.2% respectively, the municipalities spent 0.8% less money on drug policy. In terms of areas of allocation, the labelled expenditures recorded a rise in all the domains, with the exception of prevention, law enforcement, and coordination-research-evaluation. Resources from the European Social Fund used to support drug policy projects at the local level amount to an estimated CZK 100 million (€ 3,977 thousand) annually.

Health insurers' expenses incurred in relation to the treatment of substance use disorders amounted to a total of CZK 1,563 million (€ 62,168 thousand), with CZK 1,110 million (€ 44,133 thousand) spent on the treatment of alcohol use disorders (dg. F10) and CZK 453 million (€ 18,035 thousand) incurred in relation to disorders caused by substances other than alcohol (dg. F11-F19). In comparison to 2010, the expenditures on the part of health insurers recorded a 4% decline. Psychiatry and addiction medicine accounted for about 90% of the costs as regards inpatient care and almost 60% as far as outpatient care is concerned.

1.1 Legal Framework

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

1.1.1.1 Criminal Law Regulations

No changes in the laws concerning drug-related crime were made in 2012. The legal definitions of relevant criminal offences, i.e. Sections 283-287 of Act No. 40/2009 Coll., the Penal Code, as amended (the Penal Code), remained unaltered. A wide-ranging discussion was held in relation to the implementing regulations, namely Government Regulation No. 467/2009 Coll., specifying for the purposes of the Penal Code what constitutes a poison and defining the quantities greater than small for narcotic substances, psychotropic substances, any preparations containing such substances, and poisons. Reportedly, this debate was motivated by the increasing trafficking of pervitin

(methamphetamine) along the Czech-German border.[1] One of the options under consideration was the reduction of the quantity of some substances that would trigger criminal sanctions even when possessed for personal use. Before the conclusions of the discussion could be reflected in any legislative changes, the aforementioned regulation, or, strictly speaking, substantial parts thereof, was annulled on the basis of a decision of the Constitutional Court[2] dated 23 July 2013 (see also the chapter on Implementation of Laws below), as it was found contradictory to the Constitution of the Czech Republic and the Charter of Fundamental Rights and Freedoms. The change came into effect on 23 August 2013, when the decision of the Constitutional Court was promulgated in the Collection of Laws under No. 259/2013 Coll. The possession of a narcotic or psychotropic substance or a preparation containing it in a quantity greater than small for personal use continues to be a criminal offence in accordance with the stipulations of Section 284 of the Penal Code – Possession of a narcotic or psychotropic substance or poison. A quantity greater than small of such a substance, however, is not formally defined by any legal regulation and needs to be determined for the purposes of criminal proceedings by judicial practice, as was the case before 31 December 2009, i.e. prior to the coming into effect of the "new Penal Code".[3] The decision of the Constitutional Court pertained to neither the list of poisons included in Schedule 1 to the government regulation mentioned above and Government Regulation No. 455/2009 Coll., setting out for the purposes of the Penal Code which plants and mushrooms should be considered plants and mushrooms containing a narcotic or psychotropic substance and what quantities of them should be considered greater than small in accordance with the Code, nor to any other implementing regulations, as they were not the subject of the petition and, therefore, the Constitutional Court could not deal with them on its own initiative. It may be expected, however, that the other implementing regulation will also be brought before the Constitutional Court in the future, unless it is otherwise annulled.[4]

After long being called for, Act No. 45/2013 Coll., on the victims of crime, became effective on 25 February 2013. This piece of legislation provides the criminal justice system with an instrument for the protection of victims of crime, including that associated with drugs. In particular, it is expected to improve the status of crime victims and extend the range of ways in which they can be protected, informed, and provided with financial support and other types of professional assistance and benefits. Moreover, this law amends Act No. 141/1961 Coll., the Code of Criminal Procedure, as amended, by introducing a legal instrument of a preliminary injunction into criminal law with effect from 1 November 2013. One type of preliminary injunction which may be issued in relation to a person facing criminal prosecution, providing that all the statutory criteria are met, is a prohibition on their use and possession of alcoholic beverages or other addictive substances.

As regards international cooperation in tackling drug crime, changes may be expected as a result of the adoption of Act No. 104/2013 Coll., concerning international judicial cooperation in criminal matters, which becomes effective on 1 January 2014. The improvement of international cooperation, including better exchange of information about international criminal activities and mutual collaboration on specific operations, should also have a positive effect on any of the offences involving illicit trafficking in narcotic drugs and psychotropic substances that are punishable by an unsuspended prison sentence of up to five years or detention order. The cooperation also covers other areas of transnational crime such as trafficking in human beings, child pornography, corruption, and laundering of the proceeds of crime.

1.1.1.2 Changes in the Act on Addictive Substances

While undergoing no substantial changes as regards its content in 2012, Act No. 167/1998 Coll., on addictive substances, recorded two major changes in 2013 involving the enactment of the possibility of using and growing cannabis for medical purposes and the list of narcotic and psychotropic substances being incorporated into the government regulation instead of constituting a schedule to the relevant law; see also the 2011 Annual Report.

The first of the changes was brought about by the adoption of Act No. 50/2013 Coll., amending Act No. 378/2007 Coll., on pharmaceuticals, Act No. 167/1998 Coll., on addictive substances, and Act No. 634/2004 Coll., on administrative fees. The amendment became effective on 1 April 2013. The part of the new legislation concerning the cultivation of cannabis for medical purposes and the procurement of licensing for such activities will not come into effect until 1 March 2014. Until that date the patients will thus have to rely on cannabis officially imported from abroad.

The objective of the law is to provide patients in the Czech Republic with the possibility of using cannabis for treatment in indicated cases by means of the legal purchase of cannabis officially imported from abroad or grown in

[1] Nonetheless, the regulation at issue pertains to the possession of drugs for personal use rather than offences involving the manufacturing or supply of drugs.
[2] File reference Pl. ÚS 13/12.
[3] Until then, the specific quantities of drugs were laid down in the internal directives of the Police President and the Supreme Public Prosecutor, which provided the bodies involved in criminal proceedings with guidance to follow. This period also produced a large number of case law decisions which the courts should consider mandatory in making decisions about specific cases.
[4] Similar arguments, i.e. contradiction of constitutional laws, may also be raised in relation to other implementing regulations pertaining to the Penal Code, which in fact define a person's criminal liability, as is the case with Government Regulation No. 454/2009 Coll., which determines for the purposes of the Penal Code which substances should be deemed those with anabolic and other hormonal effects and what quantities of them should be considered significant and which methods should be considered those involving enhanced oxygen transfer in the human body and those producing other doping effects.

this country on the basis of a licence. Medicinal cannabis will be made available to patients with specific medical conditions on prescription only, with its supply being recorded by pharmacies. In addition, the law will make it possible for licensed producers to grow and supply medicinal cannabis to the Czech pharmaceutical market. The cultivation of cannabis by individuals for medical purposes is not allowed by the law. In April 2013 the State Institute for Drug Control adopted a measure of a general nature,[5] on the basis of which treatment with cannabis was exempted from public health insurance. In July 2013 the Ministry of Health issued Decree No. 221/2013 Coll., laying down the conditions for the prescription, preparation, supply, and use of individually prepared medicinal products containing cannabis for medical purposes, which became effective on 1 August 2013. A number of statutory parameters that have been set, such as those concerning restrictions on patients' age, dosages, the range of indications, and physicians' professional specialisations, have met with criticism from the professional community and civil society.[6]

In combination with other drawbacks, such as the relatively high price of imported cannabis, both the aforementioned norms may hamper or reduce the positive effects of this new legal regulation in terms of the availability of treatment and the impossibility of drawing a distinct line between the legal and illegal cannabis markets. In spite of the fact that the legal framework for treatment with cannabis has been formally adopted, the process has not been put into practice yet.

The second significant change concerns the amendment to the law on addictive substances. Giving rise to two separate laws, this amendment causes a distinction to be made between the legal regulations governing addictive substances on one hand and drug precursors on the other hand. A new piece of legislation, Act No. 272/2013 Coll., on drug precursors, and Act No. 273/2013 Coll., amending Act No. 167/1998 Coll., on addictive substances and on changes to some other laws, as amended, were promulgated in the Collection of Laws on 10 September 2013 and become effective as of 1 January 2014. Among other modifications, the amendment to Act. No. 167/1998 Coll. provides that the list of narcotic and psychotropic substances and preparations containing them, which was hitherto included in schedules 1 to 8 of the above law, will, in the future, be incorporated into the government regulation, i.e. into a bylaw. Given the decision of the Constitutional Court of the Czech Republic announced on 23 July 2013 (see Chapter 1.1.2), further legislative changes may be expected in this respect.

1.1.1.3 Testing of Drivers for Addictive Substances

The testing of whether a driver of a motor vehicle is under the influence of drugs, including narcotic or psychotropic substances, has become an integral part of road checks. Drivers with positive screening tests are subsequently subjected to a toxicological examination of their blood samples for narcotic or psychotropic substances. To assess whether a driver was under the influence of a narcotic or psychotropic substance, or even in a state which is incompatible with the capacity to drive, is relatively difficult in terms of time, expertise, and funding. In an effort to simplify the assessment of impaired driving in practice, administrative proceedings dealing with this type of traffic violations were informed by the expert opinion on the assessment of drivers' impairment by addictive substances issued by the Society for Forensic Medicine and Toxicology of the J. E. Purkyně Czech Medical Association. This report sets out blood sample concentration thresholds for selected common narcotic and psychotropic substances beyond which it can reasonably be concluded that the driver was influenced by the substance.[7] This professional opinion was widely used in practice. In view of the fact that this guidance is not a statutory norm, however, it was often proved necessary to have a report drawn up by a forensic expert in response to the driver's appeal in order to assess their capacity to drive or the level of impairment caused by the substance in question. In an effort to eliminate such doubts and define clear boundaries that would make it possible during administrative proceedings to judge the level of a driver's impairment using the results of toxicological examinations, Act No. 233/2013 Coll., amending Act No. 361/2000 Coll., on road traffic and amendments to certain laws (the Road Traffic Act), was adopted. With effect from 17 August 2013, it applies that "as regards other addictive substances listed in the implementing legal regulation, a driver shall be deemed to be under the influence of such an addictive substance should its quantity in the driver's blood sample reach at least the threshold limit determined in the implementing legal regulation". As the implementing regulation envisaged in the above law has not been drawn up yet, the question is how practice will deal with this legal issue in the meantime. Paradoxically, if taken to the extreme, drivers who were impaired by narcotic or psychotropic substances, but not in a state incompatible with the capacity to drive (which always needs to be established on the basis of the opinion of a forensic expert), could not be punished in misdemeanour (administrative) proceedings because of the absence of the applicable implementing regulation.

1.1.1.4 Bill on the Protection of Health against Addictive Substances

In 2012 the Ministry of Health was in the process of preparing a substantial amendment to Act. No 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances

[5] No. 04 - 13, File Reference sukls 17954/2013, The determination of the amounts of and conditions for the reimbursement of individually prepared medicinal products – compounding, dated 14 May 2013.
[6] http://www.lecebnekonopi.cz/catalogue/detail/6/58/Uhrada-lecebneho-konopi-Peticni-vybor-za-lecebne-konopi-vyvraci-argumenty-SUKL-a-medialni-vystupy-ministerstva, http://www.vlada.cz/assets/ppov/protidrogova-politika/media/lecebne_konopi_2013_07_31.pdf (13 September 2013)
[7] http://soudnilekarstvi.cz/03_pro_odborniky/ (26 August 2013)

(hereinafter referred to as Act No. 379/2005 Coll.). These legislative efforts culminated in the submission of a Bill on the protection of health against the harmful effects of tobacco, alcohol, and other addictive substances (the Bill on the Protection of Health against Addictive Substances). According to the explanatory memorandum, the reasons for the improvement of legal regulation in this area include the long-term high level of the consumption and availability of alcohol and tobacco, even among young people, and the illicit market in spirits.[8] As a result, the changes are primarily targeted at reducing the use of alcohol and tobacco. The Ministry of Health submitted this Bill for an intergovernmental review process in April 2013. For more information see also the chapters on Environmental Prevention (p. 41) and Legal Framework and Strategies and Policies in the Field of Treatment (p. 61).

1.1.1.5 WHO Framework Convention on Tobacco Control

On 30 August 2012 the Czech Republic became the 176th party to the WHO Framework Convention on Tobacco Control (FCTC), which was promulgated in the Collection of International Agreements, Item 39, under the number 71/2012. This meant the end of the long process of ratification, which started as early as on 22 December 2004, when the Government of the Czech Republic endorsed the ratification proposal. The FCTC is a binding international convention that creates an international legal environment for tackling the global tobacco epidemic. It promotes a comprehensive approach to the protection of the population against the devastating health, social, environmental, and economic consequences of tobacco use and against exposure to tobacco smoke. The FCTC became effective in 2005. Another of the parties to the FCTC is the European Union. The Czech Republic was the last EU member state to ratify the convention. From 12 to 17 November 2012 the fifth session of the Conference of the Parties to the FCTC was held in Seoul, Republic of Korea. This forum is summoned once in two years in order to review the enforcement of the Convention. It was the first time that the Czech Republic had participated in this conference as a party to the Convention.

1.1.1.6 Changes Concerning the Profession of an Addictologist

Following the adoption of new healthcare regulations in 2011 and 2012 which strengthened the legal status of the profession of an addictologist (for more details see the 2010 and 2011 annual reports), some addiction treatment services, previously registered as providers of social services, also began to obtain authorisations for the provision of health services. In addition, the incorporation of addictological services into the healthcare system is expected to reinforce their financial circumstances as they become eligible for health insurance coverage. In this context, it is of relevance that in March 2013 the internal inspection body of the Ministry of Health approved new health interventions for the profession of an addictologist. They are expected to be published in 2013 and become effective from 1 January 2014; see also the chapter Drug Services Network and Quality Assurance (p. 62). This topic will also be addressed in a 2013 issue of the *Zaostřeno na drogy* ("Focused on Drugs") bulletin (Fidesová et al., 2013).

1.1.2 Implementation of Laws

Judicial practice had a significant impact on the legal regulation of drug-related crime, as epitomised by the aforementioned decision of the Constitutional Court dated 23 July 2013 (see the chapter entitled Criminal Law Regulations). As of the date of its promulgation in the Collection of Laws, this decision of the Constitutional Court annulled a part of the stipulations of Section 289 (2) of Act No. 40/2009, which reads "and defining the quantities greater than small for narcotic substances, psychotropic substances, any preparations containing such substances, and poisons". As of its promulgation in the Collection of Laws, too, it also quashed the stipulations of Section 2 and Schedule No. 2 to Government Resolution No. 467/2009 Coll., specifying for the purposes of the Penal Code what constitutes a poison and defining the quantities greater than small for narcotic substances, psychotropic substances, any preparations containing such substances, and poisons. The decision was handed down on the basis of a ruling made in response to a petition filed by the District Court in Liberec in relation to a legal action for the offence of the possession of a narcotic or psychotropic substance or poison according to Section 284 (2) of the Penal Code which was pending before this court.[9] According to the prosecution, the constituting elements of the offence were met by the accused possessing four plastic bags holding a total of 3.25 g of pervitin containing 1.9 g of methamphetamine as an active psychoactive ingredient. Such a quantity was greater than small, as the above-cited government regulation applicable at that time stipulated that a quantity greater than small was that exceeding 2 g of pervitin, provided that it contained at least 0.6 g of the active ingredient (0.72 g in the case of hydrochloride). The District Court in Liberec concluded that the relevant statutory provision applicable to decision making about guilt and punishment, i.e. the provision of Section 289 (2) of the Penal Code, was contradictory to the constitutional order and, therefore, proceeded to discontinue the criminal prosecution and referred the case to the Constitutional Court. The Constitutional Court found that the above stipulation was indeed in contradiction of Article 39 of the Charter of Fundamental Rights and Freedoms[10] and of Article 78 of the Constitution of the Czech Republic,[11] which provide that a criminal offence may only be defined by a law, and it is exclusively the Parliament of the Czech Republic that is competent to pass such a law. With reference to these provisions, the Constitutional Court expressed its legal

[8] https://apps.odok.cz/kpl-detail?pid=KORN96WGEJXU (26 August 2013)
[9] File Reference 4 T 12/2012.
[10] Resolution of the Czech National Council No. 2/1993 Coll., on the Charter of Fundamental Rights and Freedoms as part of the constitutional order of the Czech Republic.
[11] Constitutional Act No. 1/1993 Coll., Constitution of the Czech Republic.

opinion that the legislator could define a greater-than-small quantity of a narcotic or psychotropic substance in the form of a law only. It further stated that a bylaw could only be used in the event that the enabling stipulation in Section § 289 (2) of the Penal Code determined certain criteria that would merely be specified by the Government.

1.2 National Action Plan, Strategy, Evaluation, and Coordination

1.2.1 National Action Plan and Strategy

2012 was the third year of the operation of the National Drug Policy Strategy for the Period 2010-2018 (the 2010-2018 National Strategy) and the last year of the operation of the first action plan for the implementation of the Strategy in the period 2010-2012. Three action plans, each for a period of three years, will be developed in the period during which the Strategy is in effect. The evaluation of the first action plan, for the period 2010-2012, and the preparation of the 2013-2015 Action Plan took place in 2012. For more information on the 2010-2018 National Strategy see the 2009 and 2010 annual reports.

1.2.1.1 Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2013-2015

Being the second consecutive action plan pertaining to the 2010-2018 National Strategy, the 2013-2015 Action Plan was approved by virtue of Government Resolution No. 219, dated 27 March 2013. Its activities and priorities build on the previous action plan.

According to its creators, the key objective of the 2013-2015 Action Plan is to maintain the existing activities and functions of the drug policy that have proved effective. This focus of the action plan reflects the economic recession, which has led to cuts in public expenditure and efforts to retain enough financial resources to fund measures that have already been established. But the action plan also articulates the need to respond to new developments.

Again, the action plan underlines the concept of an integrated drug policy, i.e. seeking to provide a comprehensive solution to the issue of both legal and illegal drugs. The previous 2010-2012 Action Plan included a separate domain addressing alcohol and tobacco use. The 2013-2015 Action Plan has no independent Alcohol and Tobacco domain, but the activities concerned with legal drugs are incorporated into the individual intervention areas, in line with the principle of policy integration. Nevertheless, the majority of the originally proposed tasks pertaining to alcohol were excluded from the document, as they are to be formulated in the National Action Plan for the Reduction of Alcohol-related Harm, a separate document to be developed by the Ministry of Health.

Pursuing the integration principle, the 2013-2015 Action Plan also highlights the need to address other forms of addictive behaviour such as gambling and includes several specific activities concerning such issues. Building on the previous action plan, the priorities of the 2013-2015 drug policy were laid down as follows:

- reduce excessive alcohol use and heavy cannabis use among young people,
- address the high levels of the problem use of pervitin and opiates,
- improve the effectiveness of drug policy funding,
- achieve an integrated drug policy.

1.2.1.2 National Action Plan on the Drug Information System 2013-2015

In April 2013 the Government Council for Drug Policy Coordination (GCDPC) approved the 2013-2015 National Action Plan on the Drug Information System (NAPDIS). NAPDIS covers both illegal and legal drugs. A new area under monitoring is gambling. For more details see the chapter Other Drug Policy Developments (p. 12).

1.2.2 Implementation and Evaluation of the National Strategy and Action Plan

1.2.2.1 Interim Evaluation of the Implementation of the 2010-2018 National Strategy

The interim evaluation to assess the level of fulfilment of the objectives set in the 2010-2018 National Strategy was carried out as part of the preparation of the 2013-2015 Action Plan, and its results are reflected in the new action plan. It was an internal evaluation performed by the Secretariat of the Government Council for Drug Policy Coordination (GCDPC).

- As for the strategic objective “to reduce the level of experimental and occasional drug use, particularly among young people”, it was concluded that despite the enduring high level of drug use among the general population and young people a positive declining trend in the use of illegal drugs among the general population and students has been observed.
- As regards the strategic objective “to reduce the level of problem and heavy drug use”, the central value of the estimated number of problem drug users is currently rising.
- The strategic objective “to reduce potential drug-related risks to individuals and society” has been fulfilled in the long term: the rates of drug-related infections and drug overdoses are relatively low, the level of high-risk drug using behaviour has been declining continuously, and there has been an increase in the number of drug users tested for infectious diseases, the number of contacts, and the quantity of injecting equipment exchanged.

- As for the last strategic objective, "to reduce drug availability, particularly to young people", a high level of perceived availability of cigarettes and alcohol has been observed among young people, while the availability of illegal drugs as perceived by young people has fallen. The evaluation report points out that effective measures and control mechanisms need to be established to reduce the availability of alcohol.

1.2.2.2 Evaluation of the 2010-2012 Action Plan

The Summary Report on the Implementation of the 2010-2012 Action Plan was submitted to the Government in February 2013.[12]

The evaluation of the 2010-2012 Action Plan focused on the monitoring of the implementation of the tasks laid down in the action plan, the degree of the fulfilment of the four priorities of the action plan set for the period under consideration, and the assessment of the accomplishment of the key outcomes of the action plan.[13] A total of 105 activities broken down into 185 milestones – partial phases of the activities – were evaluated. Overall, 109 (59%) milestones were completed, 34 (18%) were completed in part, and 42 (23%) were not completed or could not be evaluated. While the majority of tasks that were completed pertained to Monitoring, Research, and Evaluation (89%) and Coordination and Funding (74%), the smallest number of successfully completed tasks was associated with the domains of Treatment and Social Reintegration (39%) and Alcohol and Tobacco (25%).

The Summary Report on the Implementation of the 2010-2012 Action Plan concludes that the priorities of the drug policy for the period under consideration were not accomplished,[14] as the activities related to the respective priorities were not fully realised. The report further states that the reasons for the failure to accomplish, or fully accomplish, a relatively large number of activities and, for that matter, the respective priorities specified in the action plan included the complex nature of the activities included in the action plan and the ensuing considerable amount of time needed to complete them, insufficient human resources, the lack of funding needed to perform the tasks, and the large number of tasks assigned to a single implementing entity. Sometimes the situation was further complicated by the fact that the failure to complete one activity prevented the performance of other related activities or, in the case of legislative tasks, draft versions of legal regulations were not finally passed to become laws.

The action plan defined the key outcomes to be achieved for each intervention area; see Table 1-1.

[12] http://www.vlada.cz/assets/ppov/protidrogova-politika/strategie-a-plany/Souhrnna_zprava_o_splneni_AP_-2010-12.pdf (6 June 2013)
[13] The evaluation was carried out using information from the entities involved in the implementation of the action plan. All together, 10 government portfolios and 9 regions participated in the evaluation study. Questionnaires were used to collect data.
[14] The 2010-2012 Action Plan articulated the following priorities: a) to address the high level of the use of cannabis and other drugs among adolescents and young adults, b) to address the high levels of the problem use of opiates and pervitin by developing and applying specific programmes tailored to the users of these drugs, c) to strengthen the drug policy in relation to legal drugs (alcohol and tobacco), especially its policy and coordination mechanisms and treatment interventions, and d) to develop and improve the drug policy's overall legislative, financial, and coordination mechanisms.

Table 1-1: Completion of the key outcomes of the 2010-2012 Action Plan, by intervention areas

Completion status	Key outcomes
Primary Prevention	
Completed	To have developed methodological guidelines for the implementation of prevention programmes in schools and educational institutions
Partly completed	To have prepared a draft version of the national programme for the prevention of the use of alcohol, tobacco, and other drugs in schools and educational institutions in the broader context of the prevention of risk behaviour
Not completed	To have designed a model of an integrated intergovernmental policy for the primary prevention of risk behaviour with a focus on the issue of substance use among children and young people
	To have established a policy for the coordination of primary prevention at the national and regional levels
	To have established online counselling aimed at controlling and reducing cannabis use among heavy users of the drug
	To have created a network of counselling centres based on the existing facilities in the Czech Republic that provide cannabis users with counselling and treatment interventions
Treatment and Social Reintegration	
Completed	To have compiled examples of good practice for selected target groups with specific needs
	To have established guidelines for work with prisoners that take into account the quality standards for community drug services and the specific needs of the prison setting.
	To have increased the number of both registered healthcare facilities providing substitution treatment and patients in substitution treatment
Partly completed	To have approved a policy for outpatient and inpatient addiction treatment and aftercare
	To have proposed recommended procedures for drug users released from treatment and prison
Not completed	To have proposed recommendations for the practical implementation of new types of pharmacological or maintenance treatment and other psychosocial interventions for methamphetamine users
Harm Reduction	
Completed	To have performed an analysis of the potential distribution of harm reduction material in prisons
	To increase the number of tests performed by two thirds in comparison to 2009
	To have established methodological guidelines and standards for municipalities, nightlife establishments, and prevention programmes operating in nightlife settings.
Partly completed	To have provided the results of the feasibility study of new forms of harm reduction interventions intended to reduce drug use in open public areas in the Czech Republic
Not completed	To have developed standards for good addictological practice in pharmacies
Drug Supply Reduction	
Completed	To have established the exchange of information between the Customs Drug Unit and the National Drug Headquarters
	To have achieved higher efficiency among mobile surveillance groups focusing on drug trafficking
	To have curtailed the misuse of medication containing pseudoephedrine obtained from pharmacies
	To have proposed measures for restricting the availability of precursors used for the illicit manufacturing of pervitin
Partly completed	To have shortened the process of updating the list of narcotic and psychotropic substances
	To have curtailed the misuse of pharmacy-based supplies of substitution agents
Not completed	-
Monitoring, Research, and Evaluation	
Completed	To have assured the regular availability of the latest data pertaining to 5 key epidemiological indicators
	To have assured the availability of data on clients in contact with drug services and the interventions they provide
	To have data on heavy cannabis use
	To have data on drug use among prisoners and on available harm reduction and treatment services
	To have data on the misuse of psychotropic medication
Partly completed	To have data on school-based prevention programmes provided on a regular basis
	To have performed an evaluation of the drug policy action plan
	To have proposed measures to evaluate the effectiveness of treatment
Not completed	-
Coordination and Funding	
Completed	To have established integrated standards and quality control systems for all types of prevention
Partly completed	To have designed a system of training for regional and local coordinators, education professionals, and the staff of the prison service
	To have conducted an analysis of any potential changes in drug policy funding
	To have interventions provided as part of addiction treatment services covered by public health insurance
Not completed	-
International Cooperation	
Completed	To have ratified and implemented important international conventions, the ratification of which was hampered by the absence of the statutory criminal liability of legal entities

Completion status	Key outcomes
	To have enhanced the involvement of the Czech Ministry of Foreign Affairs, the Permanent Representation in Brussels, the permanent missions to international organisations, and embassies and consulates in the international drug policy
Partly completed	To coordinate the presentation of the Czech Republic's priorities in international forums and promote Czech interests in international institutions, such as UNODC, HDG EU, and the EMCDDA
	To have intensified the activities of the Czech Republic in relation to drug production and transit regions and countries (including Afghanistan, Latin America, Central Asia, West Africa, and the West Balkans)
Not completed	-
Alcohol and Tobacco	
Completed	To have ratified the WHO Framework Convention on Tobacco Control
Partly completed	To have clarified competences as to policy approaches to legal substances and their relationships with the drug policy concerned with illicit substances
	To have improved the enforceability of Act No. 379/2005 Coll. as regards the control of the availability of alcohol and tobacco to young people, or to have had it amended accordingly
Not completed	To have established an efficient monitoring system for legal drugs (tobacco and alcohol) and to have made the Annual Alcohol and Tobacco Report available

1.2.2.3 Evaluation of the 2011-2012 National Action Plan on the Drug Information System

In April 2013 the Government Council for Drug Policy Coordination discussed the evaluation of the 2011-2012 National Action Plan on the Drug Information System (NAPDIS). The evaluation report concludes that the objectives of the NAPDIS were accomplished, even though some of the activities fell short of completion. Shortcomings were identified in the monitoring of legal drugs, an area that falls within the competence of the Ministry of Health, particularly with respect to regular (annual) summary status reports intended to inform the competent executive and coordination bodies responsible for the drug policy.

1.2.3 Other Drug Policy Developments

A bill on the protection of health against addictive substances has been under preparation since 2011. This piece of legislation is intended to replace Act No. 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances, which provides a legislative framework for the drug policy and its coordination mechanisms. The bill includes legislative proposals prepared by the GCDPC's working group for the protection of children and young people from the misuse of alcohol; for more details see the 2011 Annual Report and the chapters on Laws, Regulations, Directives, or Guidelines in the Field of Drug Issues (p. 5) and Environmental Prevention (p. 41).

In April 2012 the Government approved the updated Rules for Granting Financial Resources from the State Budget on Drug Policy. The WHO Framework Convention on Tobacco Control was ratified by the Czech Republic in May 2012; for more details see the 2011 Annual Report.

The agenda discussed by the Government of the Czech Republic included the issue of betting games and their effects in 2012; see also the 2011 Annual Report. On the basis of its Resolution No. 655 dated 6 September 2012, the Government commissioned the National Monitoring Centre for Drugs and Drug Addiction (the National Focal Point) to carry out a study looking into social pathologies caused in the Czech Republic by gambling. The analysis will have been submitted to the Government by April 2014. The National Focal Point has established a working group comprising representatives of relevant stakeholders in order to facilitate the analysis.[15]

At the turn of 2012 and 2013 the Government Council for Drug Policy Coordination addressed the issue of the manufacturing and distribution of methamphetamine in the areas along the Czech-German border, a phenomenon which has been associated with persons of Vietnamese descent in recent years. The Ministry of the Interior was particularly active in dealing with this problem, and drugs and drug crime thus became one of the priorities for the Police of the Czech Republic in 2013. Politicians from two German states, Saxony and Bavaria, blamed what they referred to as the liberal Czech drug policy for the increased demand for pervitin on the part of German drug users. The Ministry of the Interior responded by preparing an amendment to the government regulation which determined the quantities of drugs used to differentiate between administrative and criminal offences, proposing to lower the threshold for pervitin from 2 g to 0.5 g. Following the discussion of the proposal by the Working Group on Methamphetamine at the request of the GCDPC, the Ministry of the Interior finally withdrew it. While the proposal was submitted for discussion again by the Ministry of Health as part of the review procedure, the government regulation in question was finally declared void by the Constitutional Court in July 2013; for more details see the chapter on Implementation of Laws (p. 8). Other steps taken to address the issues concerning the areas near the Czech-German border included negotiations concerning collaboration between the Ministries of the Interior of the Czech Republic, Saxony, Bavaria, and Vietnam. A meeting of the national drug coordinators from the Czech

[15] http://www.drogy-info.cz/index.php/o_nas/studie/studie_o_socialne_patologickych_dopadech_hazardnich_her_na_spolecnost_v_cr, http://www.drogy-info.cz/index.php/o_nas/pracovni_skupiny (15 August 2013)

Republic, Austria, Germany, Hungary, Poland, and Slovakia was held. In addition, the Government appointed a temporary inter-agency working group at the level of deputy ministers commissioned to coordinate law enforcement operations pursued by the relevant authorities in marketplaces near the border (these operations took place in the first half of 2013). Legislative motions were prepared in order to accelerate and simplify the process of deporting foreigners convicted of wilful criminal offences. Last but not least, in 2013 the Ministry of the Interior launched a special funding programme involving a total of CZK 5 million (€ 198 thousand) earmarked for the prevention of drug crime in areas near the border; see also the chapter Prevention of Drug-related Crime (p. 135).

The Antidrug Campaign of the Vietnamese Community in the Czech Republic, a conference seeking to engage the Vietnamese people in tackling the problem, was held in Ústí nad Labem in March 2013. The conference was hosted by the Ministry of the Interior and the Vietnamese Embassy in association with the Union of Vietnamese and the Czech-Vietnamese Association. The conference introduced the Vietnamese-Czech Antidrug League, a project that associates Vietnamese organisations in the Czech Republic and governmental bodies and institutions at both the national and local levels.

1.2.3.1 Initiatives on the Part of Civil Society and the Professional Community

In January 2012 Prague hosted a meeting of the Informal Drug Policy Dialogue series, an international initiative of two non-profit organisations – the Transnational Institute and the Diogenis Association – aimed at sharing opinions among officials, researchers, and representatives of international organisations concerned with the drug policy, such as UNODC, the WHO, and the EMCDDA. The items of the agenda dealt with during the Prague session included the new EU drug strategy for the period 2013-2020 and the future of the UN drug control conventions.

In March 2012 the General Directorate of the Prison Service of the Czech Republic and the Secretariat of the Government Council for Drug Policy Coordination organised a seminar entitled "Addressing the Drug Problem in Prison". The aim of the seminar was to identify new forms of liaison and strengthen the existing ones concerning the provision of counselling and treatment services for drug users during their prison sentence and after they have been released and to explore the resources that may enhance the effectiveness of the services and reinforce the status of such services, including substitution treatment, in the system of care.

In April 2012 the *SANANIM* civic association organised the "Crime and Drugs 2012" conference.[16] The topics featured at the conference included primary and secondary drug crime and drug offending as perceived by the community, streetworkers, and the police (Sadílková, 2012). SANANIM's annual conference in 2013 was dedicated to the issue of the family and drugs.

In addition, the issue of drug use among young people was discussed at the "Lifestyle Leading to Delinquency" conference organised by the Social Pathology Section of the Masaryk Czech Sociological Association[17] in April 2012. While primarily focusing on crime and criminogenic factors at the individual and environmental levels and young people's lifestyles, the conference also dealt with the topics of domestic violence and cyberbullying (Večerka, 2012).

The third event of this kind to take place in April 2012 was an international seminar, entitled "How to Establish Standards in the Evaluation of Drug Services", held in Prague with the participation of representatives of the EMCDDA and the European Commission. The seminar provided a platform for the exchange of experience in developing and implementing quality standards and the evaluation of drug services. The results of the project of an EU consensus on minimum quality standards for prevention, treatment, and harm reduction interventions in relation to illicit drug use (EQUS-EU) were also presented and discussed at the event.

The 51st annual national addictological conference ("AT Conference"), organised by the Society for Addictive Diseases of the J.E. Purkyně Czech Medical Association, was held in May 2012. Abandoning the idea of a single central theme ("motto"), the conference covered multiple issues, including therapists' health, the concept of a network of addiction treatment services, harm reduction strategies, and the dissemination of research among practitioners.[18]

A conference of the Hradec Králové region on the prevention of risk behaviour took place in September 2012. Entitled "Children and Drugs",[19] the event focused on school-based prevention, prevention standards, and the testing of children and adolescents for drug use.

September 2012 also witnessed the organisation of the SOCIALIA conference, hosted by the Faculty of Education of the University of Hradec Králové, specifically by its Department of Social Pathology and Sociology in association with the Department of Social Pedagogy. The conference featured the topic "The Family and Social Pathologies".[20]

[16] http://www.sananim.cz/projekty/odborne-konference.html (22 July 2013)
[17] http://www.ceskasociologicka.org/index.php/akce-mss/314-sbornik-sekce-socialni-patologie-ivotni-styl-smujici-k-delikvenci (24 July 2013)
[18] http://www.at-konference.cz/archiv/rocnik-2012/ (22 July 2013)
[19] http://www.prevence-info.cz/udalost/krajska-konference-kralovehradeckeho-kraje-k-problematice-prevence-rizikoveho-chovani-dite-d (24 July 2013)

In addition, the final conference of the VYNSPI project was held in September 2012. It was organised by the Department of Addictology of the First Faculty of Medicine of Charles University in Prague and of the General University Hospital in Prague (the Department of Addictology), in association with the National Institute for Education and other regional partners; for more details see the chapter on Prevention (p. 40).

In October 2012 the Institute for Criminology and Social Prevention hosted a one-day professional seminar featuring the topic "Drug-related Crime in the Czech Republic in the Light of Recent Research".[21]

The one-day seminar "Pregnant Drug Users",[22] organised by the Czech Outreach Work Association and intended for practitioners from low-threshold services, was also held in October.

The same month saw the organisation of a two-day addictological conference of the South Bohemia region,[23] entitled "Local Sources and Internal Springs". It was dedicated to the issue of the funding of social services and the liaison between service providers and the local government. Another annual session of the conference in 2013, featuring the topic "Off Centre", will address the issues of social exclusion, minorities, and work with specific drug using populations.

Held for the third time in November 2012, the Cannafest international fair, subtitled "Cannabis – the Potential Revealed", focused on the possibility of the medical use of cannabis and the issues related to cannabis growing and the criminalisation vs. decriminalisation of such activities.[24]

In November 2012, too, a conference on "The Drug Policy and Its Funding" was held at the Chamber of Deputies of the Parliament of the Czech Republic.

In the same month, the Addictology Prize was awarded for the seventh time as part of a one-day seminar on addictological care for children and adolescents. The 2012 award was conferred upon Dr. Lumír Ondřej Hanuš.[25]

December 2012 witnessed what was already the 9th annual conference Primary Prevention of Risk Behaviour. Subtitled "Prevention in Motion…",[26] the event addressed topics concerning cooperation between families and schools in primary prevention, prevention in institutional care, the testing of children and adolescents in schools and educational institutions when drug use is suspected, and primary prevention counselling. The 2013 conference will be entitled "One World is Not Enough, or Converging the Parallel Worlds of Medical and School-based Prevention".

The "Iron Addictologist" amateur triathlon race, organised by the PREVENT civic association, took place again in České Budějovice in August 2013. It is a "national sports and social event held to increase the awareness of addiction services and addictions".[27]

1.2.4 Coordination Arrangements

1.2.4.1 Coordination at the National Level

The Government Council for Drug Policy Coordination, an advisory body to the Government of the Czech Republic as regards the drug policy, met four times in 2012. In order to ensure horizontal coordination on the national level, the GCDPC has five permanent committees and four permanent working groups for specific areas of the drug policy. The GCDPC further appoints additional working groups when needed; see Table 1-2.

[20] http://www.uhk.cz/cs-cz/konference/socialia-2012/Stranky/default.aspx (24 July 2013)
[21] http://www.ok.cz/iksp/archiv12.html (24 July 2013)
[22] http://www.streetwork.cz/index.php?option=com_content&task=view&id=3472 (24 July 2013)
[23] http://www.akjck.cz/ (24 July 2013)
[24] http://www.cannafest.cz/pro-navstevniky/odborna-konference/ (24 July 2013)
[25] http://www.adiktologie.cz/cz/articles/detail/594/4093/Regionalni-konference-projektu-NETAD-a-Cena-adiktologie-2012 (30 September 2013)
[26] http://www.pprch.cz/Minule-rocniky/IX-rocnik-konference-PPRCH-2012/ (24 July 2013)
[27] http://www.os-prevent.cz/, http://www.zelezny-adiktolog.cz (11 September 2013)

Table 1-2: Overview of the GCDPC's committees and working groups in 2012

Committees	Permanent working groups	Ad hoc working groups
Committee of Departmental and Institutional Representatives	for methamphetamine	for making cannabis available for treatment and research in the Czech Republic
Committee of Regional Representatives	for drug use prevention and harm reduction at dance parties	
Subsidy Committee	the National Focal Point's six working groups concerned respectively with population and school surveys on drug use, drug treatment demands, drug-related infections, drug-related deaths, the system of early warning against new drugs, and criminal justice data.	for the protection of children and young people from the misuse of alcohol
Certification Committee		
Committee for Drug-related Data Collection		for drug policy funding

Three ad hoc working groups operated as part of the Government Council for Drug Policy Coordination in 2012. Two of them – the working group for making cannabis available for treatment and research in the Czech Republic and the working group for the protection of children and young people from the misuse of alcohol – have wound up their operations. The working group for drug use prevention and harm reduction at dance parties developed no activities. In 2012 the GCDPC resumed the activities of the working group for drug policy funding in order to facilitate the proposal for structural changes in the funding of the drug policy.

The most important topics discussed at the GCDPC's sessions in 2012 and in the first half of 2013 included the bill on the protection of health against addictive substances – for more details see the chapter on Legal Framework (p. 5) – the issue of the manufacturing and smuggling of pervitin in the areas along the Czech-German border, and the approval of the pilot testing of the updated standards of professional competency for drug services; for more information see the chapter entitled Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 61).

As regards the area of international collaboration, there were two changes as regards the Czech membership of international institutions. While in 2014 the Czech Republic will again become a member of the UN Commission on Narcotic Drugs, its membership of the Pompidou Group of the Council of Europe has been terminated as of May 2013 by virtue of a decision by the Government.

1.2.4.2 Coordination at the Local Level

In organisational terms, the coordination and implementation of the drug policy at the local level are governed by Sections 22 and 23 of Act No. 379/2005 Coll. The core means of the coordination of regional and municipal drug policies are drug coordinators, drug commissions and working groups, drug policy strategies and action plans, and evaluations of the drug situation. Regional drug coordinators prepare annual reports on the implementation of regional drug policies.

The office of a regional drug coordinator has been established in all 14 regions, with the exception of Moravia-Silesia. While in 2011 nine coordinators held this office on a full-time basis, in 2012 there were 7 full-time regional drug coordinators.

Drug policy-specific commissions exist in eight regions, while in three regions the drug policy is dealt with by commissions with a broader range of focus. Having no commissions established, the remaining three regions have appointed working groups that are responsible for drug policy coordination.

Separate drug policy documents have been drawn up in 11 regions. In the Central Bohemia, Pilsen, and Ústí nad Labem regions the drug policy is incorporated into a strategy covering the areas of social policy or crime prevention in more general terms. In 2012 new strategic drug policy documents became effective in the South Bohemia, Pardubice, Zlín, and Vysočina regions. After having no strategic document concerning drugs formulated for three years, the Karlovy Vary region formally drew up its drug policy for the period 2013-2016. The regions usually have their drug policies articulated as part of the relevant strategy or the strategy and the action plan. In 2012 the Prague Drug Commission proposed preparing three interrelated and interconnected documents: a policy, a strategy, and an action plan.

The regional drug policy strategies cover the issues of both legal and illegal drugs. Only Prague and the Liberec region also address the issue of pathological gambling in their strategies. The Liberec region had an analysis of its pathological gambling situation conducted in 2012.

At the municipal level, the coordination of the drug policy is provided through local drug coordinators, who, in 2012, had been appointed in 183 out of the total of 205 municipalities with extended competencies and in all 22 Prague city

districts. Local drug coordinators also operate in all the municipalities with extended competencies situated in the Pilsen, Liberec, Pardubice, South Moravia, Olomouc, and Vysočina regions.

Municipal drug policies are generally outlined in the local community plans of social services or in crime prevention policy documents. Some municipalities, however, have their drug policies laid down in separate documents.[28]

1.3 Economic Analysis

1.3.1 Public Expenditures

Similarly to the previous years, in 2012 the drug policy was funded from central (the national budget) and regional sources (regional and municipal budgets). Planned and identifiable expenditures earmarked for drug policy programmes are referred to as "labelled".[29] Not being subjected to annual estimates, non-labelled drug-related expenditures are not dealt with in this chapter. However, this part of non-labelled expenditures accounts for the majority of the costs related to illicit drug use; for more details see the chapter entitled Social Costs Related to Drug Use (p. 23).

Public expenditure specifically earmarked for the funding of drug policy amounted to a total of CZK 587.3 million (€ 23,358 thousand)[30] in 2012. This sum included CZK 346.8 million (€ 13,794 thousand) (59.1%) provided from the national budget and CZK 240.5 million (€ 9,564 thousand) made available from local budgets, with regions and municipalities respectively contributing CZK 176.1 million (€ 7,005 thousand) (30.0%) and CZK 64.3 million (€ 2,559 thousand) (11.0%).[31] In comparison to the previous year, the total expenditures rose by 4.2%; while the resources supplied from the national and regional budgets increased by 1.4% and 12.2% respectively, the municipalities spent 0.8% less money on drug policy. A detailed overview of labelled expenditures from public sources in 2012 is provided in Table 1-7 and Table 1-8.

The development of labelled funding provided by the national budget over time (from 2003 to 2012), broken down by government portfolios and institutions, can be seen in Table 1-3. While the declining trend in drug policy-specific expenditures provided from the national budget was reversed in 2012 after two years, the current level corresponds to that prior to the year 2006.

Table 1-3: Drug policy expenditures from the Czech national budget by government portfolios, 2003-2012 (€ thousand)

Government portfolio	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
GCDPC	3,261	3,153	3,547	3,838	3,762	4,008	3,686	3,381	3,695	3,599
Ministry of Education	293	316	315	381	452	499	426	592	528	458
Ministry of Defence	147	109	133	172	129	212	162	173	122	94
Ministry of Labour and Social Affairs*	1,391	1,323	1,546	1,753	2,054	3,186	3,282	3,628	3,129	3,355
Ministry of Health	692	829	1,124	635	801	757	569	849	861	746
Ministry of Justice	442	427	1,233	1,455	454	296	409	280	165	441
General Customs Headquarters*	708	292	487	829	963	427	120	83	79	72
National Drug Headquarters*	3,022	2,711	3,189	3,757	4,601	5,527	5,542	5,709	5,328	5,028
Total	**9,957**	**9,161**	**11,574**	**12,821**	**13,217**	**14,912**	**14,196**	**14,694**	**13,908**	**13,794**

Note: While the budgets of these portfolios or agencies did not include chapters dedicated to the drug policy, they could account for the resources, or parts thereof, spent specifically on the drug policy. Average exchange rates in respective years were used for re-calculation of expenses from CZK to €.

In 2012 the GCDPC provided CZK 85.6 million (€ 3,400 thousand) to support a total of 120 projects in the fields of prevention, harm reduction, treatment, and aftercare. The expenditure designated for the activities developed by the

[28] Such cases include the 2010-2014 Drug Policy Strategy of the Town of Milevsko, the Report on the Drug Situation in the Town of Blatná (in the South Bohemia Region), the Drug Policy Strategy of the City of Brno for the Period 2011-2014, and the Report on the Implementation of the Drug Policy of the City of Brno. A drug policy document is currently under preparation in Kladno. Local drug policy strategies have also been drawn up by the Prague city districts 4 and 14.

[29] The data were obtained from the national final accounts of the ministries whose budgets include a drug policy programme and the annual reports on the implementation of regional drug policies. Additional information was obtained directly from the representatives or contact persons of individual ministries and governmental institutions, as well as from regional drug coordinators.

[30] 2012 average axchange rate was used (1 € = CZK 25.143).

[31] All the expenditures and their changes are indicated in nominal values, unless specified otherwise.

GCDPC's Secretariat, including the National Monitoring Centre for Drugs and Drug Addiction (National Focal Point), amounted to CZK 4.9 million (€195 thousand).

According to the final national accounts, the Ministry of Education, Youth, and Sports (the Ministry of Education) spent a total of CZK 11.5 million (€ 458 thousand) on the drug policy which was used to support 102 local and three nationwide primary prevention projects. In addition to the drug policy, the subsidy system of the Ministry of Education dedicated to the primary prevention of risk behaviour also contains an item on crime prevention. As part of the prevention of risk behaviour, 179 applications for subsidies amounting to a total of CZK 20.3 million (€ 807 thousand) were accepted in 2012 (in 2011 it was 212 applications worth CZK 22 million (€ 875 thousand) (Ministerstvo školství, 2013). In addition to long-term programmes for the universal primary prevention of risk behaviour, this support is intended for projects aimed at assessing needs and the accessibility and effectiveness of services, as well as those involving the provision of evidence-based information and the education of both professionals and the general public. The programmes that receive support are mostly those provided by schools, educational institutions, non-governmental organisations, and other entities that deliver primary prevention interventions to children and adolescents.

The Ministry of Defence provided CZK 2.4 million (€ 94 thousand) of its drug policy-labelled funds to carry out 46 preventive projects, to purchase detection devices, professional literature, sports equipment, and tickets to sports and cultural events, and to lease sports and recreational facilities.

While the budget of the Ministry of Labour and Social Affairs did not include a chapter dedicated to the drug policy programme, it provided subsidies totalling CZK 84.4 million (€ 3,355 thousand) for social services projects focusing on people at risk of drug use or drug-dependent individuals.

In 2012 the Ministry of Health provided a total sum of CZK 18.8 million (€ 746 thousand) for the drug policy (11.4% less than in the previous year). As part of its subsidy proceedings, the Health Ministry supported projects focused on the provision of health services for people who are dependent on addictive substances and for relevant policy projects. In addition to the resources reserved in the budget for the drug policy, the Ministry of Health used the "National Health Programme – Health Promotion Projects" subsidy programme to support projects concerned with the primary prevention of drug use. Furthermore, projects involving addiction-related research and development received support.

The Ministry of Justice made CZK 11.1 million (€ 441 thousand) available for the drug policy in 2012, which was almost three times more than in the previous year. This increase was mainly due to more funds being allocated to the Prison Service of the Czech Republic. Projects of particular priority included those involving pre-release and post-release care. More money was also spent on drug supply reduction operations in prisons. CZK 182,000 (€ 7.2 thousand) and CZK 75,000 (€ 2.9 thousand) were earmarked for the Judicial Academy and the Institute for Criminology and Social Prevention respectively.

The budget of the General Customs Headquarters, incorporating the Customs Drug Unit, did not account for any independent drug policy programme in 2012. However, it provided investment expenditure of CZK 1.8 million (€ 72 thousand) associated with the investigation of drug trafficking.

Neither does the budget of the Ministry of the Interior account for financial resources dedicated to the drug policy programme. However, this government portfolio is responsible for the National Drug Headquarters of the Criminal Police and Investigation Service of the Police of the Czech Republic (the National Drug Headquarters), whose total expenses in 2012 amounted to CZK 126.4 million (€ 5,028 thousand), excluding investment (capital) expenditure.

In addition to the national budget, the drug policy is also funded by local budgets, i.e. those of the regions and municipalities. In 2012 the regions and municipalities provided CZK 176.1 million (€ 7,005 thousand) and CZK 64.3 million (€ 2,559 thousand), respectively, for the drug policy. The developments in drug policy-specific expenditures from local budgets over time since 2004 are summarised in Table 1-4 and a detailed overview of these local budgets by service categories and regions is provided in Table 1-5.

Table 1-4: Drug policy expenditures from local budgets, 2004-2012 (€ thousand)

Region	2004	2005	2006	2007	2008	2009	2010	2011	2012
Prague	1,344	1,436	1,536	1,938	2,563	2,288	2,468	2,230	2,525
Central Bohemia	543	672	729	768	909	608	851	722	678
South Bohemia	220	230	259	275	486	464	398	434	458
Pilsen	122	246	278	294	566	516	570	619	568
Karlovy Vary	46	61	64	66	110	44	247	203	269
Ústí nad Labem	434	387	447	385	411	418	489	436	369
Liberec	203	308	316	261	525	372	434	458	456
Hradec Králové	86	97	138	281	320	413	301	339	360
Pardubice	91	223	95	253	296	261	338	331	315
Vysočina	185	266	118	327	183	153	164	208	412
South Moravia	302	408	300	492	572	967	862	1,031	1,132
Olomouc	109	114	165	188	433	460	438	464	480
Zlín	149	137	65	225	356	441	820	303	270
Moravia-Silesia	697	485	537	1,113	1,304	1,372	1,733	1,246	1,272
Total	**4,530**	**5,068**	**5,047**	**6,867**	**9,035**	**8,777**	**10,113**	**9,025**	**9,564**

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

Drug policy expenditures are summarised in Table 1-7 by the region in which the projects were implemented. There has been a continuing decline in funds provided from municipal budgets in the Ústí nad Labem region, despite the high numbers of problem drug users which the region has been recording.

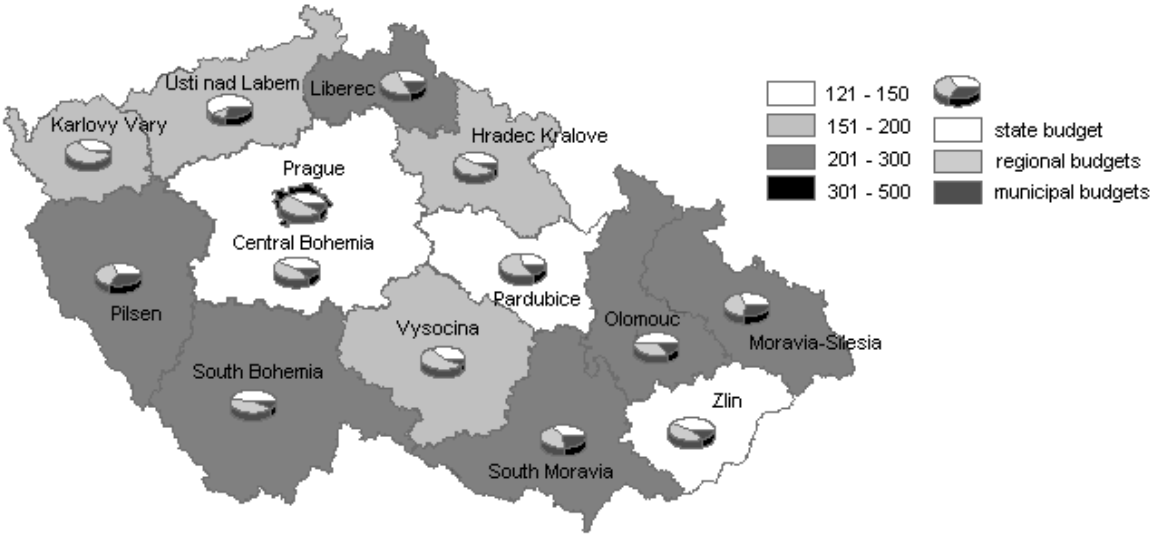
An overview of expenditures from national and local budgets in 2012 by service category is provided in Table 1-8. Out of the total amount of CZK 587.3 million (€ 23,358 thousand) labelled in the national and local budgets as drug policy-specific expenditures, CZK 161.2 million (€ 6,410 thousand) (27.4%) was earmarked for harm reduction services, CZK 112.1 million (€ 4,460 thousand) (19.1%) for treatment, CZK 48.7 million (€ 1,938 thousand) (8.3%) for primary prevention, and CZK 33.9 (€ 1,349 thousand) (5.8%) was allocated to aftercare. The sobering-up stations, which consumed CZK 79.8 million (€ 3,175 thousand) (13.6%), were funded almost exclusively from the regional budgets, and CZK 131.3 million (€ 5,222 thousand) (22.4%) was allocated to law enforcement. Resources expended on prevention, law enforcement, and coordination/research/evaluation recorded a year-on-year decline.

Table 1-5: Drug policy expenditures from local budgets by service categories, 2012 (€ thousand)

Region		Primary prevention in total	Harm reduction in total	Treatment in total	Aftercare	Sobering-up stations	Coordination /research/ evaluation	Others	Total
Regional budgets	Prague	302	444	608	136	520	46	99	**2,156**
	Central Bohemia	318	0	83	0	119	0	0	**520**
	South Bohemia	51	159	69	25	80	4	0	**387**
	Pilsen	36	70	56	31	97	0	5	**295**
	Karlovy Vary	18	20	0	0	215	0	0	**253**
	Ústí nad Labem	8	76	28	4	0	0	0	**116**
	Liberec	2	45	72	10	199	0	2	**330**
	Hradec Králové	5	50	17	0	239	8	0	**318**
	Pardubice	9	26	12	0	203	1	0	**251**
	Vysočina	17	73	40	42	190	0	0	**362**
	South Moravia	54	133	134	68	281	11	15	**695**
	Olomouc	8	74	13	13	243	0	0	**350**
	Zlín	6	72	0	0	119	0	0	**198**
	Moravia-Silesia	62	52	26	19	585	0	31	**775**
	Total	**897**	**1,293**	**1,156**	**348**	**3,089**	**70**	**152**	**7,005**
Municipal budgets	Prague	240	55	34	7	0	1	33	**369**
	Central Bohemia	36	47	0	0	76	0	0	**158**
	South Bohemia	9	46	12	5	0	0	0	**71**
	Pilsen	45	112	72	33	0	0	11	**273**
	Karlovy Vary	0	16	0	0	0	0	0	**16**
	Ústí nad Labem	0	190	12	51	0	0	0	**253**
	Liberec	7	73	33	13	0	0	0	**126**
	Hradec Králové	16	18	8	0	0	0	0	**42**
	Pardubice	11	40	11	2	0	0	0	**64**
	Vysočina	15	35	0	0	0	0	0	**50**
	South Moravia	33	188	129	35	0	2	51	**437**
	Olomouc	21	47	36	15	0	0	11	**130**
	Zlín	1	58	0	15	0	0	0	**73**
	Moravia-Silesia	0	323	129	24	10	0	10	**497**
	Total	**434**	**1,247**	**475**	**200**	**86**	**3**	**116**	**2,559**
Local budgets in total	Prague	542	499	641	143	520	47	132	**2,525**
	Central Bohemia	354	47	83	0	195	0	0	**678**
	South Bohemia	59	204	81	30	80	4	0	**458**
	Pilsen	81	182	128	64	97	0	15	**568**
	Karlovy Vary	18	36	0	0	215	0	0	**269**
	Ústí nad Labem	8	266	40	55	0	0	0	**369**
	Liberec	9	118	105	24	199	0	2	**456**
	Hradec Králové	21	67	24	0	239	8	0	**360**
	Pardubice	20	66	23	2	203	1	0	**315**
	Vysočina	33	108	40	42	190	0	0	**412**
	South Moravia	86	321	263	103	281	13	66	**1,132**
	Olomouc	29	121	48	27	243	0	11	**480**
	Zlín	7	130	0	15	119	0	0	**270**
	Moravia-Silesia	62	375	155	44	595	0	41	**1,272**
	Total	**1,331**	**2,540**	**1,631**	**548**	**3,175**	**72**	**267**	**9,564**

The data on funding at the regional level are divided according to the locations where resources were utilised by the providers of projects and programmes. The 2012 drug policy expenditures from the national and local budgets designated for use on regional levels are depicted in Map 1-1.

Map 1-1: Drug policy expenditures from national and local budgets in regions of the Czech Republic, 2012 (€ thousand per 100,000 inhabitants aged 15-64)



The total drug policy expenditures can also be divided into those earmarked for drug demand reduction (prevention, harm reduction, treatment, and aftercare) and supply reduction (law enforcement). While drug demand reduction measures are funded from both the national and local budgets, supply reduction operations are funded from the national budget only; see Table 1-6.

Table 1-6: Comparison of expenditures provided from public budgets by service categories, 2008-2012 (€ thousand)

Service category	**2008**		**2009**		**2010**		**2011**		**2012**	
	Spent	%	Spent	%	Spent	%	Spent	%	Spent	%
Prevention	2,340	9.8	2,078	9	2,463	9.9	2,234	9.7	1,938	8.3
Harm reduction	6,389	26.7	6,616	28.8	6,572	26.5	6,209	27.1	6,410	27.4
Treatment	4,890	20.4	4,278	18.6	4,304	17.4	4,155	18.1	4,460	19.1
Sobering-up stations	2,509	10.5	2,421	10.5	3,449	13.9	2,807	12.2	3,175	13.6
Aftercare	999	4.2	1,201	5.2	1,238	5	1,200	5.2	1,349	5.8
Coordination, research, evaluation	504	2.1	421	1.8	749	3	756	3.3	537	2.3
Law enforcement	6,100	25.5	5,851	25.5	5,906	23.8	5,431	23.7	5,222	22.4
Others, unspecified	217	0.9	106	0.5	125	0.5	140	0.6	267	1.1
Total	**23,947**	**100.0**	**22,973**	**100.0**	**24,807**	**100.0**	**22,933**	**100.0**	**23,358**	**100.0**

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

Drug policy projects at the local level are also supported by the European Social Fund (ESF) via the Ministry of Labour and Social Affairs. These projects are scheduled for 2-3 years. A beneficiary is provided with an advance deposit, and the eligible expenses actually incurred are then reimbursed later (mostly at 6-month intervals). Therefore, it is not possible to account for the financial resources that were provided in the individual years. In 2013 a total of CZK 110 million (€ 4.4 million) was made available for programmes intended to facilitate employment opportunities for people with drug problems as part of three grant calls announced by the Ministry of Labour and Social Affairs.[32] This finance has been monitored by the National Focal Point since 2010. In order to maintain the consistency of the time series, these resources have not been included in the total expenditure yet.

[32] Call 43 and 67: CZK 25,990,052.51 (€ 1,033 thousand) and CZK 42,075,557.00 (€ 1,673 thousand), respectively, as of 28 March 2013. Call 86: CZK 49,160,694.62 (€ 1,955 thousand) as an aggregate sum for all projects that have been approved (with commencement dates from November 2012 up to mid-2013). These projects are primarily focused on individuals at risk of addiction or dependent on addictive substances who have undergone inpatient treatment in a healthcare facility or completed outpatient treatment or are currently receiving such treatment, as well as people who are abstaining. In addition to grant calls, a separate call, A6, involving CZK 150 million (€ 5,967 thousand), has been announced. Intended for the Office of the Government of the Czech Republic, this call is aimed at supporting activities in the area of the prevention of social exclusion associated with drug use.

Table 1-7: Drug policy expenditures from national and local budgets by region of project implementation, 2012 (€ thousand)

Region	GCDPC	Ministry of Education	Ministry of Defence	Ministry of Labour and Social Affairs	Ministry of Health	Ministry of Justice	General Customs Head-quarters	National Drug Head-quarters	Total national budget	Regions	Munici-palities	Total local budgets	Total	Total (%)
Prague	916	88	–	328	258	–	–	–	**1,590**	2,156	369	**2,525**	**4,114**	**17.6**
Central Bohemia	72	76	–	315	42	–	–	–	**504**	520	158	**678**	**1,182**	**5.1**
South Bohemia	169	48	–	164	50	–	–	–	**431**	387	71	**458**	**889**	**3.8**
Pilsen	127	26	–	50	41	–	–	–	**245**	295	273	**568**	**812**	**3.5**
Karlovy Vary	62	4	–	87	0	–	–	–	**152**	253	16	**269**	**421**	**1.8**
Ústí nad Labem	216	16	–	246	37	–	–	–	**514**	116	253	**369**	**883**	**3.8**
Liberec	90	11	–	104	0	–	–	–	**205**	330	126	**456**	**661**	**2.8**
Hradec Králové	68	15	–	114	58	–	–	–	**254**	318	42	**360**	**614**	**2.6**
Pardubice	34	10	–	76	0	–	–	–	**120**	251	64	**315**	**435**	**1.9**
Vysočina	52	35	–	146	20	–	–	–	**253**	362	50	**412**	**666**	**2.9**
South Moravia	290	62	–	251	36	–	–	–	**640**	695	437	**1,132**	**1,772**	**7.6**
Olomouc	218	25	–	205	6	–	–	–	**453**	350	130	**480**	**933**	**4.0**
Zlín	77	17	–	113	6	–	–	–	**213**	198	73	**270**	**484**	**2.1**
Moravia-Silesia	178	13	–	377	1	–	–	–	**569**	775	497	**1,272**	**1,840**	**7.9**
Expenditure with regional designation	2,567	445	–	2,575	555	–	–	–	**6,142**	7,005	2,559	**9,564**	**15,707**	**67.2**
Expenditure with central designation	1,032	13	94	780	191	441	72	5,028	**7,651**	0	0	**0**	**7,651**	**32.8**
Total	**3,599**	**458**	**94**	**3,355**	**746**	**441**	**72**	**5,028**	**13,794**	**7,005**	**2,559**	**9,564**	**23,358**	**100.0**
– including investment expenditure	14	0	0	0	0	0	72	0	**86**	0	0	**0**	**86**	**0.4**
Total (%)	**15.4**	**2.0**	**0.4**	**14.4**	**3.2**	**1.9**	**0.3**	**21.5**	**59.1**	**30.0**	**11.0**	**40.9**	**100.0**	–

Table 1-8: Drug policy expenditures in the Czech Republic by service categories, 2012 (€ thousand)

Service category		GCDPC	Ministry of Education	Ministry of Defence	Ministry of Labour and Social Affairs	Ministry of Health	Ministry of Justice	General Customs Head-quarters	National Drug Squad	Total state budget	Regions	Munici-palities	Total local budgets	Total	Total (%)
Primary prevention		68	445	94	0	0	0	0	0	**607**	897	434	**1,331**	**1,938**	8.3
Harm reduction	Drop-in centres	1134	0	0	1153	66	0	0	0	**2,353**	780	706	**1,486**	**3,839**	16.4
	Outreach programmes	620	0	0	656	54	0	0	0	**1,329**	440	506	**946**	**2,275**	9.7
	Unspecified*	157	0	0		31	0	0	0	**188**	73	35	**108**	**296**	1.3
	Total	1,911	0	0	1,809	150	0	0	0	**3,870**	1,293	1,247	**2,540**	**6,410**	27.4
Treatment	Health care **	83				395	251	0	0	**729**	383	156	**540**	**1,269**	5.4
	Non-health outpatient care ***	263	0	0	283	10	37	0	0	**594**	199	161	**360**	**954**	4.1
	Therapeutic communities	789	0	0	717	0	0	0	0	**1,506**	573	158	**731**	**2,238**	9.6
	Total	1,135	0	0	1,001	405	288	0	0	**2,829**	1,156	475	**1,631**	**4,460**	19.1
Sobering-up stations			0	0	0	0	0	0	0	**0**	3089	86	**3,175**	**3,175**	13.6
Aftercare		255	0	0	546	0	0	0	0	**801**	348	200	**548**	**1,349**	5.8
Law enforcement			0	0	0	0	123	72	5028	**5,222**	0	0	**0**	**5,222**	22.4
Coordination, research, evaluation		230	13	0	0	191	30	0	0	**464**	70	3	**72**	**537**	2.3
Others, unspecified			0	0	0	0	0	0	0	**0**	152	116	**267**	**267**	1.1
Total		**3,599**	**458**	**94**	**3,355**	**746**	**441**	**72**	**5,028**	**13,794**	**7,005**	**2,559**	**9,564**	**23,358**	**100.0**

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

1.3.2 Drug Treatment Costs Incurred by Health Insurers

The costs incurred by health insurers in relation to the treatment of substance use disorders are provided with a year's delay using health account statistics compiled according to the international System of Health Accounts. They comprise directly identifiable costs, i.e. those reported as incurred in relation to the treatment of primary diagnoses, and unidentifiable costs, with no link to a diagnosis, the proportion of which spent in relation to the F10-F19 diagnoses was estimated (for more details see the 2011 Annual Report).

In 2011 the total volume of expenditures incurred by health insurance companies in relation to the treatment of substance use disorders amounted to CZK 1,563 million (€ 62,168 thousand), with CZK 1,110 million (€ 44,133 thousand) being spent on the treatment of alcohol use disorders (diagnosis F10) and CZK 453 million (€ 18,035 thousand) on disorders caused by drugs other than alcohol (dg. F11-F19); see Table 1-9.

The largest proportion of the costs incurred by health insurers in relation to the treatment of alcohol users from 2007 to 2011 was spent on treatment services (almost 72%), divided into inpatient and outpatient care modalities, which account for a little less than 64% and 8%, respectively, of these expenditures; almost one fifth of the costs were used to cover medication. The share of other types of care (including rehabilitation, long-term care, and supporting services) was small. Specialisations associated with psychiatric and alcohol/drug treatment accounted for almost 89% and over 50% respectively of the provision of inpatient and outpatient treatment services for alcohol users. As regards users of drugs other than alcohol, treatment services also consumed the largest proportion of expenditures (over two thirds) during the period under scrutiny, with the inpatient and outpatient care modalities accounting for 58% and 9% of the total costs being incurred in relation to the treatment of the F11-F19 diagnoses; almost one fifth of the health insurers' costs was used to pay for medication. A relatively high percentage (10%) was made up by the costs of supporting services that encompass the use of laboratories, transport, and emergency medical services. The share of psychiatric and alcohol/drug treatment specialisations was greater than that in alcohol use treatment, with 90% and 58% in inpatient and outpatient services respectively (Nechanská, 2013g).

1.3.3 Social Costs Related to Drug Use

A study to examine the social costs (Cost of Illness, COI) related to the use of the three major groups of addictive substances, i.e. tobacco, alcohol, and illegal drugs, in the Czech Republic in 2007 was conducted (Zábranský et al., 2011a). The total of such costs amounted to CZK 56.2 billion (€ 2,023 million), with CZK 33.1 billion (€ 1,193 million) (59.0%), CZK 16.4 billion (€ 589 million) (29.1%), and CZK 6.7 billion (€ 241 million) (11.9%) attributed to tobacco, alcohol, and illegal drugs respectively. For more thorough coverage of this study see the 2011 Annual Report. As for tobacco, the indirect costs were two-and-a-half times higher that the direct ones, particularly because of the high mortality-related costs. As far as alcohol is concerned, the direct costs were slightly higher than the indirect ones; the most significant items included the direct costs of dealing with both primary and secondary crime and the indirect costs of mortality (for more details on the effect of alcohol on mortality in the Czech Republic see the chapter Mortality of Drug Users on page 108). As regards illicit drugs, the direct costs were significantly higher than the indirect ones, with the majority of such costs being attributed to the direct costs incurred in relation to the tackling of secondary crime involving offences against property. The total costs associated with all three groups of substances represented 1.6% of GDP, which is about half as much as in other developed countries. In comparison to other countries, tobacco and alcohol use accounts for relatively more expenditure than the use of illegal drugs (Zábranský et al., 2011a).

Table 1-9: Estimated costs incurred by health insurers in relation to the F10 and F11-19 diagnoses according to the type of care, 2007-2011 (€ thousand) (Nechanská, 2013g)

Type of care	Cost of diagnosis F10					Cost of diagnoses F11-F19				
	2007	2008	2009	2010	2011	2007	2008	2009	2010	2011
Treatment services	**26,736**	**27,472**	**31,187**	**30,211**	**31,108**	**7,826**	**9,127**	**10,766**	**11,283**	**12,546**
Inpatient care	23,825	24,487	27,712	26,669	28,147	6,620	7,857	9,244	9,699	11,088
Intensive inpatient care	*1,034*	*871*	*1,264*	*1,489*	*1,221*	*323*	*339*	*467*	*532*	*495*
incl. psychiatry	47	27	44	52	89	122	111	129	117	126
Standard inpatient care	*2,961*	*3,090*	*3,673*	*2,793*	*2,567*	*1,289*	*1,552*	*1,583*	*1,659*	*1,266*
incl. psychiatry	1,479	1,478	1,501	971	1,536	870	1,031	901	915	910
child psychiatry	0	2	1	1	0	1	1	9	1	2
Long-term inpatient care	*19,809*	*20,495*	*22,746*	*22,343*	*24,330*	*5,002*	*5,955*	*7,182*	*7,492*	*9,316*
incl. alcohol/drug treatment (AT clinics)	4,681	4,026	5,287	5,331	5,543	1,686	1,591	2,198	2,242	2,460
psychiatry	15,054	16,395	17,338	16,890	18,652	3,264	4,276	4,879	5,127	6,670
child psychiatry	0	0	0	1	7	51	88	98	120	180
One-day care	22	30	30	44	28	7	11	11	17	11
Outpatient care	2,842	2,859	3,406	3,461	2,896	1,184	1,223	1,496	1,553	1,432
Primary care	51	38	58	61	60	24	15	25	28	28
Dental care	11	10	42	13	6	4	4	15	5	3
Specialised outpatient care	*2,178*	*2,248*	*2,689*	*2,737*	*2,100*	*931*	*994*	*1,193*	*1,282*	*1,098*
incl. alcohol/drug treatment (AT clinics)	313	261	281	277	296	150	128	163	144	187
psychiatry	1,363	1,347	1,303	1,279	1,438	552	582	603	639	757
child psychiatry	5	4	4	3	2	15	11	16	13	18
Other specialised outpatient services	*337*	*398*	*376*	*410*	*471*	*90*	*117*	*114*	*108*	*132*
incl. clinical psychology	289	303	336	371	434	75	82	98	92	116
psychotherapy	0	0	0	0	0	0	0	1	0	0
Home care	47	96	40	37	36	15	35	14	14	14
Rehabilitation services	**22**	**23**	**262**	**337**	**338**	**10**	**8**	**100**	**136**	**138**
Long-term care	**405**	**678**	**679**	**781**	**980**	**37**	**138**	**99**	**144**	**150**
Supporting services	**1,801**	**1,842**	**2,216**	**2,347**	**2,281**	**1,419**	**1,369**	**1,558**	**1,637**	**1,308**
Laboratories	658	696	910	999	969	1,169	1,100	1,247	1,306	999
incl. toxicology	157	148	183	175	191	295	303	388	320	363
Imaging techniques	280	275	361	374	228	84	85	122	134	74
Transport and emergency medical services	863	871	944	973	1,084	166	184	189	198	235
Medication and medical equipment and supplies	**7,974**	**7,380**	**9,050**	**8,254**	**9,281**	**2,561**	**2,753**	**3,306**	**3,233**	**3,792**
Medication	7,461	6,916	8,391	7,689	8,715	2,395	2,579	3,066	3,011	3,560
Medical equipment and supplies	513	464	658	565	566	166	174	241	222	233
Prevention	**230**	**514**	**350**	**292**	**138**	**76**	**738**	**154**	**114**	**56**
Unidentified care	**30**	**75**	**23**	**92**	**37**	**10**	**28**	**9**	**19**	**14**
Total	**37,178**	**37,953**	**43,737**	**42,270**	**44,133**	**11,931**	**14,150**	**15,981**	**16,551**	**18,035**

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

2 Drug Use in the General Population and Specific Targeted Groups

The 2012 National Survey on Substance Use confirmed the sustained level of cannabis use among the general population and the continuing decline in the level of experience with other illegal drugs. The exception is the slight increase in the lifetime prevalence of cocaine use, particularly among men and in the 35-44 age group.

All the studies carried out since 2008 have shown the same pattern of drug use among the general population. The most frequently used drug was cannabis, which had been taken at least once by 27.9% of the population (when applied to the population of the given age range, this rate corresponds to an estimated 1.9-2.2 million people). In the last year, cannabis had been used by 9.2% of the respondents, i.e. approximately 570-760 thousand individuals. According to the Cannabis Abuse Screening Test (CAST), about one third of the current cannabis users fell into the category of a moderate or high risk of cannabis-related problems. When related to the general population, these figures are equivalent to 1.2% and 1.6% of the population being exposed to a high and moderate risk because of cannabis use (i.e. approximately 87 and 116 thousand respectively).

While ecstasy was long the second most commonly used illicit drug in the Czech Republic, the surveys showed that in 2012 the second place was taken by hallucinogenic mushrooms. Other places belonged to the use of methamphetamine (pervitin) or amphetamines, cocaine, and LSD, with a rather consistently low level of lifetime prevalence (2.3-2.8%), while the Czech population's lifetime experience with heroin has shown low levels in the long term (less than 1%). Very low levels for the use of illegal drugs other than cannabis were recorded for the 12-month and 30-day time frames.

The level of risky alcohol consumption remains high in the Czech Republic. According to the CAGE screening scale, risky drinking pertains to a total of 17.0% of the population (i.e. 1.1-1.4 million people), while harmful or problem alcohol use is associated with 8.2% of the population (i.e. 500-690 thousand people).

The regional analysis of the 2011 ESPAD survey showed that experience with illegal drugs is more prevalent in Prague and the Ústí nad Labem, Karlovy Vary, Olomouc, and Moravia-Silesia regions, while the Central Bohemia, Pilsen, Hradec Králové, and Pardubice regions show relatively low levels of drug use among students. The situation is becoming more similar across the country, as the regional differences are diminishing, which further reflects the trend already observed from 2003 to 2007. Nevertheless, the situation at the regional level is relatively dynamic. While at the national level the situation concerning the use of certain drugs has remained stable, different trends can be observed in the regions.

The attitudes of the Czech public to substance use have remained relatively consistent. While the level of public acceptance of tobacco smoking has shown a slight decrease recently, a growing number of people find it acceptable to use alcohol and cannabis. In addition, there has been a continuous increase in the proportion of the population who oppose the criminalisation of cannabis users, people who use cannabis for medical purposes, and those who cultivate cannabis for their own personal use.

2.1 Drug Use in the General Population

Three studies on the level of drug use in the general population were conducted in 2012: the National Survey on Substance Use, looking thoroughly into the extent of experience with both legal and illegal drugs and into the patterns and context of their use, and two omnibus surveys using the same battery of questions to enquire about the level of prevalence of specific drugs – The Prevalence of Drug Use among the Population of the Czech Republic 2012 (ppm factum research, 2012) and the Survey on Czech Citizens' Opinions about and Attitudes to the Issues of Health and Healthy Lifestyles (INRES-SONES, 2013).

2.1.1 2012 National Survey on Substance Use

In the autumn of 2012 the Czech National Monitoring Centre for Drugs and Drug Addiction (the National Focal Point), in association with the SC&C agency, carried out a general population survey, titled the 2012 National Survey on Substance Use, using a representative sample of the population aged 15-64. A total of 6210 households was addressed as part of the survey. The final sample comprised 2134 respondents, with intentional relative overrepresentation of individuals falling into the 15-34 age group (after the exclusion of households and respondents who did not meet the criteria for inclusion in the study or refused to participate, the response rate was 62%). Four-level stratified sampling was applied.[33] Data were collected by means of personal interviews with respondents using a paper questionnaire (PAPI).

The study questionnaire was based on the European Model Questionnaire[34] (EMQ) and covered the domains of legal drugs (tobacco use, drinking, and the use of psychoactive medicines and inhalants), illegal drugs (i.e. the use of

[33] The first and second levels involved the selection of municipalities from 23 strata according to the number of inhabitants and the random sampling of streets (a total of 177 initial points) respectively. In the third step, households were randomly selected during a random walk. The fourth level involved the selection of respondents in the households using Kish tables.

[34] http://www.emcdda.europa.eu/themes/key-indicators/gps (10 September 2013)

cannabis, ecstasy, pervitin, heroin, cocaine, LSD, and hallucinogenic mushrooms), new herbal[35] and synthetic[36] drugs ("legal highs"), and attitudes to drug use. In addition, the questionnaire was complemented with selected items focusing on the perceived availability of addictive substances, a module addressing mental health, and questions concerning betting games, including a pathological gambling screening test. Following the emergence of the methanol case in September 2012 (for more details see Mass Methanol Poisonings in 2012 on page 104), when the field data collection process was already under way, a special module focused on patterns of alcohol consumption was added to the questionnaire. A total of 1660 respondents provided answers to the questions in this special module.

As regards its extent, the sample size, and the questionnaire used, the study followed up on the 2008 General Population Survey on the use of psychotropic substances in the Czech Republic (the 2008 General Population Survey)[37] (Běláčková et al., 2012). Additionally, the results after the data had been weighted for gender, age, education, region of residence, size of the municipality, and the economic status of the Czech population aged 15-64 years are presented.

The lifetime use of tobacco in the form of cigarettes, cigars, pipes, or water pipes was reported by almost 70% of the respondents, while 34.4% of the individuals had smoked tobacco in the last 30 days (40.3% of the men and 28.5% of the women); see Table 2-1. A total of 23.1% of the people (28.2% and 18.1% of the men and women respectively) reported regular daily smoking in the last month.

Alcohol had been consumed by a total of 69.9% of the respondents in the last month (78.4% of the men and 61.5% of the women). Binge drinking (5 or more drinks consumed on a single occasion) at least once a week or more frequently was reported by a total of 12.8% of the respondents (21.1% of the men and 4.9% of the women), mainly in the 35-44 age group.

According to CAGE, a four-item screening test used to assess for risky and harmful or problem alcohol use (Bühler et al., 2004, Bradley et al., 1998), 17.0% of the respondents (21.6% and 12.4% of the men and women respectively) met the criteria for the risky drinkers category (providing at least one positive answer on the CAGE scale), which corresponds to 1.1-1.4 million Czech adults. Harmful or problem drinking (2 or more positive answers) is associated with 8.2% of the population (11.8% of the men and 4.6% of the women), i.e. 500 to 690 thousand people in absolute figures. Harmful or problem alcohol use occurs most frequently in the 25-34 age group.

Tranquillisers or sleeping pills (i.e. sedatives or hypnotics) had been used by 6.1% of the respondents in the last year (4.1% of the men and 8.0% of the women), while opiate/opioid-based medication had been used by 2.6% of the respondents in the last 12 months (2.2% of the men and 2.9% of the women); see Table 2-1. While the majority of the respondents used the pharmaceuticals as recommended by physicians or pharmacists, 9.6% and 15.1% (of those who had taken the medicines in the last 12 months) had used sedatives or hypnotics and opioids, respectively, without a physician's recommendations or differently from the physician's recommendations, with men being more likely to engage in such behaviour.

The 2012 National Survey found that the most frequently used illegal drug among the general population was cannabis, the lifetime use of which was reported by 27.9% of the respondents (34.9% of the men and 21.2% of the women) aged 15-64. The second most frequently used drug was hallucinogenic ("magic") mushrooms, which had been used by 5.3% of the respondents (7.7% and 2.9% of the men and women respectively), followed by ecstasy, reported by 3.6% (5.0% and 2.2% of the men and women respectively). Experience with the use of pervitin or amphetamines, cocaine, and LSD shows relatively similar levels (2.3-2.8%), and the level of lifetime heroin use is very low (0.6%); see Table 2-1.

Among the general population, the use of illicit drugs within the last 12 months and the last 30 days shows very low levels, with the exception of cannabis, the use of which was reported by 9.2% and 4.4% of the respondents, respectively. The past-year and past-month prevalence of cannabis use is significantly higher among men from younger age categories.

Approximately 20% of those who had used cannabis in the last 12 months may be referred to as regular users (they had used cannabis at least once per week). When translated to the general population, the proportion of regular cannabis users corresponds to 1.9% of people of the age of 15-64 years (3.3% of the men and 0.6% of the women), with young adults aged 15-34 accounting for as much as 3.0%; see Graph 2-1 and Graph 2-2. It may thus involve an

[35] Herbal substances with hallucinogenic, stimulating or sedative effects available as an extract, pulp, dry matter, or a mixture. They include kratom, salvia divinorum, calea zacatechichi, damiana, and cola acuminata. None of the herbal drugs is new, but they are now offered over the internet and appear in new forms (such as extracts and mixtures) or in combination with other (synthetic) drugs.

[36] Synthetic substances with stimulant, hallucinogenic, or sedative effects sold under various names, such as El Padrino, Spice, Ex, K2, Euphoria, Ecsphoria, Diablo, Funky, and Cocolino, or simply under their chemical denomination, e.g. poppers, ketamine, GBL, mephedrone, penthedrone, methoxetamine, MDPV, 6-APB, bk-MDMA, 3,4-DMMC, etc. Their effects are often described as comparable to those of traditional drugs such as marijuana, pervitin, ecstasy, and cocaine. For example, a product marketed as "spice" is a herbal mixture additionally enriched with synthetic cannabinoids ("synthetic marijuana"), which ranks it among new synthetic rather than herbal drugs.

[37] Also known as "the General Population Survey on Drug Use and Attitudes towards Drug Use in the Czech Republic in 2008".

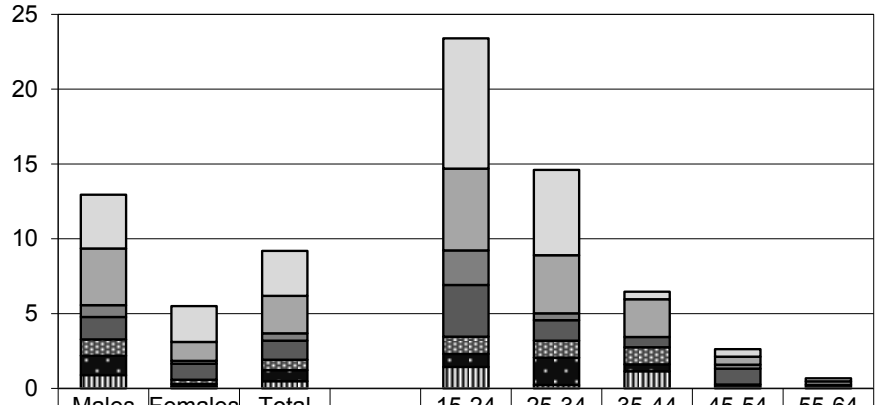
estimated 137 (95% CI: 94-181) thousand individuals aged 15-64, including approximately 124 (95% CI: 84-168) thousand men and approximately 88 (95% CI: 57-120) thousand young adults aged from 15 to 34.

Table 2-1: Lifetime prevalence rates of drug use in the general population – 2012 National Survey on Substance Use (%) (Chomynová, 2013, Národní monitorovací středisko pro drogy a drogové závislosti and SC&C, 2013)

Prevalence	**Drug**	**Gender**		**Young adults**	**Total population**
		Males	Females	15-34 years	15-64 years
		(n=1056)	(n=1072)	(n=824)	(N=2134)*
Lifetime prevalence	Tobacco	75.0	61.7	70.3	68.3
	Alcohol	-	-	-	-
	Cannabis	34.9	21.2	45.9	27.9
	Ecstasy	5.0	2.2	7.2	3.6
	Pervitin or amphetamines	3.4	1.7	4.5	2.5
	Cocaine	3.8	0.9	3.7	2.3
	Heroin	1.2	0.0	0.7	0.6
	LSD	4.4	1.2	5.4	2.8
	Hallucinogenic mushrooms	7.7	2.9	10.2	5.3
	New herbal drugs	0.9	0.6	1.6	0.7
	New synthetic drugs	0.4	0.4	0.9	0.4
	Inhalants	1.5	0.3	1.2	0.9
	Medication – sedatives, hypnotics	-	-	-	-
	Medication – opioids	-	-	-	-
Prevalence in the last 12 months	Tobacco	46.5	35.1	47.4	40.7
	Alcohol	88.8	79.4	83.8	84.0
	Cannabis	13.1	5.3	18.3	9.2
	Ecstasy	0.7	0.5	1.2	0.6
	Pervitin or amphetamines	0.7	0.3	1.0	0.5
	Cocaine	0.8	0.0	0.6	0.4
	Heroin	0.4	0.0	0.2	0.2
	LSD	0.3	0.2	0.7	0.2
	Hallucinogenic mushrooms	1.2	0.3	1.4	0.7
	New herbal drugs	0.1	0.3	0.5	0.2
	New synthetic drugs	0.3	0.0	0.3	0.1
	Inhalants	0.5	0.0	0.0	0.2
	Medication – sedatives, hypnotics	4.1	8.0	3.3	6.1
	Medication – opioids	2.2	2.9	2.5	2.6
Prevalence in the last 30 days	Tobacco	40.3	28.5	37.7	34.4
	Alcohol	78.4	61.5	68.8	69.9
	Cannabis	6.8	2.0	8.8	4.4
	Ecstasy	0.2	0.0	0.1	0.1
	Pervitin or amphetamines	0.3	0.1	0.4	0.2
	Cocaine	0.3	0.0	0.2	0.1
	Heroin	0.3	0.0	0.2	0.1
	LSD	0.1	0.1	0.2	0.1
	Hallucinogenic mushrooms	0.4	0.1	0.5	0.2
	New herbal drugs	0.0	0.0	0.0	0.0
	New synthetic drugs	0.2	0.0	0.0	0.1
	Inhalants	0.2	0.0	0.0	0.1
	Medication – sedatives, hypnotics	2.5	5.7	2.0	4.1
	Medication – opioids	0.8	1.5	0.7	1.2

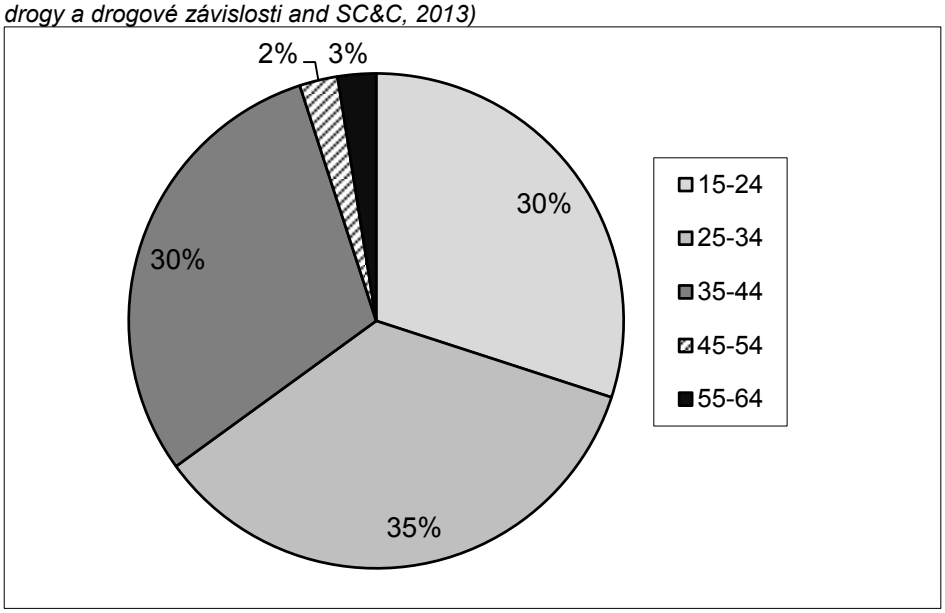
*Note: * 6 respondents did not indicate their gender.*

Graph 2-1: The prevalence of cannabis use in the last 12 months by gender and age groups (%) (Chomynová, 2013)



	Males	Females	Total		15-24	25-34	35-44	45-54	55-64
Once in the past year	3,6	2,4	3,0		8,7	5,7	0,5	0,5	0,2
Less than once per month	3,8	1,3	2,5		5,5	3,9	2,5	0,5	0,2
Once per month	0,8	0,2	0,5		2,3	0,5	0,0	0,3	0,0
Several (2-3) times per month	1,5	1,1	1,3		3,5	1,4	0,7	1,1	0,0
At least once per week (once or twice)	1,1	0,3	0,7		1,2	1,1	1,1	0,0	0,0
Several (3-4) times per week	1,3	0,2	0,7		0,9	1,8	0,5	0,3	0,2
(Almost) daily (5-7 times per week)	0,9	0,1	0,5		1,4	0,2	1,1	0,0	0,0

Graph 2-2: Respondents using cannabis at least once a week, by age groups (%) (Národní monitorovací středisko pro drogy a drogové závislosti and SC&C, 2013)



The questionnaire administered as part of the 2012 National Survey on Substance Use included the Cannabis Abuse Screening Test (CAST), a short measure used to assess problem or risky cannabis use (Piontek et al., 2008, Beck and Legleye, 2008). The distribution of the answers suggested that more than two thirds (68.9%) of current cannabis users (i.e. those who had used cannabis-related drugs in the last year) were at no or low risk related with cannabis use. On the other hand, 17.5% of the respondents fell into the category of moderate/medium risk and 13.7% of the respondents (18.0% of the men and 3.6% of the women) were found to be at high risk of cannabis-related problems; see Table 2-2.

The proportion of individuals exposed to a high risk corresponds to 1.2% of the population aged 15-64 (2.2% and 0.2% of the men and women respectively); those at moderate risk account for another 1.6% of the population (2.2% and 0.9% of the men and women respectively). When extrapolated to the population aged 15-64, these rates are equivalent to approximately 87 (51-123) thousand cannabis users at high risk and another 116 (72-152) thousand people exposed to a moderate risk in relation to their use of the drug.

There are approximately 1.8% and 3.8% of individuals at high and moderate risk, respectively, of cannabis-related problems among young adults aged 15-34. When extrapolated to the population of young adults, these rates are

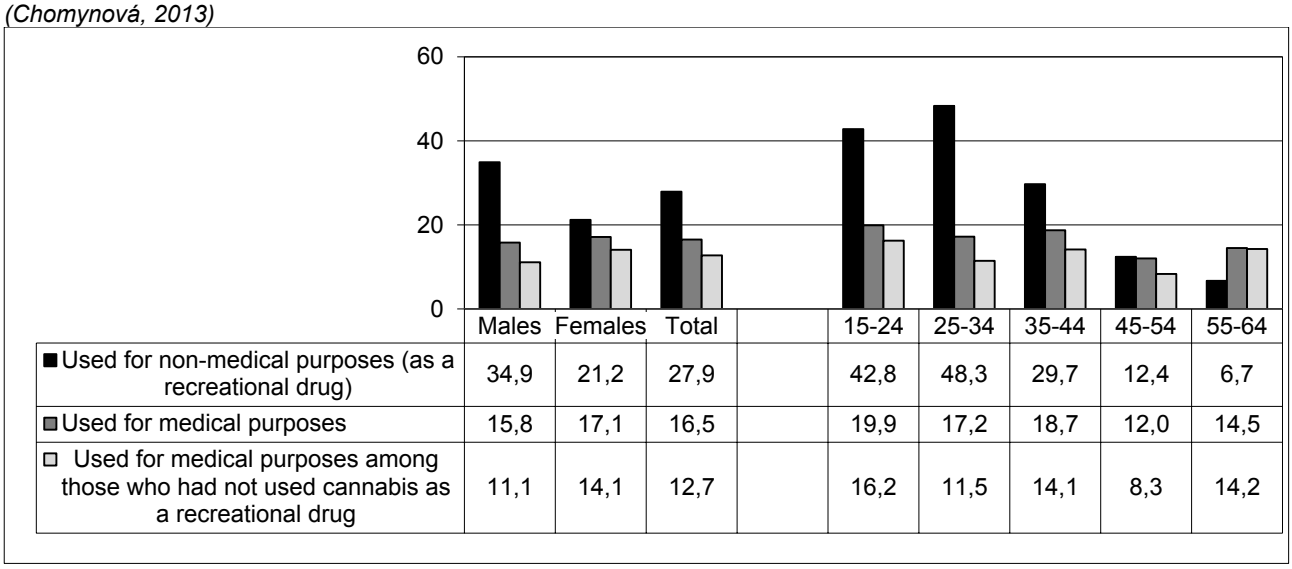
equivalent to an estimated 49 (27-74) thousand users exposed to a high risk and another 104 (71-137 thousand) young adults at moderate risk.

Table 2-2: CAST results and the occurrence of risky cannabis use (indicated as the percentage of those who had used cannabis in the last 12 months and the percentage of the general population) (Chomynová, 2013)

CAST	Males	Females	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years	Total	15-34 age group
Risky use – among those who had used cannabis in the last 12 months									
No or low risk (0-1 point)	64.8	78.2	70.9	66.7	63.0	81.8	50.0	68.9	69.9
Moderate or medium risk (2-3 points)	17.2	18.2	16.5	25.4	0.0	18.2	50.0	17.5	20.3
High risk (4 or more points)	18.0	3.6	12.7	7.9	37.0	0.0	0.0	13.7	9.8
Risky use – among the general population									
No or low risk (0-1 point)	95.5	98.8	93.3	95.2	97.7	99.5	99.8	97.2	94.4
Moderate or medium risk (2-3 points)	2.2	1.0	3.8	3.7	0.0	0.5	0.2	1.6	3.8
High risk (4 or more points)	2.3	0.2	2.9	1.1	2.3	0.0	0.0	1.2	1.8

The lifetime use of cannabis for medical purposes was reported by a total of 16.5% of the respondents (15.8% and 17.1% of the men and women respectively), while such use of cannabis in the last year was indicated by 10.7% of those surveyed (10.4% and 11.0% of the men and women respectively). The levels of cannabis use for medical purposes seem comparable for both genders and across all age groups. While the 45-54 age group recorded the same levels of cannabis use for both medical and non-medical purposes, among the 55-64 age group, notably, there is a higher percentage of respondents who reported having used cannabis for medical rather than non-medical purposes; see Graph 2-3.

Graph 2-3: Comparison of the lifetime prevalence of cannabis use for non-medical and medical purposes (%) (Chomynová, 2013)



	Males	Females	Total		15-24	25-34	35-44	45-54	55-64
Used for non-medical purposes (as a recreational drug)	34,9	21,2	27,9		42,8	48,3	29,7	12,4	6,7
Used for medical purposes	15,8	17,1	16,5		19,9	17,2	18,7	12,0	14,5
Used for medical purposes among those who had not used cannabis as a recreational drug	11,1	14,1	12,7		16,2	11,5	14,1	8,3	14,2

2.1.2 The 2012 Survey on the Prevalence of Drug Use among the Population of the Czech Republic

In December 2012 the National Focal Point, in association with the *ppm factum research* agency, conducted a research study titled "The Prevalence of Drug Use among the Population of the Czech Republic". Using a single set of questions, this omnibus survey of the general population sought to identify the level of experience with selected illegal substances among respondents above 15 years of age. A total of 976 persons over 15, out of whom 854 fell into the 15-64 age group, were contacted as part of the survey. The respondents were selected using quota sampling in such a way as to represent the population of the Czech Republic in terms of their age, gender, education, and the region and size of the place of their domicile. Data were collected using computer-assisted personal (face-to-face) interviews (CAPI). In comparison to 2011, the survey was extended to include new questions concerning the use of self-medicated psychoactive pharmaceuticals and gambling. The results, which show no major differences from those generated by the 2012 National Survey, are summarised in Table 2-3.

Table 2-3: Drug use in the general population – the 2012 Prevalence of Drug Use among the Population of the Czech Republic survey (%) (ppm factum research, 2012, Národní monitorovací středisko pro drogy a drogové závislosti and ppm factum research, 2013)

Drug	15-64 age group			15-34 age group		
	Lifetime prevalence	Prevalence in the last 12 months	Prevalence in the last 30 days	Lifetime prevalence	Prevalence in the last 12 months	Prevalence in the last 30 days
Cannabis	31.2	9.4	3.0	51.8	20.3	6.0
Ecstasy	5.5	0.8	0.2	10.1	1.8	0.6
Pervitin	1.5	0.4	0.0	2.4	0.6	0.0
Cocaine	0.2	0.0	0.0	0.0	0.0	0.0
Heroin	0.5	0.1	0.0	0.9	0.3	0.0
LSD	0.7	0.0	0.0	1.8	0.0	0.0
Hallucinogenic mushrooms	4.4	0.2	0.0	7.3	0.6	0.0
Inhalants	1.1	0.0	0.0	2.1	0.0	0.0
New synthetic drugs (incl. cathinones and synthetic cannabinoids)	0.6	0.5	0.0	0.3	0.3	0.0
Medication (incl. sedatives, hypnotics, and opioid analgesics)	15.8	8.9	3.0	16.3	8.5	2.3

2.1.3 2012 Citizen Survey

Furthermore, at the turn of November and December 2012, the National Focal Point worked with the INRES–SONES agency on collecting data about the level of drug use as part of the Survey on Czech Citizens' Opinions about and Attitudes to the Issues of Health and Healthy Lifestyles (the 2012 Citizen Survey). In its section covering health and healthy lifestyles, this omnibus survey incorporated a question inquiring about the level of experience with selected illicit substances among the respondents over 15 years of age. A total of 1802 individuals over 15, of whom 1466 were in the 15-64 age group, were addressed as part of the survey. The respondents were recruited using quota sampling in such a way as to represent the population of the Czech Republic in terms of their age, gender, and education, and the region and size of the place of their domicile. Data were collected by means of face-to-face interviews with respondents using paper questionnaires (PAPI). The response rate was 82.5%. In comparison with the previous rounds of this research carried out in 2009 and 2010, this time the survey included questions concerning psychoactive non-prescription pills and gambling, similarly to the 2012 Prevalence of Drug Use among the Population of the Czech Republic survey. The results, which are very similar to those generated by the 2012 National Survey and the 2012 Prevalence of Drug Use among the Population of the Czech Republic survey described above, are provided in Table 2-4.

Table 2-4: Drug use in the general population – the 2012 Citizen Survey (%) (Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES, 2013b)

Drug	15-64 age group			15-34 age group		
	Lifetime prevalence	Prevalence in the last 12 months	Prevalence in the last 30 days	Lifetime prevalence	Prevalence in the last 12 months	Prevalence in the last 30 days
Cannabis	35.6	13.6	5.3	54.9	24.2	10.3
Ecstasy	5.3	1.9	0.5	8.7	3.5	1.1
Pervitin	2.4	0.5	0.1	3.4	0.9	0.2
Cocaine	1.6	0.3	0.1	2.7	0.5	0.0
Heroin	0.5	0.1	0.0	0.7	0.2	0.0
LSD	3.3	1.0	0.1	5.5	1.9	0.2
Hallucinogenic mushrooms	5.9	1.6	0.3	10.1	3.2	0.7
Inhalants	1.3	0.3	0.1	1.6	0.5	0.2
New synthetic drugs (incl. cathinones and synthetic cannabinoids)	1.2	0.5	0.1	1.4	0.9	0.2
Medication (incl. sedatives, hypnotics, and opioid analgesics)	15.2	9.5	3.6	12.6	8.1	3.0

2.1.4 Research Project on Alcohol and Cannabis Use among Young Adults

The results of a study titled the Determinants of Risky Forms of Consumption of Alcohol in the Population of Young Adults: analysis of the health, social, and psychological implications (Alcohol Consumption among Young Adults)[38] that focused on the relationship between the consumption of alcohol and cannabis were published. Two-step random sampling was used to recruit a study sample of 2,221 persons aged 18-39 which was representative of the population of the Czech Republic in terms of the participants' gender, age, education, and region of residence. The average age was 29.9 years, with men accounting for 51.4%. Data were collected using the structured interview method. The response rate was 83.7%. Alcohol-related problems were measured using the AUDIT screening test; the level of alcohol consumption and the frequency of cannabis use in the last 12 months were examined. At 21.8%, the level of past-year cannabis use was in positive correlation with the frequency of beer drinking ($r = 0.27$),[39] the frequency of heavy drinking sessions ($r = 0.32$), and total AUDIT score ($r = 0.39$). Binge drinkers showed a higher risk of cannabis use (OR[40] = 4.3, 95% CI: 3.3-5.6). The results demonstrated a close relationship between heavy alcohol use and cannabis use (Csemy et al., 2012).

2.1.5 Drug Use Trends – Prevalence of Use

As the 2012 National Survey on Substance Use built on the 2008 General Population Survey in methodological terms, and given the scope of its questionnaire and the methods used to select respondents and collect data, it makes it possible to compare the data from a historical perspective. In comparison to 2008, the levels of the lifetime use of illegal drugs among the population of the Czech Republic have stabilised or declined in all three time frames under observation, including current use. The exception is a slight increase in the lifetime prevalence of cocaine use (although it still remains at relatively low levels in the EU context); see Table 2-5. In particular, cocaine use has recorded a significant rise among men (from 2.9% in 2008 to 3.8% in 2012) and in the 35-44 age group (from 1.3% to 2.9%). A minor increase in cocaine use was also ascertained among those aged 25-34.

[38] Grant No. NS9645-4/2008, Internal Grant Agency, Ministry of Health, Czech Republic, lead investigator Hana Sovinová, MD, grant recipient: the National Institute of Public Health, Prague.

[39] A correlation coefficient (r) expresses the degree of association between two variables. It takes values from -1 to +1, where r = -1 indicates a perfect negative correlation, r = +1 a perfect positive correlation, and r = 0 the non-existence of any linear relationship between two variables.

[40] The odds ratio (OR) indicates the degree of association between two variables, or an exposure and an outcome. It expresses the odds that an outcome will occur as a result of a particular exposure in comparison to non-exposure.

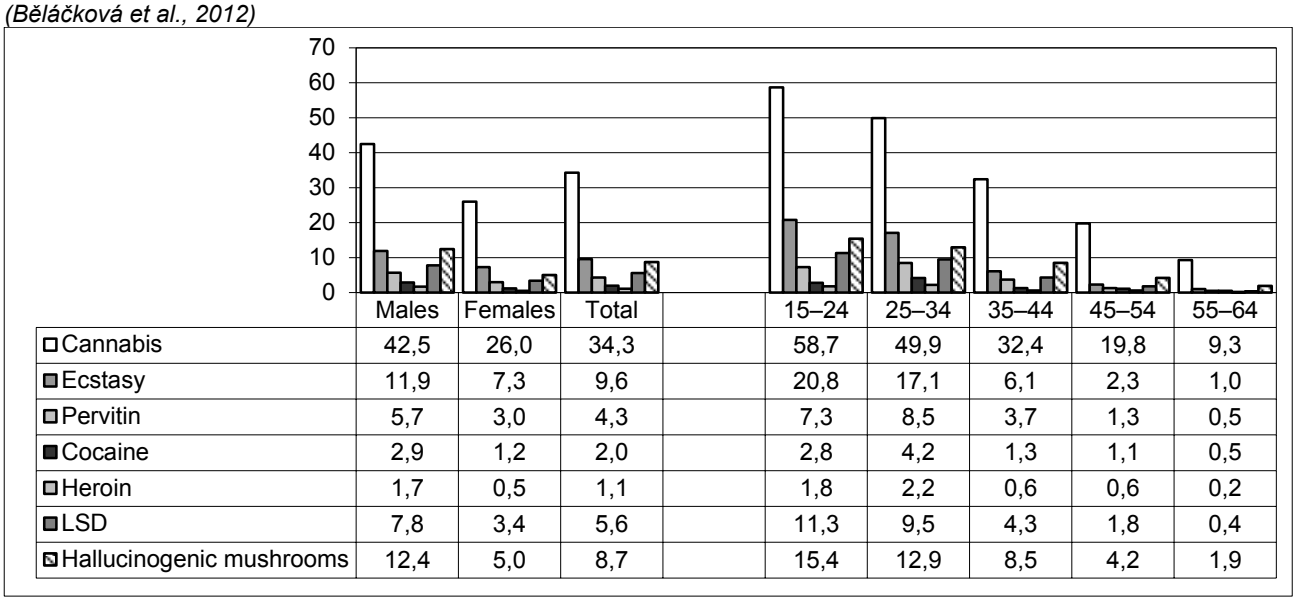
Table 2-5: Comparison of prevalence rates of drug use in different time frames, 2008 and 2012 (%) (Chomynová, 2013, Běláčková et al., 2012)

Drugs	2008 General Population Survey			2012 National Survey on Substance Use		
	Lifetime prevalence	Prevalence in the last 12 months	Prevalence in the last 30 days	Lifetime prevalence	Prevalence in the last 12 months	Prevalence in the last 30 days
Cannabis	34.3	15.3	8.6	27.9	9.2	4.4
Ecstasy	9.6	3.7	1.2	3.6	0.6	0.1
Pervitin	4.3	1.7	0.7	2.5	0.5	0.2
Cocaine	2.0	0.7	0.4	2.3	0.4	0.1
Heroin	1.1	0.5	0.1	0.6	0.2	0.1
LSD	5.6	2.1	0.7	2.8	0.2	0.1
Hallucinogenic mushrooms	8.7	3.2	1.1	5.3	0.7	0.2

Note: The 2008 survey did not cover the use of inhalants and so-called "new drugs".

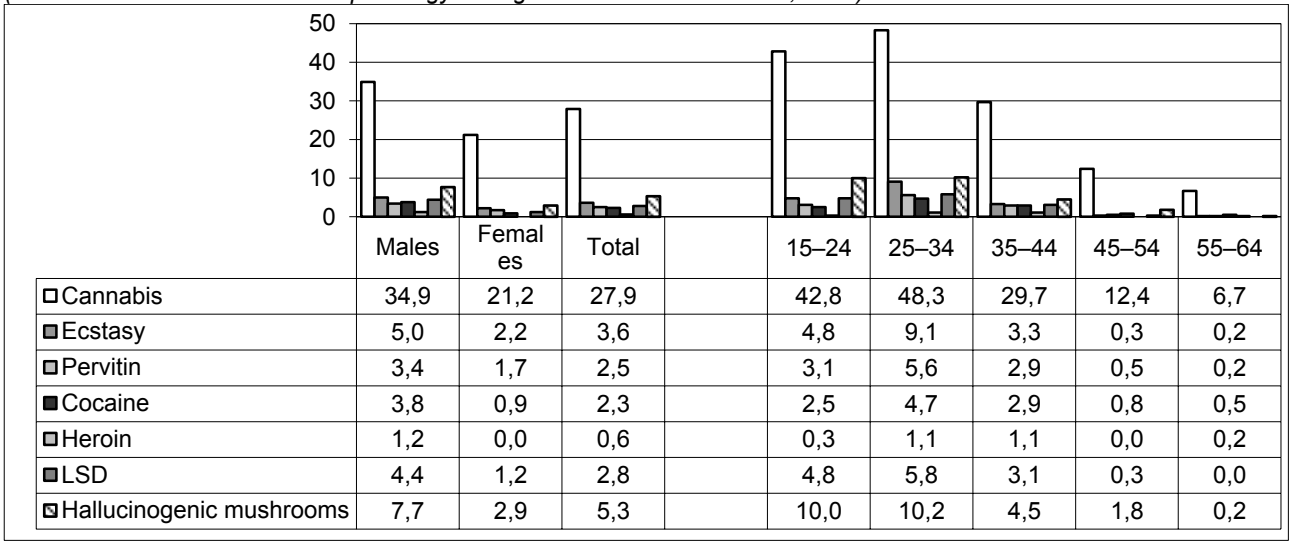
While in 2008 the highest prevalence rates of the use of all the illegal drugs under scrutiny were recorded among very young adults (the 15-24 age group), and the prevalence of experience with the drugs under study appeared to decline with age, in 2012 the highest prevalence rates were observed in the 25-34 age group; see Graph 2-4 and Graph 2-5.

Graph 2-4: Lifetime prevalence of the use of selected illicit drugs in the Czech Republic, 2008, by gender and age (%) (Běláčková et al., 2012)



	Males	Females	Total	15–24	25–34	35–44	45–54	55–64
Cannabis	42,5	26,0	34,3	58,7	49,9	32,4	19,8	9,3
Ecstasy	11,9	7,3	9,6	20,8	17,1	6,1	2,3	1,0
Pervitin	5,7	3,0	4,3	7,3	8,5	3,7	1,3	0,5
Cocaine	2,9	1,2	2,0	2,8	4,2	1,3	1,1	0,5
Heroin	1,7	0,5	1,1	1,8	2,2	0,6	0,6	0,2
LSD	7,8	3,4	5,6	11,3	9,5	4,3	1,8	0,4
Hallucinogenic mushrooms	12,4	5,0	8,7	15,4	12,9	8,5	4,2	1,9

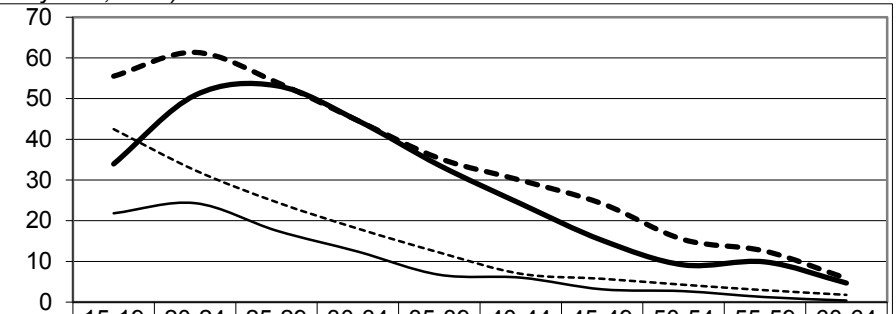
Graph 2-5: Lifetime prevalence of the use of selected illicit drugs in the Czech Republic, 2012, by gender and age (%) (Národní monitorovací středisko pro drogy a drogové závislosti and SC&C, 2013)



	Males	Females	Total	15–24	25–34	35–44	45–54	55–64
Cannabis	34,9	21,2	27,9	42,8	48,3	29,7	12,4	6,7
Ecstasy	5,0	2,2	3,6	4,8	9,1	3,3	0,3	0,2
Pervitin	3,4	1,7	2,5	3,1	5,6	2,9	0,5	0,2
Cocaine	3,8	0,9	2,3	2,5	4,7	2,9	0,8	0,5
Heroin	1,2	0,0	0,6	0,3	1,1	1,1	0,0	0,2
LSD	4,4	1,2	2,8	4,8	5,8	3,1	0,3	0,0
Hallucinogenic mushrooms	7,7	2,9	5,3	10,0	10,2	4,5	1,8	0,2

A drop in the prevalence of experience with drug use is also apparent when one takes a closer look at the levels of cannabis use according to five-year age groups. One can observe a decline in the prevalence of cannabis use in all the age groups, both as regards the lifetime prevalence and the use of cannabis in the last 12 months, and there is also an obvious shift in the peak level of experience with cannabis to an older age group. While in 2008 lifetime prevalence recorded its highest level in the 20-24 age group (and among those aged 15-19 as regards use in the last year), in 2012 it was the respondents in the 25-29 age group (20-24 as regards past-year use) who showed the highest prevalence of cannabis use; see Graph 2-6. These data suggest that over the past four years cannabis use among the youngest age group (15-19 years) has declined, which is also supported by trends identified among 16-year-olds as part of the European School Survey on Alcohol and Other Drugs (ESPAD) in 2011 (Csémy and Chomynová, 2012).

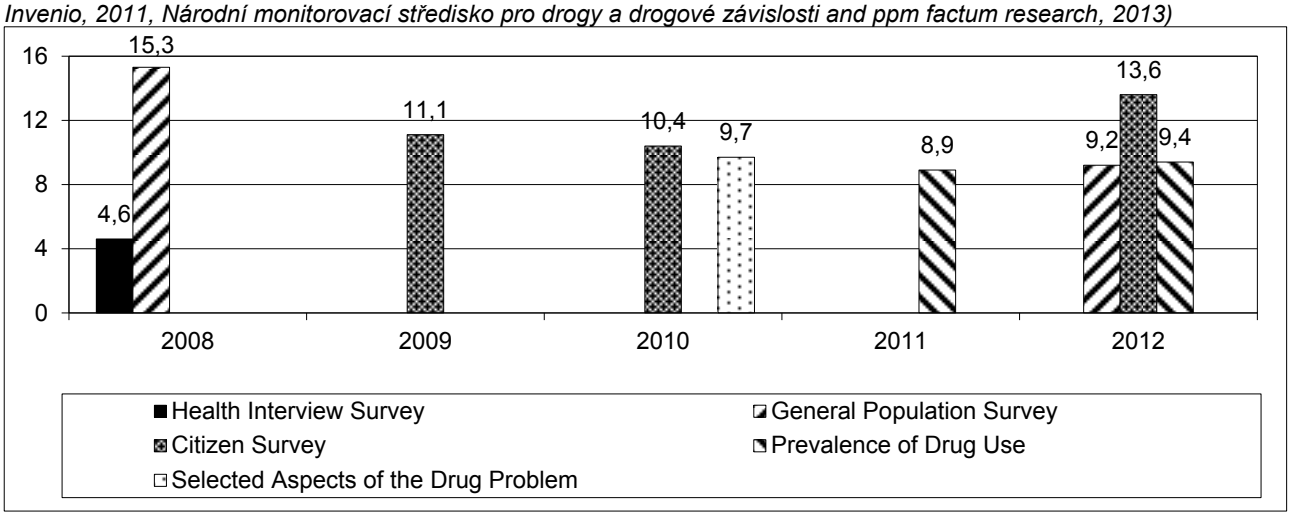
Graph 2-6: Lifetime and past-year prevalence of cannabis use, by 5-year age groups; comparison of the years 2008 and 2012 (%) (Běláčková et al., 2012, Chomynová, 2013)



	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
2012 National Survey – lifetime prevalence	33,9	50,8	53,2	44,6	33,6	24,2	15,2	9,1	9,9	4,7
2012 National Survey – 12-month prevalence	21,8	24,3	17,6	12,4	6,7	6,0	3,1	2,7	1,2	0,4
2008 General Population Survey – lifetime prevalence	55,5	61,4	54,0	44,6	35,3	29,9	24,2	15,4	12,5	5,8
2008 General Population Survey – 12-month prevalence	42,5	32,4	24,6	18,1	12,2	7,0	5,7	4,3	2,9	1,8

All the studies conducted in recent years drew the same conclusions about the patterns of illicit drug use among the general population: the most frequently used drug was cannabis, which had been taken at any point in their lives by 23-36% of the population. When converted to the population of the given age, this percentage corresponds to an estimated 2 million inhabitants of the Czech Republic. According to the 2012 National Survey, it involves 1.9-2.2 million individuals (95% CI for the lifetime prevalence of cannabis use: 26.0-29.9%). Cannabis use in the last year was reported by 9-15% of the respondents, which accounts for 570-760 thousand people, according to the 2012 National Survey. Long-term trends suggest a slight decline in mean prevalence rates of past-12-month cannabis use among the general population; see Graph 2-7.

Graph 2-7: Past-12-month prevalence of cannabis use in the general population (15-64 age group) – comparison of studies conducted from 2008 to 2012 (%) (Chomynová, 2013, Běláčková et al., 2012, Daňková, 2010, Zeman et al., 2011, Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES, 2009, Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES, 2010, Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES, 2013b, Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio, 2011, Národní monitorovací středisko pro drogy a drogové závislosti and ppm factum research, 2013)



While ecstasy was long the second most commonly used illicit drug in the Czech Republic, the 2012 National Survey and the 2012 Citizen Survey showed that in 2012 the second place was taken by hallucinogenic mushrooms. Nevertheless, in each of the surveys, the prevalence of their use in the last 12 months remained consistently below 1%. Other places are taken by the use of methamphetamine (pervitin) or amphetamines, cocaine, and LSD, with a rather consistently low level of lifetime prevalence found in the surveys carried out in 2012 (2.3-2.8%), while the Czech population's lifetime experience with heroin has shown low levels in the long term (0.3-1.1% across the studies from 2008 to 2012).

2.1.6 Drug Use Trends – Risky Cannabis Use according to CAST

The 2012 National Survey makes it possible to compare the level of risky cannabis use in the population with the results of the validation study of cannabis assessment scales carried out in 2010. According to the CAST screening test, in 2012 approximately 1.2% and 1.6% of the population aged 15-64 were identified as being at high and moderate risk respectively of cannabis use-related problems. Among young adults, in the 15-34 age group, people at high and moderate risk accounted for about 1.8% and 3.8% respectively.

Thus, in comparison to 2010, the percentage of individuals at risk of cannabis-related problems recorded a slight decline (from 3.1% to 2.8% of the population). It was especially the proportion of people exposed to a moderate or medium risk of cannabis-related problems that fell, while the percentage of the population at high risk rose further. In particular, the percentage of people at high risk increased among men (from 1.6% to 2.3%) and in the 15-24 and 35-44 age categories; see Table 2-6.

Table 2-6: CAST results and the prevalence of risky cannabis use in the population, 2010 and 2012 (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2010b, Chomynová, 2013)

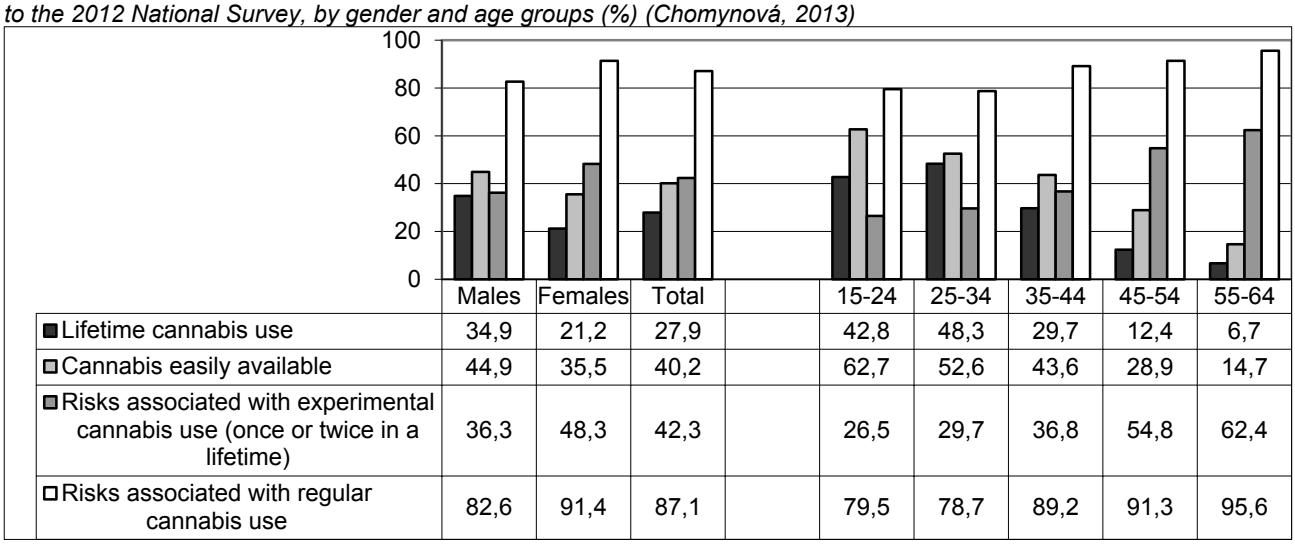
CAST	Males	Females	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years	Total	15-34 age group
Risky use in the general population – 2012 National Survey									
No or low risk (0-1 point)	95.5	98.8	93.3	95.2	97.7	99.5	99.8	97.2	94.4
Moderate or medium risk (2-3 points)	2.2	1.0	3.8	3.7	0.0	0.5	0.2	1.6	3.8
High risk (4 points or more)	2.3	0.2	2.9	1.1	2.3	0.0	0.0	1.2	1.8
Risky use in the general population – 2010 validation study									
No or low risk (0-1 point)	95.7	98.2	92.9	95.5	97.6	98.8	99.5	96.9	94.3
Moderate or medium risk (2-3 points)	2.8	1.3	4.7	3.5	1.3	1.1	0.5	2.1	4.0
High risk (4 points or more)	1.6	0.4	2.4	1.0	1.1	0.2	0.0	1.0	1.6

2.2 Attitudes to Substance Use

The 2012 National Survey on Substance Use also explored the respondents' opinions about the extent to which a person may damage their health (both physical and mental) by experimenting with cannabis or using it on a regular basis. While 42.3% of the respondents perceive use of cannabis once or twice as posing a moderate or high risk,

regular cannabis use is considered very risky by 87.1%. Women are more likely than men to consider both experimenting and regular use to be risky, and the perception of cannabis-related hazards also intensifies with age. The results of the 2012 National Survey also confirm the relationships between the level of the prevalence of drug use, the perceived availability of the drug, and the perceived risk associated with using it, i.e. availability rises and the perceived risk declines as the level of use increases; see Graph 2-8.

Graph 2-8: Prevalence of cannabis use, perceived availability of cannabis, and perceived cannabis-related risk according to the 2012 National Survey, by gender and age groups (%) (Chomynová, 2013)



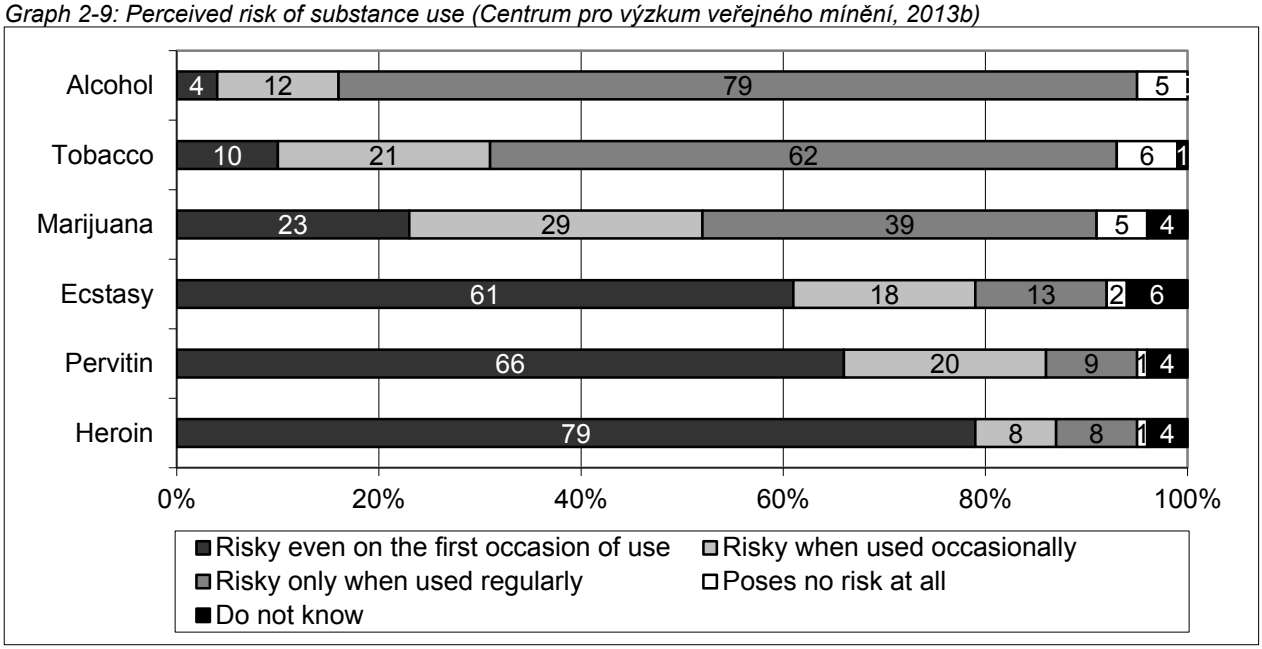
	Males	Females	Total		15-24	25-34	35-44	45-54	55-64
Lifetime cannabis use	34,9	21,2	27,9		42,8	48,3	29,7	12,4	6,7
Cannabis easily available	44,9	35,5	40,2		62,7	52,6	43,6	28,9	14,7
Risks associated with experimental cannabis use (once or twice in a lifetime)	36,3	48,3	42,3		26,5	29,7	36,8	54,8	62,4
Risks associated with regular cannabis use	82,6	91,4	87,1		79,5	78,7	89,2	91,3	95,6

2.2.1 Citizens' Opinions on Drugs

In May 2013 the Public Opinion Poll Centre carried out another round of an annual survey titled Citizens' Opinions on Drugs, focused primarily on the moral acceptance of the consumption of addictive substances and the perception of health risks associated with the use of such substances. The study sample of respondents comprised 1062 individuals above 15 years of age who were selected using quota sampling on the basis of their gender, age, and education, and the region and the size of the place of their residence.

The respondents rated the consumption of alcohol, tobacco, and cannabis as the behaviour posing the lowest risk. On the contrary, the absolute majority of the respondents found the use of other drugs (such as ecstasy, pervitin, and heroin) risky even on the first occasion of use; see Graph 2-9. In comparison to the previous years, the acceptance of smoking tobacco, and even cannabis use, seems to have declined, while the acceptance of alcohol use continues to rise.

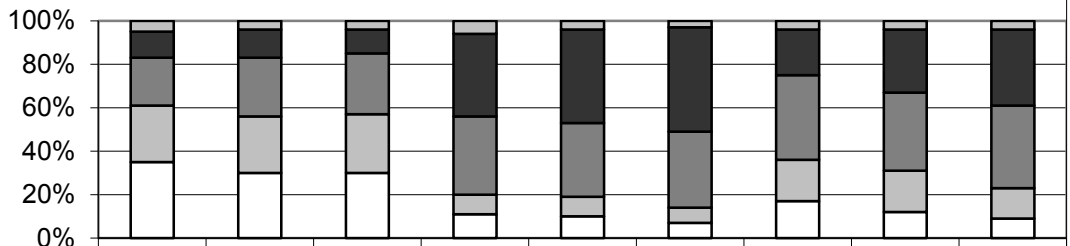
Graph 2-9: Perceived risk of substance use (Centrum pro výzkum veřejného mínění, 2013b)



People's attitudes to the criminalisation of drug users have not changed much in recent years: 57% of the respondents agree with criminal sanctions against cannabis users, while 83% of those interviewed approve of penal sanctions against users of other illegal drugs. The public appears to be more tolerant towards people who use cannabis for medical purposes – the prosecution of such individuals is approved of by only 14% of the respondents

(82% oppose criminal sanctions against this group of cannabis users). People also show a rather tolerant attitude to the cultivation of cannabis for personal use: growers should be prosecuted, according to 23% of the respondents (in comparison to 36% in 2011); see Graph 2-10.

Graph 2-10: Agreement with criminal sanctions for cannabis use and the cultivation of cannabis for personal use (Centrum pro výzkum veřejného mínění, 2012, Centrum pro výzkum veřejného mínění, 2013a)



	Cannabis use			Use of cannabis for medical purposes			Growing for personal use		
	2011	2012	2013	2011	2012	2013	2011	2012	2013
Do not know	5	4	4	6	4	3	4	4	4
Definitely disagree	12	13	11	38	43	48	21	29	35
Rather disagree	22	27	28	36	34	35	39	36	38
Rather agree	26	26	27	9	9	7	19	19	14
Definitely agree	35	30	30	11	10	7	17	12	9

2.3 Drug Use in the School Population and among Young People

No nationally representative school survey was conducted in 2012. The last national study of this type was the 2011 European School Survey on Alcohol and Other Drugs (ESPAD). As a new project, the ESPAD data were analysed at the regional level. The regional comparison is based on a sample of 16-year-old students (born in 1995), enlarged in such a way as to ensure that a sufficient number of respondents is available for each region and that the regional samples are representative of the respective regions. A total of 5,074 respondents (2,331 boys and 2,743 girls) were interviewed for the purposes of this regional comparison study.

The analysis revealed statistically significant differences among regions as regards the level of the use of legal drugs, i.e. smoking and drinking. Smoking is highly prevalent in Prague and the Ústí nad Labem, Karlovy Vary, and South Bohemia regions, while alcohol consumption reaches high levels in Prague, Central Bohemia, South Bohemia, Zlín, and Vysočina.

Experience with the illegal drugs under consideration here is more prevalent in Prague and the Ústí nad Labem, Karlovy Vary, Olomouc, and Moravia-Silesia regions, while the Central Bohemia, Pilsen, Hradec Králové, and Pardubice regions show relatively low levels of drug use. As the indicators pertaining to the use of illegal drugs are seldom found to be statistically significant, the regional differences appear to be diminishing and the situation is becoming similar across the country, which further reflects the trend already observed from 2003 to 2007.

The situation at the regional level is relatively dynamic. While at the national level the situation seems to be stable in certain aspects, some regions show major variations and fluctuations. Even in cases where a declining trend in illicit drug use was observed at the national level, there were regions experiencing developments over time which were different from the trends observed in other regions or nationwide.

Almost half of all the students (42.3%) who were interviewed have used marijuana or hashish at some point in their lives. There are statistically significant regional differences in use as regards all three of the time frames under scrutiny. While the lifetime use of marijuana was reported by 53.8% of the students in Prague and almost half of the students from the Karlovy Vary, Olomouc, and Ústí nad Labem regions, students in the Zlín, Vysočina, Pilsen, and Moravia-Silesia regions showed significantly less experience with cannabis-based drugs (less than 40%); see Table 2-7 and Map 2-1.

Table 2-7: Lifetime prevalence of illicit drug use among 16-year-olds in Czech regions according to the 2011 ESPAD survey (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2013b)

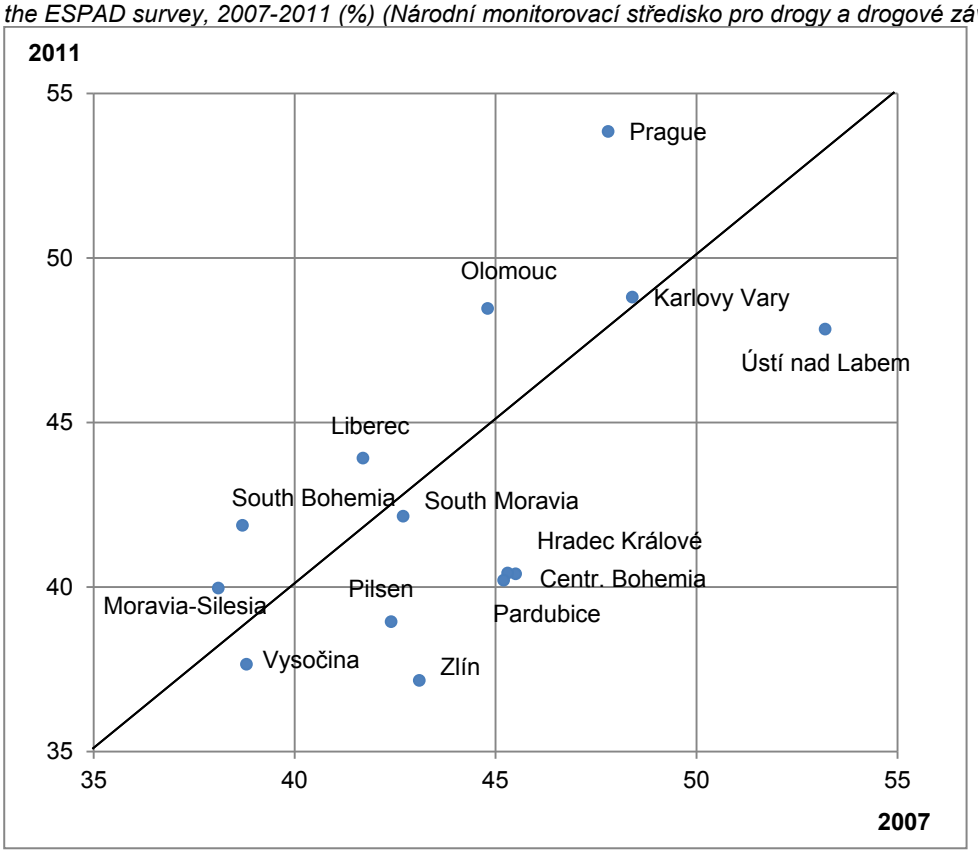
Region	Cannabis*	Ecstasy	Hallucinogenic mushrooms	LSD and other hallucinogens	Pervitin and amphetamines	Heroin and other opiates	Cocaine	Inhalants
Prague	53.8	4.4	6.5	7.9	2.2	1.8	2.2	9.2
Central Bohemia	40.4	1.6	4.7	4.0	1.6	0.9	0.0	6.4
South Bohemia	41.9	2.2	10.0	5.0	1.6	1.9	1.6	8.1
Pilsen	38.9	2.6	6.3	4.3	2.3	1.0	1.0	7.6
Karlovy Vary	48.8	3.1	7.1	5.1	2.4	0.8	1.2	8.7
Ústí nad Labem	47.8	4.0	5.1	4.3	3.5	1.3	1.1	4.0
Liberec	43.9	2.3	7.9	5.3	1.2	1.5	0.6	7.9
Hradec Králové	40.4	1.1	6.0	3.2	0.7	1.1	1.1	10.2
Pardubice	40.2	2.4	4.8	2.4	0.3	0.0	0.0	6.8
Vysočina	37.7	3.6	9.3	5.1	2.7	1.5	1.5	11.1
South Moravia	42.1	2.2	5.2	3.3	1.4	2.2	0.8	6.6
Olomouc	48.5	4.3	7.0	5.8	2.1	1.8	0.6	7.6
Zlín	37.2	2.7	6.9	6.1	3.0	1.5	0.6	9.9
Moravia-Silesia	40.0	4.5	8.2	4.8	1.8	1.5	1.0	9.0

*Note: * statistically significant regional differences, p≤ 0.05.*

Map 2-1: Lifetime prevalence of cannabis use among 16-year-olds in Czech regions according to the 2011 ESPAD survey (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2013b)

In the Czech Republic the reported levels of lifetime cannabis use dropped from 45.1% to 42.3% between the years 2007 and 2011. A closer look at the situation in the regions revealed that while the majority of regions recorded a decline in this respect (a significant decrease was observed especially in the Ústí nad Labem, Zlín, Central Bohemia, Pardubice, and Hradec Králové regions), some regions, particularly Prague and the Olomouc region, but also the South Bohemia, Liberec, and Moravia-Silesia regions, witnessed a marked increase in the lifetime prevalence of cannabis use in comparison to the previous period; see Graph 2-11.

Graph 2-11: Development of the lifetime prevalence of cannabis use among 16-year-olds in Czech regions according to the ESPAD survey, 2007-2011 (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2013b)

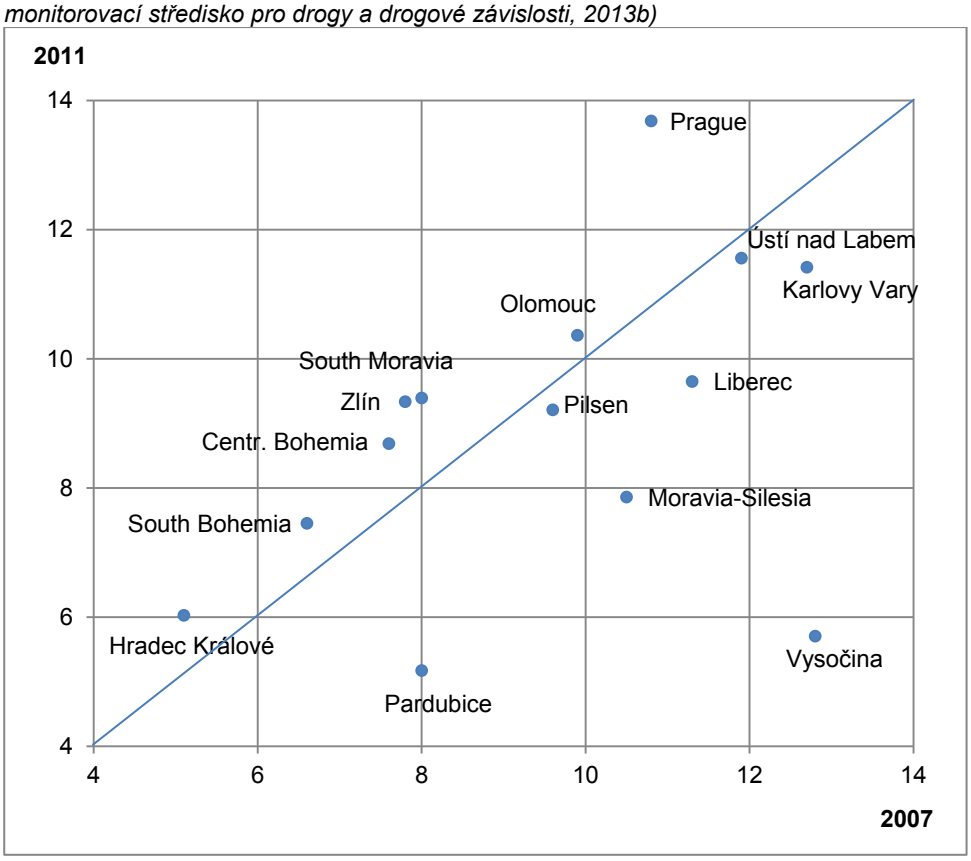


Statistically significant regional differences were found in the perceived availability of addictive substances. Again, a higher degree of availability of addictive substances as perceived by students can be observed in Prague and the Ústí nad Labem, Karlovy Vary, and Olomouc regions, i.e. in the regions that show a higher prevalence of the use of

such substances. On the contrary, addictive substances are considered less available by students in the South Bohemia, Hradec Králové, Pardubice, Zlín, and Vysočina regions, i.e. in the regions where students report lower levels of substance use.

Between 2007 and 2011 the percentage of students who found it very or fairly easy to obtain the illegal drugs under monitoring declined at the national level. A regional perspective revealed that the level of the perceived availability of cannabis dropped in all Czech regions, while the perceived availability of pervitin varied across regions. The most significant decline was recorded in the Vysočina, Pardubice, Moravia-Silesia, and Liberec regions. Nevertheless, a number of regions witnessed a rise in the number of respondents who perceived pervitin as being very or fairly easy to obtain. According to the respondents, pervitin is easier to obtain in Prague, where the largest increase in its perceived availability was also found, and the South Moravia, Central Bohemia, Zlín, and Hradec Králové regions; see Graph 2-12. The situations in the regions will be covered in more detail in the ESPAD 2011 research report, which is currently in press.

Graph 2-12: Development of the perceived availability of pervitin among 16-year-olds (% of respondents answering "very easy" or "fairly easy") in Czech regions between 2007 and 2011 according to the ESPAD survey, (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2013b)



In the autumn of 2013 the Czech Republic will participate in a study aimed at validating a new ESPAD questionnaire. The objective will be to pilot test a new questionnaire form intended for use in the next round of the international survey to be conducted in the spring of 2015.

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

In the autumn of 2012 the National Focal Point, in cooperation with the General Directorate of the Prison Service of the Czech Republic and the *ppm factum research* agency, carried out another round of a questionnaire survey of the prison population looking into offenders' substance use before and after their prison sentences, which followed up on a similar research project conducted in 2010. For more details see the chapter Drug Use and Problem Drug Use in Prisons (p. 136). More information on drug use among specific population groups is provided in the chapter Social Exclusion and Drug Use (p. 118).

3 Prevention

Coordinated by the Ministry of Education, Youth, and Sports (the Ministry of Education), the preparation of the new National Strategy for the Primary Prevention of Risk Behaviour for 2013-2018, reflecting the revision of the key primary prevention documents, was under way in 2012. For the very first time, in 2012 the regional authorities drew up their "regional prevention plans", which serve as important tools for the coordination of primary prevention efforts.

The year 2012 witnessed the launch of a number of professional publications on primary prevention which help in assuring better quality and organisation of prevention activities implemented by both external providers and, particularly, schools themselves. Additionally, many of the publications are intended to facilitate the general understanding of specific issues related to the prevention of risk behaviour.

Recent years have experienced a stronger emphasis being placed on the preventive assets of the family. This was also reflected in the development and practical implementation of several prevention tools for parents, including the Unplugged: Parents methodology, the Sunflower Garden project methodology, and the Prevention-Smart Parents portal.

Eight programmes specialising in the indicated prevention of substance use were identified in the Czech Republic, with seven of them being certified for professional competency and two also engaging in other forms of the prevention of risk behaviour.

With some exceptions, prevention campaigns in the media focus on issues related to the cessation of smoking, alcohol being served to minors, or driving under the influence of alcohol and illegal drugs. There are also preventive activities targeted at visitors to summer music festivals so as to address the population of young people at greatest risk.

3.1 Legal Framework, Strategies, and Policies in the Area of Prevention

The core documents for the area of school-based prevention are the Strategy for the Prevention of Risk Behaviour among Children and Young People in the Jurisdiction of the Ministry of Education in the Period 2009-2012, the Methodological Recommendations on the Primary Prevention of Risk Behaviour among Children and Young People, and the State Policy Concerning Children and Young People for the Period 2007-2013. The new National Strategy for the Primary Prevention of Risk Behaviour for 2013-2018 (the Primary Prevention Strategy) was approved in March 2013. It was developed in cooperation between working groups coordinated by the Ministry of Education, which were respectively concerned with the evaluation and coordination of prevention activities, the education of prevention professionals, the legal basis for prevention, and the funding of preventive interventions. The main objective of this new strategy is to prevent or reduce risk behaviour among children and adolescents by means of an effective prevention system underpinned by comprehensive synergetic efforts on the part of all the stakeholders (Ministerstvo školství, 2013).

Created on the basis of the Methodological Recommendations on the Primary Prevention of Risk Behaviour among Children, Pupils, and Students in Schools and Educational Institutions,[41] the so-called regional prevention plans provide a new tool for the better management and coordination of prevention activities in the regions. 2012 was the first year in which the regions drew up such strategies of their own, including a description of the system for the coordination of prevention activities and their institutional support for the upcoming period. Following an introduction, which summarises the demographic situation in the region, the background to the prevention plan is outlined and the strategy, including its main priorities, the network of services, and the coordination of prevention activities, is articulated. The prevention-related funding process and an overview of subsidies provided in the region are included, too.

Launched in 2006 to assure the quality of prevention activities, the national system for certifying prevention programmes was discontinued in 2011. The year 2012 experienced the finalisation of what was already the third revision of the key elements of the entire system as the Standards of Professional Competency of the Providers of Programmes of School-based Primary Prevention (Pavlas Martanová, 2012c), the Certification Rules and On-site Inspection Guidelines (Pavlas Martanová, 2012a), and the Certifier's Manual (Pavlas Martanová, 2012b) were published; for more details see the 2011 Annual Report. In 2012 the Ministry of Education prepared a new certification system which should conform to the new standards by applying to all the forms of risk behaviour. Commissioned by the Ministry of Education to do so, in June 2013 the National Institute for Education opened the Certification Office, which will be responsible for the overall coordination of the system.[42]

[41] Methodological Recommendations on the Primary Prevention of Risk Behaviour among Children, Pupils, and Students in Schools and Educational Institutions, Ref. No. 21 291/2010–28.
[42] http://www.nuv.cz/vice/pracoviste-pro-certifikace (13 August 2013)

The Czech Republic's institutions are involved in the European project[43] of introducing the existing European prevention standards into practice.[44]

September 2012 witnessed the finalisation of the VYNSPI project, the main objective of which was to establish a scheme of systematic life-long training in the prevention of risk behaviour for education professionals in schools and educational facilities. The key outcomes of the projects are available in a bilingual monothematic issue of *Adiktologie* 2012, 12(3). In addition to a number of fundamental textbooks and guidelines (for more details see the 2011 Annual Report[45]), VYNSPI[46] also involved a status analysis of the testing of students for addictive substances which was completed in 2012. Its purpose was to assist schools in dealing with situations when students are suspected of drug possession or use. In order to provide guidance on this topic, a handbook entitled "The Testing of Children and Adolescents Suspected of Drug Use in Schools and Educational Institutions" was issued in 2013 (Šejvl, 2013).

A motion for an amendment to Act No. 383/2005 Coll., on educational professionals, was under preparation in 2011. So was a motion for a modification to Government Regulation No. 75/2005 Coll., laying down the scope of the immediate instructional, educational, special educational, and pedagogical-psychological activities required from education professionals, the purpose of which was to provide school prevention workers and prevention methodologists in pedagogical and psychological counselling centres with better conditions for their activities by reducing the level of their frontline teaching responsibilities. However, no such modifications were made in 2012.

3.2 Environmental Prevention

For information about the general approaches to environmental prevention, its theoretical background, and the specific control measures adopted in the Czech Republic with respect to the availability and use of alcohol, tobacco, and other drugs see the 2011 Annual Report. The relevant legal framework is set out in Act No. 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances.

In 2012 the Ministry of Health was in the process of preparing an amendment to Act No. 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances ("Act No. 379/2005 Coll."). In view of the large number of changes that were proposed, the Health Ministry finally decided to draw up a new bill dealing with the protection of health against addictive substances. The bill was submitted for an intergovernmental review process in April 2013; see also the chapter entitled Legal Framework (p. 5). Applying stricter control measures in relation to the availability and use of tobacco and alcohol, this new piece of legislation is particularly aimed at:

- enhancing the protection of people's health against exposure to tobacco smoke in the environment and increasing the number of non-smoking areas,
- restricting the availability of tobacco, including tobacco-related products, and alcoholic beverages,
- introducing new responsibilities for the providers of catering services intended to limit the availability of alcohol and ensure that the ban on selling or serving alcohol to children and adolescents is observed, and
- improving the enforcement of the statutory obligations.

Some of the new measures intended to limit young people's access to alcohol that have been proposed were based on the conclusions of an intergovernmental working group for the Project of the Protection of Children and Young People from the Misuse of Alcohol and Other Addictive Substances, which was commissioned by the Prime Minister of the Czech Republic and reported to the National Drug Coordinator.

In comparison to the existing legal regulation, for example, the bill does not allow alcoholic beverages and tobacco, including tobacco-related products, to be sold in mobile retail outlets, by means of vending machines, or via mail order. Online sales will still be allowed in the future, provided that it can be ensured that such products are not sold to individuals under 18. As an innovation, the Ministry of Health proposed that the bill should include stipulations which impose a complete ban on smoking in the following places:

- the interiors of premises freely accessible to the public, with the exception of some public places,
- inside and outside all facilities providing social and legal protection services and premises where the business of providing day care for a child under three years old is carried on,
- playgrounds and sports facilities intended for people under 18,

[43] European Drug Prevention Quality Standards: The Prevention Standards Partnership in Phase II, co-funded by the European Commission's grant Drug Prevention and Information Programme (DPIP). http://prevention-standards.eu/the-prevention-standards-partnership-in-phase-ii/ (21 August 2013)
[44] http://prevention-standards.eu/standards/ (21 August 2013)
[45] http://www.adiktologie.cz/cz/articles/17/Monografie (21 August 2013)
[46] Full name of the project: "The Development of a System of Modular Training in the Prevention of Risk Behaviour for Educational and Counselling Professionals in Schools and Educational Institutions at the National Level, CZ.1.07/1.3.00/08.0205 ESF ECOP", http://www.adiktologie.cz/cz/articles/detail/220/1592/Tvorba-systemu-modularniho-vzdelavani-v-oblasti-prevence-socialne-patologickych-jevu-pro-pedagogicke-a-poradenske-pracovniky-skol-a-skolskych-zarizeni-na-celostatni-urovni (21 August 2013)

- outside healthcare facilities (thus far the ban applied to interiors only); it is proposed, however, that an exemption for psychiatric departments and addiction treatment facilities, where smoking is only permitted in structurally separated dedicated smoking areas, will remain in effect),
- inside all premises where food is served, irrespective of whether such establishments are operated under a catering licence.

In addition, the bill includes a new obligation for providers of catering services to ensure that there is at least one soft drink on offer for a price that is lower than the price of the cheapest alcoholic beverage of the same volume. It is also suggested that apart from selling or serving alcohol to persons under 18 years of age, the very presence of an underage person who is apparently under the influence of alcohol should also be considered illegal. It is also intended to extend the list of locations to which intoxicated individuals should be denied access and, as an innovation, it has been proposed that intoxicated individuals should not be allowed to stay in such places. Last but not least, the competencies of municipal authorities as regards the regulation of the availability and use of tobacco and alcohol are to be extended. As the bill on the protection of health against addictive substances has not been submitted to the Government of the Czech Republic yet, the above measures as proposed need to be regarded as provisional.

In early August 2013 the Chamber of Deputies of the Parliament of the Czech Republic passed a government bill concerning the mandatory identification of spirits,[47] which also introduces a reduction in the size of the largest permissible packaging of spirits from six- to one-litre containers (bottled spirits can be sold in a quantity of up to three litres per item). A proposal for an amendment to Act No. 455/1991 Coll., on licensed trades (The Trade Licensing Act),[48] introducing licences for the sale of alcohol, was also passed. The amendment should further prevent the directors and members of boards of the companies who have their trade licences suspended because of their dishonest business practices from continuing their entrepreneurial activities in the same field by establishing a new company.

Responding to the widespread cases of poisoning with methanol contained in alcoholic beverages which occurred in 2012 (for more details see the chapter entitled Mass Methanol Poisonings in 2012 on page 104), both norms constitute a part of the governmental Plan of Zero Tolerance towards the Black Market in Spirits.[49] In this document, among other points at issue, the Government commissioned the ministers and the National Drug Coordinator to devise measures aimed at:

- enhancing control over the handling of methyl alcohol (Ministry of Finance),
- reducing the maximum size of the retail packaging of spirits (Ministry of Finance),
- introducing a new design of control tape used to identify spirits which features much better security elements (Ministry of Finance),
- introducing licences for the sale of spirits which can be readily obtained upon complying with predefined requirements (Ministry of Industry and Trade),
- integrating the national regulatory authorities responsible for food control (Ministry of Agriculture),
- providing for the so-called “birth certificate for spirits” in the law (Ministry of Agriculture),
- reviewing the Penal Code as regards the definitions of criminal offences involving the illicit production and distribution of spirits (Ministry of Justice),
- finalising legislative work on the new law on addictive substances and submitting it to the Government (Ministry of Health),
- implementing legislative, organisational, and preventive measures designed to protect children and adolescents from alcohol use (Office of the Government of the Czech Republic – National Drug Coordinator, Ministry of Health).

3.3 Universal prevention

The fundamental strategy for the prevention of risk behaviour in schools and educational institutions is postulated in the Basic Preventive Programme; for more details see the 2011 Annual Report.

Practical guidance for the development of a good basic preventive programme is provided in the publication *School-based Prevention of Risk Behaviour: Proposed recommended structure of the Basic Preventive Programme* (Miovský, 2012). This document presents a draft version of a comprehensive 86-lesson school-based preventive programme which determines the amount of time to be dedicated to different types of risk behaviour, as well as drawing up a set of rules which may be used by schools to secure a safe environment.

The *Guidelines for Work with Children in Primary Prevention of Risky Behaviour* were published in 2012 (Skácelová, 2012a). A methodological guideline, *Introducing Measures to Prevent Risk Behaviour in Schools,* was issued by the Centre for Inclusive Education Support of the National Institute for Education in the same year. The main purpose of

[47] http://www.psp.cz/sqw/historie.sqw?O=6&T=939 (10 September 2013)
[48] http://www.psp.cz/sqw/historie.sqw?T=941&O=6 (10 September 2013)
[49] Government Resolution No. 735 dated 3 October 2012.

this material was to survey the needs of "basic schools"[50] in terms of the prevention of risk behaviour and offer examples of good practice. The guideline presents ten examples of specific work with a class aimed at preventing specific types of risk behaviour (Stonišová, 2012). The publication *Specialisation Study for School Prevention Workers, a Methodological Guideline and Examples of Good Practice* (Tomanová, 2012), provides guidance on how to design an integrated programme intended for (prospective) school prevention workers. Prevention for children at the first level of basic schools is covered by a methodological handbook entitled "Cats' Garden" (Exnerová, 2012).[51]

In addition to the aforementioned publications, other guidelines and textbooks with indirect links to the prevention of risk behaviour were issued in 2012. The methodological guideline *Conducting a Class Meeting* provides tips for the development of education professionals´ skills and a range of techniques for use in conducting class meetings and delivering the prevention of risk behaviour (Skácelová, 2012b). *Personal Development Methodology* (Skácelová and Macková, 2012) was created in response to the demand on the part of education professionals. This handbook offers practical techniques that can be used in working with a class. Two new publications issued in 2012 addressed the issue of crime prevention: the *School-based Crime Prevention Programme* (Kubišová, 2012) reflects long-term targeted and systematic collaboration between the police and school prevention workers which has evolved from what was initially a series of lectures delivered by the municipal police in Brno since 2007. The other publication, *The Basics of Crime Prevention for Education Professionals* (Štefunková and Šejvl, 2012), provides a general outline of crime prevention both abroad and in the domestic context. Furthermore, the year 2012 experienced the publication of the outcomes of the "Keys for Life" project, implemented by the National Institute for Children and Youth. Aimed at promoting and developing the informal and extra-curricular training of staff working with children as part of leisure-time programmes, this initiative showed some thematic overlaps with the primary prevention of risk behaviour. The guideline *Working with Children at the First Level of Basic Schools – a Selection of Techniques for an Accredited Programme* (Skácelová et al., 2012) presents a variety of games and techniques proven by long-term practice, the purpose of which is to enable children to get to know themselves better and to teach them how to communicate, work together, and appreciate each other, while promoting the overall team spirit in the class. Addressing the relevant aspects of criminal, administrative, family, social, and school law as they interact with each other, the handbook *Children´s Risk Behaviour and Its Legal Implications* (Jindrová, 2012) provides a comprehensive picture of the position of a child, or a student, within the entire legal system.

Unplugged, a school-based prevention programme, has been subjected to a thorough evaluation in the Czech Republic in recent years. It was found that Unplugged had led to a statistically significant reduction in tobacco use in the last 30 days, as well as reducing the increase in experience with such use (Miovsky, 2012). Moreover, Unplugged proved effective in reducing lifetime tobacco use, daily smoking, heavy smoking, lifetime cannabis use, frequent cannabis use, and lifetime drug use (Gabrhelík et al., 2012b). The gender-specific effects of the methodology were also analysed. As girls were found to show a more rapid increase in tobacco use, it was concluded that prevention and treatment strategies should pay more attention to girls (Gabrhelík et al., 2012a). The methodology recorded statistically significant effects on the reduction in the level of inebriety among boys, alcohol consumption among girls, and cannabis use among both genders. Notably, among girls who had had little experience with cannabis, the effect was sustained for two years following the programme (Novák, in press). In 2012 about 100 new education professionals were trained in the Unplugged school-based prevention methodology. Altogether, more than 300 individuals have been trained in the Czech Republic. A new research project, aimed at testing the effectiveness of the Unplugged methodology after it has incorporated additional sessions with students, was launched in 2013.[52]

Recently, the prevention of risk behaviour has been marked by a greater emphasis being placed on the preventive role of parents and the immediate environment of children and adolescents and on the strengthening of their relevant skills and competences. The issue of prevention in the family is addressed by *Unplugged: Parents*.[53] Translated in 2012, a year later this methodological guideline began to be pilot tested in collaboration with selected schools (Jurystová, 2012).

European Family Empowerment: Improving family skills to prevent alcohol and drug related problems,[54] a research project carried out by the Department of Addictology, 1st Faculty of Medicine, Charles University in Prague and General University Hospital in Prague, was completed in December 2012. The implementation of the project included a survey among 13-19-year-old students and their parents and the development of information materials for both parents and professionals.[55]

The topic of prevention in the family, or, more specifically, prevention with regard to children from disadvantaged settings, is explored by a publication produced as part of the Sunflower Garden project implemented by the Centre for the Family, operated by NGOs *Drop In* and *Meta*. A handbook for parents entitled *Are You Concerned about Your Child's Academic and Behaviour Problems? Let Us Look for the Answers Together* (Sedláčková et al., 2012) seeks to outline the ways of dealing with a child who may be developing learning or behavioural disorders.

[50] Attended by children aged 6-15.
[51] The above publications can be downloaded from http://adiktologie.cz/cz/articles/4/Publikace
[52] http://adiktologie.cz/cz/articles/detail/218/4280/Randomizovana-studie-univerzalni-drogove-preventivni-intervence-Unplugged-s-pridavnymi-sezenimi-zamerenymi-na-alkohol-tabak-a-konopne-drogy (2 September 2013)
[53] http://adiktologie.cz/cz/articles/detail/19/3956/Program-prevence-pro-rodice-Unplugged-Metodika-pro-lektory (21 August 2013)
[54] JLS/DPIP/2008-2/112
[55] http://adiktologie.cz/cz/articles/detail/218/4282/Posilovani-vlivu-rodiny-Zvysovani-rodinnych-dovednosti-s-cilem-preventivne-pusobit-na-uzivani-alkoholu-a-problemu-souvisejicich-s-drogami-European-Family-Empowerment-Improving-family-skills-to-prevent-alcohol-and-drug-related-problems- (2 September 2013)

Prevention-Smart Parents,[56] a portal launched in 2009 by the SANANIM civic association in collaboration with the Mentor Foundation[57] as part of the VYNSPI project, is also intended for family-based prevention.

Prevention in the family was the focus of the publication of recommendations for parents which covered a range of areas, such as the setting of rules for children in relation to drug use, spending free time together with children, and communication in the family (Nešpor, 2013) and a systematic review comparing parenting styles (Pazderková et al., 2013). A review article examining the topics of family structure, parenting styles, parental control, observation of rules, emotional relationships and communication in the family, and alcohol consumption in the family was also produced. It has been shown that different degrees of the quality and intensity of these factors and the combination and interaction thereof cause them to appear as both protective and risk factors, depending on the circumstances, and that they constitute a continuum which corresponds in this sense with the findings of common clinical practice (Čablová and Miovský, 2013).

The Ministry of Education provides approximately CZK 20 million (€ 795 thousand) annually from its budget for subsidy programmes aimed at supporting the prevention of risk behaviour among children and adolescents; for more details see the chapter entitled Economic Analysis (p. 16). In addition to long-term programmes for the universal primary prevention of risk behaviour, the Ministry of Education also supports non-specific primary prevention as represented by leisure time and informal education. Moreover, every year it contributes approximately CZK 5 million (€ 198 thousand) to regional budgets in order to secure the operation of prevention methodologists based in pedagogical and psychological counselling centres (about CZK 56,000 – € 2.2 thousand per person). In 2012, 89 prevention methodologists were active in the Czech Republic (Ministerstvo školství, 2013).

In the 2012 subsidy proceedings, the Government Council for Drug Policy Coordination supported a total of eight projects providing prevention programmes, of which four reported universal prevention interventions, five selective prevention interventions, and three concerned indicated prevention. They mostly involved blocks of primary prevention interventions, interactive seminars, situational interventions, and consultations. Indicated prevention programmes featured individual and family counselling and group work. The GCDPC provided CZK 2.2 million (€ 87,499 thousand) in total to support these projects, which was equivalent to approximately 20.4% of their total costs (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f).

"A Journey through the City Labyrinth", a board game with a preventive effect, was launched onto the market in 2012;[58] for more information see the 2011 Annual Report.

3.4 Selective Prevention

The interventions pertaining to the domain of selective prevention are targeted at the groups of people who are exposed to a danger of various types of risk behaviour, including substance use.[59] These interventions usually fall within the agenda of pedagogical and psychological counselling centres, but can also be the subject of activities pursued by specialised prevention programmes and centres operated by non-governmental organisations. These entities then deliver intervention programmes focused on whole classes or other social settings where a specific problem (such as bullying) has occurred.

Counselling and prevention activities are developed by low-threshold facilities for children and young people which also operate the so-called low-threshold clubs for children and young people. Some of them also provide outreach programmes.[60] In total, there were 249 of them in the Czech Republic in 2012. The year 2012 witnessed another round of data collection for a survey of low-threshold facilities for children and young people conducted by the Czech Outreach Work Association as part of a five-year longitudinal research project;[61] for more details see the 2011 Annual Report.

A new project of the Czech Outreach Work Association in 2012 was Streetwork Online.[62] Accordning to the association's annual report,[63] the core mission of the project is to translate the crucial elements of low-threshold social services, such as attractive leisure-time activities, safe premises, prevention, and contact, to the realm of the internet and social networks. The staff of the Streetwork Online project seek to establish online contact with teenagers in order to provide them with information and support they may need in adolescence.

In 2012 SANAM launched the *koncimshulenim.cz* website[64] intended for cannabis users. It offers information about cannabis and the risks associated with using it, as well as providing advice on how to reduce or stop cannabis use. In addition, people can use the website to complete a self-assessment test of problem cannabis use and participate in the first online treatment programme in the Czech Republic, scheduled to last 4-6 weeks.

[56] http://prevence.sananim.cz/node/2 (21 August 2013)
[57] http://www.mentorfoundation.org/ (21 August 2013)
[58] http://www.cesta-mestem.org/ (21 August 2013)
[59] For the specification of prevention typology see, for example, http://www.emcdda.europa.eu/topics/prevention (11 September 2013)
[60] http://iregistr.mpsv.cz/ (21 August 2013)
[61] http://www.streetwork.cz/index.php?option=com_content&task=view&id=3791 (21 August 2013)
[62] http://cas.sittool.net/index (21 August 2013)
[63] http://www.streetwork.cz/images/download/obcasnik15.pdf (10 September 2013)
[64] http://www.koncimshulenim.cz/ (13 September 2013)

3.5 Indicated Prevention

By definition, indicated prevention focuses on specific at-risk individuals who show signs of substance use but who at the moment do not meet the problem use and addiction criteria. This level of intervention is also aimed at the families and significant others of adolescents who fall within the target group under consideration. Indicated prevention is carried out by institutions managed by the national, regional, or local authorities (including pedagogical and psychological counselling centres, child and family counselling centres, institutions for juvenile delinquents and children with behavioural disorders, rehabilitation institutions, and educational care centres), as well as non-governmental organisations (including low-threshold facilities for children and young people).

Drawing from various sources, a recent review (Nevoralová and Šťastná, 2013) identified eight specialised programmes in the Czech Republic providing the indicated prevention (early intervention) of substance use, of which seven were certified for the professional competency of primary prevention programmes; see Table 3-1. With reference to earlier information (Širůčková et al., 2012), the eighth programme indicated by Nevoralová and Šťastná was the one provided by the pedagogical and psychological counselling centre for the Prague 6 District, which was not certified at the time of the writing of the review and about which no further details were found. The programmes are designed for adolescents aged 10-18, who are enrolled in the programme on the basis of their previous individual assessment. However, data about their effectiveness and the specific screening tools used to identify at-risk individuals are available for two programmes only. Only two programmes, too, were evaluated for their impact on the target group in terms of the improvement of peer relationships, the level of internalising (i.e. anxiety and depression) and externalising (impulsivity) behaviours, substance use, and other forms of risk behaviour. The authors suggest that the domain of indicated prevention is generally underdeveloped in the Czech Republic and that there is inconsistency in making the distinction between selective and indicated prevention (Nevoralová and Šťastná, 2013).

In the long term, the activities of *Prev-Centrum*, a civic association, are referred to as examples of good practice in the area of substance use prevention in the Czech Republic.[65]

Five years after it was developed, the *Manual for Drug prevention in the Practice of a General Practitioner for Children and Adolescents* (Cabrnochová et al., 2012) was reviewed. A new chapter, "The Structure of Motivational Interviewing with Adolescents", was included.[66]

3.6 Media and Information Campaigns

In addition to the existing web-based prevention projects,[67] a new website, *prevence-info.cz*,[68] funded and guaranteed by the Ministry of Education, was launched in January 2012. A new website, *bezcigaret.cz*,[69] was launched on 15 November 2012 on the occasion of International No Smoking Day.

Every year on 31 May the Czech Coalition against Tobacco launches a campaign on the occasion of World No Tobacco Day. An event entitled "Swap the Pack" was organised on World No Tobacco Day 2012 to support quitting smoking. Smokers could exchange packets of cigarettes for decorated non-smoking boxes prepared specially for this event by schoolchildren from Prague. Non-smoking restaurants were chosen as the topic for the 2013 campaign.

A European Commission campaign, "Ex-smokers are Unstoppable", continued in the Czech Republic in 2012. Being under way in other EU member states too, this project is aimed at promoting the cessation of smoking, especially among young people. The campaign involves the use of the iCoach, an online digital platform for assisting people with the cessation of smoking.[70]

[65] http://www.prevcentrum.cz/Primarni-prevence/Indikovana-primarni-prevence (23 August 2013)
[66] http://www.cepros.cz/lekari/manualy/inovace-manualu-drogove-prevence-v-praxi-pldd.html (16 August 2013)
[67] For example, http://www.odrogach.cz/, http://www.koncimshulenim.cz/, http://www.prevence-praha.cz/ (11 September 2013)
[68] http://www.prevence-info.cz/ (10 September 2013)
[69] http://www.bezcigaret.cz/ (21 August 2013)
[70] http://www.exsmokers.eu/ (30 September 2013)

Table 3-1: Overview of programmes providing the indicated prevention of substance use in the Czech Republic (according to Nevoralová and Šťastná, 2013)

Programme	Provider	Target group	Tools	Methods	Number of sessions/ time frame	Outcome evaluation	Focus
Individual and family counselling for experimenters and their families	Drug Prevention and Treatment Centre (Pilsen) www.cppt.cz	Children and adolescents	Not specified	One-off counselling sessions Short-term collaboration Long-term collaboration Individual counselling Family counselling	Not specified	Not specified	Drug use only
Preventure	Department of Addictology, 1st Faculty of Medicine, Charles University in Prague and General University Hospital in Prague www.adiktologie.cz	11-16 years	SURPS ESPAD	CBT Brief intervention Dealing with "hot thoughts", impulsivity, and negative automatic thoughts	4 sessions (lasting 45, 90, 90, and 45 minutes respectively)	Reduced frequency and level of alcohol use, reductions in depression, truancy, panic attacks, and impulsivity	Drug use, depression, anxiety, sensation seeking, panic attacks, impulsivity, and truancy
Early intervention programme	Orlová Contact Centre http://k-centrum-orlova.webnode.cz	Adolescents	Screening for risk behaviour – no specific tool indicated	Group work Relaxation techniques Active social learning Individual counselling Information service Distribution of information materials	Not specified	Not specified	Drug use only
Programme for experimenters and substance users, parent programme – parent group	Counselling Centre for Drug and Other Addictions (Brno) www.poradenskecentrum.cz	Adolescents	Not specified	Individual counselling Parent group	Not specified	Not specified	Drug use only
Intervention programme to address students' experimenting with addictive substances	Prospe (Prague) www.prospe.cz	Adolescents	Assessment of relationships in the class	Group work	2 months, 6x3 45-minute lessons	Not specified	Drug use only
Early intervention programme for experimenters	Renarkon (Ostrava) www.renarkon.cz	(12)15-18 years	Referral by an education professional	Group discussion Training in skills Drama therapy Relaxation techniques Art therapy techniques Family therapy	6 weeks	Not specified	Drug use only
Brave Hearts programme – the prevention of substance use and other forms of risk behaviour	SCAN Association (Tišnov) www.scan-os.cz/ (Širůčková, et al. 2012)	10-15 years, children growing up in children's homes	Diagnostic assessment	Individual work Group work Adaptation and training residential programmes	Once a week over 10 months	Greater confidence in social interactions, smaller tendency towards risk behaviour	Drug use and other forms of risk behaviour

Campaigns focused on the prevention of driving under the influence of alcohol and other drugs (for more information see the 2011 Annual Report) continued in 2012. The project named "It's Up to You",[71] intended to raise young drivers' awareness of the risks associated with impaired driving, was aimed at motorcyclists in 2012.[72] The resumption in 2013 of the "Pay Attention – Or Pay the Price!" campaign from the years 2009-2011 has been considered. The summer months of 2012 witnessed what was already the third round of a campaign against drink-driving entitled "Don't Take Other People's Future!".[73] As part of this campaign, organised by the Liberec region, the members of the public were addressed in restaurants, bars, and discos across the region and warned about the risks associated with driving under the influence of alcohol, including residual alcohol after a person had been drinking.

Under the aegis of BESIP, the Czech Government Council for Road Safety, a campaign dedicated to the safety of pedestrians in road traffic took place in the Czech Republic in May 2013 as part of the international project Road Safety Week. "Šalina[74] Pub", a project launched in June 2013 by the Starobrno brewery in partnership with the Brno Public Transport Company, promoting the idea that "a real Brno guy rides a tram and drinks Starobrno",[75] may seem controversial in this context. In one of the Brno trams, equipped with a tap bar, glass holders, and a toilet, beer is served during its operation. Needless to say, it is pedestrians under the influence of alcohol who comprise the group of road users at the greatest risk; see the chapter entitled Drugs and Road Accidents (p. 101).

Bearing a name which seeks to point out the problem of alcohol consumption among underage persons, the communication campaign "Respect 18",[76] run by the City of Pilsen, Pilsner Urquell, and the local Drug Prevention and Treatment Centre, was launched on 1 June, Children's Day, in 2013. Its objective is to change people's attitudes to this issue, as well as encouraging the enforcement of the ban on alcohol being sold and served to young people under 18. The target audience comprises the staff of pubs, bars, restaurants, or stands and the adult public – the minors' parents and friends who have already turned 18 and either tolerate the minors' consumption or intermediate it. After its evaluation, the project may also be moved from Pilsen to other areas of the Czech Republic.

Mental Health Weeks,[77] organised annually by *Fokus Praha*, was held for the 23rd time in September and October 2012. The rationale for the event is to inform the public about the issue of mental illness and the activities developed by organisations operating in the field of social and health services, as well as improving the attitudes of the Czech public towards the mentally ill. The central topic of the 2012 Weeks was addiction. Cultural events, happenings, exhibitions, lectures, workshops, and open doors days in facilities for people with mental illness took place in 24 towns and cities in the Czech Republic. The final day of the events fell on 10 October, World Mental Health Day.

Prevention projects which have long been criticised by the professional community are the "Cycle Run for the Czech Republic without Drugs" and the "Revolution Train". "Cycle Run for the Czech Republic without Drugs" took place for what was already the 10th time in 2012. The event is organised by the Say No to Drugs – Say Yes to Life civic association;[78] for more details see the 2011 Annual Report. The "Revolution Train" project was carried out in two waves in the Central Bohemia region in 2012.[79] According to its creators, the project strives to inform young people aged from 12 to 16 about the risks and consequences of drug use by means of multimedia presentations delivered on board a train. The majority of visitors (children and education professionals) rate the train positively, finding it more amusing than lectures in school. Professionals claim, however, that the project is ineffective in prevention terms, as it provides misleading information and is based on deterrence[80] (Centrum adiktologie et al., 2007). The project is funded by the Central Bohemia region, the City of Prague, and a number of business entities. In 2013 the project was also on the agenda of one of the meetings of the Government Council for Drug Policy Coordination in connection with the fact that while generously supporting the Revolution Train project, the regional authorities provide no funding to the network of certified drug services based on its territory.

[71] http://www.jetonatobe.cz/hlavni-stranka.html (20 July 2012)
[72] http://www.ibesip.cz/cz/pro-media/tiskove-zpravy/1-besip-spousti-nove-kampane-zamerene-na-motocyklisty
[73] http://www.neberdruhymbudoucnost.cz/news/183/kampan-neber-druhym-budoucnost-startuje.html (24 July 2013)
[74] A local slang term for a tram.
[75] http://www.bmhd.cz/aktuality/aktualita.php?1128, http://www.dpmb.cz/Default.aspx?seo=download&id=1635 (21 August 2013)
[76] http://www.respektuj18.cz/, http://www.cppt.cz/akce/27-respektuj18 (24 July 2013)
[77] http://www.tdz.cz/index.php?co=0 (24 July 2013)
[78] http://www.rekninedrogam.cz/o_nas.html (24 July 2013)
[79] http://www.revolutiontrain.com/cz/ (24 July 2013)
[80] http://www.adiktologie.cz/cz/articles/detail/172/988/ (21 August 2013)

4 Problem Drug Use

The number of problem drug users in the Czech Republic in 2012 was estimated to be approximately 41,300 (the central estimate), of whom 30,700 were pervitin (methamphetamine) users, 4,300 were heroin users, and 6,300 were buprenorphine users (a total of 10,600 opiate/opioid users). The number of injecting drug users (IDUs) was estimated at 38,700. The estimated number of problem drug users increased slightly in 2012. Statistically significant changes can be observed in the users of opiates/opioids, with a decrease in heroin and an increase in buprenorphine. There was a slight decline in the number of pervitin users. In the past five years the central estimate of the number of problem drug users has increased by approximately one third and the prevalence of problem drug use in the Czech Republic in 2012 reached 0.6% of the population aged 15-64. The regions with the greatest numbers of problem drug users, as well as the greatest number of opiate users, traditionally include Prague and Ústí nad Labem. A prevalence of problem drug users which is far above the average in relation to the number of inhabitants has also been reported by the Karlovy Vary region. Injecting buprenorphine is particularly widespread in Prague and in other regions of Bohemia.

Of the group of amphetamines, pervitin (methamphetamine) is the one that occurs in the Czech Republic almost exclusively. Opioids included in the estimates of problem drug use in the Czech Republic are mainly heroin and diverted buprenorphine. Besides this, to a lesser extent, problem drug use includes the use of raw opium and, increasingly, the abuse of analgesics containing opiates/opioids, such as fentanyl, codeine, or morphine. Recent years were marked by the emergence of new synthetic drugs of the cathinone or phenetylamine group. The past-year prevalence of their use has been at the 10% level among problem drug users, but only a fraction of problem drug users are currently reporting them as their primary drug, and there are also dramatic regional differences in this respect. In the Czech Republic cocaine users have not been included in estimates of problem drug users, as their numbers in the data sources used for such estimates are still on very low levels in this country.

The estimated number of problem drug users in Prague in 2011 was further specified (approximately 10,000 people). This estimate is made using the capture-recapture method applied to data about the overlaps of coded clients between the low-threshold programmes and adjusted for the number of non-coded clients.

4.1 Prevalence and Incidence Estimates of Problem Drug Use

The EMCDDA defines problem drug use as injecting drug use and/or the long-term/regular use of opioids and/or amphetamine-type drugs and/or cocaine (European Monitoring Centre for Drugs and Drug Addiction, 2009). The estimates of problem drug use in the Czech Republic include injecting drug users and the users of opioids/opiates and pervitin. Cocaine users are not included in the country's estimates as their number in the data sources used is still at a very low level in the Czech Republic.

As in previous years, the multiplication method was used to estimate the number of problem drug users in 2012 from the data on clients in low-threshold programmes in the Czech Republic. In addition, another estimate of problem drug use was repeated after two years in a survey among physicians in the country. In addition, a more accurate estimate of problem drug users in Prague was made using the capture-recapture method as described in the 2011 Annual Report.

4.1.1 Estimate of Problem Drug Use Using the Multiplication Method

Estimation using the multiplication method arises as the product of the size of the known population of problem drug users (in this case the number of problem drug users in contact with low-threshold programmes in a calendar year) and the value of the multiplier.[81] The multiplication method of estimating the number of problem drug users from the data on the clients of low-threshold programmes has been used in the Czech Republic since 2002.[82] The estimates for 2012 were obtained in the Multiplier 2013 survey; for more details see the chapter entitled Multiplier 2013 (p. 55). The current value of the multiplier for the Czech Republic and for each region is determined using the peer nomination technique, where the respondent (the programme's client) is asked to answer the following questions: “How many people you know well are regular users of pervitin and/or opiates (heroin, methadone, or buprenorphine)?” and “How many of them

[81] The sources of data on the number of problem drug users in contact are the annual final reports of projects funded in the GCDPC subsidy scheme and in 2009-2012 also an additional survey of the programmes that were not supported as part of the subsidy proceedings, and therefore did not submit a final report. The multiplier essentially expresses the proportion of problem users in contact with low-threshold programmes to all problem drug users. The rest is the hidden population of problem drug users.

[82] The value of the multiplier was first obtained using a special questionnaire module in the study of HCV among injecting drug users in 2003 (for more details on the study see the 2003 Annual Report) and applied to the estimates from 2002-2005. Estimates for 2006 were created as the sum of the estimate for the whole country outside Prague calculated using the multiplier from 2003 and the estimate for Prague, where the updated value of the multiplier was obtained as a by-product of a study entitled Sexual Behaviour of Drug Users (see the 2006 Annual Report). The multiplier was then updated in a separate survey in 2008 (estimates for 2007 and 2008) and 2010 (estimates for 2009-2011).

have been in contact with any sort of low-threshold centre or outreach programme over the past twelve months?" The multiplier is then expressed as the weighted average of the proportion of both values, reflecting the fact that the respondent is a user in contact.[83] The multiplier values obtained in individual regions in the Multiplier 2008, 2010, and 2013 surveys are provided in Table 4-1. In 2013, the value of the multiplier established using the peer nomination technique for the whole country except Prague, expressed as a percentage, was 65% (95% CI[84]: 63-70%) and declined by two percentage points compared to the value for 2011. The value of the multiplier for Prague, however, did change and was 80% (95% CI: 74-85%). The estimate of the number of problem drug users in the Czech Republic is the sum of the estimates for the individual regions (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a).

Table 4-1: Multiplier values obtained in individual regions in 2008, 2010, and 2013 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a)

Region	2008			2010			2013		
	Central value	95% CI		Central value	95% CI		Central value	95% CI	
Prague	0.76	0.63	0.90	0.80	0.69	0.91	0.78	0.77	0.80
Central Bohemia	0.81	0.73	0.88	0.69	0.52	0.87	0.73	0.71	0.75
South Bohemia	0.78	0.71	0.86	0.77	0.67	0.86	0.64	0.63	0.66
Pilsen	0.74	0.65	0.83	0.62	0.44	0.79	0.81	0.79	0.83
Karlovy Vary	0.68	0.65	0.71	0.91	0.65	1.17	0.60	0.58	0.62
Ústí nad Labem	0.65	0.58	0.71	0.62	0.56	0.68	0.70	0.69	0.71
Liberec	0.63	0.45	0.80	0.31	-3.68	4.30	0.57	0.54	0.60
Hradec Králové	0.65	0.57	0.74	0.62	0.51	0.73	0.67	0.66	0.69
Pardubice	0.68	0.65	0.71	0.81	0.64	0.97	0.49	0.45	0.52
Vysočina	0.64	0.44	0.84	0.65	0.46	0.84	0.58	0.56	0.59
South Moravia	0.58	0.47	0.70	0.53	0.43	0.64	0.76	0.74	0.79
Olomouc	0.84	0.45	1.22	0.53	0.40	0.66	0.64	0.62	0.66
Zlín	0.68	0.65	0.71	0.48	0.09	0.87	0.56	0.53	0.58
Moravia-Silesia	0.65	0.57	0.73	0.77	0.70	0.84	0.67	0.66	0.69
Czech Republic without Prague	0.68	0.65	0.71	0.67	0.63	0.70	0.65	0.63	0.70
Entire Czech Republic	**0.69**	**0.66**	**0.72**	**0.68**	**0.65**	**0.71**	**0.66**	**0.65**	**0.71**

The trends in the estimated numbers of problem drug users are influenced by both input data entries: there is a positive correlation with regard to the number of low-threshold service clients, while the multiplier value impacts on the estimates in a negative correlation (the higher the number of persons in contact, the lower the overall estimated number of problem drug users). Given that in recent years there has been increasing pressure on the economic efficiency of programmes and the number of clients is one of the indicators monitored in the funding of these services, one can assume a systematic increase in the number of reported clients as a result of more thorough records and more intensive outreach work.

In 2012, the number of problem drug users in the Czech Republic was estimated at approximately 41,300 (95% CI: 40,900-41,700), of whom 30,700 (30,550-30,800) were pervitin users, 4,300 (4,250-4,350) were heroin users, and 6,300 (6,250-6,350) were users of buprenorphine (primarily Subutex®). Therefore, opiate users were estimated at 10,600 (10,500-10,700). The estimated number of injecting drug users (IDUs) reached 38,700 (38,450-38,900).

The trends in 2002-2012 are shown in Table 4-2 and Graph 4-1. The total number of problem drug users in 2012 increased slightly (the 95% confidence interval narrowed down considerably compared with previous years as a result of the higher accuracy of the multiplier in 2013, resulting from a higher number of respondents). Statistically significant changes can be observed in the number of opiate/opioid users, with a decline in heroin use and an increase in buprenorphine use. The number of pervitin users decreased slightly. In the past five years, the central estimate of the number of problem drug users has increased by about a third.

Prevalence estimates of problem drug use by region are shown in Table 4-3 and Map 4-1, and trends in Table 4-4. The highest relative number of problem drug users was traditionally estimated in Prague and the Ústí nad Labem region, i.e. in the areas that concurrently have high prevalence levels of problem opiate

[83] Only those who stated a reasonable number of known drug users were included in the calculation (25 or less) and the weighting is the size of the population of problem drug users represented by individual respondents (number of the respondent's acquaintances).
[84] The 95% confidence interval delimits the interval in which the value occurs with a 95% probability.

users. A prevalence of problem drug users which is far above the average in relation to the number of inhabitants has also been reported by the Karlovy Vary region.

The South Bohemia and Pardubice regions provided their own estimates in their annual reports on the implementation of drug policies for 2012. The South Bohemia region, based on data from low-threshold services, estimated the number of problem drug users at 1,900 (the lower limit of the estimate). Of this number, injecting drug users are estimated at 1,700, with 80-90% of them using pervitin as their primary drug. There are approximately 200 non-injecting users of pervitin (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2013).

The Pardubice region estimated the number of problem drug users at 700-900. This is an estimate from 2003 based on data from drug services in the region (Minařík and Zahradník, 2003). According to data from the low-threshold services, there has been no significant change in the drug scene and this estimate remains valid.

Furthermore, an estimate of the hidden population of problem drug users in the city of Brno was made in 2012. The estimate is also based on data from an outreach programme operated by the *Podané ruce* association. The number of problem drug users[85] in Brno is estimated at approximately 2,000, of whom about 60% are in contact with services.

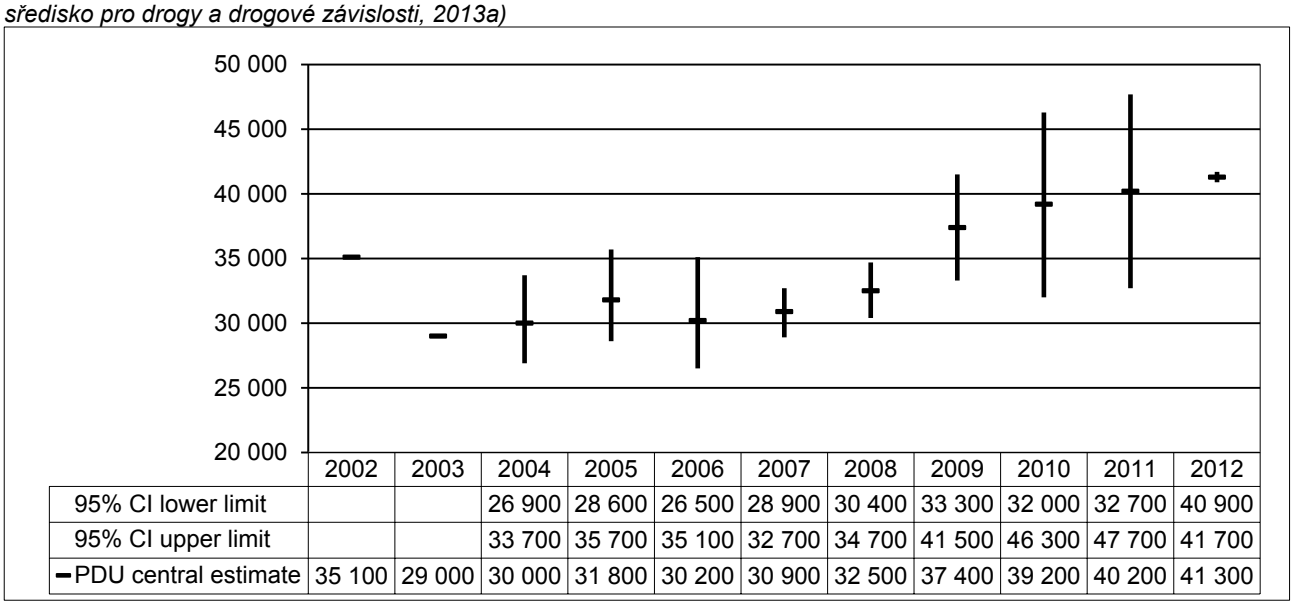
A separate estimate of the number of problem drug users in Prague in 2011 was almost 11,000, i.e. approximately 3,000 people less than the estimate obtained using the multiplication method; see the chapter entitled Estimate of Problem Drug Use in Prague Using the CRM Method (p. 53).

Table 4-2: Central values of prevalence estimates of problem drug use carried out using the multiplication method with the use of data from low-threshold programmes, 2002-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a)

Year	Problem drug users in total		Problem users of opiates/opioids				Problem pervitin users		Injecting drug users	
	Number	Per 1,000 inhabitants aged 15-64	Heroin users	Buprenorphine users	Total	Total per 1,000 inhabitants aged 15-64	Number	Per 1000 inhabitants aged 15-64	Number	Per 1000 inhabitants aged 15-64
2002	35,100	4.89	–	–	13,300	1.85	21,800	3.04	31,700	4.41
2003	29,000	4.02	–	–	10.200	1.41	18,800	2.61	27,800	3.86
2004	30,000	4.14	–	–	9,700	1.34	20,300	2.80	27,000	3.73
2005	31,800	4.37	–	–	11,300	1.55	20,500	2.82	29,800	4.10
2006	30,200	4.13	6,200	4,300	10,500	1.44	19,700	2.69	29,000	3.97
2007	30,900	4.20	5,750	4,250	10,000	1.36	20,900	2.84	29,500	4.01
2008	32,500	4.39	6,400	4,900	11,300	1.52	21,200	2.87	31,200	4.21
2009	37,400	5.04	7,100	5,100	12,100	1.63	25,300	3.40	35,300	4.75
2010	39,200	5.30	6,000	5,000	11,000	1.48	28,200	3.81	37,200	5.03
2011	40,200	5.51	4,700	4,600	9,300	1.27	30,900	4.24	38,600	5.29
2012	41,300	5.71	4,300	6,300	10,600	1.47	30,700	4.25	38,700	5.35

[85] With approximately 257,000 inhabitants aged 15-64 in Brno, the prevalence level of problem drug use is at 7.8 problem drug users per 1,000 persons aged 15-64 years.

Graph 4-1: Central values and 95% confidence intervals of prevalence estimates of problem drug use carried out using the multiplication method with the use of data from low-threshold programmes, 2002-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a)



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
95% CI lower limit			26 900	28 600	26 500	28 900	30 400	33 300	32 000	32 700	40 900
95% CI upper limit			33 700	35 700	35 100	32 700	34 700	41 500	46 300	47 700	41 700
PDU central estimate	35 100	29 000	30 000	31 800	30 200	30 900	32 500	37 400	39 200	40 200	41 300

Table 4-3: Prevalence estimates of problem drug users in the Czech Republic by region, 2012 – central values (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a)

Region	**Number of problem drug users in total**	**Number of opiate users**			**Number of pervitin users**	**Number of IDUs**
		Heroin	Buprenorphine	Total		
Prague	14,600	2,700	4,850	7,550	7,000	14,600
Central Bohemia	2,500	100	500	600	1,900	2,400
South Bohemia	2,000	< 50	250	250	1,750	2,000
Pilsen	1,250	150	150	300	1,000	1,100
Karlovy Vary	1,950	50	0	50	1,900	1,900
Ústí nad Labem	4,600	350	450	800	3,750	4,100
Liberec	1,750	< 50	< 50	< 50	1,750	1,700
Hradec Králové	1,050	100	50	150	950	1,000
Pardubice	1,000	< 50	< 50	50	950	1,000
Vysočina	750	< 50	< 50	50	700	700
South Moravia	2,650	600	< 50	600	2,050	2,400
Olomouc	2,350	50	0	50	2,300	1,900
Zlín	1,850	50	< 50	< 50	1,800	1,600
Moravia-Silesia	3,000	50	< 50	50	2,950	2,400
Entire Czech Republic	**41,300**	**4,300**	**6,300**	**10,600**	**30,700**	**38,700**

Map 4-1: Number of problem drug users per 1,000 inhabitants aged 15-64 in the Czech Republic by drug and region, 2012 – central values (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a)

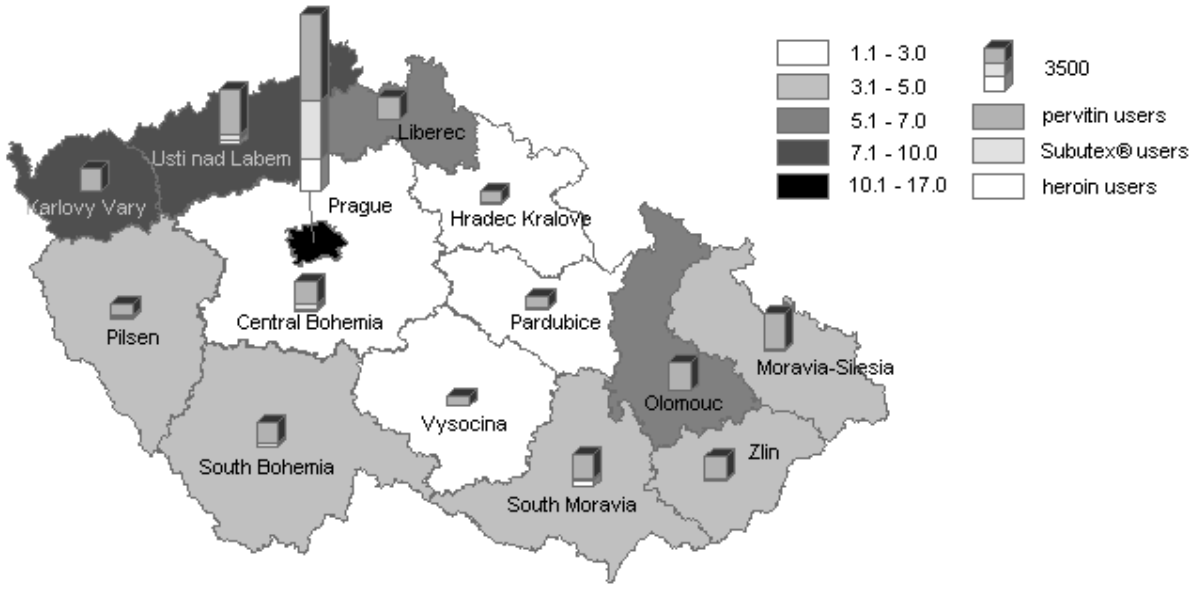


Table 4-4: Prevalence estimates of problem drug users in the Czech Republic in 2005-2012 by region, central values in absolute numbers (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a, Mravčík et al., 2012)

Region	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Prague	9,800	8,400	10,000	11,500	10.400	11,350	10,900	14,600
Central Bohemia	2,500	2,450	1,700	1,750	2,400	2,150	2,100	2,500
South Bohemia	1,700	1,750	1,500	1,550	1,500	1,400	1,300	2,000
Pilsen	1,450	1,350	1,300	1,650	2,400	2,000	1,900	1,250
Karlovy Vary	1,450	1,250	900	1,000	1,200	900	1,200	1,950
Ústí nad Labem	4,450	4,450	4,100	4,150	5,300	4,900	6,200	4,600
Liberec	750	500	500	1,500	1,300	2,650	2,800	1,750
Hradec Králové	1,150	1,050	1,750	1,100	1,000	950	1,100	1,050
Pardubice	600	350	450	450	500	400	400	1,000
Vysočina	600	350	700	500	600	600	600	750
South Moravia	2,800	3,150	3,400	3,250	3,400	3,900	4,000	2,650
Olomouc	1,900	2,350	1,650	1,600	3,000	3,300	3,200	2,350
Zlín	1,150	1,300	1,850	1,350	2,400	2,350	2,500	1,850
Moravia-Silesia	1,500	1,450	1,100	1,150	2,000	2,350	2,000	3,000
Entire Czech Republic	**31,800**	**30,200**	**30,900**	**32,500**	**37,400**	**39,200**	**40.200**	**41,300**

4.1.2 Estimate of Problem Drug Use in the Czech Republic Using the CRM Method

The 2011 Annual Report provided an estimate of problem drug use in 2006 and 2007 obtained by the capture-recapture method (CRM) using healthcare registers (Mračík and Sopko, 2013). In total, problem drug users were estimated at aproximately 24,000 in 2006 and almost 31,000 in 2007; see Table 4-5. The distribution of the central estimate by gender and age is provided in Table 4-6.

Table 4-5: Estimated number of problem drug users in the Czech Republic obtained using the capture-recapture method, 2006 and 2007 (Mravčík and Sopko, 2013)

Year	**Estimated number of problem drug users**		
	Central value	95% CI lower limit	95% CI upper limit
2006	23,885	20,662	28,533
2007	30,982	25,464	39,414

Table 4-6: The distribution of central estimate of problem drug users in the Czech Republic by age group and gender, 2006 and 2007 (Mračík and Sopko, 2013)

Gender	Year	Age group							Total
		<15	15-17	18-24	25-34	35-44	45-64	>64	
Men	2006	60	790	6,042	7,032	1,534	770	179	16,408
	2007	8	1,192	7,256	9,255	2,294	1,126	147	21,278
Women	2006	73	1,062	3,048	1,859	538	764	133	7,477
	2007	41	1,412	3,705	2,775	718	914	139	9,704
Total	**2006**	**133**	**1,853**	**9,090**	**8,891**	**2,072**	**1,534**	**312**	**23,885**
	2007	**49**	**2,604**	**10,961**	**12,030**	**3,012**	**2,040**	**286**	**30.982**

4.1.3 Estimate of Problem Drug Use in Prague Using the CRM Method

The 2011 Annual Report also presented the results of an estimate using the CRM method on data from six low-threshold programmes in Prague. A more detailed analysis of the results was made, incorporating data from a survey among clients conducted by low-threshold programmes in Prague during two weeks in September 2012. This survey made it possible to further refine the input data in the distribution table entering the model on the basis of the proportion of clients without a code (Sopko et al., 2013). The correction of the number of clients is provided in Table 4-7, the overall results in Table 4-8 and Table 4-9.

Table 4-7: Distribution of clients in Prague by the number of low-threshold programmes in which they are registered, 2011 (Sopko et al., 2013)

Number of programmes	Number of coded clients	Corrected number
1	2,722	4,071
2	476	726
3	290	463
4	296	469
5	178	277
6	28	43
Total	**3,990**	**6,049**

Table 4-8: Estimated number of problem drug users in Prague from the data of low-threshold programmes before and after correction for the non-coded clients, 2011 (Sopko et al., 2013)

Input data	Estimated number of problem drug users		
	Central value	95% CI lower limit	95% CI upper limit
Coded clients only	7,280	6,983	7,603
All clients after adjustment for the non-coded clients	10,754	10,405	11,127

Table 4-9: Comparison of the estimated number of problem drug users in Prague using the capture-recapture method (CRM) and the multiplication method (MM), 2011 (Sopko et al., 2013)

Method	Problem drug users in total	Men	Women	Drug of choice				
				Heroin	Pervitin	Buprenorphine	Cocaine	Methadone
CRM	10,754	8,056	2,689	2,581	5,592	4,732	64	860
MM	10,900	–	–	2,200	5,400	3,300	n.a.	n.a.

Note: In the multiplication method clients are assigned only one primary drug, while in the capture-recapture method client groups by drugs overlap, as clients could report more primary drugs.

4.1.4 Estimate Based on a Survey among Physicians in the Czech Republic

In addition, the regular omnibus sociological survey among physicians in the Czech Republic was conducted by INRES-SONES in November and December 2012. On the initiative of the National Focal Point, a module with questions on the prevalence of problem drug use was included in the survey again, to be answered only by general practitioners for adults and general practitioners for children and adolescents, and also including questions about the physicians' experience of administering substitution treatment (Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES, 2013a); for results concerning substitution treatment see the chapter entitled Opiate Substitution Treatment (p. 72). A similar module was included in the earlier rounds of the same survey; see the 2005, 2007, and 2010 Annual Reports. General practitioners were also asked similar questions in the 2003 survey (Mravčík et al., 2005). The 2012 survey included a total of 1,200 physicians from the entire Czech Republic. With regard to the fact that the questions about the

prevalence of problem drug users were answered only by physicians registering their patients for the purpose of capitation payments from the health insurance system, the number of general practitioners for adults and paediatricians in the sample increased to approximately double the number that would correspond to their real representation in the population of physicians in the country – 341 and 210, respectively, were included in the survey in total.

The physicians were asked questions on the number of patients they registered:

- those with injecting or regular or long-term use of opiates (heroin or substitution drugs not prescribed by a physician) or pervitin; this was followed by detailed questions on the number of users of heroin, buprenorphine not prescribed by a physician, and pervitin separately,
- regular or heavy users of marijuana or hashish,
- pathological gamblers or people who have severe problems with playing betting (gambling) games such as electronic gaming machines, other casino games, or betting (including online betting).

The results were extrapolated both to the total number of people in the Czech Republic and to the total number of general practitioners and outpatient paediatricians in the Czech Republic (Chudobová, 2013, Marková, 2013); estimates for the entire Czech Republic are shown in Table 4-10 and Table 4-11.

Table 4-10: Estimate of heavy users of cannabis and problem drug users in a survey among physicians extrapolated to the population of the Czech Republic (Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES, 2013a)

Specialisation	**Estimate**	**Heavy cannabis users**	**Problem drug users, total**	**of whom**			
				heroin users	buprenorphine users	pervitin users	IDUs
General practitioner for adults	Central value	134,608	14,109	3,181	4,115	8,213	8,818
	95% CI lower limit	102,689	11,389	2,256	2,923	6,490	7,032
	95% CI upper limit	166,527	16,830	4,106	5,307	9,936	10,604
General practitioner for children and adolescents	Central value	20,420	1,469	270	420	937	990
	95% CI lower limit	14,162	949	157	179	582	639
	95% CI upper limit	26,677	1,989	383	661	1,292	1,340
Total	**Central value**	**155,028**	**15,578**	**3,451**	**4,535**	**9,150**	**9,808**
	95% CI lower limit	116,851	12,338	2,413	3,102	7,072	7,671
	95% CI upper limit	193,204	18,819	4,489	5,968	11,228	11,944

Table 4-11: Estimate of heavy users of cannabis and problem drug users in a survey among physicians extrapolated to the total number of physicians (Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES, 2013a)

Specialisation	Estimate	Heavy cannabis users	Problem drug users, total	of whom			
				heroin users	buprenorphine users	pervitin users	IDUs
General practitioner for adults	Central value	120,770	12,659	2,854	3,692	7,369	7,912
	95% CI lower limit	94,360	10,342	2,126	2,554	5,927	6,459
	95% CI upper limit	147,180	14,976	3,583	4,831	8,811	9,364
General practitioner for children and adolescents	Central value	26,917	1,937	356	553	1,235	1,304
	95% CI lower limit	19,865	1,312	183	248	821	864
	95% CI upper limit	33,969	2,562	528	859	1,650	1,745
Total	**Central value**	**147,687**	**14,596**	**3,210**	**4,246**	**8,604**	**9,216**
	95% CI lower limit	114,225	11,653	2,309	2,801	6,747	7,323
	95% CI upper limit	181,149	17,538	4,111	5,690	10,461	11,109

The estimated number of problem drug users, constructed as the sum of the estimates of heroin, buprenorphine, and pervitin users, reached 16-17 thousand persons (the central estimate) in 2012, which is much less than the figure estimated by this method in previous years and much less than that estimated by the multiplication method; see above. The reasons for this difference are not clear. However, prevalence estimates obtained through a survey among general practitioners are burdened with a relatively high margin of error and, therefore, broad confidence intervals. As in the past years, the estimates are very likely to underestimate the number of pervitin users, for whom there is no sufficiently attractive treatment modality available from general practitioners that is similar to substitution treatment for opioid/opiate users. For the first time, the survey among physicians included a question concerning heavy cannabis users; their number was estimated at approximately 150,000. The trend of problem drug use estimates based on questionnaire surveys among general practitioners is shown in Table 4-12.

Table 4-12: Prevalence estimates of problem drug users obtained from questionnaire surveys among general practitioners, 2003, 2005, 2007, 2010, and 2012 (Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES, 2013a)

Year	Problem drug users in total		Number of IDUs		Number of opiate users		Number of pervitin users	
	Number	Per 1,000 inhabitants aged 15-64	Number	Per 1,000 inhabitants aged 15-64	Number	Per 1,000 inhabitants aged 15-64	Number	Per 1,000 inhabitants aged 15-64
2003	n.a.	–	n.a.	–	21,200	2.6*	n.a.	–
2005	32,000	4.4	n.a.	–	17,000	2.3	15,000	2
2007	28,500	3.9	n.a.	–	11,600	1.6	16,600	2.3
2010	32,900** 53,500***	4.4 7.2	23,300	3.2	20,400	2.8	12,500	1.7
2012	16,500** 14,600–15,600***	2.3**	9,500	1.3	7,700	1.1	8,800	1.2

*Note: * Per 1,000 inhabitants aged 18 and over. ** This is the sum of problem drug users by drug. *** This is estimated directly from the questions concerning the overall number of problem drug users among physicians' clients.*

4.2 Data on Problem Drug Use from Non-Treatment Sources

4.2.1 Multiplier 2013

The Multiplier 2013 study is primarily focused on finding the proportion of problem drug users (established using the peer nomination technique through questions on the respondents' peers) to estimate their number using the multiplication method (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a); see also the chapter entitled Prevalence and Incidence Estimates of Problem Drug Use (p. 48). It follows on from similar studies in 2008 and 2010. The one-page questionnaire also includes questions about the

respondents' drug use and drug-using habits. Multiplier is a cross-sectional questionnaire study among the clients of low-threshold programmes in the Czech Republic, in which the interviewers are the workers in those programmes. The study was conducted in May-June 2013, with 62 participating programmes (including 42 drop-in centres and 20 outreach programmes) from all the regions of the Czech Republic except the Zlín region.

The sample consisted of total of 1,797 clients. Men accounted for 70.1% of the sample (69.3% in 2010) and the average age of the respondents was 30.3 years (29.2 years in 2010 and 27.7 years in 2008). The average age was 31.2 and 28.1 years for men and women respectively; the youngest respondent was 16, the oldest was 63.

Most respondents reported using pervitin (85.4%), followed by buprenorphine (17.0%) and heroin (5.7%). Only 17 respondents (0.9%) reported methadone as their primary drug. Compared to the results of a similar study from 2010, the proportion of pervitin increased and the proportion of heroin decreased; the proportion of users reporting the use of buprenorphine remained approximately the same. The use of other drugs as the primary drug was reported by 221 (2.3%) respondents – mostly involving cannabis, other opiates/opioids, such as opium, fentanyl, "brown",[86] Vendal® Retard,[87] and benzodiazepines. Funky[88] and LSD were reported by three individuals respectively and two persons reported cocaine. The results by region are provided in Table 4-13.

Table 4-13: Selected main drugs used by respondents in the Multiplier 2013 survey, by regions (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a)

Region	Total respondents	Pervitin	Heroin	Buprenorphine	Methadone	Other drug
Prague	234	66.2	11.5	41.5	3.0	6.8
Central Bohemia	116	75.9	4.3	41.4	0.0	5.2
South Bohemia	142	80.3	2.1	27.5	1.4	14.8
Pilsen	140	97.1	4.3	6.4	2.1	33.6
Karlovy Vary	105	96.2	2.9	5.7	0.0	4.8
Ústí nad Labem	310	81.6	8.4	17.7	0.0	5.2
Liberec	137	98.5	1.5	1.5	0.7	43.1
Hradec Králové	85	64.7	0.0	36.5	1.2	10.6
Pardubice	63	95.2	0.0	4.8	0.0	25.4
Vysočina	112	92.9	1.8	6.3	0.0	8.9
South Moravia	87	89.7	18.4	2.3	2.3	0.0
Olomouc	87	97.7	0.0	5.7	0.0	4.6
Zlín	–	–	–	–	–	–
Moravia-Silesia	179	95.0	6.7	1.1	0.6	6.7
Total	**1,797**	**85.4**	**5.7**	**17.0**	**0.9**	**12.3**

In 2013, the questionnaire included questions on the use of selected drugs in the last 12 months. The questions were deliberately focused on fentanyl, opium, other opiates/opioids, and some of the new synthetic drugs. The results are shown in Table 4-14. The most frequently reported other opioids were heroin, buprenorphine, opium, and fentanyl, but also "brown", morphine, and codeine. As regards the new synthetic drugs, clients most often reported Funky, mephedrone, Cocolino, El Padrino, and Magico (all of them very probably contain cathinones).

[86] An opiate drug that was widespread in Czechoslovakia in the period of communism, home-produced from codeine-based medications containing codeine and morphine derivatives.
[87] A medication containing morphine.
[88] A new synthetic drug that probably contains cathinones.

Table 4-14: Prevalence of use of selected drugs in the last 12 months, according to the Multiplier 2013 survery, by regions (%) (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a)

Region	Fentanyl	Opium	Other opiate /opioid	A new synthetic drug
Prague	7.7	24.4	35.5	32.5
Central Bohemia	7.8	12.9	12.1	7.8
South Bohemia	3.5	14.8	31.0	7.0
Pilsen	23.6	14.3	17.1	3.6
Karlovy Vary	2.9	4.8	0.0	0.0
Ústí nad Labem	0.6	2.9	18.4	0.6
Liberec	0.0	5.1	5.8	10.2
Hradec Králové	1.2	37.6	32.9	18.8
Pardubice	4.8	4.8	12.7	7.9
Vysočina	0.0	16.1	11.6	17.9
South Moravia	2.3	9.2	19.5	19.5
Olomouc	9.2	74.7	14.9	1.1
Zlín	–	–	–	–
Moravia-Silesia	4.5	12.3	6.7	7.3
Total	**5.1**	**15.7**	**17.9**	**10.5**

Injecting in the last 30 days was reported by 1,707 (95.0%) of the clients, most of whom (89.6%) had injected the drug repeatedly in the last month. The questionnaire also included questions on the use of clean needles and syringes and the testing and prevention of infectious diseases; for more details see the chapters entitled Risk Behaviour of Drug Users (p. 98) and Testing for Infectious Diseases (p. 115).

4.2.2 Annual Reports from the Regions

A comprehensive analysis of the 2012 annual reports on the implementation of drug policies in the regions was conducted in 2013 (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2013). Regional drug coordinators generally did not report a significant change in the development of the drug situation in 2012. There was a further increase in the use of opiate/opioid-based drugs in the South Bohemia and Pilsen regions; see the 2011 Annual Report. Clients reported low-quality heroin, which they replaced with morphine Vendal® Retard tablets alone (in Pilsen) or in combination with Subutex® (in South Bohemia). According to the information from street workers in outreach programmes, these are medications that users are given on prescription with a minimum co-payment. The misuse of benzodiazepines and fentanyl obtained by extraction using ethanol from both unused and used transdermal patches is reported from Pilsen. The Central Bohemia region even reported the injecting use of Suboxone®[89] in 2012.

In 2012, new synthetic drugs and their sales in bricks-and-mortar shops (unlike in 2011; see the 2011 Annual Report) were reported only marginally. The existence of regular shops offering new synthetic drugs was recorded only in Hradec Králové, Pardubice, and Chrudim. For instance, a marked trend towards illicit drug users switching to new synthetic drugs in approximately 60 clients of drop-in centres was reported in Pardubice in 2012. Among them were both users for whom the new synthetic drug was the (problem) primary drugand users of other primary drugs(mainly pervitin). The reported reasons for the preference for new synthetic drugs included easy availability and lower cost than that of illegal drugs; at the same time, the clients reported more frequent health problems associated with the use of the new synthetic drugs. In the second half of 2012 the shops were closed and the clients either returned to their original drug, or first-time users of the new drugs stopped using or switched to other traditional illegal drugs; see the chapter entitled Drug Markets (p. 141).

The clients of drug services in Liberec reported the use of pervitin in combination with mephedrone, with health effects such as headaches, irritability, and deep fatigue, with the need to sleep approximately an hour after application. Services in the Karlovy Vary region highlighted the growing number of users of synthetic cannabinoids.

4.2.3 Open Drug Scenes in Prague

Open drug scenes were found mainly in the city districts of Prague 1, 2, and 5, i.e. in the very centre of Prague on Wenceslas Square and Charles Square, and in the Vrchlický Gardens near the Central Railway Station. The major part of the Prague 5 drug scene moved to Prague 4, which is probably related to the growing number of outpatient substitution centres. Smaller local drug scenes can be observed in the districts of Prague 3, 7, 8, 10, and 13 (e.g. Palmovka and the Holešovice station); for more details see the 2010 and

[89]The case probably concerned a user without opiate/opioid dependency syndrome or perhaps one suffering from its lighter form, in which the effect of naloxone on opioid receptors did not result in a withdrawal syndrome.

2011 Annual Reports. In April and May 2012, there was a shortage of substitution drugs containing buprenorphine among clients. This situation became known as the "Subutex Crisis"; for more information see the 2011 Annual Report. The methadone substitution and outpatient detoxification centre in Prague 1 (operated by Drop In, o.p.s., a centre for drug prevention and treatment) did not have sufficient space for its operation in 2012. At the end of 2011, the centre was given notice, terminating its tenancy of its premises, and had to resort to temporary solutions throughout 2012 and 2013, at first using a bus, then later merging with the same organisation's low-threshold centre.

4.2.4 Other Information on Problem Drug Use

A qualitative study was conducted to explore the process of natural recovery from long-term drug use without professional assistance, with its theoretical foundations relying on a relational perspective based on social constructionism. In the case of both alcohol and illicit drug use, spontaneous recovery is the most common method of terminating the use of these substances. However, the mechanism of this change remains unclear. The survey consisted of focused narrative interviews with 19 persons who had stopped using pervitin more than 5 years before. The study showed that the termination of long-term pervitin use is a natural process which may arise from minor dissatisfaction at the beginning, or from persistent restlessness. This may lead to a change (the so-called transient trajectory) while other persons are involved. The primary objective of this process may not be to end pervitin use. This perspective can be used when offering help to people who are trying to terminate their drug use, as the mere presence of another person can then facilitate change (Nepustil, 2013).

A qualitative study was completed in 2013 to deepen the existing body of knowledge about the use of illicit drugs in Czechoslovakia in the 1970s and 1980s and to describe the origins and development of the so-called drug subculture (particularly its hard core) and the characteristics and development of individual drug careers. The study was designed as an inductive thematic analysis of the data obtained from processing semi-structured in-depth biographical interviews. The sample was compiled using purposive selection combined with the snowball method. The respondents were old-time users, partly former or current clients of helping organisations, partly people from the hidden population of users. In total, there were 34 respondents (28 men, 6 women), aged 37-58 years (average age 47.8 years). 19 respondents were from Prague; the rest were from other regions of the country. The sample comprised predominantly problem users or chronic polydrug users – these were the key informants about the development of the hard core of the drug scene in communist Czechoslovakia. The unique feature of the Czechoslovak drug scene was home-made substances (pervitin and brown), which were obtained in a different way than their Western equivalents (cocaine and heroin). Because of the overall repressive nature of the communist regime, the drug scene was rather closed off and the availability of (hard) drugs was very uneven. The drug scene had a number of distinct segments, with different drug preferences, consumption patterns, lifestyles, attitudes to the regime, and degrees of interconnection with other anti-regime groups (the musical underground or dissidents). Hard drugs were distributed on a non-commercial or semi-commercial basis, which, in some cases, made long-term use possible while maintaining a socialised lifestyle. The results confirm that understanding the boundaries between the majority culture and a subculture as a rigid one represents a conceptual or cultural stereotype. Addictive behaviour involved the majority culture (alcohol use) and the subculture (use of other drugs) to a similar degree. During the period of communism, too, it was the specific patterns of use (occasional vs. chronic) and the user's lifestyle (socialised vs. chaotic or criminal), rather than drug preferences, that were the more fundamental dividing criteria. A combination of individual predispositions, disturbed developmental-psychological bonds, and social influences can be considered as underlying this problematic lifestyle associated with chronic drug use (Brenza, 2013).

An analysis of the psychosocial characteristics of persons included in the study on the risk factors of addiction between April 1996 and December 1998 was published in 2012 (Csémy, 1999). A detailed analysis of mortality (Zábranský et al., 2011b) and an analysis of drug careers and the typology of this cohort in terms of developmental and psychological factors had been published previously (Brenza et al., 2012); see also the 2009 and 2011 Annual Reports. A cohort of 124 persons who, at the time of their participation in the study, were adolescents in the early stages of problem drug use and agreed to a later follow-up, were contacted again after 13-14 years. 52 people (41.9%) were interviewed using a questionnaire and standard instruments to measure the severity of their drug use and problems associated with it (SDS, ASI-Lite) and a set of standard psychological scales and questionnaires. 13 persons (25%) currently had problems with drugs in terms of problem drug use. In comparison with others in the sample, the problem drug users reported more problems concerning physical health, employment, and law-abiding behaviour. The problem drug users also showed lower levels of life satisfaction, while the two groups did not differ in terms of other psychological characteristics. To a large extent, it is encouraging to find that problem (or injecting) drug use in adolescence persisted into young adulthood in only a quarter of the people (Csémy et al., 2012).

More information on problem drug users in contact with various types of services is provided in the chapters Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 61), Responses to Health Correlates and Consequences of Drug Use (p. 109) and Social Correlates and Social Reintegration (p. 118).

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

An extrapolation of the results of the 2012 National Survey on Substance Use (for more details see the chapter entitled Drug Use in the General Population and Specific Targeted Groups on p. 25) to the entire Czech population aged 15-64 years showed that there were an estimated 1.5-1.9 million daily smokers and between 730,000 and 1 million individuals engaging in frequent binge drinking (5 or more drinks on one occasion with a frequency of once a week or more often). Approximately 120 to 200 thousand persons consume excessive amounts of alcohol daily or almost daily (5-7 times a week). Between 1.1 and 1.4 million people meet the criteria for hazardous alcohol consumption on the CAGE scale, of whom 500-690 thousand were in the high-risk category in relation to alcohol; see Table 4-15.

Cannabis had been used at least once a week in the last 30 days by 2.0% of the population, i.e. an estimated 145,000 persons, of whom approximately 96,000 were aged 15-34. Cannabis was used daily (or almost daily) by 0.3% of the population, i.e. approximately 22,000 persons, of whom 14,000 were in the category of young adults (15-34). Using the CAST scale it was estimated that 2.8% of the population, i.e. an estimated 202,000 people (153,000 young adults) were at risk as a result of their use of cannabis, and 1.2% of the population, i.e. approximately 87,000 people (49,000 young adults), were at high risk.

In the Czech Republic there are an estimated 1.3 million people (18.4%) who meet the criteria for at-risk alcohol or cannabis use (at least moderate risk associated with cannabis), of whom almost 600,000 are in the 15-34 age group. Of the category of at-risk users, an estimated 665,000 persons (9.2%) meet the criteria for harmful alcohol use or are at high risk because of their cannabis use (of whom 309,000 are young adults). 0.4% of the population, i.e. an estimated 29,000 people (14,000 young adults), meet the criteria for harmful alcohol consumption while being exposed to a high risk of cannabis-related problems.

In 2012 the *Noe* drop-in centre in Třebíč conducted a survey of heavy cannabis users to determine their needs and propose appropriate harm reduction interventions (Diecézní charita Brno - Oblastní charita Třebíč, 2012). The group consisted of 100 purposefully selected heavy cannabis users contacted during street work in the afternoon and evening hours. Data were collected through structured face-to-face interviews in the field or in the drop-in centre or at another location chosen by the respondent. 93 interviews were analysed (7 interviews were excluded as impossible to evaluate), of which 71 were with men and 22 with women, mostly aged 15-18 (54%) and 25-30 years (26%). Approximately one third had secondary school education, one quarter had vocational education, and 38% basic school education; three respondents had higher secondary or university education. 47% of the respondents used cannabis daily, 27% several times a week, and 10% at weekends. All of them reported the use of marijuana, a third of them reported the use of marijuana, and hashish. No respondent indicated hashish use only.

Each respondent reported more than one method of cannabis use, with the dominant method being smoking using a glass one-hitter, joint, bong, blunt, bowl, or water pipe. Use in food was also reported in several cases. Vapourisation was only reported in 9 cases (10%).[90]

The health problems associated with cannabis use that were most frequently reported included forgetfulness, loss of motivation, heart palpitations, nausea, confusion, loss of coordination, and hallucinations. Depression, anxiety, paranoia, aggression, and disorders and loss of consciousness were reported less frequently. As regards the frequency of problems, 58% of the respondents reported rare, 9% frequent, and 6% regular frequency. The positive aspects of cannabis use that were most often reported included repose and ease of mind, a good feeling, relaxation, fun, and unwinding.

Problems with their environment as a result of cannabis use were reported by 45% of the respondents, mostly involving partner and family relationships. A third of the respondents have attempted to quit using cannabis.

When asked to specify the service they would like to use at the drop-in centre, 81% of the respondents could not provide a concrete answer.

[90] A joint is a rolled cigarette containing cannabis (most usually marijuana), often with cigarette or pipe tobacco. If wet tobacco leaves are used for wrapping instead of cigarette paper, such a cigarette is called a blunt. A bowl is the term used for a pipe with a head so small that its content can be inhaled at one breath. If made of a glass tube, it is usually referred to as a glass one-hitter. A bong is the term designating a water pipe from which the smoke, having bubbled through the water, is inhaled through the wide-open mouth directly into the lungs using the open upper end of the pipe with two openings in the side wall; bongs are usually made of transparent material in order to monitor the smoke density in the vessel. During the vapourisation process cannabis is heated in a manner that is different from the one that occurs in burning the plant material, thereby releasing THC and other active substances in gaseous form without the harmful products of combustion; this is probably the most effective and, from a health perspective, the safest way of using cannabis (Miovský et al., 2008).

Table 4-15: Heavy and risky use of tobacco, alcohol, and illicit drugs in the population (%) and extrapolation to the total population of the Czech Republic (Chomynová, 2013)

Indicator	Age group 15-64 years			Age group 15-34 years		
	Proportion (%)	Estimated number	95% CI	Proportion (%)	Estimated number	95% CI
Daily smokers	23.1	1,669,000	20.6-25.9 (1,488,000-1,871,000)	25.4	695,000	22.4-28.4 (613,000-777,000)
Regular users of alcohol (5 or more drinks with a frequency of at least once a week in 30 days)	12.8	925,000	10.1-14.2 (730,000-1,026,000)	14.8	405,000	12.3-17.2 (337,000-471,000)
Regular users of alcohol (5 or more drinks with a daily or almost daily frequency)	2.3	166,000	1.7-3.0 (123,000-217,000)	0.8	22,000	0.2-1.4 (5,000-38,000)
CAGE – at-risk drinking (score 1)	17.0	1,230,000	15.2-18.8 (1,100,000-1,360,000)	18.3	500,000	15.6-21.0 (430,000-570,000)
CAGE – harmful drinking (score 2)	8.2	590,000	6.9-9.6 (500,000-690,000)	9.7	266,000	7.6-11.8 (208,000-323,000)
Users of cannabis with a frequency of use at least once a week in 30 days	2.0	145,000	1.4-2.6 (101,000-188,000)	3.5	96,000	2.3-4.7 (63,000-129,000)
Users of cannabis with a daily frequency of use in 30 days	0.3	22,000	0.1-0.5 (7,000-36,000)	0.5	14,000	0.0-1.0 (0-27,000)
CAST – at-risk (score 2)	2.8	202,000	1.7-3.8 (123,000- 275,000)	5.6	153,000	3.6-7.7 (99,000-211,000)
CAST – high risk (score 4)	1.2	87,000	0.7-1.7 (51,000-123,000)	1.8	49,000	1.0-2.7 (27,000-74,000)
Heavy users of any drug (excluding tobacco) with a frequency of use at least once a week in 30 days	13.9	1,004,000	12.4-15.4 (896,000-1,123,000)	14.5	397,000	12.1-16.8 (331,000-460,000)
Heavy users of any drug (excluding tobacco) with a daily frequency of use in 30 days	2.5	180,000	1.8-3.2 (130,000-231,000)	1.4	38,000	0.6-2.1 (16,000-57,000)
Category of "at risk" of alcohol- or cannabis-related problems (CAGE 1+ or CAST2+)	18.4	1,330,000	16.5-20.3 (1,190,000-1,470,000)	21.8	597,000	18.8-24.8 (515,000-679,000)
Category of "at high risk" of alcohol- or cannabis-related problems (CAGE2+ or CAST4+)	9.2	665,000	7.8-10.6 (563,000-766,000)	11.3	309,000	9.0-13.6 (246,000-372,000)
Category of "at high risk of alcohol- and cannabis-related problems at the same time" (CAGE2+ and CAST4+)	0.4	29,000	0.1-0.7 (7,000-51,000)	0.5	14,000	0.0-1.0 (0-27,000)

5 Drug-Related Treatment: Treatment Demand and Treatment Availability

Approximately 250 facilities may be considered as constituting the core of specialised services for drug users and addicts. Alcohol users account for approximately 60% of the patients in medical outpatient and inpatient addiction treatment. Stimulant users have long predominated among users of substances other than alcohol in contact with drug services, with pervitin (methamphetamine) being the primary drugfor most of them. The second largest group comprises users of opiates/opioids and cannabis. Healthcare facilities report high rates of polydrug users; in inpatient psychiatric facilities they represent the most frequent diagnostic group from among the disorders caused by the use of substances other than alcohol. Users of opiates/opioids comprise the largest group in psychiatric outpatient clinics, which may be due to the provision of substitution treatment.

The number of providers of outpatient health services reporting the treatment of drug users decreased in 2012. Some 50 to 80 facilities in the Czech Republic may be considered as outpatient clinics specialising in addiction treatment ("AT clinics"). Again, there was a slight drop in the number of alcohol/drug patients in outpatient treatment, which was particularly attributed to patients using alcohol. There was an increase in the number of patients treated for stimulant use and polydrug use. By contrast, the number of patients treated for the problem use of opiates/opioids decreased.

The number of patients recorded in the Substitution Treatment Register remained almost the same. However, the Register does not yet fully account for treatment with buprenorphine-based preparations. Aggregated data about the numbers of patients in substitution treatment provided by outpatient psychiatrists and general practitioners for adults are monitored. 2298 people were reported to the Substitution Treatment Register in 2012, which is approximately two thirds of the total number reported by psychiatrists and general practitioners.

In 2012, the detoxification units were located in 17 inpatient facilities with 155 dedicated beds and detoxification was provided in an additional 14 inpatient facilities with non-dedicated beds. In total, 9,124 persons underwent detoxification from addictive substances, of whom 4,103 underwent detoxification from illicit drugs.

There has been an increase in the number of hospitalisations of illicit drug users in inpatient psychiatric facilities. The increase concerns patients admitted for disorders caused by polydrug use and the use of stimulants other than cocaine, while the number of hospitalisations for disorders caused by the use of opiates/opioids decreased.

A total of 8,955 users of drugs other than alcohol were reported to the Register of Treatment Demands in 2012, i.e. 289 persons less than in 2011. Of these, 4,313 individuals sought treatment for the first time, 199 less than the number in 2011. The number of both first treatment demands and all treatment demands decreased for the first time since 2008. Among all treatment clients there were 6,075 men (67.8%) and 2,858 women (31.9%), while there was no indication of gender in 22 patients. The order of the drugs used which are the cause of treatment demands remained the same in 2012 as in previous years – the most frequently used drug was pervitin, followed by opioids/opiates and cannabis. An aging of the population demanding treatment is apparent; their average age in 2012 was approximately 28 years.

In February 2013, a committee of the Society for Addictive Diseases of the J. E. Purkyně Czech Medical Association approved the concept of a network of specialised addiction treatment services, which redefines the types of health services for drug users and addicts. Commissioned by the Ministry of Health, a strategy for the reform of psychiatric care for the period 2014-2020, which also provides for addictological services, has been under development since August 2012. In 2013, six new health interventions linked to the paramedical profession of an addictologist were approved and addictologists will also be able now to report another two interventions that are already being provided as part of day care.

5.1 General Description, Availability, and Quality Assurance

5.1.1 Legal Framework and Strategies and Policies in the Field of Treatment

New healthcare legislation, with Act No. 372/2011 Coll., on health services, as the key law, has been in effect since 1 April 2012; see the 2011 Annual Report for more details.

In 2013, the Ministry of Health launched a review process on the bill on the protection of health against addictive substances to replace Act No. 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances. In view of the large number of changes that were proposed, the Health Ministry finally decided to draw up a new bill dealing with the protection of health against addictive substances. The bill was submitted for an intergovernmental review process in April 2013. Compared with the existing legislation, the bill includes substantial changes towards limiting the availability of alcohol and tobacco, and limiting exposure to tobacco smoke. According to Ministry of Health, there was a need to

redefine existing legal provision in the field of addiction treatment due to adoption of new legal framework in the health care in general. According to Ministry of Health, the provision on the particular types of addiction services was withdrawn from the bill on the protection of health against addictive substances since they fall under the Act No. 72/2011 Coll., on health services, as well as under the Act No. 108/2006 Coll., on social services. According to experts, the bill is not suitable and unsatisfactorily takes into account specific character of addiction treatment services, similar objections concern proposed provisions in the field of coordination of drug policy.[91].

In 2012 and 2013, work continued on the development of new health interventions delivered by paramedical addictologists (expertise no. 919) under the auspices of the Czech Association of Addictologists. The Association's working group developed new registration sheets for these new interventions in the period from November 2011 till March 2013. The interventions were approved by the relevant working bodies at the Ministry of Health[92] and will be published, subject to approval by the Minister of Health, in the Database of Health Interventions with point values assigned to them (by amending the so-called reimbursement decree); the database should be released in the second half of 2013 and take effect from 1 January 2014. The new health interventions delivered by addictologists are (Fidesová et al., 2013):

- examination by an addictologist at the start of addiction care,
- check-up by an addictologist,
- maintaining minimum contact between the addictologist and the patient,
- individual addiction treatment,
- family addiction treatment,
- group addiction treatment type I, for groups of up to 9 people.

In addition to the above new interventions, two existing interventions delivered by addictologists during treatment stays in inpatient care or while the patient is in a day-care centre were approved. They are Intervention No. 00041, which is recognised as one day of the patient's stay in the day-care centre, provided the length of the stay is at least 8 hours (or at least 6 hours, in the case of day-care centres with a psychotherapeutic programme), and Service No. 00042, which is recognised as one day of the patient's stay in a day-care centre with a programme spread out over a period of time, provided the length of the stay is at least 3 hours.

A new doctoral programme in addictology, delivered in Czech and English, was opened at the Department of Addictology in September 2012.

The Ministry of Labour and Social Affairs has implemented a project called Supporting the Processes in Social Services, funded from the European Social Fund and from the Czech Republic's national budget, since 2010.[93] The project includes 12 activities intended to contribute to the readjustment of the funding of the system of social services and the development of tools to identify the occurrence of adverse social phenomena and solutions thereof through social services, to streamline the characteristics and reporting of social services through so-called social services cards, to set up a monitoring system for social services, and to change the legislative framework for the provision of social services, in particular Act No. 108/2006 Coll., on social services.

A fundamental revision of the law on social services is planned for 2016, which should cover, inter alia, reducing the number of types of social services defined by the law, assessing the effectiveness of services, simplifying registration, quality of service (reducing the number of quality standards and criteria), social services inspections, methods of funding, and changes to the scope and content of the qualification course for social workers.[94]

5.1.2 Drug Services Network and Quality Assurance

Treatment and counselling programmes for drug users and their capacity and utilisation rates in 2012 are summarised in Table 5-1. Information about treatment and counselling services for drug users is also provided in other chapters: Responses to Health Correlates and Consequences of Drug Use (p. 109), Social Correlates and Social Reintegration (p. 118), Protective and Educational Measures (p. 132), and Drug Use and Problem Drug Use in Prisons (p. 136).

The concept of a network of specialised addiction treatment services (formerly known as the concept of a network of addiction-related health services from 2012 – see the 2011 Annual Report) was approved in February 2013 by a committee of the Society for Addictive Diseases of the J. E. Purkyně Czech Medical Association.

[91] http://www.vlada.cz/cz/ppov/protidrogova-politika/jednanirady/jednani-30--dubna-2013-105257/ (14 October 2013)
[92] http://www.mzcr.cz/Odbornik/dokumenty/zapisy-z-jednani-ps-k-szv_5579_998_3.html (16 August 2013)
[93] http://podporaprocesu.cz/ (23 July 2013)
[94] http://www.mpsv.cz/files/clanky/15652/06-Luskova_prezentace_20062013.pdf (23 July 2013)

Commissioned by the Ministry of Health, a psychiatric care reform strategy for 2014-2020 has been developed since 2012, its main purpose being to shift the centre of gravity of psychiatry from institutional care towards community-type care in the patient's natural setting. The priorities of the strategy include moving care closer to the patient, respecting their rights and individuality, strengthening primary psychiatric care, restructuring inpatient care, developing community care, facilitating the regional adjustment of services, and de-stigmatising patients and the field of addictology (Ministerstvo zdravotnictví, 2012).

A document mapping the state of psychiatric care in the Czech Republic, produced by the Psychiatric Society of the J. E. Purkyně Czech Medical Association, also dealt in detail with addictology as one of the specialised segments of psychiatric care. It states the following conclusions and recommendations for the field of addictology (Dvořáček et al., 2012):

- the system of addiction care in the Czech Republic has developed into a relatively good shape in the past 20 years (in terms of the network of facilities, education systems, quality assessment tools, and the content of treatment programmes);
- the idea of deinstitutionalisation and the idea of community care are obvious in the field – the network is made up of mutually cooperating institutions, covering healthcare, social and charitable, governmental and non-governmental, inpatient, outpatient, and intermediary organisations;
- there are professional reasons in the field for maintaining the comprehensiveness of service provision and for maintaining the balance between outpatient, inpatient, and intermediary care;
- the network of inpatient facilities needs no further changes in terms of capacity (fundamental changes have taken place in the past 20 years). The authors recommend dividing inpatient facilities into three basic types: detoxification facilities (acute standard care), superspecialised facilites at the supraregional level (with a full withdrawal management programme), and regional facilities (aimed at stabilising the patient);
- the network of outpatient facilities (medical AT clinics) can only be sufficient subject to two prequisites: that it is complemented by a network of non-medical outpatient addiction treatment facilities and that the reimbursement system for outpatient services is set up in a way that motivates people to work intensively with the patient;
- new non-medical addiction treatment outpatient facilities could be a key element in guiding the client through the system of services;
- we recommend that any consideration of reducing non-outpatient services be postponed until after the functionality of alcohol/drug treatment clinics has been sufficiently verified (5-10 years).

Table 5-1: Treatment programmes providing services to drug users in the Czech Republic, 2012

Type of programme	Total[1]			of which			
				Non-alcohol drugs		Alcohol	
	Number of facilities / programmes	Capacity (persons, beds)	Occupancy (number of persons)	Number of facilities / programmes	Occupancy (number of persons)	Number of facilities / programmes	Occupancy (number of persons)
Outpatient healthcare facilities – psychiatry (of which estimated AT clinics)	416 (50–80)	–	38,554 [2] (12,500–22,000)	355	14,681	390	22,838
Crisis centres	2	–	84	2	51	2	33
Psychotherapy clinics	7	n.a.	287	n.a.	203	n.a.	84
Outpatient (non-health) programmes run by NGOs	11 [5]	–	2,998 [5]	The target group primarily consists of users of non-alcohol (illicit) drugs.			
Healthcare facilities providing substitution treatment and reporting clients to the Substitution Treatment Register (NRULISL)	59	–	2,298	These are data on treatment provided to users of opiates, or opiates in combination with other substances (polydrug users).			
Substitution treatment provided by psychiatrists and general practitioners for adults	372	–	3,548	These are data on treatment provided to users of opiates, or opiates in combination with other substances (polydrug users).			
Sobering-up stations	17	152	28,469	–	4,968	–	23,501
Drop-in centres and outreach programmes (low-threshold programmes)	103	–	34,200	The target group of these facilities primarily consists of users of non-alcohol (illicit) drugs or problem (injecting) drug users.			
Detoxification units in inpatient healthcare facilities	17 [6] (31 [7])	155	9,124 [2]	–	4,091	–	5,021
Psychiatric hospitals for adults	18	8,847 [3] (1,315 [4])	11,280 [2]	–	4,185	–	7,095
Psychiatric wards in hospitals	30	1,268 [3]	4,021 [2]	–	1,644	–	2,377
Psychiatric hospitals for children	3	250 [3]	25 [2]	–	24	–	1
Other inpatient facilities with a psychiatric ward	2	66 [3]	90 [2]	–	19	–	71
Therapeutic communities	15–20 (9 [5])	154 [5]	401 [5]	The target group primarily consists of users of non-alcohol (illicit) drugs.			
Specialised departments for children at risk of drug addiction in residential special education facilities	5	68	159	The target group primarily consists of users of non-alcohol (illicit) drugs.			
Aftercare programmes	15–34 (11 [5])	108 [5a]	1,134 [5]	The target group primarily consists of users of non-alcohol (illicit) drugs.			
Detoxification in prisons	4	n.a.	353	These are the data on detoxification from non-alcohol (illicit) drugs.			
Substitution treatment in prisons	7	–	89	The target group consists of users of opiates, or opiates in combination with other substances (polydrug users).			
Departments for differentiated service of a sentence (voluntary treatment)	7	287	537	These are data on the treatment of users of non-alcohol (illicit) drugs.			
Departments for undergoing compulsory substance use treatment in prisons	3	128	184	These are data on the treatment of users of non-alcohol (illicit) drugs.			
Drug-free zones in prisons	34 [8]	1,918	4,549	The target group primarily consists of users of non-alcohol (illicit) drugs.			
NGO programmes in prisons	22 (9) [9]	–	595 (3,660) [10]	The target group primarily consists of users of non-alcohol (illicit) drugs.			

Note: [1]This is the total capacity and total number of users of all addictive substances; other columns contain data for alcohol and non-alcohol drugs, if available. [2] This is the number of patients with a primary diagnosis F10-F19 treated in the given year. [3] Number of all psychiatric beds. [4] Number of beds in wards for treating AT patients. [5] Number of programmes, capacity, and number of clients in programmes supported by subsidies from the Government Council for Drug Policy Coordination,[5a] sheltered housing capacity. [6]Number of detoxification units with dedicated detoxification beds. [7]Number of facilities providing inpatient detoxification to AT patients, including detoxification in various departments without dedicated beds. [8] Drug-free zones are essentially not a therapeutic programme, but rather provide a safe and motivating environment for prisoners who are ready to abstain; however, four of the drug-free zones have a therapeutic programme. [9] Number of prisons in which NGOs operated (number of prisons that reported 10 or more NGO visits per year). [10]Number of visits to prisons (number of clients).

As part of the project Mapping the Availability and Character of the Drug Services Network, the geographical availability of the drug services network in the Czech Republic (Vavrinčíková et al., 2013) was analysed. Several sources of data were used for the analysis:

- the Drug Services Census 2012 survey,
- annual reports on the implementation of the drug policy in regions,
- the database of treatment and counselling centres from the register of drug treatment demands,
- the National Health Information System.

The analytical unit used was that of the district; the sample thus contains 77 cases (76 districts and the capital, Prague). The analysis was conducted separately for the basic types of services, while some types of services were further merged (drop-in centres and outreach programmes were merged into the category of low-threshold programmes and outpatient programmes including drop-in centres were merged into the category of outpatient addiction treatment centres). The basic results by region are provided in Table 5-2 and Table 5-3. The results indicate that there are significant gaps in the availability of drug services, particularly in the Pardubice, Central Bohemia, and Liberec regions.

Table 5-2: Absence of drug services in districts by type (Vavrinčíková et al., 2013)

Type of service	**Number of districts/regions where the given type of care is non-existent**
Low-threshold programme (on aggregate)	21 districts
Alcohol/drug treatment clinic	37 districts
Substitution treatment	25 districts
Outpatient addiction treatment centre (on aggregate)	15 districts
Detoxification	55 districts, 2 regions
Alcohol/drug inpatient care	4 regions
Therapeutic community	3 regions
Follow-up treatment programme/aftercare	61 districts (35 districts*)

*Note: * 35 districts according to the 2012 Drug Services Census survey, in which the participating programmes reported considerably higher levels of the provision of aftercare than is apparent from the other sources used.*

The regional networks of services are described and evaluated by the regions in their respective annual reports (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2013). Most regions highlight the gaps in the network of healthcare facilities providing outpatient services or the small number of medical specialists working with drug users, as well as the long-term negative attitude of physicians towards drug users. The analysis of the state of affairs conducted by the regions is generally in line with the results of the analysis mentioned above, including some of the details. The shortcomings identified are provided in Table 5-4.

According to regional reports, there were some changes in the network of services in 2012 (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2013).

Some programmes ceased to exist. An attempt was made in České Budějovice to introduce a service aimed at providing drug counselling and care to children and young people brought to the sobering-up station. The pilot project was launched in June 2012 by the drug counselling centre operated by the *Prevent* civic association in collaboration with the Department of Social Affairs of the South Bohemia regional authority and the sobering-up station in České Budějovice. The implementation was complicated by the small number of clients, but also by the dismissive attitude of the parents of the children and adolescents and by a reluctance to cooperate on the part of the different components of the system. A detoxification unit was closed down in the Ústí nad Labem region in January 2012. In the Olomouc region, the drop-in centre in Hranice, a branch of the *Kappa-Help* civic association in Přerov, ceased its operations. Harm reduction services in Hranice are provided by outreach programmes. One residential facility operated by an organisation called *A Clubs Czech Republic* was closed down in the South Moravia region. Substitution treatment centres ceased to operate in the Pilsen and Karlovy Vary regions.

However, new services are being developed and created as well. In the Central Bohemia region, the *Prostor* civic association launched a new project called Streetwork Experiment in 2012, implemented in the Kolín and Kutná Hora areas. In 2013, the Pardubice region will see the launch of a project called "Back Differently" by the *Laxus* civic association, aimed at the rehabilitation of drug users returning from prison. An outreach programme called POINT 14 was expanded to include the town of Nýrsko in the Pilsen region and the Point 14 aftercare centre newly started to provide residential services for women and mothers. The drop-in centre in Žatec in the Ústí nad Labem region started its activities, providing services covering the district of Louny, and a needle exchange room was opened in Štětí. The Liberec region, after a 12-year interval, saw the reopening of a sobering-up station with a capacity of ten beds at the Liberec Regional Hospital in November 2012. In the Moravia-Silesia region, the ARKA civic association launched a support group for children and adolescents from 15 years of age overusing alcohol and for pathological gamers. The South Bohemia region saw an increase in the availability of outreach programmes, which managed to establish contact with formerly hidden groups of injecting drug users in smaller communities.

Table 5-3: The number of programmes per 100,000 inhabitants aged 15-64 by type and region and the ranking of the regions (Vavrinčíková et al., 2013)

Region	Low-threshold programmes		Drop-in centres		AT clinics		Outpatient addiction treatment centre		Detoxification		Substitution treatment		Inpatient AT care		Therapeutic community		Follow-up treatment programmes/ aftercare		Region's total ranking	
	Number	Ranking	Number	Ranking	Number	Ranking	Number	Ranking	Number	Ranking	Number	Ranking	Number	Ranking	Number	Ranking	Number	Ranking	**Points***	**Ranking**
Prague	0.8	13	0.4	13	1.6	2	3.2	1	4.8	2	1.3	1	3.1	3	0.0	11	0.3	6	**52**	**4-5**
Central Bohemia	0.8	12	0.5	11	0.6	6	1.3	12	1.0	9	0.3	8	0.0	14	0.2	6	0.1	11	**89**	**13**
South Bohemia	1.8	5	1.1	5	0.6	7	2.1	3	3.0	5	0.7	3	2.4	6	0.7	1	0.3	7	**42**	**2**
Pilsen	1.3	8	0.6	9	0.9	3	1.5	7	1.5	8	0.3	10	3.5	2	0.3	3	0.4	2	**52**	**4-5**
Karlovy Vary	2.4	2	1.3	2	0.3	10	1.6	5	0.0	14	0.5	6	0.0	14	0.0	12	0.0	14	**79**	**10**
Ústí nad Labem	2.7	1	1.4	1	0.5	9	1.9	4	0.5	12	0.2	13	1.8	7	0.2	7	0.4	4	**58**	**6**
Liberec	1.0	10	0.7	7	0.0	14	1.1	13	1.7	6	0.3	9	0.0	14	0.3	2	0.2	8	**83**	**12**
Hradec Králové	0.9	11	0.5	12	0.8	4	1.5	6	1.6	7	0.8	2	1.5	8	0.1	9	0.0	14	**73**	**8**
Pardubice	0.7	14	0.4	14	0.3	11	0.7	14	0.0	14	0.0	14	0.0	14	0.0	12	0.0	14	**121**	**14**
Vysočina	1.4	7	0.9	6	0.6	8	1.5	8	5.4	1	0.6	5	4.6	1	0.2	5	0.4	3	**44**	**3**
South Moravia	1.5	6	0.8	8	0.3	12	1.4	10	3.0	4	0.6	4	1.0	9	0.3	4	0.3	5	**62**	**7**
Olomouc	2.3	3	1.2	3	1.7	1	3.1	2	3.4	3	0.2	12	3.0	4	0.1	10	0.5	1	**39**	**1**
Zlín	2.1	4	1.2	4	0.2	13	1.3	11	1.0	10	0.3	11	2.6	5	0.0	12	0.1	10	**80**	**11**
Moravia-Silesia	1.1	9	0.7	10	0.7	5	1.4	9	0.6	11	0.5	7	0.6	10	0.2	8	0.2	9	**78**	**9**
Entire Czech Republic	**1.4**	–	**0.8**	–	**0.7**	–	**1.8**	–	**2.1**	–	**0.5**	–	**1.6**	–	**0.2**	–	**0.2**	–	–	–

*Note: * The sum of the rankings by type of service. The last column shows the ranking of the region in the drug services availability chart. The lower the value, the more accessible the drug services are.*

Table 5-4: Shortcomings in the network of drug services in 2012 mentioned in the annual reports on the implementation of the drug policy in the regions (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2013)

Region	Shortcomings in the network of drug services
South Bohemia	Absence of an outreach programme in the district of Tábor Low and uneven availability of outpatient treatment, including substitution treatment Absence of detoxification for adults Declining real expenditures to support a minimum network of services
Pilsen	Absence of outpatient psychiatric and psychotherapeutic care Absence of asylum housing or sheltered housing Absence of a crisis centre with beds
Karlovy Vary	Lack of residential treatment capacity Very limited availability of outpatient psychiatric, psychotherapeutic, and psychological care
Ústí nad Labem	Very limited availability of outpatient psychiatric and psychotherapeutic care
Liberec	Uneven availability of outpatient care and aftercare Absence of court-ordered treatment facilities Insufficient territorial coverage by outreach programmes
Hradec Králové	Absence of outreach programmes or insufficient coverage of certain areas by outreach programmes Low availability of psychiatric, hepatological, or dental care, drug users rejected by physicians
Pardubice	The network of services is totally inadequate Lack of AT and psychiatric clinics Absence of substitution treatment programmes, residential aftercare, day care centres, follow-up treatment, residential treatment, detoxification, and therapeutic communities
Vysočina	Absence of outpatient care in the districts of Pelhřimov and Havlíčkův Brod
South Moravia	Lack of street workers in Brno Excessive network of residential treatment facilities
Olomouc	Low availability of substitution treatment Insufficient support for specific primary prevention programmes
Zlín	Absence of a self-contained sobering-up station Absence of aftercare

Note: Other regions did not provide information about the weaknesses in their networks of services.

At the end of 2012 and the beginning of 2013, the Department of Addictology implemented a project entitled Needs Analysis of Children and Adolescents in Terms of Substance Use and Related Risk Behaviours in the Context of the Institutional Network of Services in Prague and Central Bohemia (Miovský et al., 2013). The study, funded by the Prague City Council, responded to the demand for a survey of the services for children and adolescents. The survey covered the institutional networks of general practitioners for children and adolescents, institutional educational facilities and institutional care facilities, social curators and social workers etc. A total of 241 facilities were contacted and 135 of them participated in the project. These facilities reported 2,583 addiction treatment clients in 2012. Through extrapolation to the whole network, the number of clients per year was estimated at 4-5 thousand. Conclusions indicated the unavailability of specialised outpatient addiction care and a need for a specialised addiction clinic with an enhanced medical component and follow-up day care programmes. The authors propose restoring the operation of the Apolinar Pediatrics and Adolescent Unit, today a part of the Department of Addictology, which functioned as a specialised regional centre in the 1960s and 1970s.

In March 2012, the Government Council for Drug Policy Coordination (GCDPC) discussed and approved a draft guidance document entitled Recommended Procedures for the Systematic Referral of Drug Users Released from Custody to Follow-up Care in Community Settings; see the chapter Social Reintegration (p. 122).

5.1.3 Quality of Drug Services

A review of the standards of professional competency for drug services (part of the GCDPC's certification system) was completed in May 2012.[95] The aims were to remove provisions that were unclear or ambiguous, clarify differences between the special and the general parts of the standards, streamline the standards, structure them better, and adjust evaluation; see also the 2011 Annual Report. In October 2012 the Government Council for Drug Policy Coordination (GCDPC) approved the piloting of the updated standards in practice, which took place from September 2012 to July 2013. A new and separate special standard for

[95] This was part of a project called Exchanging Experience and Disseminating Good Practice in the Field of Quality Control of Services for Drug Users (funded by the European Social Fund's Human Resources and Employment Operational Programme) implemented in 2009-2012 by the Centre for Quality in Social Services of the National Training Fund, a public service company.

services in prisons was drafted in 2012. However, there is no consensus in the professional community regarding this special standard. If this standard is adopted, the number of types of certified services will increase to ten.

A total of 156 programmes had valid certification from the GCDPC at the end of June 2013; see Table 5-5.

For detailed information on the system of the assurance of the professional competency of services for drug users (the certification system) see the special chapter in the 2009 Annual Report.

Table 5-5: The list of certified programmes by type in 2011-2013

Type of service	2011	2012	2013
Detoxification	2	1	2
Outreach programmes	49	50	49
Drop-in and counselling services	52	49	50
Outpatient treatment	15	13	18
Day-care programmes	1	1	1
Short- and medium-term inpatient treatment	2	2	2
Residential treatment in therapeutic communities	10	10	10
Outpatient aftercare programmes	16	17	17
Substitution treatment	8	8	7
Total	**155**	**151**	**156**

Note: As of 16 May 2011, 29 May 2012, and 28 May 2013.

5.2 The System for Collecting Data on Drug Users in Treatment

Data on drug users who use the services of treatment and counselling facilities are available from several data sources that mutually overlap to various degrees (for more information see the 2011 Annual Report). These are mainly:

- the National Health Information System (NHIS) administered by the Institute of Health Information and Statistics (IHIS) of the Czech Republic, which also collects data from inpatient and outpatient (psychiatric) healthcare facilities and data from the Substitution Treatment Register (NRULISL),
- the Register of Treatment Demands, administered by the Public Health Service, specifically the Public Health Service of the City of Prague, which conforms to the EMCDDA standard for collecting data on drug treatment demand,
- final project reports (from projects mainly carried out by NGOs) supported through the GCDPC subsidy proceedings.[96]

The first two of the above-mentioned systems are planned to be replaced by the National Drug Treatment Register; see the 2011 Annual Report.

5.3 Outpatient Treatment

5.3.1 Outpatient Psychiatric Treatment

Outpatient health services for users of alcohol and drugs are currently provided primarily in outpatient psychiatric clinics and so-called AT (alcohol and drug) clinics specialising in addiction treatment. In 2012, a total of 416 outpatient psychiatric departments and units reported treating patients using addictive substances (AT patients), i.e. patients with a primary diagnosis F10-F19. These are not solely specialised AT units, but include all outpatient psychiatric clinics that treated at least one alcohol/drug patient. Of the total number of facilities reporting care for AT patients, 343 (83%) were outpatient psychiatric clinics, 19 outpatient child psychiatry clinics, 4 outpatient sexology clinics, and 50 alcohol/drug treatment (AT) clinics; see Table 5-6.

[96] In this respect, the National Focal Point administers the UniData application for the integrated registration of clients and services (for more information see http://www.drogovesluzby.cz).

Table 5-6: The number of clinics and number of drug users in treatment, 2002-2012 (Nechanská, 2013c)

Year	Drugs other than alcohol, excluding tobacco		Alcohol		Addictive substances in total*	
	Number of clinics	Number of clients	Number of clinics	Number of clients	Number of clinics	Number of clients
2002	288	14,203	317	25,400	342	41,136
2003	312	15,786	340	25,017	368	42,881
2004	320	14,040	358	25,235	382	40,625
2005	337	16,394	379	27,440	401	44,971
2006	340	16,392	367	26,966	394	44,887
2007	311	15,684	348	25,342	367	42,196
2008	298	15,711	328	25,293	349	42,612
2009	298	16,343	331	24,206	346	41,419
2010	370	15,187	428	24,182	453	40,198
2011	394	14,535	428	23,643	454	39,033
2012	355	14,681	390	22,838	416	38,554

*Note: * including the treatment of tobacco users.*

The degree of specialisation in services for alcohol/drug (AT) patients can be judged by the proportion of patients using addictive substances out of the total number of clients of these clinics (Table 5-7), but also by the absolute number of AT patients treated in these clinics (Table 5-8). AT patients constituted a majority higher than 50% of the total number of patients of 53 outpatient facilities (13%) in total (52 outpatient facilities in 2011), of which 40 were AT clinics, 12 outpatient psychiatric clinics, and one an outpatient psychiatric clinic for children. More than 200 AT patients in their care were reported by 48 clinics in 2012 (the same as in 2011). In 2012, at least one of the two criteria was met by a total of 81 clinics (i.e. clinics where AT patients constituted more than 50% of the total number of patients or more than 200 persons), providing care to 57% of the total number of alcohol/drug patients. The proportion of patients treated for alcohol problems in these specialised clinics was lower (48%) than the proportion of patients treated for illicit drug use (70%). Of the 81 outpatient clinics, 36 were psychiatric clinics (including one child psychiatry unit) and 45 were alcohol/drug treatment clinics.

Table 5-7: Number of psychiatric outpatient facilities by type of department/unit, addictive substance, and proportion of the users of addictive substances treated in 2012 (Nechanská, 2013c)

Department/unit		Proportion of AT patients out of the total number of patients						Total
		0-10%	11-25%	26-50%	51-75%	76-90%	91-100%	
Number of outpatient units		**277**	**62**	**24**	**11**	**13**	**29**	**416**
Number of patients		**13,155**	**7,287**	**5,569**	**2,328**	**3,552**	**6,663**	**38,554**
Of whom	Alcohol	9,726	4,717	2,813	1,025	1,253	3,304	**22,838**
	Other drugs exluding tobacco	3,350	2,440	2,356	1,272	1,965	3,298	**14,681**
	Tobacco	79	130	400	31	334	61	**1,035**

Table 5-8: Number of psychiatric outpatient facilities by the number of users of addictive substances treated in 2012 (Nechanská, 2013c)

Department/ unit		Number of outpatient facilities								Total number of patients
		By number of AT patients								
		1-10	11-50	51-100	101-150	151-200	201-300	301-400	>400	**Total**
Addictive substances		66	147	93	45	17	24	9	15	**416**	**38,554**
Of whom	Alcohol	80	171	76	33	9	12	5	4	**390**	**22,838**
	Other drugs excluding tobacco	156	132	37	10	3	6	4	7	**355**	**14,681**

In 2012, there was a slight overall decrease by 479 to 38,554 patients. The number of alcohol users treated decreased (by 3%), mainly as a result of a "clean-up" in the records of one AT clinic in the Moravia-Silesia region. The number of patients using non-alcohol drugs excluding tobacco increased slightly in comparison with 2011 (by 1%), while the number of patients using tobacco increased more significantly (by 21%).

22,838 people were treated for alcohol use disorders, of whom 65% were men, 55% were aged 40-64, and 36% were aged 20-39. The proportion of patients aged 15-19 accounted for 2% and 7 children under 15 were treated.

In 2012, a total of 15,716 patients with disorders caused by the use of drugs other than alcohol were recorded, of whom 64% were men. More than two thirds of the patients with the diagnosis F11-F19 were in the 20-39 age group. The number of persons aged 15-19 amounted to 1,434 (9%) and there were 33 children of up to 15 years of age. For all the non-alcohol drugs that were monitored there was a higher proportion of men than women, except for sedatives and hypnotics, where the proportion of women was 60%.

Most users of drugs other than alcohol were treated for the problem use of opiates and opioids (25%), stimulants other than cocaine (22%), which, in the context of the Czech Republic, include primarily pervitin (19%), and polydrug use (21%). The proportion of patients treated for the use of cannabis reached 9% and that for those using sedatives and hypnotics was 14%. The number and proportion of users of other drugs was very low (Nechanská, 2013c); see Table 5-9.

Table 5-9: Development of the number of users of addictive substances treated in outpatient healthcare facilities in 1993-2012, by (groups of) addictive substances (Nechanská, 2013c)

Year	**Alcohol**	Opiates/opioids	of which heroin	non-prescription buprenorphine	non-prescription methadone	Cannabis	Sedatives and hypnotics	of which benzodiazepines	Cocaine	Other stimulants (excluding cocaine)	of which pervitin	Hallucinogens	Tobacco	Inhalants	Polydrug use	of which opiates and pervitin	opiates and other drugs excluding pervitin	pervitin and other drugs excluding opiates	Other	**Non-alcohol drugs, total**	Non-alcohol drugs excluding tobacco
1993	**49,102**	816	-	-	-	211	2,589	-	8	595	-	62	-	561	260	-	-	-	132	**5,234**	5,234
1994	**44,660**	653	-	-	-	291	2,561	-	8	706	-	87	-	380	558	-	-	-	367	**5,611**	5,611
1995	**32,956**	461	-	-	-	383	712	-	14	699	-	69	-	281	473	-	-	-	246	**3,338**	3,338
1996	**30,259**	1,619	-	-	-	474	761	-	20	1,471	-	84	-	347	685	-	-	-	480	**5,941**	5,941
1997	**31,691**	2,183	1,813	-	-	659	810	347	33	2,125	979	120	-	347	710	-	-	-	527	**7,514**	7,514
1998	**31,955**	2,255	1,823	-	-	1,039	1,011	456	95	2,896	2,436	127	-	370	1,148	-	-	-	491	**9,432**	9,432
1999	**28,022**	3,368	2,552	-	-	1,293	1,613	1,080	42	3,655	3,211	160	1,965	368	1,750	-	-	-	247	**14,461**	12,496
2000	**27,021**	3,815	3,176	-	-	1,152	1,122	491	52	3,169	2,695	244	1,277	280	1,430	-	-	-	159	**12,700**	11,423
2001	**28,582**	4,336	3,464	-	-	1,248	1,787	644	57	3,415	2,718	182	1,323	310	1,559	-	-	-	156	**14,373**	13,050
2002	**25,400**	4,029	3,171	-	-	1,505	2,292	774	63	3,185	2,719	232	1,533	261	2,480	-	-	-	156	**15,736**	14,203
2003	**25,017**	4,768	4,035	-	-	1,718	2,090	799	129	3,714	3,162	200	2,078	189	2,912	-	-	-	66	**17,864**	15,786
2004	**25,235**	4,592	3,644	-	-	1,354	2,257	1,014	79	3,025	2,579	170	1,350	180	2,279	-	-	-	104	**15,390**	14,040
2005	**27,440**	5,558	3,635	-	-	1,634	2,312	1,101	47	4,076	2,662	196	1,137	174	2,275	-	-	-	122	**17,531**	16,394
2006	**26,966**	4,640	3,357	-	-	1,681	2,190	1,153	45	3,746	3,055	137	1,529	187	3,631	-	-	-	135	**17,921**	16,392
2007	**25,342**	4,259	2,614	-	-	1,544	1,799	1,057	33	3,979	3,272	198	1,170	140	3,616	-	-	-	116	**16,854**	15,684
2008	**25,293**	4,585	3,055	-	-	1,620	2,229	1,408	73	4,103	3,330	177	1,608	79	2,489	-	-	-	356	**17,319**	15,711
2009	**24,206**	4,797	3,120	-	-	1,667	2,377	1,492	36	3,907	3,383	74	870	90	3,071	-	-	-	324	**17,213**	16,343
2010	**24,182**	4,458	3,118	-	-	1,477	2,379	1,461	59	3,361	3,003	63	829	114	2,936	-	-	-	340	**16,016**	15,187
2011	**23,643**	4,359	1,365	323	26	1,446	2,268	1,701	28	3,282	2,970	56	855	79	2,874	841	360	742	143	**15,390**	14,535
2012	**22,838**	3,984	1,256	285	18	1,426	2,241	1,858	31	3,450	3,150	60	1,035	64	3,252	1,103	197	1,224	173	**15,716**	14,681

Note: Separate data for heroin, benzodiazepines, and pervitin have been available since 1996 and for tobacco since 1998; buprenorphine, methadone (not prescribed), the combination of opiates and methamphetamine (with or without other drugs), the combination of opiates and other drugs without methamphetamine, and the combination of methamphetamine and other drugs without opiates have been tracked since 2011.

5.3.2 Opiate Substitution Treatment

From 2011 on, there are two sources of data about the number of patients in substitution treatment for dependence on opiates/opioids. The first source is the National Register of Users of Medically Indicated Substitution Substances (Substitution Treatment Register, NRULISL); the second source is the aggregated data from annual reports on the activities of psychiatric outpatient facilities and general practitioners for adults.

5.3.2.1 National Substitution Treatment Register

All physicians administering a substitution agent are obliged by law to report the individual patient's data to the Substitution Treatment Register, which has been operated in the country since May 2000. In 2012, patients in substitution treatment were reported by 59 healthcare facilities in total. The Pardubice region remains the only region that does not have an actively reporting facility (Nechanská, 2013f). Information on the development of the facilities is shown in Table 5-10 and the network of the registered facilities in Map 5-1.

Map 5-1: Network of healthcare facilities registered in the NRULISL electronic application, 2012 (Nechanská, 2013f)

During 2012, 2,298 patients (1,632 men and 666 women) were registered in the Substitution Treatment Register. Almost two thirds of these persons were aged 30-39 and a quarter of them were aged 20-29. The average age of the persons treated during the year was 32.8 years. The largest number of those treated came from Prague (41%), followed by the Central Bohemia (17%), Ústí nad Labem (15%), and South Bohemia (6%) regions. In 2012, 1,641 persons (71%) in the Register were treated with buprenorphine, while the remaining 657 persons were treated with methadone (Nechanská, 2013f); see Table 5-10.

Table 5-10: Development of the number of persons treated, number of reported treatment episodes, and number of completed treatment episodes in the NRULISL, 2000-2012, by gender (Nechanská, 2013f)

Year	Number of actively reporting facilities	Number of persons treated					Number of treatment episodes initiated			Number of treatment episodes completed		
		Men	Women	**Total**	of whom		Men	Women	**Total**	Men	Women	**Total**
					Methadone	Buprenorphine						
2000	7	173	72	**245**	245	0	207	86	**293**	72	30	**102**
2001	8	369	164	**533**	510	23	374	167	**541**	261	107	**368**
2002	8	393	167	**560**	511	49	265	106	**371**	265	110	**375**
2003	8	557	232	**789**	520	269	499	183	**682**	345	115	**460**
2004	8	605	261	**866**	546	320	375	136	**511**	430	159	**589**
2005	9	578	247	**825**	571	254	438	150	**588**	395	135	**530**
2006	12	652	286	**938**	586	352	455	175	**630**	378	145	**523**
2007	13	719	319	**1,038**	605	433	403	157	**560**	378	143	**521**
2008	24	949	407	**1,356**	689	667	621	266	**887**	389	179	**568**
2009	34	1,089	466	**1,555**	686	869	530	225	**755**	354	154	**508**
2010	45	1,500	613	**2,113**	744	1,369	830	330	**1,160**	445	170	**615**
2011	55	1,621	669	**2,290**	667	1,623	787	293	**1,080**	622	211	**833**
2012	59	1,632	666	**2,298**	657	1,641	612	234	**846**	482	189	**671**

In 2012, all the drugs used by newly reported clients at the beginning of their treatment started to be closely monitored. The most commonly used substance was heroin (48%), followed by diverted buprenorphine (32%), pervitin (22%), and prescription buprenorphine or methadone (20%).

5.3.2.2 Aggregated Reports of Substitution Treatment Provided by Outpatient Psychiatrists and General Practitioners

A total of 3,548 patients received substitution treatment from psychiatrists and general practitioners in 2012. Substitution treatment was reported by 56 outpatient psychiatric facilities and was provided to 2,357 patients (1,609 men and 748 women). More than 90% of these patients were aged 20-39, 9% were aged 40-64, and less than 1% were aged 15-19. Substitution treatment was also reported by 316 general practitioners for adults and was provided to 1,191 persons in total (748 men and 443 women). Most general practitioners had one patient in their care; only three of them treated 2-5 patients (Nechanská, 2013f); see Table 5-11.

Table 5-11: Substitution treatment for addiction to opiates/opioids provided by psychiatrists and general practitioners for adults in 2011-2012 (Nechanská, 2013f)

Year	Psychiatric clinics				General practitioners for adults			
	Number of patients			**Number of facilities**	Number of patients			**Number of facilities**
	Men	Women	**Total**		Men	Women	**Total**	
2011	1,900	886	**2,786**	**67**	776	530	**1,306**	**357**
2012	1,609	748	**2,357**	**56**	748	443	**1,191**	**316**

5.3.2.3 A Survey on Substitution Treatment among Physicians in the Czech Republic

In November and December 2012, there was a regular survey among physicians in the Czech Republic, an exercise conducted every two years by the INRES-SONES agency. On the initiative of the National Focal Point, the survey included a battery of questions concerning the prevalence of problem drug use and pathological gambling and also the experience of physicians with the provision of substitution treatment (Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES, 2013a); for results concerning problem drug use see the chapter Problem Drug Use (p. 48).

A total of 1,200 physicians from across the country were surveyed. This was a representative quota sample with respect to gender, age, mode of practising medicine (private practitioners or others), and region. 328 physicians (21.5% of the respondents) refused to give an interview. At the request of the National Focal Point the number of general practitioners for adults and general practitioners for children and adolescents was increased to approximately twice their actual representation in the population of physicians in the Czech Republic because of the prevalence estimates of problem drug users. Therefore, the sample cannot be considered representative in terms of the physician's specialisation.

A total of 40 physicians (3.3%) out of the whole sample stated that they provided substitution treatment for dependency on opioids to a total of 280 patients, an average of 7.0 patients per prescriber and 0.2 per physician in total; see Table 5-12.

Table 5-12: Physicians providing substitution and the number of patients on substitution in the survey among physicians in the Czech Republic, 2012 (Národní monitorovací středisko pro drogy a drogové závislosti & INRES-SONES, 2013a)

Specialisation	Total in the sample	Provide substitution		Number of patients on substitution		
		Number	%	Total	Average per prescriber	Average per all physicians
General practitioner for adults	341	22	6.5	87	4.0	0.26
General practitioner for children and adolescents	210	5	2.4	17	3.4	0.08
Gynaecology, obstetrics	159	2	1.3	13	6.5	0.08
Surgery	99	4	4.0	54	13.5	0.55
Internal medicine	87	1	1.1	10	10.0	0.11
Psychiatry	6	1	16.7	2	2.0	0.33
Other*	298	5	1.7	97	19.4	0.33
Total	**1,200**	**40**	**3.3**	**280**	**7.0**	**0.23**

Note: These include 1 oncologist and 2 orthopaedists who prescribed "a drug as part of substitution treatment for opiate/opioid dependence" to 94 patients in total – one may not rule out the possibility that this was treatment of pain using a preparation containing buprenorphine.

The proportions of prescribing physicians by their specialisation and the average number of patients on substitution per physician correspond with the results of the same survey in 2010; for details see the 2010 Annual Report.

Given the structure of the sample and the results based on specialisation, the number of patients on substitution was only estimated in general practitioners for adults and general practitioners for children and adolescents; the results from the sample were extrapolated to a total of 5,290 general practitioners for adults (Chudobová, 2013) and 2,075 general practitioners for children and adolescents in outpatient clinics in the Czech Republic in 2012 (Marková, 2013).

Table 5-13: Estimated number of patients in substitution treatment provided by general practitioners for adults and by general practitioners for children and adolescents, 2012 (Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES, 2013a)

Gender	Indicator	General practitioners for adults			General practitioners for children and adolescents		
		Total number of patients in treatment	of whom those treated with		Total number of patients in treatment	of whom those treated with	
			Buprenorphine	Buprenorphine combined with naloxone		Buprenorphine	Buprenorphine combined with naloxone
Men	Central value	621	465	171	118	0	94
	95% CI lower limit	158	34	13	0	-	0
	95% CI upper limit	1,083	897	328	310	-	280
Women	Central value	729	527	186	71	35	24
	95% CI lower limit	208	78	0	0	0	0
	95% CI upper limit	1,250	977	448	144	87	70
Total	**Central value**	**1,350**	**993**	**357**	**189**	**35**	**118**
	95% CI lower limit	**455**	**192**	**0**	**0**	**0**	**0**
	95% CI upper limit	**2,244**	**1793**	**747**	**436**	**87**	**351**

It can be estimated that in 2012 approximately 340 general practitioners for adults and 50 general practitioners for children and adolescents provided substitution treatment with buprenorphine-based preparations to 1,350 and 190 patients, respectively, i.e. approximately 1,500 patients in total. Compared to 2010, the estimated number of prescribers and the share of the composite formulation with naloxone (Suboxone®) increased; the estimated number of patients treated by general practitioners for adults (the number of general practitioners for children and adolescents was not estimated in 2010) remained the same (800 to 1,300 patients in 2010); see the 2010 Annual Report. In a similar survey in 2007, 240 general practitioners were estimated to prescribe Subutex® to 1,360 patients and 150 psychiatrists to prescribe Subutex® to 3,000 patients; see the 2007 Annual Report. The estimated 1,350 patients receiving substitution treatment from general practitioners corresponds well with the data from the aggregated IHIS report.

Other questions in the survey concerned reporting to the Substitution Treatment Register (NRULISL). The responses show that 82.5% of the physicians providing substitution treatment are registered, which is more than in 2010 (71.0%). The level of reporting individual patients to the register also increased compared to 2010; for example, 35.5% of the physicians providing substitution treatment always reported their cases to the register in 2010; see Table 5-14.

Table 5-14: Registration in the NRULISL and reporting of patients to the NRULISL by physicians in the survey among physicians in the Czech Republic, 2012 (Národní monitorovací středisko pro drogy a drogové závislosti & INRES-SONES, 2013a)

Specialisation	Number of physicians providing substitution treatment	Registered in the NRULISL		Reporting to the NRULISL					
				Always		Sometimes		Never	
		Number	%	Number	%	Number	%	Number	%
General practitioner for adults	22	21	95.5	13	59.1	7	31.8	2	9.1
General practitioner for children and adolescents	5	3	60.0	1	20.0	2	40.0	2	40.0
Gynaecology, obstetrics	2	2	100.0	2	100.0	0	0.0	0	0.0
Surgery	4	1	25.0	0	0.0	1	25.0	3	75.0
Internal medicine	1	1	100.0	0	0.0	1	100.0	0	0.0
Psychiatry	1	1	100.0	0	0.0	1	100.0	0	0.0
Other	5	4	80.0	2	40.0	2	40.0	1	20.0
Total	**40**	**33**	**82.5**	**18**	**45.0**	**14**	**35.0**	**8**	**20.0**

5.3.2.4 Problem Use of Substitution Substances

There were an estimated 6,300 problem (mainly injecting) buprenorphine users in the Czech Republic in 2012 (4,600 in 2011); see the chapter entitled Problem Drug Use (p. 48).

The populations of patients in substitution treatment using products containing buprenorphine and the problem users of buprenorphine, or the clients of low-threshold services, overlap. The Multiplier 2013 survey (for more details see the chapter entitled Problem Drug Use on p. 48) among clients of low-threshold facilities determined the number of problem opiate users included in a substitution treatment programme, which was calculated as a weighted average of the proportion of problem drug users that the respondent knows and who, at the same time, receive substitution treatment.

The results show that 14.3% (95% CI: 13.7-14.8%) of the problem drug users in the Czech Republic are currently in substitution treatment and the central estimate of the number of clients in substitution treatment among problem drug users in 2012 is thus approximately 5,900 people (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a); see Table 5-15. In 2010, the proportion of problem drug users participating in substitution treatment was estimated to be 8% (95% CI: 7-10%) and the estimated number of problem drug users in substitution treatment reached 3,000 in 2010 (Národní monitorovací středisko pro drogy a drogové závislosti, 2010a).

Table 5-15: Estimated number of clients in substitution treatment in 2012 among problem drug users in the Czech Republic, by region (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a)

Region	Number of problem drug users	Substitution multiplier (central value in %)	Number of persons in substitution treatment		
			Central estimate	95% CI	
				lower limit	upper limit
Prague	14,600	23.3	3,397	3,358	3,436
Central Bohemia	2,500	23.8	588	579	597
South Bohemia	2,000	12.5	248	246	250
Pilsen	1,250	9.4	118	116	119
Karlovy Vary	1,950	2.6	51	51	52
Ústí nad Labem	4,600	8.4	387	385	389
Liberec	1,750	2.0	34	34	35
Hradec Králové	1,050	15.9	170	167	172
Pardubice	1,000	3.8	38	37	38
Vysočina	750	4.6	35	35	35
South Moravia	2,650	12.7	339	334	344
Olomouc	2,350	4.2	100	99	100
Zlín	1,850	8.2	152	108	196
Moravia-Silesia	3,000	7.8	234	234	234
Entire Czech Republic	**41,300**	**14.3**	**5,891**	**5,654**	**6,127**

The estimated number of problem drug users in substitution treatment, in the context of problem drug use estimates as such, should be considered only as a guide. The overlap between substitution treatment and needle exchange programmes is a positive factor increasing the preventive effect of both harm reduction interventions (Hagan et al., 2011, Turner et al., 2011).

5.3.2.5 Import and Distribution of Substitution Drugs

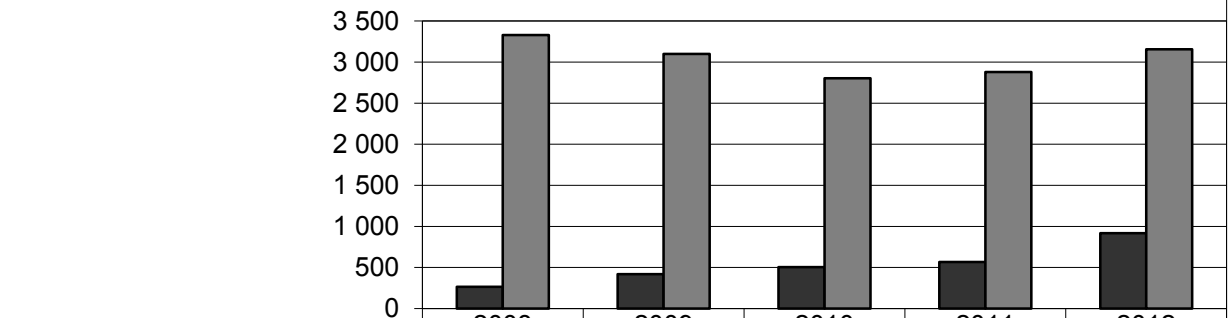
In 2012, no new product for substitution treatment for opiate dependence was introduced to the Czech market; see the 2011 Annual Report. Substitution drugs are administered only orally during treatment in the Czech Republic and may be prescribed by any physician, regardless of their specialisation. The only substitution drug partly funded from public health insurance from 2010 on is Suboxone® 8 mg, but because of the way the conditions are set reimbursement still does not happen in practice; see also the 2010 Annual Report. The purchase of the methadone substance is covered by the Ministry of Health.

In 2012, 18.0 kg of pure methadone substance was imported to the Czech Republic and 4.1 kg of buprenorphine were distributed in the preparations Buprenorphine Alkaloid®, Ravat®, Suboxone®, and Subutex®, each in a package of 7 sublingual tablets, and in two different strengths of 2 mg and 8 mg per tablet (Ministerstvo zdravotnictví ČR, 2013b); see Table 5-16. Since 2008 there has been an increase in the consumption of buprenorphine in the composite preparation Suboxone®, which also contains naloxone in addition to buprenorphine; see Graph 5-1.

Table 5-16: Amounts of substitution drugs imported (methadone) and distributed (buprenorphine), 1999-2012 (Ministerstvo zdravotnictví ČR, 2013b)

Year	Methadone - imports (kg)	Buprenorphine - distribution (g)
1999	13.5	0.0
2000	11.7	23.5
2001	0.0	86.2
2002	0.0	509.8
2003	8.1	1,309.4
2004	11.3	2,221.9
2005	5.7	2,957.3
2006	12.2	3,414.3
2007	10.8	3,315.0
2008	12.6	3,594.5
2009	15.4	3,517.0
2010	22.5	3,308.0
2011	24.3	3,446.8
2012	18.0	4,075.1

Graph 5-1: Amounts of buprenorphine distributed in single-drug products and composite product combined with naloxone, 2008-2012, in grams (Ministerstvo zdravotnictví ČR, 2013b)



	2008	2009	2010	2011	2012
Suboxone® (buprenorphine plus naloxone)	,264,7	,418,3	,503,7	,566,7	,918,2
Preparations containing buprenorphine only	3,329,8	3,098,7	2,804,4	2,880,0	3,156,9

5.3.3 Sobering-up Stations

In 2012 there were 17 sobering-up stations[97] with 152 beds in the Czech Republic and they were to be found in all regions except the Ústí nad Labem and Liberec regions.[98] The development of the capacity of the sobering-up stations and the number of patients treated in them is shown in Graph 5-2.

In 2012 a total of 28,469 persons were treated in sobering-up stations, and 84% of those treated in 2006-2012 were men (Nechanská, 2013a). Of the total number of those brought to sobering-up stations, 83% were intoxicated with alcohol and 17% with other drugs. The proportion of non-alcohol drug intoxication was higher in women (22%) than men (17%); see

[97] Act No. 379/2005 Coll. formally introduced the term "sobering-up and drug detoxification station".
[98] The sobering-up station in Liberec was reopened in November 2012 but was not registered with the Institute of Health Information and Statistics as of the end of 2012.

Table 5-17.

Graph 5-2: Development of the capacity of sobering-up stations and the number of patients treated, 1989-2012 (Nechanská, 2013a)

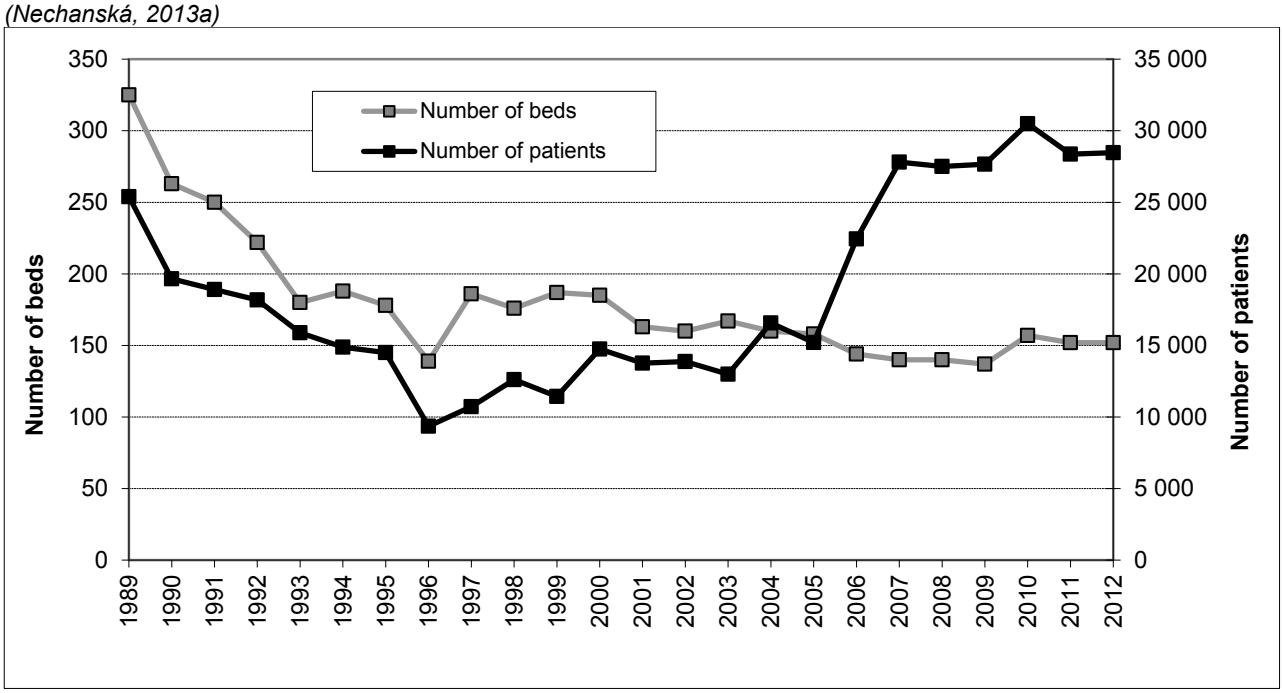


Table 5-17: Number of persons treated for intoxication with alcohol and non-alcohol drugs, by gender and age group, 2011-2012 (Nechanská, 2013a)

Year	Total number of patients	Gender		Age		
		Men	Women	0-19 years	20-64 years	65 years and over
Alcohol						
2011	**23,429**	19,381	4,048	1,631	20,432	1,366
2012	**23,501**	19,952	3,549	810	21,386	1,305
Drugs other than alcohol						
2011	**3,760**	3,412	348	396	3,251	113
2012	**4,968**	3,968	1,000	709	4,062	197
Total						
2011	**26,807**	22,526	4,281	1,948	23,406	1,453
2012	**28,469**	23,920	4,549	1,519	25,448	1,502

Two documents were published on the topic of sobering-up stations in 2013. One of them addressed the European context of the provision of services such as sobering-up stations and presented the results of a survey conducted within the Reitox network on this topic (Mravčík et al., 2013). The results show that a specific system of care for intoxicated persons that is more or less similar in terms of how it functions to the system of sobering-up stations as we know it in the Czech Republic exists in approximately a third of European countries, where it performs essentially the following basic functions:

- providing primary medical supervision and care for intoxicated persons if they cannot be cared for otherwise,
- preventing harm to health while in a state of intoxication, such as accidents, hypothermia, and suffocation as a result of the inhalation of vomit,
- providing basic information about the harmful effects of alcohol and other drugs, counselling, and motivation for further treatment,
- establishing a referral system for indicated patients to refer them to a network of addiction treatment facilities and other health and social services,
- resolving and preventing threats to other persons, public order, and property caused by the behaviour of intoxicated people.

In addition, the special system of care for intoxicated persons provides a safeguard to ensure that the system for providing intensive healthcare on one hand, and the law enforcement system on the other hand, are not overused and abused.

Previously presented in a preliminary form in the 2011 Annual Report, the results of a survey on the current state of the network of sobering-up stations in the Czech Republic were also published (Burešová et al., 2013). A questionnaire survey was conducted between May 2011 and January 2012 in all the 17 sobering-up stations in operation at the time. Data were collected via an online questionnaire, which was filled in by representatives of the individual facilities. For the purposes of verification and accuracy, this was combined with the telephone interview method. As of 1 Februry 2012, there were 17 sobering-up stations in 12 regions, with a total capacity of 150 beds. The capacity was assessed as being inadequate, especially in large cities. The client is most frequently brought to the sobering-up station by the Police of the Czech Republic or the city/municipal police, but the decision concerning admission to the unit is solely in the hands of the physician on duty at the facility. The clients of sobering-up stations do not usually include minors. Adult clients are not further reported anywhere by half of the sobering-up stations. Only a quarter of the sobering-up stations cooperate with the alcohol and drug treatment clinics (AT clinics) in their catchment area. There are more and more cases in which the clients of the sobering-up stations are intoxicated with substances other than alcohol. In addition to safe detoxification, the sobering-up stations provide clinical examination by a physician and the possibility of deploying emergency services in the event of sudden changes in the client's state of health. The most common problems for the Czech sobering-up stations, from the perspective of their operators, include the clients' insolvency, expensive debt recovery, inadequate facilities, and a lack of adequate follow-up addictological care. The operation of the station is often solely in the hands of the middle or junior medical staff, while the physician is only present to admit/release the client, otherwise remaining on duty to be called in if necessary. The amount that each client is charged for their stay in the sobering-up station ranges from CZK 600 (€ 24) to CZK 8,900 (€ 354). The results show that there are significant differences in the availability and scope of the services of the sobering-up stations in the Czech Republic, even within one and the same region, and that it would be desirable to provide a legislative or methodological framework to lay down the conditions under which the sobering-up stations operate.

5.3.4 Crisis Centres and Psychotherapy Clinics

Other healthcare facilities providing care for alcohol/drug patients include crisis centres and psychotherapy clinics. Collected by the Institute of Health Information and Statistics of the Czech Republic, information on the activities of these facilities is presented for the first time this year (Ústav zdravotnických informací a statistiky, 2013f). In 2012 care for drug users was reported by two crisis centres (with 84 patients) and 7 therapy clinics (with 287 patients). An overview of the crisis centres and psychothery clinics is provided in Table 5-18 and the development of the number of patients treated is shown in Table 5-19.

Table 5-18: Overview of crisis centres and psychotherapy clinics, 2012 (Ústav zdravotnických informací a statistiky, 2013f)

Name of facility	Location
Psychotherapy clinics	
Ondřejov Day-care Psychotherapy Sanatorium	Prague 4
Fokus Praha	Prague 6
SANANIM Day-care Centre	Praha 7
ESET Psychotherapy Clinic	Prague 11
Psychiatric Day-care Centre of the Pilsen University Hospital	Pilsen
Day-care Sanatorium, Brno Psychiatric Hospital	Brno
Elysium Day-care Psychotherapy Sanatorium, *Podané ruce* Association	Brno
Crisis centres	
RIAPS Crisis Centre, Prague Centre for Social Services	Prague 3
Ondřejov Day-care Psychotherapy Sanatorium, Crisis Centre	Prague 11

Table 5-19: Development of the number of crisis centres and psychotherapy clinics and the number of patients, 2009-2012 Ústav zdravotnických informací a statistiky, 2013f)

Year	Number of facilities	Number of patients					
		Alcohol			Other addictive substances		
		Men	Women	**Total**	Men	Women	**Total**
Crisis centre							
2009	2	24	12	**36**	14	11	**25**
2010	2	24	12	**36**	44	23	**67**
2011	3	27	22	**49**	32	33	**65**
2012	2	21	12	**33**	33	18	**51**
Psychotherapy clinic							
2009	9	117	78	**195**	37	38	**75**
2010	9	9	17	**26**	19	37	**56**
2011	8	60	61	**121**	25	41	**66**
2012	7	39	45	**84**	116	87	**203**

Starting from October 2013, the SANANIM Day-care Centre will launch a group therapy programme for cannabis users with a frequency of once a week for a period of 3 months.[99]

5.3.5 Outpatient Treatment Provided by NGOs

Outpatient treatment in the Czech Republic is also provided by NGOs. In most cases, they are co-financed from the public budget through subsidy proceedings, although some of these services also have the status of an accredited healthcare facility and are funded from the system of public health insurance. In 2012 the Government Council for Drug Policy Coordination supported 11 outpatient programmes that provided services to a total of 3,000 clients, of whom almost 1,400 were drug users. The average age of the clients using drugs exceeded 30 years for the first time during the reporting period. A total of 759 (54.4%) clients injected drugs; 671 (48.1%) used pervitin, 138 (9.9%) heroin, 125 (9.0%) cannabis, and 121 (8.7%) diverted buprenorphine. Although the number of outpatient services supported by the GCDPC subsidy proceedings has been decreasing during the years monitored, it can be stated that there is a continuous decrease in the proportion of heroin users and at the same time an increase in the average age of drug users in outpatient services. Comparisons across 2004-2012 are given in Table 5-20.

[99] http://www.sananim.cz/aktuality/129/denni-stacionar-sananim-otevira-skupinu-pro-uzivatele-marihuany.html (13 September 2013)

Table 5-20: Outpatient treatment programmes run by NGOs and selected characteristics of their clients, 2004-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Indicator	2004	2005	2006	2007	2008	2009	2010	2011	2012
Number of programmes supported by subsidies	20	18	15	13	13	15	13	12	11
Number of clients	2,506	3,127	4,301	3,044	3,958	3,833	3,304	3,334	2,998
Number of drug users	1,493	1,743	2,428	1,642	2,379	2,130	1,813	1,524	1,395
– of whom injecting drug users	697	1,034	1,024	708	940	873	774	754	759
– of whom pervitin users	540	540	771	511	644	834	720	744	671
– of whom cannabis users	339	158	405	101	133	194	193	136	125
– of whom heroin users	223	391	240	256	367	274	215	170	138
– of whom buprenorphine users	–	126	110	116	96	70	72	73	121
Average age of users of drugs other than alcohol	25.9	26.8	29.6	26.3	28.6	27.6	26.4	25.6	30.7

The Sunflower Garden programme operated by the Centre for the Family, a part of the Drop In public service company, published the results of its evaluation study (Doležalová, 2013). The programme consists of comprehensive multidisciplinary care for mothers using drugs and their children aged 3 years and above. The programme's main focal areas are truancy prevention, risk behaviour in children, and the removal of a child from parental care. The programme uses both its own methodology as well as an adopted one (Sedláčková and Hošková, 2011, Kárová, 2007). The sample consisted of 70 children with a mean age of 6 years, 46 mothers, 35 grandmothers, and 4 fathers. The mothers of 27 (38.6%) of the 70 children used pervitin before or during pregnancy, 14 (20.0%) used heroin, 11 (15.7%) used alcohol, and 4 (5.7%) were polydrug users. The evaluation was conducted using standardised screening and diagnostic tools, clinical interviews, and a questionnaire administered one year after entering the programme. The results were adjusted for the children's age. It turned out that the children in the programme achieved improvements in both fine and gross motor skills, speech, and language skills. There was no improvement in attention deficit disorders and behavioural disorders, most probably because of their underlying biological causes.

5.4 Residential Treatment

5.4.1 Detoxification Units

Detoxification from addictive substances was provided in 31 inpatient facilities in 2012 (i.e. two more than in 2011), of which 5 were university hospitals, 13 acute care hospitals, and 13 psychiatric hospitals; see Table 5-21. The Karlovy Vary region was the only one that did not provide detoxification to alcohol/drug patients. The largest numbers of facilities were located in Prague and the South Moravia and Moravia-Silesia regions (4 facilities each), then in the South Bohemia and Olomouc regions (3 facilities each), followed by the Pilsen, Ústí nad Labem, Pardubice, Hradec Králové, and Vysočina regions, each having 2 facilities. There was only one facility providing detoxification from addictive substances in each of the other regions (Nechanská, 2013e).

Table 5-21: The network of inpatient facilities providing detoxification to alcohol/drug patients and the numbers of dedicated beds in detoxification units, 2010-2012 (Nechanská, 2013e)

Year	Dedicated beds								Number of facilities with non-dedicated beds				Facilities providing detoxification, total
	University hospitals		Hospitals (acute care)		Psychiatric hospitals		**Total**						
	Number of facilities	Number of beds	Number of facilities	Number of beds	Number of facilities	Number of beds	**Number of facilities**	**Number of beds**	University hospitals	Hospitals (acute care)	Psychiatric hospitals	**Total**	
2010*	-	-	-	-	-	-	**16**	**163**	-	-	-	**12**	**28**
2011	3	29	5	39	9	82	**17**	**150**	2	8	2	**12**	**29**
2012	3	29	5	41	9	85	**17**	**155**	2	8	4	**14**	**31**

*Note: * Detailed data about the facilities and patients have only been collected since 2011.*

In total, 17 facilities had 155 beds dedicated to the detoxification of alcohol/drug patients (5 beds more than in 2011). Most beds were in the (male and female) detoxification units in the Bohnice Psychiatric Hospital in Prague, with 19 beds in total, while the Military Hospital in Olomouc had 15 dedicated beds. The psychiatric hospital in Havlíčkův Brod, University Hospital in Brno, and Child and Adolescent Detoxification Centre at the

Hospital of the Sisters of Mercy of St. Charles Borromeo in Prague had 14 beds. The smallest number of beds (2) was reported by the detoxification unit at the Central Military Hospital in Prague.

A total of 9,124 patients were hospitalised for detoxification from addictive substances in 2012. The largest proportion of patients was hospitalised in both dedicated and non-dedicated beds for detoxification from alcohol (55%, i.e. 5,021 patients), a combination of multiple substances (20%), other stimulants, primarily pervitin (14%), and opiates/opioids (5%); see Table 5-22. In 2012 the highest proportion of detoxification from alcohol (26%) and other addictive substances (31%) was recorded in Prague, where AT patients were hospitalised in four detoxification units with more than a quarter of all the dedicated beds in the Czech Republic. More than two thirds of the total number of detoxified patients were men, while more than 7% were children and adolescents under 19 years of age (Nechanská, 2013e).

Table 5-22: Number of persons hospitalised for detoxification from addictive substances, 2011-2012 (Nechanská, 2013e)

Year	**Number of facilities**	**F10 (alcohol)**	F11 (opiates/opioids)	F12 (cannabis)	F13 (sedatives/hypnotics)	F14 (cocaine)	F15 (other stimulants)	F16 (hallucinogens)	F17 (tobacco)	F18 (inhalants)	F19 (other psychoactive substances)	F19 (polydrug use)	**Drugs other than alcohol, total**	**Total number of people**
2011	**29**	**3,960**	442	196	220	13	1,034	4	2	4	10	1,276	**3,201**	**7,161**
2012	**31**	**5,021**	477	213	273	19	1,284	5	6	12	20	1,794	**4,103**	**9,124**

Detoxification was also provided in 4 prisons in 2012; see the chapter entitled Responses to Drug-related Health Issues in Prisons (p. 138).

5.4.2 Psychiatric Inpatient Facilities

In the Czech Republic, inpatient treatment of patients addicted to drugs is predominantly provided by psychiatric hospitals and hospital-based psychiatric wards. In psychiatric hospitals, in particular, this type of care was provided in specialised addiction treatment units. While there was a further decline in the number of beds in psychiatric hospitals in 2012, the number of beds in alcohol/drug treatment units increased slightly. The number of psychiatric wards in hospitals decreased (Nechanská, 2013d). Data on the number of facilities (wards), beds, and patients are given in Table 5-23.

Table 5-23: Number of inpatient psychiatric facilities and their total capacity and utilisation by users of drugs other than alcohol (excluding tobacco), 2002-2012 (Nechanská, 2013d)

Year	**Psychiatric hospitals for children**			**Psychiatric hospitals for adults**				**Psychiatric wards in hospitals**			**Other inpatient facilities***		
	Number	Total number of beds	Number of patients	Number	Total number of beds	of which AT beds	Number of patients	Number	Total number of beds	Number of patients	Number	Total number of beds	Number of patients
2002	4	368	13	17	9,677	1,194	2,494	33	1,546	1,200	2	66	10
2003	4	368	17	17	9,609	1,275	2,536	33	1,517	1,480	2	66	5
2004	4	368	27	17	9,583	1,266	2,880	33	1,501	1,763	2	66	6
2005	3	320	27	17	9,538	1,316	3,104	32	1,439	1,584	3	126	115
2006	3	320	29	17	9,442	1,347	3,200	31	1,420	1,846	3	126	211
2007	3	320	16	16	9,307	1,347	3,489	32	1,419	1,834	3	126	158
2008	3	300	25	16	9,240	1,319	3,527	32	1,396	1,708	3	126	168
2009	3	260	21	17	9,207	1,330	3,578	31	1,383	1,709	3	126	156
2010	3	260	31	17	9,058	1,314	3,550	31	1,374	1,644	3	126	131
2011	3	260	32	18	8,994	1,305	3,976	31	1,328	1,466	2	66	13
2012	3	250	24	18	8,847	1,315	4,185	30	1,268	1,644	2	66	19

*Note: * These are psychiatric wards in other specialised treatment institutions and other inpatient facilities.*

After a period showing a decline in the number of hospitalisations for substance use disorders (i.e. a primary diagnosis F10-F19), there was again a slight increase (by 1%) to 15,419 in 2012. This increase is attributable mainly to hospitalisations related to illicit drug use, the number of which increased by more than 7% to 5,872. The number of hospital admissions for alcohol use disorders decreased by more than 2% to 9,544 in 2012.

Patients with the primary diagnosis F10 accounted for almost two thirds of all hospital admissions for disorders caused by psychoactive substances, while men represented more than 68%. More than a half (55%) of those patients were aged 40-59 and 79% of the patients were aged 30-59. Hospital admissions of 3 child patients aged 0-14 and 83 juvenile patients aged 15-19 were recorded. In terms of regional distribution, most alcohol-related hospital admissions were recorded in patients from the Olomouc, Zlín, and Moravia-Silesia regions.

As regards hospitalisations for disorders caused by the use of drugs other than alcohol, the most common cause was polydrug use (55%), followed by the use of stimulants other than cocaine (34%) and the use of opiates/opioids (7%). Nearly half of the illicit drug users admitted to hospitals (45%) were aged 20-29, 28% were aged 30-39, 12% were aged 15-19, and there were 32 children under 15. The majority of those admitted to hospital in connection with drugs other than alcohol were males (67%). An exception to this is the diagnosis F13 (sedatives and hypnotics), where almost 42% of the patients were aged 42-59 and the majority (68%) were females. In terms of regional distribution, the largest numbers of patients admitted to hospitals in connection with illicit drug use had their permanent residence in the Ústí nad Labem region and Prague. The development of hospitalisations for each group of addictive substances is shown in Table 5-24.

Table 5-24: Development of the number of hospitalisations for disorders caused by alcohol and other psychoactive substances in inpatient psychiatric facilities, 1997-2012 (Nechanská, 2013d)

Year	**F10 (alcohol)**	F11 (opiates/opioids)	F12 (cannabis)	F13 (sedatives/hypnotics)	F14 (cocaine)	F15 (other stimulants)	F16 (hallucinogens)	F17 (tobacco)	F18 (inhalants)	F19 (polydrug use)	**Non-alcohol drugs (excluding tobacco)**	**Addictive substances total**
1997	**10,240**	1,170	48	162	7	895	26	6	139	994	**3,441**	**13,687**
1998	**10,060**	1,625	57	175	6	1,198	64	0	138	1,281	**4,544**	**14,604**
1999	**9,597**	2,072	60	153	9	1,083	39	0	110	1,228	**4,754**	**14,351**
2000	**9,958**	2,328	65	154	5	901	41	1	135	1,454	**5,083**	**15,042**
2001	**10,241**	2,084	79	165	5	816	33	1	106	1,498	**4,786**	**15,028**
2002	**10,561**	918	92	153	9	926	16	2	128	1,475	**3,717**	**14,280**
2003	**11,139**	989	112	155	13	986	15	6	153	1,615	**4,038**	**15,183**
2004	**11,738**	1,068	96	200	3	1,230	21	2	129	1,929	**4,676**	**16,416**
2005	**11,984**	988	118	227	9	1,292	15	1	94	2,087	**4,830**	**16,815**
2006	**11,053**	915	152	246	7	1,681	9	2	107	2,169	**5,286**	**16,341**
2007	**10,877**	907	150	227	3	1,731	12	0	80	2,387	**5,497**	**16,374**
2008	**10,722**	735	165	280	3	1,594	13	4	50	2,588	**5,428**	**16,154**
2009	**10,419**	713	181	306	6	1,552	5	2	67	2,634	**5,464**	**15,885**
2010	**10,003**	696	199	306	2	1,626	9	3	42	2,476	**5,356**	**15,362**
2011	**9,765**	448	185	354	5	1,723	5	1	22	2,745	**5,487**	**15,253**
2012	**9,544**	396	215	345	2	1,873	3	3	27	3,011	**5,872**	**15,419**

5.4.3 Therapeutic Communities for Drug Users

There are 11 therapeutic communities associated in the specialist section of the Association of Non-Governmental Organisations (A.N.O.).[100] As of August 2013, there were 14 programmes in the Czech Republic in the Register of Social Services Providers maintained by the Ministry of Labour and Social Affairs registered as therapeutic communities whose primary target group is people at risk of dependency on addictive substances or dependent on them.[101] Nine therapeutic communities were supported in the GCDPC subsidy proceedings in 2012. Final reports on project implementation, and therefore, the details of the clients and the services provided are available from the nine communities supported by the GCDPC (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f); see Table 5-25. The capacity of these therapeutic communities in 2012 was 158 beds and a total of 402 drug users with an average age of 27.3 years underwent treatment in them. Of the total number of clients in therapeutic communities, 342 (85.1%) had injected drugs prior to treatment; 303 (75.4%) had used pervitin and 55 (13.7%) heroin. There were no significant changes in the structure of the clients compared to 2011. The average age of the clients entering treatment communities increased further, while the number of opiate users decreased further, a trend observed in other types of services (e.g. outpatient and low-threshold services) as well. In 2012, 108 clients

[100] http://www.asociace.org/sekce-terapeutickych-komunit-clenske-organizace.html (21 August 2013)
[101] http://iregistr.mpsv.cz/ (21 August 2013)

(26.9%) successfully completed their treatment programme. 145 clients (36.1%) dropped out of the treatment, 27 of them terminating treatment within two weeks of its commencement, and another 60 clients left treatment within three months of starting. The average duration of the treatment of all clients was 196 days.

Table 5-25: Therapeutic communities supported by GCDPC subsidies and their clients, 2003-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Indicator	2003	2004	2005	2006	2007	2008	2009	2010	2011*	2012
Number of communities	17	14	12	12	11	10	10	10	10	9
Capacity	238	218	183	185	169	138	160	160	158	154
Number of clients	510	546	491	451	472	427	349	408	402	401
– injecting drug users	428	429	400	375	347	326	343	350	351	342
– pervitin users	270	306	287	281	291	283	276	292	313	303
– opiate users	187	151	132	93	66	67	69	68	46	55
Average age of clients	23.4	24.2	24.9	25.1	24.2	23.8	26.6	26.7	27.2	27.3
Successful completion of treatment	–	134	102	124	124	123	93	118	106	108
Early termination of treatment	–	252	219	171	164	153	163	150	163	145
Early termination to successful completion ratio	–	1.9 : 1	2.1 : 1	1.4 : 1	1.3 : 1	1.2 : 1	1.8 : 1	1.3 : 1	1.5 : 1	1.3 : 1
Average duration of treatment (days)	190	–	177	189	186	188	181	185	193	196

*Note: * The data included nine communities subsidised by the GCDPC and the Vršíček therapeutic community.*

Data concerning therapeutic communities were thoroughly analysed and published in a 2012 facility survey, the Drug Services Census (Mravčík and Nechanská, 2013); for more information on the survey see the 2011 Annual Report. The survey also included counting clients and capacity on the single reference date of 20 June 2012. The sample under study consisted of 255 programmes, of which 15 reported a therapeutic community as the type of service provided. A total of 293 dedicated beds were available in them. 214 staff were employed full-time in these 15 therapeutic communities, with a total of 199.3 full-time equivalents (FTE). Of these, most were psychotherapists (34.3), general and psychiatric nurses (30.2), social workers (28.3), or addictologists (24.8 FTE). The target groups of all the therapeutic communities were clients with problems caused by illicit drug use. The clients of most therapeutic communities also included users of psychoactive pills and alcohol. The target group of 12 therapeutic communities also included gamblers. There were 319 clients in total on the day of the census. Most clients (60%) were men. More than 85% of the overall number of clients were aged 15-44 and there were 10 children in therapeutic communities who were under 15 on the day of the census (these were apparently the children of the female clients in those therapeutic communities). The structure of the therapeutic communities' clients by type of substance or type of non-substance disorder is provided in Table 5-26.

Table 5-26: Number of users by type of problem and by region of registered office of the therapeutic community, as of 20 June 2012 (Mravčík and Nechanská, 2013)

Regional location	Number of facilities	Number of users							Total
		Pervitin only	Opiates only	Pervitin and opiates concurrently	Other non-alcohol drugs	Alcohol and non-alcohol drugs concurrently	Alcohol only	Non-substance disorders / gambling	
Prague	**1**	0	0	1	0	8	9	1	**19**
Central Bohemia	**3**	21	3	3	2	9	13	3	**54**
South Bohemia	**2**	23	4	4	0	5	0	0	**36**
Pilsen	**1**	6	0	2	3	0	0	0	**11**
Karlovy Vary	**0**	0	0	0	0	0	0	0	**0**
Ústí nad Labem	**1**	9	5	0	0	1	0	0	**15**
Liberec	**1**	6	1	1	0	6	0	0	**14**
Pardubice	**0**	0	0	0	0	0	0	0	**0**
Hradec Králové	**1**	9	0	0	0	2	40	3	**54**
Vysočina	**1**	4	0	3	1	2	0	0	**10**
South Moravia	**2**	6	1	1	0	9	1	0	**18**
Olomouc	**1**	15	1	0	0	0	0	0	**16**
Zlín	**0**	0	0	0	0	0	0	0	**0**
Moravia-Silesia	**1**	7	1	1	0	3	0	0	**12**
Total	**15**	**106**	**16**	**16**	**6**	**45**	**63**	**7**	**259**

The topic of therapeutic communities is covered by the bilingual monothematic issue of *Adiktologie*, 2013, 13(2). This issue also published the results of a research study entitled "Treatment Outcome Evaluation of Therapeutic Communities for Drug Addicts", conducted by the SANANIM civic association (Šefránek, 2013); see also the 2011 Annual Report.

5.4.4 Specialised Departments in Residential Special Education Facilities

The Ministry of Education manages a system of alternative educational care for children at risk. The system comprises educational establishments for young people in institutional care, protective custody, or preventive care. They include institutions for juvenile delinquents and children with behavioural disorders ("diagnostic institutions"), children's homes with schools, rehabilitation institutions, children's homes, and educational care centres. In 2012 there were altogether 238 facilities of this type in operation, of which five also had departments that specialised in the treatment of children at risk of drug addiction. The total capacity of these special departments was 68 places and 159 children stayed in them in 2012;[102] see Table 5-27 and Table 5-28.

Table 5-27: Educational facilities for children in institutional care or protective custody and for preventive care in the Czech Republic, 2009-2012

Type of facility	Number of facilities			
	2009	2010	2011	2012
Children's home	155	150	149	147
Children's home with school	29	31	31	30
Rehabilitation institution	34	33	33	29
Diagnostic institution for children	8	9	8	8
Diagnostic institution for adolescents	4	4	4	4
Diagnostic institution for children and adolescents	1	0	1	1
Diagnostic institution for children of foreigners	1	1	1	1
Educational care centre*	17	17	17	18
Entire Czech Republic	**249**	**245**	**244**	**238**

Note: The number relates to organisations; including off-site facilities, there are 41 establishments.

[102] Information provided by the Ministry of Education, Department of Special Education and Institutional Care, 12 September 2013.

Table 5-28: Capacity and number of children with drug use problems in specialised departments of educational facilities providing institutional, protective, and preventive care in the Czech Republic, 2009-2012

Facility	Capacity				Number of children			
	2009	2010	2011	2012	2009	2010	2011	2012
Dvůr Králové Rehabilitation Institution	24	24	24	24	31	32	38	45
Klíčov Rehabilitation Institution	8	8	8	8	14	19	20	21
Žulová Rehabilitation Institution	8	8	8	8	15	12	13	12
Hostouň Rehabilitation Institution	16	16	16	16	25	27	33	27
Dobřichovice Diagnostic Institution, Řevnice facility	18	12	12	12	67	47	51	54
Total	**74**	**68**	**68**	**68**	**152**	**137**	**155**	**159**

5.5 Treatment Demand Register

In 2012 the Register of Treatment Demands received data from 206 centres (64 low-threshold centres, 71 healthcare outpatient clinics, 22 non-healthcare outpatient clinics, and 49 residential facilities) out of the total of 268 registered facilities. The most sought-after type of facility has traditionally been the low-threshold centre; as in the previous years, the clients of these facilities accounted for more than half of treatment demands – more than 58% of first treatment demands and 51% of all treatment demands. While outpatient facilities (providing both healthcare and non-healthcare services) were the most widely represented type among the centres, they comprised just one fifth of the total volume of treated drug users reported. The largest number of facilities was located in the Moravia-Silesia region (36 centres), followed by Prague, with 31 centres (Petrášová and Füleová, 2013).

In 2012 a total of 8,955 treated drug users were reported, i.e. 289 less people than in 2011. Of these, 4,313 individuals sought treatment for the first time, 199 clients less than in 2011. The number of first treatment demands, as well as all treatment demands, in the Register of Treatment Demands decreased for the first time since 2008.

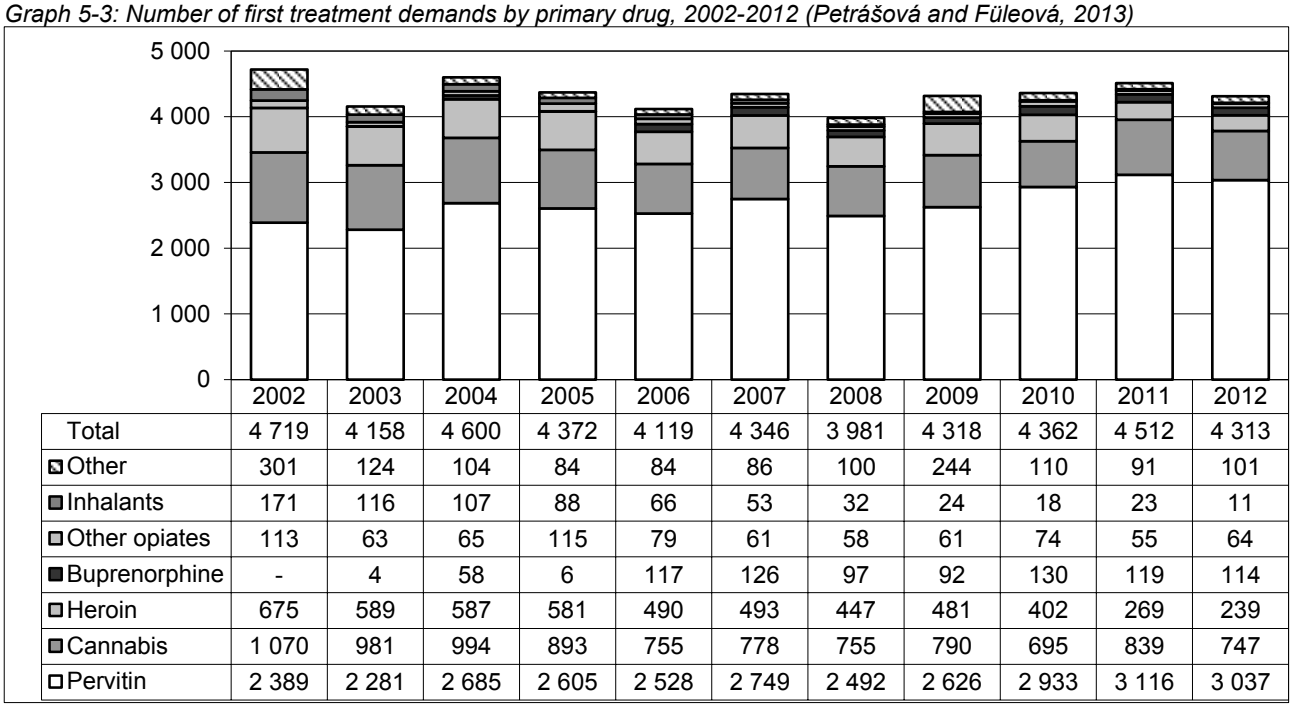
Among the newly registered drug users there were 2,902 men (67.4%) and 1,401 women (32.6%); there was no indication of gender in 10 patients. Among all the treatment clients there were 6,075 men (67.8%) and 2,858 women (31.9%), there was no indication of gender in 22 patients.

The order of the drugs used which are the cause of first treatment demands remained the same in 2012 as in previous years. Users of pervitin predominate among first treatment demands (70.4% of all newly registered clients). The next most frequent drugs were cannabis (17.3%) and opiates (9.7%), mainly heroin (5.5%) (Petrášová and Füleová, 2013). Trends in the numbers of first treatment demands according to the drug used are shown in Graph 5-3.

Among all the clients receiving treatment during 2012, the most commonly used drug was pervitin (66.9%). The second most frequently used drug was opiates (18.0%) – mainly heroin (9.8%) – and then cannabis (12.4%). Trends in the numbers of all treatment demands according to the drug used are shown in Graph 5-4.

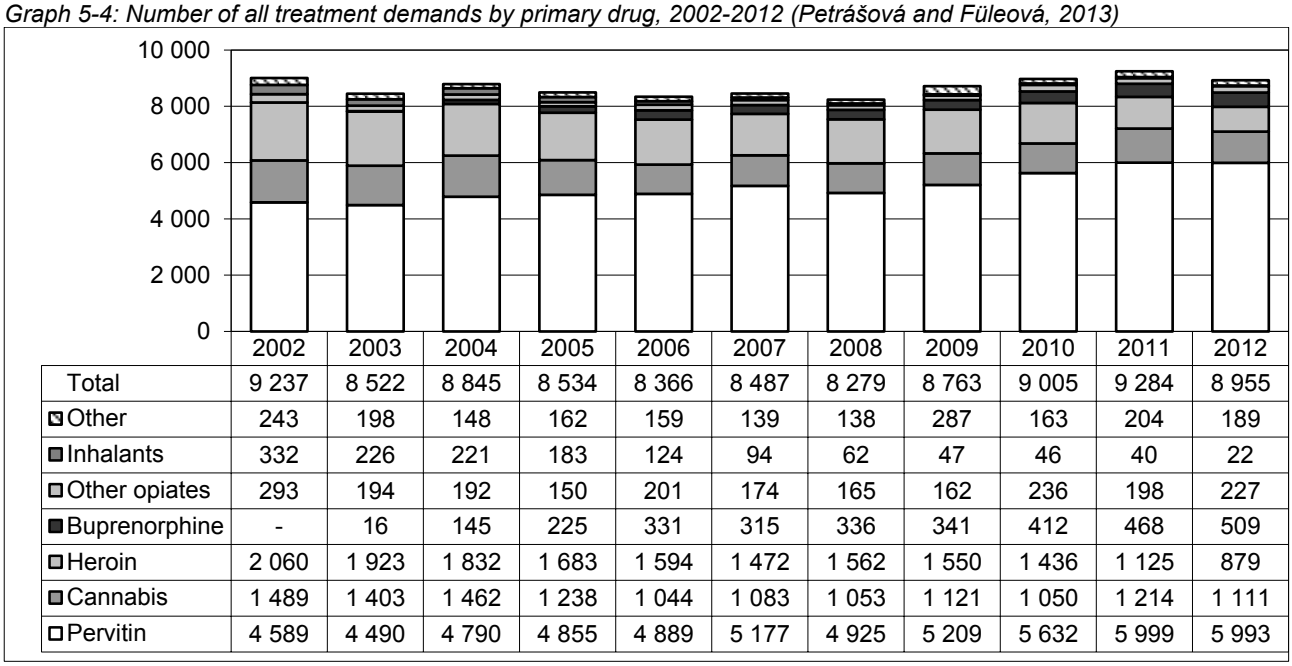
The highest number of treatment demands per 100,000 inhabitants was recorded in the Olomouc region (152.8 per 100,000 inhabitants), followed by the Vysočina region (137.7) and Prague (125.3). The highest proportion of users of stimulants was reported in the Liberec region (82.6%) and the Ústí nad Labem region (80.7%), while the lowest proportion of stimulant users in treatment was reported in Prague (53.4%). Opiate users were most represented among applicants in Prague (32.3%) and the Central Bohemia region (29.5%). The highest proportions of cannabis users were reported from the Pilsen (29.5%), Vysočina (25.7%), Pardubice (25.3%), and Moravia-Silesia (20.5%) regions (Petrášová and Füleová, 2013); see Map 5-2.

Graph 5-3: Number of first treatment demands by primary drug, 2002-2012 (Petrášová and Füleová, 2013)



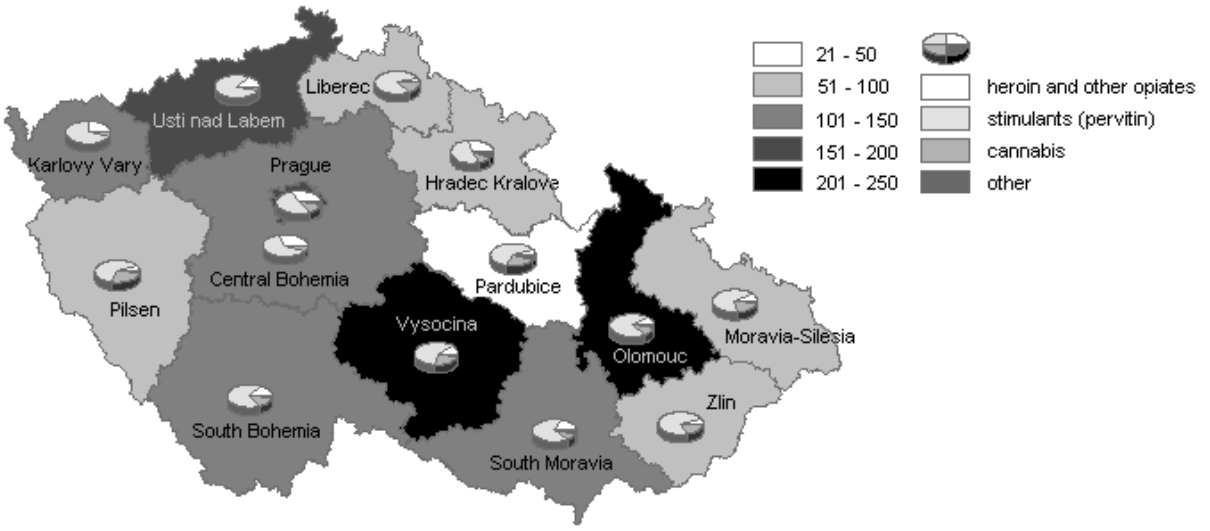
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	4 719	4 158	4 600	4 372	4 119	4 346	3 981	4 318	4 362	4 512	4 313
Other	301	124	104	84	84	86	100	244	110	91	101
Inhalants	171	116	107	88	66	53	32	24	18	23	11
Other opiates	113	63	65	115	79	61	58	61	74	55	64
Buprenorphine	-	4	58	6	117	126	97	92	130	119	114
Heroin	675	589	587	581	490	493	447	481	402	269	239
Cannabis	1 070	981	994	893	755	778	755	790	695	839	747
Pervitin	2 389	2 281	2 685	2 605	2 528	2 749	2 492	2 626	2 933	3 116	3 037

Graph 5-4: Number of all treatment demands by primary drug, 2002-2012 (Petrášová and Füleová, 2013)



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	9 237	8 522	8 845	8 534	8 366	8 487	8 279	8 763	9 005	9 284	8 955
Other	243	198	148	162	159	139	138	287	163	204	189
Inhalants	332	226	221	183	124	94	62	47	46	40	22
Other opiates	293	194	192	150	201	174	165	162	236	198	227
Buprenorphine	-	16	145	225	331	315	336	341	412	468	509
Heroin	2 060	1 923	1 832	1 683	1 594	1 472	1 562	1 550	1 436	1 125	879
Cannabis	1 489	1 403	1 462	1 238	1 044	1 083	1 053	1 121	1 050	1 214	1 111
Pervitin	4 589	4 490	4 790	4 855	4 889	5 177	4 925	5 209	5 632	5 999	5 993

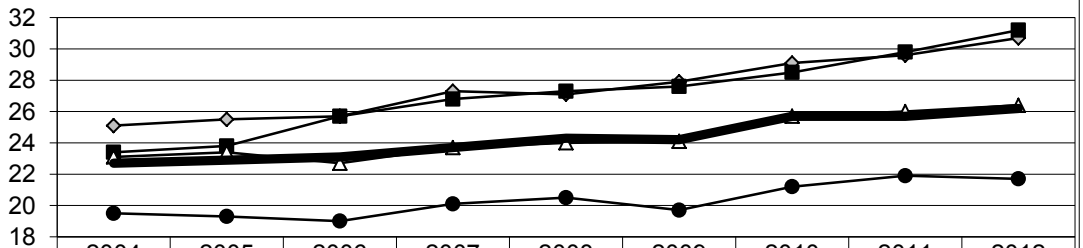
Map 5-2: Number of all treatment demands according to drug type, by region, per 100,000 inhabitants aged 15-64 years, 2012 (Petrášová and Füleová, 2013)



The representation of males and females among those making treatment demands has remained stable in the long term and corresponds to a 2:1 male-to-female ratio. The highest proportion of males is among all treated users of cannabis (72.6%) and opiates (72.5%). An exception to this is the case of hypnotics and sedatives, with a higher proportion of women (53.3%) than men in all treatment demands.

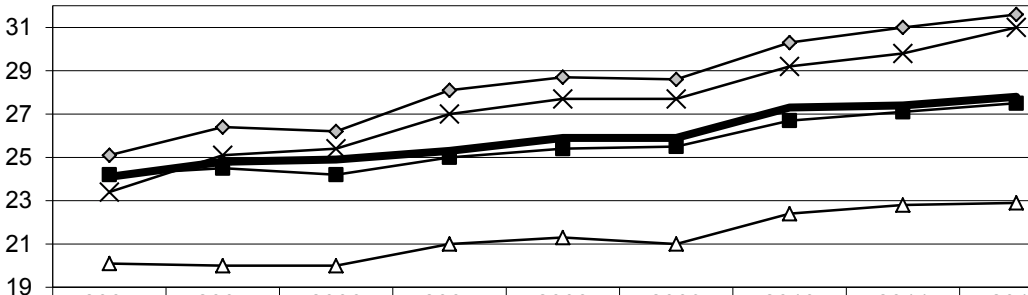
In the medium term, the average age shows a noticeable growing trend; see Graph *5-5* and Graph 5-6. The average age in 2012 was 26.2 years for first treatment demands and 27.8 years for all treatment demands, an increase of 3.5 and 3.7 years, respectively, since 2004. In 2004-2012, the group with the fastest-growing average age was that of the users of opiates, particularly buprenorphine, whose average age increased by almost eight years. On the contrary, cannabis users are the youngest group in the long term. With the gradual increase in the average age of those making treatment demands, one can also observe a decrease in the age of the youngest users in treatment, those under 19 years of age; see Table 5-29.

Graph 5-5: Average age of first treatment, by selected drugs, 2004-2012 (Petrášová and Füleová, 2013)



	2004	2005	2006	2007	2008	2009	2010	2011	2012
Heroin	25,1	25,5	25,7	27,3	27,1	27,9	29,1	29,6	30,7
Buprenorphine	23,4	23,8	25,7	26,8	27,3	27,6	28,5	29,8	31,2
Pervitin	23,1	23,4	22,7	23,7	24,0	24,1	25,7	26,0	26,4
Cannabis	19,5	19,3	19,0	20,1	20,5	19,7	21,2	21,9	21,7
All drugs	22,7	22,9	23,1	23,7	24,3	24,2	25,7	25,7	26,2

Graph 5-6: Average age of all drug treatment demands, by selected drugs, 2004-2012 (Petrášová and Füleová, 2013)



	2004	2005	2006	2007	2008	2009	2010	2011	2012
Heroin	25,1	26,4	26,2	28,1	28,7	28,6	30,3	31,0	31,6
Buprenorphine	23,4	25,1	25,4	27,0	27,7	27,7	29,2	29,8	31,0
Pervitin	24,2	24,5	24,2	25,0	25,4	25,5	26,7	27,1	27,5
Cannabis	20,1	20,0	20,0	21,0	21,3	21,0	22,4	22,8	22,9
All drugs	24,1	24,8	24,9	25,3	25,9	25,9	27,3	27,4	27,8

In 2012 the number of problem drug users was 8,124 (90.7%) among all treatment demands and 3,751 (87.0%) among first treatment demands.[103] There is still a high proportion of injecting drug users demanding treatment; injecting drug use was reported by 6,151 (68.7%) of all treatment demands and 2,614 (60.6%) of first treatment demands.

Daily drug use was reported by 2,413 people demanding treatment (1,113 first treatment demands), while another 2,024 (1,116 first treatment demands) used drugs 2-6 times a week (22.6% and 25.9%, respectively). Daily use was reported in 29.0% of heroin users, 19.9% of pervitin users, and 75.4% of buprenorphine users.

The socio-economic characteristics of those demanding treatment have hardly changed in recent years. Of the total number of 8,955 people making treatment demands in 2012, 12.2% were homeless and another 10.0% resided in institutions (prisons, institutions, hostels, or shelters); a permanent place of residence was reported by 44.4% of those demanding treatment.

Approximately a third of all the registered drug users in treatment, including new ones, live with their parents, 21.8% of all treatment clients report living alone, and 7.7% of the users in treatment live with their children. People with a temporary place of residence, placed in an institution, or who are even homeless are significantly more frequent among drug users treated repeatedly and long-term drug users than among first treatment demands.

54.5% of treatment demands were made by unemployed or temporarily employed people; regular employment was reported by 17.8% of those making treatment demands. In total, 44.7% of the clients in 2012 had basic or incomplete basic education, while secondary education was reported by 40.0% of those demanding treatment (Petrášová and Füleová, 2013).

The trends of selected characteristics among treatment demands are shown in Table 5-29. More information about injecting drug use among those demanding treatment is provided in the chapter entitled Risk Behaviour of Drug Users (p. 98).

[103] i.e. injecting drug users and/or long-term/regular users of opioids and/or amphetamine-type drugs and/or cocaine/crack.

Table 5-29: Selected characteristics of first treatment demands and all treatment demands, 2002-2012 (Petrášová and Füleová, 2013)

Year	Total number of clients	of which (%)			
		Problem drug users	Injecting drug users	Persons aged under 19 years	Women
First treatment demands					
2002	4,719	73.6	58.5	42.4	32.7
2003	4,158	76.9	60.5	43.5	32.7
2004	4,600	80.5	64.9	36.0	32.7
2005	4,372	82.3	64.0	34.4	31.6
2006	4,119	84.4	62.5	32.2	33.6
2007	4,346	78.9	63.3	30.7	33.3
2008	3,981	86.1	62.0	29.8	33.8
2009	4,318	83.5	55.6	27.0	32.6
2010	4,363	87.7	61.8	22.3	31.2
2011	4,512	86.1	57.1	23.4	31.3
2012	4,313	87.0	60.6	17.6	32.5
All treatment demands					
2002	9,237	80.6	67.4	30.0	31.3
2003	8,522	82.9	70.0	29.8	31.0
2004	8,845	84.5	72.0	26.3	30.6
2005	8,534	86.4	71.8	24.2	30.5
2006	8,366	89.1	72.4	21.6	31.7
2007	8,487	84.1	72.0	21.1	32.6
2008	8,279	90.5	72.3	19.6	32.2
2009	8,763	89.1	66.6	18.3	32.3
2010	9,005	91.4	69.8	15.2	31.8
2011	9,284	90.1	66.3	15.8	31.3
2012	8,955	90.7	68.7	12.7	31.9

6 Health Correlates and Consequences of Drug Use

The relatively favourable situation concerning the occurrence of infections among drug users continued in 2012. Five new cases of HIV-positive people who contracted the infection through injecting drug use were identified. HIV seroprevalence among injecting drug users remains below 1% in the Czech Republic. The number of newly reported cases of viral hepatitis C (HCV) among injecting drug users rose slightly in the last year, while that of viral hepatitis B (HBV) remained almost at the same level as in 2011. While the number of reported cases of syphilis among injecting drug users is lower, the cases of gonorrhoea recorded an increase. The number of reported cases of tuberculosis among injecting drug users has not changed much.

The prevalence of HCV among injecting drug users ranges from approximately 20-30% in low-threshold programmes and 40-50% in prisons up to 60-70% in substitution treatment. These results, however, need to be interpreted with caution, bearing in mind the possibility of a sampling error: in low-threshold programmes, screening results do not include already positive cases, while treatment programmes and prisons possibly show cases examined on suspicion of infection, which may, on the contrary, artificially inflate the prevalence rates.

The Treatment Demand Register has seen a relatively large proportion of injecting drug users in the long term; pervitin (methamphetamine) and opiate (heroin and buprenorphine) users account for approximately 80% and 90% respectively of injecting drug users seeking treatment. Among the clients of outpatient psychiatric clinics, the percentage of people who use both pervitin and opiates by injecting is lower. The available data suggest a declining trend in needle sharing among people who inject drugs.

The 2012 data on drug-related deaths from forensic medicine departments were not available at the time of the writing of this annual report. The information on drug overdoses provided by the Deaths Information System shows that there were a total of 45 cases of overdoses on illegal drugs and inhalants (27 cases in 2011), with a year-on-year increase in the number of reported cases of overdoses on opiates/opioids, stimulants (pervitin), and inhalants. There were 317 cases of fatal overdoses on ethanol identified in 2012, which is approximately the same number as in the previous year. Widespread cases of poisoning with methanol present in illegal spirits were recorded in the Czech Republic from September 2012 to mid-July 2013 (in 47 people the poisoning had fatal consequences).

The traffic police records indicate that the number of drunk driving accidents decreased in 2012; the number of accidents that occurred under the influence of drugs increased slightly, but still represents only a fraction of the number of accidents occurring under the influence of alcohol.

6.1 Drug-Related Infections

6.1.1 Newly diagnosed (reported) cases

6.1.1.1 HIV/AIDS

In 2012, there were five new cases of HIV diagnosed among injecting drug users (IDUs), i.e. persons who very probably experienced HIV transmission through injecting drug use. Another six newly diagnosed HIV-positive persons had a history of injecting drug use. Although there has been a marked increase in the total number of newly discovered HIV positive cases in the country since 2002, especially in the group of homosexual men, the incidence in the group of injecting drug users is still relatively low; see Table 6-1(Státní zdravotní ústav Praha, 2013b).[104]

Table 6-1: The number of newly diagnosed HIV cases in the Czech Republic, 2012, by route of transmission (Státní zdravotní ústav Praha, 2013b)

Route of transmission		Year									Total
		1985–2004	2005	2006	2007	2008	2009	2010	2011	2012	
IDU		**33**	**4**	**4**	**12**	**8**	**4**	**4**	**7**	**5**	**81**
of whom	men	27	3	3	5	7	4	3	7	2	**61**
	women	6	1	1	7	1	0	1	0	3	**20**
Homo-/bisexual intercourse and IDU		**11**	**1**	**1**	**5**	**4**	**3**	**3**	**5**	**4**	**37**
Other with a history of IDU		**27**	**2**	**1**	**4**	**2**	**3**	**5**	**2**	**2**	**48**
Other without a history of IDU		665	83	85	100	134	146	168	139	201	**1,721**
Total		**736**	**90**	**91**	**121**	**148**	**156**	**180**	**153**	**212**	**1,887**

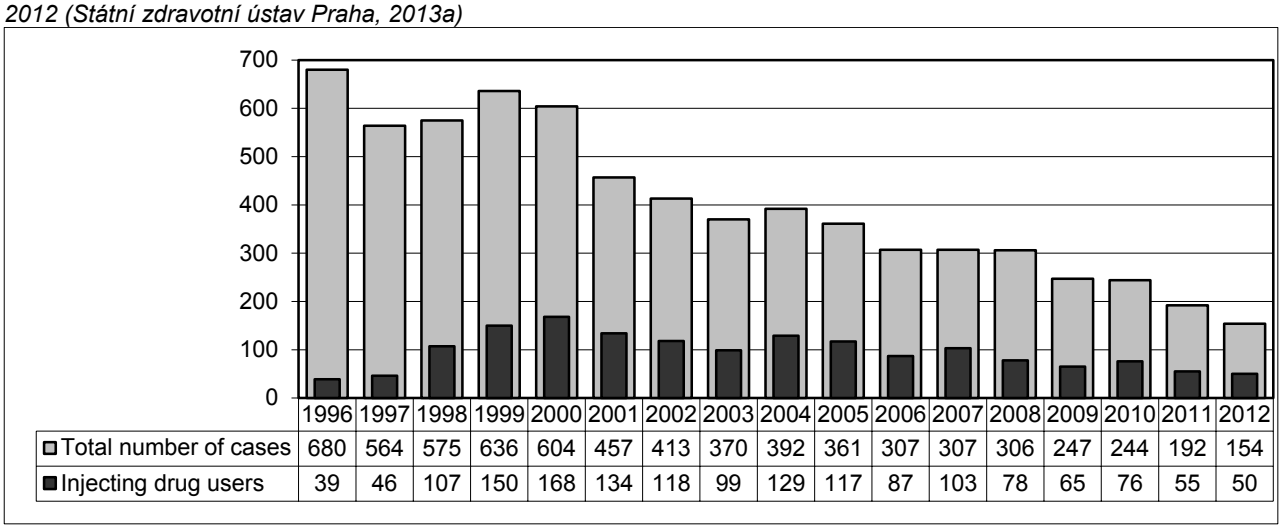
Note: The number of cases is being corrected for previous years – the corrections stem from duplicates that were found and from subsequent clarification of information regarding the route of transmission.

[104]The monitoring of HIV/AIDS in the Czech Republic is conducted by the National Reference Laboratory for AIDS at the National Institute of Public Health in Prague.

6.1.1.2 Viral hepatitis

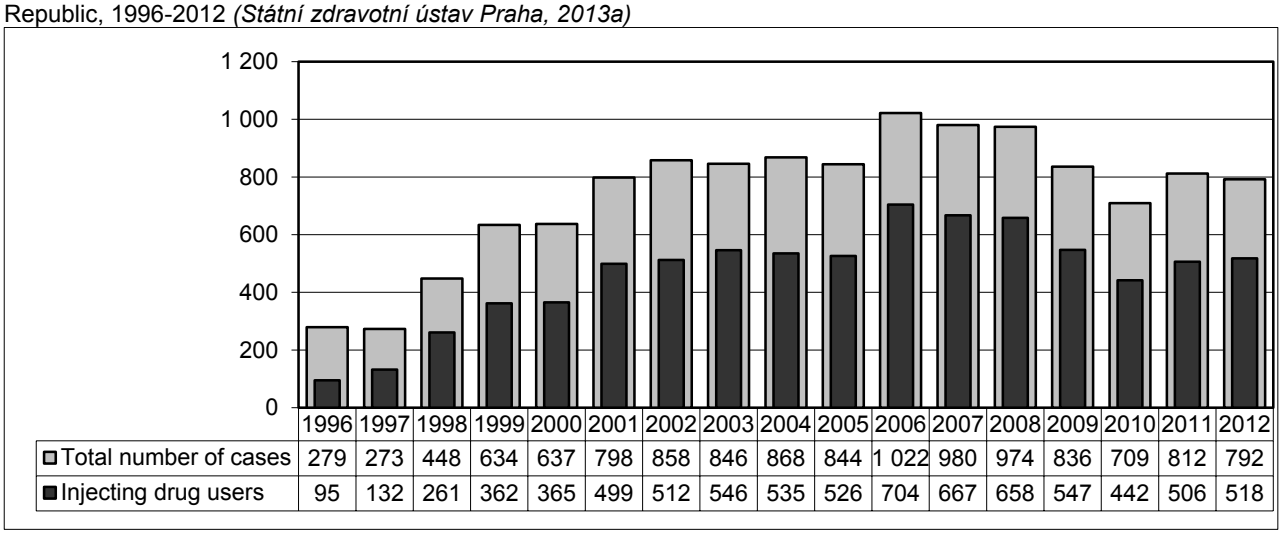
The total number of newly reported cases of acute viral hepatitis B (HBV, diagnosis B16) has been declining in recent years, both overall and among IDUs. After a period of a decline in viral hepatitis C (HCV, diagnosis B17.1 and B18.2), the number of cases among IDUs increased by nearly 15% in 2011, while it did not change much in 2012. In the long term, the average age of infected injecting drug users is increasing (Státní zdravotní ústav Praha, 2013a);[105] see Graph 6-1, Graph 6-2, and Graph 6-3.

Graph 6-1: Reported incidence of acute HBV among all patients and injecting drug users in the Czech Republic, 1996-2012 (Státní zdravotní ústav Praha, 2013a)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total number of cases	680	564	575	636	604	457	413	370	392	361	307	307	306	247	244	192	154
Injecting drug users	39	46	107	150	168	134	118	99	129	117	87	103	78	65	76	55	50

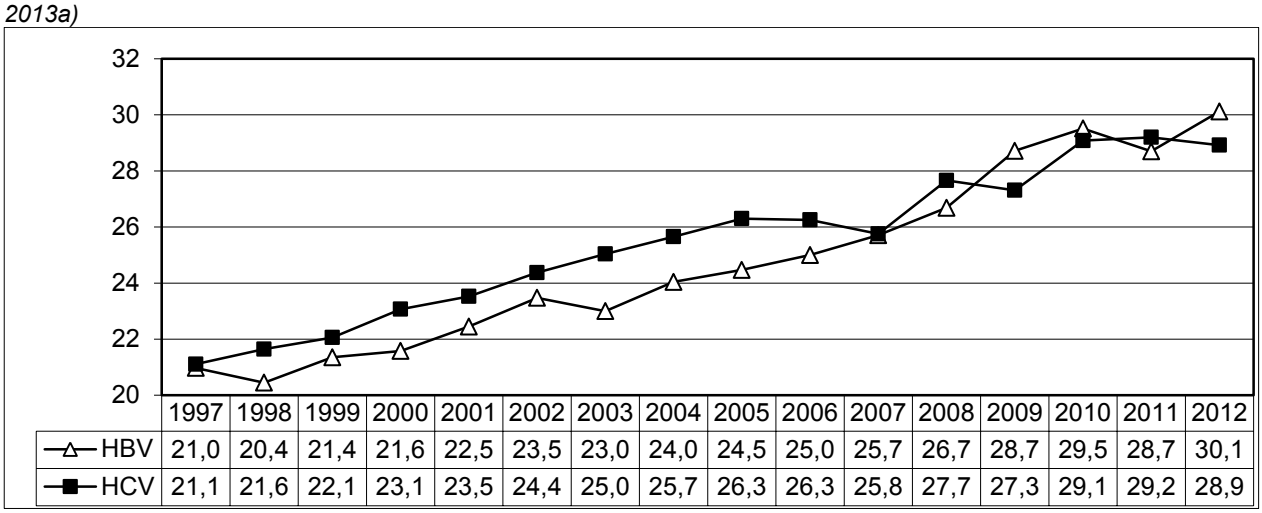
Graph 6-2: Reported incidence of acute and chronic HCV among all patients and injecting drug users in the Czech Republic, 1996-2012 *(Státní zdravotní ústav Praha, 2013a)*



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total number of cases	279	273	448	634	637	798	858	846	868	844	1 022	980	974	836	709	812	792
Injecting drug users	95	132	261	362	365	499	512	546	535	526	704	667	658	547	442	506	518

[105] Data on the incidence of viral hepatitis come from the information system on infectious diseases (EPIDAT), administered by the National Institute of Public Health in Prague, to which confirmed cases, suspected cases, being a carrier of the disease, and the detection of the disease at death are reported.

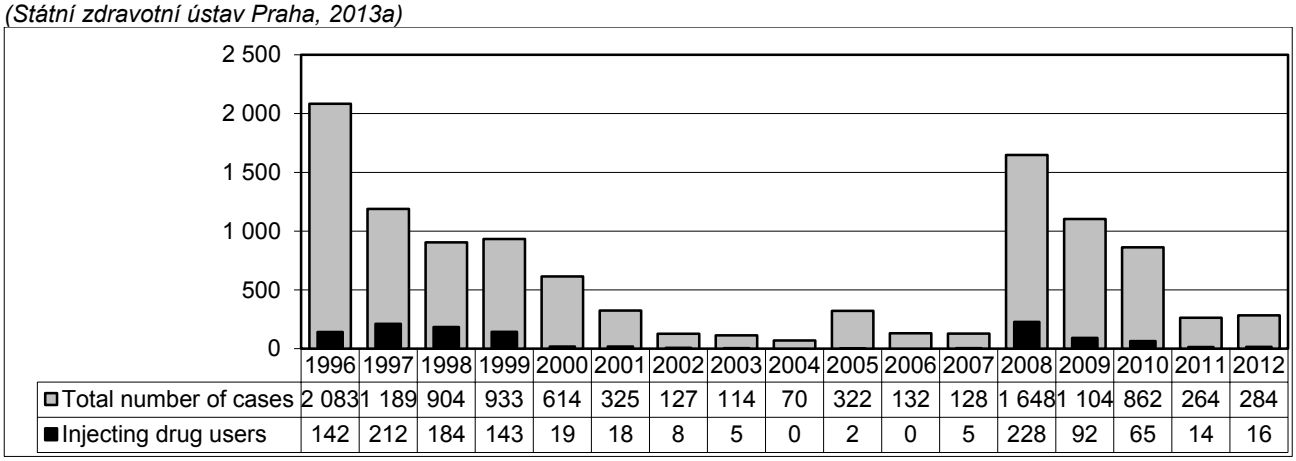
Graph 6-3: Average age of injecting drug users with reported HBV and HCV, 1997-2012 (Státní zdravotní ústav Praha, 2013a)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
HBV	21,0	20,4	21,4	21,6	22,5	23,5	23,0	24,0	24,5	25,0	25,7	26,7	28,7	29,5	28,7	30,1
HCV	21,1	21,6	22,1	23,1	23,5	24,4	25,0	25,7	26,3	26,3	25,8	27,7	27,3	29,1	29,2	28,9

Following the epidemic of viral hepatitis A (HAV, dg. B15) which broke out mainly in Prague and Central Bohemia in 2008 and was associated with IDUs at the beginning (see the 2008 Annual Report), the number of cases in 2011 returned to the low pre-epidemic values (Státní zdravotní ústav Praha, 2013a); see Graph 6-4.

Graph 6-4: Reported incidence of HAV among all patients and injecting drug users in the Czech Republic, 1996-2012 (Státní zdravotní ústav Praha, 2013a)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total number of cases	2 083	1 189	904	933	614	325	127	114	70	322	132	128	1 648	1 104	862	264	284
Injecting drug users	142	212	184	143	19	18	8	5	0	2	0	5	228	92	65	14	16

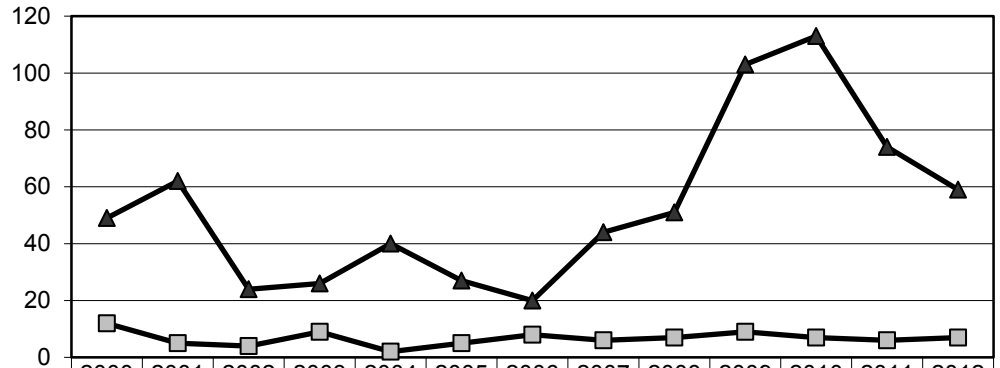
6.1.1.3 Sexually Transmitted Diseases

The development of the total number of reported cases of sexually transmitted diseases,[106] i.e. syphilis and gonorrhea, and the number of cases among injecting drug users (IDUs) and alcohol users, are shown in Graph 6-5 and Graph 6-6.

Following an increase in the number of cases of syphilis in 2006-2010, both among IDUs and overall, the number of reported cases decreased in 2011-2012. The number of reported cases of syphilis among alcohol-dependent persons was much lower and does not vary much in the long term. The total number of reported cases of gonorrhoea decreased over the period, while the number of cases among IDUs and alcohol users has remained low in the long term. Data on the prevalence of high-risk behaviour pertaining to the reported cases of sexually transmitted diseases indicate that concurrent commercial sex and injecting drug use is relatively common. In 2000-2012, injecting drug use was found in a total of 20.8% of syphilis cases in commercial sex workers and 16.5% of the infected injecting drug users (mainly females) were concurrently commercial sex workers (Nechanská, 2013b).

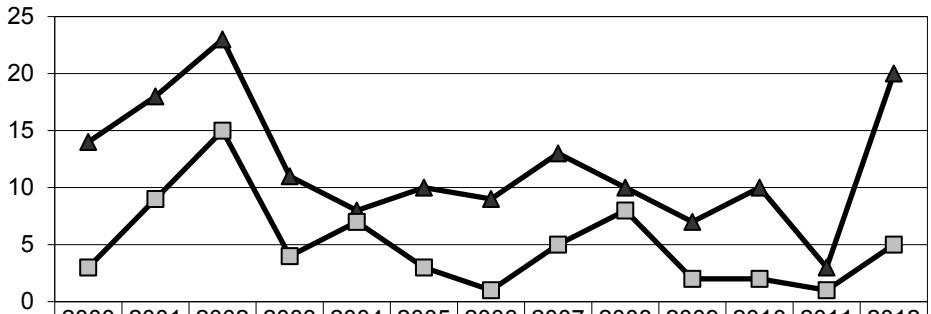
[106] All persons found to have a sexually transmitted disease, who died from such a disease, or are suspected to be suffering from or infected with a sexually transmitted disease in the Czech Republic are mandatorily reported to the National Register of Sexually Transmitted Diseases. Syphilis (diagnoses A50 to A53), gonorrhoea (diagnosis A54), lymphogranuloma venereum (diagnosis A55), and chancroid (A57) are subject to reporting from all healthcare facilities. The risk factors surveyed include alcohol use, injecting drug use, and prostitution. The National Register of Sexually Transmitted Diseases uses categories with the headings "alcoholic" and "intravenous drug user" in its reports.

Graph 6-5: Reported incidence of syphilis among all patients and among injecting drug users and alcoholics in the Czech Republic, 2000-2012 (Nechanská, 2013b)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Syphilis, total	967	1 376	976	849	684	523	502	822	850	997	1 022	737	696
Syphilis in IDUs	49	62	24	26	40	27	20	44	51	103	113	74	59
Syphilis in alcoholics	12	5	4	9	2	5	8	6	7	9	7	6	7

Graph 6-6: Reported incidence of gonorrhoea among all patients and among injecting drug users and alcoholics in the Czech Republic, 2000-2012 (Nechanská, 2013b)



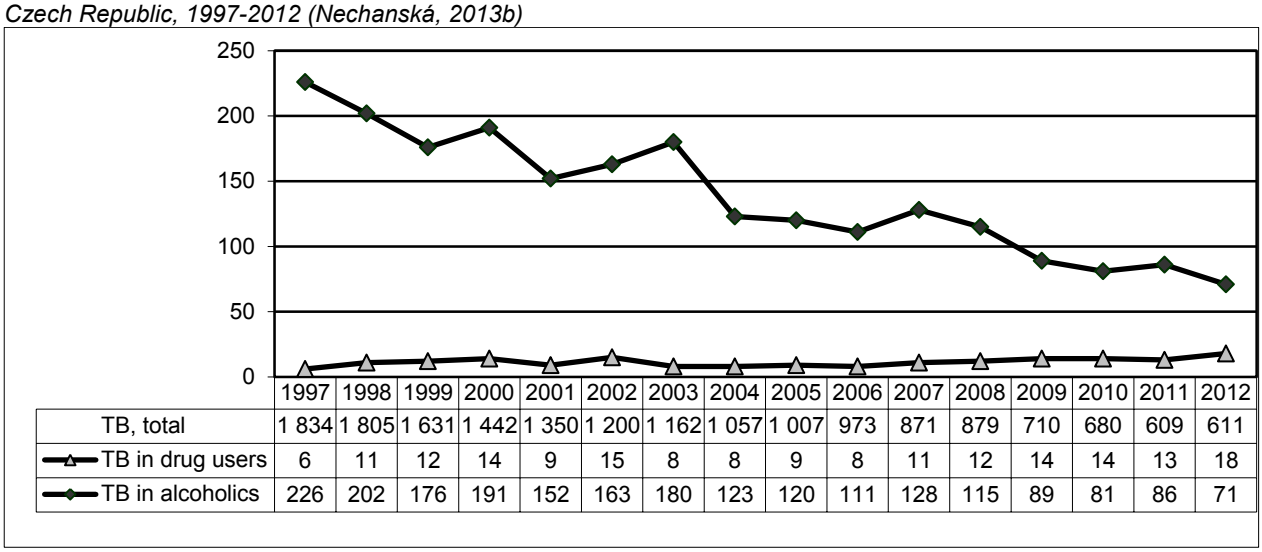
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Gonorrhoea, total	888	880	911	1 030	947	859	1 082	1 149	816	724	756	709	1 151
Gonorrhoea in IDUs	14	18	23	11	8	10	9	13	10	7	10	3	20
Gonorrhoea in alcoholics	3	9	15	4	7	3	1	5	8	2	2	1	5

6.1.1.4 Tuberculosis

In 1997-2012, the number of registered TB cases reported annually decreased[107] by three times. Men accounted for almost two-thirds (64%) of the total number of cases. The number of reported cases among alcohol users is much higher than that among non-alcohol drug users,[108] and a downward trend is observed among alcohol users (Nechanská, 2013b); see Graph 6-7.

[107] Data on the prevalence of tuberculosis (TB, diagnosis A31) are obtained from the Tuberculosis Register, which monitors people who have been diagnosed with active tuberculosis or other mycobacteriosis in the Czech Republic.
[108] The Tuberculosis Register uses categories with the headings "alcoholic" and "drug addict" in its reports.

Graph 6-7: Reported incidence of tuberculosis among all patients and among users of alcohol and other drugs in the Czech Republic, 1997-2012 (Nechanská, 2013b)



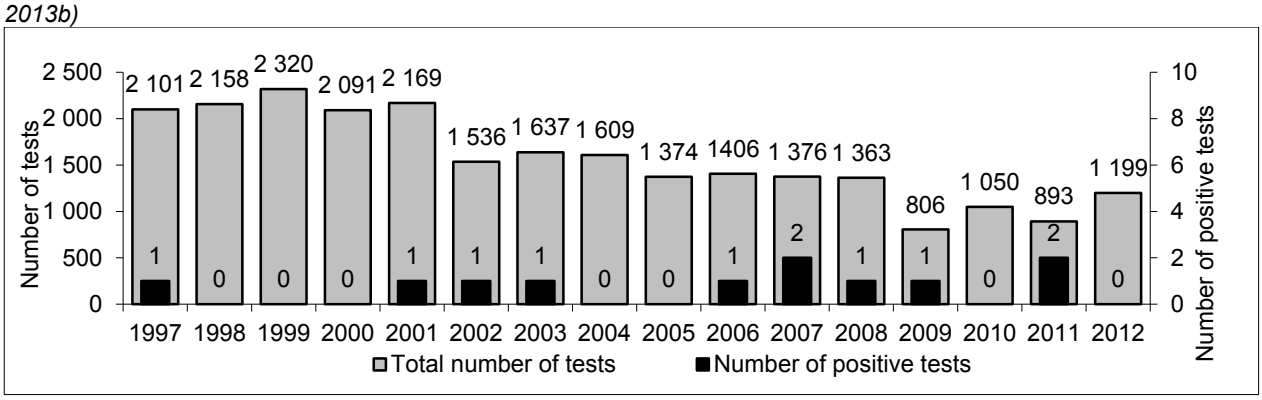
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
TB, total	1 834	1 805	1 631	1 442	1 350	1 200	1 162	1 057	1 007	973	871	879	710	680	609	611
TB in drug users	6	11	12	14	9	15	8	8	9	8	11	12	14	14	13	18
TB in alcoholics	226	202	176	191	152	163	180	123	120	111	128	115	89	81	86	71

6.1.2 Prevalence of Infections among Drug Users

6.1.2.1 Monitoring of HIV Tests in Laboratories (Laboratory Surveillance)

In 2012, the National Reference Laboratory for AIDS recorded 1,199 examinations of IDUs, all with negative results[109] (Státní zdravotní ústav Praha, 2013b); see Graph 6-8.

Graph 6-8: Results of testing for HIV antibodies among injecting drug users, 1997-2012 (Státní zdravotní ústav Praha, 2013b)



6.1.2.2 Testing for Infections among IDUs in Low-Threshold Programmes

The testing for infections in low-threshold programmes in the Czech Republic has been monitored since 2004. The 2012 results were collected using an online questionnaire survey in June and July 2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013e). A total of 38 low-threshold programmes (52 in 2011) participated in the survey; the results are shown in Table 6-2. As in previous years, the results suggest relatively low levels of infections among clients of low-threshold facilities, but it is necessary to consider the fact that neither the set of low-threshold programmes that participated nor the analysis of the sample of the clients who were tested forms a representative sample of low-threshold programmes or problem drug users. This is a diagnostic screening, which is probably used to a greater extent by hitherto negative clients. These results therefore underestimate the true prevalence of infections among injecting drug users or clients of low-threshold facilities.

[109] These are cases in which information about drug use is known prior to the test or is reported as the reason for testing. Injecting drug users can also be tested for many other reasons, and in these cases it only becomes apparent afterwards that the subject was an injecting drug user; this was also how other reported HIV positive cases among IDUs were identified. Testing in low-threshold facilities for drug users is not recorded by the National Reference Laboratory for AIDS in its entirety.

Table 6-2: Results of testing for infections among injecting drug users in low-threshold facilities, 2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013e)

Infection	Indicator tested	Number of programmes by type of test			Number of tests		Number of persons		
		Rapid	Laboratory	Total	Total	Positive	Total	Positive	Positive (%)
HIV	anti-HIV	27	6	33	1,920	2	1,683	2	0.1
HCV	anti-HCV	30	5	33*	1,821	306	1,582	294	18.6
HBV	HBsAg**	19	0	19	609	4	515	4	0.8
	anti-HBc IgG***	0	4	4	170	1	164	1	0.6
Syphilis	anti-treponema pallidum	21	4	25	1,337	28	1,182	28	2.4

*Note: * Some facilities simultaneously offered rapid tests and laboratory testing of samples ** An antigen indicating acute or chronic active HBV infection, *** anti-HBc IgG are antibodies generated during an acute HBV infection, but they last even long after recovery.*

The table below shows the regional distribution of facilities and the results of testing for HCV. As in the previous case, the sample is not a representative sample of drug users or facilities (despite repeated calls some facilities refused to participate in the survey) and the indication criteria for the testing of clients may vary between the various facilities. However, it is clear that the regional distribution of HCV infection among IDUs shows considerable variation in the Czech Republic. In some regions (including Central Bohemia, Moravia-Silesia, and Zlín), the proportion of reactive tests is very low, while e.g. in Prague almost one third of the tests performed were reactive and in the Karlovy Vary region as many as 7 out of 10 tests performed were reactive; see Table 6-3.

Table 6-3: Results of HCV testing among drug users in low-threshold facilities by programme site, 2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013e)

Region	Number of facilities		Number of persons tested		
	Returned the questionnaire	Tested for HCV	Total	of whom positive	
				number	%
Prague	4	3	489	160	32.7
Central Bohemia	3	3	134	9	6.7
South Bohemia	4	4	70	11	15.7
Pilsen	2	2	66	10	15.2
Karlovy Vary	1	1	10	7	70.0
Ústí nad Labem	5	3	137	41	29.9
Liberec	0	-	-	-	-
Hradec Králové	2	2	120	5	4.2
Pardubice	0	-	-	-	-
Vysočina	3	3	149	4	2.7
South Moravia	4	3	151	23	15.2
Olomouc	2	2	85	11	12.9
Zlín	3	3	108	8	7.4
Moravia-Silesia	4	3	45	3	6.7
Total*	**38**	**33**	**1,582**	**294**	**18.6**

*Note: * One facility did not provide its identification details, including the region of operation.*

The total number of low-threshold facilities in the Czech Republic which offered testing for the infections being monitored and the number of tests performed and their trends are given in the chapter on Testing for Infectious Diseases (p. 115).

6.1.2.3 Testing for Infectious Diseases among Clients in the Register of Treatment Demands

The data about testing for infections, including the results of the tests, are also captured by the Register of Treatment Demands (Petrášová and Füleová, 2013). This information is provided by the clients themselves or is obtained from their records; only tests with known results for IDUs are included; see Table 6-4. Although the information value of the data is limited, they indicate a stable and relatively low seroprevalence of the infections monitored among IDUs.

Table 6-4: Results of testing for HIV, HAV, HBV, and HCV among IDUs demanding treatment, self-reported, 2003-2012 (Petrášová and Füleová, 2013)

Year	HIV		HAV		HBV		HCV	
	Total tested	Positive tests (%)	Total tested	Positive (%)	Total tested	Positive (%)	Total tested	Positive (%)
2003	2,471	0.8	2,132	7.1	2,504	11.2	2,884	31.5
2004	2,483	0.4	2,059	5.5	2,581	9.9	2,913	33.6
2005	2,253	0.2	1,931	4.5	2,332	10.1	2,577	35.0
2006	2,196	0.5	1,997	3.3	2,290	10.0	2,497	32.6
2007	1,905	0.3	1,774	3.3	2,004	8.4	2,168	31.0
2008	2,332	0.6	2,271	8.4	2,463	8.9	2,636	32.0
2009	2,558	0.5	2,307	6.1	2,553	8.3	2,852	29.8
2010	2,865	0.6	2,515	5.8	2,837	8.1	3,189	30.4
2011	2,933	0.9	2,429	5.5	2,915	7.2	3,276	28.7
2012	2,942	0.7	2,428	7.0	2,888	10.3	3,286	29.2

6.1.2.4 Testing for Infectious Diseases among Patients in the Substitution Treatment Register

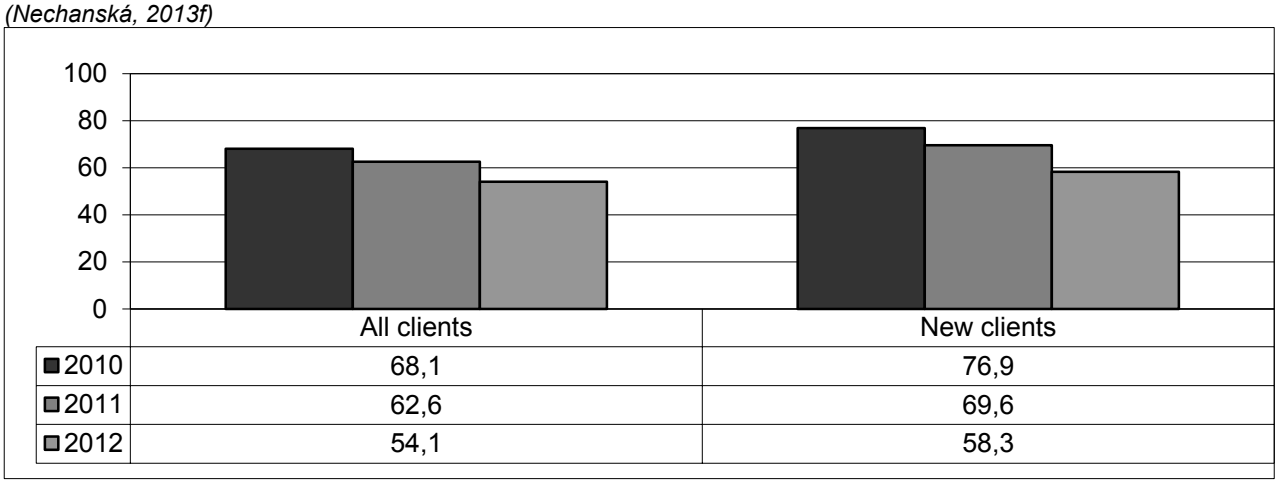
The results of the 2012 testing for HIV, HBV, and HCV among those registered in the Substitution Treatment Register are given in Table 6-5. In total, 2,298 persons who were treated were reported in the register in 2012. 291 persons were tested for HIV, all testing negative. 270 individuals were tested for antibodies against HCV (anti-HCV), with 146 testing positive (seroprevalence 54.1%). Of these 146 persons, 87 were tested for direct identification of the HCV virus (PCR-RNA), and 52 tests (59.7%) were positive, indicating that the infection had reached its chronic phase (Nechanská, 2013f). The HCV seroprevalence trend is shown in Graph 6-9.

Table 6-5: Results of the testing of patients receiving opioid substitution treatment for HIV, HBV, and HCV, 2012 (Nechanská, 2013f)

Infection	Indicator tested	All clients			New clients		
		Total tested	Number of positive results	Positive tests (%)	Total tested	Number of positive results	Positive tests (%)
HIV	anti-HIV	291	0	0.0	144	0	0.0
HCV	anti-HCV	270	146	54.1	139	81	58.3
HBV	HBsAg*	289	27	9.3	150	13	8.7
	anti-HBc IgG **	262	96	36.6	135	56	41.5

*Note: * An antigen indicating acute or chronic active infection, ** anti-HBc IgG are antibodies generated during an acute HBV infection, but they last even long after recovery.*

Graph 6-9: HCV seroprevalence trend among patients in substitution treatment who were tested, 2010-2012 (%) (Nechanská, 2013f)



6.1.2.5 Testing among Drug Users in Prisons

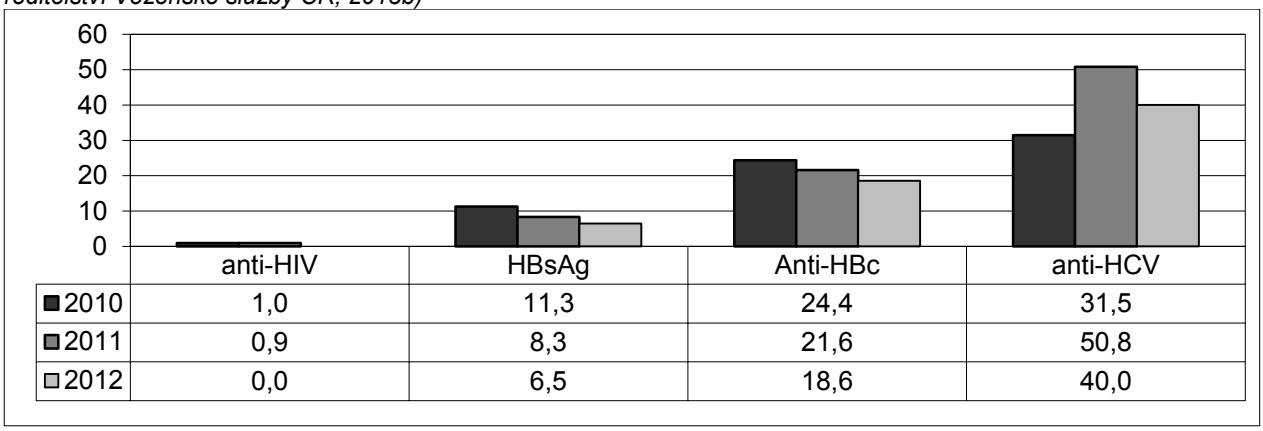
The Prison Service monitors the examinations of imprisoned injecting drug users for selected infections;[110] see Table 6-6. A year-on-year comparison is provided in Graph 6-10.

Table 6-6: Results of testing for HIV, HBV, and HCV among injecting drug users in prisons, 2012 (Generální ředitelství Vězeňské služby ČR, 2013b)

Infection	Indicator tested		Start of serving prison sentence	Start of remand	In the course of prison sentence	Total
HIV	anti-HIV	Total tested	0	0	1,445	1,445
		Positive	0	0	0	0
		Positive (%)	–	–	0.0	0.0
HBV	HBsAg*	Total tested	1,440	1,531	1,325	4,296
		Positive	98	86	94	278
		Positive (%)	6.8	5.6	7.1	6.5
	anti-HBc IgG**	Total tested	1,307	1,042	1,132	3,481
		Positive	207	228	211	646
		Positive (%)	15.8	21.9	18.6	18.6
HCV	anti-HCV	Total tested	1,666	1,730	1,606	5,002
		Positive	782	606	614	2,002
		Positive (%)	46.9	35.0	38.2	40.0

*Note: * An antigen indicating acute or chronic active HBV infection, ** antibodies generated during an acute HBV infection but they last even long after recovery.*

Graph 6-10: Trend of selected serological markers of HIV, HBV, and HCV among injecting drug users in prison, 2010-2012 (%) (Generální ředitelství Vězeňské služby ČR, 2011, Generální ředitelství Vězeňské služby ČR, 2012, Generální ředitelství Vězeňské služby ČR, 2013b)



	anti-HIV	HBsAg	Anti-HBc	anti-HCV
2010	1,0	11,3	24,4	31,5
2011	0,9	8,3	21,6	50,8
2012	0,0	6,5	18,6	40,0

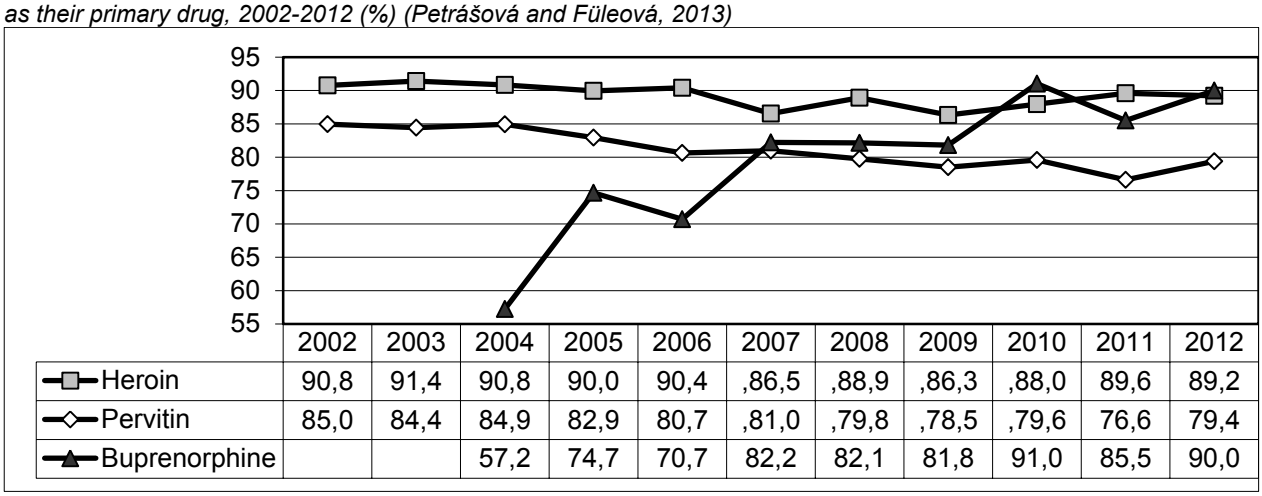
6.1.3 Risk Behaviour of Drug Users

6.1.3.1 Proportion of Injecting Use

The prevalence of injecting drug use among those demanding treatment is very high in the long term and it is the most common method used for the application of pervitin, heroin, and buprenorphine (Petrášová and Füleová, 2013); see Graph 6-11.

[110] However, the sample of prisoners is not representative and repeated tests on the same (positive) person in the various stages of serving a custodial sentence cannot be ruled out; therefore, caution must be exercised in the interpretation and generalisation of the results and trends.

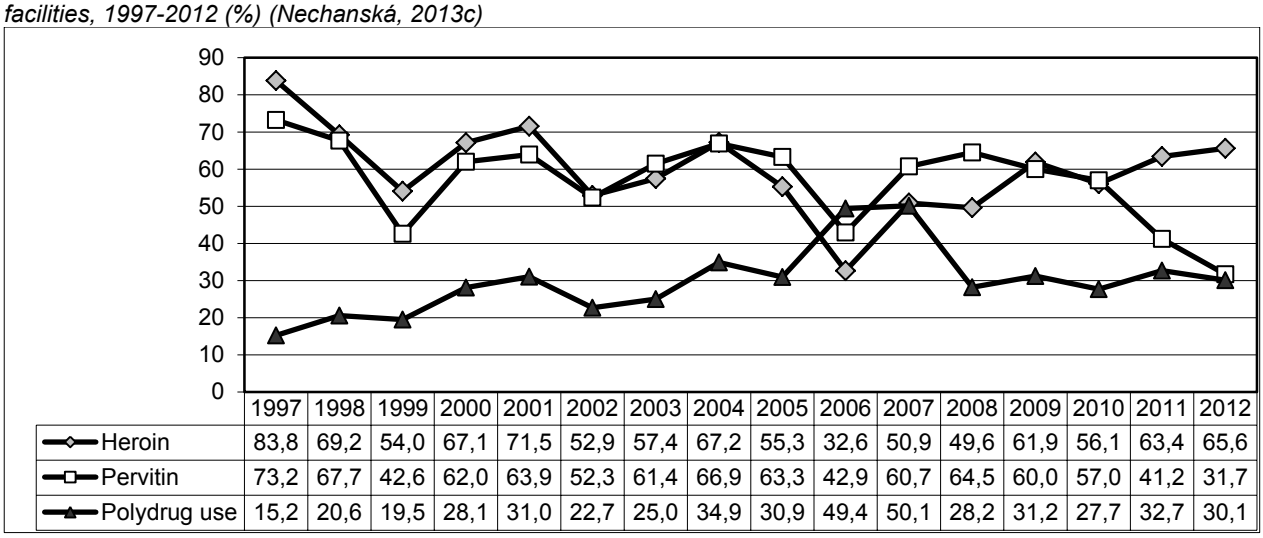
Graph 6-11: Trends in the proportion of IDUs among those demanding treatment with heroin, pervitin, and buprenorphine as their primary drug, 2002-2012 (%) (Petrášová and Füleová, 2013)



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Heroin	90,8	91,4	90,8	90,0	90,4	,86,5	,88,9	,86,3	,88,0	89,6	89,2
Pervitin	85,0	84,4	84,9	82,9	80,7	,81,0	,79,8	,78,5	,79,6	76,6	79,4
Buprenorphine			57,2	74,7	70,7	82,2	82,1	81,8	91,0	85,5	90,0

The proportion of injecting among the patients treated by outpatient psychiatric facilities has been slowly rising, with minor fluctuations, since 2006. Since 2008, the rates of injecting among pervitin users have been declining, while the proportion of injecting drug use in polydrug users has remained almost unchanged; see Graph 6-12.

Graph 6-12: Trends in the proportion of injecting heroin, pervitin, and polydrug users treated at outpatient psychiatric facilities, 1997-2012 (%) (Nechanská, 2013c)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Heroin	83,8	69,2	54,0	67,1	71,5	52,9	57,4	67,2	55,3	32,6	50,9	49,6	61,9	56,1	63,4	65,6
Pervitin	73,2	67,7	42,6	62,0	63,9	52,3	61,4	66,9	63,3	42,9	60,7	64,5	60,0	57,0	41,2	31,7
Polydrug use	15,2	20,6	19,5	28,1	31,0	22,7	25,0	34,9	30,9	49,4	50,1	28,2	31,2	27,7	32,7	30,1

6.1.3.2 Sharing of Needles and Syringes

The proportion of injecting drug users demanding treatment who reported sharing needles and syringes at any time in the past has been decreasing in the long term; see Table 6-7.

Table 6-7: Sharing of needles and syringes at any time in the past reported by IDUs demanding treatment, 2002-2012 (Petrášová and Füleová, 2013)

Year	Number of IDUs	Number of those sharing	Proportion of those sharing (%)
2002	6,437	2,590	40.2
2003	5,901	2,356	39.9
2004	6,314	2,725	43.2
2005	5,769	2,421	42.0
2006	5,860	2,313	39.5
2007	5,338	2,139	40.1
2008	5,766	2,057	35.7
2009	6,012	2,263	37.6
2010	6,581	2,146	32.6
2011	6,471	2,136	33.0
2012	6,481	1,976	30.5

The repeated Multiplier study (for more information see the chapter Problem Drug Use on p. 48 and the 2009 Annual Report) conducted among clients of low-threshold facilities in the Czech Republic between 2010 and 2013 included a question on the use of sterile needles and syringes the last time they administered the drug. The results suggest an increasing level of use of sterile paraphernalia for injecting drugs; see Table 6-8.

Table 6-8: Reported use of sterile needles and syringes on the occasion of the last administration of the drug among clients of low-threshold programmes in the Multiplier 2010 and 2013 surveys who reported injecting drug use in the last month (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a)

Year	Number of IDUs	Proportion of those using sterile paraphernalia	
		number	%
2010	567	463	81.7
2013	1,701	1,509	88.7

6.2 Other Drug-Related Health Correlates and Consequences

6.2.1 Psychiatric Comorbidity

The issue of dual-diagnosis clients in therapeutic communities for addicts is dealt with by Kalina and Vácha (2013), who provide information on the prevalence of psychiatric comorbidity and the treatment of clients in the Němčice and Karlov therapeutic communities operated by the SANANIM civic association. In 2011, 92 clients were treated by a psychiatrist in both programmes (of whom approximately a half were indicated for regular psychiatric care); their primary drugwas pervitin in two thirds of the cases and opiates/opioids in one third of the cases; approximately a third of the clients were polydrug users. Personality disorders with significant emotional, relational, and behavioural complications were observed in 35 clients. Depressive or anxiety disorder was diagnosed in 23 clients (often concurrently with personality disorder) and psychotic disorder in 15 clients (including 12 cases of paranoid psychosis resulting from pervitin use). Psychopharmaceuticals were used by 50 out of the total number of 92 clients in psychiatric care at some period of time during their stay in the community – mostly SSRI- or SNRI-type antidepressants, non-inhibiting antipsychotics, and tranquillisers. There was a special group of 12 clients without psychopathology on admission to the therapeutic community whose state of mental health worsened during treatment and who developed so-called “post-abstinence psychopathology”, usually with symptoms of depression and anxiety, but also with paranoid symptoms and self-harming. This condition may be a withdrawal-induced latent mental disorder that had previously been "self-medicated" by drugs. Clients with a dual diagnosis were more represented among those who discontinued treatment in a therapeutic community.

Additionally, an analysis of a sample of 90 clients addicted to drugs other than alcohol and 30 alcohol-dependent clients admitted to the Bílá Voda Psychiatric Hospital in 1997-1998 and 2005, respectively, was published. A psychodiagnostic assessment of the sample was made using the Rorschach projective test and the figure drawing test. The results showed a high incidence of psychopathology in the areas of self-concept, internalisation of object relations, pathological defence, superego integration, and emotional problems, which did not correlate with the duration of their drug use. The author considers a psychopathology characterised as a low level of personality organisation to be the unifying disposition for substance abuse (Jeřábek, 2013).

6.2.2 Non-Fatal Drug Intoxications

The collection of data about non-fatal intoxications[111] has been performed by the Public Health Service within a special warning (sentinel) system since 1995. However, there are considerable regional differences in the data collection systems, which complicate the interpretation of the current state of affairs and trends. 1,039 cases of non-fatal intoxications with drugs were reported in 2012; see Table 6-9. Pervitin (25%) and benzodiazepines (20%) make up the highest proportion of the intoxications reported.

[111]This system reports cases of overdoses, as well as other health complications that require emergency hospitalisation. Various types of healthcare facilities report to the system, particularly emergency units.

Table 6-9: Non-fatal drug intoxications in the Czech Republic registered by the Public Health Service, 2002-2012 (Petrášová and Füleová, 2013)

Drug	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Pervitin	191	149	180	222	231	343	364	187	148	150	260
Heroin	176	152	179	244	149	190	166	122	162	96	77
Methadone	6	3	2	10	7	2	1	1	0	0	0
Subutex®	–	2	12	14	18	32	7	0	0	0	0
Other opiates	23	22	20	19	21	40	17	42	24	32	42
Benzodiazepines	89	157	126	153	124	139	113	180	136	138	206
Other sedatives and hypnotics	137	82	103	88	107	125	135	127	112	105	120
Cannabis	101	90	84	73	72	127	108	105	102	84	125
Inhalants	58	69	64	48	28	31	9	33	18	25	26
Psilocybin	7	4	10	6	5	10	9	7	4	2	7
Cocaine, crack	2	6	5	7	8	1	7	2	0	1	5
Datura stramonium	0	0	0	1	0	1	5	2	0	0	2
LSD	2	3	7	3	5	7	4	13	3	7	15
MDMA	4	8	3	8	12	12	3	1	2	0	4
Other known drugs and medications	179	100	92	111	89	124	140	173	137	139	147
Other, unknown	25	34	65	186	78	71	58	23	1	26	3
Total	**1,000**	**881**	**952**	**1,193**	**954**	**1,255**	**1,146**	**1,018**	**849**	**805**	**1,039**

In addition, information on the occurrence of intoxications with addictive substances is available from the National Register of Hospitalisations (NRHOSP).[112] Despite the obvious shortcomings in the coding of substances by physicians, one can see a long-term decline in the number of admissions for drug poisoning; Ústav zdravotnických informací a statistiky, 2013b); see Table 6-10.

Table 6-10: Number of admissions to acute care hospitals for intoxication caused by drugs, 2002-2012 (Ústav zdravotnických informací a statistiky, 2013b)

Drug	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Heroin (T40.1)	58	32	27	24	18	31	41	19	20	17	4
Methadone (T40.3)	3	3	1		6	1	2	3	2	1	2
Other opiates/opioids (T40.0, T40.2)	69	77	50	71	79	64	62	50	62	57	79
Cocaine (T40.5)	0	0	2	7	2	1	4	1	3	1	1
Cannabis (T40.7)	78	77	95	78	67	55	86	66	66	58	57
LSD (T40.8)		2	4		6	5	3	4	1	2	2
Pervitin and other stimulants (T43.6)	22	31	24	25	22	29	30	25	25	17	30
Other and unspecified drugs (T40.4, T40.6, T40.9)	145	142	100	116	146	136	83	94	77	79	87
Illegal drugs, total	**375**	**364**	**303**	**321**	**346**	**322**	**311**	**262**	**256**	**232**	**262**
Alcohol (T51.0, T51.9)	1,243	1,447	1,505	1,220	1,184	1,161	1,125	919	724	714	738
Inhalants (T52.0–T52.9)	426	406	434	401	401	306	264	230	243	241	262
Total	**2,044**	**2,217**	**2,242**	**1,942**	**1,931**	**1,789**	**1,700**	**1,411**	**1,223**	**1,187**	**1,262**

6.2.3 Drugs and Road Accidents

Since 2003, cases have been analysed of ethanol and other drugs[113] in victims of traffic accidents autopsied by forensic medicine departments in the Czech Republic; see the chapter entitled Drug-Related Deaths in

[112] This register is managed by the Institute of Health Information and Statistics and records only cases requiring hospitalisation for more than 24 hours. Cases of accidental, intentional, or undetermined poisoning caused by illegal drugs were extracted, i.e. diagnoses of intoxications with non-alcohol drugs, excluding medications (diagnoses T40 and T43.6), and the toxic effect of alcohol (T51.0, T51.9) and the toxic effect of organic solvents (T52.0-T52.9).

[113] A test is considered to be positive for ethanol if the level of ethanol is higher than 0.2 g/kg (Společnost soudního lékařství a soudní toxikologie, 1999), positive for cannabis if THC or its active metabolite is proven (i.e. not THC-COOH, for instance), and positive for

the Special Mortality Register (p. 105). So-called "active participants in traffic accidents" (pedestrians, cyclists, and drivers) are monitored separately.[114] The data for 2012 are not yet available; for more data until 2011 see the 2011 Annual Report. Among the active participants who died in traffic accidents in 2011 and were autopsied by forensic medicine departments in the Czech Republic (except for the Na Bulovce University Hospital),[115] 111 active road users were identified as being positive for ethanol (including 38 drivers) and 21 were positive for any of the narcotic and psychotropic substances that were monitored (8 of them drivers), which suggests a higher prevalence of substance use among victims of traffic accidents than is apparent from police records; see Table 6-11.

Table 6-11: Road accidents in the Czech Republic, 2003-2011 – the influence of alcohol and other drugs (Ředitelství služby dopravní policie Policejního prezidia ČR, 2013)

Year	Accidents					Death in accidents (within 24 hours after the accident)				
	Total	Under the influence of alcohol		Under the influence of other drugs		Total	Under the influence of alcohol		Under the influence of other drugs	
	Number	Number	%	Number	%	Number	Number	%	Number	%
2003	195,851	9,076	4.9	39	0.02	1,319	111	8.5	0	0.0
2004	196,484	8,445	4.5	53	0.03	1,215	59	4.9	1	0.1
2005	199,262	8,192	4.3	60	0.03	1,127	59	5.2	0	0.0
2006	187,965	6,807	3.8	64	0.03	956	42	4.3	1	0.1
2007	182,736	7,266	4.3	78	0.04	1,123	36	3.2	2	0.2
2008	160,376	7,252	4.8	109	0.07	992	80	8.1	1	0.1
2009*	74,815	5,725	8.1	137	0.18	832	123	14.9	6	0.7
2010	75,522	5,015	6.6	165	0.22	753	102	13.5	15	2.0
2011	75,137	5,242	7.5	165	0.24	707	89	12.6	10	1.4
2012	81,404	4,974	6.7	173	0.22	681	45	6.6	9	1.3

*Note: * Effective from 1 January 2009, the estimated damage limit for the mandatory reporting of accidents to the police was increased from CZK 50,000 (€ 1.9 thousand) to CZK 100,000 (€ 3.9 thousand); as a result, the number of accidents reported dropped.*

In 2012, the Police of the Czech Republic recorded 4,974 accidents caused under the influence of alcohol (i.e. 6.7% of the total), with 45 fatalities (i.e. 6.6% of the total) and another 2,525 persons injured. The regions with the highest proportion of these accidents were the Zlín region (12.3%) and the Karlovy Vary region (11.3%). The largest numbers of fatalities in these accidents occurred in the Liberec, Hradec Králové, and Central Bohemia regions (with 9, 7, and 6 deaths, respectively). The highest proportion of fatal accidents occurred in the Liberec region – 36.0%. No fatal traffic accident caused under the influence of alcohol was reported from the Karlovy Vary region in 2012. A level above 1.5‰ was most commonly found in the person at fault (in 2,770 cases). As regards the type of road users, the highest proportion of accidents under the influence of alcohol was caused by cyclists (31%), followed by moped riders (25%), coachmen (20%), and pedestrians (16%). Of the total number of 4,974 accidents caused under the influence of alcohol, 4,030 (81%) were caused by drivers of motor vehicles, of which 3,582 (72%) were caused by the drivers of passenger cars, 727 (15%) by cyclists, and 206 (4%) by pedestrians. In comparison to 2011, there was a decrease in the number of accidents taking place under the influence of alcohol involving drivers of motor vehicles. The largest numbers of accidents caused under the influence of alcohol and registered with the police fell on a Saturday (1,271 accidents) or Sunday (991 accidents) and, conversely, the fewest accidents involving alcohol were recorded on Tuesdays (Ředitelství služby dopravní policie Policejního prezidia ČR, 2013).

Of the 173 accidents taking place under the influence of drugs other than alcohol, 19 were in combination with alcohol. In the 154 accidents that occurred under the influence of non-alcohol drugs only, 71 people were injured and three people died.

The traffic police test drivers for alcohol and, since 2007, they have also tested drivers for narcotic and psychotropic substances using screening saliva tests.[116] If the rapid on-site test for non-alcohol drugs is positive, it is necessary to carry out a specialist medical and subsequent toxicological examination. The number of positive tests for narcotic and psychotropic substances and alcohol among drivers in 2007-2013 is shown in Table 6-12.

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inhalants if a post-mortem examination detects substances which do not develop post mortem or are not indicated in some physiological or pathological conditions (e.g. acetone, acetaldehyde, n-propanol, n-butanol).

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

[115] Data were not available at the time of the closing of the 2011 Annual Report.

[116] DrugWipe tests are used; see http://www.affiniton.com/products_drugWipe.html (13 September 2013).

Table 6-12: Positive tests for narcotic and psychotropic substances and alcohol (ethanol) among drivers, 2007-2013 (Ředitelství služby dopravní policie Policejního prezidia ČR, 2013)

Year	Narcotic and psychotropic substances	Ethanol
2007	347	7,395
2008	794	7,600
2009	1,149	13,298
2010	1,450	13,268
2011	1,717	12,777
2012	2,195	11,046
2013 (first half)	1,580	4,657

6.2.4 Injuries under the Influence of Drugs and Alcohol

The number of accidents under the influence of drugs other than alcohol treated in outpatient surgical[117] units in 2012 decreased by almost a half, as did their share in the total number of the injuries treated. The number and proportion of accidents under the influence of alcohol in 2001-2012 did not change significantly (Ústav zdravotnických informací a statistiky, 2013d); see Table 6-13.

Table 6-13: Number of injuries treated in surgical wards in total and under the influence of alcohol and drugs, 2001-2012, in thousands (Ústav zdravotnických informací a statistiky, 2013d)

Year	Total number of injuries	of which under the influence of	
		alcohol	other drugs
2001	1,681,741	37,954	816
2002	1,776,050	42,414	919
2003	1,806,886	39,182	869
2004	1,824,015	40,608	819
2005	1,841,339	40,205	1,071
2006	1,855,697	38,584	1,085
2007	1,794,213	41,498	1,433
2008	1,649,519	39,116	1,671
2009	1,640,975	45,606	1,446
2010	1,661,721	35,041	1,996
2011	1,696,419	42,940	2,696
2012	1,739,243	41,252	1,442

Furthermore, all cases with an external cause of injury and those under the influence of drugs were extracted from the National Register of Hospitalisations.[118] The proportion of accidents occurring under the influence of alcohol in the period 2002-2012 increased from 2.7% to 3.5%. The number of accidents occurring under the influence of illegal drugs, psychoactive medication, and inhalants was low and both their absolute number and their proportion decreased over the reporting period (Ústav zdravotnických informací a statistiky, 2013c).

[117] The data are drawn from the data sheet tracking treatment in the field of surgery, completed annually by each outpatient department or unit for surgery. The data sheet tracks the number of injuries treated in surgical departments and, separately, the number of accidents that occurred under the influence of alcohol or under the influence of drugs.

[118] Cases with a primary diagnosis or any secondary diagnosis F10.0 and T51.0 or T51.9 were identified to determine injuries under the influence of alcohol, cases with a primary diagnosis or any secondary diagnosis F11.0 or F12.0 or F14.0 or F15.0 or F16.0 or F19.0 or T40 or T43.6 for illegal drugs, cases with a primary diagnosis or any secondary diagnosis F18.0 or T52 for inhalants, and cases with a primary diagnosis or any secondary diagnosis F13.0 or T42 or T43, except T43.6, for psychoactive medication.

Table 6-14: Development of hospitalisations for injury, overall and under the influence of drugs, 2002-2012 (Ústav zdravotnických informací a statistiky, 2013c)

Rok	Total	of which resulting from accidents under the influence of				
		addictive substances, total	alcohol	illicit drugs	psychoactive medication	inhalants
2002	187,090	**8,942**	4,959	443	3,350	441
2003	196,577	**9,080**	5,373	428	3,090	421
2004	203,211	**9,681**	6,010	402	3,098	446
2005	202,815	**9,341**	5,845	391	2,991	415
2006	195,803	**8,659**	5,216	423	2,872	412
2007	191,937	**9,157**	5,878	410	2,812	315
2008	196,013	**9,588**	6,650	425	2,566	271
2009	198,738	**9,670**	6,974	370	2,385	242
2010	200,319	**9,163**	6,615	365	2,255	249
2011	200,553	**9,416**	6,807	326	2,325	250
2012	205,090	**10,032**	7,190	384	2,519	271

6.2.5 Mass Methanol Poisonings in 2012

An outbreak of mass methanol poisonings started in Havířov on 3 September 2012. By 6 September 2012, it was confirmed that people admitted to the department of anaesthesiology and resuscitation of the Havířov Hospital and Polyclinic had been poisoned as a result of having consumed alcohol. The first deaths occurred on the same day. By mid-July 2013 132 people had been poisoned, and 47 people had died; the majority of cases occurred by late September 2012. The number of cases in this mass poisoning by region is provided in Table 6-15, the long-term trend in Table 6-16.

On 11 September 2012, the Minister of Health issued a warning against the consumption of alcohol of unclear origin and on 12 September the Minister of Health announced an emergency measure, which prohibited the operators of food stalls, mobile kiosks, and other mobile and temporary operations to serve and sell distilled liquor-type spirits and *tuzemák* ("Czech rum") with an alcohol content over 30%. At the same time, a Crisis Committee was established by virtue of Government Resolution No. 675. At the regional level, working groups on the issue of methyl alcohol poisoning were established on 12 September and their activity was coordinated by the directors of the regional outlets of the Public Health Service. Because of the growing number of hospitalisations and deaths resulting from methyl alcohol poisoning (despite the intensive control activities of all the relevant authorities) and with regard to the fact that contaminated spirits had also been found in regular bricks-and-mortar shops, a new emergency measure was announced on 14 September, extending the ban to include all points of sale. Food business operators, including persons engaged in catering, were prohibited from selling spirits with an ethanol content above 20% until further notice. Following debates on how to secure the safety of spirits produced in the Czech Republic, the Ministry of Finance issued Decree No. 310/2012 Coll.,[119] which introduced a new control tape for all spirits with an ethanol content of 20% or higher produced after 27 September 2012. As a result of pressure from the European Commission and ongoing discussions with representatives of the European Commission, the emergency measure was extended on 20 September and a ban was imposed on the export of spirits. On 26 September 2012, the Czech government approved Government Regulation No. 317/2012 Coll., which laid down the procedure for the proof of origin of certain types of ethanol, distilled alcohol, and certain kinds of spirits, stipulating that spirits placed on the Czech market must be accompanied by a certificate of origin for alcohol and spirits. The prohibition ended on 27 September with a new emergency measure imposed by the Ministry of Health, which stipulated a gradual lifting of the ban on the spirits market. The sale and export of spirits produced after 31 December 2011 was prohibited unless they were supplied with proof of the origin of the alcohol, and it was ordered that within 60 days, all opened packages of spirits, except those whose safety had been demonstrated by laboratory tests, would have to be mandatorily destroyed (Ministerstvo zdravotnictví, 2013a, Kvášová, 2013).

[119]Ministry of Finance Decree No. 310/2012 Coll. amending Decree No. 149/2006 Coll. implementing Act No. 676/2004 Coll., on the mandatory labelling of spirits and amending Act No. 586/1992 Coll., on income tax.

Table 6-15: Number of cases of poisoning and deaths from methanol poisoning from the onset of the mass poisonings in September 2012 till 16 July 2013, by region of occurrence (Kvášová, 2013)

Region	Total number of poisonings	of which deaths
Prague	5	2
Central Bohemia	9	3
South Bohemia	1	0
Pilsen	0	-
Karlovy Vary	3	0
Ústí nad Labem	1	1
Liberec	1	0
Hradec Králové	1	0
Pardubice	2	0
Vysočina	0	-
South Moravia	9	4
Olomouc	14	9
Zlín	20	4
Moravia-Silesia	66	24
Total	**132**	**47**

Table 6-16: Trend of accidental, intentional, or unspecified poisonings by methanol and deaths resulting from them in the Czech Republic, 2002-2012

Year	Number of persons hospitalised*	Number of deaths**
2002	11	0
2003	8	2
2004	12	0
2005	9	3
2006	8	1
2007	2	1
2008	7	1
2009	3	3
2010	11	3
2011	10	3
2012	97	36

*Note: Sources: * National Register of Hospitalisations, Institute of Health Information and Statistics, ** Deaths Information System, Czech Statistical Office.*

6.3 Drug-Related Deaths and Mortality of Drug Users

6.3.1 Drug-Related Deaths in the Special Mortality Register

In the Czech Republic, a forensic medical examiner carries out a mandatory autopsy in all cases of sudden death in which the examining practitioner could not determine the cause of death and in all cases of violent deaths (all injuries and poisonings). Since 1998 direct drug-induced deaths (fatal overdoses), and since 2003 also indirect drug-related deaths (with the presence of drugs), have been monitored on a routine basis by means of a special register kept by all the thirteen departments of forensic medicine, with close collaboration between the National Focal Point and the Society for Forensic Medicine and Toxicology of the J. E. Purkyně Czech Medical Association. The data for 2012 were not available at the closing date of the 2012 Annual Report. Detailed data until 2011 are provided in the 2011 Annual Report.

From 2014, this information system should be transformed to the new National Register of Autopsies and Toxicology Tests Carried Out at the Department of Forensic Medicine, according to Act No. 372/2011 Coll., on health services and the terms and conditions of the provision thereof.

In 2011, 190 fatal overdoses on illicit drugs, inhalants, and psychotropic medications were identified. Of this number, 28 cases fell under the standard EMCDDA selection D for drug-related deaths, i.e. cases of fatal overdoses on illegal drugs and inhalants (of which 16 were on pervitin, 6 on opiates/opioids, and 4 on inhalants) and 162 cases of fatal overdoses on psychotropic medications. Additionally, in 2011 113 deaths with the presence of drugs were identified, mostly accidents and suicides other than overdoses under the influence of psychoactive drugs, methamphetamine, and cannabis.

6.3.2 Drug-Related Deaths in the Deaths Information System

When data on drug-related deaths are being extracted from the Deaths Information System, known as the general mortality register, the EMCDDA criteria are used, based on the selection of an appropriate diagnosis as the cause of death, or a combination of the causes of death and the mechanism of death.

The structure of fatal drug overdoses in 2012, according to the EMCDDA standard selection and expanded selection B[120] by age, gender, and type of drug is shown in Table 6-17 and the development of deaths by drug in 1994-2012 is shown in Table 6-18 (Ústav zdravotnických informací a statistiky, 2013a).

Table 6-17: Fatal drug overdoses in the Czech Republic according to selection B and expanded selection B in the general mortality register by groups of drugs, age groups, and gender (Ústav zdravotnických informací a statistiky, 2013a)

Drug	**Age group**												**Total**		
	<15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>64	Men	Women	**Total**
Opiates/opioids	0	0	1	2	2	2	1	2	3	3	0	1	11	6	**17**
Cannabis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Cocaine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other stimulants	0	0	0	4	0	0	1	0	1	0	0	1	5	2	**7**
Hallucinogens	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Unspecified drugs	0	0	1	1	0	0	0	1	2	2	1	0	4	4	**8**
Selection B (standard)	**0**	**0**	**2**	**7**	**2**	**2**	**2**	**3**	**6**	**5**	**1**	**2**	**20**	**12**	**32**
Inhalants	0	0	0	2	0	0	4	3	1	0	1	2	11	2	**13**
Selection B (expanded)	**0**	**0**	**2**	**9**	**2**	**2**	**6**	**6**	**7**	**5**	**2**	**4**	**31**	**14**	**45**

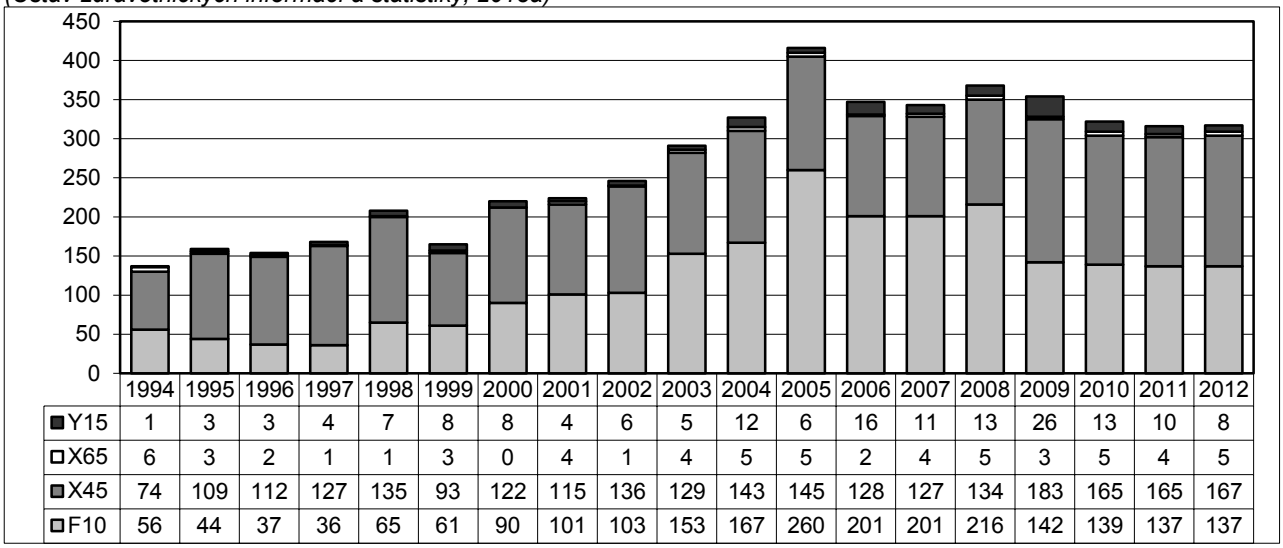
[120] As a standard, EMCDDA selection B is used. This consists of selecting deaths where the primary cause of death is a mental disorder or behavioural disorder caused by illegal drugs and combinations thereof (diagnoses F11-F19, excluding F13, F17, and F18) or in cases where there was accidental, intentional, or undetermined poisoning caused by illegal drugs, i.e. a combination of diagnoses listed under the letters X or Y with diagnoses for poisoning caused by the given substance (diagnoses T40 and T43.6). In an effort to bring selection B from the general register as close to selection D from the special mortality register as possible, selection B was expanded to include inhalants, i.e. diagnosis F18 (a mental disorder or behavioural disorder caused by the use of inhalants) and diagnoses X46, X66, and Y16 in combination with diagnosis T52, i.e. accidental, intentional, or undetermined poisoning caused by inhalants.

Table 6-18: Fatal drug overdoses in the Czech Republic according to selection B and expanded selection B in the general mortality register by groups of drugs, 1994-2012 (Ústav zdravotnických informací a statistiky, 2013a)

Year	Opiates/ opioids	of which methadone	Cannabis	Cocaine	Other stimulants	Hallucinogens	Unspecified drugs	Selection B (standard)	Inhalants	Selection B (expanded)
1994	7	0	0	0	0	0	3	**10**	12	**22**
1995	0	0	0	0	0	0	3	**3**	9	**12**
1996	2	0	0	0	0	0	4	**6**	18	**24**
1997	4	0	0	0	0	0	9	**13**	17	**30**
1998	7	0	0	0	0	0	9	**16**	10	**26**
1999	14	1	1	0	1	0	8	**24**	14	**38**
2000	11	0	0	0	0	0	12	**23**	19	**42**
2001	18	0	0	0	0	0	13	**31**	21	**52**
2002	6	0	0	0	3	0	4	**13**	17	**30**
2003	12	0	0	0	2	0	4	**18**	14	**32**
2004	2	0	0	0	1	0	11	**14**	14	**28**
2005	9	0	0	1	2	0	7	**19**	16	**35**
2006	11	0	1	1	1	0	5	**19**	14	**33**
2007	6	1	1	0	2	0	10	**19**	15	**34**
2008	9	0	0	0	7	0	8	**24**	8	**32**
2009	20	1	1	0	2	0	10	**33**	10	**43**
2010	13	1	0	0	8	0	8	**29**	13	**42**
2011	12	0	0	1	3	1	5	**22**	5	**27**
2012	17	1	0	0	7	0	8	**32**	13	**45**

317 cases of fatal overdoses on ethanol were identified in 2012; the development of these overdoses since 1994 is shown in Graph 6-13 (Ústav zdravotnických informací a statistiky, 2013a).

Graph 6-13: Structure of fatal alcohol overdoses in the Czech Republic in the general mortality register, 1994-2012 (Ústav zdravotnických informací a statistiky, 2013a)



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Y15	1	3	3	4	7	8	8	4	6	5	12	6	16	11	13	26	13	10	8
X65	6	3	2	1	1	3	0	4	1	4	5	5	2	4	5	3	5	4	5
X45	74	109	112	127	135	93	122	115	136	129	143	145	128	127	134	183	165	165	167
F10	56	44	37	36	65	61	90	101	103	153	167	260	201	201	216	142	139	137	137

Note: F10 – mental and behavioural disorders resulting from the use of alcohol, X45 – accidental poisoning by and exposure to alcohol, X65 – intentional self-poisoning by and exposure to alcohol, Y15 – poisoning by and exposure to alcohol, undetermined intent.

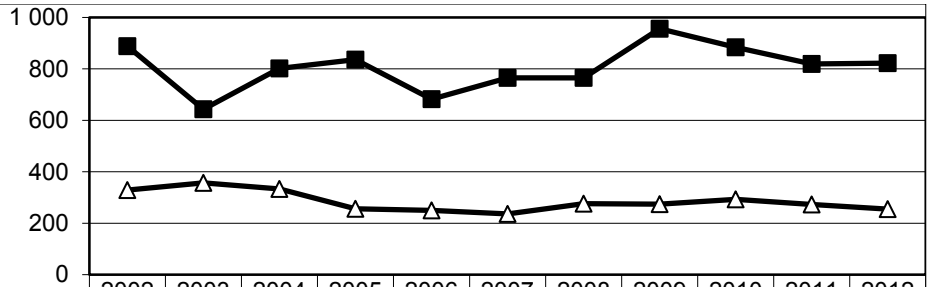
6.3.3 Autopsies Performed by Forensic Medicine Departments

Another source of information on the occurrence of drug-related deaths is the annual forensic medicine data sheets.[121] The number of deaths related to the consumption of addictive substances (i.e. indirect deaths)

[121] Each forensic medicine department or independent forensic toxicology unit completes the data sheet. The data sheet contains the number of autopsies carried out, broken down into various categories. There is separate monitoring for the autopsies performed on the victims of overdoses on alcohol and narcotic and psychotropic substances, i.e. cases where the substance itself or associated complications such as choking on vomit or pneumonia led to death (i.e. essentially direct drug-induced deaths), and the autopsies in cases of deaths related to the use of alcohol and/or narcotic and psychotropic substances, i.e. cases of positive evidence that the presence of the substance was a secondary finding and death was caused by a mechanism other than an overdose, such as injury resulting from a fall or traffic accident (indirect drug-related deaths). The data sheet is aggregated; it is not possible to differentiate individual substances or causes of death.

according to the annual data sheets is approximately three times higher than the number of fatal overdoses. Developments in the total number of autopsies and autopsies following an overdose in connection with the use of alcohol and/or narcotic and psychotropic substances are shown in Graph 6-14 (Ústav zdravotnických informací a statistiky, 2013e).

Graph 6-14: Number of autopsies performed by forensic medicine departments, 2002-2012 (Ústav zdravotnických informací a statistiky, 2013e)



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Autopsies, total	10,520	11,730	12,725	12,842	12,790	13,517	13,573	13,402	13,721	14,046	14 183
of them fatal overdoses on alcohol and/or other drugs	,329	,357	,333	,256	,250	,236	,276	,274	,293	,273	255
of them deaths related to the use of alcohol and/or other drugs	,888	,643	,802	,836	,682	,765	,765	,956	,884	,819	822

6.3.4 Mortality of Drug Users

The Substitution Treatment Register also includes the deaths of clients among the reasons for terminating treatment. In 2012, a total of 2,298 persons were registered as being in treatment (Nechanská, 2013f), with the deaths of four of these patients being reported, representing an annual gross mortality rate of approximately 1.3‰. Despite the very low numbers, the data since 2000 show a declining mortality trend among registered patients; see Table 6-19. However, the mortality rate in the Register is underestimated because physicians do not report all of their patients' deaths to it.

Table 6-19: Mortality rate for patients in the Substitution Treatment Register, 2000-2012 (Nechanská, 2013f)

Year	Number of registered patients in treatment	Number of registered patients who died	Mortality rate (‰)
2000	245	0	0.0
2001	533	2	3.8
2002	560	0	0.0
2003	789	2	2.5
2004	866	2	2.3
2005	825	1	1.2
2006	938	1	1.1
2007	1,038	0	0.0
2008	1,356	3	2.2
2009	1,555	3	1.9
2010	2,113	4	1.9
2011	2,290	4	1.7
2012	2,298	3	1.3

A study estimating the influence of alcohol (or ethanol) on mortality in the Czech Republic in 1994-2010 was published (Kohoutová, 2013). The method used was the etiologic fraction, which in this case indicates the proportion of deaths that occurred as a result of alcohol use. Deaths resulting from alcohol consumption in 2010 accounted for approximately 6% of the total mortality from all causes and this proportion varies according to gender and age. The proportion is approximately 10% for men and 2% for women. The proportion of women almost doubled in the period from 1994-2010. Although in absolute numbers most deaths caused by alcohol occur in the oldest groups of the population, as a result of their higher overall mortality, alcohol causes the greatest relative damage in young adults and those in middle age. The proportion of deaths resulting from alcohol consumption is the highest in the 35-44 age group, reaching almost 26% in men and 17% in women. The youngest age group, aged 15-24, accounts for 15% (men) and 11% (women) of the deaths resulting from alcohol consumption. Alcohol is the greatest contributory factor for liver diseases (fibrosis, cirrhosis, hepatitis, esophageal varices), causing more than 80% of these diseases in men and 60% in women.

7 Responses to Health Correlates and Consequences of Drug Use

Harm reduction has been one of the main areas of the Czech drug policy in the long term. Low-threshold drop-in centres and outreach programmes across the Czech Republic form the basis of the network of services in this area. Data from low-threshold programmes indicate that pervitin (methamphetamine) and opiate users account for most of the clients (57% and 27%, respectively). There was a marked increase in the number of buprenorphine users (at the expense of heroin users), as well as in that of cannabis users. The average age of the clients continues to grow and a large number of clients in contact with harm reduction services report injecting drug use (80%).

Needle and syringe exchange services were provided by 103 low-threshold programmes in 2012. Almost 5.4 million items of injecting equipment were supplied, which means no further year-on-year increase. The available information indicates that there were at least 27 programmes in the Czech Republic in 2012 that distributed gelatine capsules as an oral alternative to injecting. More than 46 thousand such capsules were supplied to clients.

In 2012, a total of 64 low-threshold facilities offered HIV testing, 67 HCV testing, and 48 HBV testing, and 46 low-threshold facilities offered syphilis testing. Although the availability of testing for the clients of low-threshold programmes has varied over time, there is an apparent increase in the number of tests performed in the medium term. The Czech Republic still lacks formal guidelines for the testing and prevention of infections among drug users that would take into account both the specific needs of this population and the Czech system of low-threshold services.

Specific harm reduction programmes in recreational settings were conducted in 2012 by a total of three programmes. 1,145 contacts were made at thirteen music events.

A total of seven AIDS centres, which also operate at the regional level, provide care for HIV-infected persons and AIDS patients in the Czech Republic. HCV treatment was provided to injecting drug users (IDUs) by a total of 38 viral hepatitis treatment centres (out of the total of 53 centres providing HCV treatment), treating 745 former or current injecting drug users (64% of all the patients) in 2012. The number of patients who entered HCV treatment in prison increased.

7.1 Legal Framework, Strategies, and Policies for Harm Reduction

In 2010 the government adopted the National Drug Policy Strategy for 2010-2018, in which harm reduction forms one of the four pillars; for details see the 2010 Annual Report and the chapter entitled National Action Plan, Strategy, Evaluation, and Coordination (p. 9). The 2013-2015 Action Plan contains a number of new tasks, in particular in the area of the prevention of infections, including the availability of harm reduction programmes to groups which are difficult to reach or in socially excluded communities. It also contains the task of issuing a guideline for infection testing in drug services. The guideline is primarily the responsibility of the Ministry of Health, as the exceedingly restrictive standpoints and ambiguous requirements represent a barrier to the further development of the prevention of infections among drug users in the Czech Republic; see also the 2011 Annual Report.

The National Programme for HIV/AIDS in the Czech Republic for 2013-2017[122] contains a number of activities that are also targeted at injecting drug users. For example, the programme states that it is necessary "... in the environment of community services and community centres, to promote the use of rapid screening tests and modify the methodological, organisational, and technical framework for the provision of rapid tests to the at-risk groups so as to ensure the availability and provision of such tests in accordance with the laws and regulations of the Czech Republic".

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

In the Czech Republic, the prevention of overdoses is conducted through the counselling and education of drug users as part of the services provided by low-threshold and treatment facilities. For low-threshold programmes see below; treatment is discussed in the chapter entitled Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 61). No programmes have been implemented or tested in the Czech Republic regarding the distribution of naloxone to drug users for the treatment of opiate overdoses on a self-help basis. For details of the activities of low-threshold services in this area see the 2011 Annual Report.

It should also be noted within the context of this chapter that an increased number of cases involving the use of fentanyl have been reported in certain areas. Because both its effective and lethal dosages are low (50-80 times lower than those of heroin), the drug represents an increased risk of overdosing (including fatal overdoses); for details see the chapter entitled Data on Problem Drug Use from Non-Treatment Sources on p. 55.

[122] As adopted by Government Resolution No. 956 of 20 December 2012.

7.3 Prevention and Treatment of Drug-Related Infectious Diseases

7.3.1 Low-Threshold Harm Reduction Programmes

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

The network of low-threshold facilities in the Czech Republic comprises drop-in centres and outreach programmes for drug users. Their number has remained relatively stable in recent years;[123] there were 103 of them in operation in 2012.

Over 34 thousand drug users were in contact with low-threshold programmes in 2012, with pervitin users accounting for two thirds of them (19,457), followed by opiate users (9,160) and cannabis users (3,303); see Table 7-1. The number of cocaine users in contact remains very low (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f).

The service most commonly used in low-threshold programmes is the exchange of needles and syringes and distribution of paraphernalia, which is understandable, considering the historically high percentage of injecting drug users among the clients of harm reduction programmes; see Table Table 7-2.

The structure of the clients of low-threshold programmes has changed only slightly in recent years. Pervitin and opiate users represent the predominant group (with 57% and 27%, respectively). Data reported by low-threshold programmes point out a marked increase in the number of buprenorphine users (with the corresponding decrease in the number of heroin users) as well as in that of cannabis users. The average age of the clients continues to grow (by five years of age since 2004) and a large number of clients in contact with low-threshold services report injecting drug use (80%).

In terms of regional distribution, the low-threshold programmes in Prague, followed by those in the Ústí nad Labem and Moravia-Silesia regions, reported the highest numbers of contacts in 2012. The highest number of interventions pertaining to exchange programmes (number of exchanges) was reported by the services in Prague, followed by the Ústí nad Labem and Moravia-Silesia regions (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f). A detailed account of the services reported by the low-threshold programmes in 2012 by region is provided in Table 7-3.

Table 7-1: Clients of Czech low-threshold programmes, 2004-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Indicator	2004	2005	2006	2007	2008	2009	2010	2011	2012
Number of low-threshold programmes	92	92	90	109	100	95	96	99	103
Number of drug users	24,200	27,800	25,900	27,200	28,300	30,000	32,400	35,500	34,200
– injecting drug users	16,200	17,900	18,300	20,900	22,300	23,700	24,500	25,300	27,550
– pervitin users	12,200	12,300	12,100	14,600	14,900	16,000	17,500	19,400	19,450
– illicit opiate/opioid users	6,000	6,800	6,900	7,300	8,300	8,900	8,100	6,800	6,900
– heroin users	–	–	4,000	4,100	4,600	4,950	4,200	3,300	2,800
– buprenorphine users	–	–	2,900	3,200	3,700	3,950	3,900	3,500	4,100
– cannabis users	4,100	3,600	2,700	2,000	1,700	2,200	1,900	3,200	3,300
– inhalant users	560	470	450	390	300	250	300	250	150
Average age of drug users (years)	23.4	25.0	25.3	26.1	26.4	27.4	27.0	28.1	28.5

[123] The number of programmes is influenced by the projects submitted by low-threshold facilities to subsidy proceedings and by the formal differentiation of the individual activities. A drop-in centre and an outreach programme may both be operated by one and the same entity within a single project, while in other cases or in other years, they may form two or more separate projects. Information about the services provided in the low-threshold facilities is mainly available from the final reports drawn up by the facilities for the purposes of the subsidy proceedings of the Government Council for Drug Policy Coordination.

Table 7-2: Selected services of low-threshold facilities, 2006-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Indicator	2006	2007	2008	2009	2010	2011	2012
Needle/syringe exchange	191,000	215,800	217,200	237,800	234,900	256,500	240,100
Food service	97,600	94,100	87,800	108,800	107,700	100,700	94,300
Hygiene service	41,100	40,000	34,800	44,300	56,300	53,000	46,400
Individual counselling	21,900	24,100	21,000	27,800	37,600	30,800	34,000
Medical attendance	10,500	9,400	7,700	10,200	9,700	9,500	9,200
Crisis intervention	1,800	1,600	1,100	1,600	2,400	2,400	1,800
Group counselling	1,500	1,000	1,100	1,300	1,300	700	500
Total number of contacts	322,900	338,100	329,500	365,600	396,800	415,400	421,500

Table 7-3: Selected services of low-threshold centres by region, 2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Region	Contact	First contact	Needle/syringe exchange	Food service	Hygiene service	Individual counselling	Referral*	Medical attendance	Crisis intervention	Group counselling
Prague	138,421	968	109,781	24,320	6,796	4,434	4,047	3,940	162	163
Central Bohemia	20,308	565	12,564	4,375	1,962	2,975	1,563	148	35	8
South Bohemia	18,879	752	9,534	7,623	2,794	2,272	1,573	441	127	69
Pilsen	20,685	522	6,860	5,195	2,669	2,172	1,345	684	165	96
Karlovy Vary	30,862	665	9,857	5,123	2,736	611	417	383	115	6
Ústí nad Labem	51,845	1,310	33,148	7,795	4,551	2,314	1,324	714	79	2
Liberec	11,737	366	6,859	4,890	2,027	321	666	47	45	0
Hradec Králové	9,973	300	4,264	4,738	3,641	848	141	87	43	3
Pardubice	2,768	136	1,612	407	654	102	129	10	5	0
Vysočina	8,746	306	2,716	4,052	1,494	1,297	555	125	25	0
South Moravia	30,057	696	14,728	6,489	4,469	3,248	584	668	66	82
Olomouc	22,571	1,696	5,617	4,235	2,453	3,445	2,741	882	179	54
Zlín	10,814	329	3,555	872	910	1,505	1,145	253	43	0
Moravia-Silesia	43,803	1,001	19,030	14,201	9,273	8,463	894	790	712	55
Total	**421,469**	**9,612**	**240,125**	**94,315**	**46,429**	**34,007**	**17,124**	**9,172**	**1,801**	**538**

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

In the first half of 2012, the Department of Addictology conducted a study involving the institutional analysis of the low-threshold services for substance users, aimed at the preparedness of these services for transformation and inclusion into the healthcare system (Burešová, 2012). A total of 60 facilities (39 drop-in centres and 21 outreach programmes) participated in the questionnaire survey. They are summarised in Table 7-4.

Table 7-4: Summary of low-threshold facilities participating in the study (Burešová, 2012)

Type of services provided	Drop-in centres		Outreach programmes		Total	
	Number	%	Number	%	Number	%
Social service	34	87	20	95	54	90
Health service	1	3	1	5	2	3.3
Combination of social and health service	2	5	0	0	2	3.3
Other	2	5	0	0	2	3.3
Total	**39**	**100**	**21**	**100**	**60**	**100**

The analysis shows that a major proportion of the low-threshold drug services (harm reduction programmes) in the Czech Republic are provided outside the healthcare system. The vast majority of these services is provided by social service facilities; 87% of the drop-in centres and 95% of the outreach programmes are only registered as a social service. The survey also indicated that social work was the most common intervention, even though most facilities also provide purely health-related interventions such as medical attendance (90%) and testing for infections (68%).

The potential barriers to the entry of social services into the healthcare system are mainly related to the requirements concerning the staffing, as well as the technical and material resources. Only less than a half of the facilities employed a qualified addictologist. The teams of 30% of the facilities included a qualified addictologist authorised to work without professional supervision. The most common healthcare qualification found in the contact centres was that of a nurse; only five facilities included a physician in their team (either as a part-time employee or as a contractor). Both the drop-in centres and outreach programmes most commonly employed social workers. A half of the programmes showed interest in a change in their status. However, three quarters of them did not have enough information about the registration process. Nine facilities reported that they were preparing for a change of status. The authors of the study believe that the lack of interest may be caused by an effort to maintain the current situation because the process of the transformation into a healthcare facility is demanding in terms of money, staff, and time (Burešová, 2012).

More details on the clients of low-threshold facilities are also provided in the chapter entitled Data on Problem Drug Use from Non-Treatment Sources (p. 55).

7.3.1.1 Needle and Syringe Exchange Programmes

Programmes for the exchange of needles, syringes, and other injecting paraphernalia were provided by 103 low-threshold programmes in 2012. While the number of exchanges had increased continuously until 2011, this trend practically stopped in 2012, when nearly 5.4 million needles and syringes were distributed (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f). The trend in the number of programmes and the number of syringes distributed is shown in Table 7-5, and the numbers of syringes issued in each region are shown in

Table 7-6.

According to the information available from the final reports, each injecting drug user who visited a low-threshold facility in 2012 received more than 190 sterile needles or syringes on average. The regional distribution of the needles and syringes provided in each region corresponds with the relative numbers of injecting (problem) drug users; see Map 7-1 and Map 4-1 (p. 52).

Table 7-5: Exchange programmes in the Czech Republic, 1998-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Year	Number of exchange programmes	Number of needles and syringes supplied
1998	42	486,600
1999	64	850,285
2000	80	1,152,334
2001	77	1,567,059
2002	88	1,469,224
2003	87	1,777,957
2004	86	2,355,536
2005	88	3,271,624
2006	93	3,868,880
2007	107	4,457,008
2008	98	4,644,314
2009	95	4,859,100
2010	96	4,942,816
2011	99	5,292,614
2012	103	5,356,318

Table 7-6: Number of needles and syringes distributed in the exchange programmes, 2004-2012, by region (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Region*	2004	2005	2006	2007	2008	2009	2010	2011	2012
Prague	1,210,704	1,697,554	1,850,330	2,071,788	2,060,588	2,130,729	2,130,433	2,198,651	2,266,917
Central Bohemia	66,600	110,325	168,220	215,640	309,590	345,214	350,052	332,827	414,080
South Bohemia	102,621	124,454	141,825	212,791	228,872	239,690	183,278	202,545	206,812
Pilsen	88,450	116,611	157,317	189,894	207,938	188,416	190,648	181,408	204,094
Karlovy Vary	35,756	58,680	66,382	83,462	79,834	102,467	141,437	177,835	151,514
Ústí nad Labem	351,561	479,383	612,259	655,882	637,887	678,007	604,191	735,929	616,574
Liberec	33,467	32,800	47,756	63,967	129,903	87,272	129,995	150,793	174,742
Hradec Králové	41,021	86,221	98,269	139,075	173,417	183,186	200,616	253,306	217,837
Pardubice	36,081	38,725	48,144	29,908	52,690	62,541	84,950	88,867	93,781
Vysočina	39,348	61,425	68,682	99,447	65,343	81,127	89,846	86,053	79,474
South Moravia	165,846	173,090	227,833	269,236	264,872	252,145	286,251	331,113	311,566
Olomouc	85,872	96,416	150,024	134,433	137,321	164,699	197,767	199,930	175,940
Zlín	41,977	52,169	69,005	115,744	89,913	111,099	96,330	91,471	88,882
Moravia-Silesia	56,232	143,771	162,834	175,741	206,146	232,508	257,022	261,886	354,105
Total	**2,355,536**	**3,271,624**	**3,868,880**	**4,457,008**	**4,644,314**	**4,859,100**	**4,942,816**	**5,292,614**	**5,356,318**

Map 7-1: Number of needles and syringes distributed in Czech regions in 2012, per 1,000 inhabitants aged 15-64 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

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

Programmes for distributing gelatine capsules to pervitin users have been described in detail previously; see the 2009 and 2010 Annual Reports. A total of 38 low-threshold programmes provided their responses as part of the 2012 monitoring survey of the tests for infections and their prevention among drug users in low-threshold programmes (see also the chapter entitled Drug-Related Infections on p. 91). Twenty-seven (71%) of these services conducted a capsule distribution programme and issued more than 50,000 capsules. Gelatine capsule distribution has become a standard part of the services offered by low-threshold programmes in the Czech Republic, and some of the clients use the capsules as an alternative to injecting (see e.g. Nezdarová, 2011, Mravčík et al., 2011b). According to the findings of a survey aimed at the experience of the clients of an outreach programme in Prague with the use of gelatine capsules, the capsules are a rather marginal alternative to the widespread injecting application. Nevertheless, it should be noted that the structure of the clients of outreach programmes in Prague is very specific, in particular because of the widespread injecting use of opioids intended for substitution treatment

(Nezdarová, 2011). However, validated information on the methods of use of these capsules and their potential benefits in terms of harm reduction principles remains unavailable.

Table 7-7: Information about the gelatine capsule distribution programmes in low-threshold facilities in the Czech Republic, 2008-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013e)

Year	Number of programmes which responded to the questionnaire	Capsule distribution programmes		Number of capsules distributed
		Number	Percentage (%)	
2008	50	16	32.0	23,865
2009	20	14	70.0	28,638
2010	43	30	69.8	56,868
2011	52	42	80.8	72,609
2012	38	27	71.1	46,830

The Multiplier 2010 study examined whether clients had received the capsules for the oral application of the drug at least once in the last year. This applied to 189 of the total of 642 respondents (29.4%), most of whom (87.8) were pervitin users; see the 2010 Annual Report. In the follow-up Multiplier 2013 survey, the question whether the client had received capsules through a harm reduction programme concerned the past-30-day time frame. In 2013 a total of 339 clients (19%) had received a gelatine capsule in the last month, 323 (95%) of whom were pervitin users; see also the chapter entitled Problem Drug Use on p. 48.

7.3.1.2 Testing for Infectious Diseases

The National Focal Point is informed about the number of testing programmes and number of tests performed in low-threshold facilities by the final reports concerning projects supported as part of the subsidy proceedings of the Government Council for Drug Policy Coordination. The results of the tests performed by some of these programmes are available from another source, i.e. the monitoring of the tests for infections in low-threshold programmes; for detailed information see the chapter entitled Drug-Related Infections 91. Overall, 64 low-threshold facilities offered HIV testing, 67 HCV testing, and 48 HBV testing, and 46 low-threshold facilities offered syphilis testing in 2012; see Table 7-8. Even though the number of facilities which offer testing for infections has varied in recent years, there is an apparent medium-term increase in the number of tests performed (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f).

Table 7-8: Number of tests for infections and number of low-threshold facilities providing the tests, 2003-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Year	HIV		HBV		HCV		Syphilis	
	Programmes	Tests	Programmes	Tests	Programmes	Tests	Programmes	Tests
2003	64	2,629	21	739	60	2,499	4	209
2004	58	2,178	25	932	53	2,582	1	84
2005	54	2,425	28	1,370	55	2,664	2	54
2006	46	1,253	56	693	62	1,133	3	209
2007	53	609	19	370	24	401	4	62
2008	50	1,120	18	399	40	862	3	124
2009	47	1,592	23	560	43	1,501	4	143
2010	58	1,821	40	1,200	59	2,134	20	771
2011	78	2,833	69	1,598	80	3,158	66	1,516
2012	64	2,892	48	1,468	67	3,011	46	1,969

The clients' history of HIV, HBV, and HCV testing is also monitored in the Register of Treatment Demands. The information contained in these items is mostly self-reported but may also come from the client's documentation or from reports on the examination of infection as part of the relevant treatment episode. The percentage of injecting drug users demanding treatment in 2002-2012 who self-reported previous infection testing is shown in Table 7-9.

Table 7-9: Percentage of clients (injecting drug users) demanding treatment in 2002-2012 who had previously been tested for HBV, HCV, and HIV (Petrášová and Füleová, 2013)*

Year	HBV	HCV	HIV
2002 (N = 6,225)	39.8	45.6	47.7
2003 (N = 5,959)	41.3	47.8	48.2
2004 (N = 6,364)	38.7	44.8	52.8
2005 (N = 6,125)	39.8	44.1	54.8
2006 (N = 6,022)	38.4	42.2	55.7
2007 (N = 6,109)	37.4	40.3	53.4
2008 (N = 5,986)	42.1	45.0	55.1
2009 (N = 6,157)	42.9	48.2	57.8
2010 (N = 6,581)	43.1	48.5	57.7
2011 (N = 6,471)	45.0	50.6	57.1
2012 (N = 6,481)	44.6	50.7	55.2

Note: The proportion of injecting drug users tested (regardless of the knowledge of test outcome) out of all injecting drug users demanding treatment in that year.*

The Multiplier 2013 project (for detailed information see the chapter entitled Problem Drug Use on p. 48), which was primarily intended to estimate the proportion of problem drug users in contact with low-threshold facilities, also sought to find out whether the clients had been tested for HIV and HCV. 51.0% of the 1,797 respondents reported having been tested for HIV in the last 12 months (in comparison with 49.2% in 2010) and 57.5% for HCV (58.4% in 2010). The data suggests a much higher (and consistent) level of HIV and HCV testing among drug users than that suggested by the above-mentioned data regarding the tests performed by low-threshold facilities.

7.3.2 HIV/AIDS and Viral Hepatitis C Treatment

The standard antiviral treatment of HCV comprises the dual combination of pegylated interferon α (PEG-IFN) and ribavirin (RBV). In 2011, the USA and later Europe approved direct antivirals (the protease inhibitors telaprevir and boceprevir) for the treatment of HCV genotype 1 in combination with PEG-IFN and RBV. This approach shows greater efficiency in previously treated and previously untreated patients than the conventional dual combination treatment. However, this approach also shows a high occurrence of adverse effects, as well as high treatment costs, which limits the recruitment of patients for treatment (Tungol et al., 2011, Assis and Lim, 2012, Řehák, 2012). In November 2012, the Czech Society for Hepatology and the Society for Infectious Diseases of the J. E. Purkyně Czech Medical Association agreed with the care-payers (the General Health Insurance Company and the Professional Association of Health Insurance Companies) on payment for HCV treatment with direct antivirals for 120 patients in 17 centres (Česká hepatologická společnost, 2012).

In 2012, the Institute for Health Information and Statistics started monitoring the total number of patients and that of injecting drug users treated for HCV for the first time in its annual overview of gastroenterology and infectious diseases. There were a total of 38 facilities of both specialisations treating 745 (former or current) injecting drug users in 2012 (Nechanská, 2013b); see Table 7-10.

Table 7-10: Total number of patients treated and of IDUs treated for HCV with antivirals, by gender and age, 2012 (Nechanská, 2013b)

Indicator	Number of facilities	Number of patients	of whom		of whom in age groups		
			males	females	under 19	20-64	65 and over
Infection Department							
Total patients	30	853	494	359	50	760	43
– of whom IDUs	24	521	314	207	29	472	20
Gastroenterology							
Total patients	23	311	165	146	1	310	0
– of whom IDUs	14	224	112	112	1	223	0
Total							
Total patients	**53**	**1,164**	**659**	**505**	**51**	**1,070**	**43**
– of whom IDUs	**38**	**745**	**426**	**319**	**30**	**695**	**20**

The data provided by the Prison Service of the Czech Republic show that in 2012 a total of 272 persons commenced HCV treatment while serving custodial sentences; compared to the 239 prisoners treated for HCV in 2011 and 69 prisoners in 2010, this means a continuous increase (Generální ředitelství Vězeňské služby ČR, 2013b).

For detailed information on the organisation of the treatment of HIV/AIDS and viral hepatitis in injecting drug users (IDUs) in the Czech Republic see the 2011 Annual Report and a detailed article on HCV treatment in IDUs (Mravčík, 2012).

7.3.3 Programmes Aimed at Drug Use in Recreational/Nightlife Settings

Specific harm reduction programmes in recreational/nightlife settings were conducted in 2012 by a total of three programmes,[124] while there were six programmes in 2011; see the 2011 Annual Report (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h). Interventions were conducted at 13 music events, where a total of 1,145 contacts with drug users were made. This fluctuation in the availability of services in recreational and nightlife settings, i.e. the number of programmes providing this type of intervention, reflects both the insufficient amount of funding provided for the implementation of these programmes and the negative political and departmental standpoints regarding screening tests for the quality of ecstasy at dance parties, which used to form part of the interventions in recreational and nightlife settings in the past; for details see the 2007-2010 Annual Reports.

7.4 Responses to Other Health Correlates and Consequences of Drug Use

The treatment of dual-diagnosis drug users in the Czech Republic usually takes place within the network of treatment facilities in consideration of these drug users' specific needs; see the chapter entitled Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 61). However, there is no dedicated facility in the Czech Republic for addicts with comorbid psychotic disorders (Kalina and Vácha, 2013).

[124] Olomouc Outreach Programmes (by *the Podané ruce* association), South Bohemia Streetwork (by the *PREVENT* civic association), and Outreach Programme, *Drop In, o. p. s.*

8 Social Correlates and Social Reintegration

The social correlates of drug use include low education, unemployment, relationship and family problems, low-quality and unsteady housing, or even homelessness. These problems may often occur simultaneously and may even lead to social exclusion. They are manifested to a higher degree in certain population groups, such as ethnic and national minorities (mainly Roma in the Czech Republic), the homeless, migrants, and immigrants.

The Social Service Register contains 35 programmes dealing with aftercare for drug users. Nevertheless, a 2012 facility survey, the Drug Services Census, indicates that social work and support services intended to facilitate the social reintegration of drug users are provided by tens to hundreds of addiction treatment facilities and programmes; such services mainly involve assistance with housing, employment, and debts.

In 2013 a questionnaire survey was conducted in socially excluded communities of the Czech Republic in order to assess the situation concerning substance use and gambling. With a year's delay, the 2011 data from the programme of support for field social work in Roma communities were made available. Specific programmes addressing substance use-related problems in socially excluded areas are lacking. Most of the interventions are targeted at the key challenges that socially excluded communities are facing: unemployment, debts, and housing issues. The most common substance used in socially excluded communities in the Czech Republic is alcohol, with cannabis and pervitin (methamphetamine) being the most frequently used illegal drugs.

This year is the first time that the findings of the pan-European 2010 EMIS study, which assessed the risk behaviour of men who have sex with men, including drug use, have been available.

8.1 Social Exclusion and Drug Use

Social exclusion as a phenomenon often occurs among various population groups whose lifestyle or other characteristics distinguish them from the general population. The important factors that contribute to social exclusion include insufficient (financial) resources, a low level of education, unemployment, disturbed family relations, loss of housing, and, consequently, general changes in lifestyle associated with drug use. These factors are also often barriers to the successful reintegration of socially excluded persons into (general) society (European Monitoring Centre for Drugs and Drug Addiction, 2003). In their study on social exclusion, Mareš et al. (2008) highlight the phenomenon of the concentration of the excluded persons within a certain territory. The main problems include crime, using alcohol and other drugs, and other asocial behaviours which consume the inhabitants of the territory and spill over to the surrounding areas. The inhabitants of such communities are often victims of crime, loansharking, and epidemics which thrive there while the surrounding society cares little about these issues. It is because this society considers these problems as being internal for the relevant territory and its inhabitants, and it only seeks to ensure that the problems do not cross the border of the territory (intervening only when they do).

The social characteristics of the drug users demanding treatment are provided in the chapter entitled Drug-Related Treatment: Treatment Demand and Treatment Availability(p. 61).

8.1.1 Drug Use among Socially Excluded Groups

In cooperation with the Agency for Social Inclusion, the National Focal Point conducted a survey named Gambling and Drug Issues in Socially Excluded Communities in 2013. Its objective was to map the situation in the areas of gambling and drug use within the context of other socially problematic phenomena in municipalities which include socially excluded communities (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura pro sociální začleňování, 2013). A total of 22 areas where the Agency for Social Inclusion currently operates were contacted. These areas include approximately 30 municipalities with socially excluded communities. The respondents in the survey were the contact persons of the Agency for Social Inclusion, who had the opportunity to discuss the given issue with the relevant stakeholders in the municipality (e.g. drug-related NGOs, local drug coordinators, crime prevention managers, departments for social affairs, the municipal police, and the Police of the Czech Republic).

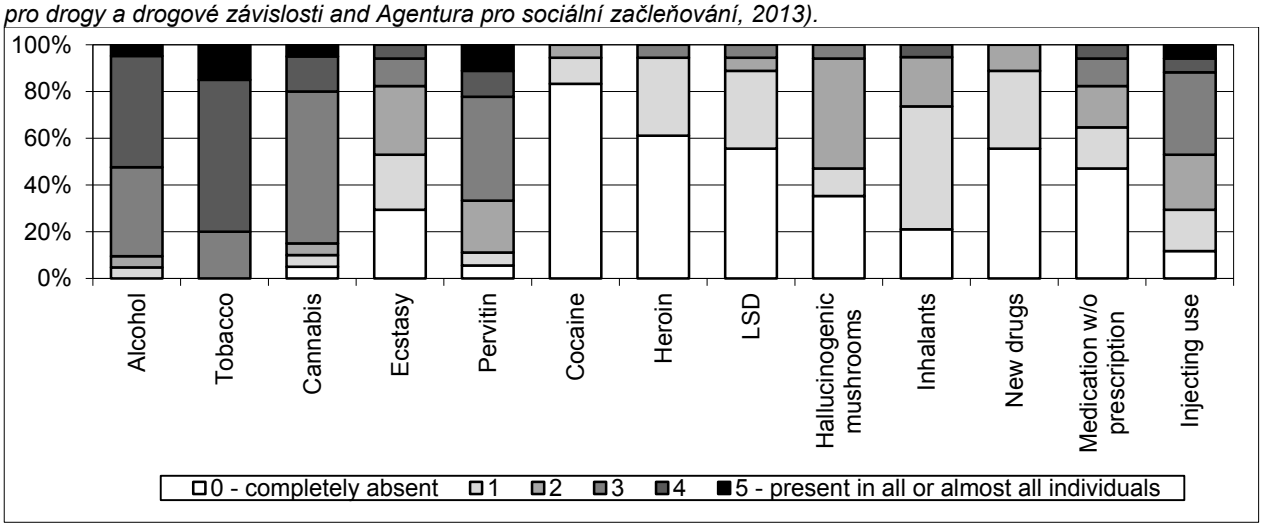
A total of 22 completed questionnaires were returned, with each questionnaire covering one or more socially excluded communities. Overall, information about 38 socially excluded communities was collected.[125]

A total of three questions were aimed at drug use. The first one, for adults and children under 15 years separately, concerned the level of drug use in the communities in question. The answers showed that the drugs which were most commonly used by adults included tobacco, alcohol, and cannabis. In comparison, the respondents estimated that the rarest drugs included cocaine, heroin, LSD, and new drugs. The responses also indicated that injecting drugs was relatively common among the adult inhabitants of the socially excluded communities; see Graph 8-1.

[125] Bruntál: 2 communities, Děčín, Mělník area – 3 communities, Havířov – 2 communities, Hodonín, Jirkov, Kolín, Krupka, Kutná Hora, Litvínov, Nové Sedlo, Odry, Osoblaha – 4 communities reported on together, Rumburk – 2 communities, Sokolov, Sokolov area – 9 communities reported on together, Šternberk, Teplá, Toužim, Velké Hamry, Větřní, and Žlutice.

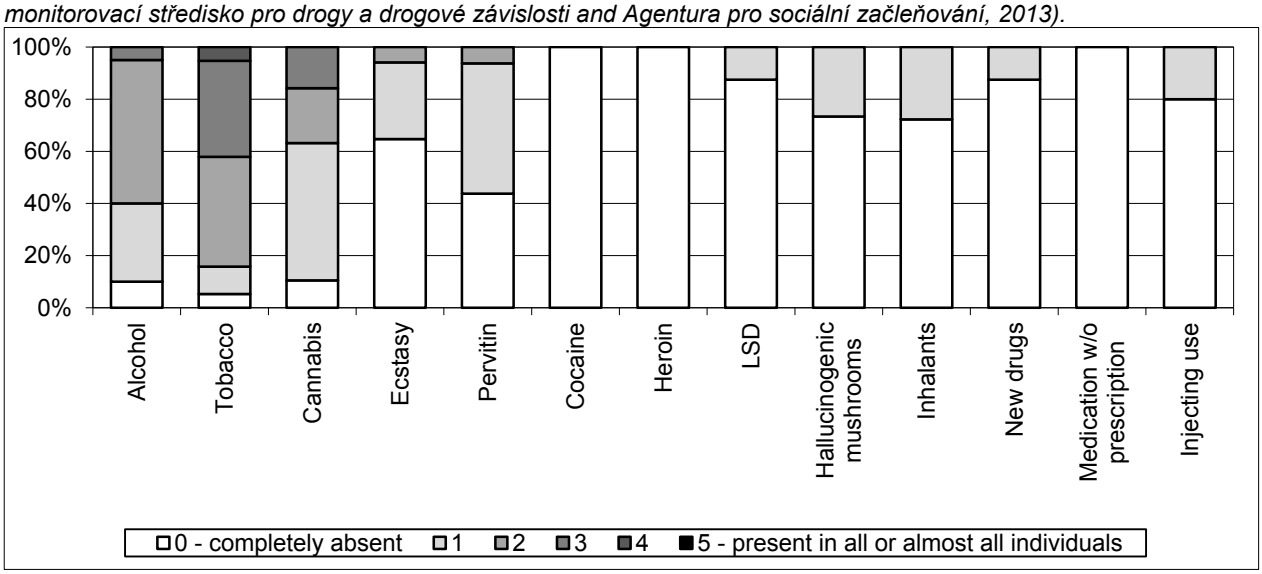
The drugs that were most prevalent among the children living in the socially excluded communities were also alcohol, tobacco, and cannabis but all to a lesser degree than that reported by the adult inhabitants of the communities. Using other drugs and injecting drugs was very rare among the children in the socially excluded communities, according to the respondents; see Graph 8-2.

Graph 8-1: Estimated level of drug use among adults in socially excluded communities (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura pro sociální začleňování, 2013).



Note: The scoring used a 0-5 scale (with "0" meaning that the phenomenon never occurs and "5" meaning that it occurs in all or almost all persons).

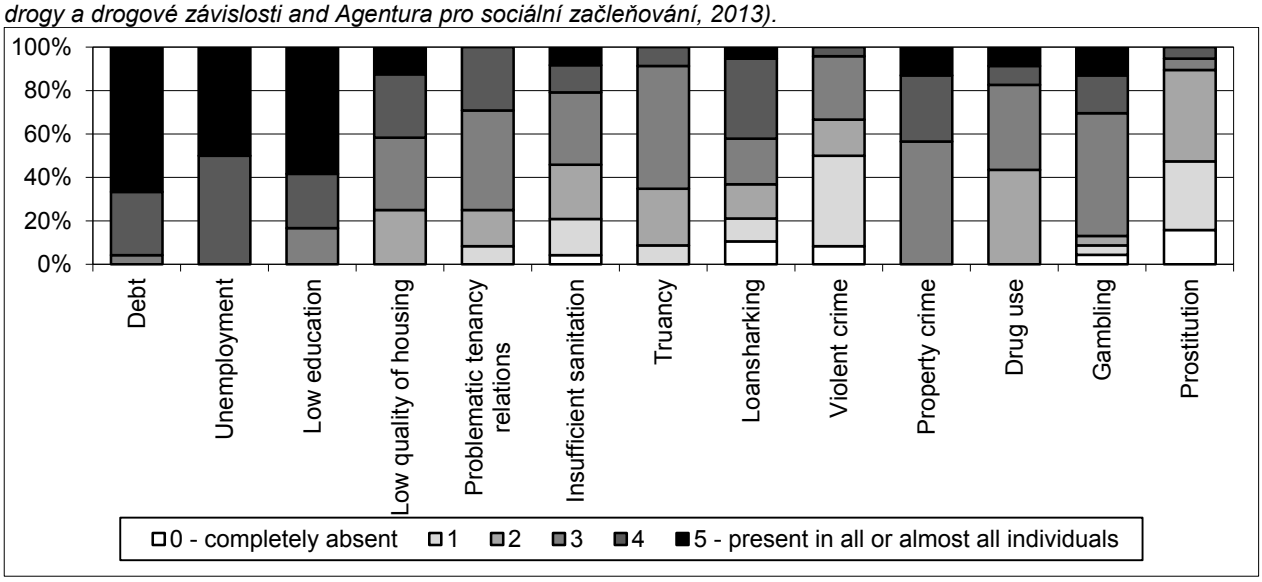
Graph 8-2: Estimated level of drug use among children under 15 years in socially excluded communities (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura pro sociální začleňování, 2013).



Note: The scoring used a 0-5 scale (with "0" meaning that the phenomenon never occurs and "5" meaning that it occurs in all or almost all persons).

The second question concerned drug use within the context of other socially problematic phenomena. The respondents were asked to estimate to what extent socially problematic phenomena were present in the community monitored by them. The respondents considered debt, unemployment, low education, and property crime, as well as a low quality of housing, gambling, problematic tenancy relations, and drug use the most pressing issues in the socially excluded communities. On the contrary, prostitution and violent crime were considered the least problematic issues; see Graph 8-3.

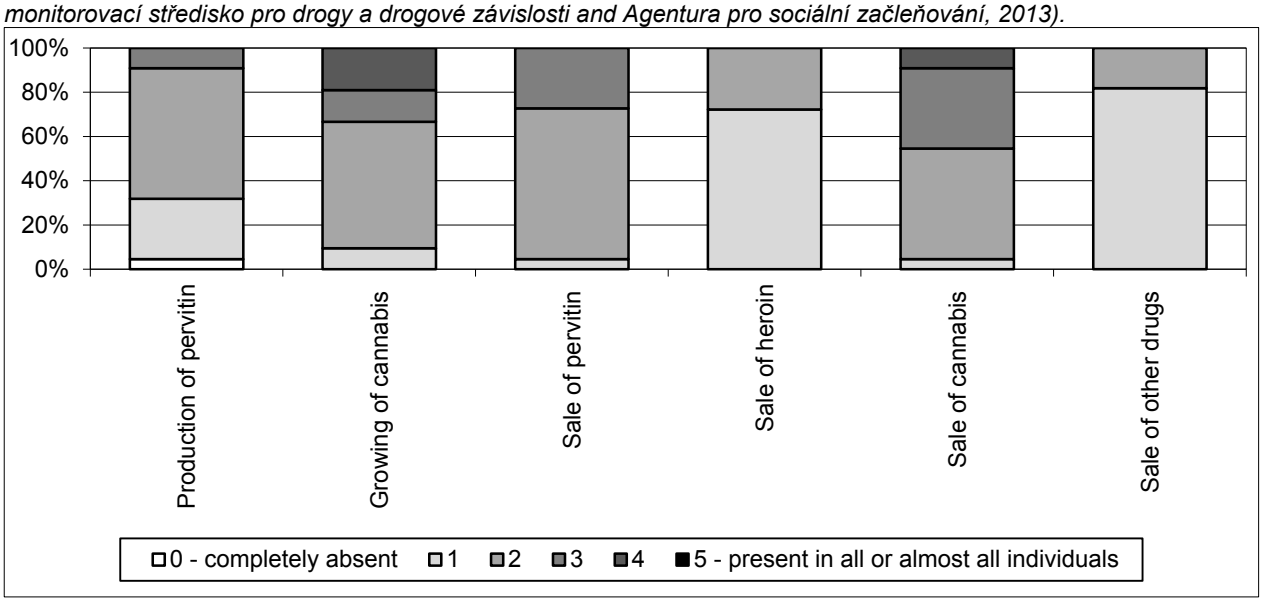
Graph 8-3: Estimated level of negative phenomena in socially excluded communities (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura pro sociální začleňování, 2013).



Note: The scoring used a 0-5 scale (with "0" meaning that the phenomenon never occurs and "5" meaning that it occurs in all or almost all persons).

This question also included an estimate of the level of the illicit production and distribution of drugs. The respondents tended to report cannabis growing and sales, as well as pervitin sales, most commonly, for which phenomena values between 1 and 4 were reported, with "2" being the most common value, representing the mean incidence. On the contrary, the sale of heroin and other drugs (LSD, ecstasy, and dance drugs) was the rarest; see Graph 8-4.

Graph 8-4: Estimated level of illicit drug production and distribution in socially excluded communities (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura pro sociální začleňování, 2013).



Note: Other drugs reported by the respondents included LSD, ecstasy, and dance drugs.

The third open question was aimed at detailed information regarding the observed links between drug use and other negative phenomena in socially excluded communities. The responses included individual cases of driving under the influence of drugs, vandalism, losing custody of children, and discarded injecting needles.

8.1.2 Roma Communities

In the long term, the Czech Government Council for Roma Minority Affairs has been involved in addressing the situation of Roma communities in the Czech Republic. The Agency for Social Inclusion in Excluded Localities has been in operation in the Czech Republic since 2007. At the beginning, its activities concerned 13 pilot communities[126] and, as of the end of 2012, it was operating in a total of 26 locations, the same number as in the

[126] http://www.socialni-zaclenovani.cz/agentura-pro-socialni-zaclenovani-zverejnila-vysledky-evaluace-cinnosti-v-pilotnich-lokalitach (26 August 2013)

previous year. Drug-related data are available from several communities[127] (Agentura pro sociální začleňování, 2013).

The 2011 figures from the Field Social Workers Support Programme[128] regarding the types of problems addressed by the Roma field social workers in Roma communities have become available (Kancelář Rady vlády pro záležitosti romské menšiny, 2012), while the 2012 data are yet to be published. In 2011, a total of 13,154 clients were reported (8,654 of whom were over the age of 15 and 4,500 persons were under 15). Women accounted for 51% of the clients. The number of illiterate clients of the field social services was 309, i.e. approximately 2.5% of the total figure. A total of 39,383 contacts were reported. The most common problems that were addressed included unemployment (34%), debt (31%), and housing (17%). The most commonly reported risk behaviours in the socially excluded Roma communities included drug use (2.3%), the level of which remained consistent with that reported in the previous years, truancy (2.2%), crime (1.2%), and gambling (1.1%); see Table 8-1.

Table 8-1: Clients of field social workers in Roma communities, by type of problem, 2007-2011 (Kancelář Rady vlády pro záležitosti romské menšiny, 2012)

Problem type	2007		2008		2009		2010		2011	
	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)
Unemployment	2,916	17.5	2,598	19.8	3,070	22.1	3,067	18.8	6,881	34.3
Debt	5,314	31.9	3,779	28.7	3,722	26.8	5,943	36.4	6,384	31.8
Housing problems	3,364	20.2	2,432	18.5	2,408	17.3	3,741	22.9	3,500	17.4
Poor sanitary conditions	1,204	7.2	1,282	9.7	1,309	9.4	1,088	6.7	1,012	5.1
Problematic tenancy relations	1,522	9.1	1,285	9.8	1,413	10.2	1,286	7.9	758	3.8
Drug use	391	2.3	344	2.6	291	2.1	–	–	467	2.3
Truancy	716	4.3	1,000	7.6	679	4.9	612	3.8	451	2.2
Crime	574	3.4	636	4.8	532	3.8	269	1.6	235	1.2
Gambling	302	1.8	323	2.5	236	1.7	142	0.9	223	1.1
Loansharking	320	1.9	696	5.3	218	1.6	143	0.9	120	0.6
Prostitution	39	0.2	51	0.4	25	0.2	24	0.1	44	0.2
Total	**16,662**	**100.0**	**13,144**	**100.0**	**13,903**	**100.0**	**16,315**	**100.0**	**20,075**	**100.0**

Note: The total number of clients by problem may be higher than the total number of clients, most probably because of the combination of multiple problems in individual clients and because of the method of reporting in the individual years. The Field Social Work Performance Report form changed in 2010 and problems associated with the use of illicit drugs were not monitored in that year.

The 2012 annual reports on the implementation of the drug policy in the regions indicate that there are no specific programmes aimed at drugs among persons living in socially excluded communities, bar a few exceptions. Drug services usually work with drug users from excluded communities as a part of their standard operations. The outreach programmes involving the Roma communities in the South Bohemia and Pilsen regions have noted a new trend of the injecting use of pervitin. The services in Pilsen have stated that, unlike heroin, pervitin is not seen as a problem drug by Roma. The services in South Bohemia have reported a significant increase in the production of pervitin among Roma. In terms of drug services, Roma most commonly used needle and syringe exchange programmes (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2013).

A specific drug-related project aimed at Roma is being implemented in Brno. In 2011 and 2012 the South Moravia region funded the Programme for the Protection of Public Health and Promotion of Outreach Work among Persons at Risk of Addiction in the Excluded Communities in Brno, which is implemented by the *Podané ruce* association, which mainly provided the service to Roma. At the end of 2012, the efforts of the programme were resumed by the project of a therapeutic centre in the socially excluded communities in Brno, which also offered a substitution treatment programme in addition to preventive programmes, counselling, needle and syringe exchange, and testing.

A long-term outreach programme aimed at the Roma users of drugs other than alcohol is being implemented by the *SANANIM* civic association in Prague.

[127] For example, the drug situation has been described as critical in Rumburk and a working group has been established to address the situation there. In Bruntál, new projects of social services for drug users have been launched. Among other activities, the municipality of Cheb is also implementing an individual project concerning counselling for those in danger of addiction. At the end of 2012 the municipality of Jáchymov approved the operation of the *Kotec* civic association on its territory, where *Kotec* is to provide an outreach programme for drug users starting in 2013. An outreach programme for drug users is also being implemented for drug users in Kadaň. In Litvínov, outreach social work and harm reduction services are provided by the *Most k Naději* civic association. The municipality of Obrnice emphasises the need for preventive programmes aimed at children and adolescents.

[128] One of the subsidy programmes administered by the Government Council for Roma Minority Affairs.

8.1.3 Other Ethnic Minorities and Migrants

A 2009 study by the Institute of International Relations addressed the issue of the Vietnamese community in the Czech Republic and its criminal activities (Nožina, 2009). The study also covers drug-related issues, in terms of which the Vietnamese community is mainly active in the illegal production and distribution of drugs. In the early 1990s the police statistics started to show drug-related offences committed by persons of Vietnamese descent, predominantly involving the illegal production and distribution of drugs. At the beginning, heroin (especially brown heroin) dominated this illegal business with 80%, followed by ecstasy and LSD. Other substances distributed and used by the Vietnamese on the territory of the Czech Republic included pervitin, hashish, marijuana, opium, and – to a lesser extent – cocaine. The so-called "shooting galleries" appeared, i.e. places where the drug was made and sold and where the buyer could also use the drug. In recent years, the Vietnamese community has mainly been involved in the production and large-volume trafficking of pervitin and cannabis; for details see also the chapter entitled Drug Markets (p. 141).

8.1.4 Men Who Have Sex with Men

The EMIS pan-European study of the behaviour of gay men and other men who have sex with men (MSM) – The European MSM Internet Survey – was conducted in 2010 (Procházka, 2011). It mainly focused on preventive behaviour regarding HIV and other sexually transmitted diseases and it also included questions regarding the use of alcohol and illicit drugs. The data were obtained from 35 European countries through an online questionnaire. The study was implemented by the Robert Koch Institut in Berlin; the Sexology Institute and the Czech AIDS Help Society participated in the Czech Republic. The total number of respondents exceeded 180,000, with 2,500 coming from the Czech Republic. The average age of the respondents was 30 years; the Czech Republic was one of the five countries with the youngest respondents, with their average age reaching 27 years. 4% of the respondents reported being HIV positive (2.7% in the Czech Republic).

9% of the Czech respondents reported they were problem alcohol users. 77% of the respondents reported having consumed alcohol in the past week. Still, over one third of the respondents replied to another question that they did not drink or use drugs at all. 49% of the men admitted having used illegal drugs, most commonly marijuana and dance drugs but, quite often, also ketamine. 37% of the men reported having used tobacco in the past 24 hours. 3% referred to themselves as heavy users of recreational drugs. Only just over one per cent (1.2%) admitted having injected a drug. 4.5% of the men who were clients of commercial sex workers reported injecting drugs and their average age was also significantly higher than that of the providers of commercial sex, among whom injecting drugs was reported by 3%. More than a quarter of the men (27%) had inhaled poppers in the last year. A tenth of the Czech respondents had experience with erection-enhancing drugs (with a view to the low age of the group, this figure exceeds the prevalence of erectile dysfunction and only confirms recreational use as reported from other countries).

8.1.5 The Homeless

A Study of Homelessness in Ostrava was performed in 2012 (Hruška, 2012). The interviews with 18 respondents included a question concerning the use of drugs by the respondent or his/her partner. The interviews suggest a negative view of the use of illegal drugs by the homeless – 15 persons reported that they did not use drugs and 3 persons did not answer the question. All 18 respondents reported drinking alcohol.

In August 2013 the Czech government approved the Policy for Preventing and Addressing Homelessness in the Czech Republic until 2020 (Ministerstvo práce a sociální věcí ČR, 2013). The Policy focuses on the issue of poverty and on fundamental topics in addressing homelessness, such as accessible housing and healthcare, increased awareness, and the cooperation of the relevant stakeholders. It emphasises a comprehensive and coordinated approach to combating homelessness. As far as drugs are concerned, the study describes drug and alcohol use as a risk factor for the development of homelessness.

8.2 Social Reintegration

It is especially aftercare services that are concerned with the social reintegration of drug users and support for them after treatment. They include outpatient aftercare programmes, which may be extended to encompass other support services, in particular sheltered housing and protected employment (sheltered workshops, protected and supported employment). In August 2013, a total of 35 aftercare programmes for the target group of persons at risk of addiction or persons with a substance addiction were included in the Register of Social Service Providers, administered by the Ministry of Labour and Social Affairs.[129] Nevertheless, a 2012 facility survey, the Drug Services Census, indicates that social work and support services intended to facilitate the social reintegration of drug users are provided by tens to hundreds of addiction treatment facilities and programmes; such services mainly involve assistance with housing, employment, and debts (Nechanská et al., 2013); for details see also the 2011 Annual Report.

The final reports on projects subsidised by the Government Council for Drug Policy Coordination provide information about 11 aftercare programmes. Ten programmes offered their clients sheltered housing and one programme

[129] http://iregistr.mpsv.cz/ (21 August 2013)

reported that it offered protected employment in 2012. Altogether, 1,134 clients (457 of them male) used the aftercare services; 578 (51.0%) of them used to inject drugs before they entered treatment; 591 (52.1%) used to use pervitin, 109 (9.6%) heroin, and 21 (1.8%) clients used to use cannabis. The capacity of the sheltered housing facilities was 108 in 2012; a total of 4 clients worked in sheltered workshops (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f); seeTable 8-2.

Table 8-2: Facilities providing aftercare according to the final reports on projects subsidised by the Government Council for Drug Policy Coordination, 2006-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Indicator	2006	2007	2008	2009	2010	2011	2012
Number of facilities	18	18	18	15	16	15	11
Number of aftercare clients	904	883	1,041	986	987	1,095	1,134
Sheltered housing places	126	126	283	134	127	129	108
Number of clients in sheltered housing	235	261	–	–	–	–	–
Number of clients in sheltered workshops	40	44	25	29	25	20	4

Unstructured aftercare was provided by ten facilities and used by 676 clients, 174 of whom were men, in 2012. The average age of the clients was 29.8 years, yet another increase against the previous years. A total of 274 clients (40.5%) used to inject drugs before they entered treatment; 292 (43.2%) had used pervitin, 19 (7.2%) heroin, and 10 clients (1.5%) used to use cannabis (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f); see Table 8-3.

Table 8-3: Facilities providing unstructured aftercare according to the final reports on projects subsidised by the Government Council for Drug Policy Coordination, 2006-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Indicator	2006	2007	2008	2009	2010	2011	2012
Number of facilities	10	12	12	11	13	13	10
Number of clients	380	389	487	443	494	624	676
– injecting drug users	230	236	306	235	335	274	274
– pervitin users	216	209	259	246	286	272	292
– opiate users	78	69	71	64	82	57	49
– cannabis users	–	–	–	–	10	12	10
Average age of clients	26.4	29.3	30.3	30.4	28.3	29.2	29.8

Eleven facilities provided intensive aftercare within a long-term structured programme (typically involving sheltered housing or protected employment); their total capacity of 227 beds was used by 458 clients (283 of whom were men) and the average age of the clients of the structured programmes was 31, a continuing increase against the previous years. A total of 304 clients (66.4%) used to inject drugs before they entered treatment; 299 (65.3%) had used pervitin, 60 (13.1%) heroin, and 11 clients (2.4%) used to use cannabis (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f); see Table 8-4.

Table 8-4: Facilities providing structured aftercare according to the final reports on projects subsidised by the Government Council for Drug Policy Coordination, 2006-2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013f)

Indicator	2006	2007	2008	2009	2010	2011	2012
Number of facilities	16	15	15	12	13	14	11
Capacity	365	325	283	316	269	228	227
Number of clients	524	494	554	543	493	471	458
– injecting drug users	364	360	422	392	385	361	304
– pervitin users	304	284	317	329	297	305	299
– opiate users	105	104	105	99	73	91	60
– cannabis users	–	–	–	5	5	11	11
Average age of clients	27.1	26.6	28.7	29.2	28.8	29.5	31.0

A drug services survey was performed in 2012. Social work and support services promoting the social reintegration of drug users are provided by tens to hundreds of facilities, with such services mainly involving assistance with housing, employment, and debt. The detailed results were presented in the 2011 Annual Report and in the *Zaostřeno na drogy* ("Focused on Drugs") bulletin, No. 5/2013 (Nechanská et al., 2013). As reported by the drop-in centre in Ústí nad Labem, the involvement of the clients in public services contributed to the maintenance of the working routine and to reduced drug use (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2013).

According to the Association for the Services of Alcoholics Anonymous, a total of 50 AA groups were operating in 40 Czech cities in August 2013.[130] According to the available information, there are two Narcotics Anonymous groups, one in Prague and one in Brno.[131]

The 2012 data from debt counselling centres regarding the causes of debt, including any links to drug use, were provided in the 2011 Annual Report. Data from the debt counselling centres in 17 cities for the first half of 2013 are also available.[132] Out of the 3,904 clients who received debt counselling, a total of 77 reported a link between their debt and drug use, and 24 reported a connection with gambling (Národní monitorovací středisko pro drogy a drogové závislosti and Asociace občanských poraden, 2013).

In March 2012 the Government Council for Drug Policy Coordination discussed and approved the guideline document *Recommended Procedures for the Systematic Referral of Drug Users Released from Custody to Follow-up Care in Community Settings*. The proposed measures include informing the prisoners about the drug services provided both in prisons and in the community, intermediating aftercare as a part of counselling, and intensifying the cooperation between the Prison Service and the regional drug coordinators. The other measures include implementing interventions in the area of overdose prevention after release, the provision of assistance in accessing aftercare as early as during the therapeutic programmes in prison, incorporating groups aimed at relapse prevention into the therapeutic programmes, drug testing, and keeping records of drug testing.[133]

[130] http://www.anonymnialkoholici.cz/setkani/adresar-skupin.html (14 August 2013)
[131] http://anonymni-narkomani.webnode.cz/ (14 August 2013)
[132] Bohumín, Brno, České Budějovice, Jihlava, Karviná, Liberec, Most, Nymburk, Ostrava, Pardubice, Prague 1, 2, 3 and 12, Rokycany, Rumburk, Rychnov nad Kněžnou, Šumperk, Třebíč, Valašské Meziříčí.
[133] http://www.vlada.cz/assets/ppov/protidrogova-politika/jednanirady/zaznam-z-jednani-080312.pdf (23 September 2013)

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

Drug-related criminal offences accounted for 1.3% of all the reported crimes. Prague and the Karlovy Vary and Central Bohemia regions were the regions with the highest number of drug-related offences per 100 thousand inhabitants in 2012.

A total of 2,827 persons were prosecuted for drug-related crime in 2012, most commonly for the illicit production, smuggling, and sale of pervitin (methamphetamine) and cannabis. 2,368 were charged and final sentences were imposed on 2,079 persons. The most common sanction imposed was a term of suspended imprisonment. The number of persons prosecuted and that of those persons sentenced for drug-related offences have been increasing in the long term.

The drug-related offences associated with the production, sale, and smuggling of drugs tend to represent approximately 80% of the drug-related offences; there is an increasing share of offences involving the unauthorised handling of drugs for personal use (16% in 2012). The share of the other types of drug-related offences (unauthorised possession of an article for the production of drugs, and promoting drug use) is low and is decreasing in the long term.

Proceedings regarding a total of 304.7 thousand misdemeanours were held in 2012, with 1,285 cases involving the unauthorised handling of narcotic and psychotropic substances, an increase of 10% against 2011. As in the previous year, these misdemeanours accounted for approximately 0.4% of all the misdemeanours.

According to the data of the Police of the Czech Republic, 18.4 thousand offences were committed under the influence of drugs, i.e. over 15% of the offences that were cleared up. Of this figure, 16.1 thousand offences were committed under the influence of alcohol and 2.3 thousand under the influence of drugs other than alcohol.

A second round of the questionnaire study of drug use among prisoners serving a prison sentence took place in late 2012. Nearly 50% of the respondents reported lifetime experience with an illegal drug. Over 21% had used an illegal drug in the last 12 months and 9% in the last 30 days. Most commonly, this concerned the use of cannabis, pervitin, or amphetamine, as well as sedatives obtained without a prescription. In comparison with the general population of the same gender and age, prisoners tend to have much more experience with all illegal drugs (much less so in the case of cannabis), which especially applies to women serving a prison sentence, whose lifetime prevalence of drug use is a multiple of that reported by women in the general population. 26% of the respondents serving a prison sentence could be referred to as problem drug users.

9.1 Drug-Related Crime

Also referred to as “primary drug-related crime”, drug-related crime encompasses the offences of the unauthorised handling of narcotic and psychotropic substances and articles intended for their manufacture, and inciting or enticing others to use addictive substances other than alcohol. The conduct representing these offences is defined by Act No. 40/2009 Coll., the Penal Code (“the Penal Code”), which came into force on 1 January 2010, and replaced the previous Act No. 140/1961 Coll. (the “old Penal Code”).[134] A summary of the primary drug-related offences according to the old Penal Code and the Penal Code is provided in Table 9-1. The text and tables further below provide data for the same offence according to the provisions of the old Penal Code and the Penal Code, and the name of the relevant category is in the “Section of the old Penal Code/Section of the New Penal Code” format.

Table 9-1: Primary drug-related offences and their description (according to the old Penal Code and new Penal Code)

Act No. 140/1961 Coll. (old Penal Code)	Act No. 40/2009 Coll. (Penal Code)	Offence
Section 187	Section 283	Unauthorised production and other handling of narcotic or psychotropic substances and poisons
Section 187a	Section 284	Possession of narcotic or psychotropic substances and poisons (for personal use)
–	Section 285	Unauthorised cultivation of plants and mushrooms containing narcotic or psychotropic substances for personal use
Section 188	Section 286	Manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance and poison
Section 188a	Section 287	Inciting, promoting, or enticing substance use
–	Section 288*	Production and other handling of substances with a hormonal effect

*Note: * The data regarding the constituting elements of this offence are not provided in the Annual Report.*

[134] The two norms continued to run in parallel in 2012. The cases which had not been closed prior to the coming into force of the Penal Code were judged according to that legal norm which stipulated milder penalties for the conduct in question.

Data on drug-related crime are collected and evaluated by a number of agencies, depending on their tasks during criminal proceedings. Comprehensive information about the offences reported and individuals prosecuted is kept by the Headquarters of the Police of the Czech Republic within the Crime Statistics Record System. A dedicated police unit – the National Drug Headquarters of the Criminal Police and Investigation Service of the Police of the Czech Republic – deals specifically with drug-related crime, maintaining its own information system concerning drug-related offences. The statistics from the public prosecutors' offices and courts are prepared by the Ministry of Justice of the Czech Republic, and information about persons awaiting trial in custody and those sentenced is collected by the Prison Service and the Probation and Mediation Service of the Czech Republic.

Information about persons arrested or prosecuted for drug-related offences is recorded in the systems of the National Drug Headquarters, the Police Headquarters, and the Ministry of Justice. Any differences in the data from these sources arise mainly from different reporting practices and data collection procedures.

9.1.1 Drug Law Offences

According to the data from the Criminal Statistics Record System, a total of 2,827 persons were prosecuted for drug-related offences in 2012. Of this figure, 14% were women and 5% were persons under the age of 18 (Policejní prezidium Policie ČR, 2013). 2,368 persons were charged. Final judgements were issued in the cases of 2,079 persons, 41% of whom had no previous convictions (Ministerstvo spravedlnosti ČR, 2013a).

In comparison with the previous period, there was an increase in the number of persons arrested (National Drug Headquarters), prosecuted (Police Headquarters), and sentenced (Ministry of Justice) in 2012. The most significant increase occurred in the number of arrests (National Drug Headquarters) and marked the highest year-on-year increase in the past 10 years. The number of persons arrested and prosecuted (National Drug Headquarters and the Police Headquarters) has been increasing since 2007, and the number of persons sentenced for drug-related offences started to increase in 2008; see Table 9-2.

Table 9-2: Number of persons arrested, prosecuted, charged, and sentenced for drug-related offences, 2002-2012 (Národní protidrogová centrála SKPV Policie ČR, 2013a, Ministerstvo spravedlnosti ČR, 2013b, Ministerstvo spravedlnosti ČR, 2013a)

Year	Arrested (National Drug Headquarters)	Prosecuted (Police Headquarters)	Prosecuted (Ministry of Justice)	Charged (Ministry of Justice)	Sentenced (Ministry of Justice)
2002	2,000	2,204	2,504	2,247	1,216
2003	2,357	2,295	3,088	2,737	1,304
2004	2,157	2,149	2,944	2,589	1,376
2005	2,168	2,209	2,429	2,157	1,326
2006	2,198	2,344	2,630	2,314	1,444
2007	2,031	2,023	2,282	2,042	1,382
2008	2,322	2,296	2,304	2,100	1,360
2009	2,340	2,415	2,553	2,332	1,535
2010	2,525	2,437	2,377	2,152	1,652
2011	2,759	2,782	2,798	2,549	1,870
2012	3,065	2,827	2,593	2,368	2,079

Criminal proceedings were most commonly instigated against persons for the unauthorised production or other handling of narcotic and psychotropic substances; see Table 9-3. The composition of the drug-related offences by the type of offence did not change significantly in comparison with the previous year.

Table 9-3: Number of persons arrested, prosecuted, charged, and sentenced for drug-related offences in 2012, by type of offence (Národní protidrogová centrála SKPV Policie ČR, 2013a, Policejní prezidium Policie ČR, 2013, Ministerstvo spravedlnosti ČR, 2013b, Ministerstvo spravedlnosti ČR, 2013a)

Offenders, by phase of criminal proceedings	Sec. 187/ Sec. 283		Sec. 187a/ Sec. 284		Sec. 285		Sec. 188/ Sec. 286		Sec. 188a/ Sec. 287		Total	
	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)
Arrested (National Drug Headquarters)	2,519	82.2	309	10.1	172	5.6	50	1.6	15	0.5	3,065	100.0
Prosecuted (Police Headquarters)	2,277	80.5	300	10.6	160	5.7	69	2.4	21	0.7	2,827	100.0
Prosecuted (Ministry of Justice)	2,102	81.1	247	9.5	104	4.0	126	4.9	14	0.5	2,593	100.0
Charged (Ministry of Justice)	1,949	82.3	217	9.2	72	3.0	119	5.0	11	0.5	2,368	100.0
Sentenced (Ministry of Justice)	1,631	78.5	238	11.4	99	4.8	98	4.7	13	0.6	2,079	100.0

According to the data of the National Drug Headquarters, drug offenders were most commonly arrested for the illicit production, smuggling, and sale of pervitin in 2012. The second most common reason for arrest was the cultivation, smuggling, and sale of cannabis; see Table 9-4.

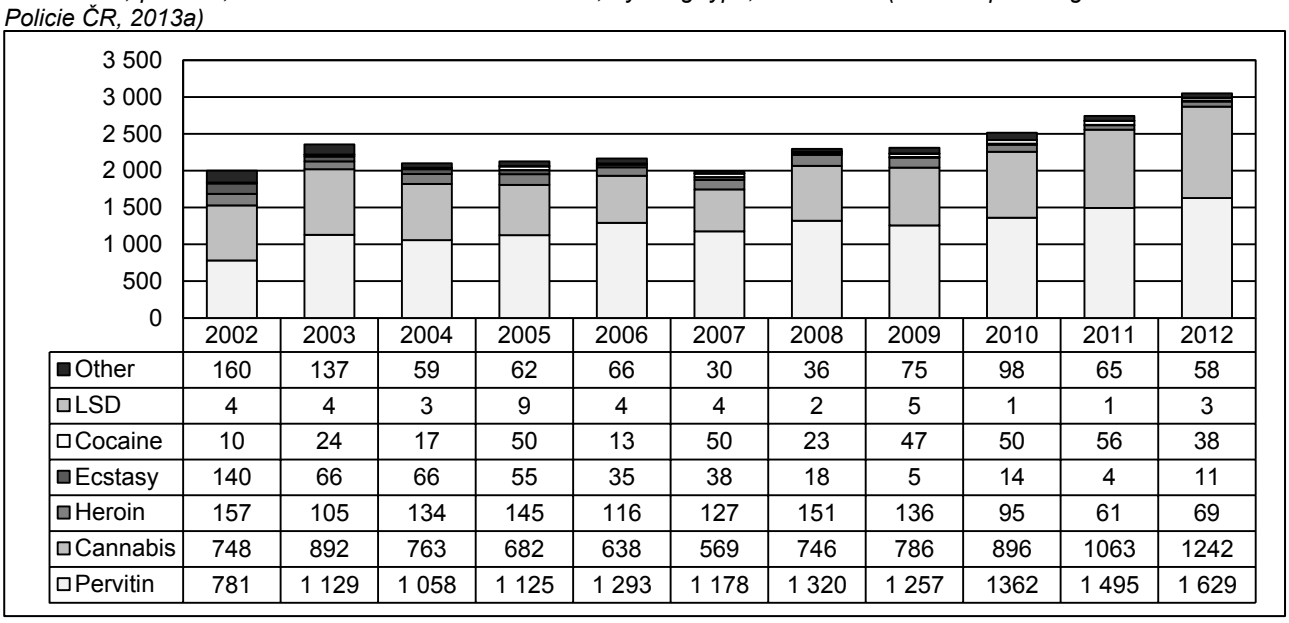
Table 9-4: Number of persons arrested in 2012, by main drug type and drug offence type (Národní protidrogová centrála SKPV Policie ČR, 2013a)

Drug	Production, smuggling, and sale		Possession and cultivation for personal use		Promoting drug use		Total	
	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)
Cannabis	870	33.9	372	77.3	5	33.3	1,247	40.7
Pervitin	1,548	60.3	81	16.8	3	20.0	1,632	53.2
Cocaine	31	1.2	7	1.5	0	–	38	1.2
Heroin	59	2.3	10	2.1	0	–	69	2.3
Ecstasy	7	0.3	4	0.8	0	–	11	0.4
LSD	1	0.0	2	0.4	0	–	3	0.1
Amphetamine	9	0.4	0	–	0	–	9	0.3
Other drugs	44	1.7	5	1.0	7	46.7	56	1.8
Total number of persons	**2,569**	**100.0**	**481**	**100.0**	**15**	**100.0**	**3,065**	**100.0**

Note: Production, smuggling, and sale concerns Section 187 of the old Penal Code/Section 283 of the Penal Code and Section 188 of the old Penal Code/Section 286 of the Penal Code; possession for personal use includes Section 187a/Section 284 and Section 285 of the Penal Code; promoting drug use includes Section 188a of the old Penal Code/Section 287 of the Penal Code.

The number of persons arrested in connection with pervitin has been growing since 2009, with their share among all the persons arrested for drug-related offences consistently corresponding to approximately 54%. As far as cannabis is concerned, its share of the persons arrested has been growing since 2007. While only 29% of the persons were arrested in connection with cannabis in 2007, the share was 41% in 2012. At the same time, the highest year-on-year increase in the number of persons arrested in connection with cannabis in the past 10 years was reported in 2012. The share of persons arrested in connection with heroin decreased in the period 2008-2012, from approximately 7% in 2008 to approximately 2% in 2012. The proportion of those arrested in connection with cocaine has been even lower in the long term; see Graph 9-1.

Graph 9-1: Number of persons arrested for the offences of the unauthorised handling of narcotic and psychotropic substances, poisons, and articles for their manufacture, by drug type, 2002-2012 (Národní protidrogová centrála SKPV Policie ČR, 2013a)



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Other	160	137	59	62	66	30	36	75	98	65	58
LSD	4	4	3	9	4	4	2	5	1	1	3
Cocaine	10	24	17	50	13	50	23	47	50	56	38
Ecstasy	140	66	66	55	35	38	18	5	14	4	11
Heroin	157	105	134	145	116	127	151	136	95	61	69
Cannabis	748	892	763	682	638	569	746	786	896	1063	1242
Pervitin	781	1 129	1 058	1 125	1 293	1 178	1 320	1 257	1362	1 495	1 629

Similarly to the concept of drug-related crime, offences committed in connection with alcohol, i.e. "alcohol-related offences", include the exposure of children to alcoholic beverages (Section 218 of the old Penal Code/Section 204 of the Penal Code). Data from the Criminal Statistics Records System indicate that 101 offences of the exposure of a child to alcoholic beverages were reported (Policejní prezidium Policie ČR, 2013).

According to the records of the Ministry of Justice, the number of persons prosecuted for all drug-related offences, except that of promoting drug use, decreased in 2012. The highest number of persons was prosecuted for the unauthorised handling of pervitin – 1,288 individuals (Section 187 of the old Penal Code/Section 283 of the Penal Code). The second largest group was that of people prosecuted for the same offence in connection with cannabis – 752 individuals. Despite the increase in the number of persons prosecuted in connection with cannabis, the group of those prosecuted in connection with pervitin remains the largest; see Table 9-5.

Table 9-5: Number of persons prosecuted in 2012, by main drug type and drug-related offence type (Ministerstvo spravedlnosti ČR, 2013b)

Drugs	**Sec. 187/Sec. 283**		**Sec. 187a/ Sec. 284**		**Sec. 285**		**Sec. 188/Sec. 286**		**Sec. 188a/ Sec. 287**		**Total**	
	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)
Cannabis	752	32.9	151	55.1	97	90.7	20	14.8	8	53.3	1,028	36.5
Pervitin	1,288	56.3	83	30.3	7	6.5	104	77.0	3	20.0	1,485	52.7
Cocaine	45	2.0	3	1.1	0	0.0	0	0.0	0	0.0	48	1.7
Heroin	77	3.4	8	2.9	0	0.0	0	0.0	0	0.0	85	3.0
Ecstasy	13	0.6	6	2.2	0	0.0	0	0.0	0	0.0	19	0.7
Other drugs	111	4.9	23	8.4	3	2.8	11	8.1	4	26.7	152	5.4
Total number of persons	**2,286**	**100.0**	**274**	**100.0**	**107**	**100.0**	**135**	**100.0**	**15**	**100.0**	**2,817**	**100.0**

Note: The data provided in the "Total" row are not the aggregate number and percentage of drug-related offences by drug type because certain persons were prosecuted for the violation of multiple drug-related sections of the Penal Code or in connection with multiple drug types; a single person can therefore appear in the statistics several times.

A decrease in the number of the persons charged was reported for all the drug-related offences in 2012. Most people were charged for the unauthorised production, smuggling, and sale of pervitin; see Table 9-6.

Table 9-6: Number of persons charged in 2012, by main drug type and drug-related offence type (Ministerstvo spravedlnosti ČR, 2013b)

Drugs	Sec. 187/ Sec. 283		Sec. 187a/ Sec. 284		Sec. 285		Sec. 188/ Sec. 286		Sec. 188a/ Sec. 287		Total	
	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)
Cannabis	658	30.9	127	52.0	67	89.3	17	13.4	6	50.0	875	33.8
Pervitin	1,235	58.0	81	33.2	7	9.3	99	78.0	3	25.0	1,425	55.1
Cocaine	45	2.1	3	1.2	0	0.0	0	0.0	0	0.0	48	1.9
Heroin	77	3.6	7	2.9	0	0.0	0	0.0	0	0.0	84	3.2
Ecstasy	12	0.6	6	2.5	0	0.0	0	0.0	0	0.0	18	0.7
Other drugs	102	4.8	20	8.2	1	1.3	11	8.7	3	25.0	137	5.3
Total number of persons	**2,129**	**100.0**	**244**	**100.0**	**75**	**100.0**	**127**	**100.0**	**12**	**100.0**	**2,587**	**100.0**

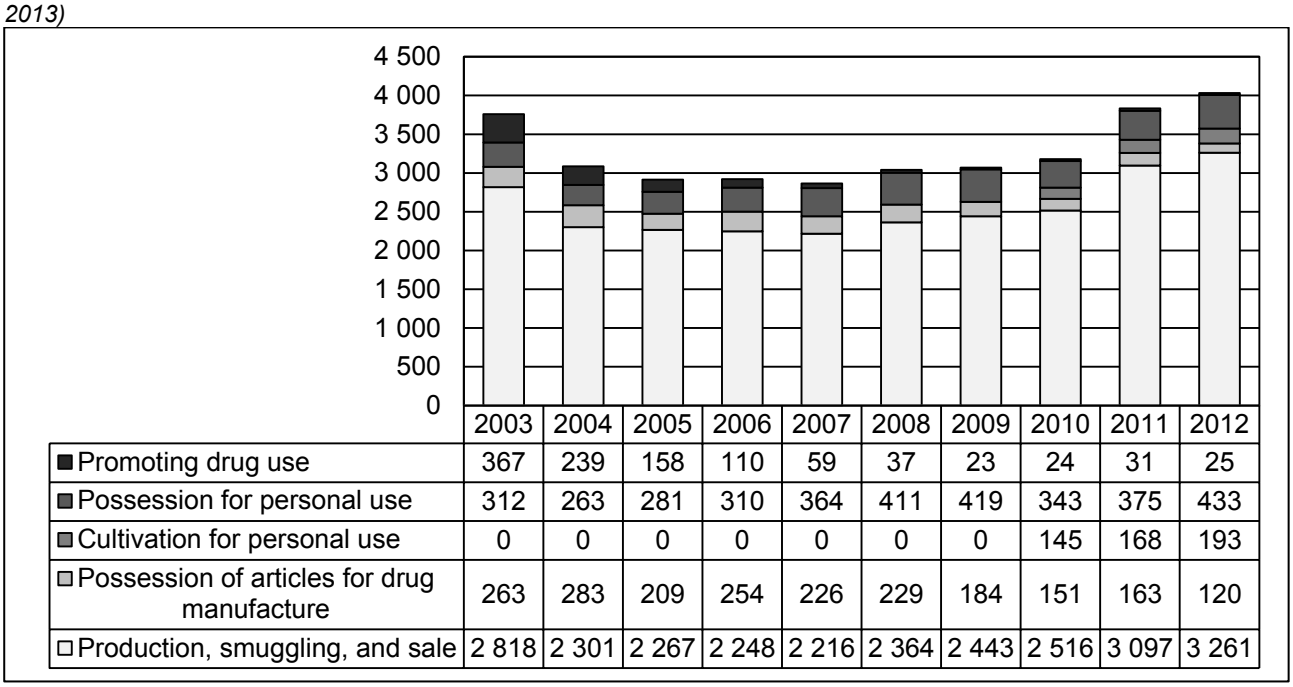
Note: The data provided in the "Total" row are not the aggregate number and percentage of drug-related offences by drug type because certain persons were prosecuted for the violation of multiple drug-related sections of the Penal Code or in connection with multiple drug types; a single person can therefore appear in the statistics several times.

The total number of drug-related offences and their share in the reported crimes have been rising since 2007; see Table 9-7. A major part in this trend is played by the growing number of offences involving the production, smuggling, and sale of drugs (Section 187 of the old Penal Code/Section 283 of the Penal Code, Section 188 of the old Penal Code/Section 286 of the Penal Code). The proportion of persons prosecuted on the grounds of production, distribution, and sale (Section 187 of the old Penal Code/Section 283 of the Penal Code) consistently account for approximately 80%. The proportion of individuals prosecuted for the unauthorised handling of narcotic and psychotropic substances for personal use (Section 187a/Section 284 and Section 285 of the Penal Code) is approximately 15%; see Graph 9-2.

Table 9-7: Development of the number of drug-related offences and their share of the offences reported in 2002-2012 (Policejní prezidium Policie ČR, 2013)

Year	Offences reported	Number of drug-related offences	Percentage of drug-related offences
2002	372,341	4,330	1.2
2003	357,740	3,760	1.1
2004	351,629	3,086	0.9
2005	344,060	2,915	0.9
2006	336,446	2,922	0.9
2007	357,391	2,865	0.8
2008	343,799	3,041	0.9
2009	332,829	3,069	0.9
2010	313,387	3,179	1.0
2011	317,177	3,834	1.2
2012	304,528	4,032	1.3

Graph 9-2: Number of drug-related offences reported in 2003-2012, by drug offence type (Policejní prezidium Policie ČR, 2013)



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Promoting drug use	367	239	158	110	59	37	23	24	31	25
Possession for personal use	312	263	281	310	364	411	419	343	375	433
Cultivation for personal use	0	0	0	0	0	0	0	145	168	193
Possession of articles for drug manufacture	263	283	209	254	226	229	184	151	163	120
Production, smuggling, and sale	2 818	2 301	2 267	2 248	2 216	2 364	2 443	2 516	3 097	3 261

As in the previous year, the highest number of drug-related offences reported and of persons prosecuted in connection with drug-related offences was recorded in Prague and in Central Bohemia. The regions with a high absolute number of drug-related offences and of persons prosecuted in connection with drug-related offences in 2012 also included the Moravia-Silesia, Ústí nad Labem, and South Moravia regions. The highest increase in drug-related crime was observed in Prague (by 146 drug-related offences) and in the Central Moravia region (by 138 drug-related offences). The number of reported drug-related offences decreased in 5 regions. The greatest decrease in drug-related crime was observed in the Vysočina region (by 134 drug-related offences) and in the Zlín region (by 37 drug-related offences). Prague, followed by Karlovy Vary and Central Bohemia, were the regions with the highest number of drug-related offences in relative terms per 100 thousand inhabitants aged 15-64 in 2012. On the contrary, the lowest number of drug-related offences per 100 thousand inhabitants aged 15-64 was reported in the Pardubice, Zlín, and South Moravia regions; see Table 9-8 and Map 9-1.

Table 9-8: Drug-related offences reported and persons prosecuted for drug-related offences in 2012, by region (Policejní prezidium Policie ČR, 2013)

Region	**Drug-related offences reported**			**Persons prosecuted for drug-related offences**		
	Number	Share (%)	Per 100 thousand persons aged 15-64	Number	Share (%)	Per 100 thousand persons aged 15-64
Prague	1,064	26.4	123.8	404	14.3	47.0
Central Bohemia	621	15.4	70.6	424	15.0	48.2
South Bohemia	233	5.8	53.4	192	6.8	44.0
Pilsen	209	5.2	53.3	153	5.4	39.0
Karlovy Vary	150	3.7	71.2	124	4.4	58.9
Ústí nad Labem	297	7.4	51.8	292	10.3	51.0
Liberec	161	4.0	53.4	160	5.7	53.0
Hradec Králové	145	3.6	38.7	129	4.6	34.4
Pardubice	103	2.6	29.2	76	2.7	21.5
Vysočina	182	4.5	52.0	113	4.0	32.3
South Moravia	243	6.0	30.4	223	7.9	27.9
Olomouc	176	4.4	40.2	159	5.6	36.3
Zlín	122	3.0	30.2	102	3.6	25.3
Moravia-Silesia	326	8.1	38.3	276	9.8	32.4
Total	**4,032**	**100.0**	**55.8**	**2,827**	**100.0**	**39.1**

Map 9-1: Drug-related offences, 2012, in relative terms per 100 thousand inhabitants aged 15-64, by region (Policejní prezidium Policie ČR, 2013)

9.1.2 Sentences for Drug-related Offences

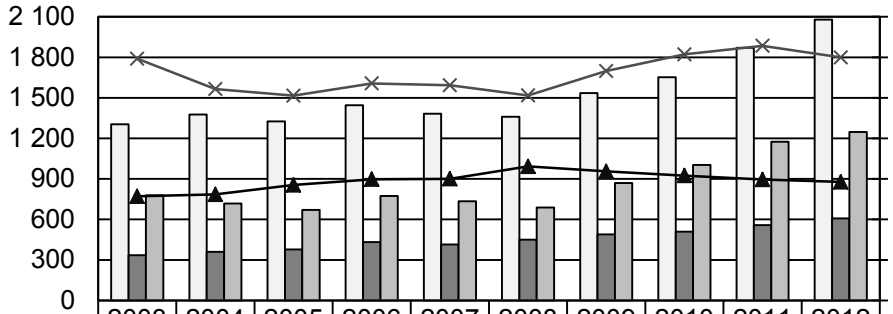
Final sentences for drug-related offences were imposed on 2,079 persons in 2012. Women accounted for nearly 15% of this figure and juveniles for over 3%. The share of women and juveniles remained essentially identical in comparison with 2011. People with no previous convictions accounted for 41% of the individuals upon whom a final sentence was imposed. In terms of age, the 30-39 age group was the largest (29%). As Table 9-9 shows, suspended imprisonment (62%), unsuspended imprisonment (30%), and community service (6%) were the most commonly imposed sentences in 2012. Supervision by a probation officer was ordered in 17% of the cases of suspended prison sentences (compared to 21% in 2011). Compared to the previous year, there was a decrease in the share of suspended prison sentences (by 3 percentage points), while the share of community service increased (by 2 percentage points). In 2012 sentences of community service were most commonly imposed upon individuals convicted of the possession of drugs for personal use and for the unauthorised cultivation of plants and mushrooms containing narcotic or psychotropic substances. Most of the unsuspended sentences of imprisonment were for a period of from one to five years.

Table 9-9: Sentences imposed for drug-related offences in 2012, by type of offence (Ministerstvo spravedlnosti ČR, 2013a)

Sentences for drug-related offences	**Sec. 187/ Sec. 283**		**Sec. 187a/ Sec. 284**		**Sec. 285**		**Sec. 188/ Sec. 286**		**Sec. 188a/ Sec. 287**		**Total**	
	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)
Unsuspended imprisonment	527	33.2	36	15.5	7	7.1	34	35.1	4	30.8	608	30.0
Suspended imprisonment	937	59.1	171	73.4	73	73.7	58	59.8	8	61.5	1,247	61.5
House arrest	7	0.4	2	0.9	2	2.0	0	–	0	–	11	0.5
Community service	94	5.9	17	7.3	8	8.1	4	4.1	0	–	123	6.1
Prohibition of activity	2	0.1	0	–	0	–	0	–	0	–	2	0.1
Forfeiture of property	0	–	0	–	0	–	0	–	0	–	0	–
Fine	9	0.6	4	1.7	3	3.0	0	–	0	–	16	0.8
Forfeiture of articles	1	0.1	2	0.9	6	6.1	0	–	0	–	9	0.4
Expulsion	8	0.5	0	–	0	–	1	1.0	1	7.7	10	0.5
Prohibition of entry and residency	1	0.1	1	0.4	0	–	0	–	0	–	2	0.1
Total	**1,586**	**100.0**	**233**	**100.0**	**99**	**100.0**	**97**	**100.0**	**13**	**100.0**	**2,028**	**100.0**

Since 2008, the number of persons sentenced for drug-related offences has been increasing, while the number of unsuspended prison sentences has been declining in favour of suspended prison sentences and other sanctions; see Graph 9-3.

Graph 9-3: Development in the number of persons sentenced and structure of sanctions imposed for drug-related offences, 2003-2012 (Ministerstvo spravedlnosti ČR, 2013a)



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Persons sentenced	1 304	1 376	1 326	1 445	1 382	1 360	1 535	1 652	1 870	2 079
Unsuspended sentences	335	360	378	432	415	450	489	509	558	608
Suspended sentences	778	718	670	774	734	688	869	1 003	1175	1 247
Share of unsuspended sentences	26%	26%	29%	30%	30%	33%	32%	31%	30%	29%
Share of suspended sentences	60%	52%	51%	54%	53%	51%	57%	61%	63%	60%

9.1.3 Protective and Educational Measures

A sentence of compulsory (court-ordered) treatment is one of the most common protective measures that is imposed. It is served either in the residential or outpatient form on the basis of a final judgement of the court. The court may impose this sanction on offenders who abuse addictive substances and have committed an offence under the influence of, or in connection with, the abuse of such a substance. The compulsory treatment sentence is served in healthcare facilities. Compulsory treatment was imposed upon 258 persons in 2012: non-alcohol drug addiction treatment concerned 103 individuals, while alcohol addiction treatment concerned 155 persons. Compulsory alcohol treatment was most frequently imposed upon persons sentenced for the offences of abuse of a person living in a shared home (30 persons), disorderly conduct (27), assault (23), theft (16), or robbery (15). Compulsory drug treatment was most frequently imposed upon offenders who had committed the offences of theft (30 persons), unauthorised production and possession of narcotic and psychotropic substances and poisons (23 persons), disorderly conduct (14), arbitrary interference with the home (13), or abuse of a person living in a shared home (10). The trend since 2004 is shown in Graph 9-4 (Ministerstvo spravedlnosti ČR, 2013a).

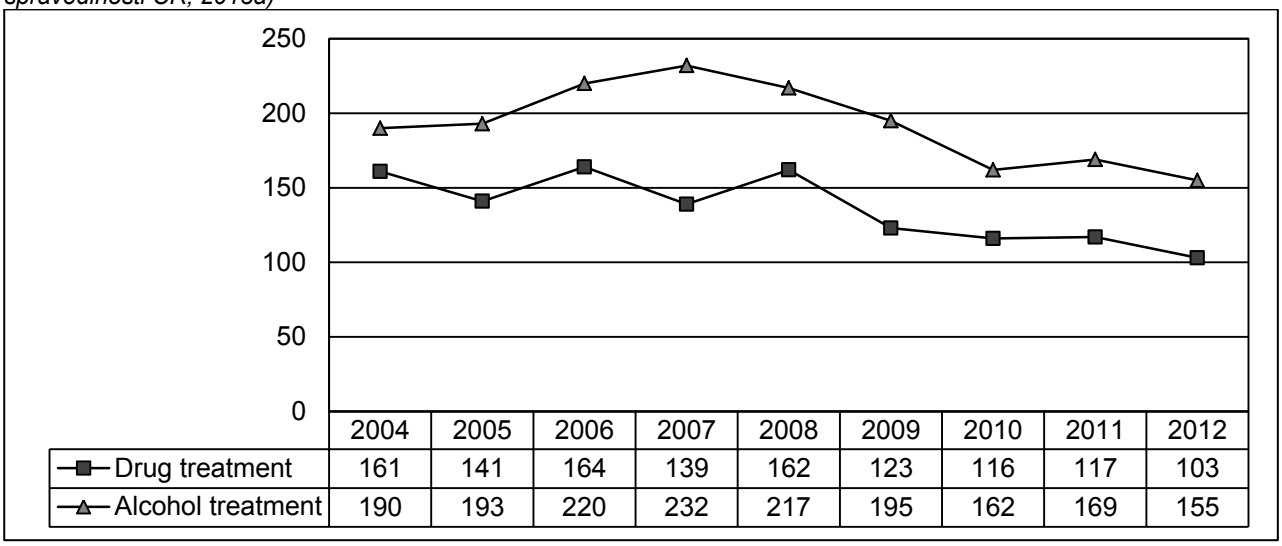
If imposed in addition to a prison sentence, the inpatient form of compulsory treatment can also be served in prison. There were specialised wings available for this purpose in four prisons in 2012: the Rýnovice, Opava, Heřmanice, and Znojmo prisons (Generální ředitelství Vězeňské služby ČR, 2013c). If it is obvious from the personality of the offender that sufficient protection of the public cannot be achieved by compulsory treatment, the court may impose a measure in the form of security detention. Security detention could be served in two institutions – in Brno and in Opava. Security detention was not imposed upon any offender in connection with drug-related crime in 2012 (Ministerstvo spravedlnosti ČR, 2013a).

The court may also impose appropriate measures or obligations within the scheme of diversion from criminal proceedings or as part of alternative sentencing. The obligation to undergo substance addiction treatment was imposed upon 156 individuals, and a restriction in the form of compulsory abstinence from using alcohol or other addictive substances was imposed upon 499 persons in 2012. In comparison with the previous year, 2012 saw an increase in the number of persons upon whom a restriction or an obligation was imposed in connection with drug use (Probační a mediační služba ČR, 2013).

Educational measures may also be imposed upon adolescent and very young offenders. In 2012 educational measures were imposed in connection with drug-related offences in the form of supervision by a probation officer (upon five persons), educational obligations[135] (upon six persons), and educational restrictions[136] (upon eleven persons) (Ministerstvo spravedlnosti ČR, 2013a).

[135] Such as the obligation to live with their parents, pay compensation for damage, or undergo substance addiction treatment.
[136] Such as a prohibition on attending certain events and maintaining contact with certain individuals.

Graph 9-4: Development in the number of compulsory treatment orders imposed in 2004-2012 (Ministerstvo spravedlnosti ČR, 2013a)



	2004	2005	2006	2007	2008	2009	2010	2011	2012
Drug treatment	161	141	164	139	162	123	116	117	103
Alcohol treatment	190	193	220	232	217	195	162	169	155

In 2012 the Probation and Mediation Service registered a total of 31,129 clients, i.e. individuals sentenced to a non-custodial sentence, individuals upon whom a restriction or obligation had been imposed, or prisoners released on parole.

A total of 820 (2.6%) of them had been sentenced for the offence of unauthorised production or other handling of narcotic and psychotropic substances or possession of articles intended for manufacture (Section 187/283, Section 188/286), 88 persons (0.3%) had committed the offence of drug possession for personal use (Section 187a/284), 25 persons (0.08%) the offence of unauthorised cultivation of plants or mushrooms containing narcotic and psychotropic substances for personal use (Section 285), and seven persons (0.02%) the offence of promoting drug use (Section 188a/287). Compulsory drug addiction treatment had been imposed upon 79 clients of the Probation and Mediation Service in 2012, 47 of whom had been ordered to undergo compulsory alcohol treatment and 32 compulsory drug treatment. An obligation to undergo the appropriate type of drug rehabilitation programme, which does not represent compulsory treatment according to the Penal Code, was imposed upon 3 clients of the Probation and Mediation Service.

As a part of the supervision of probation, in particular when checking adherence to the obligation to abstain from alcohol or other substances,[137] a total of 3,091 tests were conducted in 2012, 731 of which returned a positive result. THC and pervitin were the substances detected most often.

When a penal measure is waived or suspended, educational measures may be imposed upon a juvenile in the form of their probation programme. Two probation programmes accredited by the Ministry of Justice that focused on drug use were implemented in 2012: *Proboš* (implemented by Renarkon) and *Auritus* (implemented by the Tábor Parish Charity) (Probační a mediační služba ČR, 2013).

9.1.4 Misdemeanours Involving the Unauthorised Handling of Narcotic and Psychotropic Substances

According to Section 30 of Act No. 200/1990 Coll. on misdemeanours, a misdemeanour (administrative offence) is committed by any individual who possesses, without authorisation, a small quantity of narcotic or psychotropic substances (Subsection 1(j)) and/or cultivates, without authorisation, a small quantity of plants or mushrooms containing narcotic or psychotropic substances (Subsection 1(k)). A fine of up to CZK 15 thousand (€ 597) may be imposed for these misdemeanours.

The records of the administrative authorities indicate a total of 530,815 misdemeanours for 2012. Another 142,583 misdemeanours were pending from the previous period. Proceedings regarding a total of 304,665 thousand misdemeanours were held in 2012, with 1,285 cases involving the unauthorised handling of narcotic and psychotropic substances (0.4%, the same figure as in the previous year). The misdemeanours mostly concerned the unauthorised possession of narcotic and psychotropic substances according to Section 30 (1) (j). A decreasing trend in the number of misdemeanours committed by juveniles can be observed since 2010. The regions with the highest absolute number of misdemeanours reported in 2012 included Prague, Pilsen, Ústí nad Labem, and Central Bohemia; see Table 9-10. In comparison with the previous year, the most significant increase in the number of misdemeanours handled was observed in the Liberec region (43 misdemeanours in 2011, against 87 in 2012). Conversely, the most significant decrease was observed in the Pilsen region (with 136 misdemeanours in 2011, against 85 in 2012).

[137] Imposed under Section 48 (4) (h) of Act No. 40/2009 Coll.

Because of a change in the reporting system, data regarding the breakdown of the misdemeanours by drug type are not available from 2010 onwards; for details see the 2010 Annual Report. However, we can assume, on the basis of the drug use prevalence studies, that the misdemeanours were most commonly associated with cannabis and pervitin.

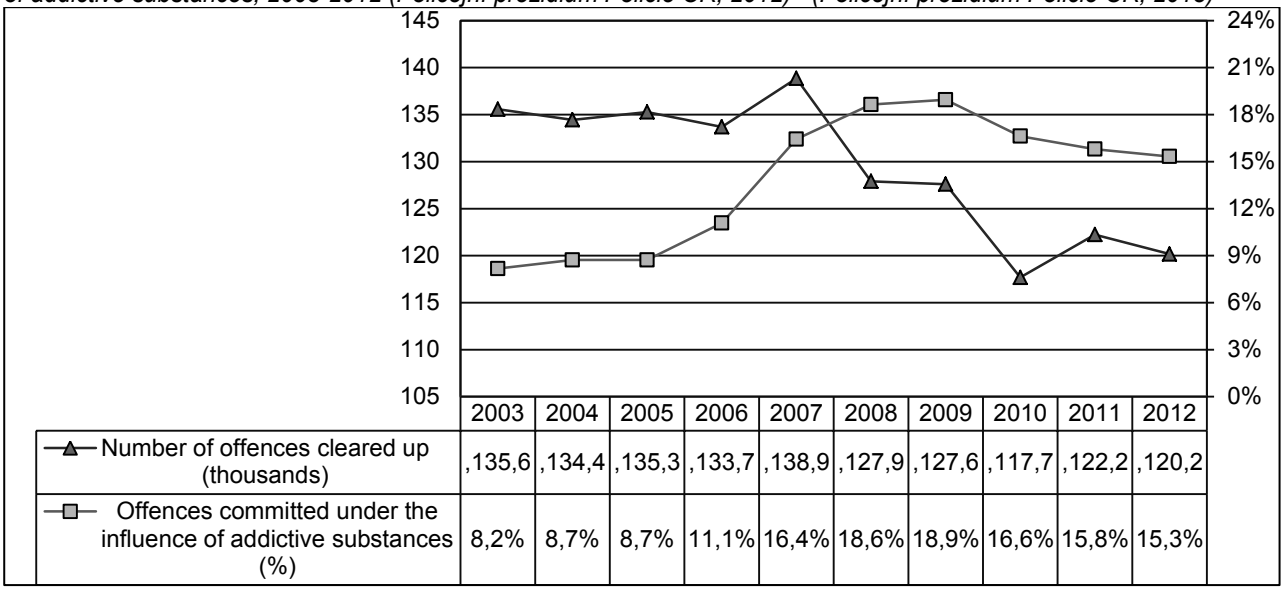
Table 9-10: Drug-related misdemeanours in 2012, by misdemeanour type, the offender's age, and region (Ministerstvo vnitra ČR, 2013)

Region	Possession		Cultivation of plants or mushrooms		Total drug-related misdemeanours	Total misdemeanours
	Total	of whom under 18 years	Total	of whom under 18 years		
Prague	197	2	5	0	202	33,189
Central Bohemia	122	14	5	2	127	36,945
South Bohemia	67	13	14	0	81	13,285
Pilsen	79	8	6	0	85	15,837
Karlovy Vary	36	2	1	0	37	10,757
Ústí nad Labem	126	15	6	0	132	33,770
Liberec	77	11	10	0	87	23,419
Hradec Králové	44	8	4	0	48	12,507
Pardubice	34	12	7	0	41	9,786
Vysočina	19	4	8	0	27	9,932
South Moravia	108	20	7	0	115	34,326
Olomouc	67	13	16	3	83	14,753
Zlín	90	16	13	1	103	19,157
Moravia-Silesia	106	11	11	0	117	37,002
Total	**1,172**	**149**	**113**	**6**	**1,285**	**304,665**

9.2 Other Drug-related Crime

Also referred to as "secondary drug-related crime", other drug-related crime encompasses those criminal offences which do not directly involve the handling of illegal substances but are committed in connection with the use of such substances (Zábranský et al., 2011a). A total of 120.2 thousand offences were cleared up in 2012, according to the data of the Police of the Czech Republic reported from the Criminal Statistics Records System. According to the police records, offences committed under the influence of addictive substances accounted for 18.4 thousand offences (15.3% of all the offences that were cleared up). The share of offences committed under the influence of addictive substances increased steadily between 2005 and 2009. However, the trend has been reversed in the past three years; see Graph 9-5.

Graph 9-5: Development in the number of offences cleared up and the share of offences committed under the influence of addictive substances, 2003-2012 (Policejní prezidium Policie ČR, 2012) (Policejní prezidium Policie ČR, 2013)



A total of 16.1 thousand offences committed under the influence of alcohol, i.e. 87.6% of all the offences committed under the influence of addictive substances, were reported by the police in 2012; see Table 9-11. They were most commonly the offences of endangerment under the influence of an addictive substance and inebriation (48%), road traffic accidents caused by negligence (17%), voluntary bodily harm (6%), and disorderly conduct (6%). 2.3 thousand

offences, i.e. 12.4% of the offences committed under the influence of addictive substances, were committed under the influence of drugs other than alcohol in 2012. The offenders most typically committed the offences of endangerment under the influence of addictive substances (67%), obstructing justice (12%), or theft (4%). In the long term, there is an apparent high percentage of offences committed under the influence of alcohol, even though the number has been decreasing and the percentage of offences committed under the influence of other substances has been increasing since 2007.

Table 9-11: Number of offences committed under the influence of alcohol and other substances, 2003-2012 (Policejní prezidium Policie ČR, 2013)

Year	Offences committed under the influence of alcohol		Offences committed under the influence of drugs other than alcohol		Total offences committed under the influence of addictive substances
	Number	Share (%)	Number	Share (%)	
2003	10,143	91.5	939	8.5	11,082
2004	10,916	93.0	816	7.0	11,732
2005	11,020	93.4	781	6.6	11,801
2006	14,075	95.0	735	5.0	14,810
2007	22,030	96.5	793	3.5	22,823
2008	22,826	95.7	1,019	4.3	23,845
2009	22,277	92.1	1,900	7.9	24,177
2010	17,290	88.4	2,277	11.6	19,567
2011	17,168	88.9	2,142	11.1	19,310
2012	16,130	87.6	2,289	12.4	18,419

In 2012 the Probation and Mediation Service kept records on a total of 31,129 clients. Substance use was found in 562 clients (1.8%) during criminal proceedings or during contact with the Probation and Mediation Service staff. A total of 182 of them used alcohol and 380 used drugs other than alcohol. Alcohol users had most typically committed the offences of endangerment under the influence of an addictive substance (27%), theft (14%), obstructing justice (14%), disorderly conduct (12%), or arbitrary interference with the home (8%). The users of drugs other than alcohol had most typically committed the offences of theft (32%), unauthorised production and other handling of narcotic and psychotropic substances (29%), obstructing justice (15%), endangerment under the influence of an addictive substance (11%), or arbitrary interference with the home (6%). In comparison with the previous period, the number of clients increased by nearly 15% in 2012 and, at the same time, the number of people in whom drug use was found decreased (Probační a mediační služba ČR, 2013).

Estimates of secondary drug-related crime are made on the basis of the data from the Criminal Statistics Records System every two years. The most recent estimate was made in 2011; see the 2011 Annual Report.

9.3 Prevention of Drug-related Crime

The prevention of drug-related crime generally falls within the competence of the Ministry of the Interior, which coordinates the relevant activities across the government portfolios, as well as with the Police of the Czech Republic and other stakeholders, both directly and through the National Crime Prevention Committee. 2012 was the year of the application of the Crime Prevention Strategy for 2012-2015. This Strategy includes only the activities of the government portfolios represented in the National Crime Prevention Committee and addresses both crime as such and phenomena which increase the risk of criminal behaviour. As for its objectives, the introductory section of the Strategy refers to the Statement of Policy of the government of 4 August 2010, in which drug-related crime is highlighted as one of the areas which require particular attention. However, the objectives of the strategy are formulated in a rather general manner. The Government Council for Drug Policy Coordination is one of the entities involved in the implementation of the Crime Prevention Strategy.

At the national level, crime prevention is supported from a specific funding envelope (Ministerstvo vnitra ČR, 2011). In response to an increase in drug-related crime in the regions along the border with Germany, a special funding programme, Prevention of Drug-related Crime in the Border Region, has been established for 2013. It seeks to support projects aimed at the prevention of involvement in drug-related crime, at increasing the motivation to cooperate with the police in detecting drug-related crime, and at preventing drug use. The defined priority target groups include the populations of socially excluded communities, foreigners (in particular, Vietnamese nationals), middle schoolers, adolescents, and the general public.

Crime prevention is also an area of focus of the Ministry of Education, Youth, and Sports, whose competence covers the prevention of risk behaviours among children and young people, i.e. including the prevention of crime and drug use; for detailed information see the chapter entitled Preven (p. 40).

9.4 Drug Use and Problem Drug Use in Prisons

The Prison Service administered 36 prisons in 2012. The prison population decreased against the previous year: as of 31 December 2012, it comprised 22,612 persons, 20,429 of whom had been sentenced and 2,183 were awaiting trial. 32 persons were committed to detention institutions. Women and juveniles accounted for 6.4% and 0.8% of the prison population, respectively. The number of foreign nationals remained below 8% of the prison population. The most common prison term was 1-2 years. The number of persons imprisoned for drug-related offences decreased to 1,645, i.e. by nearly 26%, against the previous year. The decrease in the number of prisoners occurred for all types of drug-related offences; the drop was most significant as far as individuals imprisoned for the offence of unauthorised production and other handling of narcotic and psychotropic substances were concerned. There was a decrease by 17% in the number of offences directly related to intoxication with an addictive substance (Section 201 of the old Penal Code/Section 274 of the Penal Code and Section 201a of the old Penal Code/Section 360 of the Penal Code) in 2012; see Table 9-12.

Table 9-12: Number of individuals imprisoned for drug-related offences and offences related to drug use, as of 31 December of the given year (Generální ředitelství Vězeňské služby ČR, 2013a)

Year	Sec. 187/ Sec. 283	Sec. 187a/ Sec. 284	Sec. 188/ Sec. 286	Sect. 188a/ Sec. 287	Sec. 201/ Sec. 274	Sec. 201a/ Sec. 360	Total
2007	1,314	101	144	69	299	95	**2,022**
2008	1,257	127	185	93	554	158	**2,374**
2009	3,073	323	365	138	1,595	106	**5,600**
2010	1,696	143	145	32	936	27	**2,979**
2011	1,929	126	155	26	1,077	27	**3,340**
2012	1,399	120	112	14	883	33	**2,561**

Note: Sec. 201 of the old Penal Code/Sec. 274 of the Penal Code – endangerment under the influence of an addictive substance; Sec. 201 of the old Penal Code/Sec. 360 of the Penal Code – inebriation.

Information about the number of drug users in prison, obtained from examinations/treatment interventions by general practitioners, from drug screening tests, and drug seizures in prisons, is again available for 2012 (Generální ředitelství Vězeňské služby ČR, 2013c, Generální ředitelství Vězeňské služby ČR, 2013a). As far as the provision of healthcare is concerned, a total of 412,928 examinations or treatment interventions involving prisoners were performed in 2012. On the basis of the findings of the examinations or treatment interventions, the medical service reported 11,463 persons with a history of drug use (11,534 persons in 2011).

A total of 37,411 drug screening tests of prisoners were performed (compared to 24,704 in 2011); 23,322 of the tests were for drugs other than alcohol (22,827 in 2011). Over 47% of the tests were performed on prisoners entering prisons to await trial or serve their sentence (11,115 tests); only tests for non-alcohol drugs were performed among this group. 4,754 positive results were identified (43% of the persons entering prison to await trial or serve a prison sentence); 2,021 persons tested positive for THC, 1,144 for pervitin, 401 for benzodiazepines, and 166 for opiates. Polydrug use was identified in 909 persons (8%). In comparison with the previous year, there was an increase in the number of persons entering prison to await trial or serve a prison sentence who tested positive for the use of cannabis. Unlike among those persons who are already awaiting trial in custody or serving a prison sentence, confirmation tests are not usually performed on those entering prison, and the results are therefore for reference only. As for the persons awaiting trial in custody or serving a prison sentence (12,207 tests), 530 positive results were confirmed (4% of the inmates tested), 34 of which were positive alcohol tests. The positive results were mostly found in individuals serving their prison sentence. THC (234 individuals), pervitin (188), and benzodiazepines (45) were the substances detected most frequently. Polydrug use was confirmed in 47 cases (0.4% of the inmates tested). In comparison with the previous year, there was an increase in the number of inmates who are awaiting trial in custody or are serving a prison sentence and who tested positive for the use of cannabis.

The prison service reported a total of 75 seizures of drugs (totalling 110 grams) and 9 seizures of medicines (a total of 58 grams and 384 tablets) containing narcotic or psychotropic substances in 2012. Methamphetamine (36 seizures totalling 31.6 grams) and cannabis (34 seizures totalling 70.2 grams) were the drugs seized most frequently. The drugs, including medicines, were mainly seized during checks on correspondence (39 cases) and when prisoners were searched (24 cases). In addition to drugs, 22 syringes and a fermented substance containing ethanol were found. Trained drug-sniffing dogs are used during the searches. A total of 632,634 searches using drug-sniffing dogs were performed in 2012. In 50 cases, the dog indicated a place where a suspicious substance was later found; in another 78 cases the drug-sniffing dog indicated a place where a drug had probably been placed but the substance was not found.

9.4.1 Questionnaire Survey of Drug Use among Prisoners

The second round of the questionnaire survey of drug use among prisoners serving a prison sentence took place in late 2012 (Národní monitorovací středisko pro drogy a drogové závislosti and Generální ředitelství Vězeňské služby ČR, 2013). The survey was conducted by the National Focal Point in cooperation with the Prison Service of the Czech Republic. The collection and acquisition of data was provided by the *ppm factum research* agency through

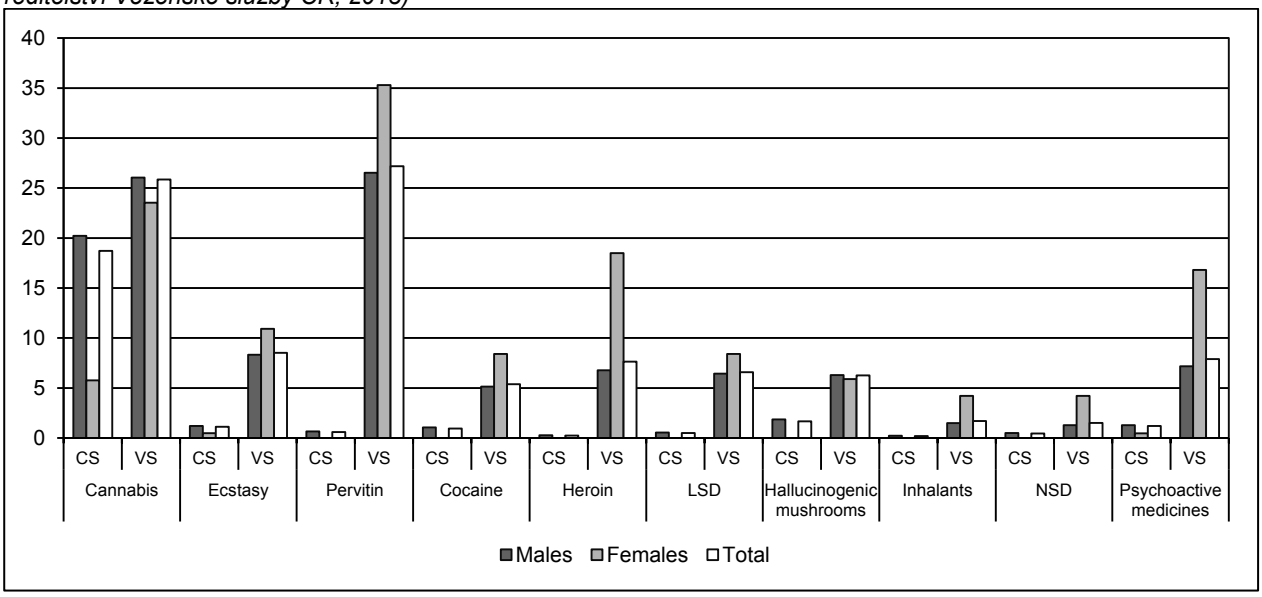
trained administrators. For the results of the first round of the study see the 2010 Annual Report and *Zaostřeno na drogy* (Focused on Drugs) 5/2011 (Mravčík et al., 2011a).

The 2012 sample consisted of 2,000 individuals serving their prison sentence. The respondents were randomly selected from the 20,716 individuals serving their prison sentence in the 36 prisons in the Czech Republic as of the date of selection. A total of 1,641 questionnaires were returned, providing a response rate of 82%. The questionnaires were administered in groups. The questionnaire used in the first round of the study, modified with regard to the current trends and experience obtained from the previous study, was applied to collect the data. The questionnaire focused on several sets of issues. In addition to the demographic characteristics, the survey concerned areas such as the respondent's criminal career, experience with addiction treatment, prevalence of drug use, including problem drug use and drug use before and after entering prison, gambling, and the availability of drugs in prison.

49.8% of the respondents reported lifetime illicit drug use. In addition to alcohol, the respondents' experience was mostly with cannabis, pervitin, or amphetamines and with sedatives obtained without a prescription. A total of 39.1% had used cannabis, 36.0% pervitin or amphetamines, 18.9% ecstasy, 16.1% hallucinogenic mushrooms, 14.7% LSD, 13.6% cocaine, and 13.2% heroin at least once. 16.5% of the respondents reported having used medicines with a sedative effect obtained without a prescripttion. 2.2% of the respondents had tried mephedrone. Over 21.1% had used an illegal drug in the last 12 months and 8.9% in the last 30 days. Most commonly, this concerned the use of cannabis, pervitin, or amphetamine, as well as self-medicated sedatives.

The comparison of the lifetime prevalence of illicit drug use between the inmates and the general population of the same gender and age shows a significantly higher lifetime prevalence of addictive substance use among the individuals serving a prison sentence. A higher prevalence rate is mainly evident as regards the use of pervitin, amphetamine, heroin, and cocaine. For these substances, the prevalence rates among the prisoners are a multiple of those reported by the general population. Experience with cannabis is an exception. While 39.1% of prisoners have tried cannabis, the figure was 44.5% of the general population, after adjustment for age and gender. Women serving a prison sentence show higher prevalence rates of illicit drug use than imprisoned men, and the rates are more than strikingly higher than those reported by women among the general population, in particular as far as pervitin, heroin, and cannabis were concerned; see Graph 9-6.

Graph 9-6: Comparison of the 12-month prevalence rates of drug use among the general population as recorded by the 2012 National Survey on Substance Use (CS) and among offenders before entering prison (VS), shown as percentages by gender, 2012 (Chomynová, 2013, Národní monitorovací středisko pro drogy a drogové závislosti and Generální ředitelství Vězeňské služby ČR, 2013)



Note: The results of the general population survey were weighted according to the gender and age of the prison study sample.

According to the respondents, alcohol made in prison, cannabis, and pervitin were the most easily available addictive substances in prison. Approximately 16% of the respondents considered these substances easily available. In terms of availability, these substances were followed by sedatives, which were found easily available by 13% of the respondents. On the contrary, alcohol smuggled in from the outside (11%) and ecstasy (7%) were considered the least available drugs.

A total of 17.8% of the respondents had used an addictive substance during one of their previous prison sentences. This most commonly involved alcohol made in prison (11.1%), cannabis (10.9%), and pervitin (10.3%), followed by self-medicated sedatives (7.9%). The other substances that were reported were all below 5%.

A total of 28.5% of the respondents admitted having injected a drug at least once in their lifetime. 18.8% of the respondents had injected a drug in the last month before entering prison to serve their current prison sentence. A total of 11.4% of the respondents had shared a needle or a syringe (i.e. 40% of those who reported a history of injecting drug use). Injecting drug use while serving one of their prison sentences was reported by 6.7% of the respondents. 5% of the respondents had shared a needle/syringe in prison (i.e. 75% of those who reported injecting drug use in prison).

25.9% of the prisoners, i.e. 5,400 when converted to the general prison population, can be referred to as problem drug users (i.e. injecting drug users or those who repeatedly used pervitin, opiates, or cocaine in the month before entering prison).

Before entering prison to serve their sentence, 5.1% of the respondents had received alcohol addiction treatment, 9.1% had received treatment for addiction to another substance, and 3.9% had received substitution therapy before they entered the prison to serve their current sentence (Národní monitorovací středisko pro drogy a drogové závislosti and Generální ředitelství Vězeňské služby ČR, 2013).

9.5 Responses to Drug-related Health Issues in Prisons

Prevention, addiction treatment, and harm reduction interventions were carried out in prisons through drug prevention counselling centres, drug-free zones, specialised wings, and programmes provided by NGOs.

Drug prevention counselling centres operated in all the prisons. In 2012, a total of 7,309 persons used the services of one of these centres, 1,086 more than in the previous year. In all the prisons, drug prevention counselling centres provided information and individual counselling services. More comprehensive programmes were offered by special prison departments – the so-called drug-free zones with a standard or therapeutic regime. The main purpose of a standard drug-free zone is to motivate the prisoners to abstain and follow a drug-free routine. This type of department was available in 31 prisons, with the capacity being 1,805 in 2012. A total of 4,252 individuals used the opportunity to be placed in these wings, 2,264 of whom were newcomers in 2012. 87 inmates were expelled for violating the rules. In comparison with 2011, the number of newcomers increased (from 2,138 in 2011), while the number of persons expelled for violating the rules dropped (107 in 2011). The target group for the drug-free zones with a therapeutic regime[138] comprises drug users only. The programme is aimed at promoting therapy either while in prison or after release. These departments mostly also accept prisoners who have undergone a treatment programme in one of the specialised wings. This type of wing was available in four prisons (Kuřim, Příbram, Vinařice, and Znojmo) in 2012. Their capacity was 113 beds. In 2012, the opportunity to be placed in these zones was taken by 297 persons, 158 of whom were newly assigned to these zones. 20 inmates were expelled for violating the rules. As of the end of 2012, there were 126 prisoners serving their sentence in these wings. The proportion of individuals in whom a drug test showed drug use remained unchanged against the previous year (1.6% both in 2011 and in 2012).

Addiction treatment while serving a prison sentence could be provided by 11 specialised wings in 2012. In seven prisons (Bělušice, Nové Sedlo, Ostrov, Pilsen, Příbram, Valdice, and Všehrdy), these specialised wings were intended for voluntary treatment, while in four prisons (Heřmanice, Opava, Rýnovice, and Znojmo) they were used for serving court-ordered compulsory treatment. The capacity of 287 beds in these specialised wings was the same as in 2011. The opportunity to undergo voluntary treatment in one of the specialised wings was taken by 537 persons (with 268 new entries) in 2012. Altogether, 169 persons successfully completed the programme, and one was expelled for violating the rules. A total of 435 drug screening tests were conducted in the specialised wings for voluntary treatment in 2012, returning four positive results.

Compulsory alcohol, drug, and gambling treatment could also be served as a part of a prison sentence.[139] There were five such wings used for this purpose in four prisons, one of which was intended for women (Opava). The number and profile of these wings remained unchanged in comparison with the previous year. The capacity of the specialised wings for compulsory addiction treatment was 178 places in 2012. In 2012, the Prison Service registered a total of 230 persons assigned to one of these wings, 104 of whom successfully completed the programme and eight being expelled for non-compliance. A total of 179 tests were performed in the compulsory treatment wings in 2012, all of them negative. An overview of the number, capacity, and utilisation of the drug-free zones and specialised wings is provided in Table 9-13.

[138] The programme includes at least 10 hours of structured, managed activities per week.

[139] In 2011, the General Directorate of the Prison Service stated in its opinion that the healthcare provided by the existing specialised wings for compulsory treatment cannot be considered institutional health care. “Protective” treatment is therefore delivered in prisons in the outpatient form. The percentage of outpatient treatment cases in prison thus started to increase in 2011. The opinion of the Prison Service is codified by the new Act No. 373/2011 Coll. on specific health services, which came into force on 1 April 2012. According to Section 83 (2) of this Act, compulsory treatment can be provided in the healthcare facilities of the Prison Service while an offender is serving a prison sentence. This concerns compulsory institutional treatment provided in the form of one-day care, and compulsory treatment provided on an outpatient basis; see also the chapter entitled Leg (p. 5).

Table 9-13: Number, capacity, and use of drug-free zones and specialised wings, 2006-2012 (Generální ředitelství Vězeňské služby ČR, 2013c)

Year	Drug-free zones			Voluntary treatment departments			Compulsory treatment departments		
	Number of prisons	Capacity	Number of people	Number of prisons	Capacity	Number of people	Number of prisons	Capacity	Number of people
2006	31	1,665	3,201	6	286	625	3	105	162
2007	35	1,877	3,524	6	258	419	3	114	200
2008	33	1,998	3,646	6	262	422	3	120	206
2009	33	2,057	4,224	7	294	507	3	120	117
2010	33	2,075	3,443	7	300	437	3	109	128
2011	33	1,905	4,279	7	287	535	3	113	206
2012	34	1,918	4,549	7	287	537	3	128	184

Ten prisons are qualified to provide substitution therapy, seven of which reported treating patients in 2012. The substitution treatment programmes in prisons reported 89 clients, i.e. 10 less than in the previous year. In comparison with 2011, the average treatment period was reduced to approximately 3.9 months; see Table 9-14. Methadone was the substitution substance. In order to be included in a substitution therapy programme in prison, the clients had to have been included in a substitution therapy programme before they entered the prison to await trial in custody or to serve their prison sentence.

Table 9-14: Number of individuals undergoing substitution therapy and average treatment period (in months) in the individual prisons, 2010-2012 (Generální ředitelství Vězeňské služby ČR, 2013c)

Prison	2010		2011		2012	
	Number of individuals	Treatment period	Number of individuals	Treatment period	Number of individuals	Treatment period
Brno	11	11.0	22	3.0	28	4.0
Břeclav	0	–	0	–	0	–
Kuřim	7	19.5	12	2.0	13	3.0
Litoměřice	10	4.8	11	1.0	9	3.0
Opava	5	6.0	13	1.5	5	1.0
Ostrava	0	–	0	–	0	–
Prague-Pankrác	15	8.3	24	5.2	15	5.0
Prague-Ruzyně	1	1.0	0	–	0	–
Příbram	16	6.5	14	11.0	17	8.0
Rýnovice	2	4.0	3	12.0	2	3.0
Total	**67**	**7.6**	**99**	**5.1**	**89**	**3.9**

Detoxification was provided by four prisons in 2012. Acute withdrawal treatment was received by 353 persons, 270 of whom were men and 83 women. Opiate users accounted for 84% and pervitin users for 16% of the persons detoxified. There was an increase by 14% in the number of persons undergoing withdrawal management in comparison with the previous year (309 persons in 2011). Cells in the crisis departments were used to pacify the acutely intoxicated.[140] In 2012, this concerned 67 cases, i.e. 7 cases more than in the previous year.

A total of 22 prisons cooperated with an NGO on implementing the activities aimed at prevention, addiction treatment, and harm reduction, 9 of which reported intensive cooperation (10 or more visits per year). The NGOs providing drug services in prisons, the number of visits, and the number of clients are listed in Table 9-15. A total of 3,660 individuals awaiting trial in custody or serving a prison sentence were in contact with an NGO in 2012. In addition to working with imprisoned clients, the NGOs also focused on post-penitentiary care. As far as this topic is concerned, the Government Council for Drug Policy Coordination discussed and approved the guideline document *Recommended Procedures for the Systematic Referral of Drug Users Released from Custody to Follow-up Care in Community Settings* in March 2012; for details see the chapter entitled Social Reintegration(p. 122).

[140] The crisis departments in prisons are used for prisoners going through an acute mental crisis.

Table 9-15: NGOs providing drug services in prisons, number of visits, and number of prisoners contacted (Generální ředitelství Vězeňské služby ČR, 2013c)

Name of NGO	Prison	Number of visits	Number of clients
CPPT	Pilsen	40	186
Laxus	Horní Slavkov, Jiřice, Ostrov, Rýnovice, Stráž p. R.	117	501
Magdaléna	Příbram	2	12
Blue Cross, Czech Republic	Heřmanice	1	17
Most k naději	Bělušice	2	78
Podané ruce	Brno, Kuřim, Mírov, Rapotice, Znojmo, Olomouc	303	2,107
Point 14	Drahonice	4	37
Renarkon	Heřmanice	2	34
Riaps	Hradec Králové	25	183
Sananim	Opava, Pilsen, Prague-Ruzyně, Světlá n. S., Vinařice	96	406
White Light I.	Nové Sedlo, Bělušice	3	99
Total	–	**595**	**3,660**

Note: If an individual was contacted multiple times during a single day, e.g. if they participated in a debate and then used individual counselling, only a single contact has been included for that day. If the contacts were made on multiple days, each day is included as a contact.

10 Drug Markets

An estimated 11.6 tonnes of cannabis, 5.9 tonnes of pervitin (methamphetamine), 0.8 tonnes of heroin, 0.7 tonnes of cocaine, 62.3 million tablets of ecstasy, and 75.8 million doses of LSD were consumed in the Czech Republic in 2012. The domestic production covers all the pervitin and most of the cannabis consumed.

The average THC concentration in the cannabis grown indoors that was seized was 10-15%. In 2012, the Police of the Czech Republic detected 199 indoor cannabis cultivation sites; in 19 other cases the cannabis was grown in a plastic greenhouse. The data regarding drug-related crime indicate that the share of people of Vietnamese descent involved in the cultivation and distribution of cannabis and in importing indoor cultivation equipment increased significantly. The number of marijuana seizures and the quantities seized have been increasing since 2009. In 2012, the Police of the Czech Republic and the Customs Administration of the Czech Republic reported 558 seizures of a total of 653 kg of marijuana, 90.1 thousand cannabis plants, and 21 kg of hashish.

Produced only domestically, pervitin is mainly made in low-volume domestic laboratories, which can easily be moved. In 2012 the police detected 235 such cooking labs. Pseudoephedrine, extracted from over-the-counter medicines imported mainly from Poland but also from Germany and Hungary, was used as the main precursor in the manufacture of pervitin. Altogether, 355 seizures of a total of 32 kg of pervitin were reported in the Czech Republic in 2012.

Cocaine mostly entered the Czech Republic through Czech couriers or in postal consignments containing various articles. A total of 44 seizures of cocaine were made in 2012, involving a total of 8 kilograms.

As far as heroin is concerned, the Czech market is supplied using small shipments. The purity of the heroin distributed to the end users after further diluting was around 5%. In comparison with the previous year, there was an increase in both the number of seizures and the total quantity seized. Altogether, 41 seizures of a total of 8 kg were reported in 2012.

A total of 18 new types of synthetic drugs were intercepted in the Czech Republic in 2012. The substances seized in the largest quantities included 4-methylethcathinone (126 kg), the synthetic cannabinoid AM-2201 (4 kg), and the tryptamine 5-MeO-AMT (1,5 kg). The new psychoactive substances were mainly sold via e-shops.

In 2012, the National Drug Headquarters, working with the Customs Drug Unit and other law enforcement and regulatory authorities, focused on the drug market in the border region in North-West Bohemia, where it is mainly stimulated by the demand for pervitin and cannabis from German nationals.

10.1 Drug Consumption

10.1.1 Estimated Drug Consumption Based on Data from Users

The estimated consumption figures specified below are based on the data regarding average drug consumption and level of drug use from general population surveys conducted in 2008 (Běláčková et al., 2012) and 2012 (Chomynová, 2013) and from the annual estimates of problem drug use (Národní monitorovací středisko pro drogy a drogové závislosti, 2013a). It is especially the decrease in drug use indicated by the general population surveys carried out since 2008 that impacts on the decreasing estimated consumption in the Czech Republic.

The first preliminary estimates for 2012 are available: an estimated 11.6 tonnes of cannabis, 5.9 tonnes of pervitin, 0.8 tonnes of heroin, 0.7 tonnes of cocaine, 62.3 million tablets of ecstasy, and 75.8 million doses of LSD were consumed in the Czech Republic (Vopravil, 2013). In 2011, an estimated 18.2 tonnes of cannabis, 4.6 tonnes of pervitin, 1.2 tonnes of heroin, 869.5 kilograms of cocaine, 4.6 million tablets of ecstasy, and one million doses of LSD were consumed in the Czech Republic (Vopravil, 2012); for details see the 2011 Annual Report.

The 2011 Annual Report also indicates the estimated drug consumption based on the analysis of surface and waste waters.

The *Noe* drop-in centre in Třebíč conducted a survey among heavy cannabis users in 2012 (Diecézní charita Brno - Oblastní charita Třebíč, 2012). The study sample consisted of 93 face-to-face interviews with the users; for details see the chapter entitled Intensive, Frequent, Long-term, and Otherwise Problematic Forms of Drug Use (p. 59). Nearly a third (31%) of the respondents mostly obtained marijuana from their friends for free and 28% grew it themselves. The purchases usually involved quantities of 1-2 grams; about ten per cent of the respondents purchased larger quantities, most typically 10 grams. The price was between CZK 50 (€ 2) and CZK 250 (€ 10) per gram, most usually CZK 200 (€ 8). The average consumption by users who used the drugs on a daily basis was 0.94 grams per day; those who used cannabis several times per week averaged 3 grams per week. The most frequently reported sources of money included work and pocket money; 7% of the respondents reported that they stole to obtain the money. The respondents mainly used cannabis in the company of friends; only a small proportion of them preferred solitary use of the drug.

10.2 Availability and Supply

10.2.1 Perceived Availability of Drugs, Exposure, and Access to Drugs

Among other aspects, the 2012 National Survey on Substance Use (for details see the chapter entitled Drug Use in the General Population and Specific Targeted Groups on p. 25) looked into the perceived availability of illegal drugs. Cannabis was found fairly easy or very easy to obtain by 40.2% of the respondents (44.9% of the men and 35.5% of the women); obtaining the drug was easiest for the youngest age group (62.7%). The perceived availability of marijuana decreases with the age of the respondents. Ecstasy is the second most easily available drug (it was fairly easy or very easy to obtain for 15.8% of the respondents), with hallucinogenic mushrooms coming third (14.8%). Except for obtaining cannabis, over 40% of the respondents reported that obtaining drugs was rather difficult or even impossible for them, and over 40% more of them were unable to rate the availability of drugs (Chomynová, 2013).

In the same survey, 16.0% of the respondents reported being offered marijuana or hashish in the last 12 months (21.2% of the men and 11.0% of the women). Nearly a half (40.7%) of the respondents in the 15-24 age group and nearly a quarter of those aged 25-34 had been offered cannabis in the last year.

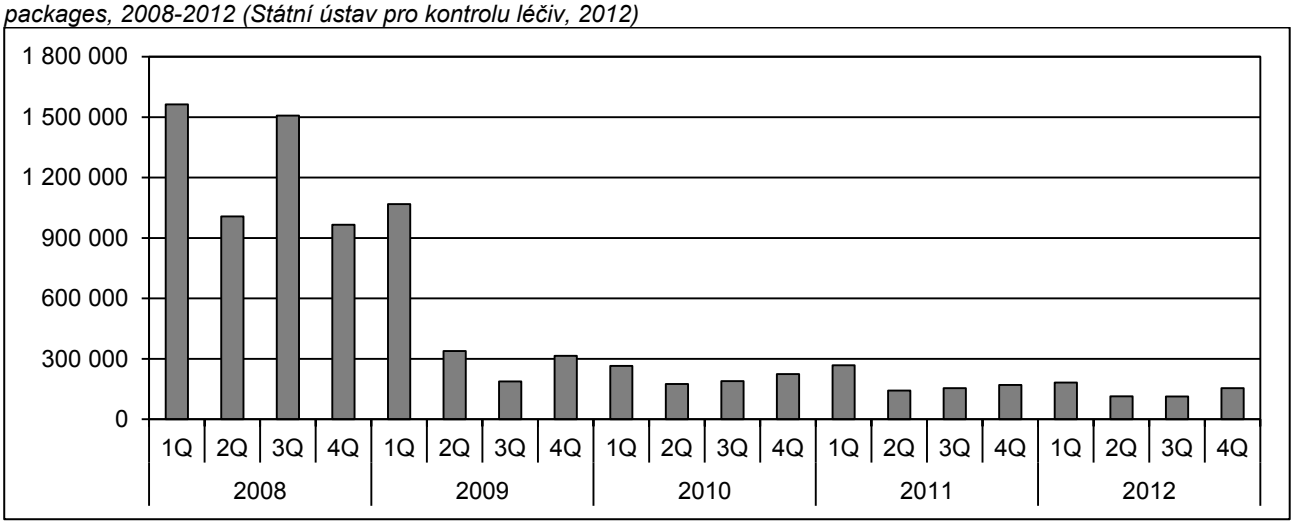
10.2.2 Domestic Production, Imports, and Exports

Information provided by the National Drug Headquarters of the Police of the Czech Republic and by the Customs Drug Unit represents the basic sources of data. This mainly concerns the number of seizures of the individual drugs and the quantities seized, broken down by the location of the seizure (Národní protidrogová centrála SKPV Policie ČR, 2013b; Ministerstvo financí, 2013).

The average THC concentration in the cannabis grown indoors that was seized was 10-15%. In 2012, the Police of the Czech Republic and the Customs Administration of the Czech Republic detected 199 indoor cannabis cultivation sites; in 19 other cases the cannabis was grown in plastic greenhouses. As in the previous year, the National Drug Headquarters and the Supreme Public Prosecutor's Office noted cases of the involvement of groups of Vietnamese nationals in the cultivation of cannabis, distribution of marijuana, and importing of equipment for indoor cultivation (Národní protidrogová centrála SKPV Policie ČR, 2013b, Nejvyšší státní zastupitelství, 2013). Two particular problems were the large scale of the criminal activities pursued and the high degree of organisation of the criminal groups. The trend observed in 2012 was the specialisation of these groups in cannabis cultivation or in the distribution of marijuana. The marijuana grown in large-volume plantations was intended both for the domestic and foreign markets. The sale of pervitin was also detected during the investigation of cases involving marijuana distribution. In 2012, the National Drug Headquarters, working with the Customs Drug Unit and other authorities, focused on detecting criminal activities in the border areas of the Ústí nad Labem, Karlovy Vary, and Pilsen regions, which is also evident from the reported data. The investigation of drug-related crime in these areas revealed numerous cases of the distribution of marijuana and pervitin in Vietnamese-managed marketplaces, the smuggling of small quantities of drugs by German nationals, and the shipping of larger quantities through consignments transported by couriers. As for the method used for smuggling marijuana from the Czech Republic, rather frequent cases of utilising air mail were detected by the Customs Drug Unit. These mainly concerned quantities of up to 100 grams, shipped to the UK or the USA.

Pervitin is made in the Czech Republic, mainly in low-volume, easily movable cooking labs. However, the National Drug Headquarters has noted an increasing number of seizures of high-volume laboratories in recent years. The number of cooking labs detected decreased from 388 in 2011 to 235 in 2012. In recent years, it has mainly been pseudoephedrine, extracted from over-the-counter medicines, that has been used as the main precursor in the manufacture of pervitin. Although the introduction of controlled sales of these medicines in May 2009 resulted in the expected decrease in their sales, at the same time, it led to an increase in illegal imports, in particular from Poland, Germany, and Hungary; see Graph 10-1. In addition to pseudoephedrine, ephedrine imported from the Netherlands, the West Balkans, and Ukraine was also used for the manufacture of pervitin. A case involving the production of ephedrine in the Czech Republic was also investigated. In 2012, the National Drug Headquarters, working with the Customs Drug Unit and other law enforcement and regulatory authorities, focused on the drug market in the border region in North-West Bohemia, where it is mainly stimulated by the demand for pervitin and cannabis from German nationals. A total of 561 drug-related offences, i.e. 172 more than in the previous year, were detected in the Ústí nad Labem, Karlovy Vary, and Pilsen regions, according to the data of the National Drug Headquarters. A total of 13.8 kilograms of pervitin were seized in these regions, i.e. approximately 12.6 kg more than in 2011. On the contrary, the number of cooking labs that were dismantled decreased from 66 labs in 2011 to 37 in 2012. The investigation of drug-related crime in these regions revealed a number of cases involving the distribution of marijuana and pervitin in Vietnamese-managed marketplaces or the smuggling of small quantities of drugs by German nationals. Extended cooperation between the Czech and German law enforcement and customs authorities was used in the investigation of drug-related crime in the regions along the German border, following the meeting of the Ministers of the Interior of the two countries in Hof, Germany, on 13 February 2012 ("the Hof Dialogue").

Graph 10-1: Development of the sales of medicines containing pseudoephedrine in the Czech Republic, by number of packages, 2008-2012 (Státní ústav pro kontrolu léčiv, 2012)



Cocaine is imported to the Czech Republic from South America, the only area of the world where the drug is produced. In 2012, the transit countries included Italy, Spain, the Netherlands, and Austria. As for the method of transport, the most common cases detected involved smuggling by couriers, in postal consignments containing various articles, in shipping containers, and on luxury yachts. Nationals of Central and Eastern European countries, the Balkans, and the Baltic countries were often used as couriers, transporting cocaine in body cavities and in their luggage. The weight of the drug that was smuggled varied between 0.5 grams and 5 kilos. As in the previous years, West African nationals, mostly those from Nigeria, as well as groups from the West Balkans, participated in the trafficking and distribution of the drug.

As in 2011, heroin tended to be imported in small shipments of several kilograms. Ethnic Albanians were significantly involved in the trafficking and distribution of heroin in 2012 but the National Drug Headquarters also noted the involvement of groups originating from Turkey, Nigeria, and the Balkans. The data regarding seizures indicate the trend of smuggling heroin on trucks transporting textiles and on refrigerated trucks transporting fresh food. The purity of the heroin distributed to the end users was around 5%. In addition to heroin, tablets of the substitution preparations containing buprenorphine, in particular those of Subutex®, continued to appear on the black market. One innovation was that the availability of fentanyl in the form of transdermal patches was noted on the black market. According to the National Drug Headquarters, the price of a single patch was approximately CZK 3,000 (€ 120). As for the distribution paths, cases involving the sale of fentanyl patches by the relatives of seriously ill patients who used the patches for pain treatment and cases of the smuggling of the patches from Germany were reported. In addition to fentanyl, Vendal® Retard (a morphine-based analgesic) was also available on the black market. The demand for the new opiate-type substances was probably stimulated by the lack of availability or low quality of the heroin sold on the street.

10.2.3 New Psychoactive Substances on the Czech Drug Scene

Since 2010, there has been an apparent increase in the presence of new psychoactive substances – synthetic and herbal substances with a stimulating, hallucinogenic, or sedative effect, sold under a number of trade names or, in the case of synthetic substances, directly under their chemical name – in the Czech Republic.[141] The new synthetic drugs are predominantly imported from Asian countries, mainly from China and India. When imported, they are declared as another type of goods or under a different chemical name. They include synthetic cannabinoids, phenetylamines, cathinones, tryptamines, piperazines, and substances of other chemical groups. A total of 18 new types of psychoactive drugs were intercepted in the Czech Republic in 2012. The substances seized in the largest quantities included 4-methylethcathinone (126 kg), the synthetic cannabinoid AM-2201 (4 kg), and the tryptamine 5-MeO-AMT (1,5 kg). As for herbal substances, the 2011 and 2012 records of the Customs Drug Unit reported seizures of khat[142] – 48.9 kg in 2011 and 79.1 kg in 2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2013c).

The new psychoactive substances were mainly sold via e-shops. The number of retail outlets, which had become abundant between the end of 2010 and April 2011, decreased significantly after the coming into force of the amendment to Act No. 167/1998 Coll. on addictive substances in April 2011.

[141] Herbal substances are sold in the form of extracts, pulp, powders, or mixtures. Synthetic substances are purposely selected to avoid the international control system, as well as the national control system of the target country.

[142] Khat – a very old cultivated plant containing the stimulant cathinone, used by chewing, in particular in Yemen, Ethiopia, Sudan, Eritrea, Djibouti, Somalia, and Kenya (i.e. in the Horn of Africa and in a part of the Arabian Peninsula), where the plant is legal. It is also used by ethnic minorities originating from these countries. Khat is legal in a number of EU Member States, while in the Czech Republic it was included in the list of narcotic and psychotropic substances in 2011.

In February 2012, a total of 19 e-shops offering new psychoactive substances via a Czech website were identified, 11 of which were selling only synthetic substances. The most frequent articles offered by the shops included kratom[143] and the synthetic substances 6-APB and 4-FA. Eight e-shops declared that the products were not intended to be taken internally and that the retailer waived any responsibility for harm incurred if the products were used in a manner contradictory to their purpose. The websites of five e-shops provided information about the legality of the products on offer in the Czech Republic. The same number of e-shops was identified in February 2013 as a year earlier but the number of e-shops offering only synthetic substances decreased to four. The most common synthetic substances offered included 3,4-dimethylmetcathinone, 3-methylmethcathinon, and pentedrone. The most common herbal products included *Turnera diffusa*,[144] kanna,[145] and *Nymphaea caerulea*,[146] sold as mixtures or extracts. Even though the number of e-shops which offered synthetic drugs decreased in 2013, the overall number of substances on offer was a multiple of that offered a year earlier. While the 19 e-shops identified in 2012 offered a total of 12 various synthetic substances, in 2013 the same number of e-shops offered 42 synthetic substances in total (Národní monitorovací středisko pro drogy a drogové závislosti, 2013d).

As for the synthetic opiate fentanyl, the National Drug Headquarters reported one seizure of this substance in the form of a transdermal patch in 2012. According to information from the National Drug Headquarters and from low-threshold programmes, fentanyl patches were available on the black market, whereas in 2011 they seemed to be unavailable. The use of fentanyl by problem drug users was reported in 2012 by low-threshold facilities in Prague and in the Pilsen and Moravia-Silesia regions; see also the chapter entitled Problem Drug Use (p. 48).

10.3 Seizures

Information provided by the National Drug Headquarters of the Police of the Czech Republic and by the Customs Drug Unit represents the basic sources of data concerning drug seizures. The number of seizures and the quantities of the individual drugs seized in 2007-2012 are provided in Table 10-2. As in the previous years, marijuana was the drug that was seized most frequently. The Police of the Czech Republic and the Customs Administration of the Czech Republic reported a total of 558 seizures of a total of 563 kg of this drug in 2012, i.e. 123 kg more than in the previous year. The number of marijuana seizures and the quantities seized have been increasing since 2009. A total of 259 seizures of a total of over 90 thousand cannabis plants were reported. This is the highest number of seizures of cannabis plants since 2007. The Police of the Czech Republic dismantled 199 cannabis cultivation sites in 2012, an increase by 34 sites against 2011. Plantations of between 6 and 49 plants accounted for the highest share (35%) among the dismantled cultivation sites. Cultivation sites with over one thousand plants represented 18% of the seizures. As in the previous years, the largest numbers of cultivation sites were detected in Prague (27 in 2012, compared to 38 in 2011), in Central Bohemia (23 in 2012, compared to 22 in 2011), and in the Ústí nad Labem region (22 in 2012, compared to 19 in 2011. The number of hashish seizures was the same in 2012 as in the previous year but the quantity seized was a multiple of that seized in 2011 (2.4 kg in 2011, compared to 20.5 kg in 2012).

Pervitin was the second most commonly seized drug. Altogether, 355 seizures of a total of 31.9 kg of pervitin were reported in 2012. The total quantity of pervitin seized increased by 11.9 kg against 2011. This is historically the highest quantity of the drug seized annually. In 2012 the police detected 235 cooking labs, i.e. 103 less than in the previous year. This figure represents the lowest number of cooking labs detected since 2004. Most of the seizures involved small, easily movable operations. The highest numbers of cooking labs were detected in the Zlín (34), South Moravia (29) and Moravia-Silesia (26) regions. In 2011, the top regions included the Ústí nad Labem (49), Olomouc (38), and Zlín (34) regions. As for medicines containing pseudoephedrine as the main precursor for the manufacture of pervitin, Sudafed® and Cirrus® were the most commonly seized preparations. The smuggling of medicines containing pseudoephedrine (especially from Poland) is predominantly motivated by the control of the sale of these medicines in the Czech Republic, the lower price, and, especially, there being a higher content of pseudoephedrine per unit than in the medicines available on the Czech market. In 2012, the Customs Drug Unit and the National Drug Headquarters seized a total of 199,980 tablets of medicines containing pseudoephedrine, a decrease by 48% against the previous year (480,604 tablets were seized in 2011). A decrease in the seizures of ephedrine, the original precursor in the manufacture of pervitin, was also reported in 2012 in comparison with the period 2009-2011. A total of 2,167 grams of ephedrine was seized in 2012 (compared to 2,317 grams and 4,070 tablets in 2011). The seizures of the individual medicines in 2012 are summarised in Table 10-1.

[143] Leaves of the *Mitragyna speciosa* tree, which is native to Indochina, Malaysia, and Southeast Asia (Thailand). When chewed, it releases a number of psychoactive substances with a mild sedative and anxiolytic effect. It is legal in the countries of its origin, as well as in a number EU Member States, including the Czech Republic.
[144] *Turnera diffusa* or *Turnera aphorodisiaca*, known as damiana, is a shrub native to America whose leaves are used as an aphrodisiac.
[145] Kanna (*Sceletium tortuosum*) is a succulent herb found in South Africa. It is usually chewed to achieve a mildly euphoric and anxiolytic effect.
[146] *Nymphaea caerulea*, also known as the blue Egyptian water lily, is a plant whose flower is traditionally smoked or drunk as a potion. Its effects are mildly euphoric, anxiolytic, and aphrodisiac.

Table 10-1: Quantities of medicines containing pseudoephedrine seized in 2007-2012 (Národní protidrogová centrála SKPV Policie ČR, 2013b)

Medicine	2007	2008	2009	2010	2011	2012
Ephedrine (g)	1,185	1,677	6,023	8,152	2,317	2,167
(tablets)	–	–	–	15,000	4,070	0
Pseudoephedrine (g)	218	–	–	2,179	2,880	2,307
(tablets)	–	–	–	–	40	0
Modafen®(tablets)	3,480	7,876	840	3,356	2,762	2,208
Nurofen Stop Grip® (tablets)	11,948	21,785	876	0	14,892	228
Panadol Plus Grip® (tablets)	72	17,021	1,224	0	0	0
Paralen® Plus	–	2,261	1,440	144	0	0
Acatar® (tablets)	–	–	3,508	26,924	240	168
Apselan® (tablets)	–	–	–	–	–	160
Cirrus® (tablets)	–	–	6	68	17,551	24,788
Ibuprofen® (tablets)	–	–	80	0	0	0
Ibuprom® (tablets)	–	–	22,080	551	1,474	0
Neoafrin® (tablets)	–	–	–	–	–	2,492
Sudafed® (tablets)	–	–	12,231	278,133	403,105	169,348
Reactine® duo (tablets)	–	–	–	–	10,940	0
Rhinafen® (tablets)	–	–	–	–	960	0
Rhinopront® (tablets)	–	–	–	–	540	588
Zyrtec® (tablets)	–	–	–	–	28,140	0

Even though the number of cocaine seizures was the same as that in the previous year, the quantity seized was lower by half. A total of 44 seizures of cocaine were made in 2012, involving a total of 8.1 kg. The number of seizures and the quantity of heroin seized increased from 34 seizures of 4.7 kg in 2011 to 41 seizures of 7.6 kg in 2012. According to the National Drug Headquarters and the Customs Drug Unit, heroin is predominantly supplied to the Czech market in small shipments.

The number of ecstasy and LSD seizures decreased against 2011. The quantity of the two drugs that was seized was also significantly lower. The number of ecstasy tablets that were seized decreased from 13,000 tablets in 2011 to 1,782 tablets in 2012; with regard to LSD doses the decrease was from 1,313 in 2011 to 44 in 2012.

Table 10-2: Number of seizures and quantities of the individual drugs seized in 2007-2012 (Národní protidrogová centrála SKPV Policie ČR, 2013a)

Year		Marijuana (g)	Pervitin (g)	Heroin (g)	Cannabis plants (pcs)	Hashish (g)	Ecstasy (tablets)	Cocaine (g)	LSD (doses)
2007	Number	563	374	96	46	25	30	38	5
	Quantity	122,124	5,978	20,332	6,992	387	62,226	37,587	117
2008	Number	602	405	105	69	30	18	24	5
	Quantity	392,527	3,799	46,302	25,223	696	16,610	7,631	246
2009	Number	384	326	73	117	41	13	26	5
	Quantity	171,799	3,599	31,257	33,427	12,499	198	12,904	142
2010	Number	455	283	61	189	27	16	42	8
	Quantity	277,988	21,301	30,453	64,904	9,354	865	14,162	1,218
2011	Number	508	304	34	240	24	15	44	7
	Quantity	440,780	20,054	4,730	62,817	2,375	13,000	16,071	1,313
2012	Number	558	355	41	259	24	12	44	3
	Quantity	563,335	31,901	7,576	90,091	20,532	1,782	8,050	44

10.4 Price/Purity

The information about the prices of drugs comes from the drug-related offences investigated by the Police of the Czech Republic and is thus available only for a limited number of cases with regard to the nature of the criminal activities detected. The information about drug purity comes from the data provided by the Departments for Forensic and Technical Analyses of the regional police headquarters and from the Forensic Science Institute in Prague. The collected data have a very limited informative value because of the low number of cases in which the price of the drug is known and because of the low number of samples that were analysed. In addition, samples obtained from the seizures of larger quantities of drugs with a higher concentration of the active substance are not distinguished from samples of street drugs with lower purity.

The price and potency of marijuana did not change significantly in comparison with 2011. The lowest THC concentration was 0.1%, while the highest was 24.8%. According to the information from the National Drug Headquarters, the wholesale price of marijuana was between CZK 70,000 (€ 2.8 thousand) and 100,000 (€ 3,9 thousand) per 1 kg of dry matter. For heroin, the lowest concentration of the active substance was 5.6%, while the highest was 39.5%. The price of heroin did not change in comparison with 2011. A significant change was reported for cocaine, whose purity decreased from 45.0% in 2011 to 36.9% in 2012. The price was known only for a very low number of the samples that were seized. The average content of the pure drug in the samples of pervitin that were analysed was 71.6% (the lowest being 9.8% and the highest 83.0%). In comparison with the previous year, the price of pervitin did not change significantly. The price and purity of ecstasy tablets are difficult to evaluate because of the very low number of samples analysed; see Table 10-3 and Table 10-4.

Table 10-3: Average drug purity values in 2007-2012, as a percentage of the pure drug (Národní protidrogová centrála SKPV Policie ČR, 2013b)

Year		Marijuana	Hashish	Ecstasy*	Pervitin	Heroin	Cocaine
2007	No. of samples	177	2	31	123	31	48
	Average purity	4.7	8.1	27.4	66.4	17.4	49.1
2008	No. of samples	404	5	20	145	47	35
	Average purity	5.5	5.2	17.5	64.3	22.6	43.5
2009	No. of samples	289	3	6	144	57	21
	Average purity	8.1	15.9	3.4	68.1	16.6	33.1
2010	No. of samples	391	8	9	160	51	35
	Average purity	7.7	9.3	15.3	64.4	24.6	27.9
2011	No. of samples	497	24	5	163	31	52
	Average purity	7.2	11.0	43.0	69.0	14.0	45.0
2012	No. of samples	599	11	7	146	40	49
	Average purity	7.1	12.2	37.5	71.6	14.7	36.9

*Note: The concentration of THC is provided for cannabis. * The average purity of ecstasy tablets is expressed as the average quantity of MDMA in milligrams in one tablet containing MDMA.*

Table 10-4: Average and most commonly reported (modus) prices of drugs, 2007-2012 (€) (Národní protidrogová centrála SKPV Policie ČR, 2013a)

Year		Marijuana (g)	Hashish (g)	Ecstasy (tablet)	Pervitin (g)	Heroin (g)	Cocaine (g)	LSD (dose)
2007	Average	7	10	8	43	42	78	7
	Modus	4	8	8	38	38	76	8
2008	Average	7	9	8	43	41	76	7
	Modus	8	9	8	38	38	76	4
2009	Average	8	10	8	49	48	73	8
	Modus	9	11	9	38	38	95	8
2010	Average	8	9	8	51	51	79	8
	Modus	10	10	10	40	40	79	8
2011	Average	8	9	6	52	44	90	8
	Modus	8	-	6	40	40	81	-
2012	Average	8	8	10	49	43	70	8
	Modus	8	-	-	40	40	60	-

Note: Prices rounded to €. 2012 average exchange rate was used (1 € = 25.143).

PART B

LIST OF TABLES

LIST OF GRAPHS

LIST OF MAPS

SELECTED DRUG-RELATED CZECH WEBSITES

The following list provides selected websites of key institutions and services concerned with drug-related issues. An exhaustive list of helping organisations is provided in the Help Map application available at www.drogy-info.cz.

An application used to register drug-related services and their clients: http://www.drogovesluzby.cz

Adiktologie – odborný časopis pro prevenci, léčbu a výzkum závislostí (*Adiktologie* – a professional journal for the prevention, treatment of, and research into addiction): http://www.adiktologie.cz/Casopis-Adiktologie.html

Agentura pro sociální začleňování (Agency for Social Inclusion): http://www.socialni-zaclenovani.cz/

Alcoholics Anonymous: http://www.anonymnialkoholici.cz/

A.N.O. – Asociace nestátních organizací poskytujících adiktologické a sociální služby pro osoby ohrožené závislostním chováním (Association of NGOs providing addictological and social services for people at risk of addictive behaviour): http://www.asociace.org/

Benzodiazepine counselling service (administered by SANANIM, a civic association): http://www.benzo.cz/

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

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

Česká asociace adiktologů (Czech Association of Addictologists): http://www.asociace-adiktologu.cz/

Česká asociace streetwork (Czech Outreach Work Association): http://www.streetwork.cz/

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

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

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

Information portal and database of social prevention services for people at risk of social exclusion: https://www.sluzbyprevence.mpsv.cz/

Drug information server (administered by SANANIM, a civic association): http://www.drogy.net/

Drug counselling service (administered by SANANIM, a civic association): http://www.drogovaporadna.cz/

EXTC – web counselling – prevention of synthetic drug abuse: http://www.extc.cz/

Hygienická stanice hl. m. Prahy, referát drogové epidemiologie (Public Health Office in Prague, Drug Epidemiology Unit): http://www.hygpraha.cz

Information for the staff and clients of outreach programmes and drop-in centres (administered by SANANIM, a civic association): http://www.edekontaminace.cz/

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

Klinika adiktologie 1. LF UK a VFN v Praze (Department of Adictology, First Faculty of Medicine, Charles University in Prague and General University Hospital in Prague): http://www.adiktologie.cz/

Ministerstvo spravedlnosti (portál českého soudnictví) (Ministry of Justice – portal of Czech judiciary): http://portal.justice.cz/

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

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

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

Ministerstvo zdravotnictví (Ministry of Health):

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

Národní program řešení problematiky HIV/AIDS (National HIV/AIDS Programme): http://www.mzcr.cz/Verejne/Pages/133-narodni-program-reseni-problematiky-hivaids.html, http://www.aids-hiv.cz/

Národní protidrogová centrála služby kriminální policie a vyšetřování, Policie ČR (National Drug Headquarters, Criminal Police and Investigation Service, Police of the Czech Republic): http://www.policie.cz/narodni-protidrogova-centrala-skpv.aspx

Národní ústav pro vzdělávání (National Institute for Education – a training and counselling centre for education professionals): http://www.nuv.cz/

Poslanecká sněmovna Parlamentu ČR, Výbor pro zdravotnictví, Zdravotní výbor (Chamber of Deputies of the Parliament of the Czech Republic, Health Committee): http://www.psp.cz/sqw/fsnem.sqw?f1=8&f2=6&id=963

Prevention and treatment of alcohol dependence: http://www.alkohol-alkoholismus.cz/

Prevention of risk behaviour: http://www.prevence-info.cz/

Primary prevention information portal (administered by SANANIM, a civic association): http://www.odrogach.cz/

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

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

Rada vlády pro koordinaci protidrogové politiky (Government Council for Drug Policy Coordination): http://rvkpp.vlada.cz

Register of social service providers: http://www.mpsv.cz/cs/3880

"Safer Party" initiative: http://www.saferparty.cz

Sdružení azylových domů v ČR (Czech Association of Shelters): http://www.azylovedomy.cz/

Společnost pro návykové nemoci České lékařské společnosti J. E. Purkyně (Society for Addictive Diseases of J. E. Purkyně Czech Medical Association): http://snncls.cz/

Společnost sociálních pracovníků ČR (Czech Association of Social Workers): http://socialnipracovnici.cz/

Správa uprchlických zařízení (Administration of Facilities for Refugees): http://www.suz.cz/

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

Státní ústav pro kontrolu léčiv (State Institute for Drug Control): http://www.sukl.cz/

UN Information Centre in Prague: http://www.osn.cz/

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

Ústav zdravotnických informací a statistiky ČR (Institute of Health Information and Statistics of the Czech Republic): http://www.uzis.cz/

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

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

ABBREVIATIONS

2007-2009 Action Plan – Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2007 to 2009

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

2010-2018 National Strategy – National Drug Policy Strategy for the Period 2010-2018

AA – Alcoholics Anonymous

Annual Report – Annual (National) Report: The Czech Republic – Drug Situation

AT – Alcohol – Toxicomania (AT clinic – a name for an outpatient medical facility dealing with alcohol/drug treatment)

Centre for Addictology – Centre for Addictology, Department of Psychiatry, First Faculty of Medicine of Charles University in Prague and General University Hospital in Prague (part of the Department of Addictology since 2012)

CI – confidence interval

CRM – capture-recapture method

Department of Addictology – Department of Addictology, First Faculty of Medicine of Charles University in Prague and General University Hospital in Prague

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

EPIDAT – register of infectious diseases

ESF – European Social Fund

ESPAD– European School Survey on Alcohol and Other Drugs

EU – European Union

GCDPC – Government Council for Drug Policy Coordination

GDP – Gross domestic product

HAV – hepatitis A virus, viral hepatitis A

HBV – hepatitis B virus, viral hepatitis B

HCV – hepatitis C virus, viral hepatitis C

IDU(s) – injecting drug user(s)

NFP – National Focal Point (Czech National Monitoring Centre for Drugs and Drug Addiction)

NGO(s) – non-governmental organisation(s)

NRHOSP - National Register of Hospitalisations

NRLUD - National Drug Treatment Register

NRULISL – Substitution Treatment Register

TB – tuberculosis

TC – therapeutic community

UNOCD – United Nations Office on Drugs and Crime

WHO – World Health Organisation

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ISBN 978-80-7440-078-0

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Publisher / Úřad vlády České republiky ▪ nábřeží Edvarda Beneše 4 ▪ CZ-118 01 Praha 1 ▪ Phone +420 296 153 222 ▪ www.drogy-info.cz