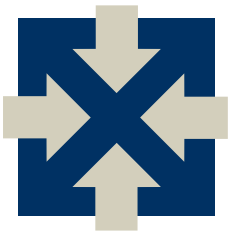
Annual Report

The Czech Republic

2010 Drug Situation

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



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Annual Report: The Czech Republic – 2010 Drug Situation

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SUMMARY

The preparation and enforcement of the national drug policy is the responsibility of the Government of the Czech Republic. Its main advisory body for drug-related issues is the Government Council for Drug Policy Coordination (GCDPC), which met five times in 2010.

The evaluation of two previous drug policy strategic documents – the National Drug Policy Strategy for the Period 2005–2009 and the 2007–2009 Action Plan – was finalised in 2010.

In May 2010 the Government approved the new National Drug Policy Strategy for the Period 2010–2018. The Strategy will be complemented with action plans, each spanning a three-year period. The first of them, covering the period 2010–2012, defines four priorities: (1) to reduce the high level of the use of cannabis, in particular, and other legal and illegal drugs; (2) to adopt specific measures aiming at reducing the problem use of opiates and methamphetamine (known locally as pervitin); (3) to strengthen the drug policy in relation to legal drugs (alcohol and tobacco), and (4) to develop and generally improve the drug policy's legislative, financial, and coordination mechanisms.

A new Penal Code has been effective in the Czech Republic since 1 January 2010. It also introduced significant changes in the statutory provisions pertaining to primary drug crime. To a certain degree, the new legal regulation differentiates drugs according to their health and social risks, as it makes a distinction between cannabis and other drugs as regards the cultivation of cannabis for personal use and the possession thereof for personal use. In addition to the above-mentioned differentiation of drugs, the Penal Code newly provides for the offence of the unauthorised cultivation of a small quantity of plants containing a narcotic or psychotropic substance. Subsequently, the Government passed two regulations determining greater-than-small quantities of drugs and plants or mushrooms that contain narcotic or psychotropic substances.

Public expenditure on drug policy amounted to a total of CZK 627.4 million (€ 24,807 thousand) in 2010. This sum included CZK 371.6 million (€ 14,694 thousand) provided from the state budget, and the regions and municipalities contributed CZK 193.7 million (€ 7,660 thousand) and CZK 62.1 million (€ 2,454 thousand), respectively. In comparison to 2009, total expenses showed a nominal increase on all three levels by 3.3%; however, year-on-year changes in the data collection methodology need to be taken into account. On the central level, there was a significant decrease in expenditure on the part of the Government Council for Drug Policy Coordination. On the regional level, there was a marked increase in aggregate year-on-year expenditure – this particularly applied to the regions of Karlovy Vary, Zlín, and Moravia-Silesia. Over one third of regional expenditures, however, was earmarked to finance sobering-up stations and the treatment of intoxicated people. The aggregate of funds expended by municipalities experienced a slight increase. Out of the total comprised of all three levels of public budgets, CZK 166.2 million (€ 6,572 thousand, 26.5%) was earmarked for harm reduction services, CZK 108.9 million (€ 4,304 thousand, 17.4%) for treatment, CZK 62.3 million (€ 2,463 thousand, 9.9%) for primary prevention, and CZK 31.3 million (€ 1,238 thousand, 5.0%) for aftercare. The sobering-up stations, funded almost exclusively from the regional budgets, cost CZK 87.2 million (€ 3,449 thousand, 13.9%), and CZK 149.4 million (€ 5,906 thousand, 23.8%) was earmarked for law enforcement.

Health insurers' expenses incurred in relation to the use of drugs other than alcohol amounted to CZK 448 million (€ 7,703 thousand) in 2009 (the latest year for which relevant data are available).

The surveys investigating public attitudes to drug use indicate that the Czech population is relatively tolerant towards the use of cannabis: an absolute majority supports the legalisation of the cultivation and possession of cannabis, especially for medical purposes. In 2010 and in the first half of 2011 discussions and initiatives on the use of medical cannabis took place. The general public, the professional community, and politicians and representatives of the public administration were involved in these events and activities.

The surveys carried out in the past three years indicate that the level of experience with the use of illicit drugs among the general population remains stable; the most frequently used illegal drug is cannabis (23–34%, according to the study), followed by ecstasy (4–10%). The last-year use of cannabis was reported by 10–15% of respondents, while less than 4% of the adults that were interviewed reported the use of other illegal drugs. The last-month use of illegal drugs other than cannabis has long been reported by less than 1% of respondents. Young adults aged from 15 to 34 years show higher prevalence rates: approximately one fifth of them had experienced cannabis in the last year, and 2–4%, approximately 2%, and 1–2% had used ecstasy, hallucinogenic mushrooms, and pervitin respectively. The current prevalence rates of the use of other drugs (including cocaine) among young adults are below 1%.

The 2010 HBSC international survey showed that 30.5% of students in the ninth grade of elementary school in the Czech Republic have tried cannabis at least once in their lifetime. 21.5% and 10.9% of ninth-graders had used cannabis in the last year and last month respectively; the differences between boys and girls were very small. In comparison to the previous round of HBSC, carried out in 2006, a rise in both the lifetime and last-year prevalence rates of cannabis use was observed.

In 2010 the very first representative study on drug use among the prison population was conducted. It was found that the individuals starting their prison sentences show much greater experience of drug use than the general population. This particularly applies to women in general and to both genders as far as the use of heroin, pervitin, and cocaine is concerned.

Dance party-goers and people associated with nightlife settings constitute another subpopulation showing a significantly higher level of the prevalence of illicit drug use. Apart from cannabis, the main drugs used among this group include ecstasy, pervitin, cocaine and hallucinogens.

A special study focusing on the use of new synthetic drugs (legal highs) showed that almost 5% of young adults in the Czech Republic aged 15–34 have tried them; a similar result was also generated by the Eurobarometer survey conducted among young Czechs aged 15–24 (4%).

The estimated number of problem drug users continued to rise in 2010; the mean estimate reached the level of 39.2 thousand people. In comparison to the previous years, however, this increase is not statistically significant. While the year 2010 recorded a dramatic increase in the number of problem users of pervitin (28.2 thousand), the number of problem opiate users fell significantly (11.0 thousand). The number of injecting drug users also rose (to approximately 37.2 thousand). Traditionally, Prague and Ústí nad Labem are the regions showing the highest rates of problem drug users, as well as of opiate users. In Prague and other Bohemian regions, in particular, the injecting use of Subutex® became widespread. The concurrent use of pervitin and opiates is common. In general, 0.5% of the Czech adult population is affected by problem drug use.

It is estimated that one tenth to one quarter of offenders, i.e. approximately 2–5 thousand people, show signs of current problem drug use when starting their prison sentences. Thus, their prevalence of problem drug use is about 20–50 times higher than that among the general population.

In addition, the levels of the current heavy or problem use of other drugs were estimated. In the Czech Republic, at least once per week in the last month, sedatives were used by almost one million people, cannabis by 360 thousand people, ecstasy by 35 thousand people, hallucinogenic mushrooms by 30 thousand people, and cocaine by almost 15 thousand people aged 15–64, with young adults accounting for the largest proportion of users of these drugs. While for 70% of cannabis users, the use of this drug poses a relatively minor risk, up to 10% of cannabis users are exposed to a significant risk of cannabis use-related problems and dependence. When extrapolating this proportion to the entire population of the Czech Republic, we may conclude that approximately 1.0–1.5% of the adult population, i.e. 75–110 thousand cannabis users, is at high risk. Hazardous or harmful use of alcohol is attributed to 1 to 1.4 million people in the Czech Republic, with an estimated 50–150 thousand individuals up to the age of 64 being at high risk of dependence or already dependent.

The relatively favourable situation concerning the occurrence of infections among injecting drug users continued in 2010; HIV seroprevalence among this high-risk group remains below 1%. In 2010 seven HIV-positive people who may have contracted the virus through injecting drug use were newly identified. The numbers of newly reported cases of viral hepatitis C among injecting drug users have also been declining in recent years. The number of HBV cases recorded a slight year-on-year increase in 2010. Depending on the study sample's characteristics and selection criteria, the prevalence of viral hepatitis C among drug users ranges from approximately 20% in low-threshold programmes to 40% in prisons or 70% among the clients of substitution treatment. An increased level of the incidence of syphilis among injecting drug users continued to be observed in 2010.

There has been a long-term steady decline in the rate of injecting among pervitin and heroin users; the administration of Subutex® by injecting is common. Injecting users among heroin and pervitin users account for approximately 60% of clients of outpatient psychiatric services and 90% and 80%, respectively, of cases recorded in the register of drug treatment demands. The available data suggest that there has been a long-term steady decrease in the level of high-risk behaviour, such as needle sharing, among injecting drug users.

The information provided by the register of autopsies maintained by forensic medicine departments shows that the year 2010 witnessed another increase in the number of fatal overdoses on illicit drugs and inhalants to a total of 55 cases. In comparison to 2009, the number of fatal overdoses on inhalants, in particular, grew dramatically; 16 cases meant double the previous year's figure. The numbers of cases of fatal overdoses on opiates/opioids (19 cases) and pervitin (18 cases) remained almost on the same level. Cocaine was not detected in any cases of fatal overdose in 2010. For the very first time in Czech history, two fatal overdoses with the presence of the synthetic opioid fentanyl were reported. Similar trends in the occurrence of fatal drug overdoses may be observed from a long-term perspective in the Czech Republic's general mortality register; the comparison of data collected on the basis of various selection criteria shows that in recent years there have been 30–70 cases annually of fatal overdoses on street drugs in the Czech Republic. Calculated on the basis of analogical selection criteria, the rate of fatal overdoses on alcohol is approximately tenfold. The year 2010 recorded a further increase in pervitin-related deaths other than by overdose, while the number of such indirect deaths with the presence of THC fell.

The traffic police records indicate that the number and proportion of accidents caused while under the influence of alcohol, as well as the number of people killed in such accidents, dropped in 2010. This positive trend has been

confirmed by the data on autopsies of road accident casualties examined at forensic medicine departments. On the contrary, the numbers of accidents caused while under the influence of drugs other than alcohol and of people killed in such accidents are growing; the comparison with the data provided by forensic surgeons suggests, however, that the rates are still underreported by the police.

In the Czech Republic, drug users and addicts may seek help from a network of services providing a wide range of interventions which experienced no major changes in 2010.

The number of drug users listed in the Public Health Service's Register of Treatment Demands has been rising in recent years. 9,005 drug users sought treatment services in 2010, i.e. approximately 200 persons more than in 2009. In comparison to the previous years, the slightly declining trend has been reversed, and the number of those in treatment returned to its 2004 and 2005 levels. Stimulant users have long predominated among those demanding treatment. They comprised the largest group among all treatment demands (62.9%) and among clients demanding treatment for the first time in their life (67.5%); the number of pervitin users also showed the highest year-on-year increase in 2010. The second most numerous group was still made up of opiate users (23.1%), while cannabis users ranked second among first treatment demands (15.9%). A slight aging of the treatment demand population is apparent; their average age has increased by more than four years over the past decade, reaching 27.3 years in 2010. Women continue to account for one third of treatment demands. The Ústí nad Labem and Prague regions report the highest prevalence and incidence of treatment demands.

There has been a long-term increase in the number of patients in substitution treatment. This applies to both specialised (methadone) centres and other facilities providing clients with products containing buprenorphine (primarily Subutex® and Suboxone®); however, treatment with these preparations has not been fully included in the substitution register, despite the existing statutory requirement.

The number of psychiatric outpatient services reporting the treatment of users of alcohol and other drugs rose by almost one third to 453 facilities in 2010. A maximum of 50–70 of those, however, may be considered the so-called AT outpatient services, i.e. facilities specialising in clients with addiction issues. The number of patients engaged with psychiatric outpatient services recorded a year-on-year decline, including all three of the largest groups of patients, i.e. those in treatment for opiate/opioid, stimulant, and polydrug use.

The year 2010 experienced a moderate drop in the number of users of alcohol and non-alcohol drugs admitted to psychiatric inpatient facilities. The decline in drugs other than alcohol was due to the lower numbers of patients admitted for disorders caused by polydrug and opiate/opioid use; on the contrary, the number of hospitalisations for disorders caused by the use of stimulants (i.e. mainly pervitin) grew. The number of hospitalisations for alcohol reached the level of approximately 10 thousand per year, while the number of people admitted to hospital for non-alcohol drugs roughly made up half of that number. In the Czech Republic, detoxification units are situated in 16 inpatient facilities with 163 beds designated for this purpose. An additional 12 inpatient facilities provided detoxification in beds which were not specifically designated for this intervention. A total of 6,650 people underwent detoxification from addictive substances, including 3,092 cases of addiction to illegal drugs, during the year under observation.

There are 36 prisons in the Czech Republic where drug users are provided with drug-free zones and various types of counselling and treatment services, such as drug prevention counselling centres and specialised wings for both voluntary and court-ordered treatment programmes. Almost no changes in their number occurred in 2010; the number of prisons providing detoxification rose from 4 to 5. Eight prisons provided methadone substitution treatment in 2010. The care of drug-using inmates was complemented by additional services delivered by 15 non-governmental organisations in 32 prisons. It is estimated that approximately one quarter of the individuals starting their prison sentence who may be referred to as problem drug users are placed in specialised prison wings or other departments providing professional care, such as drug-free zones.

The number of low-threshold programmes for drug users has fluctuated around 100 on a year-on-year basis. In the past six years, however, a significant increase in the number of clients in contact with these has been observed. There has also been a long-term rise in the number of contacts with IDUs and the amount of injecting equipment and paraphernalia exchanged; almost 5 million hypodermic needles and syringes were distributed in 2010. The programmes for the distribution of gelatine capsules as an oral alternative to the administration of pervitin by injecting have also expanded. According to the available information, there are at least 30 capsule programmes in the Czech Republic, with one quarter of their clients being actively involved in the provision of the services. Almost 60 thousand capsules were handed out in 2010.

The past three years experienced a gradual increase in the number of tests for infectious diseases carried out among drug users in contact with low-threshold services. In comparison to the previous years, however, the rate of tests for infections performed on clients of low-threshold services remains relatively low.

Specific harm reduction services aimed at club and dance settings were provided by four organisations as part of five programmes in 2010. However, the provision of these interventions has been discouraged recently.

In the Czech Republic, the treatment and care of people infected with HIV or with AIDS is provided at seven AIDS centres and is predominantly covered by health insurance; the provision of dispensary care and therapy for uninsured HIV-positive clients, which potentially also applies to injecting drug users, poses a problem. A questionnaire survey was conducted in centres for the treatment of viral hepatitis in the spring of 2011. Its outcomes included the estimate that injecting drug users (mostly ex-IDUs) were treated for viral hepatitis C in 39 centres in 2010.

Various police sources and information available from public prosecutors' offices indicate that approximately 2.4 to 2.5 thousand individuals were prosecuted for drug-related criminal offences in the Czech Republic in 2010. Almost 2.2 thousand people were indicted, which corresponds to the enduring rate of 90% of those prosecuted. Almost 1.7 thousand individuals were convicted in 2010. Women account for 15% of drug offenders. The largest proportion of offences (approximately 80%) pertains to the manufacturing and trafficking of drugs and dealing in them. Drug crime associated with pervitin (approximately 55–70%, depending on the source of data) and cannabis shows the highest rates; the involvement of heroin and cocaine, respectively, in offending remains below 5%. The regions reporting the highest relative rates of drug offending include Prague, Central Bohemia, Karlovy Vary, and Ústí nad Labem. 1,021 misdemeanours of the possession of a small quantity of a drug or the cultivation of a small quantity of a plant containing a narcotic or psychotropic substance for personal use were registered in 2010. In the majority of cases (94%), such misdemeanours involved the possession of drugs; only 6% of the misdemeanours concerned the cultivation of plants containing a narcotic or psychotropic substance.

There has been a long-term increase in the number of people prosecuted for drug-related offences, and the proportion of people prosecuted for the possession of drugs for personal use is also rising. From the long-term perspective, there has been an increase in the number of pervitin-related drug crimes, while offending associated with ecstasy and heroin recorded a decline; the number of cocaine-related cases remains relatively small.

Out of the aggregate of 117.7 thousand, 19.6 thousand (16.6%) criminal offences were committed under the influence of an addictive substance, 17.3 thousand (14.7%) and 2.3 thousand (1.9%) under the influence of alcohol and drugs other than alcohol respectively, in 2010.

Marijuana and methamphetamine (pervitin) were the most widely available drugs in 2010. The popularity and availability of cocaine is increasing. The prices and purity of drugs are stable or within the range where moderate year-on-year fluctuations may be observed in certain substances.

The majority of the marijuana produced is intended for the domestic market. Part of the production of cannabis grown under artificial lighting is well organised and mostly involves people of Vietnamese origin. 278 kg of marijuana and almost 65 thousand cannabis plants were seized, which is twice as many cannabis plants as in 2009. The number of cannabis plantations detected is also growing – 145 were discovered.

Pervitin is made by domestic manufacturers, particularly in small home labs. Nevertheless, the large-scale production of pervitin, controlled by organised groups originating from Vietnam or Albania, is becoming a common practice. Pervitin is generally manufactured using medication containing pseudoephedrine, mainly imported from Poland. The drug is primarily intended for the Czech market. A minor proportion of the production is exported abroad, particularly to Germany, which is especially facilitated by German citizens who are involved in the individual trafficking of small quantities as part of drug tourism. A total of 21.3 kg of pervitin was seized, which is the largest amount in the past four years, and 307 pervitin cooking labs were detected.

Cocaine is mainly associated with the recreational and nightlife settings in the Czech Republic. In addition to Albanians, Romanians, and Bulgarians, people originally from West Africa, mostly Nigeria, are engaged in the import and distribution of cocaine. The body cavities of couriers (swallowers) are used to smuggle the drug. Couriers bring cocaine directly from South America or from Western European countries. Since 2008 there has been an increase in both the number of seizures and the quantity of the cocaine seized; the year 2010 recorded 42 seizures of cocaine in a total quantity of 14.2 kg.

The demand for heroin on the Czech market is satisfied by means of small shipments (up to 10 kg), and the drug is diluted (mostly with paracetamol and caffeine) before being sold at the street level. The purity of the street heroin seized ranged from 5 to 10%. The quantity of the heroin seized and the number of seizures remain stable; there are approximately 50–100 seizures annually, involving a total quantity of 20–40 kg.

Since 2010 the Czech Republic has experienced a rise in the emergence of legal highs. They are substances with effects similar to traditional drugs such as pervitin, marijuana, ecstasy, and hallucinogens, but are not subject to international and national illicit drug control systems, as they are not scheduled as illegal narcotic and psychotropic substances. They are primarily imported from Asia (China, in particular) and include mainly synthetic cannabinoids and cathinone derivatives, especially mephedrone. In 2010 the Customs Administration seized and analysed approximately 250 kg of new synthetic drugs (including 80 kg of mephedrone). In response to the increased supply of legal highs, Act No. 167/1998 Coll., on addictive substances, was amended in the spring of 2011; 33 new substances, including 30 synthetic drugs, were added to its schedules.

This annual report concludes with three chapters on selected issues addressing in greater detail the interventions for drug users in prison, drug-using parents and their children, and drug tourism. The first chapter provides a thorough summary of drug-related health policies and services within the prison system of the Czech Republic in the context of the general health care provided to incarcerated offenders. The aim of the second selected issue is to cover the prevalence of pregnant drug users and those users who are already parents of minor children and trends and characteristics pertaining to them, as well as describing specific services designed for such users and their children in the Czech Republic. Given the complex nature of the topic and the lack of data, the last chapter on a selected issue provides a rather unsystematic outline of information about the association between cross-border travel and drug use, or drug tourism, in the Czech Republic.

PART A: NEW DEVELOPMENTS AND TRENDS

1 Drug Policy: legislation, strategies, and economic analysis

A new Penal Code has been effective in the Czech Republic since 1 January 2010. It also introduced significant changes in the statutory provisions pertaining to primary drug crime. To a certain degree, the new legal regulation differentiates drugs according to their health and social risks, as it makes a distinction between cannabis and other drugs as regards the cultivation of cannabis for personal use and the possession thereof for personal use. In addition to the above-mentioned differentiation of drugs, the Penal Code newly provides for the offence of the unauthorised cultivation of plants containing a narcotic or psychotropic substance. In addition, the Government passed two regulations determining greater-than-small quantities of drugs and plants or mushrooms that contain narcotic or psychotropic substances.

In response to the widespread massive supply of legal highs that occurred at the end of 2010, Act No. 167/1998 Coll., on addictive substances, was amended in the spring of 2011; 33 new substances were added to its schedules.

The evaluation of two previous strategic drug policy documents – the National Drug Policy Strategy for the Period 2005–2009 and the 2007–2009 Action Plan – was finalised in 2010.

In May 2010 the Government approved the new National Drug Policy Strategy for the Period 2010–2018. The Strategy is complemented with action plans, each spanning a three-year period. The first of them, covering the period 2010–2012, which was endorsed by the Government in January 2011, defines four priorities for the period of its operation: (1) to reduce the high level of the use of cannabis, in particular, and other legal and illegal drugs; (2) to adopt specific measures aiming at reducing the problem use of opiates and pervitin; (3) to strengthen the drug policy in relation to legal drugs (alcohol and tobacco), and (4) to develop and improve the overall legislative, financial, and coordination mechanisms of the drug policy.

In May 2011 the Government Council for Drug Policy Coordination (GCDPC) approved the National Action Plan on the Drug Information System for the period 2011–2012. It is a useful tool in planning and coordinating the system of the collection, analysis, and dissemination of information on the drug situation in the Czech Republic.

In 2010 and in the first half of 2011 discussions and initiatives on the use of medical cannabis took place. The general public, the professional community, and politicians and representatives of the public administration were involved in these events and activities.

Public expenditure on drug policy amounted to a total of CZK 627.4 million (€ 24,807 thousand) in 2010. This sum included CZK 371.6 million (€ 14,694 thousand) provided from the state budget, and the regions and municipalities contributed CZK 193.7 million (€ 7,660 thousand) and CZK 62.1 million (€ 2,454 thousand), respectively. In comparison to 2009, total expenses showed a nominal increase on all three levels by 3.3%; however, year-on-year changes in the data collection methodology need to be taken into account. On the central level, there was a significant decrease in expenditure on the part of the Government Council for Drug Policy Coordination. On the regional level, there was a marked increase in aggregate year-on-year expenditure – this particularly applied to the regions of Karlovy Vary, Zlín, and Moravia-Silesia. Over one third of regional expenditures, however, was earmarked to finance sobering-up stations and the treatment of intoxicated people. The aggregate of funds expended by municipalities experienced a slight increase. Out of the total comprised of all three levels of public budgets, CZK 166.2 million (€ 6,572 thousand, 26.5%) was earmarked for harm reduction services, CZK 108.9 million (€ 4,304 thousand, 17.4%) for treatment, CZK 62.3 million (€ 2,463 thousand, 9.9%) for primary prevention, and CZK 31.3 million (€ 1,238 thousand, 5.0%) for aftercare. The sobering-up stations, funded almost exclusively from the regional budgets, cost CZK 87.2 million (€ 3,449 thousand, 13.9%), and CZK 149.4 million (€ 5,906 thousand, 23.8%) was earmarked for law enforcement.

Health insurers' expenses incurred in relation to the use of drugs other than alcohol amounted to CZK 448 million (€ 7,703 thousand) in 2009 (the latest year for which relevant data are available).

1.1 Legal Framework

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

1.1.1.1 Penal Code

Act. No. 40/2009, Coll., the Penal Code, became effective on 1 January 2010. It also introduced significant changes in the statutory provisions pertaining to primary drug crime. To a certain degree, the new legal regulation differentiates drugs according to their health and social risks as it makes a distinction between cannabis and other drugs in relation to the cultivation of cannabis for personal use and the possession of this substance for personal use. As far as other types of the unauthorised handling of drugs are concerned, the new Penal Code makes no further distinction between different drug categories. In addition to the aforementioned differentiation of drugs, the Penal Code also introduced the "privileged" (carrying less severe sanctions) constituent elements of the offence of

the unauthorised cultivation of plants containing a narcotic or psychotropic substance (Section 285 of the law cited above). For more details on the statutory provision covering the individual constituent elements of primary drug-related offences see the 2009 Annual Report and the special issue of the *Zaostřeno na drogy* (Focused on Drugs) bulletin (Zeman and Gajdošíková, 2010).

1.1.1.2 Changes Concerning Misdemeanour (Administrative) Proceedings

As regards the consideration of misdemeanours against protection from alcoholism and abuse of other substances (such as the possession of a small quantity of a drug or the cultivation of up to five cannabis plants), changes were adopted in relation to the settlement of misdemeanours by means of "ticket proceedings", i.e. a fine. Act No. 200/1990 Coll., on misdemeanours, allows for the application of such simplified misdemeanour proceedings in the event that all the circumstances of the misdemeanour have been reliably identified, a reprimand has been found insufficient, and the person accused of the misdemeanour is willing to pay the fine. The amendment to Act No. 273/2008 Coll., on the Police of the Czech Republic, implemented by virtue of Act No. 150/2011 Coll., clearly stipulates in relation to misdemeanours involving narcotic or psychotropic substances that the police should destroy such substances or make them available for the purposes of education, training, and/or tests and forensic, expert, and research activities. Prior to the amendment being effective, the police were pointing out that the drug could not be seized as part of ticket proceedings.

1.1.1.3 Changes in the Act on Addictive Substances

In 2010 there was a massive increase in the supply of new synthetic drugs (legal highs). This involved new substances which are not included in the schedules attached to the international conventions governing the illicit handling of narcotic or psychotropic substances (i.e. the 1960 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances) or the national norm represented by Act No. 167/1998 Coll., on addictive substances. This state of affairs made it impossible or very difficult to prosecute individuals who handled such substances on an illegal basis, as it is Act No. 167/1998 Coll. that determines what constitutes a narcotic or psychotropic substance for the purposes of the criminal prosecution of primary drug-related offences (excluding the offence of the promotion of drug use). Therefore, the law-makers decided to adopt Act No. 106/2011 Coll., dated 6 April 2011, by means of which Act No. 167/1998 Coll., on addictive substances, was amended. An additional 33 substances were added to the list of narcotic and psychotropic substances already scheduled in the appendices of the law on addictive substances; they not only include the legal highs, but also substances used in pharmacy and medicine (such as ketamin and tapentadol). Salvinorin A (a Salvia divinorum alkaloid) was also added to the schedule.

1.1.1.4 Changes in the Act on Harm Caused by Tobacco Products, Alcohol, and Other Addictive Substances

An amendment to Act No. 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances, promulgated in the Collection of Laws under No. 305/2009 Coll., became effective on 1 July 2010. The objective of the amendment was to specify in more accurate terms the measures intended to ensure protection from harm caused by tobacco products, with a special focus on passive smoking, including greater protection of children and young people against the adverse effects of smoking.

The amendment introduced a number of desirable changes and detailed specifications, including better definitions of public places where smoking is prohibited, the exact division of the competences of the regulatory authorities, and stricter sanctions for selling tobacco, electronic cigarettes, and alcohol to individuals under 18 years of age. As far as a ban on smoking in restaurants and other similar establishments is concerned, the legal regulation has remained lenient and rather ineffective in terms of the prevention of passive smoking and protection against it. The recent amendment failed to include an absolute ban on smoking in restaurants and other public places serving food and drinks, which is presently a common practice in some EU member states and elsewhere in the world.

1.1.1.5 Changes Concerning the Profession of an Addictologist

The year 2010 experienced the continuation of legislative work concerning efforts related to the profession of an addictologist being duly provided for in the legal regulations. The profession of an addictologist was added to the Health Ministry's Decree No. 39/2005, Coll., setting out the minimum requirements for academic programmes designed to provide professional qualifications for the performance of a non-medical health profession, specifically Section 20a, by virtue of the amendment effected by the Health Ministry's Decree No. 129/2010 Coll.

Furthermore, the Health Ministry's Decree No. 221/2010 Coll., concerning the requirements for material and technological equipment of healthcare facilities, also stipulated the specific requirements for the material and technological equipment of healthcare facilities focused on addiction treatment. The special equipment identified by the decree includes an alcotest, a tester for the presence of drugs, and an autonomous safety signalling device in the event that substitution treatment is provided. A therapy room is to be available in addiction day care centres.

The profession of an addictologist was included in Government Regulation No. 222/2010 Coll., on the catalogue of jobs in public services and administration, as Item 2.19.31, with salary grades ranging from 9 to 11. The current pay

range applies to addictologists who have acquired a bachelor's degree in the field. It is assumed that an amendment to the decree will be adopted which should also involve the extension of the salary range that would include the graduates of master's studies in addictology.

In relation to the above, the Health Ministry's Decree No. 55/2011 Coll., concerning the activities of health professionals and other practitioners, was issued in 2011. It sets out specific activities which an addictologist is allowed to perform either without a physician's expert supervision and indication or on the basis of a physician's indication or expert supervision.

1.1.1.6 Proposed Changes in Relation to Compulsory Treatment and Security Detention

In summer 2011 the Parliament of the Czech Republic considered an amendment to Act No. 40/2009 Coll., the Penal Code, and Act No. 141/1961 Coll., on criminal proceedings (the Code of Criminal Procedure) which, if passed in the present wording[1], will considerably moderate the conditions for the imposition of security detention orders on drug users for both obligatory and optional reasons. As an innovation, the amendment provides that in specific cases security detention may be imposed on the perpetrators of felonies (i.e. for offences carrying a prison sentence of a minimum of 5 years), while the existing regulation makes it possible to impose security detention on the perpetrators or repeated perpetrators of particularly serious crimes (i.e. criminal offences carrying a sentence of a minimum of 10 years' imprisonment). If adopted, the legal regulation as proposed would lead to a dramatic extension of the range of possibilities for imposing security detention on problem drug users. This wider range of possibilities emerges in combination with the fact that repeated offending, even if it only involves small-scale dealing in drugs or the manufacturing of drugs for personal use, has been regarded as a circumstance conditioning the application of a stricter punishment range of 2–10 years since the effective date of the new Penal Code (Section 283, Subsection 2, Letter b) of the new Penal Code).

In addition to the moderation of the conditions for the imposition of security detention, the amendment also allows for the dramatic loosening of the terms governing the change of compulsory treatment to security detention by modifying Section 99 (5) of the new Penal Code. As an innovation, a court might change institutional compulsory treatment to security detention if compulsory treatment imposed on and undergone by a person does not fulfil its purpose or does not provide sufficient protection for the public, particularly in cases where an offender escapes from a healthcare facility, uses violence against the staff of a healthcare facility or other individuals undergoing compulsory treatment, and/or repeatedly refuses to accept examining or treatment interventions or otherwise expresses a negative attitude to compulsory treatment. In the most extreme cases, the offender's "otherwise expressing their negative attitude to compulsory treatment" may also provide grounds for compulsory treatment being changed to security detention. Among drug users, however, the aforementioned conditions may be a common sign of a lack of motivation to treatment as part of the compulsory treatment order, which is usually addressed using motivational work with the client. Such a vague definition of the terms for compulsory treatment being changed to detention poses a potential danger of the instrument of security detention being overused.

1.1.2 Implementation of Laws

The changes in the practical application of the legal norms concerning illegal drugs are immediately associated with Act No. 40/2009 Coll., the Penal Code, coming into force. In 2010, both the new Penal Code and the previous penal code defined by Act No. 140/1961 Coll., effective until 31 December 2009 (the old Penal Code), were applied by the courts in deciding about primary drug-related crime, as the punishability of an act is considered in the light of the law that was effective at the time when the offence was committed. The more recent legal regulation is only applied when it is more favourable for the offender. Thus, as regards criminal offences committed prior to 1 January 2011, the court had to consider which of the two criminal codes was more favourable for the offender. This issue was also addressed in the decisions of the Supreme Court of the Czech Republic. Another area of problems concerned the assessment of the scale (significant, substantial, and large) of the perpetrators' involvement in primary drug-related offences in the light of the new legal regulation. It may be concluded that, to a significant degree, it should also be possible to make use of the existing case law decisions in applying the new Penal Code. Of all the decisions, the Resolution of the Supreme Court of the Czech Republic, Case File 4 Tdo 827/2010, dated 15 September 2010, should be highlighted. In this ruling, the court also concluded that the scale of the perpetrator's offending against a child should be assessed in stricter terms than the same scale of offending against an adult consumer. In this respect, thus, the new judicial practice should differ considerably from the previous verdicts. No other decisions on how to address certain ambiguities arising in association with the application of the new Penal Code (such as those involving the possession of small quantities of multiple substances for personal use and the cultivation of medicinal cannabis) have been handed down as yet.

As for the practical application of provisions governing the misdemeanours of the possession of a small quantity of drugs for personal use and the cultivation of a small quantity of plants or mushrooms containing narcotic or psychotropic substances for personal use, Section 30 (1) (j) and (k), respectively, of Act No. 200/1990 Coll., on misdemeanours, it may be stated that, given the number of drug users, or the number of people in the Czech

[1] http://www.psp.cz/sqw/text/tiskt.sqw?O=6&CT=297&CT1=0 (2011-09-06)

Republic who are in possession of a small quantity of drugs for personal use, and the relatively small number of misdemeanours that have been considered, the level of law enforcement in relation to drug-related misdemeanours is low. While the main reason appears to be the hidden character of such illicit activities, the complex and costly nature of administrative proceedings may also play a role. Drug-related offences and misdemeanours are covered in more detail in the chapter on Drug-Related Crime (p. 116).

With respect to administrative proceedings pertaining to road traffic, we may point out the enduring inconsistent and often erroneous practices used in the testing of drivers for other addictive substances than alcohol. Incorrectly, drivers who test positive for cannabis on the basis of a screening test tend to be subsequently subjected to a urine test only in order to further specify the test results, instead of having their blood samples tested for active THC metabolites that are indicative of the possible influence on the driver's volitional and recognition capacities rather than the mere use of the drug in the past as identified on the basis of urine testing. Hence, the results of urine tests in themselves do not provide evidence of whether the driver was really under the influence of an addictive substance while driving or whether they were even in a state inconsistent with the capacity to drive a motor vehicle. Such circumstances should be examined by a forensic expert in medicine, a psychiatrist specialising in addictive diseases, which in practice is rather the case in relation to the defence of a person subjected to administrative proceedings. In the future, it would be useful to determine a specific procedure corresponding to the state of the art in the field under consideration.

1.2 National Action Plan, Strategy, Evaluation, and Coordination

1.2.1 National Action Plan and Strategy

In 2010 the Government discussed significant strategic documents pertaining to the drug policy. In June 2010 the Government considered and approved a report on the evaluation of the 2005–2009 National Drug Policy Strategy and a report on the evaluation of the implementation of the 2007–2009 Action Plan. In May 2010 the Czech Government adopted its new National Drug Policy Strategy for the Period 2010–2018. The Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2010–2012 was approved by the Government in January 2011.

1.2.1.1 National Drug Policy Strategy for the Period 2010–2018

The National Drug Policy Strategy for the Period 2010–2018[2] is not very different from the previous strategy covering the period from 2005 to 2009. The basic structure, principles, key areas of interest, and pillars of the drug policy remained unaltered. However, the strategy is newly perceived as a long-term document, the purpose of which is to define, in political terms, the framework for the drug policy, the key areas of interest, and the principles and approaches underpinning the Czech drug policy.

Therefore, the new national strategy was conceived in such a way as to remain in effect for 9 years. It defines four general objectives which correspond to the four pillars of the drug policy – Prevention, Treatment and Social Reintegration, Harm Reduction, and Drug Supply Reduction – complemented by three supporting domains: Coordination and Funding, Monitoring, Research, and Evaluation, and International Cooperation. See the 2009 Annual Report for more information.

Specific short-term drug policy procedures and measures are defined in the action plans for the implementation of the National Drug Policy Strategy (Action Plans). Three Action Plans, each spanning a period of three years, will be drawn up during the term of the Strategy.

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

The 2010–2012 Action Plan was approved by the Government in January 2011[3], on the second occasion of its being included in the agenda of the Government's session[4].

The Action Plan defines the following four priorities for the period of its operation. They should be pursued while maintaining the best practices from the previous years:

- to implement interventions aimed at reducing the high level of the use of cannabis, in particular, and other legal and illegal drugs. The reason for the setting of this priority is that, from a long-term perspective, the Czech

[2] Approved by virtue of Government Resolution No. 340, dated 10 May 2010. Available for downloading at http://www.vlada.cz/cz/ppov/protidrogova-politika/dokumenty/narodni-strategie/narodni-strategie-protidrogove-politiky-na-obdobi-2010-az-2018-71880/ (2011-09-05).

[3] Approved by virtue of Government Resolution No. 47, dated 19 January 2011. Available for downloading at http://www.vlada.cz/cz/ppov/protidrogova-politika/dokumenty/akcni-plan/akcni-plan-realizace-narodni-strategie-protidrogove-politiky-na-obdobi-2010-az-2012-80326/.

[4] The Government did not approve the 2010-2012 Action Plan on the first occasion of its being submitted for consideration. The wording of the draft resolution was returned to the author for review. The original draft resolution which the Government refused to approve committed the Government to earmarking financial resources for the implementation of activities set out in the Action Plan (approximately CZK 54 million over three years). The final wording commits the individual ministries to allocating financial resources for the implementation of the Action Plan "depending on the possibilities of the state budget".

Republic has been reporting the highest prevalence rates of the use of cannabis (as well as some other drugs, both legal and illegal) among European countries, particularly as far as children and young people are concerned. Unlike in some Western European countries, no targeted measures aimed at reducing (heavy) cannabis use have been taken in the Czech Republic thus far;

- 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. In the Czech Republic, problem drug use especially involves pervitin and also opiates/opioids. However, specific demand reduction and supply reduction interventions aimed at pervitin users are lacking. As far as opiate substitution is concerned, control and registration procedures (and the enforcement of such procedures) need to be reinforced and reimbursement for such interventions from public health insurance should be introduced;
- to strengthen the drug policy in relation to legal drugs (alcohol and tobacco), primarily in terms of policy and coordination mechanisms and treatment. As an innovation, an independent Alcohol and Tobacco domain was created in the Action Plan in relation to this priority. The evaluation of the 2005–2009 national strategy concluded that the previous strategy had failed in its effort to integrate legal drugs into the drug policy system, which is demonstrated by the inconsistent structure of coordination mechanisms in relation to legal drugs, the limited availability of data on the extent and consequences of the use of alcohol and tobacco, and on the measures being adopted or by the absence of a solid network and range of services intended for the users of legal drugs. As a result, by means of this dedicated area of interest, the Action Plan seeks to pay more attention to ways of interconnecting/incorporating the legal drug policy, particularly in terms of coordination and the availability of information;
- to develop and improve the drug policy's overall legislative, financial, and coordination mechanisms. This priority reflects the results of the evaluation of the previous strategy, which suggest that it is necessary to pay special attention to the funding of the drug policy and the effective utilisation of the financial resources that are available, the coordination of multi-source funding, and seeking ways in which to facilitate the transition from a subsidy system to a system of reimbursement for services (including reimbursements from health insurance).

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

1.2.1.3 Implementation of the 2010–2012 Action Plan

In order to facilitate the more effective evaluation of the implementation of the Action Plan, each intervention area encompasses milestones and deadlines for the completion of the activities, evaluation indicators, and the party responsible for the task and/or cooperating on the fulfilment thereof. Prerequisites are also defined for each activity. They refer to conditions which must be met for a given activity to be carried out. In particular, these assumptions involve the specification of the financial amounts needed for the implementation of the activity and the adoption of the relevant legislation.

The course of the implementation of the 2010–2012 Action Plan should be evaluated annually. In view of the fact that the 2010–2012 Action Plan was adopted by the Government in January 2011, the 2010 evaluation was not conducted as planned. A report on the implementation of the Action Plan in the year 2010 and in the first half of 2011 will be submitted to the Government Council for Drug Policy Coordination in October 2011.

1.2.1.4 Evaluation of the National Strategy and of the Action Plan

The evaluation of two previous drug policy strategic documents – the National Drug Policy Strategy for the Period 2005–2009[5] and the 2007–2009 Action Plan[6] – was finalised in 2010. Summaries of the conclusions of both evaluation reports were published in the 2009 Annual Report and in journals (Kiššová and Mravčík, 2011).

1.2.2 Other Drug Policy Developments

The year 2010 experienced the initiation of an update of a long-term programme for the promotion of the health status of the population of the Czech Republic – Health for All in the 21st Century – which falls within the responsibility of the Ministry of Health (Division for Public Health Protection and Support). Objective No. 12 addresses a reduction of the harm caused by alcohol, drugs, and tobacco. The evaluation of the accomplishment of the objectives was conducted until the end of 2010. The update has not been concluded as yet and the results have not been published.

In May 2011 the Government Council for Drug Policy Coordination (GCDPC) approved the National Action Plan on the Drug Information System for the period 2011–2012 (NAPDIS). It is a useful tool in planning and evaluating the drug information system and in coordinating the activities of the institutions involved in the monitoring of the drug situation. NAPDIS sets out the objectives of the drug information system for the given period, defines the main sources of data, and assigns tasks and deadlines for the completion of such tasks.

[5] http://www.vlada.cz/cz/ppov/protidrogova-politika/dokumenty/narodni-strategie/evaluace-narodni-strategie-protidrogove-politiky-na-obdobi-20052009--86798/ (2011-08-26)
[6] http://www.vlada.cz/cz/ppov/protidrogova-politika/dokumenty/akcni-plan/hodnoceni-implementace-akcniho-planu-2007-2009-74816/ (2011-08-26)

For more information about legal measures see the chapter on Legal Framework (p. 6).

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

In 2010 and in the first half of 2011 discussions and initiatives on the use of medical cannabis took place. The general public, the professional community, and politicians and representatives of the public administration were involved in these events and activities.

A seminar entitled Prospects of Treatment with Cannabis: Health, Legislation, Politics was held at the Chamber of Deputies in April 2010; for more details see the 2009 Annual Report. In August 2011, as a follow-up to the seminar, experts, patients, and civil society initiated the Medical Cannabis petition appealing for legislative changes which would enable patients in the Czech Republic to gain access to treatment with cannabis and make it possible to facilitate research into medical cannabis.[7]

A different Petition for Medical Cannabis was publicised in November 2010[8]. It called for legislative changes to the effect that patients could grow their own cannabis for medical use and that cannabis could be used for research purposes. The requirements articulated in the petition were also forwarded by electronic mail to the Chamber of Deputies of the Parliament of the Czech Republic, which received 308 and 320 e-mail messages from citizens in 2010 and 2011 respectively (by 24 August).[9]

The issue of the use of medical cannabis in the Czech Republic was also addressed by an expert debate organised as part of the mission of the International Narcotics Control Board (INCB). The discussion was held with the participation of an INCB ambassador and Czech professionals concerned with drug-related issues (including therapists, police officers, researchers, and civil servants). The discussion also touched upon another topic being addressed by the professional community, namely facilities intended for the administration of narcotic or psychotropic substances under medical supervision (drug consumption rooms).

In addition to the initiatives advocating the medical use of cannabis (see above), there are also initiatives that campaign for the complete decriminalisation of *Cannabis Indica* in the Czech Republic. In May 2010 the *Legalizace.cz* civic association organised the Million Marijuana March 2010, a regular annual demonstration in support of the legalisation of cannabis for medicinal purposes and of the growing and possession for personal use and the introduction of the controlled and taxable sale of cannabis.[10] According to the organisers, almost six thousand people participated in the demonstration.[11]

Apart from the initiatives advocating the legalisation of cannabis, there are civil associations in the Czech Republic that are calling for a stricter drug policy and severe sanctions for (drug-related) criminal offences, as well as opposing the legalisation of any narcotics. In July 2010, the Patriotic Front civil association[12], for example, published on its website Five Articles of the Young Christian Democrats, in which they declare "a fierce fight against crime and drugs, including marijuana"[13]. Nevertheless, activities such as these are less visible in the public domain than those pursued by the champions of the legalisation of marijuana.

The Prague Declaration (on the principles of effective local drug policies) was published in October 2010. This initiative came into existence on the occasion of the international conference Urban Drug Policies in the Globalised World, held in Prague at the turn of September–October 2010. The declaration was prepared as a statement of representatives of municipal governments, decision makers responsible for local and municipal drug policies, drug prevention, treatment, and harm reduction professionals, coordinators of drug policy at all levels (international, national, regional, and local), and researchers active in the field of drugs.[14]

The long-term explosive situation concerning the open drug scene in Prague, and harm reduction services in Prague in general, did not undergo any major changes in the period 2010–2011. During the second half of 2010 and the first half of the year 2011 efforts to solve the situation concerning the location of the *K-centrum* low-threshold facility, operated by the *SANANIM* civic association, in the Prague 5 District continued. The moving of *K-centrum* met with strong resentment on the part of local residents, who, in August 2010, founded the civic association Na Skalce Residents against Drugs[15]. Controversies between the civic association and SANANIM staff members led to open conflict; for more details see also the 2009 Annual Report. In June 2011 the administrator of the *K-centrum* low-threshold facility announced that it would try to find another place and make every effort to clear the *Na Skalce* premises at the end of 2011[16]. The public nuisance associated with drug users continues to be a problem on

[7] http://www.lecebnekonopi.cz/ (2011-08-26)
[8] http://konopijelek.eu/?q=content/petice-za-l%C3%A9%C4%8Debn%C3%A9-konop%C3%AD (22.10.2011)
[9] Personal communication with the Public Relations Department of the Chamber of Deputies of the Parliament of the Czech Republic, August 2011.
[10] http://www.legalizace.cz/projekty/co-je-mmm-million-marihuana-march/historie-mmm/mmm2010/ (2011-08-22)
[11] http://www.legalizace.cz/2011/05/legalizace-konopi-je-legitimni-pozadavek/ (2011-08-15)
[12] http://www.vlasteneckafronta.cz/ (2011-08-26)
[13] http://www.narmyslenka.cz/view.php?cisloclanku=2010070084 (2011-08-19)
[14] http://www.praguedeclaration.com/cz/ (2011-08-23)
[15] http://rejstrik.penize.cz/ares/22854355-rezidenti-na-skalce-proti-drogam, http://ne-drogam-na-skalce.webnode.cz/ (2011-08-26)
[16] http://sananim.cz/aktuality/63/k-situaci-kontaktniho-centra-na-skalce.html (2011-08-15)

Wenceslas Square and in the surrounding areas. Neither have conflict situations between law enforcement units (Police of the Czech Republic and the City Police) and street workers dropped in numbers. Local authorities have made repeated attempts to deal with the situation in specific areas. Such measures included the termination of lease contracts with three outpatient physicians providing substitution treatment in the Prague 5 District (in the immediate vicinity of the *Na Skalce* location) in March 2011 and the termination of the lease contract with a low-threshold methadone centre in *Ve Smečkách* street, in the Prague 1 District, in July 2011 because of complaints from residents discontented with the existence of the service in their neighbourhood[17]. The unsatisfactory situation concerning the open drug scenes in several high-profile locations within the central Prague area was also addressed by the Prague Drug Forum XXL, an expert discussion held on 2 October 2010 at the end of the Urban Drug Policies in the Globalised World international conference. Heads of the different city district authorities, local political representatives, and Prague city districts' drug coordinators participated in this moderated debate.[18]

In early November 2010, as part of the initiative We Have Had Enough of This! (*Máme toho dost!*), the Government received a second memorandum from providers of drug services, in which the representatives of drug services and the professional community called the Government's attention to the possible disintegration of the existing network of services as a result of the cuts in financial resources earmarked for subsidies, as well as urging the Government to consider the provision of funds for the operation of the network. Furthermore, suggestions as to how to deal with the existing situation were submitted to the Government as part of the initiative[19]. In this way, the service providers built up on the legendary Christmas Memorandum[20] of December 1992. Subsequently, a special session of the Government Council for Drug Policy Coordination (GCDPC) was convened in December 2010 in order to address the issue of the funding of the network of services in 2011 and the minimisation of the impact of the drop in the volume of funds earmarked for the service network. Although no major decisions were adopted at the meeting, the GCDPC reviewed its priorities in relation to the 2011 subsidy proceedings (see below).

Various conferences and seminars were organised by professional associations and regional authorities in 2010. Major events included the 49th national addictological conference (AT Conference), organised by the Society for Addictive Diseases of the J.E. Purkyně Czech Medical Association, featuring the topic "Alcohol, Tobacco, and Psychoactive Medication in the Czech Republic: the 2010 Situation"[21], held in April 2010 and the 7th international conference on Primary Prevention of Risk Behaviour. Conventions held on the regional level included the 3rd Conference on Primary Prevention in the Moravia-Silesia Region, the Pilsen Region's 4th AT Conference, the 4th Regional Conference of Drug Professionals of the South Bohemia Region, the Conference on Addiction in the Zlín Region, and the Youth and Drugs 2010 conference organised by SANANIM in Prague; see also the chapter on Media Campaigns, Conferences, and Other Activities with Media Response (p. 46).

Considerable attention on the part of the public and the media was drawn to new synthetic drugs (legal highs) which began to emerge in 2010 and 2011. These substances were sold as collectables in bricks-and-mortar shops (especially those belonging to the Amsterdam Shop network); for more details see the chapter New Drugs on the Czech Drug Scene (p. 133).

1.2.3 Coordination Arrangements

1.2.3.1 Coordination at the National Level

The Government Council for Drug Policy Coordination (GCDPC), the main coordinating body of the Government for issues related to the drug policy, met five times in 2010.[22] In order to ensure horizontal coordination on the national level, the GCDPC has five committees and four working groups for specific areas of the drug policy which deliver their opinions and recommendations in relation to materials that are submitted for consideration and on specific drug policy-related issues. An overview of these bodies is provided in the 2008 Annual Report.

The last significant changes in the composition of the GCDPC occurred in 2007, when the Ministers of Foreign Affairs and of Trade and Industry respectively resigned from their membership of the GCDPC of their own free will, but the GCDPC was also newly enlarged with the addition of representatives of non-governmental organisations, the Association of Regions, the Society for Addictive Diseases of the J.E. Purkyně Czech Medical Association, and the executive vice-chair who can also discharge the office of the director of the GCDPC Secretariat. The number of members stabilised at 13 in 2007.

The question of the GCDPC's composition was raised again in the first half of the year 2011 in relation to the updating of the GCDPC's statute. Negotiations on the new statute's wording lasted about half a year. The main

[17] http://www.praha1.cz/cps/socialni-pece-a-zdravotnictvi.html (2011-08-23)
[18] http://www.urbandrugpolicy.com/cz/catalogue/detail/1/117/ (2011-08-26)
[19] http://www.proadis.cz/Aktuality.aspx?News=33 (2011-08-18)
[20] In the Christmas Memorandum, non-governmental organisations alerted the Government about the lack of drug policy services, vision, and coordination. The Government responded promptly by establishing the National Drug Commission (the present Government Council for Drug Policy Coordination) and adopting the first drug policy vision for the period 1993-1996. This memorandum is regarded as one of the early milestones of the modern Czech drug policy.
[21] http://www.at-konference.cz/ (2011-08-23)
[22] http://the GCDPC.vlada.cz (2011-09-05)

advisory body to the Government Council for Drug Policy Coordination, which is the Committee of Departmental and Institutional Representatives, recommended to the GCDPC that, as part of the updating of its statute, it should reduce the number of its members, proposing that the GCDPC's composition should return to its pre-2007 structure. The Committee of Departmental and Institutional Representatives further recommended that the representatives of the regions, the medical association, and non-governmental organisations should no longer be members of the GCDPC. The main rationale for such changes was to make the GCDPC a purely political body comprising governmental representatives (the ministers whose agenda pertains to the drug policy). It was further suggested that the professional community would be represented in the GCDPC's advisory bodies (committees and working groups), which express their opinions on the materials submitted to the GCDPC. At its meeting on 17 May 2011, the GCDPC did not accept the recommendations of its advisory body and recommended that the Government should endorse the GCDPC's statute in a wording which allows the continued membership of the representatives of the professional community, the regions, and the non-governmental sector. As of August 2011 the updated statute was still awaiting consideration by the Government.

Priorities for the 2011 departmental subsidy proceedings were reviewed in 2010. In consequence of the cuts in funding, the Ministry of Health decided to exclude harm reduction programmes from the areas receiving support in the first round. In the second round, following negotiations with the GCDPC, the Ministry of Health released an additional CZK 2 million (€ 79 thousand) to enhance the 2010 subsidy proceedings and supported the harm reduction services. The GCDPC reviewed the priorities of its subsidy proceedings for 2011; the GCDPC chose to provide priority support to outpatient services, low-threshold centres, and outreach programmes. On the other hand, support for projects involving primary prevention, the evaluation of services, and the provision of information was curtailed considerably.

The Government Council for Drug Policy Coordination continued to be kept informed about the availability of medicines containing pseudoephedrine (which is the main pervitin precursor in the Czech Republic) and about the impact of the measures adopted in May 2009 in order to restrict the dispensation of such products in pharmacies. The conclusions of the latest report from June 2011 showed that, while the measures led to a long-term reduction in the supply of medicines containing pseudoephedrine in Czech pharmacies, the levels of production and availability of pervitin remained the same, and there was a dramatic increase in the quantities of pseudoephedrine smuggled in from the neighbouring countries, especially from Poland. Therefore, the GCDPC adopted a resolution requesting attention to be drawn to the problem of the high level of availability of pharmaceuticals containing pseudoephedrine within the EU and, if practical, talks with the neighbouring countries to be initiated in order to reduce the availability of such products at national levels.

An interdepartmental working group for the Project of the Protection of Children and Young People from the Misuse of Alcohol and Other Addictive Substances was established in early 2011. The goal of the project is to introduce measures aimed at limiting the availability of alcohol to children and young people under 18, particularly by enhancing the enforcement of legislation and imposing more stringent sanctions on violations of the laws. By the end of 2011 the working group is to submit proposals for legislative changes in four areas: (1) to simplify the process of evidence taking – to minimise the risk of the failure of evidence of alcohol being served to or consumed by a minor; (2) to introduce the one-off principle – enable police officers and other regulatory authorities to impose effective sanctions even for one-off violations of regulations; (3) to improve the efficiency of the enforcement system – to modify the police practices and delegate the relevant control powers to other entities, as well as improving the coordination and liaison among all stakeholders, and (4) to raise the liability of people who operate outlets serving alcohol.

1.2.3.2 Coordination at the Local Level

Coordination instruments used by the regions are similar to those existing at the national level. On the basis of Act No. 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances, the regions and the municipalities with extended competencies, respectively, have established the offices of a regional drug coordinator and a local drug coordinator. The drug policy is coordinated by means of regional drug commissions, working groups, and regional drug policy strategies and/or action plans. Reports on the implementation of regional drug policies are produced every year. The collaboration between the national and the regional levels on the coordination and harmonisation of the drug policy was institutionalised in the form of the Committee of Regional Representatives, comprising the regional drug coordinators.

The office of a regional drug coordinator has been established in all the regions, with the exception of the Moravia-Silesia region[23]. The regional drug coordinators mostly work as junior officials in divisions for social services, prevention, and humanitarian or health affairs (in two cases they are department managers). Generally, the regional drug coordinators are members of the regional advisory bodies related to the drugs issue. However, they are seldom involved in decision-making processes at the regional level, which is a point of concern that was also included in the agenda of the GCDPC's meeting in May 2010. The GCDPC asked its member delegated by the Association of

[23] In the Moravia-Silesia region, the drug coordinator's responsibilities are covered by a different position.

Regions of the Czech Republic to call upon the representatives of the regions to facilitate the regional drug coordinators' structural involvement in decision-making processes at the regional level.

Specific drug policy commissions exist in seven out of 14 regions. In the regions where such commissions are absent there are at least working groups concerned with drug policy coordination.

In 2009 and 2010, the validity of some regions' strategic documents expired and new documents were prepared. 12 regions have drawn up their drug policy strategies. In the Pilsen and Ústí nad Labem regions, drug-related issues are incorporated into a broader strategy that covers the fields of social policy and crime prevention in general. In 2010 the Moravia-Silesia, Karlovy Vary, and Pardubice regions had no effective drug policy strategies in place, as the validity of the previous documents had expired and the new ones had not been approved yet.

The Prague drug commission developed the 2010–2012 Drug Policy Action Plan of the Capital City, Prague, which, however, was considered by neither the City Council nor the City Assembly. It is currently being updated for the years 2011 and 2012. It will then be submitted for approval[24].

Drug policy coordination at the municipal level is provided through local drug coordinators. They have been appointed in all the Prague city districts and in the majority of the municipalities with extended competencies. Their office is also established in line with Act No. 379/2005 Coll. Some of the municipalities develop their own drug policy plans and/or write final reports on the implementation of their drug policies. Some of the regions maintain a system of training for local coordinators and/or hold regular meetings.

Information on regional and municipal coordination instruments is summarised in Table 1-1.

[24] 2010 annual report on the implementation of the drug policy of the Capital City, Prague.

Table 1-1: Overview of regional and municipal coordination instruments in 2010

Region	Advisory/coordination bodies for drug policy	Working groups	Strategies/action plans	Working position of regional drug coordinators (workload), a membership in an advisory body	Number of municipalities with a local drug coordinator
Prague	Drug Commission of the Prague City Council	Drug Commission's working groups (units): – primary prevention – treatment and aftercare – harm reduction – data collection	2008–2012 Drug Policy Strategy of the Capital City, Prague Evaluation: 2008–2009 Action Plan	Head of Drug Prevention Department (1.0), a secretary of the commission (since 2011 a member)	22 out of 22
Central Bohemia	Regional Drug Commission	Working groups developing the strategy	No strategic document was in effect in 2010.	Division of Social Affairs (0.5), a secretary of the commission	24 out of 26
South Bohemia	Regional Drug Coordination Group	–	2010–2011 South Bohemia Drug Policy Strategy Evaluation: 2005–2009 South Bohemia Drug Policy Strategy	Head of Department of Prevention and Humanitarian Activities (1.0), a head of the group	16 out of 17
Pilsen	Social Commission of the Pilsen Regional Council	Established as needed.	Pilsen Region Policy Document on the Prevention of Crime and Socio-pathological Phenomena 2009–2011 No evaluation was carried out.	Social Department, Division of Social Affairs (0.5), coordinator is not a member	15 out of 15
Karlovy Vary	Regional Drug Commission of the Karlovy Vary Regional Council	Working group on the implementation of the regional drug policy	No strategic document was in effect in 2010. No evaluation was carried out.	Department of the Development of Social Services (1/3), a secretary of the commission	3 out of 7
Ústí nad Labem	Commission of the Ústí nad Labem Regional Health Council	–	Medium-term Plan for the Development of Social Services in the Ústí nad Labem Region 2008–2011 No evaluation was carried out.	Department of Humanitarian Activities of the Social and Health Division (no specific workload has been determined), coordinator is not a member	11 out of 16
Liberec	Drug Commission of the Liberec Regional Council	*Ad hoc* working groups on: – primary prevention – harm reduction – treatment and resocialisation – coordination	Liberec Regional Drug Policy Action Plan 2010–2012 Evaluation: Drug policy action plan for the period 2008–2009	Department of Coordination and Medium-term Planning, Division of Social Affairs (1.0), a secretary of the commission	10 out of 10
Hradec Králové	Commission for Specific Prevention of the Hradec Králové Regional Council*	*Ad hoc* working groups on strategy: – primary prevention group – harm reduction, treatment, and resocialisation group	2008–2010 Hradec Králové Regional Drug Policy Strategy 2008–2010 Action Plan for its implementation 2011–2015 Hradec Králové Regional Drug Policy Strategy 2011–2015 Action Plan for its implementation Evaluation: 2008–2010 Action Plan for the Implementation of the Hradec Králové Regional Drug Policy Strategy	Department of Prevention, Development, and Social and Legal Protection, Division of Social Affairs (1.0), a member of the commission	15 out of 15

Region	Advisory/coordination bodies for drug policy	Working groups	Strategies/action plans	Working position of regional drug coordinators (workload), a membership in an advisory body	Number of municipalities with a local drug coordinator
Pardubice	Drug Policy Coordination Commission of the Pardubice Regional Council	–	The year 2010 was not covered by any strategic document. 2011–2018 Pardubice Regional Drug Policy Strategy Evaluation: 2005–2009 Pardubice Regional Drug Policy Strategy	Health Division, Health Care Department (1.0). Since January 2011 Division of Social Affairs, Policy Department (0.5), a member of the commission	15 out of 15
Vysočina	Social and Drug Policy Commission of the Vysočina Regional Council	–	Vysočina Regional Drug Policy Strategy for the Years 2006–2010 No evaluation was carried out.	Division of Social Affairs, Department of Social Services (1.0), coordinator is not a member	15 out of 15
South Moravia	–	Working group on crime prevention (also deals with the issues of drug prevention)	2010–2018 South Moravia Regional Drug Policy Strategy Framework Implementation Plan for the South Moravia Regional Drug Policy in 2012 No evaluation was carried out.	Department of Prevention and Leisure-time Activities, Division of Education (1.0), a permanent host of the commission	21 out of 21
Olomouc	Commission for Crime Prevention and Drug Addiction	–	2005–2010 Olomouc Regional Strategic Drug Plan 2011–2014 Olomouc Regional Strategic Drug Plan Evaluation: 2005–2010 Olomouc Regional Strategic Drug Plan	Health Division (1.0), coordinator is not a member	13 out of 13
Zlín	Commission on Drug and Crime Prevention of the Zlín Regional Council	–	Zlín Regional Drug Policy Vision for the Years 2010–2014 Action plan as part of the vision Evaluation: Action plan – interim evaluation for the year 2010	Non-governmental Sector Department, Governor's Office (1.0), a member of the commission	13 out of 13
Moravia-Silesia	–	Working group on drug prevention as part of the Social Committee of the Regional Assembly	No strategic document was in effect in 2010. 2011–2014 Moravia-Silesia Regional Drug Policy Strategy No evaluation was carried out.	No drug coordinator has been appointed – drug-related issues are dealt with by a staff member of the Division of Social Affairs (0.5), a member of the working group	17 out of 22

*Note: Source: Annual reports on the implementation of regional drug policies. * The drug commission in the Hradec Králové region was dissolved in 2008.*

1.3 Economic Analysis

1.3.1 Public Expenditures

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

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

The total sum of labelled expenditures earmarked for the drug policy amounted to CZK 627.4 million (€ 24,807 thousand)[25] in 2010, which is 3.3% more in comparison to the year 2009[26]. It should be taken into account, however, that the extent of the expenditure that is included may vary on a year-on-year basis. Generally, it should also be noted that more sources of expenditures attributable to the drug policy are being identified and scrutinised. This year, for example, they are the expenditures of the Ministry of Health, which newly includes selected health promotion and research projects.

2010 expenditures from the state budget amounted to a total of CZK 371.6 million (€ 14,694 thousand); the trends of ministries and institutions from 2002 to 2010 are summarised in Table 1-2.

The Office of the Government of the Czech Republic provides subsidies for drug policy programmes endorsed by the Government Council for Drug Policy Coordination. In 2010 such subsidies were used to support a total of 139 local prevention, harm reduction, treatment, and aftercare projects to the tune of almost CZK 82.0 million (€ 3,242 thousand). The expenditure designated for the activities developed by the GCDPC's Secretariat, including the National Monitoring Centre for Drugs and Drug Addiction (National Focal Point), amounted to CZK 3.5 million (€ 138 thousand).

According to the final national accounts, the Ministry of Education, Youth, and Sports (the Ministry of Education) spent a total of CZK 15.0 million (€ 592 thousand) on the drug policy in 2010. The resources provided by the Ministry of Education concerned prevention. There was a change in subsidy proceedings in 2010: all the deliverers of programmes were given grants directly (until 2009 schools and educational facilities were supported by means of subsidies from the Ministry of Education forwarded to regions); see also the chapter on Prevention (p. 41).

The resources from the budget of the Ministry of Defence spent on the drug policy programme in 2010 amounted to CZK 4.4 million (€ 173 thousand). First and foremost, this money was used to purchase detection devices, services involving the provision of professional seminars, professional literature, sports equipment, and tickets to sports and cultural events.

Although the budget of the Ministry of Labour and Social Affairs does not include expenses earmarked for the drug policy programme, in 2010 it provided CZK 91.7 million (€ 3,628 thousand) worth of subsidies for projects aimed at the target group consisting of individuals at risk of the use of addictive substances and dependency on them. These funds were used to operate low-threshold centres, outreach programmes, social counselling, therapeutic communities, and aftercare services[27].

In 2010 the Ministry of Health provided a total amount of CZK 21.5 million (€ 849 thousand) for the drug policy, including CZK 814 thousand (€ 32 thousand) dedicated to capital expenditure. As part of the Drug Policy of the Ministry of Health subsidy programme, projects involving substitution treatment, detoxification, outpatient treatment, inpatient treatment, and harm reduction services for drug addicts were supported in 2010 with a total of CZK 9.3 million (€ 368 thousand). Another subsidy programme, National Health Programme – Health Promotion Projects, the resources for which were included in the drug policy-specific expenditures for the first time in 2010, was used to support four projects concerned with the prevention of tobacco and alcohol use to the tune of CZK 747 thousand (€ 30 thousand)[28]. Additionally, ten projects focused on substance use-related research and development were supported with a total amount of CZK 10.3 million (€ 407 thousand) provided from the budget of the Ministry of Health in 2010.

In 2010 the Ministry of Justice provided CZK 7.1 million (€ 280 thousand) for the drug policy, of which the Judicial Academy used CZK 147 thousand (€ 6 thousand), the Institute for Criminology and Social Prevention spent CZK 45 thousand (€ 2 thousand), and CZK 600 thousand (€ 24 thousand) was earmarked for subsidies to NGOs providing services in prisons. The largest amount of resources, CZK 6.3 million (€ 249 thousand), was consumed by the Prison Service of the Czech Republic (the Prison Service), including CZK 2.9 million (€ 115 thousand) used to

[25] 2010 average exchange rate was used (1€ = CZK 25.290).
[26] All the expenditures and their changes are indicated in nominal values.
[27] The expenditures on the part of the Ministry of Labour and Social Affairs do not include subsidies for special-regime homes providing services for older clients dependent on alcohol.
[28] A total of 30 projects to the tune of CZK 4.2 million (€ 166 thousand) were supported in 2010 as part of the "National Health Programme – Health Promotion Projects" subsidy programme.

reduce drug supply (particularly to monitor the presence of narcotic and psychotropic substances) and CZK 3.4 million (€ 134 thousand) provided for drug demand reduction and coordination (especially for the treatment of drug-dependent offenders).

The budget of the General Customs Headquarters, incorporating the Customs Drug Unit, did not account for any independent drug policy programme in 2010. However, it provided investment expenditure of CZK 2.1 million (€ 83 thousand) associated with the investigation of drug trafficking.

Neither does the budget of the Ministry of the Interior involve any expenditure on the drug policy programme. However, this ministry is responsible for the National Drug Headquarters of the Criminal Police and Investigation Service of the Police of the Czech Republic (the National Drug Headquarters), whose 2010 total expenditures amounted to CZK 144.4 million (€ 5,709 thousand), which did not include investment (capital) expenditure.

Table 1-2: Drug policy expenditures from the Czech state budget in 2002–2010 by ministries/departments (€ thousand)

Allocation	2002	2003	2004	2005	2006	2007	2008	2009	2010
GCDPC	2,886	3,261	3,153	3,547	3,838	3,762	4,008	3,686	3,381
Ministry of Education	299	293	316	315	381	452	499	426	592
Ministry of Defence	125	147	109	133	172	129	212	162	173
Ministry of Labour and Social Affairs	1,104	1,391	1,323	1,546	1,753	2,054	3,186	3,282	3,628
Ministry of Health	808	692	829	1,124	635	801	757	569	849
Ministry of Justice	302	442	427	1,233	1,455	454	296	409	280
General Customs Headquarters	863	708	292	487	829	963	427	120	83
National Drug Headquarters	n.a.	3,022	2,711	3,189	3,757	4,601	5,527	5,542	5,709
Total	**6,387**	**9,957**	**9,161**	**11,574**	**12,821**	**13,217**	**14,912**	**14,196**	**14,694**

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

In addition to the state budget, the drug policy is also funded by local budgets, i.e. those of regions and municipalities[29]. In 2010 regions and municipalities provided CZK 193.7 million (€ 7,660 thousand) and CZK 62.1 million (€ 2,454 thousand), respectively, for this field. The funds provided by regions in 2010 and the trends since 2002 are indicated in Table 1-3. In their annual reports on the implementation of the drug policy, some regions[30] also stated financial resources to the tune of CZK 46,353 thousand (€ 2 thousand) drawn from the European Social Fund, which were used to support programmes intended for drug users.

[29] The data on regional and municipal expenditure are based on the annual reports of drug policy implementation in regions and/or the specifying information requested from regional drug coordinators.
[30] South Bohemia, Pilsen, Liberec, Hradec Králové, Pardubice, Vysočina, and South Moravia regions.

Table 1-3: Drug policy expenditures from Czech regional budgets in 2002–2010 (€ thousand)

Regions	2002	2003	2004	2005	2006	2007	2008	2009	2010
Prague	399	391	820	1,029	1,147	1,463	2,006	1,852	2,046
Central Bohemia	114	251	432	495	505	625	713	473	645
South Bohemia	95	88	181	175	212	223	408	379	331
Pilsen	0	31	47	113	82	65	256	250	274
Karlovy Vary	3	16	16	35	29	41	53	23	232
Ústí nad Labem	47	237	248	232	242	174	203	189	184
Liberec	0	86	181	271	285	233	459	314	325
Hradec Králové	24	30	63	69	102	244	277	364	273
Pardubice	49	47	56	185	58	198	224	200	269
Vysočina	0	57	129	233	109	285	157	134	134
South Moravia	97	63	157	249	300	306	341	713	636
Olomouc	3	10	41	67	72	90	334	333	346
Zlín	36	110	75	71	49	170	178	334	696
Moravia-Silesia	74	94	112	147	157	505	921	968	1,267
Total	**952**	**1,510**	**2,558**	**3,369**	**3,349**	**4,624**	**6,530**	**6,528**	**7,660**

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

2010 drug policy expenditures from the state, regional, and municipal budgets are shown in Table 1-7. The detailed summary of the data on funding at the regional level is divided according to the locations where resources were utilised by the providers of projects and programmes. The 2010 drug policy expenditures from the state and local budgets designated for use on regional levels are depicted by regions in Map 1-1.

The trends in drug policy expenditure on drug demand reduction (prevention, treatment, aftercare, and harm reduction) and drug supply reduction (law enforcement) in the Czech Republic in 2002–2010 are summarised in Table 1-4.[31]

An overview of expenditures from state and local budgets in 2010 by service category[32] is provided in Table 1-8. Out of labelled 2010 drug policy expenditures amounting to a total of CZK 627.4 million (€ 24,807 thousand), CZK 166.2 million (€ 6,572 thousand, 26.5%) was earmarked for harm reduction services, CZK 108.9 million (€ 4,304 thousand, 17.4%) for treatment, CZK 62.3 million (€ 2,463 thousand, 9.9%) for primary prevention, and CZK 31.3 million (€ 1,238 thousand, 5.0%) was allocated to aftercare. The sobering-up stations, which consumed CZK 87.2 million (€ 3,449 thousand, 13.9%), were funded almost exclusively from the regional budgets, and CZK 149.4 million (€ 5,906 thousand, 23.8%) was earmarked for law enforcement. A comparison of expenditures from public budgets from 2007 to 2010, by service category, is provided in Table 1-5.

[31] Until 2006 the expenditure on demand reduction included resources expended by the GCDPC, the Ministry of Education, Youth, and Sports, the Ministry of Defence, the Ministry of Labour and Social Affairs, and the Ministry of Health, while expenditure on supply reduction included resources consumed by the Ministry of Justice, the General Customs Headquarters, and the National Drug Headquarters. Since 2007 the data have been more accurate, and the Ministry of Justice's expenditures have been divided between the two areas to reflect their actual purpose. As a result, the consistency of the data over time is impaired.

[32] The categories and their subcategories include: Prevention, Harm Reduction (low-threshold drop-in centres, low-threshold day care centres, and outreach streetwork programmes), Treatment (encompasses both health care – substitution programmes, detoxification, outpatient and inpatient alcohol/drug treatment services, social services provided in institutional care – and non-health outpatient care – crisis intervention, social counselling, non-medical outpatient treatment provided by NGOs, and therapeutic communities), Sobering-up Stations, Aftercare, Law Enforcement, Coordination (including monitoring and research, the evaluation of services, the dissemination of information, and training) and Others (not specified above).

Map 1-1: 2010 drug policy expenditures from state and local budgets in regions of the Czech Republic (CZK thousand per 100,000 inhabitants aged 15–64)

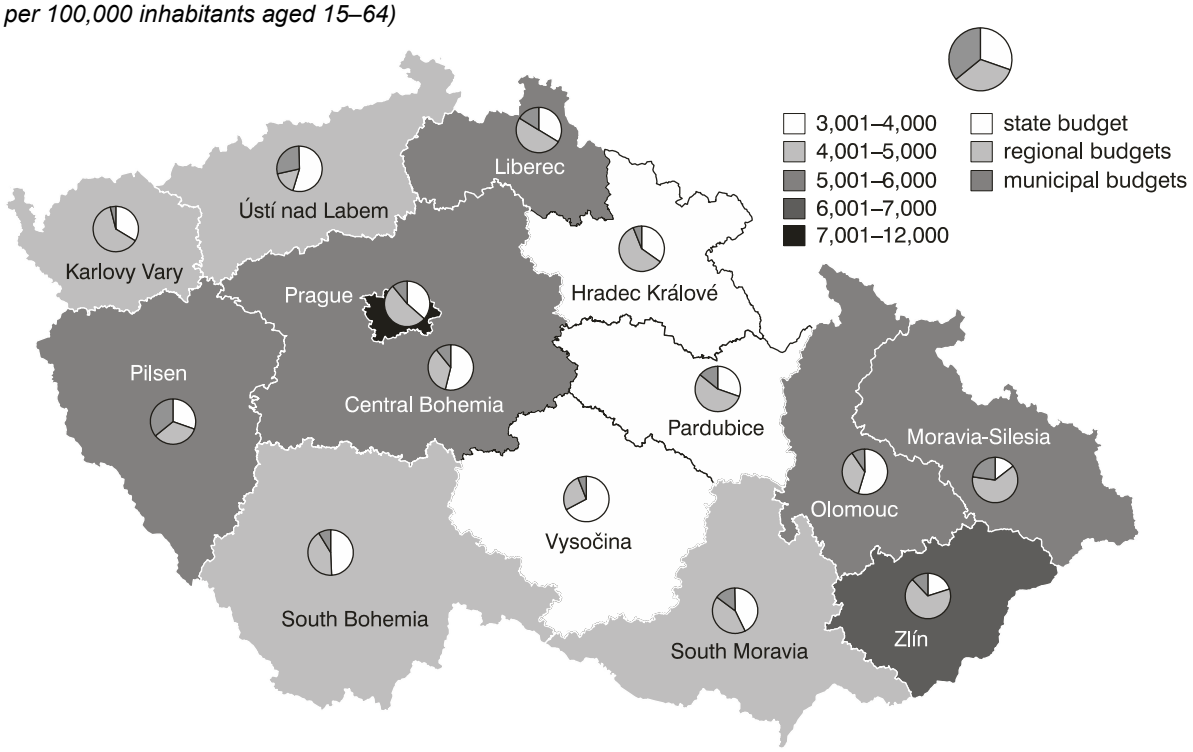


Table 1-4: Drug policy expenditures from state and local budgets in 2002–2010 (€ thousand)

Year	Demand reduction*				Supply reduction**	Total
	State budget	Regional budgets	Municipal budgets	Total	State budget	
2002***	5,397	952	n.a.	6,349	1,204	7,553
2003	5,785	1,510	n.a.	7,295	4,172	11,467
2004	5,731	2,558	1,972	10,261	3,430	13,691
2005	6,666	3,369	1,699	11,733	4,909	16,642
2006	6,780	3,349	1,699	11,828	6,041	17,869
2007	7,425	4,624	2,243	14,292	5,792	20,084
2008	8,812	6,530	2,505	17,847	6,100	23,947
2009	8,345	6,528	2,249	17,122	5,851	22,973
2010	8,788	7,660	2,454	18,901	5,906	24,807

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

Table 1-5: Comparison of expenditures provided from public budgets by service category from 2007 to 2010

Service category	2007		2008		2009		2010	
	€ thousand	%	€ thousand	%	€ thousand	%	€ thousand	%
Prevention	1,753	8.7	2,340	9.8	2,078	9.0	2,463	9.9
Harm reduction	5,078	25.3	6,389	26.7	6,616	28.8	6,572	26.5
Treatment	5,496	27.4	7,399	30.9	6,699	29.2	7,754	31.3
Aftercare	739	3.7	999	4.2	1,201	5.2	1,238	5.0
Coordination, research, evaluation	605	3.0	504	2.1	5,851	1.8	749	3.0
Law enforcement	5,792	28.8	6,100	25.5	421	25.5	5,906	23.8
Others, unspecified	620	3.1	217	0.9	106	0.5	125	0.5
Total	**20,084**	**100.0**	**23,947**	**100.0**	**22,973**	**100.0**	**24,807**	**100.0**

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

The structure of budgets for projects subsidised by the Government Council for Drug Policy Coordination [33], including resources other than those made available from the state and local budgets, is outlined in Table 1-6. In 2010 approximately half of their income originated from the state budget, with the GCDPC providing almost one third of the sum. Approximately one third of all the income originated from local budgets and 14% from other home sources (mainly the services' own earnings). The period 2006–2010 showed an increase in the proportion of funding contributed by the Ministry of Labour and Social Affairs, while the amount of resources available from the GCDPC's subsidies declined.

Table 1-6: Income of providers of drug policy programmes subsidised by the GCDPC in 2006–2010 (by source)

Source	2006		2007		2008		2009		2010	
	€ thousand	%	€ thousand	%	€ thousand	%	€ thousand	%	€ thousand	%
State budget	**5,585**	**51,3**	**5,984**	**52,9**	**6,352**	**53,9**	**6,283**	**54,0**	**5,880**	**51.3**
GCDPC	3,841	35,3	3,798	33,6	3,573	30,3	3,527	30,3	3,214	28.0
Ministry of Education	56	0,5	59	0,5	115	1,0	54	0,5	53	0.5
Ministry of Labour and Social Affairs	1,460	13,4	1,872	16,6	2,350	19,9	2,441	21,0	2,428	21.2
Ministry of the Interior	4	0,0	5	0,0	5	0,0	0	0,0	0	0.0
Ministry of Health	134	1,2	203	1,8	240	2,0	238	2,0	117	1.0
Ministry of Justice	4	0,0	14	0,1	22	0,2	21	0,2	21	0.2
Other ministries	0	0,0	0	0,0	18	0,1	0	0,0	0	0.0
Labour Offices	86	0,8	34	0,3	29	0,2	0	0,0	48	0.4
Local budgets	**3,504**	**32,2**	**3,821**	**33,8**	**4,033**	**34,2**	**4,204**	**36,1**	**3,933**	**34.3**
Regions	1,886	17,3	2,312	20,4	1,796	15,2	2,441	21,0	3,443	30.0
Municipalities	1,618	14,9	1,508	13,3	2,237	19,0	1,763	15,2	490	4.3
Other home resources	**1,790**	**16,5**	**1,213**	**10,7**	**1,249**	**10,6**	**990**	**8,5**	**1,613**	**14.1**
Sponsorship and fundraising	306	2,8	212	1,9	240	2,0	199	1,7	258	2.3
Services' own earnings and clients' contributions	542	5,0	516	4,6	480	4,1	538	4,6	750	6.5
Endowments	362	3,3	55	0,5	51	0,4	0	0,0	106	0.9
Others	579	5,3	430	3,8	477	4,1	253	2,2	498	4.3
Foreign resources	**0**	**0,0**	**291**	**2,6**	**154**	**1,3**	**153**	**1,3**	**39**	**0.3**
EU funds	0	0,0	237	2,1	111	0,9	153	1,3	39	0.3
Other foreign resources	0	0,0	55	0,5	43	0,4	0	0,0	0	0.0
Total	**10,879**	**100,0**	**11,309**	**100,0**	**11,787**	**100,0**	**11,630**	**100,0**	**11,465**	**100.0**

Note: 2009 average exchange rate was used (1€ = CZK 26.445) for recalculation in 2006–2009. 2010 average exchange rate (1€ = CZK 25.290) was used) for recalculation in 2010.

[33] The set of projects supported by the GCDPC may be considered the core of the Czech network of drug services provided by the non-governmental non-health sector.

Table 1-7: 2010 drug policy expenditures from state and local budgets by location (region) of use (€ thousand)

Regions	GCDPC	Ministry of Education	Ministry of Defence	Ministry of Labour and Social Affairs	Ministry of Health	Ministry of Justice	General Customs Head-quarters	National Drug Head-quarters	Total state budget	Regions	Municipa-lities	Total local budgets	Total	Total (%)
Prague	801	49	–	409	145	–	–	–	**1,405**	2,046	422	**2,468**	**3,873**	**15.6**
Central Bohemia	94	71	–	803	27	–	–	–	**995**	645	206	**851**	**1,846**	**7.4**
South Bohemia	160	37	–	149	44	–	–	–	**390**	331	67	**398**	**788**	**3.2**
Pilsen	163	19	–	52	16	–	–	–	**251**	274	295	**570**	**821**	**3.3**
Karlovy Vary	54	16	–	45	15	–	–	–	**129**	232	16	**247**	**376**	**1.5**
Ústí nad Labem	274	21	–	252	26	–	–	–	**572**	184	305	**489**	**1,062**	**4.3**
Liberec	65	29	–	133	0	–	–	–	**227**	325	109	**434**	**661**	**2.7**
Hradec Králové	79	41	–	18	24	–	–	–	**162**	273	28	**301**	**462**	**1.9**
Pardubice	52	30	–	66	0	–	–	–	**148**	269	69	**338**	**486**	**2.0**
Vysočina	61	58	–	217	7	–	–	–	**342**	134	30	**164**	**506**	**2.0**
South Moravia	270	33	–	302	43	–	–	–	**648**	636	226	**862**	**1,510**	**6.1**
Olomouc	194	47	–	276	6	–	–	–	**523**	346	92	**438**	**961**	**3.9**
Zlín	73	22	–	104	1	–	–	–	**201**	696	124	**820**	**1,020**	**4.1**
Moravia-Silesia	141	24	–	133	1	–	–	–	**299**	1,267	466	**1,733**	**2,032**	**8.2**
Expenditure with regional designation	2,481	497	–	2,959	355	–	–	–	**6,292**	7,660	2,454	**10,113**	**16,405**	**66.1**
Expenditure with central designation	900	95	173	668	494	280	83	,5,709	**8,402**	0	0	**0**	**8,402**	**33.9**
Total	**3,381**	**592**	**173**	**3,628**	**849**	**280**	**83**	**,5,709**	**14,694**	**7,660**	**2,454**	**10,113**	**24,807**	**100.0**
– including investment expenditure	0	0	0	0	32	0	83	0	**115**	0	0	**0**	**115**	**0.5**
Total (%)	**13.6**	**2.4**	**0.7**	**14.6**	**3.4**	**1.1**	**0.3**	**23,0**	**59.2**	**30.9**	**9.9**	**40.8**	**100.0**	**–**

Table 1-8: 2010 drug policy expenditures in the Czech Republic by service categories (€ thousand)

Service category		GCDPC	Ministry of Education	Ministry of Defence	Ministry of Labour and Social Affairs	Ministry of Health	Ministry of Justice	General Customs Head-quarters	National Drug Head-quarters	Total state budget	Regions	Municipa-lities	Total local budgets	Total	Total (%)
Primary prevention		110	592	173	–	30	0	–	–	**905**	1,024	535	**1,559**	**2,463**	**9.9**
Harm Reduction	Low-threshold centres	974	–	–	1,273	48	–	–	–	**2,296**	890	689	**1,579**	**3 874**	**15.6**
	Outreach programmes	549	–	–	740	16	–	–	–	**1,305**	606	454	**1,060**	**2 365**	**9.5**
	Unspecified*	220	–	–	,0	1	–	–	–	**221**	82	30	**112**	**332**	**1.3**
	Total	1,744	–	–	2,013	64	0	0	0	**3,821**	1,578	1,173	**2,750**	**6 572**	**26.5**
Treatment	Health care**	50	–	0	36	302	46	–	–	**434**	280	79	**360**	**794**	**3.2**
	Non-health outpatient care ***	266	–	–	323	0	101	–	–	**690**	355	189	**544**	**1 234**	**5.0**
	Therapeutic communities	730	–	–	838	0	–	–	–	**1,568**	559	148	**708**	**2 276**	**9.2**
	Total	1,046	0	0	1,197	302	148	0	0	**2,693**	1,195	417	**1,612**	**4 304**	**17.4**
Sobering-up stations		–	–	–	0	0	–	–	–	**0**	3,418	32	**3,449**	**3,449**	**13.9**
Aftercare		290	–	–	418	0	0	–	–	**707**	325	205	**531**	**1,238**	**5.0**
Law enforcement		–	–	0	0	0	115	83	5,709	**5,906**	0	0	**0**	**5,906**	**23.8**
Coordination, research, evaluation		192	0	0	0	420	18	0	0	**630**	83	36	**119**	**749**	**3.0**
Others, unspecified		0	0	0	0	32	0	0	0	**32**	37	55	**93**	**125**	**0.5**
Total		**3,381**	**592**	**173**	**3,628**	**849**	**280**	**83**	**5,709**	**14,694**	**7,660**	**2,454**	**10,113**	**24,807**	**100.0**

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

1.3.2 Drug Treatment Costs Incurred by Health Insurance Companies

In 2010, for the first time, it was possible to obtain data, pertaining to the period 2007–2009, on the costs incurred by health insurance companies in relation to the treatment of drug users. The data are processed by the Czech Statistical Office using the information from health account statistics compiled in line with the System of Health Accounts international methodology designed for the comprehensive reporting of all the expenditures[34] on health care, or health services in general terms, while differentiating between the individual sources of the funding of health care. In the Czech Republic, health care is funded from three main sources: health insurers (public health insurance), public budgets (the state budget, local budgets), and households. Covering approximately three quarters of all the expenses, health insurers provide the largest segment of funding.

The total volume of expenditures incurred by health insurers amounted to CZK 169 billion (€ 6,682 million) in 2007, CZK 180 billion (€ 7,117 million) in 2008, and CZK 209 billion (€ 8,264 million) in 2009. CZK 6.4 billion (€ 253 million), CZK 6.6 billion (€ 261 million), and CZK 7.7 billion (€ 304 million) were spent on the treatment of mental and behavioural disorders (Chapter V, ICD-10) in 2007, 2008, and 2009 respectively. On the basis of data reported by health insurers, the annual costs of treatment related to conditions caused by psychoactive substance use (excluding alcohol; dg. F11–F19) were estimated to have amounted to CZK 336 million (€ 13,267 thousand), CZK 395 million (€ 15,628 thousand), and CZK 448 million (€ 17,703 thousand) in the years 2007, 2008, and 2009 respectively.

In this section, the costs incurred by health insurers in relation to the F11–F19 diagnostic groups are broken down according to the type of healthcare facility and the type of health care provided, as specified in the code list of contractual specialisations.

The diagnosis classification may be used to divide the health insurers' costs into those associated with the primary diagnosis and other costs bearing no relationship to the diagnosis. The diagnosis-related costs are categorised into diagnosis groups which correspond to the ICD-10 chapters and are further broken down into diagnosis classes. The F11–F19 diagnoses, i.e. mental and behavioural disorders caused by psychoactive substances other than alcohol, constitute one of the diagnosis classes. In the tables below, these directly identifiable costs incurred by health insurers are indicated in the column called Identifiable diagnosis-specific costs. They accounted for an average of 70% of the total annual costs incurred by health insurers in relation to treatment for the use of drugs other than alcohol in the period under scrutiny.

The remaining costs with no link to a diagnosis had to be adjusted before being processed. They had to be set apart from health insurance companies' operating costs, per capita payments to general practitioners for adults, per capita payments to general practitioners for children and adolescents, and some other costs of care which cannot be determined on the basis of contractual specialisations, or are recorded separately for the sake of greater statistical accuracy, but are defined using other suitable methods, such as a group of health interventions and codes from the classifiers of health resources. The following costs incurred by health insurers were further excluded from these additional costs of care: convalescent care, spa care in spa sanatoria for children, acute and emergency care provided abroad, refunds to patients, vaccination provided by general practitioners for children and adolescents, preventive check-ups by general practitioners, and occupational medicine related to the specialisation of an occupational physician for adults. On average, in the years 2007–2009 these costs accounted for almost a quarter of the costs other than those linked to a specific diagnosis.

Following the above adjustments, the other costs were used as the basis for the estimation of the total amount of unidentifiable costs of the F11–F19 diagnoses. The share of the costs of this group of diagnoses in the overall identifiable costs (i.e. diagnosis-related costs) was used to estimate the share of the costs of this group of diagnoses in the total amount of unidentifiable costs. This total volume of the remaining costs incurred by health insurers in relation to drug treatment was further broken down according to the type of healthcare facility and the type of health care provided (by different specialist physicians).

The costs incurred by health insurers in relation to the treatment of users of non-alcohol drugs by different health facilities are summarised in Table 1-9. Unidentifiable costs attributed to the different types of facilities were estimated using the structure of the overall unidentifiable costs. The largest proportion of the total costs (73%) incurred by health insurers (i.e. both directly identifiable and estimated unidentifiable expenditures) in relation to the F11–F19 diagnoses was spent on inpatient healthcare facilities in the period under study (hospitals and psychiatric hospitals consumed 30% and 39%, respectively, of the resources). These costs encompass those expended on inpatient care, as well as those covering other types of care, including outpatient and pharmaceutical services, provided by these inpatient facilities. Independent outpatient facilities accounted for 7% of the total costs incurred by health insurers in relation to the F11–F19 diagnoses, of which 3% and almost 14% were paid to specialist physicians (mainly outpatient psychiatric services) and pharmacies respectively. The cost

[34] Although there is a material distinction between the terms "expenditure" and "cost" involving different accruals, both terms will be used interchangeably and referred to as "costs" throughout the following section.

of pharmacies (44%) and hospitals (35%) was estimated to constitute the largest proportion of unidentifiable costs incurred by health insurers.

Health insurers' unidentifiable costs were broken down to account for the individual specialisations and other costs using the same method as that applied when categorising the costs according to different healthcare facilities. The largest proportion of the total costs incurred by health insurers in the years 2007–2009 was spent on specialisations associated with inpatient psychiatric and alcohol/drug treatment (approximately one half). Specialisations associated with outpatient psychiatric and alcohol/drug treatment accounted for 5%, while prescription medication was covered by 18% of the costs incurred by health insurers. The cost of prescription medication was estimated to constitute the largest proportion of unidentifiable costs (60%). Health insurers' costs by specialisation are presented in Table 1-10.

Table 1-9: Costs incurred by health insurance companies in relation to the F11–F19 diagnoses according to the type of health facility in 2007–2009 (€ thousand)

Type of health facility	2007			2008			2009		
	Identifiable diagnosis-specific costs	Estimated unidentifiable costs	Overall costs	Identifiable diagnosis-specific costs	Estimated unidentifiable costs	Overall costs	Identifiable diagnosis-specific costs	Estimated unidentifiable costs	Overall costs
Hospitals (university hospitals and acute care)	2,843	1,337	4,180	3,099	1,588	4,687	3,262	1,994	5,256
Psychiatric institutes for adults	5,154	3	5,156	5,997	3	6,000	6,835	3	6,838
Psychiatric institutes for children	56	0	56	95	0	95	79	0	79
Other inpatient facilities	163	156	319	156	170	327	230	216	446
Inpatient facilities in total	**8,216**	**1,496**	**9,711**	**9,348**	**1,761**	**11,109**	**10,406**	**2,213**	**12,619**
Independent specialists	377	39	416	376	69	445	422	116	538
Drug treatment facilities	49	0	49	62	0	62	82	0	82
Independent psychologists' facilities	40	0	40	39	0	39	56	0	56
Other outpatient facilities	339	156	495	295	132	427	342	207	549
Independent outpatient facilities in total	**805**	**195**	**1,000**	**772**	**200**	**97**	**901**	**323**	**1,225**
Medical transport and emergency services	171	6	177	176	2	178	188	3	191
Psychotherapeutic day care centres	37	0	38	29	1	30	25	1	26
Other special facilities	3	0	4	5	1	6	6	1	6
Special facilities in total	**211**	**6**	**218**	**210**	**3**	**213**	**219**	**5**	**224**
Pharmacies	74	1,926	2,001	43	2,067	2,109	15	2,184	22
Medical device dispensaries	1	79	80	1	101	102	0	115	115
Facilities of pharmaceutical services in total	**75**	**2,005**	**2,080**	**44**	**2,168**	**2,211**	**15**	**2,298**	**2,313**
Other healthcare facilities*	**4**	**0**	**5**	**6**	**1**	**7**	**30**	**97**	**128**
Unspecified healthcare facilities	**44**	**209**	**253**	**817**	**298**	**1,115**	**518**	**677**	**1,195**
Health insurers' costs in total	**9,356**	**3,911**	**13,267**	**11,197**	**4,431**	**15,628**	**12,089**	**5,614**	**17,703**

*Note: * Public health authorities, other agencies of the Ministry of Health, and other health establishments. 2010 average exchange rate (1€ = CZK 25.290) was used) for recalculation in all years.*

Table 1-10: Costs incurred by health insurance companies in relation to the F11–F19 diagnoses according to the type of specialisation in 2007–2009 (€ thousand)

Specialisation		**2007**			**2008**			**2009**		
		Identifiable diagnosis-specific costs	Estimated unidentifiable costs	Overall costs	Identifiable diagnosis-specific costs	Estimated unidentifiable costs	Overall costs	Identifiable diagnosis-specific costs	Estimated unidentifiable costs	Overall costs
Specialisations associated with outpatient psychiatric and alcohol/drug treatment		768	19	787	790	1	791	855	2	858
Specialisations associated with inpatient psychiatric and alcohol/drug treatment		6,579	0	6,579	7,792	0	7,792	9,017	0	9,017
Complement* specialisations		1,299	77	1,375	1,215	86	1,301	1,353	150	1,504
Clinical psychology services		83	0	83	90	0	90	107	1	108
Emergency medical services		148	0	148	157	0	157	165	0	165
Other specialisations		475	945	1,420	547	1,151	1,699	558	1,715	2,273
Other costs		5	2,870	2,875	605	3,193	3,799	33	3,745	3,778
Including	Prescription drugs	0	2,504	2,504	0	2,686	2,686	0	3,207	3,207
	Medical devices	3	304	3,7	5	332	337	1	421	422
	Preventive programmes (utilisation of prevention fund)	0	62	62	599	146	745	27	111	138
Health insurers' costs in total		**9,356**	**3,911**	**13,267**	**11,197**	**4,431**	**15,628**	**12,089**	**5,614**	**17,703**

*Note: * Common clinical and paraclinical units. 2010 average exchange rate (1€ = CZK 25.290) was used) for recalculation in all years.*

2 Drug Use in the General Population and Specific Targeted Groups

Two independent surveys on representative samples of the population of the Czech Republic were carried out in 2010. The prevalence levels of illicit drug use identified by both surveys are very much the same. The surveys carried out in the past three years show that the level of experience with the use of illicit drugs among the general population is stable, with cannabis and ecstasy being the most frequently used illegal drugs in the adult population (23–34 and 4–10% respectively). The last-year use of cannabis was reported by 10–15% of respondents, while less than 4% of the adults that were interviewed reported the use of other illegal drugs. The last-month use of illegal drugs other than cannabis has long been reported by less than 1% of respondents. Young adults aged from 15 to 34 show higher levels of use: approximately one fifth of them had experienced cannabis in the last year.

The HBSC international survey showed that the number of students in the ninth grade of elementary school who had used marijuana rose between 2006 and 2010 to reach the level of 30.5% for lifetime prevalence and 21.5% for last-year prevalence.

According to a study focusing on intensive cannabis use, the use of cannabis poses a relatively low risk for 70% of users. Up to 10% of cannabis users, however, are at significant risk of problems associated with the use of cannabis-based drugs and dependence on them. When extrapolated to the Czech population as a whole, this proportion corresponds to approximately 1.0–1.5% of the adult population, i.e. 75–110 thousand high-risk cannabis users, mainly young adults.

A special study focusing on the use of legal highs (which have effects similar to those produced by traditional illegal drugs but are not scheduled as illegal substances) showed that almost 5% of young adults in the Czech Republic have tried these substances; a similar result was also generated in the Czech Republic by the Eurobarometer survey.

The surveys investigating public attitudes to drug use indicate that the Czech population is generally tolerant towards the use of cannabis: an absolute majority supports the legalisation of the cultivation and possession of cannabis, especially for medical purposes.

Additionally, the first representative study on drug use among the prison population was conducted and the results of further studies on drug use in nightlife settings were made available. Both subpopulations show dramatically higher levels of experience of drug use than the general population.

2.1 Drug Use in the General Population

2.1.1 Representative Studies in 2010

2.1.1.1 Survey on Czech Citizens' Opinions and Attitudes

As part of the Survey on Czech Citizens' Opinions about and Attitudes to the Issues of Health and Healthy Lifestyles conducted by the INRES–SONES Agency (2010 Citizen Survey), a representative sample comprising 1793 inhabitants of the Czech Republic aged over 15 years was interviewed in the autumn of 2010[35]. In addition to questions concerning the issue of health and healthy lifestyles, the respondents were asked about their experience with illicit drug use.

Traditionally, cannabis (marijuana and hashish) is by far the most widespread illegal drug; 30.5% of the respondents have used the drug at least once in their lifetime, with men showing considerably higher levels of use than women (38.6% vs. 22.3%) (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010b). According to this 2010 study, almost half of the respondents (49.3%) in the 15–34 age group have had some experience with cannabis. However, the prevalence of marijuana use in the last year was significantly lower. The last-year use of marijuana was reported by 10.4% of the respondents (aged 15–64), of whom men and women accounted for 14.8% and 6.0% respectively; 27% of the respondents in the 15–34 age group reported having tried a cannabis-based drug in the last year. The last-month use of cannabis was reported by 4.2% of the population aged 15–64, with the highest rates again being observed among the 15–24 (8.9%) and 25–34 (7.2%) age groups.

2.1.1.2 Selected Aspects of the Drug Problem from Citizens' Perspective

In September 2010 the Institute for Criminology and Social Prevention carried out a survey called Selected Aspects of the Drug Problem from Citizens' Perspective. Among other variables, the study, conducted in association with the *Factum Invenio* Agency, looked into citizens' experiences with addictive substances. The survey was designed as an omnibus study applying the face-to-face interview method to a representative sample of the population of the Czech Republic aged over 15 years. The sample, comprising 2044 respondents, was recruited using quota sampling; see Table 2-2.

[35] Results presented below are for the 15-24 (very young adults), 15-34 (young adults), and 15-64 (adults in total) age groups, i.e. standard EMCDDA age groups.

In comparison to the aforementioned 2010 Citizen Survey, the lifetime prevalence of cannabis use in the 15–64 age group identified by this study shows a lower level, 23.4% (Institut pro kriminologii a sociální prevenci, 2010). As regards the last-year and last-month prevalence rates of the use of cannabis, however, both studies produced very similar results; according to the 2010 survey conducted by the Institute for Criminology and Social Prevention, the respective prevalence rates were 9.7% and 4.5%. In the 15–34 age group, i.e. young adults, lifetime experience with cannabis reached 38.9%; the prevalence rates for use in the last year and last 30 days were reported at 20.3% and 9.2%. The second most commonly used addictive substance among people of this age group (15–34 years) was ecstasy, with the respective prevalence rates of 14.7%, 3.9%, and 1.3%, followed by hallucinogenic mushrooms, amphetamines (pervitin), and LSD. For all the drugs, men showed higher prevalence rates of use than women. The highest level of experience with illegal drugs was reported by very young adults aged 15–24.

Table 2-1: Prevalence rates of use of selected illicit drugs recorded by the 2010 Citizen Survey, in % (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010b)

Prevalence	**Drug**	**Gender**		**Selected age groups**		**Total**
		Males (n=751)	Females (n=736)	15–24 years (n=270)	15–34 years (n=615)	15–64 years (N=1487)
Lifetime prevalence	Marijuana or hashish	38.6	22.3	52.2	49.3	30.5
	Ecstasy	4.8	3.1	7.4	7.8	4.0
	Amphetamines, pervitin	1.9	1.0	2.2	2.9	1.4
	Cocaine	1.5	0.4	0.4	1.6	0.9
	Heroin	0.5	0.1	0.0	0.5	0.3
	LSD	4.1	1.0	3.7	5.0	2.6
	Hallucinogenic mushrooms	5.7	2.9	8.9	8.1	4.3
	Inhalants	1.3	0.8	1.1	1.5	1.1
Prevalence in the last 12 months	Marijuana or hashish	14.8	5.8	23.7	20.7	10.4
	Ecstasy	0.8	0.7	2.6	1.6	0.7
	Amphetamines, pervitin	0.4	0.3	0.4	0.8	0.3
	Cocaine	0.7	0.0	0.0	0.5	0.3
	Heroin	0.3	0.0	0.0	0.3	0.1
	LSD	0.4	0.1	0.7	0.7	0.3
	Hallucinogenic mushrooms	1.6	0.5	2.6	2.3	1.1
	Inhalants	0.7	0.5	0.0	0.8	0.6
Prevalence in the last 30 days	Marijuana or hashish	6.0	2.3	8.9	8.0	4.2
	Ecstasy	0.1	0.0	0.0	0.2	0.1
	Amphetamines, pervitin	0.0	0.0	0.0	0.0	0.0
	Cocaine	0.1	0.0	0.0	0.2	0.1
	Heroin	0.3	0.0	0.0	0.3	0.1
	LSD	0.1	0.0	0.0	0.2	0.1
	Hallucinogenic mushrooms	0.5	0.1	0.4	0.7	0.3
	Inhalants	0.3	0.4	0.0	0.5	0.3

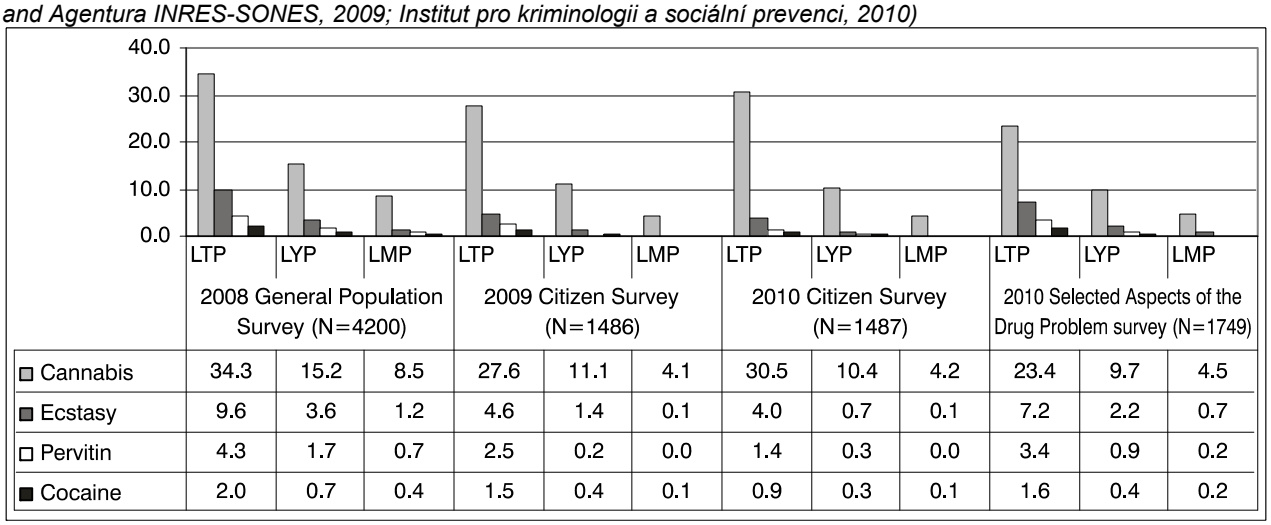
Table 2-2: Prevalence rates of use of selected licit and illicit drugs recorded by the 2000 survey Selected Aspects of the Drug Problem from Citizens' Perspective, in % (Institut pro kriminologii a sociální prevenci, 2010)

Prevalence	Drug	Gender		Selected age groups		Total
		Males (n=859)	Females (n=890)	15–24 years (n=271)	15–34 years (n=674)	15–64 years (N=1749)
Lifetime prevalence	Tobacco	78.2	59.9	71.2	72.3	68.9
	Alcohol	95.2	93.3	90.8	93.8	94.2
	Marijuana or hashish	29.8	17.3	40.2	38.9	23.4
	Ecstasy	8.5	6.0	16.6	14.7	7.2
	Amphetamines, pervitin	4.0	2.9	6.6	5.9	3.4
	Cocaine	2.3	0.9	1.5	1.9	1.6
	Heroin	1.9	0.4	1.8	1.8	1.1
	LSD	3.3	1.9	5.2	4.7	2.6
	Hallucinogenic mushrooms	6.8	4.2	11.8	9.2	5.4
Prevalence in the last 12 months	Tobacco	55.8	37.8	57.6	52.5	46.6
	Alcohol	90.6	85.4	84.9	89.3	87.9
	Marijuana or hashish	13.6	5.8	25.1	20.3	9.7
	Ecstasy	2.8	1.6	6.6	3.9	2.2
	Amphetamines, pervitin	0.9	0.8	2.6	1.6	0.9
	Cocaine	0.6	0.2	0.0	0.4	0.4
	Heroin	0.5	0.1	0.4	0.3	0.3
	LSD	0.7	0.2	1.5	0.9	0.5
	Hallucinogenic mushrooms	1.3	0.6	3.0	1.9	0.9
Prevalence in the last 30 days	Tobacco	48.4	32.5	46.5	43.8	40.3
	Alcohol	74.7	57.5	60.5	67.1	66.0
	Marijuana or hashish	6.6	2.4	12.5	9.2	4.5
	Ecstasy	1.2	0.3	3.0	1.3	0.7
	Amphetamines, pervitin	0.1	0.3	1.1	0.4	0.2
	Cocaine	0.2	0.1	0.0	0.3	0.2
	Heroin	0.2	0.1	0.0	0.1	0.2
	LSD	0.1	0.0	0.0	0.1	0.1
	Hallucinogenic mushrooms	0.2	0.2	0.4	0.3	0.2

2.1.2 Comparison of Drug Use Prevalence Rates as Recorded by Selected Surveys from the Period 2008–2010

The surveys carried out in the years 2008–2010 show the same pattern of drug use among the general population, with (slight) differences found in the prevalence rates for the individual types of drugs. The most frequently used illicit drug is cannabis (23.4–34.3%, depending on the study), followed by ecstasy (4.0–9.6%). Last-year cannabis use was reported by 9.7–15.2% of the respondents, while the use of other illegal drugs was reported by less than 4% of the respondents. The last-month use of illegal drugs other than cannabis was reported by less than 1% of the respondents, which has been the case for a long time; see Figure 2-1. The differences in prevalence rates generated by the surveys result from the different data collection methodologies and different contexts of the studies; the highest prevalence rates of the use of addictive substances were recorded by the 2008 General Population Survey on the Use of Psychotropic Substances in the Czech Republic, a monothematic research project focusing specifically on illicit drug use.

Figure 2-1: Comparison of prevalence rates of the use of illegal drugs as recorded by selected surveys from the period 2008–2010, for the 15–64 age group, in % (Běláčková and Horáková, 2011; Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010b; Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2009; Institut pro kriminologii a sociální prevenci, 2010)



	2008 LTP	2008 LYP	2008 LMP	2009 LTP	2009 LYP	2009 LMP	2010 LTP	2010 LYP	2010 LMP	2010 (N=1749) LTP	2010 (N=1749) LYP	2010 (N=1749) LMP
Cannabis	34.3	15.2	8.5	27.6	11.1	4.1	30.5	10.4	4.2	23.4	9.7	4.5
Ecstasy	9.6	3.6	1.2	4.6	1.4	0.1	4.0	0.7	0.1	7.2	2.2	0.7
Pervitin	4.3	1.7	0.7	2.5	0.2	0.0	1.4	0.3	0.0	3.4	0.9	0.2
Cocaine	2.0	0.7	0.4	1.5	0.4	0.1	0.9	0.3	0.1	1.6	0.4	0.2

Note: LTP – lifetime prevalence, LYP – prevalence of use in the last 12 months, LMP – prevalence of use in the last 30 days.

2.1.3 Validation Study of Cannabis Scales

In the autumn of 2010, in association with the EMCDDA and the *Median Agency*, the National Focal Point conducted a study aimed at validating the Cannabis Abuse Screening Test (CAST), a short scale used to assess the level of intensive or risky cannabis use, against M-CIDI scale (Munich – Composite International Diagnostic Interview), a standard diagnostic measure for the assessment of disorders associated with drug use. The CAST scale validation study was conducted on a sample of 358 respondents (265 individuals aged 15–64, to which another 93 people in the 15–34 age group were added) who had reported the use of cannabis in the last 12 months. This final study sample was recruited from a sample of 2461 responents from the general population in the 15–64 age group, with the addition of respondents aged 15–34. Data were collected using the CAWI (Computer-Assisted Web Interviewing) method, i.e. via the internet, which resulted, as expected, in the overrepresentation of the segment of the population with higher education. Hence, the basic sample cannot be considered representative of the Czech Republic. After the sample had been adjusted by reweighting, the prevalence levels identified corresponded to the results of the representative surveys specified above.

The respondents included in the CAST module who had reported the use of marijuana or hashish in the last 12 months were asked to answer six questions inquiring about various aspects of problem cannabis use[36]. The transformation and the summing-up of all six variables result in a scale from 0 to 6, where one point or none indicates low risk, 2–3 points moderate risk, and 4 or more points show high-risk cannabis use which already requires professional intervention (Beck and Legleye, 2008).

The respondents' distribution on the CAST risk scale suggests that the use of cannabis-related drugs poses a relatively low risk for 71.2% of users. On the contrary, 9.5% of cannabis users (12.2% and 5.0% of men and women respectively) expose themselves to a significant risk, and, accordingly, it would be appropriate to provide them with professional interventions; see Table 2-3. When extrapolated to the Czech population as a whole, this proportion corresponds to approximately 1.0–1.5% of the adult population, i.e. 75–110 thousand high-risk cannabis users. Although the number of respondents from older age groups is relatively small, the 35–44 age group appears to show the highest rates of cannabis users at most risk.

[36] The respective items concerned cannabis use before midday, when alone, memory problems, recommendations from friends and parents to reduce or stop cannabis use, unsuccessful attempts to reduce or stop cannabis use, and use-related problems (arguments, fights, accidents, bad results at school, etc.).

Table 2-3: CAST scale results – levels of risk (probability of cannabis-related problems) among current cannabis users, in % (Národní monitorovací středisko pro drogy a drogové závislosti, 2010b)

CAST levels of risk	Gender		Age groups					
	Male	Female	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	15–64 years
	General population (n=164)	General population (n=101)	Over-sampled population (n=158)	Over-sampled population (n=109)	General population (n=44)	General population (n=20)	General population (n=28)	General population (n=265)
No or low risk	66.5	79.2	75.9	71.6	65.9	65.0	89.3	71.2
Moderate risk	21.3	15.8	15.8	22.0	18.2	30.0	10.7	19.3
High risk	12.2	5.0	8.2	6.4	15.9	5.0	0.0	9.5

The M-CIDI questionnaire, containing 8 items measuring cannabis abuse and 11 items testing for cannabis dependence, was used as a comparative module in validating the CAST scale. Developed on the basis of the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the questionnaire may be used to assess cannabis abuse and dependence.

When evaluated against the DSM-5 criteria, the M-CIDI results suggest that 67.8% of users of cannabis (those who had used it in the last 12 months) show no signs of dependence or abuse of the substance, while 21.4% and 10.8% of the users meet the criteria for cannabis abuse and dependence respectively. When this methodology was used, because of the very small sample again, cannabis users in the 35–44 age group also accounted for the largest proportion of people meeting the dependence criteria; see Table 2-4.

Table 2-4: M-CIDI scale results, in % (Národní monitorovací středisko pro drogy a drogové závislosti, 2010b)

M-CIDI	Total	Gender		Age				
	15–64 years	Male	Female	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years
	General population (n=265)	General population (n=164)	General population (n=101)	Over-sampled population (n=158)	Over-sampled population (n=109)	General population (n=44)	General population (n=20)	General population (n=28)
No signs	67.8	63.6	74.8	66.9	73.1	61.5	78.6	70.1
Cannabis abuse	21.4	26.0	13.8	24.1	15.6	18.5	14.1	29.9
Cannabis dependence	10.8	10.4	11.4	9.0	11.3	20.0	7.3	0.0

2.1.4 Use of New Synthetic Drugs

In the spring of 2011 the National Focal Point, in association with the *Median Agency*, carried out a questionnaire survey among internet users looking into the use of new synthetic drugs (legal highs) and the market practices associated with them (Národní monitorovací středisko pro drogy a drogové závislosti and Median, 2011a). These substances produce effects similar to those caused by illegal drugs, but are not controlled as narcotic and psychotropic substances under Act No. 167/1998 Coll., on addictive substances. 1091 respondents aged from 15 to 34, which constitutes a representative group of internet users, participated in the survey.

Out of the total number of respondents, lifetime cannabis use was reported by 56.3% (61.9% and 50.3% of men and women respectively). A total of 10.6% reported that they had used ecstasy (12.3% and 8.9% of men and women respectively) and 10.8% had used hallucinogenic mushrooms (13.9% and 7.5% of men and women respectively). 7.3% of the respondents reported experience with pervitin or amphetamines, and 7.9% had used LSD; see Table 2-5. The last-year use of cannabis, hallucinogenic mushrooms, LSD, and ecstasy was reported by 20.5%, 2.7%, 2.6%, and 2.4% of the respondents respectively. In the last month, cannabis had been used by 9.5% of the respondents, while last-month ecstasy use was reported by 1.2%; see Table 2-5. The lifetime use of inhalants, ketamine, Subutex®, GHB, and poppers was reported by 3.1%, 1.4%, 0.9%, 1.1%, and 4.4% of the respondents respectively.

Similarly to the general population, men in the internet user population were more likely to have used illegal drugs. The results indicate that internet users show higher prevalence rates than the general population, which, to a varied extent, applies to all the drugs, in particular to cocaine.

A total of 50 respondents (4.5%) reported that they had used any one of the new synthetic drugs (6% and 3% of men and women respectively). A similar level of experience with the use of the new synthetic drugs among young adults in the Czech Republic was also recorded by the Eurobarometer survey (see below).

Table 2-5: Prevalence rates of use of selected legal and illegal drugs among the general population of internet users aged 15–34, in % (Národní monitorovací středisko pro drogy a drogové závislosti and Median, 2011a)

Prevalence	Drug	Gender		Age		Total
		Males (n=562)	Females (n=529)	15–24 (n=478)	25–34 (n=613)	15–34 (n=1091)
Lifetime prevalence	Tobacco	83.3	82.4	80.9	84.4	82.9
	Alcohol	98.8	97.3	98.5	97.8	98.2
	Marijuana and hashish	61.9	50.3	56.8	55.8	56.3
	Ecstasy	12.3	8.9	9.8	11.2	10.6
	Amphetamines, pervitin	7.0	7.6	7.1	7.3	7.3
	Cocaine	9.7	3.5	8.5	4.2	5.0
	Heroin	2.4	0.8	2.6	0.9	1.6
	LSD	9.8	5.8	8.7	8.1	7.9
	Hallucinogenic mushrooms	13.9	7.5	12.8	9.3	10.8
Prevalence in the last 12 months	Tobacco	49.7	50.9	57.7	44.5	50.2
	Alcohol	95.4	91.8	95.1	92.6	93.8
	Marijuana and hashish	26.6	14.1	28.4	14.4	20.5
	Ecstasy	3.6	1.1	3.6	1.4	2.4
	Amphetamines, pervitin	2.4	0.8	2.4	0.9	1.6
	Cocaine	3.2	0.2	2.4	1.2	1.7
	Heroin	0.9	0.0	0.9	0.2	0.5
	LSD	4.1	0.9	4.7	0.9	2.6
	Hallucinogenic mushrooms	3.9	1.3	4.9	0.9	2.7
Prevalence in the last 30 days	Tobacco	39.6	41.8	45.7	36.7	40.6
	Alcohol	88.1	77.8	85.2	81.5	83.1
	Marijuana and hashish	13.9	4.9	14.3	5.8	9.5
	Ecstasy	2.2	0.2	1.9	0.7	1.2
	Amphetamines, pervitin	1.2	0.1	1.1	0.3	0.7
	Cocaine	1.4	0.1	1.4	0.3	0.8
	Heroin	0.6	0.0	0.5	0.2	0.3
	LSD	1.2	0.0	0.9	0.4	0.6
	Hallucinogenic mushrooms	1.2	0.0	0.9	0.4	0.6

The second part of the survey involved a more detailed analysis of 151 respondents aged 15–34 (including 99 men) who had used any of the new synthetic drugs under study. Fifty of these respondents were recruited from the sample described above and another 101 respondents were selected using the snowball sampling technique. This part of the research focused on the use and procurement of these new synthetic drugs and specific aspects of the market in these drugs.

It was found that this subset of users of new synthetic drugs shows much greater experience with the use of all the legal and illegal drugs under scrutiny than their peers in the general population. For example, cannabis, ecstasy, pervitin, cocaine, and heroin had been used by 71%, 32%, 18%, 15%, and 7% of the respondents, respectively, in the last year; see Table 2-6. On the contrary to traditional results, women showed higher levels of experience with illicit drug use than men in a number of cases.

Table 2-6: Prevalence rates of use of selected legal and illegal drugs among internet users aged 15–34 who had used new synthetic drugs (legal highs), in % (Národní monitorovací středisko pro drogy a drogové závislosti and Median, 2011a)

Prevalence	Drug	Gender		Age		Total
		Males (n=99)	Females (n=52)	15–24 (n=109)	25–34 (n=42)	15–34 (n=151)
Lifetime prevalence	Tobacco	94.0	94.2	94.5	92.8	94.0
	Alcohol	100.0	100.0	99.9	100.0	100.0
	Marijuana and hashish	90.0	96.1	92.7	90.5	92.1
	Ecstasy	52.2	63.5	58.8	49.9	56.2
	Amphetamines, pervitin	20.2	23.1	40.4	35.7	39.0
	Cocaine	31.3	30.7	28.5	38.1	31.1
	Heroin	15.1	19.2	16.5	16.7	16.6
	LSD	30.3	48	50.4	26.2	31.8
	Hallucinogenic mushrooms	43.5	48.1	45.0	52.3	45.0
	Inhalants	21.2	26.9	24.8	19.0	23.1
	Ketamine	17.2	19.2	19.2	14.3	17.8
	Subutex®	19.3	17.2	19.3	16.7	18.5
	GHB	15.2	11.5	13.8	14.4	13.9
	Poppers	27.3	17.3	23.9	23.7	23.8
Prevalence in the last 12 months	Tobacco	85.9	86.5	88.1	80.9	86.1
	Alcohol	99.0	98.1	98.1	100.0	98.7
	Marijuana and hashish	71.8	69.2	71.6	69.1	70.9
	Ecstasy	32.3	32.7	34.0	28.5	32.4
	Amphetamines, pervitin	18.2	17.3	17.5	19.0	17.8
	Cocaine	17.2	11.5	14.7	16.7	15.2
	Heroin	7.0	7.7	5.5	11.9	7.3
	LSD	16.2	13.4	16.5	11.9	15.2
	Hallucinogenic mushrooms	16.2	23.1	19.3	23.7	18.5
	Inhalants	10.1	7.7	8.3	11.9	9.2
	Ketamine	9.1	5.7	7.3	9.5	7.9
	Subutex®	11.2	5.7	8.3	11.9	9.2
	GHB	8.1	1.9	4.6	9.6	6.0
	Poppers	18.2	7.7	13.8	16.6	14.5
Prevalence in the last 30 days	Tobacco	77.8	76.9	78.9	73.8	77.5
	Alcohol	86.9	90.4	86.2	92.9	88.1
	Marijuana and hashish	46.5	28.8	40.4	40.5	40.4
	Ecstasy	14.1	7.7	13.8	7.1	11.9
	Amphetamines, pervitin	11.1	7.7	9.2	11.9	9.9
	Cocaine	6.1	1.9	5.5	2.4	4.6
	Heroin	4.0	1.9	1.8	7.1	3.3
	LSD	5.1	3.8	3.7	7.1	4.6
	Hallucinogenic mushrooms	7.1	1.9	4.6	7.1	5.3
	Inhalants	4.0	5.8	2.8	9.5	4.6
	Ketamine	4.0	1.9	1.8	7.1	3.3
	Subutex®	6.1	1.9	3.7	7.1	4.6
	GHB	3.0	0	0.9	4.8	2.0
	Poppers	6.1	1.9	3.7	7.1	4.6

The question about the use of new synthetic drugs (legal highs) was open-ended – all 151 users of new synthetic drugs (NSDs) could state up to 10 NSDs that they had used, as it turned out that the way of inquiring about the use of specific NSDs poses a complex methodological problem. The reasons are that:

- NSDs and preparations which contain them are mostly supplied with no information about their composition;
- the chemical names of NSDs are complicated for a non-professional and there are no generally accepted single names (such as heroin or pervitin) for the substances under consideration;
- the commercial names of NSDs vary and it is not clear which specific substances they are associated with, and the market in NSDs may undergo changes in this respect.

A total of 149 valid responses were received to the open-ended question about the type of substance used (2 respondents could not remember the name of the NSD used). The answers included a mix of generic chemical names such as mephedrone, JWH, butylone, and DOB), the commercial names of the products (including Kokolino, Amsterdam, Rotterdam, and Euphoria), or various general descriptions (such as legal cannabis or substances similar to marijuana, pervitin, and cocaine). Following their categorisation, it may be estimated that at least one third of the respondents have used mephedrone or another cathinone (including mephedrone, butylone, products with the commercial names Konkret or Magic Apple, and so-called "legal speed") and approximately 10–15% have used herbal preparations containing synthetic cannabinoids (Euphoria, Spice, Amsterdam, legal cannabis, or substances similar to marijuana). In addition to a wide range of other chemical or commercial names for drugs belonging to different groups (including tryptamines, phenethylamines, and hallucinogens in general), the respondents often reported that they had used drugs referred to as similar to traditional drugs (ecstasy, LSD, etc.); in most cases it was impossible to establish what specific NSD they meant. Out of this sample comprising 151 respondents who have used new synthetic drugs at least once in their lifetime, 80% and 7% reported the use of NSDs in the last year and the last month respectively; the fact that the majority of lifetime experiences are concentrated within the period of the past year also shows that NSDs are a relatively new phenomenon. Regular use in the last year was reported by 2% of the respondents, repeated use by 51%, and one-off experience was stated by 47% of the respondents; thus, the majority of NSD users may rather be referred to as experimenters (Národní monitorovací středisko pro drogy a drogové závislosti and Median, 2011a).

For more information on new synthetic drugs (legal highs) see the chapters on Drug Use in the Nightlife Setting (p. 38) and Drug Markets (p. 131).

2.1.5 Attitudes towards Substance Use

2.1.5.1 Public Opinion Poll Centre's Surveys

The Public Opinion Poll Centre's annual survey of tolerance towards selected groups of people, involving a sample of 1306 respondents aged over 15 years, was conducted in March 2011. The research project includes items concerning drug addicts and people dependent on alcohol. The level of tolerance is identified by means of a question in which the respondents were asked to choose groups of people whom they would not like to have as their neighbours. Traditionally, Czech citizens were least tolerant towards drug addicts (89% would not like to have them as their neighbours), people with a criminal history (80%), and people dependent on alcohol (79%). In all these groups, however, relatively stable levels over time can be observed; the public acceptance of gays and lesbians is rising, while growing intolerance towards the mentally ill and people with a different skin colour has been experienced since 2003 (Centrum pro výzkum veřejného mínění, 2011b).

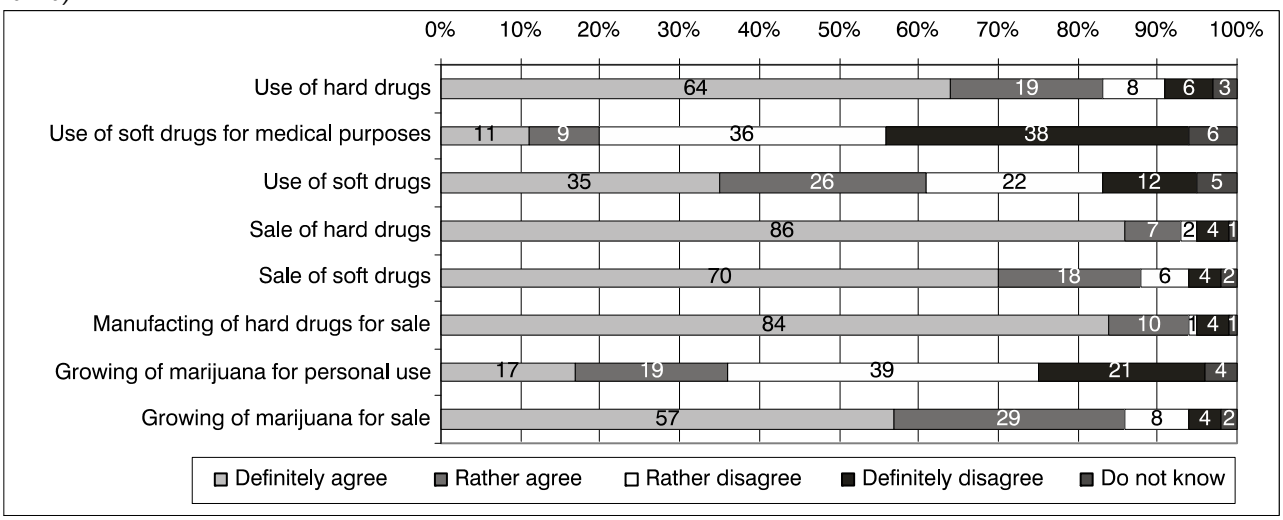
In May 2011 the Public Opinion Poll Centre conducted another representative survey (Citizens about Drugs) using a sample of 1115 respondents aged over 15 who were asked about their personal level of acceptance of substance use, their perception of the issue of drug treatment and support for drug users, and drug-related activities they consider criminally sanctionable.

The survey also addressed the direct and indirect experience of illicit drug use. A total of 26% of the respondents reported having used cannabis in their lifetime (47% and 54% of the respondents aged 15–19 and 20–29 respectively), and 4% reported experience with another drug, including pervitin, heroin, and ecstasy. A total of 42% of the respondents personally know somebody who has used cannabis and 17% of the respondents know users of other illegal drugs.

A total of 82% of the respondents find tobacco smoking acceptable and 77% also consider the consumption of alcohol acceptable behaviour. The use of pills (such as sleeping pills, painkillers, and tranquillisers) also meets with a high level of acceptance. Cannabis use, too, is acceptable for 25% of the interviewees (Centrum pro výzkum veřejného mínění, 2011a).

The vast majority of the respondents agree with criminal prosecution for the production and sale of drugs (88%–94% of the respondents); 86% of the interviewees are in favour of sanctions for the growing of marijuana for sale. 83% of the respondents stated that users of drugs other than cannabis should be prosecuted and 61% were in favour of the prosecution of cannabis users. A total of 60% of the interviewees were against sanctions for the cultivation of marijuana for personal use and 74% of the respondents were against sanctions for the medical use of cannabis; see Figure 2-2.

Figure 2-2: Attitudes towards criminal sanctions for selected activities, in % (Centrum pro výzkum veřejného mínění, 2011a)



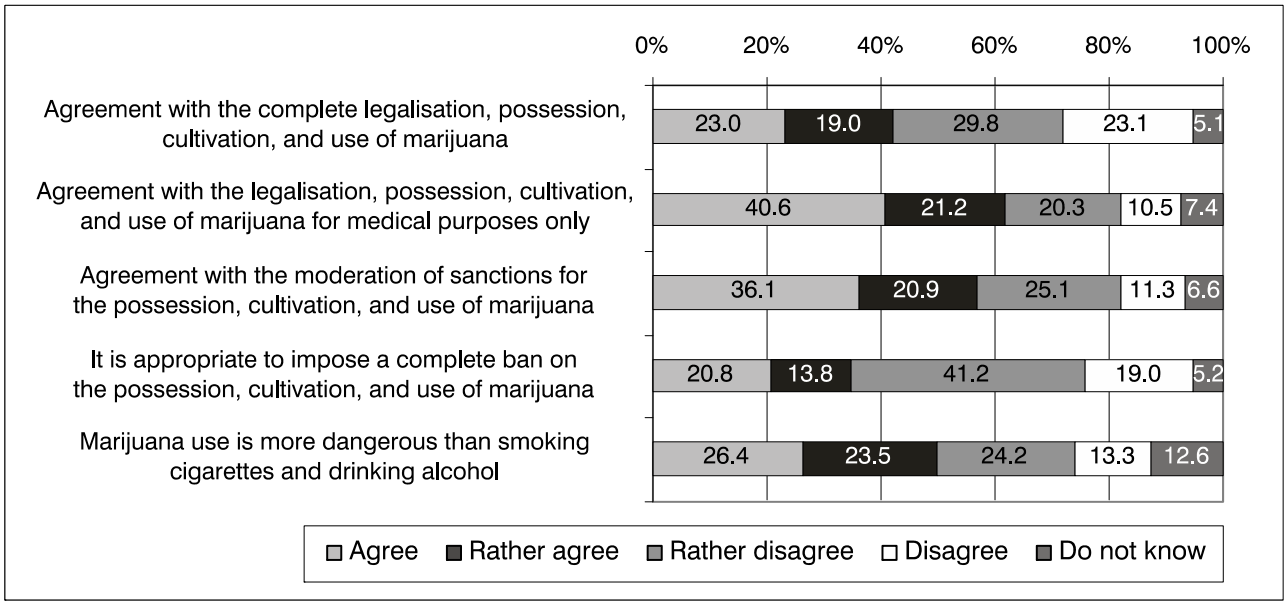
2.1.5.2 Public Attitudes towards the Legalisation of Cannabis

From May to June 2010 the SANEP Company conducted an internet survey involving a sample of 11,003 respondents aged 18–69 which focused on public attitudes towards the legalisation of marijuana, specifically on attitudes towards the possession, cultivation, and use of marijuana.

A total of 42% of the respondents supported the legalisation of the possession, cultivation, and use of cannabis, while 61.8% agreed with the legalisation of cannabis for medical use. 57% of the respondents agreed with the moderation of criminal sanctions for the possession and growing of cannabis (SANEP s.r.o., 2011).

A total of 49.9% of the respondents regarded marijuana use as being riskier than cigarette smoking and drinking, 37.5% found it less risky, and 12.6% of the respondents did not respond to this question; see Figure 2-3.

Figure 2-3: Public attitudes to the legalisation of marijuana according to the 2010 SANEP survey, in % (SANEP s.r.o., 2011)



2.1.5.3 Eurobarometer: Young People's Attitudes to Drugs

In 2011, as part of the Eurobarometer thematic survey, the Czech Republic became involved in a comparative study concerning young people's attitudes to drugs. A total of 503 respondents aged from 15 to 24 were interviewed in the Czech Republic. Data were collected using a telephone questionnaire (the Computer-Assisted Telephone Interview – CATI – method). The respondent sample was recruited by means of random sampling from a database of (landline) telephone numbers complemented by the snowball sampling technique involving the respondents providing contacts to their peers. The items under study included the perceived availability of both legal and illegal drugs, sources of information about drugs, drug-related health risks, and legal aspects of drug use.

The survey showed that, in comparison to their peers in other European countries, young people in the Czech Republic report relatively easy access to alcohol, tobacco, and cannabis (75% of the interviewees reported that it is

rather easy for them to obtain marijuana or hashish), but, contrary to other countries, they consider it more difficult to obtain heroin and cocaine (only 6% and 8% of the respondents, respectively, find these drugs easily available) (The Gallup Organization, 2011).

Altogether, 47% of the interviewees reported having experienced cannabis (26% of the respondents within the EU as a whole), and 23% reported cannabis use in the last year. The study also looked into the use of new synthetic drugs (legal highs). In the Czech Republic, the use of these drugs was reported by 4% of respondents (in comparison to 5% in the whole of the EU).

Young people obtain information about drugs mostly from the internet or friends. The media were the third most frequently reported source of such information in the Czech Republic, while information from parents and/or relatives or information from health professionals or specialised drug centres (provided as part of prevention programmes) prevailed in other European countries. It is also mostly through media campaigns and prevention programmes that young people learn about drug-related health risks; young people in the Czech Republic more frequently refer to the internet as their source of such information.

In comparison to their European peers, young Czechs were more frequent to regard regular cocaine use as very risky (98% of the respondents find it high-risk), but they tend to underestimate the risks associated with ecstasy use (31% consider the experimental use of ecstasy free of risk, in comparison to 11% in the whole of the EU) and cannabis (70% consider the experimental use of cannabis to be without risk, in comparison to 44% in the whole of the EU). The survey showed that drug use-related risks tend to be particularly underestimated by those who have personal experience of using illegal drugs (The Gallup Organization, 2011).

2.2 Drug Use in the School Population and among Young People

2.2.1 ESPAD Study

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

The fifth round of the survey was planned for the year 2011. Field data collection was carried out among a sample comprising students in the ninth grade of elementary school and in the first year of secondary school (students born in 1995). The first results of the survey will be made available at the end of 2011.

2.2.2 HBSC Study

The year 2010 experienced what was already the fifth occasion of the Czech Republic participating in the Health Behaviour in School-aged Children (HBSC) international survey. The survey focuses on health and health behaviours among children in three age cohorts – 11, 13, and 15 years old. It has been organised by the World Health Organisation (WHO) every four years since 1985; the Czech Republic has participated in the project since 1994. Questions enquiring about experience with the use of illicit drugs were only included in the questionnaire for 15-year-old students. The last round but one of the survey was conducted in 2006; for a summary of the results see the 2006 Annual Report. The international report was published in 2008 (World Health Organization, Regional Office for Europe, 2008).

As part of the latest round of the study, conducted in the spring of 2010, a total of 1522 fifteen-year-old students in the ninth grade of elementary school in all the regions of the Czech Republic were addressed. The use of alcohol, tobacco, and cannabis (the only illicit substance covered by the survey) were looked into that year.

30.5% (31.3% and 29.8% of boys and girls respectively) of the respondents have used cannabis at least once in their lifetime, while the use of cannabis in the last year was reported by 21.5% of the students (21.4% and 21.6 of boys and girls respectively); see Table 2-7. 10.9% of ninth-graders had used cannabis in the last month; it is this time span that shows the greatest difference between boys (12.1%) and girls (9.7%), although, generally speaking, the levels of cannabis use show only subtle gender differences in early adolescence (Csémy and Sovinová, 2011).

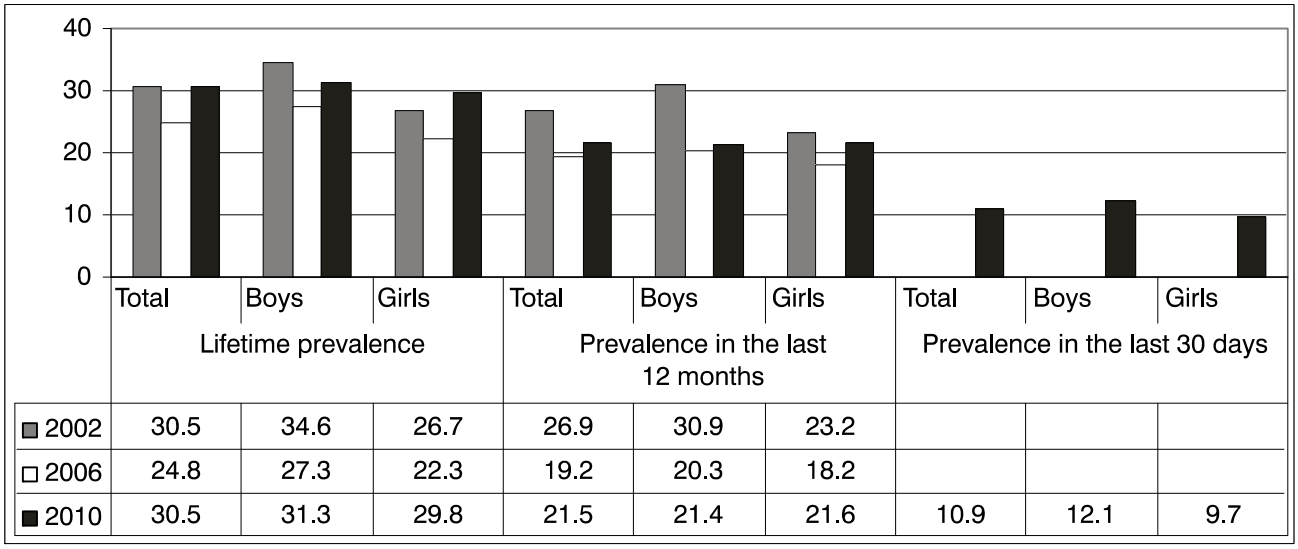
Approximately one half of the respondents reported having used cannabis once or twice. The more frequent use of cannabis (three times or more in the last month) was reported by a total of 5.0% of the students.

Table 2-7: Prevalence of use of cannabis among 15-year-old elementary school students as recorded by the 2010 HBSC 2010 survey, in % (Csémy and Sovinová, 2011)

Prevalence	Gender	Rate (%) N=1522	Frequency of use		
			Once or twice	3-9 times	10 times or more
Lifetime prevalence	Total	30.5	15.0	9.1	6.4
	Boys	31.3	15.4	8.4	7.4
	Girls	29.8	14.6	9.8	5.5
Prevalence in the last 12 months	Total	21.5	11.1	6.1	4.3
	Boys	21.4	11.1	5.7	4.6
	Girls	21.6	11.1	6.5	4.0
Prevalence in the last 30 days	Total	10.9	5.9	2.8	2.2
	Boys	12.1	6.3	3.1	2.7
	Girls	9.7	5.5	2.4	1.7

While there was a drop in both the lifetime and last-year prevalence rates between the years 2002 and 2006, an increase can be observed between 2006 and 2010 (from 24.8% in 2006 to 30.5% in 2010). This rise is more pronounced among girls; see Figure 2-4. The prevalence rates concerning the use of cannabis in the last year increased only slightly, from 19.2% to 21.5%.

Figure 2-4: Trends in prevalence rates of cannabis use among the population of 15-year-olds recorded by the HBSC surveys in the years 2002, 2006, and 2010, in % (Mravčík et al. 2003; Mravčík et al. 2007; Csémy and Sovinová, 2011)



	Lifetime prevalence			Prevalence in the last 12 months			Prevalence in the last 30 days		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
2002	30.5	34.6	26.7	26.9	30.9	23.2			
2006	24.8	27.3	22.3	19.2	20.3	18.2			
2010	30.5	31.3	29.8	21.5	21.4	21.6	10.9	12.1	9.7

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

2.3.1 Drug Use among the Prison Population

A questionnaire survey of the use of addictive substances among offenders serving their prison sentences took place in the autumn of 2010. It was conducted by the National Focal Point in cooperation with the General Directorate of the Prison Service of the Czech Republic; for more details see the chapter on Drug Use and Problem Drug Use in Prisons (p. 125).

2.3.2 Drug Use among Children in Socially Excluded Roma Localities

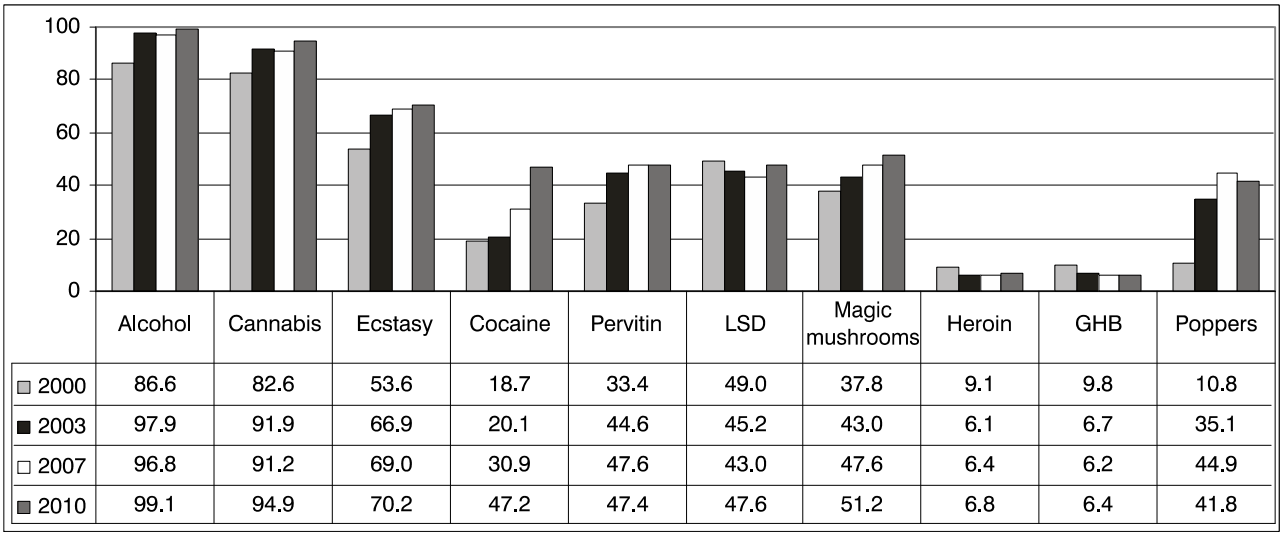
Commissioned by the Agency for Social Inclusion in Roma Localities, in 2010 *SocioFactor Company* developed the Methodology for Research into the Use of Addictive Substances among Young People in Socially Excluded Localities (SocioFactor s.r.o., 2010); for more information see the 2009 Annual Report.

2.3.3 Drug Use in the Nightlife Setting

Another round of the Dance and Drugs survey, looking into the use of drugs in the nightlife setting, was carried out in 2010. It was the fourth inquiry focused on recreational drug users since 2000. An online questionnaire promoted by the media oriented towards electronic dance music and by means of social networks was validly completed by 1099 respondents, who were, on average, 24.7 years old and 35.1% of whom were women. Experience with legal and illegal drugs, the context of drug use, and respondents' attitudes were investigated. In comparison to the previous years, a module examining the use of new synthetic drugs (legal highs) and experience with the purchase of these substances was newly incorporated into the survey.

The most commonly used drugs among the population of clubbers and dance partygoers remain alcohol and tobacco, which the vast majority of the respondents have used. The most popular illegal drug is still marijuana, which has been used at some point in lifetime by 94.9% of the respondents; 77.1% and 54.6% did so in the last 12 months and the last 30 days respectively. Ecstasy is the second most commonly used illicit drug. Lifetime ecstasy use was reported by 70.2% of the respondents and 42.6% and 19.9% had used the drug in the last year and the last month respectively. A comparison to the previous years confirms the growing prevalence of cocaine use. Cocaine has been used at some point in lifetime by almost one half of the sample (47.2%); 28.6% had used it in the last 12 months and one tenth (10.8%) had done so in the last 30 days.

Figure 2-5: Lifetime prevalence of use of selected drugs among dance partygoers in 2000, 2003, 2007, and 2010, in % (Kubů et al. 2000; Kubů et al. 2006; Národní monitorovací středisko pro drogy a drogové závislosti, 2008b; Národní monitorovací středisko pro drogy a drogové závislosti, 2011e)



	Alcohol	Cannabis	Ecstasy	Cocaine	Pervitin	LSD	Magic mushrooms	Heroin	GHB	Poppers
2000	86.6	82.6	53.6	18.7	33.4	49.0	37.8	9.1	9.8	10.8
2003	97.9	91.9	66.9	20.1	44.6	45.2	43.0	6.1	6.7	35.1
2007	96.8	91.2	69.0	30.9	47.6	43.0	47.6	6.4	6.2	44.9
2010	99.1	94.9	70.2	47.2	47.4	47.6	51.2	6.8	6.4	41.8

Mephedrone, the new synthetic drug that attracts close media attention in the Czech Republic, has been used at some point in lifetime by 3.8% of the respondents. Other new synthetic drugs have been tried by a smaller proportion of the sample: 2.6%, 1.3%, and 3.3% of the respondents reported having experienced piperazines, dextromethorphan, and the Spice herbal mixture containing synthetic cannabinoids. The respondents appear to have by far the most experience with herbal drugs: so-called herbal ecstasy, salvia divinorum, and ephedra have been used at some point by 13.4%, 23.2%, and 8.1% of them respectively. Experience with the purchase of new synthetic drugs was reported by over one third of the sample (36.1%), with the most frequent venues of purchase being Czech music festivals (10.7%) and Czech e-shops (7.8%).

Furthermore, the year 2010 saw the continuation of the data collection process as part of the evaluation of the 2010 Safer Party Tour project, following up on a similar initiative carried out in the years 2008 and 2009, which provided preventive and harm reduction services at a total of nine music events; for more information see the chapter on Selective prevention (p. 44). The questionnaire survey among the project's clients included 49 respondents aged 18–34 years, the average age of the entire sample being 24.2. Males comprised three quarters of the respondents. During the survey, less than one third (32.6%) of the project's clients were students, while almost half of them were in employment or carrying on a business.

At least one experience with any of the drugs under study was reported by the vast majority of clients (89.7%) who completed the questionnaire. Two thirds (65.3%) and 46.9% of the respondents had used at least one of the drugs under study in the last 12 months and the last 30 days, respectively. The prevalence rates of the use of the substances under scrutiny during the specific recall periods are summarised in Table 2-8.

It should be pointed out, however, that the data generated by the 2010 Safer Party Tour project are not representative in any respect and, given the small number of questionnaires that were collected, the results are more of an illustrative nature. The relevance of the data is further compromised by the fact that the 2010 Safer Party Tour project was not present at any of the major music festivals in the Czech Republic.

Table 2-8: 2010 Safer Party clients' reported prevalence of drug use, in % (Národní monitorovací středisko pro drogy a drogové závislosti, 2011b)

Drug	Lifetime	Last 12 months	Last 30 days	This event
Cannabis	57.1	36.7	26.5	53.1
Ecstasy	55.1	18.4	2.0	14.3
Pervitin/amphetamine	51.0	8.2	4.1	2.0
LSD	57.1	20.4	2.0	4.1
Magic mushrooms	69.4	32.7	6.1	4.1
Poppers	40.8	6.1	2.0	0.0
Opiates/heroin	10.2	0.0	0.0	0.0
Cocaine	36.7	16.3	0.0	6.1
Mephedrone	2.0	2.0	0.0	0.0
Ketamine	12.2	8.2	0.0	0.0
Syrup (dextromethorphan)	4.1	0.0	0.0	0.0

3 Prevention

In the Czech Republic, the coordination of the primary prevention of risk behaviour among children and young people, including the primary prevention of substance use, is within the competence of the Czech Ministry of Education, Youth, and Sports (the Ministry of Education). The main documents in this area are the Strategy for the Prevention of Risk Behaviour among Children and Young People in the Jurisdiction of the Ministry of Education in the Period 2009–2012 and the Methodological Guidance on the Primary Prevention of Risk Behaviour in Children and Young People. The Standards of Primary Prevention and the process of certification of primary prevention programmes are major quality control tools in the field of prevention; the latter was temporarily halted in mid-2010 because of the transformation of the system.

In 2010, there was a fundamental change in the Ministry of Education grant scheme in terms of deadlines and the overlap of topics with other departments, while the emphasis was placed on balancing the distribution of funds of the state budget between service providers, the main criterion being the quality of services on the basis of their professional competency certification. The allocation of grants has significantly strengthened the role of the regions and the Committee of Regional School Prevention Coordinators was established. In 2010, using its grant scheme, the Government Council for Drug Policy Coordination (GCDPC) supported 14 projects implementing universal and selective prevention activities within the school setting and another eight projects with a focus on selective and indicated prevention, educational activities, and information supply in the area of prevention.

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

With few exceptions, prevention campaigns in the media focus on the issue of driving under the influence of alcohol and illicit drugs (e.g. the Pay Attention – Or Pay the Price! and Designated Driver campaigns). Prevention activities are often targeted at participants in summer music festivals (e.g. the Promile INFO, Safer Party Tour, and It's Up To You projects) to reach the group of young people most at risk.

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

In 2010, the Government approved the 2010–2018 National Strategy and 2010–2012 Action Plan. Prevention is one of the four pillars of the strategy and all four priorities of the Action Plan tie in with it, to a greater or lesser extent (see chapter National Action Plan, Strategy, Evaluation, and Coordination, p. 9). For prevention, the action plan defines the following areas of activity:

- the initiation of interventions aimed at reducing the intensive use of cannabis and other drugs among youth and young adults;
- the introduction of methods of screening and early intervention programmes, especially for children and young people, into practice;
- the unification of primary prevention coordination on both the horizontal and vertical levels.

In the Czech Republic, the coordination of the primary prevention of risk behaviour among children and young people, including the primary prevention of substance use, is within the competence of the Czech Ministry of Education, Youth, and Sports. On the horizontal level, the Ministry of Education cooperates with other ministries (e.g. the Ministry of Health, Ministry of the Interior, Ministry of Labour and Social Affairs, and Ministry of Defence), as well as with local authorities (regions and municipalities) and providers of counselling, training, and methodological services in primary prevention, i.e. other organisations directly controlled by the Ministry of Education, NGOs, universities, or regional counselling facilities. In 2010, the role of the regions in cooperation with the Ministry of Education was significantly strengthened. The Committee of Regional School Prevention Coordinators was established as an advisory body to the Ministry of Education; its main objective is to coordinate activities at the regional and district levels by integrating procedures, collaboration in the allocation of subsidies, data collection, the provision of information, and approaches in the area of risk behaviour prevention. On the vertical level, the ministry provides methodological guidance and coordination to regional school prevention coordinators (staff members of regional authorities), local prevention workers (the staff at pedagogical and psychological counselling centres), and school prevention workers (selected teachers in schools and schooling facilities).

The currently valid 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 defines the target groups and the fundamental concepts of prevention. The strategy introduced the term "risk behaviour" to replace the previously used terms "socially pathological phenomenon" or "social pathology".

In 2010, Methodological Guidance on the Primary Prevention of Risk Behaviour in Children and Young People (Ministry of Education document ref. no.: 21291/2010-28) was approved; the document (a) defines in greater detail the current terminology, which is consistent with the terminology in EU countries and integrates prevention into the

school curriculum and school rules; (b) describes the various institutions within the system of prevention and the role of teaching staff; (c) defines the Prevention Programme and the Minimum Prevention Programme, and (d) recommends procedures for schools and schooling facilities in the presence of selected patterns of risk behaviour of children and young people. The methodological guidelines also include a what-to-do-when manual, which defines the various types of risk behaviour, recommends appropriate procedures to deal with specific situations, defines the legislation, and summarises the sources of information. However, the methodological guidance was later withdrawn, the amendment of controversial passages being cited as the reason by the Ministry of Education.

Since 2009 the Ministry of Education has supported the project The Development of a System of Modular Training in the Prevention of Social Pathologies for Education and Counselling Professionals in Schools and Educational Institutions at the National Level, which aims to develop systematic training of education professionals at schools in the area of risk behaviour prevention and to pilot the proposed changes in five regions of the Czech Republic. The project, in collaboration with the Centre for Addictology and the SANANIM civic association, also saw the launch in 2010 of an online learning programme for parents entitled Prevention-Smart Parents[37], developed by The Mentor Foundation of the UK.

The ministry promotes primary prevention programmes as part of its grant scheme. In 2010, the grant system was transformed. The changes related to the following: a) the introduction of multiannual planning for up to 3 years; b) the merger of several programmes into one grant scheme title, where the Ministry of Education is the sole donor (until now, part of the Ministry of Education subsidies covering programmes implemented by schools was distributed by the regional authorities); c) strengthening collaboration with regional school prevention coordinators in allocating grants, and d) the introduction of electronic processing of grant applications.

In 2010, the Government Council for Drug Policy Coordination supported a total of 14 projects providing universal and selective prevention activities within the school setting. Most often these were lectures (7 projects), universal primary prevention packages (6 projects), and selective prevention packages (6 projects). According to the final reports from the facilities supported by the CGDPC in 2010, universal and selective prevention projects approached 580 schools, 4,086 classes, and 55,151 children. In total, 29,697 interventions within the school setting were reported – Table 3-1. Some types of interventions are only provided (or reported) minimally, or not at all. Prevention activities outside the school setting in 2010 were reported by a total of 8 programmes. These most commonly included individual counselling and group work (5 projects) and family and telephone counselling (4 projects). Educational activities (training workshops and consultations) were also undertaken and information services provided. In total, 3,680 interventions were delivered and 1,411 children and 228 other people were reached as part of the indicated prevention, educational activities, and information service (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)[38].

[37] http://prevence.sananim.cz/ (2011-09-05)

[38] In the area of primary prevention, the PrevData application designed to keep records of clients and interventions provided in prevention programmes has been in place since 2008. For more information see http://www.drogovesluzby.cz.

Table 3-1: Universal and selective prevention projects delivered within the school setting; supported by GCDPC subsidies in 2010 (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Type of intervention	Number of projects	Number of interven-tions	Total time (h)	Number of schools	Number of classes	Number of children	Number of other people (education professionals, parents)
Universal primary prevention							
Primary prevention package	6	1,748	2,939	184	1,182	7,519	1,251
Interactive seminar	2	3	148	56	7	60	83
Lectures	7	149	263	88	305	3,865	219
Feature programme (show)	1	10	30	31	78	1,910	89
Event with overnight stay	1	3	150	–	–	84	107
Consultation	3	2,866	750	108	87	–	1,055
Telephone consultation	3	964	139	69	–	–	54
E-mail consultation	3	288	53	55	–	–	77
Situational intervention	0	–	–	–	–	–	–
Providing information by telephone	3	1,064	39	39	26	36	70
Providing information via the internet	1	96	24	34	34	–	26
Providing information in person	2	61	35	44	–	2	30
Selective primary prevention							
Primary prevention package	6	1,238	2,056	135	2,656	4,666	675
Event with overnight stay	1	2	72	3	–	47	7
Consultation	5	1,581	468	85	113	348	688
Telephone consultation	5	172	32	9	15	6	29
E-mail consultation	3	141	29	8		8	20
Situational intervention	4	52	16	14	6	127	20
Providing information by telephone	4	155	32	46	12	20	55
Providing information via the internet	3	129	54	42	16	16	42
Providing information face to face	4	89	22	29	8	52	33
Total*	**14**	**9,296**	**6,230**	**580**	**4,086**	**55,151**	**4,535**

*Note: * This is not the sum of the dates specified in each column; some facilities failed to provide information about the various types of services provided, but provided only information about the number of interventions and contacts accomplished in the category in total.*

Obtaining subsidies from the budgets of the Ministry of Education and the GCDPC is contingent upon certification[39] of the prevention programme in question. The certification of professional competency guarantees a minimum quality of the prevention programmes delivered and allows public funds to be spent more efficiently. The certification system in the field of prevention was launched in 2006 (Ministerstvo školství, mládeže a tělovýchovy, 2005) – for more information see the 2006 and 2009 Annual Reports. The certification procedure is based on the standards of professional competency for the providers of the primary prevention of substance use; it is conducted by the Certification Agency established at the Institute for Pedagogical and Psychological Counselling (IPPP). The Certification Agency's activities were suspended as of 16 July 2009 as a result of the transformation of the certification system; they were resumed on 1 August 2010.

From 1 July 2011, the Ministry of Education established the National Institute for Education[40]. It is a counselling and training facility for education professionals, which came into existence through the merger of the National Institution of Technical and Vocational Education with the Research Institute of Education in Prague and the Institute for Pedagogical and Psychological Counselling.

The Ministry of Health is another key department in the area of prevention. The National Health Programme – Health Promotion Projects subsidy scheme is an important tool for the Ministry of Health in primary prevention and health promotion in general. In this programme, annual support is provided to projects including those focused on the prevention of addiction, especially in relation to alcohol and tobacco. The Ministry of Health's work in health promotion and primary prevention is greatly supported by the activities of the National Institute of Public Health and

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

[40] http://www.nuv.cz/ (2011-08-31)

partly also by regional public health authorities. The National Institute of Public Health implemented a number of activities in this area in 2010. The local health promotion offices in the regions of the Czech Republic implemented a number of intervention activities, including lectures, talks, and the distribution of health educational. The National Institute of Public Health also coordinated the Health Promoting Schools programme and organised accredited training programmes for education professionals working in kindergartens and basic and secondary schools – including one entitled How (Not) To Become a Junkie, a course designed to provide an overview of the methodology of this interactive game for children.

As regards the regional public health authorities, the scope of their activities and focus of health policy and health promotion varies across the different regions. In general, however, the regional public health authorities in some regions also contributed to primary drug prevention in 2010, delivering lectures, talks, collaborating – to a varying extent – with regional drug coordinators, participating in regional drug policy working groups or commissions, etc.

3.2 Universal Prevention

The Minimum Prevention Programme is the fundamental strategy of risk behaviour prevention in schools and educational facilities, drawn up by the school prevention worker in collaboration with the school management and other education professionals. The Minimum Prevention Programme is subject to checks by the Czech Schools Inspectorate. The most frequently reported shortcomings of the school minimum prevention programmes in 2010, as in the previous years, included a shortage of funds to implement prevention activities, low levels of support for the school prevention workers from the school management, and the perfunctory nature and fragmented structure of the minimum prevention programmes. Schools can implement prevention activities on their own or in cooperation with external entities (such as NGOs or the Police of the Czech Republic).

A number of major prevention programmes of national importance were under way in 2010.

The implementation of the international Unplugged prevention programme (part of the EU-Dap 2 project) entered its final phase in the Czech Republic. The programme is aimed at preventing the use of addictive substances (alcohol, tobacco, and illicit drugs) by pupils in the 6th grade, i.e. children aged 12–14. The research project is being implemented in 70 schools (an experimental group of 966 pupils from 37 schools; a control group of 888 pupils from 33 schools). The sixth and final round of data collection was carried out in June 2010 – for more information see the 2009 Annual Report. In this project, another 46 education professionals were trained in the Olomouc, Ústí nad Labem, and Brno regions in 2010. The dissemination of the methodology was coordinated by the Centre for Addictology in cooperation with regional institutions. 2010 also saw the establishment of a new team of certified trainers who will participate in disseminating the methodology for the Unplugged prevention programme in other parts of the Czech Republic. A total of 120 people (mostly education professionals) were trained in the methodology of the Unplugged programme between 2006 and the end of 2010. Evaluation two years after the completion of the programme performed on a sample of pupils who enrolled in the Unplugged programme, compared with the control group (a total of 1,761 students, average age 14.1, the proportion of boys being 51.5%) showed that students enrolled in the programme exhibit statistically significantly lower rates of smoking, frequent smoking, frequent inebriation, frequent cannabis use, and the use of any drug. A borderline effect was found for daily smoking. The authors conclude that Unplugged is an effective prevention programme for elementary schools and recommend it to be applied nationwide (Gabrhelik et al. 2011).

Another research project is a longitudinal study implemented by the Faculty of Education and the Faculty of Medicine at Masaryk University in Brno, focusing on the primary prevention of smoking and health promotion among the target group of children aged 7–11. The output of the project in 2010 consists of five manuals for the educational programme Non-Smoking Is Normal for pupils in the first to fifth years of elementary schools, including a video/DVD and a health mascot. The programme is unique in that the intervention targets children of early school age (6 to 11). The programme has a positive influence mainly on the cognitive components of personality (Hrubá and Žaloudíková, 2011).

In 2010 the Centre for Addictology participated in an international study, Empowering Families: Increasing family skills to work towards preventing alcohol use and drug-related problems[41]. The project aims to map the potential preventive effects of the family in reducing undesirable forms of addictive behaviour in children and adolescents and the involvement of entire families in prevention. The key component of the study is a questionnaire survey among children in the school class and their parents that focuses on risk and protective factors in the family.

3.3 Selective prevention

Selective prevention programmes are focused on vulnerable groups of the population showing a higher risk of addictive substance use. From a long-term perspective, the use of addictive substances among children and adolescents from ethnic minorities in the Czech Republic is a serious problem which has not been managed sufficiently.

[41] European Family Empowerment: Improving family skills to prevent alcohol and drug-related problems (JLS/DPIP/2008-2/112).

Since 2009 the Centre for Addictology has implemented a research project aimed at gaining experience with prevention measures, research, early diagnosis, and interventions used in relation to working with children and adolescents from ethnic minorities who are at risk of social exclusion and the consequences of addictive substance use (Šťastná, 2010; Šťastná et al. 2010). During 2009, a study was implemented to determine whether and to what extent helping professionals encounter juvenile users of volatile substances. The study focused on addiction services (including detoxification units and departments, day care programmes, therapeutic communities and after-care facilities, and psychiatric hospitals and clinics), outpatient medical specialists (including child psychiatrists, paediatricians, and pulmonologists), institutional care facilities for children (including children's homes, rehabilitation institutions, and institutions for juvenile delinquents and children with behavioural disorders), and pedagogical and psychological counselling centres. The next phase of the project tested two prevention tools (the SURPS questionnaire and the PREVenture methodology for indicated primary prevention – for more information see the 2009 Annual Report) and one research tool (narrative data analysis). A conference on substance use among children from ethnic minorities was held in Prague in March 2010 at the end of the project[42].

Over the long term, the activities of *Prev-Centrum*, a civic association, which implements the Happy Class programme[43], or the activities of the *Prostor* civic association in Kolín[44], are presented as examples of good practice in the area of selective (and indicated) prevention. The activities of *Anima*[45], a civic association operating a Children's Club for children from families affected by addiction or from at-risk environments, can also be presented as an example. The Counselling Centre for Drug and Other Addiction and the Pedagogical and Psychological Counselling Centre in Brno organise parents' groups for families at risk of addiction, children's groups, and crisis intervention and follow-up assistance for children, young people, and parents.

Low-threshold facilities (clubs) for children and young people are active in the area of selective prevention for children and young people vulnerable to risk behaviour and social exclusion. These facilities primarily provide outpatient services to unorganised children with risky lifestyles. The basic means of establishing contact with the target group is an offer of leisure activities. The aim is to improve the quality of life of the target groups by preventing and reducing the social and health risks associated with their way of life, enabling them to orientate themselves in their social environment and to create conditions allowing them to deal with their adverse social situation if they want to. The low-threshold facilities for children and young people provide educational, instructional, and engagement activities free of charge. They provide a social service under Act No. 108/2006 Coll., on social services, and are therefore financed by subsidies from the Ministry of Labour and Social Affairs. In August 2011, there were 233 low-threshold facilities for children and young people across the Czech Republic in the register of social services[46]. A major achievement in 2010 was the extensive research of the Czech Streetwork Association that focused on how services are provided in low-threshold facilities for children and young people, evaluation of the success of working with clients, and identification of the key factors in this respect[47].

In 2010, in collaboration with other providers of drug services (the SANANIM, Podané ruce, Prevent, and Semiramis civic associations and the CPPT public service company), the Chilli.org civic association implemented the third year of its project Safer Party Tour, focused on drug prevention and harm reduction interventions at summer dance and music festivals[48]. A total of 499 contacts (75% of them men) were recorded at 9 festivals. The services at dance events included an offer of advice and providing objective information about legal and illegal psychoactive substances, informing users of the substances about their short-term, long-term, and side effects, safer use, dosage and legislative issues, as well as offering medical treatment and the distribution of harm reduction materials such as condoms, earplugs, syringes, and plasters. The highest demand was for condoms, information on safe drug use, and bottled water and earplugs. The 2010 Safer Party Tour project also included monitoring of the provision of a safe environment for visitors to dance events. Similarly to previous years, music festivals vary in the level of provision to ensure the safety and health of participants and the persistent major shortcomings identified are the absence of free drinking water, inadequate hygiene in toilets, and the confiscation of soft drinks at the entrance (Národní monitorovací středisko pro drogy a drogové závislosti, 2011b) – see also the chapters on Drug Use in the Nightlife Setting (p. 38) and Programmes Aimed at Drug Use in Recreational Settings (p. 111).

Since 2005, the Promile INFO internet and text message service operated by SANANIM has been in place in the Czech Republic. This is a simple application that helps users ascertain their approximate blood alcohol level and about how long it will take for them to sober up and be able to drive again. The service is available in 2011 at stalls at summer music festivals[49].

[42] http://www.adiktologie.cz/cz/articles/detail/365/1749/ (2011-08-17)
[43] http://www.prevcentrum.cz/CPP/SPP.aspx (2011-09-14)
[44] http://www.os-prostor.cz/cz/programy-primarni-prevence-sluzby (2011-09-14)
[45] http://www.anima-os.cz/?dklub (2011-09-14)
[46] http://iregistr.mpsv.cz/ (2011-08-17)
[47] http://www.streetwork.cz/index.php?option=com_content&task=view&id=3181 (2011-09-05)
[48] http://www.saferparty.cz/ (2011-08-23)
[49] http://promile.info/ (2011-08-23)

3.4 Indicated prevention

Indicated primary prevention involves individual work with at-risk individuals, their families, and the close community. These individuals exhibit early signs of substance use but do not meet the criteria for problem drug use and dependency. In the Czech Republic, indicated prevention is carried out by institutions established 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 (e.g. low-threshold facilities for children and young people – see above).

For projects pertaining to early assessment and intervention tools and methodologies see the 2009 Annual Report.

3.5 Media Campaigns, Conferences, and Other Activities with Media Response

In November 2010, the seventh annual conference on the primary prevention of risk behaviour, entitled Education and Professionalism in Primary Prevention, was held[50]. The conference topics corresponded with the VYNSPI nationwide project. Also presented at the conference was a monograph entitled Primary Prevention of Risk Behaviour within the School System[51], which outlines the basic concepts of the primary prevention of risk behaviour applied in the country. The publication acquaints readers with the basic topics and concepts of primary prevention in an integrated and structured manner (Miovský et al. 2010).

At the end of September and the beginning of October 2010, a conference was held in Prague titled Urban Drug Policies in the Globalised World, during which the interactive workshop Primary Prevention at the Urban Level was also organised. The conference was promoted by posters placed on municipal advertising spaces and in the Prague metro[52].

Figure 3-1: Posters placed in Prague in September and October 2010 highlighting the conference Urban Drug Policies in the Globalised World

The SANANIM civic association, in collaboration with the Society for Addictive Diseases of the J. E. Purkyně Czech Medical Association, organised a conference entitled Youth and Drugs 2010 on 20–21 April 2010. The topic of the conference was to work with juvenile clients from the perspectives of addictology, psychotherapy, and social education[53].

From May to October 2011, there was an exhibition in the Prague Police Museum marking the 20th anniversary of the founding of the National Drug Headquarters. At the opening ceremony, awards were handed over to students of schools of applied arts who participated in a nationwide competition for the best anti-drug poster, entitled In the Right Direction[54].

In 2010 the ZKUS civic association announced a photography competition Take a Picture of Your Drug intended targeted students of elementary and secondary schools[55], to highlight positive alternatives to drug use. The

[50] http://www.pprch.cz/ (2011-08-23)
[51] http://www.adiktologie.cz/cz/articles/17/Monografie (2011-08-23)
[52] http://www.urbandrugpolicy.com/cz/ (2011-08-23)
[53] http://konference.sananim.cz/ (2011-08-23)
[54] http://www.policie.cz/clanek/soutez-a-vystava-v-jeden-den.aspx (2011-08-23)
[55] http://www.zkus.org/index.php?option=com_content&task=view&id=66&Itemid=1 (2011-08-23)

competition took place as part of the project of the European Action on Drugs (EAD)[56] and the SES civic association.

Since 1997 the Association of Communication Agencies (AKA) has organised the EFFIE Awards, a competition for the most effective advertising, which assesses the effectiveness of campaigns in relation to the resources spent. Pilsner Urquell won in the category of food and beverages in 2010 with its advertisement entitled Stay in the Game, aimed at promoting the consumption of non-alcoholic beer. The campaign was targeted at men aged over 30; the main idea of the campaign, "I'd like to have a beer, but I can't because I need a clear head", was targeted at athletes, drivers, and people at work[57]. In 2009, the Ministry of Transport (Czech Government Council for Road Safety, BESIP) won this first prize in the category of social, cultural, and environmental marketing with its campaign called Pay Attention – Or Pay the Price![58], which focused on road safety. The main topics of the campaign were speeding and aggression behind the wheel, the use of safety restraint systems (seat belts and car seats for children), and driving under the influence of alcohol and illicit drugs. The campaign itself also took place in 2010 and its target groups were drivers aged 18–60 and families with children aged under 14.

Another project of the Czech Government Council for Road Safety (BESIP) that continued to be implemented in 2010 was the Designated Driver campaign[59], aimed directly at preventing alcohol and drug use while driving. As part of the project, what is already the seventh year of the prevention multimedia show The Action is taking place in 2011, focused on young and novice drivers in the target group of secondary school students. The project is to show young people the tragic consequences of accidents caused by drivers under the influence of drugs. In 2011, BESIP launched a new roadshow called It's up to you, intended to familiarise young drivers with the risk of driving under the influence of substances; the project takes the form of BESIP stalls at music festivals, where participants can get information materials, but also single-use alcohol testers for drivers. The campaign's slogan Want to see the next fest live? is meant to alert drivers to the fact that they may not live to the next festival if they drive under the influence of alcohol or drugs. The attractions of the BESIP stalls at festivals include so-called drunken spectacles, which simulate the state of mind after the consumption of alcohol or other addictive substances.

To prevent driving under influence of alcohol, representatives of the Police of the Czech Republic and the Czech Beer and Malt Association signed a memorandum of cooperation to improve the situation in the field of road safety in the Czech Republic. The cooperation includes the project entitled I'm Driving – I Drink Non-Alcoholic Beer, which aims to promote non-alcoholic beer among drivers[60].

[56] http://ec.europa.eu/ead/ (2011-09-06)
[57] http://www.effie.cz/cz/results/campaign.php?cmpid=168 (2011-08-23)
[58] http://www.nemyslis-zaplatis.cz/, http://www.effie.cz/cz/results/campaign.php?cmpid=153 (2011-08-23)
[59] http://www.ibesip.cz/Kampane-projekty, http://www.domluvme-se.cz (2011-08-23)
[60] http://www.policie.cz/clanek/spolecne-proti-alkoholu-za-volantem.aspx (2011-08-23)

4 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 Czech definition does not include cocaine use as the number of cocaine users in the data sources used for estimates (particularly those pertaining to the use of specialised services) is still at a very low level in the Czech Republic. For similar reasons, as far as the amphetamine group is concerned, the number of pervitin (methamphetamine) users is only estimated. The opioids typically used in the Czech Republic mainly include heroin and Subutex® (the use of raw opium also appears seasonally).

In 2010, the estimated number of problem drug users further increased – the mean estimate using data on clients of low-threshold programmes reached 39 thousand. The growth mainly involved pervitin users (28 thousand), while the number of opiate users decreased (11 thousand). The estimated number of injecting drug users also increased (to approximately 37.2 thousand). 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. Injecting Subutex® is particularly widespread in Prague but also common in other Bohemian regions. The concomitant use of pervitin and opiates is also common.

In 2010, estimates were made of the current scope of the heavy and problematic use of other illicit drugs.

4.1 Prevalence and Incidence Estimates of Problem Drug Use

As in previous years, the multiplication method was used to estimate the number of problem drug users in 2010 from the data on clients in low-threshold programmes and through a survey conducted among physicians in the Czech Republic.

4.1.1 Estimate Using the Multiplication Method

The multiplication method consists of multiplying the known number of problem drug users in a given source (in this case the number of problem drug users in contact with low-threshold programmes in the given calendar year[61]) by the multiplier[62]. The value of the multiplier for the Czech Republic and for each region was established on the basis of the Multiplier 2010 survey, conducted among the clients of low-threshold facilities using the *peer nomination technique*[63] – see also the 2009 Annual Report.

With regard to the methods used, trends in the estimates of problem drug users are sensitive to changes in the input data: there is a positive correlation with regard to the number of low-threshold service clients, while the multiplier value impacts on the estimates in a negative correlation. For multiplier values for individual regions see the 2009 Annual Report. In 2010, the value of the multiplier for the whole country, without Prague, expressed as a percentage, was 67% (95% CI[64]: 63–70%) and declined by one percentage point compared to its 2008 value. On the contrary, the value of the multiplier for Prague rose by four percentage points to reach a level of 80% (95% CI: 70–91%). The estimate of the number of problem drug users in the Czech Republic is the sum of the estimates for the individual regions.

The total number of problem drug users in the Czech Republic in 2010 was thus estimated at 39,200 (95% CI: 32,300–46,300), of whom 28,200 (27,300–29,100) were pervitin users, 6,000 (5,500–6,400) were heroin users, and 5,000 (4,700–5,400) were Subutex® users. Therefore, the number of opiate users is estimated at 11,000 (10,400–11,600). The number of injecting drug users (IDUs) was estimated at 37,200 (36,000–38,500).

Estimates of the number of problem drug users from 2002 to 2010 are shown in Table 4-1. There was an increase in the estimated total number of problem drug users in 2010. The mean estimate value of the number of opiate users decreased (a change compared to 2009, when there was an increase) and there was a further increase in the number of pervitin users. There was also a further increase in the estimated number of injecting drug users. With

[61] The sources of data on the number of problem drug users in contact with low-threshold programmes are the annual final reports of projects funded under the GCDPC subsidy proceedings and, in 2009 and 2010, also a survey of the programmes that were not supported in the subsidy proceedings, and therefore did not submit a final report.

[62] The multiplier essentially expresses the proportion of problem users in contact with low-threshold programmes. The rest is the hidden population of problem drug users.

[63] In the questionnaire study, clients of low-threshold programmes were asked to answer the following questions: (1) "How many people you know well are regular users of pervitin and/or opiates (heroin, Subutex® or Suboxone®)?" and (2) "How many of them have been in contact with any sort of low-threshold centre or outreach programme over the past twelve months?" The multiplier is then expressed as the weighted average quotient of both values, with the respondent being taken into account as a user in contact with a low-threshold programme. Only those who stated a reasonable number of known drug users were included in the calculation (arbitrarily 25 or less), in order to exclude non-credible estimates from the analysis, and the weighting is the size of the population of problem drug users represented by individual respondents (the number of the respondent's acquaintances). With regard to the fact that in all surveys to date, peer nomination questions were posed only to users in contact with low-threshold facilities and not to a representative sample of problem drug users, the assumption can be made that the real proportion of problem drug users in contact with low-threshold programmes will be somewhat lower than is expressed by the multiplier.

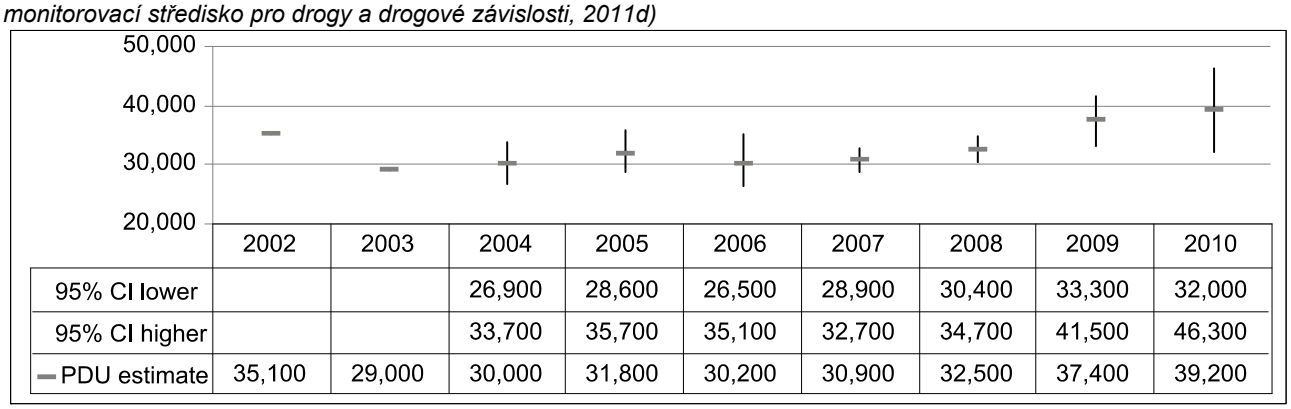
[64] 95% confidence interval, i.e. the interval in which the value occurs with a 95% probability.

regard to the year-on-year overlap of confidence intervals, there was a statistically significant decrease in the estimated total number of problem heroin users and an increase in the number of problem pervitin users. An overview of statistical significance of the changes in the estimated total number of problem drug users is provided in Figure 4-1 – there has been overlap in the confidence intervals of estimates from past years, meaning that the trend observed in mean estimate values must be interpreted with caution.

Table 4-1: Mean values of prevalence estimates of problem drug use carried out using the multiplication method with the use of data from low-threshold programmes in 2002–2010 (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011d)

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

Figure 4-1: Mean values and 95% confidence intervals of prevalence estimates of problem drug use carried out using the multiplication method with the use of data from low-threshold programmes in 2002–2010 (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011d)



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

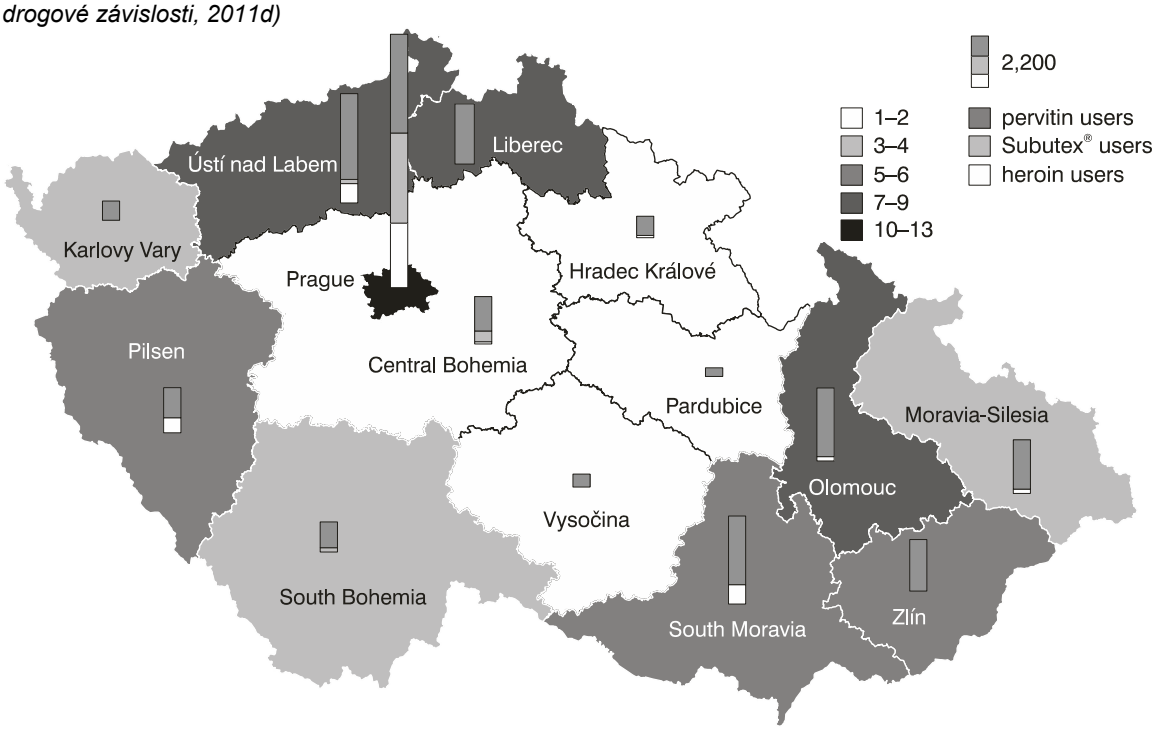
The highest number of problem drug users was traditionally estimated in Prague and the Ústí nad Labem region, i.e. in the areas that concurrently have the highest number of problem opiate users. In 2010, Prague had the highest estimated number of both opiate users and pervitin users. Prevalence estimates of problem drug use by region are shown in Table 4-2 and Map 4-1.

Table 4-2: Prevalence estimates of problem drug users in the Czech Republic in 2010 by region – mean values (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011d)

Region	Total number of problem drug users	Number of opiate users			Number of pervitin users	Number of IDUs
		Heroin	Subutex®	Total		
Prague	11,350	2,900	4,050	6,950	4,400	11,350
Central Bohemia	2,150	150	450	600	1,600	2,150
South Bohemia	1,400	50	150	200	1,200	1,400
Pilsen	2,000	650	50	700	1,300	1,900
Karlovy Vary	900	50	< 50	50	850	800
Ústí nad Labem	4,900	850	200	1,050	3,850	4,900
Liberec	2,650	< 50	< 50	< 50	2,600	2,400
Hradec Králové	950	50	50	100	850	950
Pardubice	400	50	< 50	50	350	400
Vysočina	600	< 50	< 50	50	550	550
South Moravia	3,900	850	< 50	850	3,100	3,700
Olomouc	3,300	150	< 50	150	3,100	2,850
Zlín	2,350	50	< 50	50	2,300	2,050
Moravia-Silesia	2,350	200	< 50	200	2,150	1,800
The Czech Republic	**39,200**	**6,000**	**5,000**	**11,000**	**28,200**	**37,200**

Note: The data in the table are rounded.

Map 4-1: Number of problem drug users per 1,000 inhabitants aged 15–64 and the number of problem users of opiates and pervitin in regions of the Czech Republic in 2010 – mean values (Národní monitorovací středisko pro drogy a drogové závislosti, 2011d)



Estimates of problem drug use in individual regions since 2005 are available, making it possible to observe trends in drug use at the regional level; see Table 4-3. The highest year-on-year increases are evident in Prague and the Liberec region and, in Moravia, in the South Moravia, Olomouc, and Moravia-Silesia regions. Other regions saw a decline, while the prevalence of problem drug users remained (almost) unchanged in the Vysočina and Zlín regions.

Table 4-3: Estimates of problem drug use carried out using the multiplication method with the use of data from low-threshold programmes by region in 2005–2010, mean values (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011d)

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

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

In addition, the regular omnibus representative sociological survey among physicians in the Czech Republic was conducted by INRES-SONES in November and December 2010. 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, also including questions about the physicians' experience of administering substitution treatment (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010a); for results concerning substitution treatment see the chapter on Opiate Substitution Treatment (p. 60). A similar module was included in the previous rounds of the same survey in 2005 and 2007 (Mravčík et al. 2006; Mravčík et al. 2008) and general practitioners were also asked similar questions in the 2003 survey (Mravčík et al. 2005). In 2010, the sample included a total of 1,178 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 general practitioners for children and adolescents in the sample increased to approximately double the number that would correspond to their real representation in the population of physicians in the country – in total, 342 and 212, respectively, were included in the survey.

The physicians were asked questions about the number of problem drug users among their patients. In comparison to the surveys in 2005 and 2007, the questions were more detailed and concerned the overall number of problem drug users, as well as, specifically, the numbers of injecting drug users and problem users of heroin, Subutex® not prescribed by a physician, and pervitin. The results obtained from the physicians in the sample were extrapolated to the total number of general practitioners and paediatricians in the Czech Republic (Ústav zdravotnických informací a statistiky, 2011a).

On the basis of the answers to the question concerning the overall number of problem drug users among the physicians' clients, the total number of problem drug users for 2010 was estimated at approximately 53,500 (95% CI: 30,800–76,200). If the total number was estimated as the aggregate of problem users of pervitin, heroin, and illegally obtained Subutex®, then the overall estimate would be 32,900 (21,400–44,400). The number of injecting drug users was estimated at 23,300 (10,100–36,600), that of problem pervitin users at 12,500 (8,800–16,100), that of heroin users at 12,900 (4,100–21,700), and that of users of illegally obtained Subutex® at 7,500 (1,000–14,000). The results of the questionnaire surveys among general practitioners are provided in Table 4-4.

Prevalence estimates obtained through general practitioners are burdened with a relatively high margin of error (see confidence intervals). As in previous years, the estimates are very likely to overestimate the number of opiate users and underestimate the number of pervitin users. Users of opiates have the option of Subutex® substitution treatment administered by a general practitioner, which can lead to increased contact with the physician; there is no such treatment option available to pervitin users from general practitioners.

Table 4-4: Prevalence estimates of problem drug users obtained from questionnaire surveys among general practitioners in 2003, 2005, 2007, and 2010 (Mravčík et al. 2008; Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010a)

Year	Total number of problem drug users		Number of injecting drug users		Number of opiate users		Number of pervitin users	
	Number	Per 1,000 people aged 15–64	Number	Per 1,000 people aged 15–64	Number	Per 1,000 people aged 15–64	Number	Per 1,000 people 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

*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.*

4.1.3 Problem Drug Users on the Open Drug Scene in Prague

Prague, similarly to other major cities, has for a long time been faced with the existence of open drug scenes. The current problem concerns mainly the city centre, but also other city districts, especially Prague 2 and 5, i.e. areas in the very centre of Prague, Wenceslas Square and Charles Square, the *Vrchlického sady* park, and the main railway station, but also in the district of *Smíchov* around the intersection at *U Anděla* and around the bus station at *Na Knížecí*. Dealing with the problems associated with these open drug scenes gave rise to numerous conflict situations between Prague's city districts themselves, as well as between the city districts and the Municipal Authority of the City of Prague, and between outreach programmes and the officers of the state and municipal police forces operating on the drug scene. So far, there is no comprehensive consensus or outline of a solution to this phenomenon in Prague that would be accepted by all stakeholders. The open drug scenes are places where, in particular, problem (injecting) drug users are found. The problems mainly relate to public nuisance; there are complaints from residents, shopkeepers, and owners of businesses about harassment by drug users in attractive tourist destinations of Prague and the distribution and use of drugs in public (Procházková and Herzog, 2010; Pracovní skupina Harm Reduction při Protidrogové komisi hlavního města Prahy, 2010).

In 2009–2010, the total number of people on open drug scenes in Prague was estimated to be at least 2,500 persons during the year. The number of daily users in open drug scenes was estimated at 300–500 people on Wenceslas Square, 50–200 people in the district of Smíchov in the area at *Na Knížecí*, and (in the period between April and October 2009) 50–200 people on Charles Square (Procházková and Herzog, 2010; Pracovní skupina Harm Reduction při Protidrogové komisi hlavního města Prahy, 2010).

4.2 Data on Problem Drug Use from Non-Treatment Sources

The results and comparisons of analyses assessing the needs of clients in low-threshold programmes in Prague in 2003 and 2010 were published (Šťastná, 2010; Šťastná et al. 2011). In 2003, a total of 30 clients of low-threshold services participated in the study (of whom 24 were men) and two focus groups were conducted with 16 staff members from six low-threshold programmes. In 2010, a total of 25 clients participated in the study (including 21 men) and one focus group was conducted with six staff members of low-threshold services.

This chapter presents the results of the interviews with the clients. Although the samples are relatively small and the results therefore need to be assessed with caution, the identical methodology used in both surveys allows comparisons to be made. In 2003, the average age of the respondents was 29 (men 30, women 24), whereas in 2010 it was 32.7 (men 36.4, women 29). Approximately two thirds of the respondents to both studies lacked permanent housing. All the respondents from both samples had completed elementary education and the structure of both samples was similar in terms of education. Approximately two thirds of them were unemployed in both 2003 and 2010.

In both surveys, the respondents used a similar range of drugs. Besides alcohol and tobacco, pervitin, Subutex®, and cannabis were those used most frequently. Heroin use was mentioned more frequently in 2003. Most respondents have been injecting drugs for more than two years; not a single respondent had been injecting for less than 12 months in the 2010 study. The frequency of use was daily or almost daily in most cases.

The use of buprenorphine-based drugs was reported by 16 respondents (64%) in 2010 (15 used Subutex®, 1 used Suboxone®). The doses used ranged from 1 mg once or twice a week to 12 mg daily. Most respondents reported a dose of 1–2 mg daily. Injecting was the most commonly reported method of using Subutex®. The respondents also mentioned that they commonly combine Subutex® with alcohol, pervitin, or marijuana.

A total of eight respondents (50% of those using buprenorphine) reported the purchase of Subutex® on the black market, where, according to them, it is easily accessible on workdays, while at weekends its availability decreases. The respondents also point out the high uncertainty as to whether the substance is really Subutex® when buying it

on the black market (for example, one respondent said there was a 60% certainty that it was indeed Subutex®). The price of Subutex® on the black market is usually around CZK 400 (€ 16) per 8-mg tablet, while the normal (recalculated) price of Subutex® from a pharmacy is CZK 200 (€ 8) per tablet. In total, 5 respondents had been on substitution treatment at some point, of whom four were on it during the survey. Using Subutex® prescribed by a physician was mentioned by three respondents (two of them reported injecting use). One respondent was on substitution treatment (150 mg daily) in 2010, using methadone in combination with pervitin. Another four respondents reported a combination of both methods to obtain Subutex®, i.e. both on the black market and on prescription from a physician. The following practice has been described: because of a lack of money to buy Subutex® on prescription in a pharmacy, the user exchanges the prescription for less than the prescribed amount of Subutex® on the black market.

Substitution treatment with buprenorphine was more attractive to the respondents than treatment with methadone. The clients saw the advantage of prescription Subutex® in its availability, the disadvantage in its high price. However, according to the respondents, legally obtained buprenorphine is still cheaper than drugs on the black market and the income from legal employment is sufficient to cover the cost of buying it at a pharmacy. Another advantage is the certainty that the tablet bought at a pharmacy is really Subutex®. However, four respondents said that Subutex® was expensive for them, and are inclined either to complete abstinence or the use of methadone. Methadone substitution treatment is only attractive for clients from a financial point of view as it is provided to them free of charge. The clients see the main problem in having to attend daily to receive the dose. They perceive methadone as a substitution drug for severely dependent long-term users with no prospect of abstinence. The main reasons cited as to why the respondents participate in substitution treatment included:

- daily access to the substitution substance,
- no need to steal to obtain money for the drug,
- the possibility of going to work regularly, and
- the chance of complete abstinence.

More information on problem drug users in contact with different types of services is provided in the chapters on Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55), Responses to Health Correlates and Consequences (p. 104), and Social Correlates and Social Reintegration (p. 112).

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

The chapter on Drug Use in the General Population (p. 28) details the results of the testing of the CAST scale used to identify the risk of problems associated with cannabis use. When extrapolating the results to the adult population in the Czech Republic, one can estimate that there are approximately 75–110 thousand people at high risk of problems associated with cannabis or cannabis dependence; see the chapter on Validation Study of Cannabis Scales (p. 31).

The data on the prevalence of current repeated drug use (use at least once a week in the last month) from the 2008 General Population Survey on the use of psychotropic substances in the Czech Republic (Běláčková and Horáková, 2011) were extrapolated to the population aged 15–64 in the Czech Republic. The results thus obtained indicate that in 2008 there were approximately 360 thousand regular users of cannabis, 37 thousand users of pervitin, 36 thousand ecstasy users, and 31 thousand users of hallucinogenic mushrooms. Sedative users, probably numbering approximately 990 thousand, are the highest in number; see Table 4-5. Estimates of the number of users of LSD, cocaine, and heroin are rather tentative as a result of the relatively low prevalence of these drugs. The users of illicit drugs are mainly young adults.

Table 4-5: The estimated number of people aged 15–64 in the Czech Republic in 2008 who had used the drug at least once a week in the last month (Běláčková and Horáková, 2011)

Drug	Prevalence (%)	Confidence interval (%)	Estimated number of users	95% confidence interval
Sedatives	13.4	12.4–14.4	989,230	915,674–1,062,786
Cannabis	4.9	4.3–5.5	361,458	314,866–408,050
Pervitin	0.5	0.3–0.7	37,414	22,083–52,746
Ecstasy	0.5	0.3–0.7	35,716	20,734–50,697
Hallucinogenic mushrooms	0.4	0.2–0.6	31,231	17,217–45,244
LSD	0.3	0.1–0.5	22,465	10,573–34,358
Cocaine	0.2	0.1–0.3	13,928	4,559–23,297
Heroin	0.1	0.0–0.2	7,369	551–14,187

The general population studies (see above) and other sources of data[65] show that in addition to the problem use of opiates and pervitin, which the majority of drug policy measures in the Czech Republic focus on, heavy cannabis use and the abuse of psychoactive pills are serious phenomena in terms of the exposure of the general population and public health consequences. Therefore, the 2010–2012 Action Plan that is currently in force lays down a number of tasks to reduce heavy cannabis use and to monitor developments in the area of the abuse of medication.

4.3.1 Estimated Prevalence of Hazardous Alcohol Use

In 2010, an estimate was made of the prevalence of hazardous alcohol use patterns identified using the AUDIT (Alcohol Use Disorders Identification Test)[66] measure in two studies – a survey of a general population sample of 1,326 individuals and the pilot testing of brief interventions for hazardous or heavy alcohol use among 2,589 general practitioners' patients (Sovinová and Csémy, 2010). The proportion of men in the two research projects was 49.9% and 49.3%, respectively, and the age of the participants in both studies ranged between 18 and 64, with mean ages of 39.2 and 42.9, respectively. The results are shown in Table 4-6.

Table 4-6: The estimated prevalence of hazardous patterns of alcohol use in the general population of the Czech Republic aged 18–64, in % (Sovinová and Csémy, 2010)

Sample	Gender	Low risk	Hazardous or harmful drinking (abuse)	High-risk drinking, risk of dependency (addiction)
General population	Males	67.1	29.1	3.8
	Females	90.4	9.3	0.3
	Total	78.7	19.2	2.1
General practitioners' patients	Males	76.7	22.2	1.1
	Females	93.5	6.3	0.2
	Total	85.3	14.0	0.7

When recalculated to the population of the Czech Republic aged 18–64, the number of people using alcohol in a hazardous or harmful manner in 2010 can be estimated at 990 thousand to 1.4 million (of whom 800 thousand to 1 million were men and 220–320 thousand were women) and the number of people with a considerable risk of alcohol dependency at 50–150 thousand (of whom 40–135 thousand were men and 7–10 thousand were women).

[65] For instance, the data on the treatment of drug users and the deaths associated with drug use; see the chapter on Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55) and the chapter on Drug-Related Deaths and Mortality of Drug Users (p. 95).

[66] AUDIT contains 10 items and the score is 0-40 points, depending on the answers. The recommended rating is: 0-7 points – drinking with a low risk, 8-19 points – hazardous or harmful drinking (abuse), 20-40 points – high-risk drinking with a substantial probability of alcohol dependency. For details see e.g. http://www.drogy-info.cz/index.php/o_nas/evaluace/banka_evaluacnich_nastroju.

5 Drug-Related Treatment: Treatment Demand and Treatment Availability

The number of outpatient facilities providing treatment for drug users in 2010 grew by almost a third; despite this, the number of outpatients in treatment decreased. This was mainly due to a year-on-year decrease of over 7% in patients using illegal drugs (excluding alcohol and tobacco). There was also a decline among the three largest patient groups – those treated for opiate/opioid, stimulant, and polydrug use.

In 2010 two new sobering-up stations were registered to treat acutely intoxicated persons, and this had an impact on the increase in the number of beds and number of persons admitted.

Once again the number of patients in substitution treatment rose, both in specialised centres and in other medical practices prescribing buprenorphine products (Subutex® and Suboxone®). Treatment involving these products is still not fully recorded in the Substitution Treatment Register.

For the first time, data on patient detoxification in inpatient healthcare facilities were collected. It was found that in 2010, detoxification units were located in 16 inpatient facilities with 163 dedicated beds, and patients also underwent detoxification in non-dedicated beds in another 12 facilities. In the reporting year a total of 6,650 persons underwent addictive substance detoxification, with 3,092 of these persons undergoing detoxification from illicit drugs.

To process hospitalisations in 2010, the methodology for selecting facilities included under psychiatric inpatient facilities was changed. Besides psychiatric hospitals and psychiatric wards in general hospitals, data were also processed for other inpatient facilities that operate inpatient psychiatric wards. In 2010 there was a decrease in the number of hospitalisations of illicit drug users in these facilities. This decline is attributable to patients hospitalised for disorders caused by polydrug and opiate/opioid use; the number of hospitalisations for disorders caused by the use of other (non-cocaine) stimulants increased.

The number of drug users in the Public Health Service's Register of Treatment Demands has risen. In 2010, a total of 9,005 drug users sought treatment services, which is about 200 more than in 2009. In comparison with previous years, the slight downward trend is shifting, bringing the number of treatment demands up to the same levels as in 2004 and 2005.

Treatment demands have long been dominated by stimulant users, the largest group among all those making treatment demands (62.9%) and among first-time treatment demands (67.5%); the number of pervitin users also shows the largest year-on-year increase. The second largest group is composed of opiate users (23.1%), while cannabis users were in second place among first-time demands (15.9%); this is unchanged from 2009. In terms of age structure, a slight aging of the population among those making treatment demands is evident. Although the average age rose slightly year-on-year, in the medium term there is a clear increasing trend. The average age of those making treatment demands for the first time was 25.7 years and 27.3 years for all demands in 2010. Over the past decade, the average age of those making first-time demands and repeat demands has risen by over four years. Women steadily make up one third of treatment demands. The highest relative prevalence and incidence of treatment demands was recorded in the Ústí nad Labem region and in Prague. These characteristics correspond to the gender and geographical distribution of problem drug users in the Czech Republic.

5.1 Strategy/Policy

In 2010 the Government approved the National Drug Policy Strategy for the Period 2010–2018, and in 2011 it approved the 2010–2012 Action Plan. Treatment and social reintegration are one of the four pillars of the strategy, and all four priorities of the action plan concern this area (for more information see the chapter on National Action Plan, Strategy, Evaluation, and Coordination, p. 9). The Action Plan defines the following areas of activities for treatment and social integration:

- conceptual definition of the availability and continuity of treatment and after-care programmes for drug users;
- the development of special interventions for selected target groups of drug users, including increasing the quality of substitution treatment for opiate users;
- the development of programmes for drug users in prison and keeping these programmes available.

Several healthcare regulations related to the profession of an addictologist and conditions for operating healthcare facilities focused on addiction treatment were amended in 2010; see the chapter on Legal Framework (p. 6).

The First Faculty of Medicine at Charles University in Prague (Centre for Addictology) offers bachelor's and master's programmes in addictology. An accredited training qualification course called Addictologist consisting of over 900 lessons was opened in September 2011. The 2008 and 2009 Annual Reports provide details on professional competency and training for practitioners in the field of addictology.

5.2 Treatment System

Treatment and counselling programmes for drug users and addicts and the capacity and occupancy of these programmes in 2010 are summarised in Table 5-1.

Information on treatment and counselling services designated for drug users is also provided in the other chapters. Treatment services available in prisons are covered in the chapter on Responses to Drug-related Health Issues in Prisons (p. 128) and the selected issue chapter on Drug-Related Health Policies and Services in Prison (p. 139); low-threshold drop-in and counselling services and outreach programmes are described in the chapter on Responses to Health Correlates and Consequences (p. 104) and after-care programmes are discussed in the chapter on Social Correlates and Social Reintegration (p. 112).

Table 5-1: Treatment programmes providing services to drug users in the Czech Republic in 2010

Type of programme	Total[1]			Alcohol and non-alcohol drugs			
				Illegal 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 psychiatric facilities	453	–	40,198 [2]	370	15,187	428	24,182
Outpatient (non-healthcare) programmes operated by NGOs	13 [5]	–	1,813 [5]	Non-alcohol (illegal) drug users are the main target group for these facilities			
Day care centres	1	10	40	Non-alcohol (illegal) drug users are the main target group for these facilities			
Registered healthcare facilities providing substitution treatment	45	–	2,113	Opiate users are the target group for these facilities			
Sobering-up stations	16	157	30,487	Alcohol users are the main target group for these facilities. Separate data for alcohol and illegal drugs are not available.			
Low-threshold (drop-in) centres and outreach programmes	96	–	32,374	Non-alcohol (illegal) drug users, specifically problem (injecting) drug users, are the main target group for these facilities			
Detoxification units in inpatient healthcare facilities	16 [6] (28 [7])	163	6,650 [2]	–	3,091	–	3,558
Psychiatric institutes for adults	17	9,058 [3] (1,354 [4])	10,835 [2]	–	3,550	–	7,285
Psychiatric department in hospitals	31	1,374 [3]	4,024 [2]	–	1,644	–	2,378
Psychiatric institutes for children	3	260 [3]	33 [2]	–	31	–	2
Other inpatient facilities with psychiatric department	3	126	469 [2]	–	131	–	338
Therapeutic communities	15–20	160 [5]	408 [5]	Non-alcohol (illegal) drug users are the main target group for these facilities			
Specialised departments in residential special education facilities for children at risk of drug addiction	5	68	137	Non-alcohol (illegal) drug users are the main target group for these facilities			
After-care programmes	25–30	127 [5]	987 [5]	Non-alcohol (illegal) drug users are the main target group for these facilities			
Detoxification units in prisons	5	n/a	686	This regards data on non-alcohol (illegal) drug detoxification			
Substitution treatment in prisons	8	n/a	67	Opiate users are the target group for these programmes			
Departments for differentiated service of a sentence (voluntary treatment)	7	300	437	This regards data on the treatment of non-alcohol (illegal) drug users			
Departments for undergoing compulsory substance use treatment in prisons	3	109	128	This regards data on the treatment of non-alcohol (illegal) drug users			
Drug-free zones in prisons	33 [8]	2 075	3,443	Non-alcohol (illegal) drug users are the main target group for these facilities			
NGO programmes in prisons	15/32 [9]	–	707 [10]	Non-alcohol (illegal) drug users are the main target group for these programmes			

Note: [1]This is the total capacity and total number of users of all addictive substances; if available, data for alcohol and non-alcohol drugs are given in the subsequent columns. [2]This is the number of patients with the primary dg. F10–F19. [3]Number of all psychiatric beds. [4]Number of beds in all facilities treating AT patients. [5]Data from programmes supported by grants from the Government Council for Drug Policy Coordination in 2010 (13 outpatient programmes,10 therapeutic communities, and a total of 16 after-care programmes, 13 of which are intensive after-care programmes that provide sheltered housing). [6]Number of detoxification units with dedicated beds. [7]Total number of inpatient facilities providing detoxification to AT patients, including 12 facilities providing detoxification in various wards and departments without dedicated beds. [8]In principle, drug-free zones are not a treatment programme, but rather a safe, motivating environment for prisoners who are prepared to abstain; that said, four drug-free zones have a therapy programme. [9]Number of programmes/prisons in which these operated. [10]Number of visits to prisons.

5.2.1 Professional Competency of Services and Quality Assurance

Detailed information about the system for securing professional competences for drug services (certification system) is provided in the Selected Issue on History, Methods, and Implementation of National Treatment Guidelines in the 2009 Annual Report.

In May 2011, a total of 155 programmes had valid certificates of professional competency; see Table 5-2.

Table 5-2: Overview of certified programmes by type as of 16 May 2011

Type of service	Number of programmes
Detoxification	2
Outreach programmes	49
Low-threshold and counselling services	52
Outpatient treatment	15
Day care programmes	1
Short- and medium-term residential treatment	2
Inpatient treatment in therapeutic communities	10
Outpatient after-care programmes	16
Substitution treatment	8
Total	**155**

In October 2010, the Government Council for Drug Policy Coordination approved changes to the basic certification process documents – the Certification Rules and the Local Audit Methodology.

As part of the operational programme Human Resources and Employment, announced by the Ministry of Labour and Social Affairs, the Exchange of Experience and Dissemination of Best Practice in Drug Service Quality Management project has been implemented since 2009. The aim of this project is to develop best practices of services and evaluate the quality of these services; for more information see the 2009 Annual Report. An expert group for innovating the standards of professional competency also worked in the project.

5.2.2 Outpatient Treatment

5.2.2.1 Psychiatric Facilities

Outpatient medical treatment for alcohol and drug users is currently provided primarily at outpatient psychiatric facilities and at AT (alcohol/drug treatment) facilities specialised in treating addiction; these were formerly alcohol addiction counselling services. The number of these specialised facilities ranged from 165 to 180 between 1963 and 1993. In recent years the network of AT outpatient facilities has not been centrally administrated and their number is not monitored. It is estimated that there are currently between 50 and 70 psychiatric outpatient facilitiesspecialising in addiction treatment in the Czech Republic (Mravčík et al. 2011a).

In 2010 a total of 453 outpatient psychiatric departments and units reported having patients who used legal or illegal drugs. As these wards and facilities include all outpatient facilities that treated at least one patient, these are not solely specialised AT clinics. Compared to 2009, the number of these healthcare facilities increased by 107 (i.e. nearly 31%); see Table 5-3. This high increase is mainly due to the thorough collection of data from facilities that treated even just a single patient with the primary diagnosis of F10–F19. Growth was especially evident among outpatient facilities that treated a maximum of 50 patients in 2010 (from 147 in 2009 to 258 in 2010); see Table 5-4. A total of 428 outpatient facilities had patients using alcohol on record. Nearly 79% of these facilities were specialised psychiatric services, while 10% of the facilities were located in the outpatient areas of a hospital. A total of 370 outpatient facilities cared for users of illegal addictive substances, with nearly 78% of these being psychiatric clinics and almost 10% being located in the outpatient areas of a university hospital or emergency care hospital; see Table 5-5. The greatest percentage of out-patient facilities caring for addictive substance users were in Prague (17%), South Moravia (13%), and Moravia-Silesia (12%). Clinics with over 300 patients on record were predominantly located in Prague (11 out of 29 clinics) and in the Moravia-Silesia region (6 clinics); see Table 5-6 (Nechanská, 2011c).

Table 5-3: Number of outpatient healthcare facilities and number of addictive substance users treated in 2000–2010 (Nechanská et al. 2011; Nechanská, 2011c)

Year	Illegal drugs		Alcohol		Addictive substances total*	
	Number of facilities	Number of clients	Number of facilities	Number of clients	Number of facilities	Number of clients
2000	272	11,423	298	27,021	320	39,721
2001	285	13,050	309	28,582	330	42,955
2002	288	14,203	317	25,400	342	41,136
2003	312	15,786	340	25,017	368	42,881
2004	320	14,040	358	25,235	382	40,625
2005	337	16,394	379	27,440	401	44,971
2006	340	16,392	367	26,966	394	44,887
2007	311	15,684	348	25,342	367	42,196
2008	298	15,711	328	25,293	349	42,612
2009	298	16,343	331	24,206	346	41,419
2010	370	15,187	428	24,182	453	40,198

*Note: *Includes tobacco users treated.*

Table 5-4: Number of outpatient healthcare facilities according to number of addictive substance, alcohol, and drug users treated in 2006–2010 (Nechanská et al. 2011; Nechanská, 2011c)

Number of clients	Illegal drugs					Alcohol					Addictive substances total				
	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010
1–10	161	140	124	118	174	85	85	72	69	128	72	63	53	49	88
11–50	110	107	114	119	132	144	133	123	124	158	120	110	101	98	170
51–100	34	30	24	23	25	63	64	69	70	73	83	90	86	81	72
101–150	11	9	10	11	11	30	21	24	21	35	40	31	37	43	52
151–200	4	7	7	4	8	15	17	14	18	12	16	17	16	18	17
201–300	10	7	6	11	10	15	13	11	14	12	29	24	24	23	25
301–400	3	5	4	5	4	5	6	5	8	6	10	11	8	14	16
Over 401	7	6	9	7	6	10	9	10	7	4	24	21	24	20	13
Total	**340**	**311**	**298**	**298**	**370**	**367**	**348**	**328**	**331**	**428**	**394**	**367**	**349**	**346**	**453**

Table 5-5: Number of addictive substance users (including alcohol and tobacco users) treated in outpatient healthcare facilities in 2006–2010 (Nechanská et al. 2011; Nechanská, 2011c)

Type of facility	2006		2007		2008		2009		2010	
	Number of facilities	Number of clients	Number of facilities	Number of clients	Number of facilities	Number of clients	Number of facilities	Number of clients	Number of facilities	Number of clients
Inpatient facilities with psychiatric outpatient facilities	60	13,081	54	12,458	53	11,725	55	10,259	59	9,717
Independent psychiatric specialists	300	25,563	279	23,119	265	24,524	259	25,386	354	25,858
Addiction treatment facilities	5	1,498	5	1,513	5	1,334	5	1,604	6	1,109
Other outpatient facilities	29	4,745	29	5,106	26	5,029	27	4,170	34	3,514
Total	**394**	**44,887**	**367**	**42,196**	**349**	**42,612**	**346**	**41,419**	**453**	**40,198**

Table 5-6: Number of outpatient healthcare facilities according to number of addictive substance users treated and facility locations in 2010 (Nechanská, 2011c)

Region	Number of clients								Total number of facilities	Total number of clients
	1–10	11–50	51–100	101–150	151–200	201–300	301–400	Over 401		
Prague	19	26	9	6	1	5	6	5	**77**	**9,175**
Central Bohemia	6	14	3	7	0	2	1	0	**33**	**2,485**
South Bohemia	5	9	3	2	0	1	0	0	**20**	**926**
Pilsen	10	7	3	1	2	1	0	2	**26**	**2,525**
Karlovy Vary	2	6	2	0	1	1	0	0	**12**	**702**
Ústí nad Labem	9	8	5	4	1	1	1	0	**29**	**1,864**
Liberec	3	4	2	2	2	1	0	0	**14**	**1,082**
Hradec Králové	6	10	3	1	1	0	3	0	**24**	**1,864**
Pardubice	0	8	1	3	1	1	0	0	**14**	**1,036**
Vysočina	6	12	4	3	0	3	0	0	**28**	**1,727**
South Moravia	12	24	9	6	3	4	0	1	**59**	**4,081**
Olomouc	6	16	9	4	0	1	1	2	**39**	**3,781**
Zlín	2	4	10	6	0	2	1	0	**25**	**2,427**
Morava-Silesia	2	22	9	7	5	2	3	3	**53**	**6,523**
Total	**88**	**170**	**72**	**52**	**17**	**25**	**16**	**13**	**453**	**40,198**

5.2.2.2 Opiate Substitution Treatment

In 2010, three products for the substitution treatment of opiate addiction were available: (1) methadone prepared from an imported generic substance, available in specialised substitution centres since 1997; (2) Subutex®, containing buprenorphine as the active substance, available since 2000, and (3) Suboxone®, a combined medicinal product containing buprenorphine and naloxone as the active ingredients, available since February 2008. Subutex® and Suboxone®, which are available in pharmacies as proprietary medicinal products, can be prescribed by any medical doctor, regardless of their specialisation. Substitution drugs are administered only orally in treatment.

Additional proprietary medicinal products (PMPs) containing methadone or buprenorphine[67] for substitution treatment were registered in the Czech Republic in 2009–2011, and several were released onto the market. It has been possible for Suboxone® 8 mg to be partially reimbursed from the resources of the health insurance system since 2010[68].

A total of 22.5 kilograms of pure methadone substance was imported into the Czech Republic and 3,308 grams of buprenorphine in Subutex® and Suboxone® were distributed in 2010; see Table 5-7. Since 2008 there has been a decline in the share of Subutex® and an increase in the share of Suboxone® in the total amount of buprenorphine distributed (consumed) for substitution treatment, although Subutex® retains a dominant share (Ministerstvo zdravotnictví ČR, IOPL, 2011); see Figure 5-1.

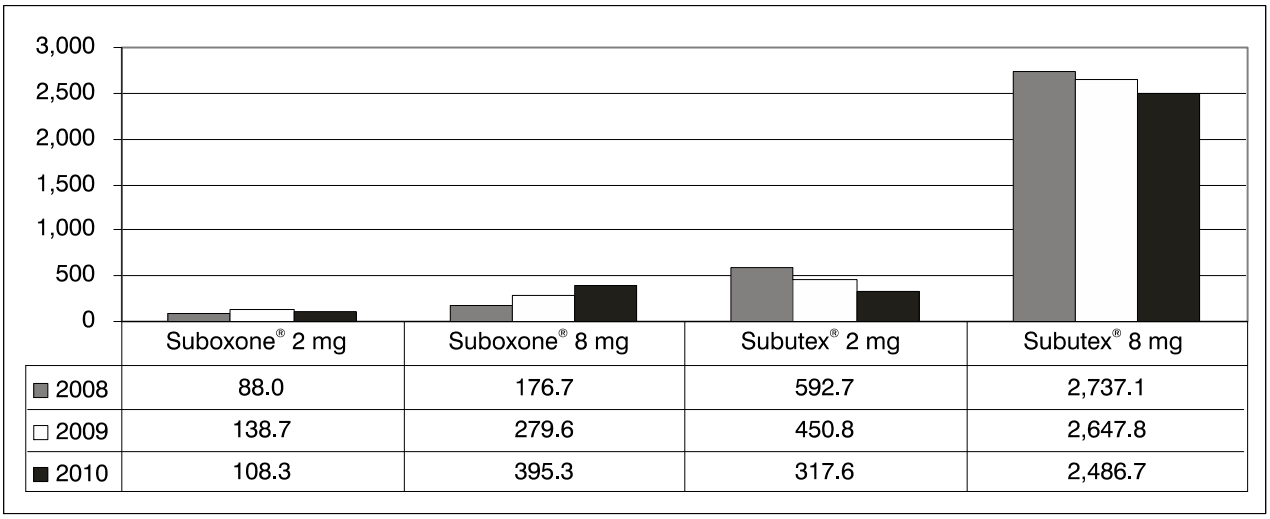
[67] On 18 March 2009, the State Institute for Drug Control (SUKL) registered Methadone-Zentiva® 5mg/ml in the form of an oral solution in packages of 10, 50, and 1000 ml; on 1 July 2011, the Institute's decision not to grant reimbursement for this medication from the public health insurance system came into legal force. Whether (and when, if so) the proprietary medicinal product methadone will be placed on the market despite the fact that reimbursement from the public health insurance system was not granted is not yet known. The main reasons not to grant the reimbursement included the inferior safety profile of the medication (a higher risk of overdose in comparison with buprenorphine) and the fact that the public health insurance system already provides reimbursement for Suboxone® 8 mg. In addition, on 29 October 2009 the State Institute for Drug Control (SUKL) registered the medication Buprenorphine Alkaloid® in strengths of 0.4 mg, 2 mg, and 8 mg in the form of sublingual tablets and on 19 May 2010 the medicinal product Ravata® in strengths of 2 mg and 8 mg, also in the form of sublingual tablets. Buprenorphine Alkaloid® was placed on the Czech market on 28 January 2011, in strengths of 2 mg and 8 mg, and Ravata® on 15 June 2011 in the same strengths. The latest substitution product, authorised in the Czech Republic on 15 September 2010, is Addnok®, containing buprenorphine, also in strengths of 0.4 mg, 2 mg, and 8 mg; this product has not yet been placed on the market.

[68] On 1 February 2010, a decision by the State Institute for Drug Control (SUKL) came into effect on the basis of which Suboxone® 8 mg is partly reimbursed. Reimbursement is subject to medical expertise (it must be prescribed by a psychiatrist or physician with specialisation in the field of addiction), and the treatment is not reimbursed without the patient's compliance (for example, if they miss an appointment); an additional condition for the reimbursement of Suboxone® is that treatment must take place in (selected) specialised medical facilities. This is the first time in the country's history that a medicinal product for substitution treatment for opiate/opioid addiction has been covered by the public health insurance system. However, the nature and scope of the conditions for reimbursement are such that, in practice, the cost is never covered by the public health insurance system.

Table 5-7: Imported (methadone) and distributed (buprenorphine) quantities of substitution drugs in 1999–2010 (Ministerstvo zdravotnictví ČR, IOPL, 2011)

Year	Methadone – import (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

Figure 5-1: Quantity of buprenorphine (g) distributed in individual medicinal products in 2008–2010 (Ministerstvo zdravotnictví ČR, IOPL, 2011)



	Suboxone® 2 mg	Suboxone® 8 mg	Subutex® 2 mg	Subutex® 8 mg
2008	88.0	176.7	592.7	2,737.1
2009	138.7	279.6	450.8	2,647.8
2010	108.3	395.3	317.6	2,486.7

All physicians administering a substitution drug are obliged by law to report patient data to the National Register of Users of Medically Indicated Substitution Substances (NRULISL, the Substitution Treatment Register). This register has been in existence since May 2000 and is administered and compiled by the Institute of Health Information and Statistics of the Czech Republic. An electronic web-based NRULISL application has been in operation since November 2007[69]. As there are still some practices which do not have a personal computer or are not connected to the internet, NRULISL was adapted in 2010 so that patient reporting could also be conducted using paper forms[70].

A total of seven accredited methadone centres provided substitution therapy in 2000, and their number gradually increased to 13 facilities in 2007. Another 11 reporting facilities were added in 2008, when unaccredited facilities also started to report to the electronic version of the Substitution Treatment Register (such as psychiatric outpatient facilities and general practitioners). By 2009 there were 34 healthcare facilities reporting treated clients, including general practitioners of adult medicine (two facilities), psychiatric outpatient facilities (five facilities), eight prisons, and a military hospital. In 2010 the number of reporting facilities rose to 45, mainly as a result of reporting from independent psychiatric services and AT outpatient units at hospitals. The methadone centre *Ulice – Agentura sociální práce*, a civic association, in Pilsen started to report clients in June 2010, followed by the AT clinic at Semily Hospital (Liberec Region) in December 2010. As a result, the Pardubice Region remains the only region that does not have an actively reporting facility (Nechanská et al. 2011; Nechanská, 2011g); see Table 5-8.

[69] At https://snzr.uzis.cz/nrulisl/. Until 2007 the register was maintained as a simple database, and the reports were collated only from specialised substitution treatment centres accredited by the Ministry of Health and forwarded by way of paper forms and reports taken by telephone.

[70] However, use is subject to the consent of the administrator of the register (Institute of Health Information and Statistics) because without an online connection, the physician is unable to verify that the patient is not already being treated at another facility. Permission is restricted to a period of approximately three months, during which the physician should obtain an appropriate computer and connection to the internet.

Table 5-8: Number of healthcare facilities actively reporting clients to the Substitution Treatment Register, by region, 2000–2010 (Nechanská et al. 2011; Nechanská, 2011g)

Regional location	2000*	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Prague	2	2	2	2	2	2	3	3	4	6	10
Central Bohemia	1	1	1	1	1	1	1	1	2	3	3
South Bohemia	0	0	0		0	1	1	1	2	1	2
Pilsen	0	0	0	0	0	0	0	0	0	1	2
Karlovy Vary	0	0	0	0	0	0	1	1	2	1	2
Ústí nad Labem	1	1	1	1	1	1	1	1	1	2	2
Liberec	0	0	0	0	0	0	0	0	0	0	1
Hradec Králové	1	1	1	1	1	1	1	2	3	4	4
Pardubice	0	0	0	0	0	0	0	0	0	0	0
Vysočina	0	0	0	0	0	0	0	0	1	1	1
South Moravia	1	1	1	1	1	1	1	1	2	2	4
Olomouc	1	1	1	1	1	1	1	1	1	1	1
Zlín	0	0	0	0	0	0	0	0	0	1	2
Morava-Silesia	0	1	1	1	1	1	1	1	2	2	3
Military hospital	0	0	0	0	0	0	0	0	0	1	1
Prison Service of the Czech Republic	0	0	0	0	0	0	1	1	4	8	7
Total	**7**	**8**	**8**	**8**	**8**	**9**	**12**	**13**	**24**	**34**	**45**

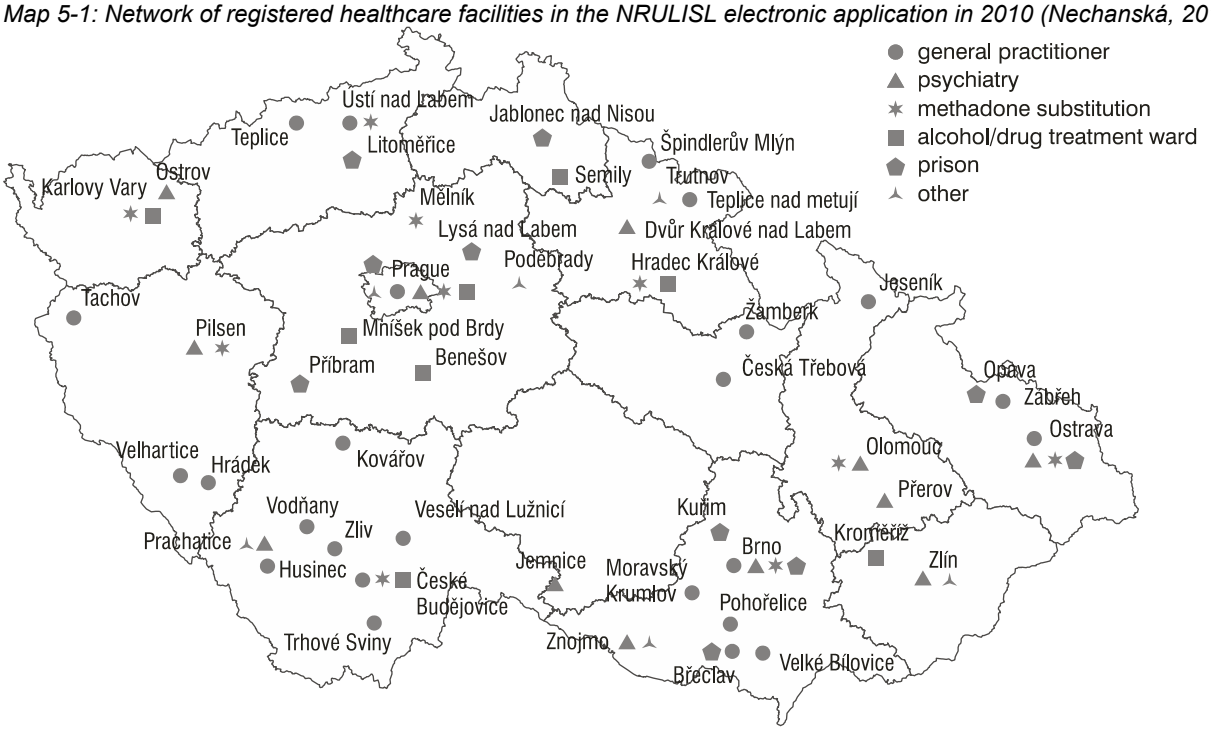
*Note: * The facility started to report clients to the Substitution Treatment Register from May 2000.*

At the end of 2010 a total of 96 facilities were registered in the Substitution Treatment Register (of these, 22 were AT outpatient facilities, 25 outpatient psychiatric facilities, 29 general practitioners of adult medicine, 8 other departments and units, and 11 prisons); see Table 5-9 and Map 5-1 (Nechanská et al. 2011; Nechanská, 2011g).

Table 5-9: Number of registered healthcare facilities in the NRULISL electronic application, 2007–2010 (Nechanská et al. 2011; Nechanská, 2011g)

Name of department/ward	Year of registration				Total
	2007	2008	2009	2010	
AT outpatient facilities	0	11	3	8	22
Psychiatrist outpatient facilities	1	11	8	5	25
General practitioner for adults	0	4	19	6	29
Other departments/units	0	1	3	4	8
Prison Service of the Czech Republic	0	10	0	1	11
Military hospital	0	0	1	0	1
Total	**1**	**37**	**34**	**24**	**96**

Map 5-1: Network of registered healthcare facilities in the NRULISL electronic application in 2010 (Nechanská, 2011g)



In November and December 2010, INRES-SONES conducted a regular representative omnibus sociological study among Czech physicians. On the initiative of the National Focal Point, the study included a module with questions concerning the prevalence of problem drug use and physicians' experience of administering substitution treatment (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010a); for results regarding the problem use of substitution medication, see the chapter on Problem Drug Use (p. 48).

In 2010 a total of 1,178 physicians from throughout the Czech Republic were questioned. The group was proportionally representative of the general Czech population of physicians in terms of gender, age, method of practising medicine (private practice vs. other), and region. There were 340 physicians (22.3% of those contacted) who refused to participate in the interview. At the request of the National Focal Point, the number of general practitioners of adult medicine and paediatricians was increased to approximately double their actual representation in the Czech population of physicians because of problem drug use prevalence estimates. The selected group therefore cannot be considered representative in terms of specialisation – the number of psychiatric specialists, for example, is very low.

A total of 31 physicians (2.6%) out of the total sample stated that they provide substitution treatment for addiction to opiates to a total of 271 patients, with an average of 8.7 patients per prescribing physician and 0.23 patients per physician in total; see Table 5-10. 14 physicians reported methadone, 18 Subutex®, and four Suboxone® as the substance their patients receive as treatment.

Table 5-10: Physicians providing substitution treatment and the number of patients in substitution treatment in the 2010 survey of Czech physicians (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010a)

Specialisation	**Total in the sample**	**Provides substitution treatment**		**Number of patients in substitution treatment**		
		Number	Share (%)	Total number	Average per prescribing physician	Average for all physicians
General practitioner for adults	342	17	5.0	86	5.1	0.25
General practitioner for children and adolescents	212	3	1.4	120	40.0	0.57
Practical independent gynaecology	154	2	1.3	4	2.0	0.03
Surgery	95	2	2.1	13	6.5	0.14
Internal	107	6	5.6	46	7.7	0.43
Psychiatry	8	1	12.5	2	2.0	0.25
Other	260	0	0.0	0	0.0	0.00
Total	**1178**	**31**	**2.6**	**271**	**8.7**	**0.23**

The proportions found for prescribing physicians according to their specialisation, as well as the average number of patients in substitution treatment per physician, correspond with the results of the same study conducted in 2007, although some specialisations (psychiatrists) are underrepresented in the 2010 survey. In 2007 it was found that 11% of psychiatrists, 2% of surgeons, 1% of internists, and 5% of general practitioners of adult medicine provided substitution treatment (Subutex®), which is practically the same as the percentage found in 2010. The average number of patients in substitution treatment per general practitioner overall also remained practically unchanged – 0.25% (for more information see the 2007 Annual Report).

Given the structure of the study sample and the results based on specialisation, the number of patients in substitution treatment in the Czech Republic was estimated only for general practitioners of adult medicine – the results obtained from the general practitioners in the sample were extrapolated to the total number of 5,298 general practitioners of adult medicine in the Czech Republic in 2010.

Table 5-11: Estimate of the number of patients in opiate substitution treatment provided by general practitioners for children and adolescents in 2010 (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010a)

Gender	Indicator	Total patients in substitution treatment	Treated with Subutex®	Treated with Suboxone®	Treated with methadone
Males	Mean value	744	496	77	170
	95% confidence interval	248–1,239	101–890	0–178	25–316
Females	Mean value	589	155	77	356
	95% confidence interval	0–1,224	42–268	0–178	0–910
Total	**Mean value**	**1,332**	**651**	**155**	**527**
	95% confidence interval	**279–2,385**	**171–1,130**	**0–337**	**0–1,169**

It can be estimated that, in 2010, approximately 230 general practitioners of adult medicine in the Czech Republic provided Subutex® or Suboxone® to their patients, prescribing Subutex® to approximately 650 patients and Suboxone® to 160 patients. After extrapolation, there are approximately 1,300 patients in substitution treatment under the care of general practitioners – this figure probably also includes patients on methadone, which is only available at (specialised) methadone substitution centres. In 2007, there were an estimated total of 240 general practitioners prescribing Subutex® to 1,360 patients (furthermore, there were an estimated 150 psychiatrists prescribing Subutex® to 3,000 patients in 2007); see the 2007 Annual Report.

Additional questions in the study related to reports made to the Substitution Treatment Register (NRULISL). The responses show that just 71% of the physicians providing substitution treatment are registered, and only a third of the physicians who provide substitution report patients to the register; for a breakdown by specialisation see Table 5-12.

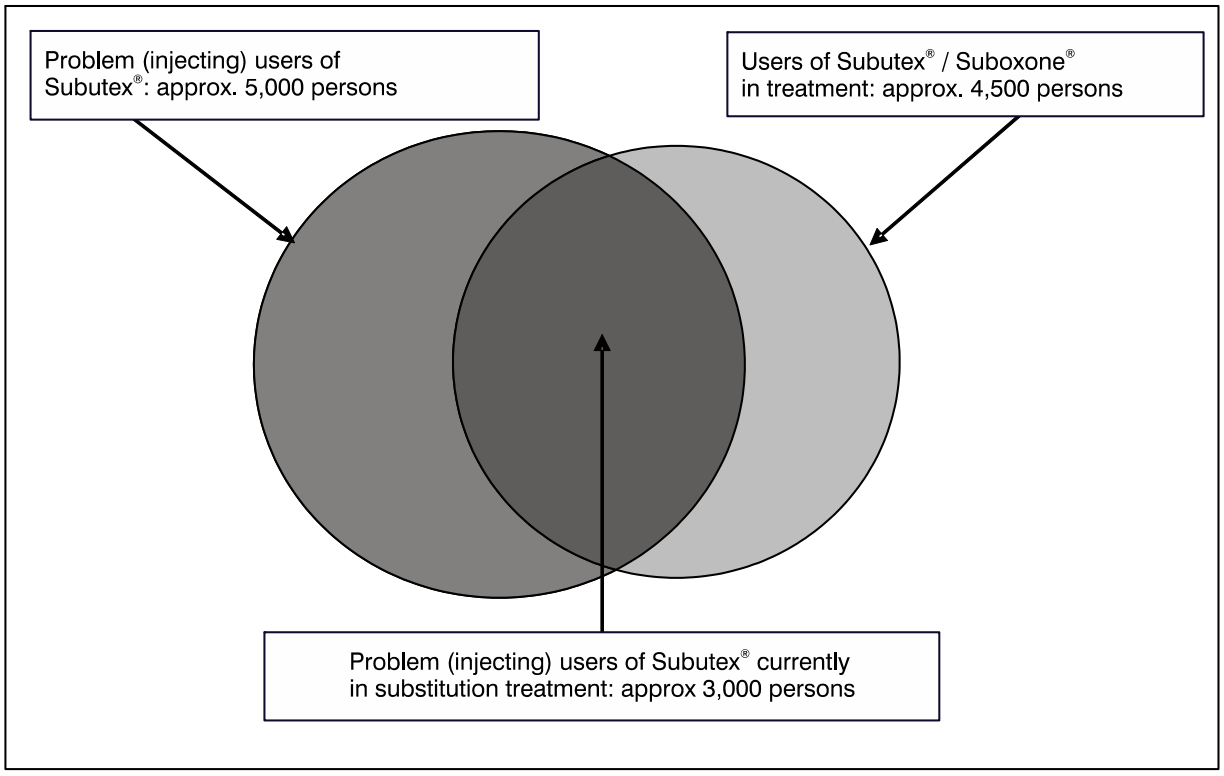
Table 5-12: Registration in NRULISL and patient reporting to NRULISL in the 2010 survey of Czech physicians (Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010a)

Specialisation	Number of physicians providing substitution treatment	Registered in NRULISL		Reports patients to NRULISL					
				Yes		Yes, but not always		No	
		Number	%	Number	%	Number	%	Number	%
General practitioner for adults	17	13	76.5	7	41.2	6	35.3	4	23.5
General practitioner for children and adolescents	3	2	66.7	0	0.0	2	66.7	1	33.3
Practical independent gynaecology	2	2	100.0	2	100.0	0	0.0	0	0.0
Surgery	2	0	0.0	0	0.0	0	0.0	2	100.0
Internal	6	4	66.7	2	33.3	2	33.3	2	33.3
Psychiatry	1	1	100.0	0	0.0	1	100.0	0	0.0
Total	**31**	**22**	**71.0**	**11**	**35.5**	**11**	**35.5**	**9**	**29.0**

The population of substitution treatment patients taking medicinal products containing buprenorphine and problem users of buprenorphine (especially Subutex®) overlap. In the Multiplier 2010 study (for more information see the chapter on Problem Drug Use, p. 48) focused on the estimated share of problem drug users in contact with low-threshold facilities, data were found regarding the proportion of problem opiate users who were included in the substitution programme in 2009. The share of problem users who are participating in substitution treatment was estimated at 8% (95% CI: 7–10%) of problem drug users or 23% (95% CI: 20–27%) of problem opiate users – this represents an estimated approximately 3,000 people (mean estimate); for more information see the 2009 Annual Report.

The overlap of both groups – groups of patients using medicinal products containing buprenorphine in treatment and groups of patients in contact with low-threshold programmes with problem use (administration by injection and/or not prescribed by a doctor, black market products) of products containing buprenorphine (especially Subutex®) – is generally described in Figure 5-2. The interface between substitution treatment and other harm reduction interventions can be viewed as a positive factor[71] and used in the treatment process, where it is still viewed negatively and as a stigma.

Figure 5-2: Overlap of problem Subutex® users and substitution treatment patients using buprenorphine-based products in 2009–2010, estimate based on available data

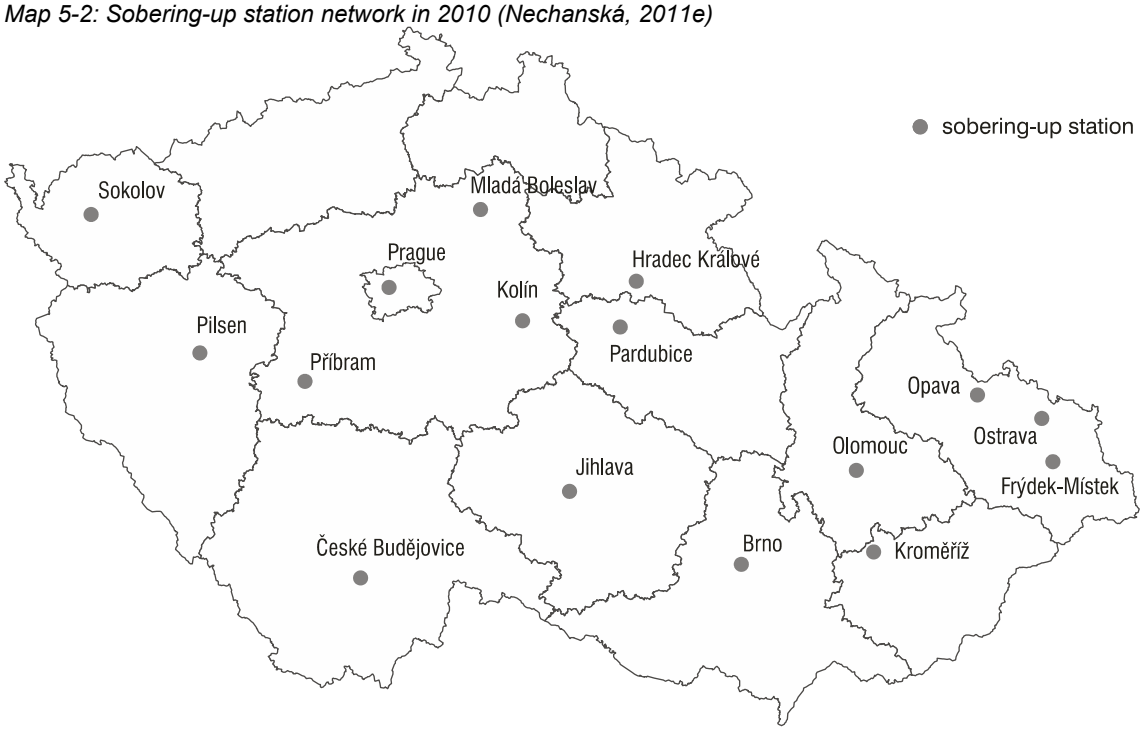


5.2.2.3 Sobering-up Stations

Sobering-up stations – special healthcare facilities for short-term stays (in the range of several hours) and for detoxification in case of acute intoxication, particularly alcohol intoxication – are a special type of outpatient facility in the Czech Republic. The first information about the number of sobering-up stations is available from 1963, when 21 facilities with 222 beds were reported. Numbers peaked at the end of the 1980s, when 34 stations with about 330 beds were reported; in 2009 there were just 14 facilities with 137 beds. Two new sobering-up stations were reported in 2010 in the Central Bohemia and Olomouc regions, raising the number of sobering-up stations to 16 with a total of 157 beds. In 2010 sobering-up stations were located in all regions except Ústí nad Labem and Liberec – Map 5-2 (Nechanská et al. 2011; Mravcík et al. 2011a; Nechanská, 2011e).

[71] The current involvement in both types of interventions is proving to be associated with a lower risk of HIV and HCV infection among injecting drug users and with a reduction in risk behaviour among injecting drug users (Van den Berg et al. 2007; Turner et al. 2011; Hagan et al. 2011).

Map 5-2: Sobering-up station network in 2010 (Nechanská, 2011e)



5.2.2.4 Outpatient Treatment Provided by NGOs

Outpatient treatment in the Czech Republic is also available through NGOs; some of these programmes are accredited as healthcare facilities, and some also provide substitution treatment (these facilities and their clients may also be included in other reporting systems); the common denominator is that the NGOs apply for grants from the state budget to provide their services. In 2010 the Government Council for Drug Policy Coordination funded 13 outpatient programmes that provided services to a total of 1,813 drug-using clients (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j); see Table 5-13.

Table 5-13: Outpatient treatment facilities operated by NGOs and client numbers in 2003–2010 (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Year	Number of subsidised programmes	Number of clients – drug users
2003	19	1 590
2004	20	1 493
2005	18	1 743
2006	15	2 428
2007	13	1 642
2008	13	2 379
2009	15	2 130
2010	13	1 813

In addition, only one facility in Prague, which has been run by the SANANIM civic association since 1996, offers long-term outpatient treatment in the form of a three-month course of treatment at a day care centre. The capacity of the programme is approximately ten persons.

5.2.3 Residential Treatment

5.2.3.1 Detoxification Units

Detoxification units are inpatient healthcare facilities which are usually established and operated as adjuncts to psychiatric wards and addiction treatment departments. These serve for short-term (usually one to three weeks) residential treatment aimed at managing the withdrawal syndrome prior to entering other (typically also residential) abstinence-oriented treatment.

Further information about detoxification units was first obtained in late August and early September during a study conducted by the Institute of Health Information and Statistics for the purposes of the Czech National Monitoring Centre for Drugs and Drug Addiction (the National Focal Point); for more information see the 2009 Annual Report[72].

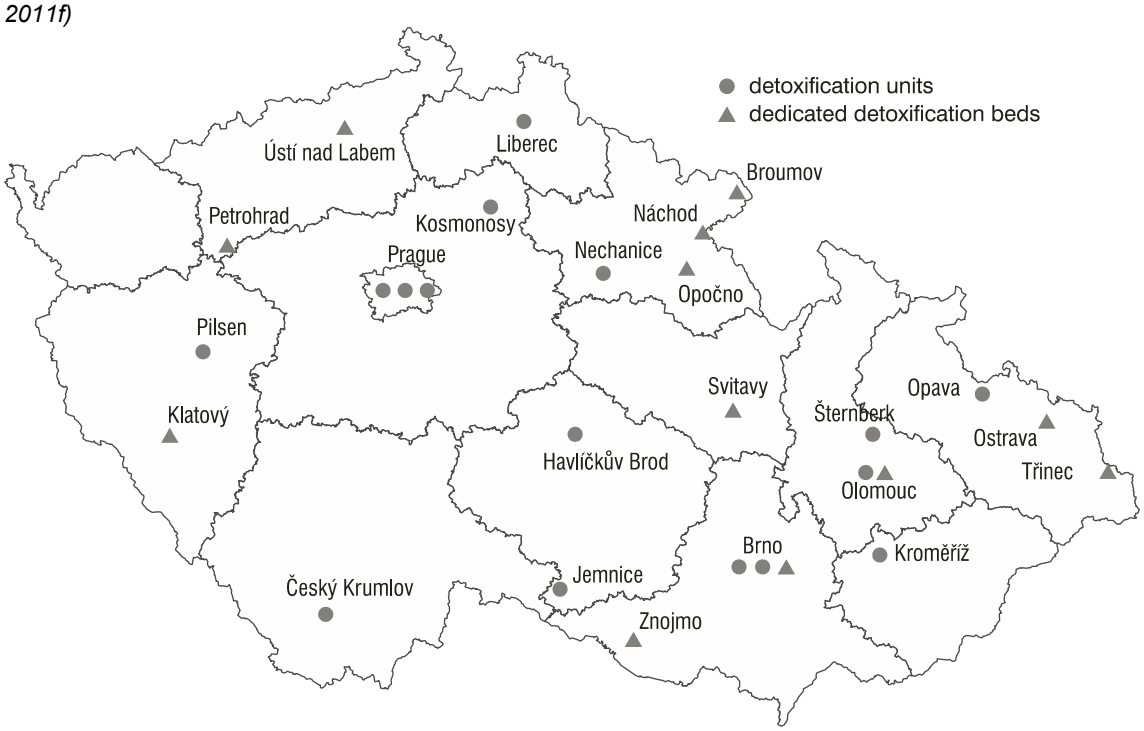
[72] On the basis of the results of this study, the Institute of Health Information and Statistics added an extra table entitled ”Psychoactive substance detoxification in hospital wards and psychiatric hospitals” to its annual collection of data on the bed capacity of healthcare

In 2010 there were 16 inpatient facilities that reported having dedicated beds for addictive substance detoxification, with three in university hospitals, four in hospitals, and nine in psychiatric institutes. The largest number of detoxification units was in Prague[73], and there were no detoxification units in the Karlovy Vary, Ústí nad Labem, and Pardubice regions. Patients undergoing detoxification were hospitalised in another 12 inpatient facilities, even though these facilities did not have specially designated beds for this type of treatment; these were mainly emergency care hospitals[74]. In sum, detoxification was carried out in 28 inpatient facilities in 2010 – four university hospitals, 14 hospitals, and ten psychiatric hospitals. The only region where the detoxification of alcohol/drug-using patients was not carried out was the Karlovy Vary region; see Map 5-3 and Table 5-14.

A total of 163 beds are designated to the detoxification of alcohol/drug-using patient in 16 detoxification units. The largest number of beds (16) was in the detoxification units (male and female) at the Bohnice Psychiatric Institute in Prague, while the Military Hospital in Olomouc had 15 dedicated beds. Patients were hospitalised in 14 beds at the Havlíčkův Brod Psychiatric Hospital and at the Detoxification Centre for Children and Adolescents at the Hospital of the Sisters of Mercy of St Charles Borromeo. The lowest bed capacity (four beds) was reported by the detoxification unit at the Kroměříž Psychiatric Hospital (Nechanská, 2011f).

Detoxification was also carried out in five prisons in 2010; for more information see the chapter on Responses to Drug-related Health Issues in Prisons (p. 128).

Map 5-3: Network of detoxification units and facilities providing detoxification in non-dedicated beds in 2010 (Nechanská, 2011f)



facilities as of 31 December 2010. All hospitals and psychiatric hospitals received this table to complete. As a result, numbers were obtained regarding designated beds in detoxification units as of 31 December 2010 and regarding patients who underwent detoxification in 2010 in detoxification units, as well as other departments and wards that did not have beds specially dedicated to detoxification. Information on the duration of the detoxification was also obtained.

[73] Prague is also home to the only detoxification unit in the Czech Republic designated for children and adolescents – the Detoxification Centre for Children and Adolescents at the Hospital of the Sisters of Mercy of St Charles Borromeo (for more information see the 2008 Annual Report).

[74] Detoxification was carried out in standard beds in various departments in inpatient facilities. In most cases these were psychiatric departments, juvenile psychiatric departments, or departments for treating alcohol/drug-using (AT) patients (nine facilities). Detoxification was carried out in the internal departments of two facilities, and one facility admitted patients to detoxification according to the current free bed capacity, mainly in the psychiatric departments but also in the internal and paediatrics departments.

Table 5-14: Network of inpatient facilities providing the detoxification of alcohol/drug-using patients and numbers of dedicated beds in detoxification units in 2010 (Nechanská, 2011f)

Region	**Dedicated beds**								**Non-dedicated beds**				**Facilities providing detoxification – total**
	University hospital		Hospital (emergency care)		Psychiatric institutes		**Total**		University hospital	Hospital (emergency care)	Psychiatric institutes	**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**	Number of facilities				
Prague	1	9	1	14	1	16	**3**	**39**	0	0	0	**0**	**3**
Central Bohemia	0	0	0	0	1	9	**1**	**9**	0	0	0	**0**	**1**
South Bohemia	0	0	0	0	1	13	**1**	**13**	0	0	0	**0**	**1**
Pilsen	1	6	0	0	0	0	**1**	**6**	0	1	0	**1**	**2**
Karlovy Vary	0	0	0	0	0	0	**0**	**0**	0	0	0	**0**	**0**
Ústí nad Labem	0	0	0	0	0	0	**0**	**0**	0	1	1	**2**	**2**
Liberec	0	0	1	5	0	0	**1**	**5**	0	0	0	**0**	**1**
Hradec Králové	0	0	0	0	1	6	**1**	**6**	0	3	0	**3**	**4**
Pardubice	0	0	0	0	0	0	**0**	**0**	0	1	0	**1**	**1**
Vysočina	0	0	1	14	1	5	**2**	**19**	0	0	0	**0**	**2**
South Moravia	1	14	0	0	1	10	**2**	**24**	0	2	0	**2**	**4**
Olomouc	0	0	1	15	1	12	**2**	**27**	0	1	0	**1**	**3**
Zlín	0	0	0	0	1	4	**1**	**4**	0	0	0	**0**	**1**
Morava-Silesia	0	0	0	0	1	11	**1**	**11**	1	1	0	**2**	**3**
Czech Republic total	**3**	**29**	**4**	**48**	**9**	**86**	**16**	**163**	**1**	**10**	**1**	**12**	**28**

5.2.3.2 Psychiatric Inpatient Facilities

Data on the number of facilities (wards), number of beds, and patients is given in Table 5-15, together with data from other facilities with a psychiatric ward since 2002.[75]

Psychiatric institutes and hospital psychiatric departments predominantly provide residential medical treatment of patients with addictive substance dependencies. Psychiatric institutes in particular organise treatment in departments that specialise in treating addiction. Though the network of psychiatric institutes and psychiatric departments has remained practically unchanged in recent years, the total number of beds is falling. Despite a further drop in the number of beds in psychiatric institutes in 2010 (down 149 beds), the number of beds in alcohol/drug treatment facilities has increased. The number of hospital psychiatric departments remained the same in 2010, but there has been a slight decrease in the number of beds (Nechanská et al. 2011).

Court-ordered compulsory treatment, including its institutional form, is described in the chapter on Interventions in the Criminal Justice System (p. 125).

Table 5-15: Number of psychiatric inpatient facilities, total bed capacity, and occupancy by users of drugs other than alcohol (excluding tobacco) in 2000–2010 (Nechanská et al. 2011)

Year	Psychiatric institutes for children			Psychiatric institutes for adults				Psychiatric departments in hospitals			Other outpatient facilities		
	Number	Total number of beds	Number of patients	Number	Total number of beds	– alcohol /drug treatment 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

*Note: *These are psychiatric wards in other specialised therapeutic institutes and other inpatient facilities.*

5.2.3.3 Therapeutic Communities for Drug Users

A therapeutic community (TC) is another type of residential treatment programme. The history of therapeutic communities for drug addicts in the Czech Republic is summarised in the chapter on Treatment in the 2008 Annual Report. Therapeutic communities in the Czech Republic are associated in the section of therapeutic communities of the Association of Non-governmental Organisations (A.N.O.), which had 11 members as of August 2011[76]. In the Register of Social Services Providers maintained by the Ministry of Labour and Social Affairs, as of August 2011 there were 14 programmes registered as therapeutic communities in the Czech Republic that primarily target people who are at risk of addiction or who are already addicted to substances[77]. In 2010, ten therapeutic communities obtained subsidies from the Government Council for Drug Policy Coordination (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j).

5.2.3.4 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. Four types of institutional facilities (institutions for juvenile delinquents and children with behavioural disorders (diagnostic institutions), children's homes with schools, rehabilitation institutions, and children's homes) and one type of preventive care facility (educational care centres) cooperate with each other. The facilities are established by the Ministry of Education, Youth and Sports, Regional Authorities, or the private sector. In all there are 272 facilities in the Czech Republic; see Table 5-16. Diagnostic institutions are administered by the Ministry of Education, while children's homes are usually administered by the regional authorities, churches, private entities, or the Ministry of Education. Rehabilitation institutions are administered by the Ministry of Education or the private sector; some also specialise in underage mothers with children or adolescents who use drugs. In terms of organisation, educational

[75] To process hospitalisations in 2010, the methodology for selecting facilities included among psychiatric inpatient facilities was changed. Besides psychiatric hospitals and psychiatric departments of general hospitals, data were also processed for other inpatient facilities that operate psychiatric inpatient departments. PATEB s.r.o., a healthcare facility that offers solely psychiatric care, including care for addictive substance users, has been among these facilities since 2005. As a result, a discussion was held on changing its classification and since 1 January 2011 this facility has been included under the psychiatric hospitals. The other two facilities that are in the new selection are dedicated to adult psychiatry and geriatric psychiatry; the number of hospitalised drug users is minimal.

[76] See http://www.terapeutickekomunity.org/, accessed on 9 August 2011.

[77] See http://iregistr.mpsv.cz/, retrieved on 9 August 2011.

care centres report to diagnostic institutions or rehabilitation institutions. In this case they are not independent, but they can be managed by private entities. The number of children in the facilities is increasing each year. In 2003 there were 7,250 children placed in these facilities, while in 2009 and 2010 this number had risen to 7,820 and 7,397, respectively. Educational care centres reported a total of 8,064 clients in 2010[78].

Table 5-16: Educational facilities for young people in institutional care, protective custody, or preventive care in the Czech Republic in 2009–2010

Types of facilities	Number of facilities	
	2009	2010
Children's homes	155	150
Children's homes with schools	29	31
Rehabilitation institutions	34	33
Diagnostic institutions for children	8	9
Diagnostic institutions for adolescents	4	4
Diagnostic institution for children and adolescents	1	–
Diagnostic institution for children of foreigners	1	1
Educational care centres*	17	17
Czech Republic total	**249**	**245**

*Note: * The number relates to organisations; including detached facilities, this relates to around 40 facilities.*

Five facilities contain departments that specialise in treating children at risk of drug addiction. The total capacity of these departments in 2010 was 68 spaces, and 137 children were placed there; see Table 5-17.

Table 5-17: 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 in 2009–2010

Facility	Capacity		Number of children	
	2009	2010	2009	2010
Dvůr Králové Rehabilitation Institution	24	24	31	32
Klíčov Rehabilitation Institution	8	8	14	19
Žulová Rehabilitation Institution	8	8	15	12
Hostouň Rehabilitation Institution	16	16	25	27
Dobřichovice Diagnostic Institution, Řevnice facility	18	12	67	47
Total	**74**	**68**	**152**	**137**

5.3 Characteristics of Clients in Treatment

5.3.1 Systems for Collection of Data on Drug Users in Treatment

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

- The Public Health Service, specifically the Public Health Office in Prague, has administered the Register of Treatment Demands since 1995. Drug users who, in any given year, sought treatment, counselling, or social services in designated facilities for drug users, whether healthcare or non-healthcare (such as therapeutic communities and low-threshold centres) facilities, are included in this register. Separate records of first-time treatment demands are also kept. The data set and its structure and the definitions in use comply with the treatment demand collection standard issued by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The register does not effectively cover treatment provided by general practitioners or through substitution treatment and in-prison treatment (Studničková, 2009).
- Other sources of data about drug users in treatment include health registers and statistical reporting systems maintained by the Czech Institute of Health Information and Statistics (IHIS). These include the Substitution Treatment Register (NRULISL – see above) and compulsory data reported by inpatient and outpatient (psychiatric) facilities. More facilities report to the IHIS system than to the Public Health Service system; however, the system only accounts for healthcare facilities.
- Data on clients of NGOs or programmes delivered with financial support from the state budget and the services provided by them are mainly available from the final reports of projects supported by subsidies from the Government Council for Drug Policy Coordination. This information is processed annually by the National Focal

[78] Information provided by the Ministry of Education's Department of Prevention, Special Education, and Institutional Education in September 2010 and August 2011.

Point. In particular, the data cover low-threshold harm reduction programmes, as well as other types of services provided by NGOs (outpatient treatment, after-care, and inpatient treatment in therapeutic communities)[79].

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

5.3.2 Treatment Demand Register

In 2010, the Register of Treatment Demands received data from 214 centres (70 low-threshold centres, 94 outpatient facilities, and 50 inpatient 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 – 59.1% of first-time treatment demands and 51.7% of all treatment demands. Inpatient facilities were the most widely represented type among the centres; however, they comprised just 19.7% of first-time demands and 23.2% of all treatment demands of the total volume of treated drug users reported in 2010 (Studničková and Petrášová, 2011).

A total of 9,005 drug users sought treatment services in facilities in 2010, which is about 300 persons more than in 2009. Of these, 4,362 individuals sought treatment for the first time, which is about the same number of first-time demands as in 2009. In comparison with previous years, the slight downward trend has been reversed and treatment demands are rising slightly, bringing the numbers up to the same levels as in 2004 and 2005. Women steadily make up one third of treatment demands (Studničková and Petrášová, 2011).

The order of drugs used which are the cause of all (including first-time) treatment demands has remained the same as in previous years. Users of stimulants predominate among treatment demands – both overall (62.9%) and among first-time demands (67.5%). Most cases related to pervitin (62.5% and 67.2%, respectively). The second largest group of all demands are opiate users (23.1%), while cannabis users predominate among first-time treatment demands (15.9%). Trends in the numbers of treatment demands according to the drug used are given in Figure 5-3 and Figure 5-4.

The prevalence and incidence of treatment demands and the representation of treatment demands by drug type is not the same throughout the Czech Republic. It is evident from the available data that the greatest prevalence and incidence of treatment demands are in the Ústí nad Labem region and in the City of Prague. The share of stimulants (pervitin) is relatively predominant in all regions throughout the Czech Republic – from 49.0% in Prague to 85.0% in South Bohemia. Opiate users were most markedly represented in treatment demands in Prague (38.9%) and Central Bohemia (37.9%). The greatest proportion of cannabis users among treatment demands is reported by the Vysočina (26.5%), Pilsen (24.1%), and Moravia-Silesia (21.1%) regions; see Map 5-2.

5.3.2.1 Selected Characteristics of Treatment Demands

The representation of males and females among those making treatment demands has been stable in the long term and corresponds to a 2:1 male-to-female ratio. The greatest proportion of males is among the users of inhalants and cannabis; the lowest is among the users of other drugs and pills, where women comprise half of all users. In the group of sedative and hypnotic users, the share of females and males is even. The share of females is relatively high among stimulant users (34.2%), and females represent 29.6% of opiate users (Studničková and Petrášová, 2011).

In terms of age structure, a slight aging of the population among those making treatment demands is evident – Figure 5-5 and Figure 5-6. Although the average age grew slowly year-on-year, in the medium term there is a clear rising trend. The average age was 27.3 years for first-time treatment demands and 27.3 years for all demands in 2010, an increase of 4.5 and 4 years, respectively, since 2002. People in treatment for heroin use for the first time have aged the most – since 2000 one can observe a nearly eight-year increase in the average age to the current 29.1 years. In 2009 the most numerous age group among all and among first-time treatment demands was 25-to-39-year-olds, accounting for 42.9% of all demands and 52.2% of first-time demands. Similarly to 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 under 19 years of age; see Figure 5-7 and Figure 5-8.

In the long term, users of heroin and cocaine have been among the oldest and, at the same time, most rapidly aging groups of those demanding treatment. On the other hand, the youngest group making treatment demands are cannabis users (21.2 years among first-time demands and 22.4 years among all demands). The high prevalence of

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

cannabis, especially among adolescents and young adults, is also confirmed by data from general population surveys; see the chapter on Drug Use in the General Population (p. 28).

The greatest number of people demanding treatment in 2010 stated that they were injecting drug users, followed by smoking (13.9%) and inhaling/snorting (12.3%).

In 2010, those making their first treatment demands reported the daily use of drugs in 1,308 cases (30.0%); an additional 1,013 users (23.2%) used a drug 2–6 times per week. Heroin was most frequently used daily by newly recorded users (54.8%). Pervitin was used on a daily basis by 23.7% of people demanding treatment for the first time; the most widely-reported frequency of use of pervitin was 2–6 times per week (27.8%). All those making treatment demands reported the daily use of drugs in 2,731 cases (30.3%); an additional 1,930 users (21.4%) used a drug 2–6 times per week. Among all heroin users in treatment, about half of those demanding treatment reported daily use. Among pervitin users, a lower frequency of use was more common, at several times per week (25.4%) as opposed to daily use (21.9%). The majority of buprenorphine users (63.3%) also reported daily drug use in their demand for treatment (Studničková and Petrášová, 2011).

The socioeconomic characteristics of those demanding treatment have changed little over the past years. Out of the total of 9,005 treatment demands in 2010, 13.6% were from homeless people and another 9.7% were from people residing in institutions (e.g. prisons, institutional care, hostels, or sheltered housing); only 45.3% gave a permanent address. A third of all registered drug users in treatment live with their parents; 21.3% of all clients in treatment stated that they live alone, with 19.3% of newly registered clients living alone; 666 drug users in treatment (7.4%) stated that they live with children (for more information on the issue of drug-using parents and pregnant drug users see the selected issue chapter on Drug Users with Children, p. 148). The number of people without a permanent home is significantly greater among repeatedly treated and long-term drug users than among those demanding treatment for the first time. The percentage of homeless people has been increasing among all clients and first-time demands since 2006 (Studničková and Petrášová, 2011).

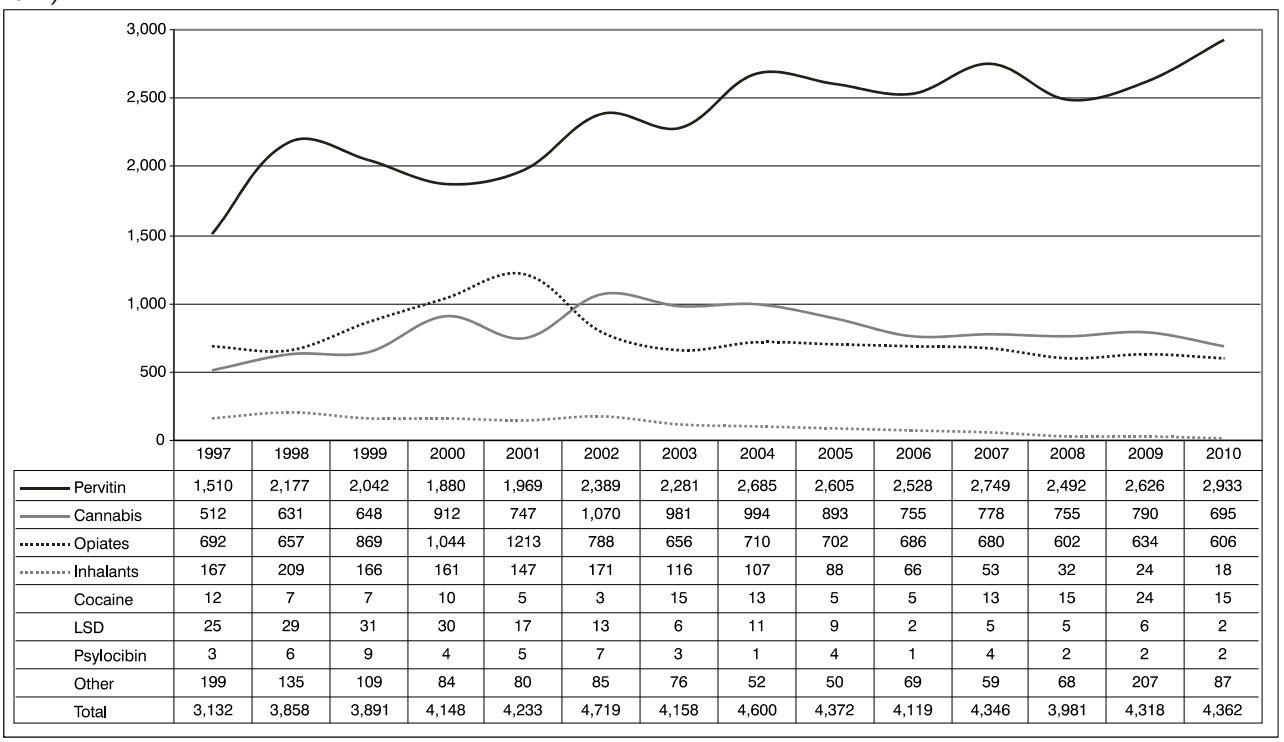
More than a half of treatment demands were from unemployed people or people with temporary jobs (57.0%). A total of 13.4% of first-time treatment demands and 16.0% of all treatment demands were from people who stated they had regular employment. Nearly half of treatment demands were from people who had just a basic education, and 45.4% had completed secondary school (Studničková and Petrášová, 2011).

In 2010, 8,232 treatment demands (91.4% of all treatment demands) and 3,827 first treatment demands (87.7%) were from drug users classified under the definition of problem users[80]. There is a persistently high share of injecting drug users among treatment demands – a total of 6,284 demands (69.8% of all demands) and 2,695 first-time demands (61.8%) stated that they were injecting drug users, a slight increase compared to 2009. Trends for selected characteristics among those demanding treatment are shown in Figure 5-7 and Figure 5-8. Further information about injecting drug users among those demanding treatment is provided in the chapter on Risk Behaviour of Drug Users (p. 90).

As was the case in 2009, the typical profile for a client in treatment in 2010 is an unemployed male of Czech nationality between 25 and 30 years of age, who has completed his basic education, from Prague or Central Bohemia, with a permanent place of residence, living alone or with his parents, and using stimulants (pervitin). He uses the drug several times per week, mostly by injecting.

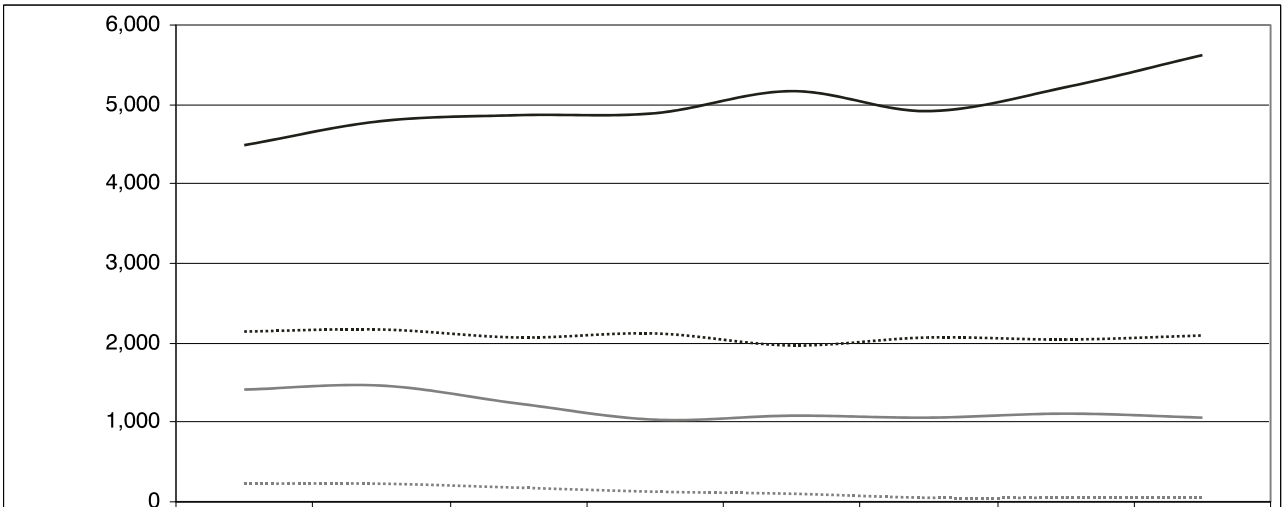
[80] The EMCDDA defines problem drug use as injecting drug use and/or the long-term/regular use of opiates and/or amphetamine-type drugs and/or cocaine (European Monitoring Centre for Drugs and Drug Addiction, 2009). Cocaine use in the Czech Republic is at a very low level. The prevalence of problem cocaine use has not been estimated; for more information see the chapter on Problem Drug Use (p. 48).

Figure 5-3: Number of first-time treatment demands according to drug used in 1997–2010 (Studničková and Petrášová, 2011)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Pervitin	1,510	2,177	2,042	1,880	1,969	2,389	2,281	2,685	2,605	2,528	2,749	2,492	2,626	2,933
Cannabis	512	631	648	912	747	1,070	981	994	893	755	778	755	790	695
Opiates	692	657	869	1,044	1213	788	656	710	702	686	680	602	634	606
Inhalants	167	209	166	161	147	171	116	107	88	66	53	32	24	18
Cocaine	12	7	7	10	5	3	15	13	5	5	13	15	24	15
LSD	25	29	31	30	17	13	6	11	9	2	5	5	6	2
Psylocibin	3	6	9	4	5	7	3	1	4	1	4	2	2	2
Other	199	135	109	84	80	85	76	52	50	69	59	68	207	87
Total	3,132	3,858	3,891	4,148	4,233	4,719	4,158	4,600	4,372	4,119	4,346	3,981	4,318	4,362

Figure 5-4: Number of all treatment demands according to drug used in 2002–2010 (Studnicková and Petrášová, 2011)



	2003	2004	2005	2006	2007	2008	2009	2010
Pervitin	4,490	4,790	4,855	4,889	5,177	4,925	5,209	5,632
Opiates	2,133	2,169	2,058	2,126	1,961	2,063	2,053	2,084
Cannabis	1,403	1,462	1,238	1,044	1,083	1,053	1,121	1,050
Inhalants	226	221	183	124	94	62	47	46
Ecstasy	50	37	23	12	11	14	8	7
Cocaine	22	18	15	12	22	24	38	23
LSD	15	19	10	4	7	6	6	3
Other	183	129	152	155	132	132	281	160
Total	8,522	8,845	8,534	8,366	8,487	8,279	8,763	9,005

Map 5-4: Number of all treatment demands according to drug type in regions of the Czech Republic in 2010, per 100,000 inhabitants aged 15–64 (Studničková and Petrášová, 2011)

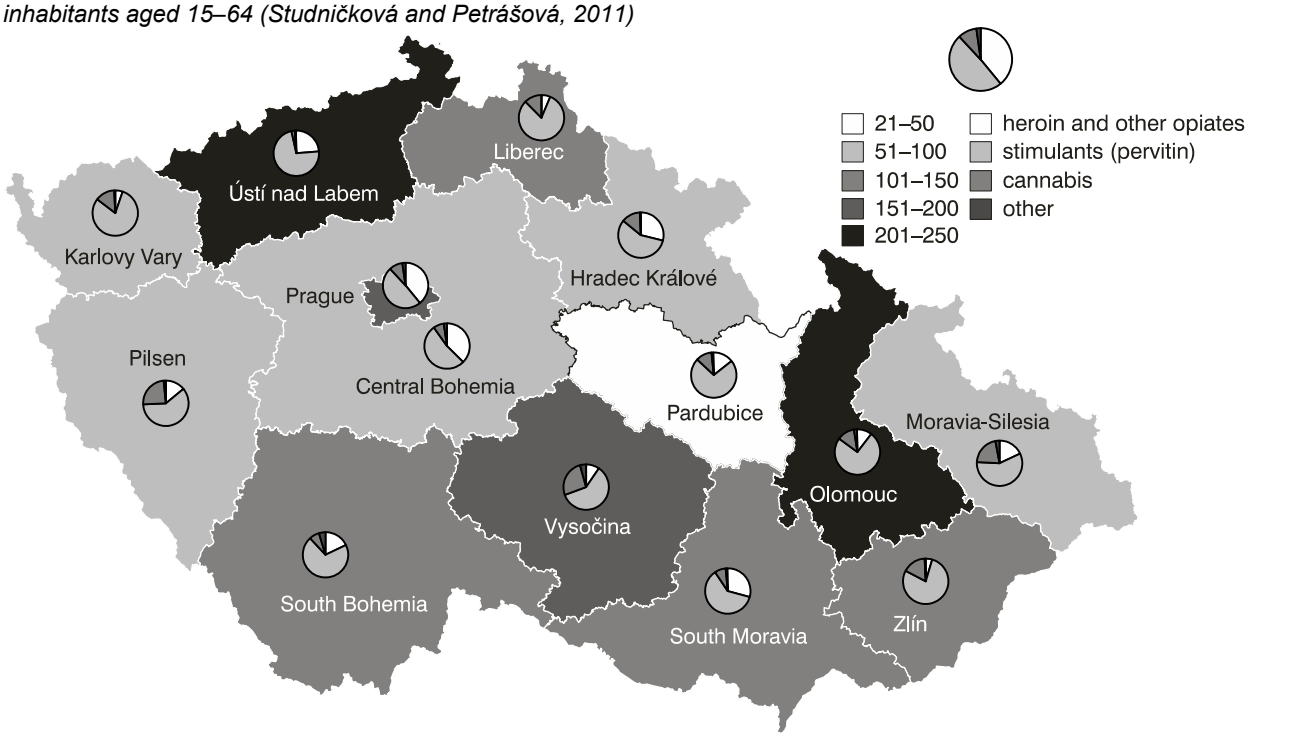
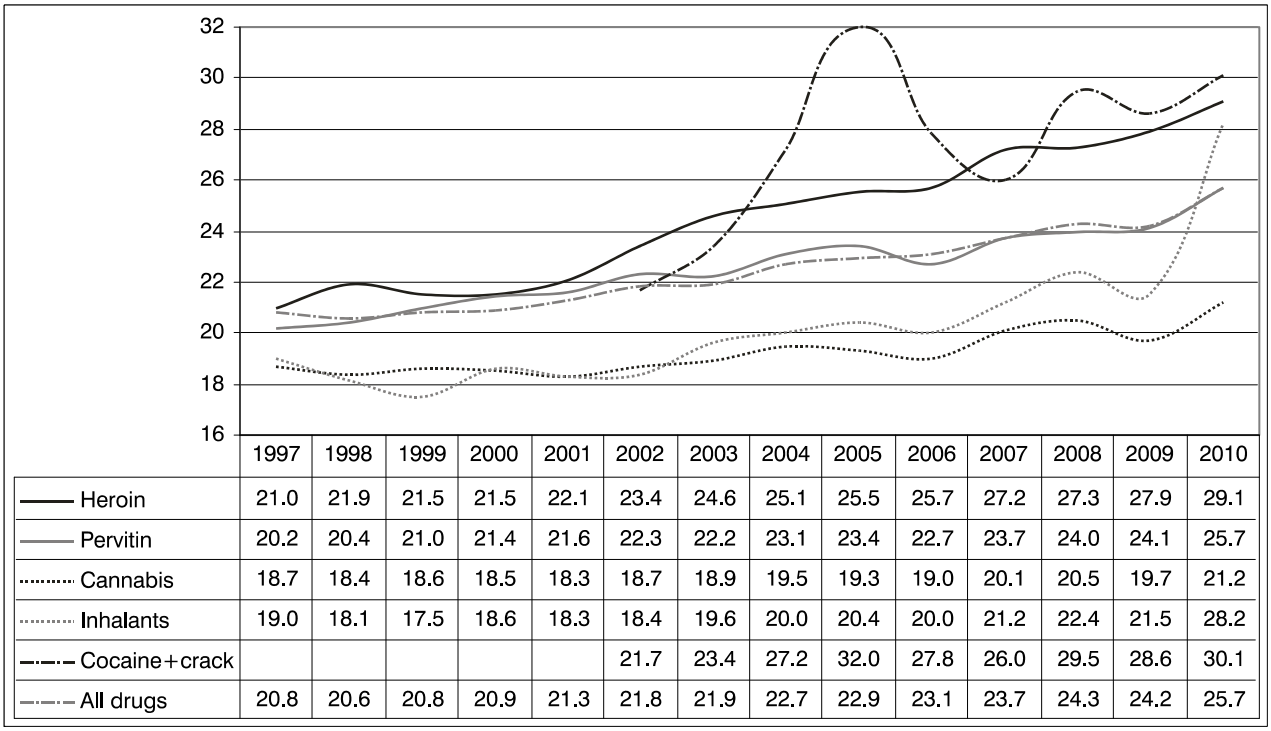
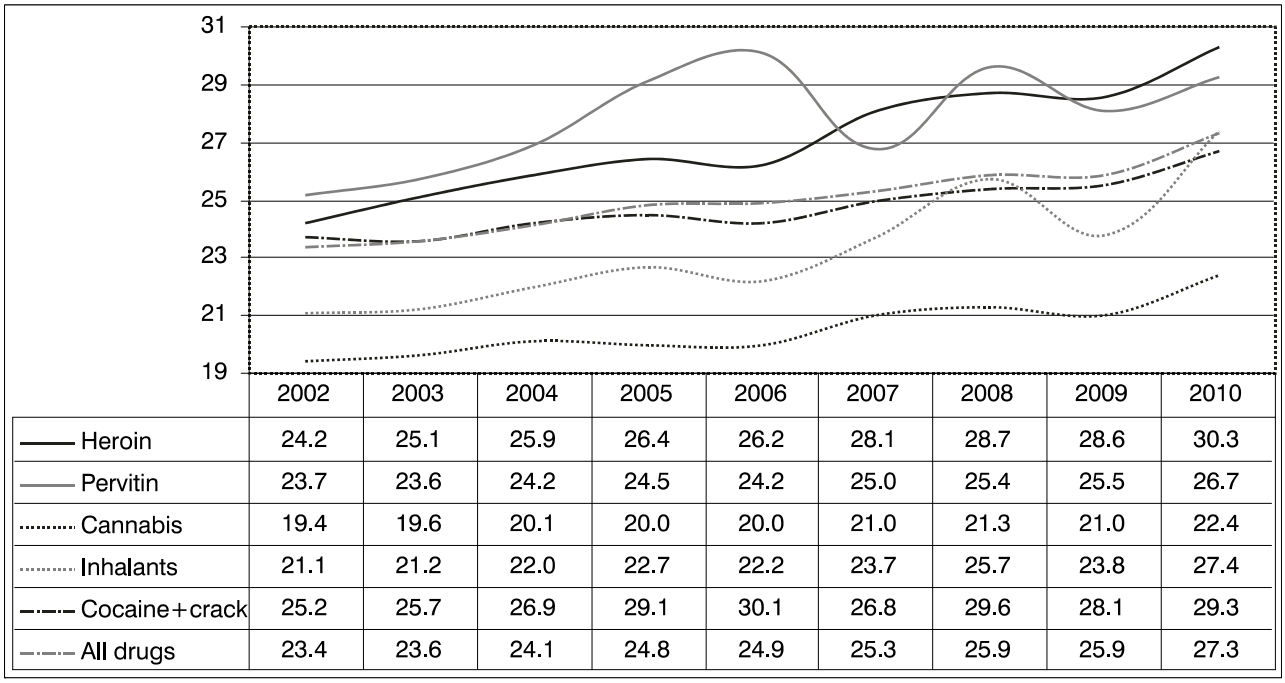


Figure 5-5: Average age of first-time treatment demands according to selected drugs in 1997–2010 (Studničková and Petrášová, 2011)



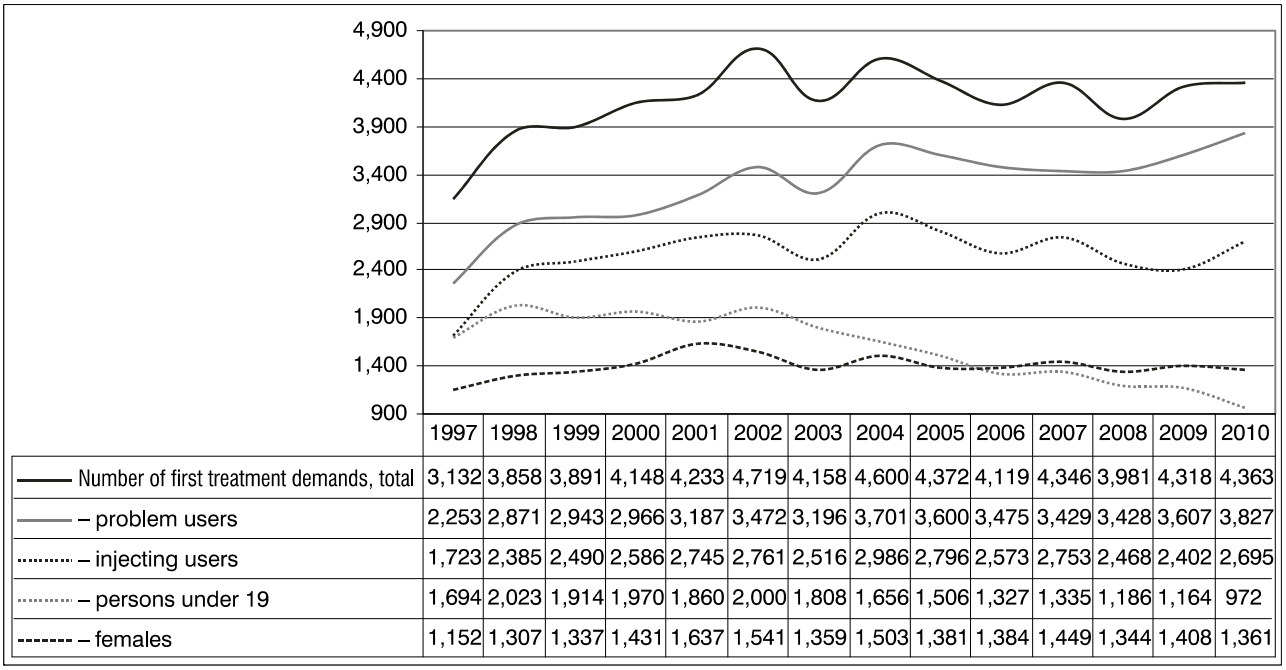
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Heroin	21.0	21.9	21.5	21.5	22.1	23.4	24.6	25.1	25.5	25.7	27.2	27.3	27.9	29.1
Pervitin	20.2	20.4	21.0	21.4	21.6	22.3	22.2	23.1	23.4	22.7	23.7	24.0	24.1	25.7
Cannabis	18.7	18.4	18.6	18.5	18.3	18.7	18.9	19.5	19.3	19.0	20.1	20.5	19.7	21.2
Inhalants	19.0	18.1	17.5	18.6	18.3	18.4	19.6	20.0	20.4	20.0	21.2	22.4	21.5	28.2
Cocaine+crack						21.7	23.4	27.2	32.0	27.8	26.0	29.5	28.6	30.1
All drugs	20.8	20.6	20.8	20.9	21.3	21.8	21.9	22.7	22.9	23.1	23.7	24.3	24.2	25.7

Figure 5-6: Average age of all treatment demands according to selected drugs in 2002–2010 (Studničková and Petrášová, 2011)



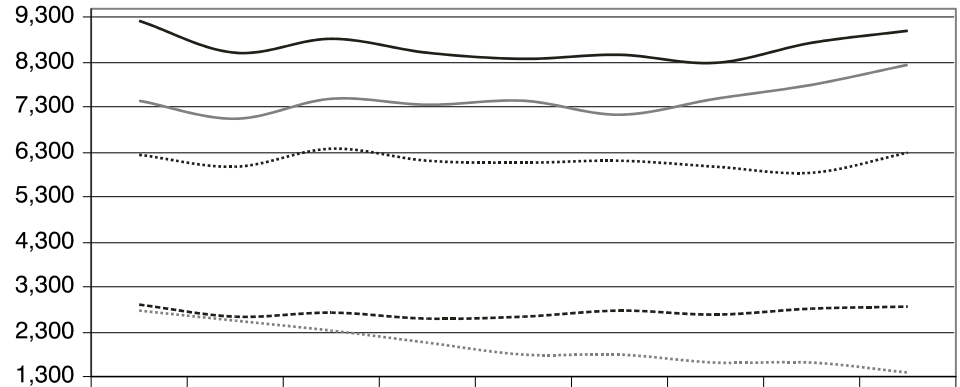
	2002	2003	2004	2005	2006	2007	2008	2009	2010
Heroin	24.2	25.1	25.9	26.4	26.2	28.1	28.7	28.6	30.3
Pervitin	23.7	23.6	24.2	24.5	24.2	25.0	25.4	25.5	26.7
Cannabis	19.4	19.6	20.1	20.0	20.0	21.0	21.3	21.0	22.4
Inhalants	21.1	21.2	22.0	22.7	22.2	23.7	25.7	23.8	27.4
Cocaine+crack	25.2	25.7	26.9	29.1	30.1	26.8	29.6	28.1	29.3
All drugs	23.4	23.6	24.1	24.8	24.9	25.3	25.9	25.9	27.3

Figure 5-7: Selected characteristics of first treatment demands in 1997–2010 (Studničková and Petrášová, 2011)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of first treatment demands, total	3,132	3,858	3,891	4,148	4,233	4,719	4,158	4,600	4,372	4,119	4,346	3,981	4,318	4,363
– problem users	2,253	2,871	2,943	2,966	3,187	3,472	3,196	3,701	3,600	3,475	3,429	3,428	3,607	3,827
– injecting users	1,723	2,385	2,490	2,586	2,745	2,761	2,516	2,986	2,796	2,573	2,753	2,468	2,402	2,695
– persons under 19	1,694	2,023	1,914	1,970	1,860	2,000	1,808	1,656	1,506	1,327	1,335	1,186	1,164	972
– females	1,152	1,307	1,337	1,431	1,637	1,541	1,359	1,503	1,381	1,384	1,449	1,344	1,408	1,361

Figure 5-8: Selected characteristics of all treatment demands in 2002–2010 (Studničková and Petrášová, 2011)



	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of first treatment demands, total	9,237	8,522	8,845	8,534	8,366	8,487	8,279	8,763	9,005
– problem users	7,441	7,067	7,473	7,372	7,451	7,137	7,490	7,811	8,233
– injecting users	6,228	5,964	6,364	6,125	6,054	6,109	5,986	5,840	6,284
– persons under 19	2,773	2,541	2,322	2,064	1,811	1,792	1,625	1,604	1,370
– females	2,895	2,646	2,709	2,602	2,656	2,763	2,663	2,829	2,866

5.3.3 Clients in Outpatient Treatment

5.3.3.1 Psychiatric Outpatient Clients

In 2010, 40,198 alcohol and drug users were treated in outpatient psychiatric facilities, which is nearly 3% less than in 2009. Of these, 16,016 were users of non-alcohol drugs (dg. F11–F19) and 15,187 were users of illicit drugs, excluding tobacco (dg. F11–F19, excluding F17). Because of the thoroughness of the collection of the annexes to psychiatric data reports which provide information on patients who use psychoactive substances, there was a significant increase in the number of outpatient clinics that completed this annex. Despite this, in 2010 the number of alcohol/drug users in outpatient treatment fell, mainly because of patients using illegal substances (other than alcohol and tobacco). Their numbers fell by 1,156 patients (7%) year-on-year, particularly as a result of the decline in the number of users treated for the use of opiates/opioids, other non-cocaine stimulants, and polydrug use, i.e. the three largest patient groups according to the drugs used. It was mainly males who contributed to this decline, the main reasons being the closure of the psychiatric outpatient unit at the SANANIM drop-in centre in the Prague 5 District and the reduction of the number of patients reported by the Prison Service of the Czech Republic. The number of patients using alcohol remained nearly the same as in the previous year, while the number of patients using tobacco fell by nearly 5%.

The users of drugs (excluding alcohol and tobacco) included 9,804 males (65%) and 5,383 females (35%). Most patients were 20–39 years old (68%); less than 12% of patients were under 20. The greatest proportion comprised patients who abuse opiates and opioids (28%), with a significant percentage of heroin users (70% of opiate/opioid users). Another drugs associated with a high share of patients in treatment included stimulants other than cocaine (21%); the proportion of pervitin users increased from under 87% in 2009 to nearly 90% in 2010 as a result of the more rigorous reporting of these patients. In 2010 there was a 64% increase in the number of patients using cocaine (to 59 patients), mainly because of an increase in the number of patients treated in the Olomouc region (from 18 to 37 patients). The number of males in treatment fell in 2010, while the number of females remained nearly the same. The share of children under 15 years of age and adolescents (15–19 years) also remained at the same levels, while patient numbers in other age groups under scrutiny fell. Trends in the number of patients are provided in Table 5-18 (Nechanská, 2011c).

Table 5-18: Trends in the number of addictive substance users in treatment at outpatient healthcare facilities in 1993–2010 according to addictive substance groups (Nechanská et al. 2011; Mravcík et al. 2011a; Nechanská, 2011c)

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

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

5.3.3.2 Clients in Opiate Substitution Treatment

In 2010 there were 2,113 persons in treatment (1,500 males and 613 females) aged 17 to 58 and registered in the Substitution Treatment Register. The oldest patients were males. The trend since 2000 is presented in detail in Table 5-19. In comparison to 2009, the number of patients in treatment in the Substitution Treatment Register increased by 565 clients (+37%). Over half of the people treated in 2010 were aged 30–39, and nearly 38% were aged 20–29. In the study year there was also an increase in the number of people aged 30–39 (up nearly 4%) and a decline in the number of people aged 20–29. Less than 1% of patients were under 20. The average age of people in treatment was 31.1 in the study year, with males being an average of 2.5 years older than females (32.0 and 29.5 years old, respectively). The average duration of treatment (treatment episode) in 2010 was 690 days, which was the same for both males and females. The largest number of people in treatment was reported by *Remedis, s.r.o.*, a facility based in Prague (440 people, a fifth of the total number of people in treatment in the Czech Republic), followed by the Masaryk Hospital in Ústí nad Labem (343 people, i.e. over 16%), Drop-In (235 people, 11%), *Podané ruce* association (181 people, 9%), and a psychiatric outpatient facility and alcohol/drug treatment outpatient facility in Prague (176 people, 8%).

In 2010 nearly two thirds of the persons in treatment recorded in the Substitution Treatment Register were treated with buprenorphine (1,369 people), with nearly three quarters receiving Subutex® (1,054 people) and one quarter receiving Suboxone® (315 people). The remaining 744 people received methadone; see Table 5-19.

Substitution treatment was started 1,160 times among a total of 1,023 people in 2010, with 631 (61.7%) of these entering substitution treatment for the first time in their lives[81]. In total, treatment was terminated 615 times among a total of 507 people (364 males and 143 females) in 2010, which is a fifth more than in 2009; see Table 5-19. The average duration of all terminated treatments was 499 days, being 517 days among males and 453 days among females (Nechanská et al. 2011; Nechanská, 2011g).

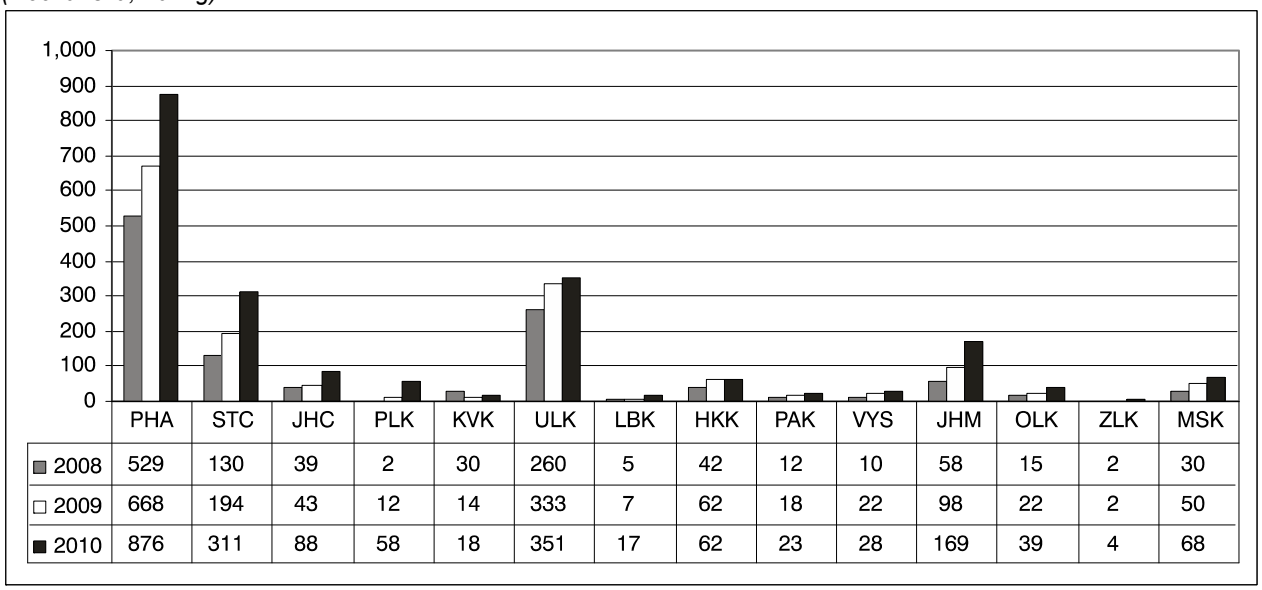
The number of patients in substitution treatment rose in all regions. The greatest absolute growth was among people residing in Prague, Central Bohemia, and South Moravia. The greatest percentage growth was among people residing in the Pilsen region, up nearly fivefold from 2009 (from 12 to 58 people). The most likely main cause of this was the introduction of substitution treatment at a new methadone centre in Pilsen. The figure also more than doubled for people residing in South Bohemia (from 43 to 88 people); see Figure 5-9.

Table 5-19: Trends in persons in treatment, reported and terminated treatment cases in the Substitution Treatment Register by gender, 2000–2010 (Nechanská et al. 2011; Nechanská, 2011g)

Year	Number of persons in treatment					Number of new treatment cases			Number of terminated treatment cases		
	Males	Fem.	Total	Treated with		Males	Fem.	Total	Males	Fem.	Total
				Methadone	Buprenorphine						
2000	173	72	**245**	245	0	207	86	**293**	72	30	**102**
2001	369	164	**533**	510	23	374	167	**541**	261	107	**368**
2002	393	167	**560**	511	49	265	106	**371**	265	110	**375**
2003	557	232	**789**	520	269	499	183	**682**	345	115	**460**
2004	605	261	**866**	546	320	375	136	**511**	430	159	**589**
2005	578	247	**825**	571	254	438	150	**588**	395	135	**530**
2006	652	286	**938**	586	352	455	175	**630**	378	145	**523**
2007	719	319	**1,038**	605	433	403	157	**560**	378	143	**521**
2008	949	407	**1,356**	689	667	621	266	**887**	389	179	**568**
2009	1,089	466	**1,555**	686	869	530	225	**755**	354	154	**508**
2010	1,500	613	**2,113**	744	1,369	830	330	**1,160**	445	170	**615**

[81] Patients entering substitution treatment more than once is no exception. Of the 1,023 people who entered a treatment programme in 2010, two reported treatments in the year under monitoring were on record among 91 people (9%), 15 people had reported entering treatment three times, four people entered treatment four times, one client entered five times, and the remaining 912 people (89%) had only one commencement of treatment on record. There was an average of 1.2 attempts at treatment per person in 2010.

Figure 5-9: Trends in the number of clients in substitution treatment by region of permanent residence in 2008–2010 (Nechanská, 2011g)



	PHA	STC	JHC	PLK	KVK	ULK	LBK	HKK	PAK	VYS	JHM	OLK	ZLK	MSK
2008	529	130	39	2	30	260	5	42	12	10	58	15	2	30
2009	668	194	43	12	14	333	7	62	18	22	98	22	2	50
2010	876	311	88	58	18	351	17	62	23	28	169	39	4	68

5.3.3.3 Clients in NGO Outpatient Programmes

In 2010, outpatient treatment was also available from 13 NGOs subsidised by the Government Council for Drug Policy Coordination. Services were provided to 1,813 illegal drug users, of whom 866 (47.8%) were males and 947 (52.2%) females; their average age was 26.4 years old. A total of 774 clients (42.7%) injected drugs; 720 (39.7%) used pervitin, 215 (11.9%) heroin, 193 (10.6%) cannabis, and 72 (4.0%) Subutex® (obtained illegally). In comparison with 2009 there was a drop in the number of clients, especially among pervitin users. A comparison with 2003–2010 is provided in Table 5-20 (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j).

Table 5-20: Outpatient treatment programmes operated by NGOs and selected client characteristics in 2003–2010 (Mravčík et al. 2010; National Monitoring Centre for Drugs and Drug Addiction, 2011j).

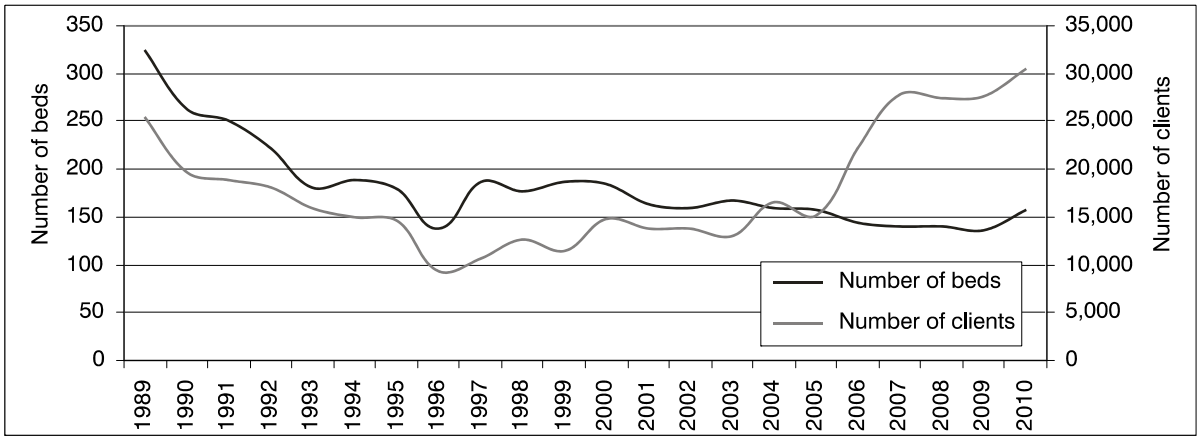
Indicator	2003	2004	2005	2006	2007	2008	2009	2010
Number of programmes subsidised	19	20	18	15	13	13	15	13
Number of clients	2,820	2,506	3,127	4,301	3,044	3,958	3,833	3,304
Number of drug users	1,590	1,493	1,743	2,428	1,642	2,379	2,130	1,813
– injecting drug users	848	697	1,034	1,024	708	940	873	774
– pervitin users	547	540	540	771	511	644	834	720
– cannabis users	246	339	158	405	101	133	194	193
– heroin users	310	223	391	240	256	367	274	215
– Subutex® users	–	n/a	126	110	116	96	70	72
Average age of drug users	23.6	25.9	26.8	29.6	26.3	28.6	27.6	26.4

In the long term, only one facility in the Czech Republic has offered an intensive three-month outpatient treatment programme in a day care centre – operated by SANANIM in Prague and in existence since 1996. The capacity of the programme is ten persons. In 2010 services were provided to 40 clients (10 males, 30 females) whose average age was 26.9 years. A total of 28 clients were injecting drug users before treatment; 20 clients were pervitin users and 10 clients were opiate users. Over half of the clients (52.5%) completed the treatment successfully. The length of treatment of one client was an average of two months (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j).

5.3.3.4 Sobering-up Station Clients

Until 2005, the number of clients at sobering-up stations reflected the number and capacity of the stations, but since that year a drop in capacity but an increase in client numbers, especially men, can be observed. In 2010, when the number of patients also rose year-on-year in connection with the increase in the number of facilities and spaces, 30,487 people were treated at sobering-up stations; see Figure 5-10. Of the total number of patients, 25,732 were males and 2,422 patients were under 20 years of age (Nechanská et al. 2011; Mravcík et al. 2011a; Nechanská, 2011e).

Figure 5-10: Trends in the capacity of sobering-up stations and the number of patients treated in 1989–2010 (Nechanská et al. 2011; Nechanská, 2011e)



5.3.4 Clients in Inpatient Treatment

5.3.4.1 Detoxification Unit Clients

A total of 6,650 patients were hospitalised for addictive substance detoxification in 2010. Of this number, 82% were in detoxification units, while the remainder were hospitalised in facilities with non-dedicated beds. A total of 3,558 patients (54%) were hospitalised for alcohol detoxification and 3,092 patients (46%) were in for non-alcohol detoxification. The largest numbers of hospitalisations were at facilities in Prague, followed by the South Bohemia and South Moravia regions.

Nearly 39% of hospitalisations for detoxification from drugs other than alcohol were due to polydrug detoxification, over a quarter were for detoxification from other stimulants (mainly pervitin), and 21% were other opiate/opioid detoxification cases. Hospitalisations for other non-alcohol drugs represented less than 13%; see Table 5-21. Of the three largest substance groups, polydrug detoxification had the longest average duration – nearly 12 days. For other stimulants this was nearly nine days, and for opiates/opioids over seven days. Hospitalisations for other non-alcohol drugs had an average treatment period of 11.6 days (Nechanská, 2011f).

Table 5-21: Number of people hospitalised for detoxification from addictive substances in 2010 (Nechanská, 2011f)

Region of facility's location	**Number of healthcare facilities**	**Number of persons in detoxification for**												**Total number of people**
		Alcohol	Opiates/opioids	Cannabinoids	Sedatives and hypnotics	Cocaine	Other stimulants	Hallucinogens	Tobacco	Inhalants	Other psychoactive substances	Polydrug use	**Non-alcohol drugs, total**	
Prague	**3**	**1,078**	191	46	47	0	228	1	1	1	2	530	**1,047**	**2,125**
Central Bohemia	**1**	**67**	34	5	12	0	31	0	0	0	0	37	**119**	**186**
South Bohemia	**1**	**248**	116	22	18	10	207	0	0	3	0	134	**510**	**758**
Pilsen	**2**	**152**	22	3	17	0	21	0	0	0	0	62	**125**	**277**
Karlovy Vary	**0**	**0**	0	0	0	0	0	0	0	0	0	0	**0**	**0**
Ústí nad Labem	**2**	**112**	74	4	5	0	54	0	0	1	0	71	**209**	**321**
Liberec	**1**	**20**	0	0	1	0	0	0	0	0	3	3	**7**	**27**
Hradec Králové	**4**	**158**	3	5	0	0	28	0	0	0	0	34	**70**	**228**
Pardubice	**1**	**146**	0	0	4	0	0	0	0	0	0	0	**4**	**150**
Vysočina	**2**	**387**	33	10	25	21	17	3	0	3	0	48	**160**	**547**
South Moravia	**4**	**407**	83	20	31	1	79	1	0	2	2	111	**330**	**737**
Olomouc	**3**	**388**	25	7	14	0	71	0	0	0	0	42	**159**	**547**
Zlín	**1**	**139**	5	1	3	0	13	0	0	0	0	29	**51**	**190**
Morava-Silesia	**3**	**256**	75	22	15	0	95	1	0	2	0	91	**301**	**557**
Czech Republic Total	**28**	**3,558**	**661**	**145**	**192**	**32**	**844**	**6**	**1**	**12**	**7**	**1,192**	**3,092**	**6,650**

5.3.4.2 Clients of Psychiatric Inpatient Facilities

In 2010 inpatient psychiatric facilities admitted 15,362 patients for disorders induced by the use of addictive substances (primary diagnosis F10–F19), which is down by over 3% compared to 2009. This decline is attributable to patients hospitalised for disorders caused by alcohol use which have shown a significant decline since 2005. In 2010 there were 10,003 hospitalisations reported for disorders caused by alcohol use and 5,356 hospitalisations reported for disorders caused by the use of other non-tobacco psychoactive substances (Nechanská, 2011d).

Polydrug use (dg. F19) was again the most common cause (46%) of illegal drug users (dg. F11–F16, F18, F19) being admitted to inpatient psychiatric facilities in 2010. Other causes of hospitalisation included stimulant use (30%) and opioid use (13%). There were 31 hospitalisations in psychiatric institutes for children resulting from polydrug use and the use of stimulants other than cocaine, cannabis, and inhalants. Of all hospitalisations for illegal drugs, the majority are of males (66%); see Table 5-22. The average period of treatment for hospitalisations resulting from illegal drug use was 31.8 days. In psychiatric institutes for adults and children this was 40.8 days, while in hospital psychiatric wards this was 12.1 days. Over 45% of illegal drug users admitted to hospital were aged 20–29, nearly 27% were 30–39 years old, and persons under 20 made up 14% of the total number of hospitalised illicit drug users. Diagnosis F13 (sedatives and hypnotics) is the exception, with nearly half of the patients being between 40 and 59 years of age and two thirds of those hospitalised with this primary diagnosis being females. In terms of regional distribution, the highest rate of patients hospitalised in connection with illegal drugs was among permanent residents of the Ústí nad Labem region (91 hospitalisations per 100,000 residents) and Prague (79 hospitalisations). The Karlovy Vary, Liberec, and Moravia-Silesia regions were also above the nationwide average (50 hospitalisations) (Nechanská, 2011d).

The trend in the number of hospitalised patients by individual drug (groups) varies. In 2001 and 2002 there was a significant decrease in the number of hospitalisations resulting from disorders caused by opioids (F11). With minor fluctuations, this has continued into the following years. The number of admissions to hospital because of polydrug use disorders (F19) has been increasing in the long term, rising 2.6 times from 1997 to 2009, but this number fell for the first time in 2010. The number of hospitalisations resulting from the use of stimulants other than cocaine (F15) increased by over 82% in the period 1997–2010. There was a slight decline from 2007 until 2010, when there was an increase compared to the previous year. The number of hospitalisations resulting from disorders induced by other drugs is much lower by comparison; there were declines in most categories in 2010, but slight increases for cannabinoids and hallucinogens (Nechanská et al. 2011; Mravcík et al. 2011b; Nechanská, 2011d); see Table 5-23.

Table 5-22: Number of hospitalisations resulting from disorders caused by the use of alcohol and other psychoactive drugs in psychiatric inpatient facilities in 2010 according to type of healthcare facility, gender, and diagnosis (Nechanská, 2011d)

Addictive substance	**Psychiatric institutes for children**		**Psychiatric institutes for adults**		**Hospital psychiatric departments**		**Other inpatient facilities**		**Psychiatric inpatient facilities, total**		
	Males	Fem.	Males	Fem.	Males	Fem.	Males	Fem.	Males	Fem.	**Total**
Opiates/ opioids	0	0	268	103	203	103	14	4	485	210	**695**
Cannabinoids	6	0	66	13	84	24	4	2	160	39	**199**
Sedatives/ hypnotics	0	0	58	112	44	90	2	0	104	202	**306**
Cocaine	0	0	1	0	1	0	0	0	2	0	**2**
Other stimulants	0	8	721	336	282	217	27	35	1,030	596	**1,626**
Hallucinogens	0	0	4	0	4	1	0	0	8	1	**9**
Inhalants	3	0	24	7	6	1	1	0	34	8	**42**
Polydrug use	6	8	1 314	522	384	200	28	14	1,732	744	**2,476**
Illegal drugs, total	**15**	**16**	**2,456**	**1,093**	**1,008**	**636**	**76**	**55**	**3,555**	**1,800**	**5,355***
Alcohol	2	0	5,141	2,144	1,430	948	244	94	6,817	3,186	**10,003**
Tobacco	0	0	0	1	2	0	0	0	2	1	**3**
Addictive substances Total	**17**	**16**	**7,597**	**3,238**	**2,440**	**1,584**	**320**	**149**	**10,374**	**4,987**	**15,361**

*Note: * Age and gender were not provided in one case of hospitalisation with the primary diagnosis F11 (opiates/opioids)*

Table 5-23: Number of hospitalisations resulting from disorders caused by alcohol and other psychoactive substances in psychiatric inpatient facilities in 1997–2010 (Nechanská et al. 2011; Nechanská, 2011d)

Year	Number of hospitalisations for the diagnosis											
	F10 (alcohol)	F11 (opioids)	F12 (cannabis)	F13 (sedatives/hypnotics)	F14 (cocaine)	F15 (stimulants)	F16 (hallucinogens)	F17 (tobacco)	F18 (inhalants)	F19 (polydrug use)	**Drugs (except 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**

5.3.4.3 Clients of Therapeutic Communities

As in 2009, the Government Council for Drug Policy Coordination granted subsidies to ten therapeutic communities in 2010. Data about the number of clients and services provided are available from these communities' final reports (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j); see Table 5-24.

The capacity of the therapeutic communities was 160 beds, and 408 drug users with an average age of 26.7 years completed treatment there. Of the total number of clients of therapeutic communities, before entering therapy 350 (85.8%) were injecting drug users, 292 (71.6%) used pervitin, and 68 (16.7%) heroin. There were 118 clients (28.9%) who successfully completed the programme; the average duration of a successful (completed) treatment was 324 days. A total of 150 (36.8%) clients dropped out, with 25 terminating their treatment within two weeks of starting it and another 66 clients leaving within three months of starting. The average duration of the treatment of all patients was 185 days. A comparison with 2003–2010 is provided in Table 5-24.

Table 5-24: Therapeutic communities and their clients in 2003–2010 (Mravčík et al. 2010; National Monitoring Centre for Drugs and Drug Addiction, 2011j)

Indicator	2003	2004	2005	2006	2007	2008	2009	2010
Number of communities	17	14	12	12	11	10	10	10
Facility capacity	238	218	183	185	169	138	160	160
Number of clients	510	546	491	451	472	427	349	408
– injecting drug users	428	429	400	375	347	326	343	350
– pervitin users	270	306	287	281	291	283	276	292
– heroin users	187	151	132	93	66	67	69	68
Average client age	23.4	24.2	24.9	25.1	24.2	23.8	26.6	26.7

Since the beginning of 2007, a study entitled Treatment Outcome Evaluation of Therapeutic Communities for Drug Users has been conducted at five therapeutic communities associated in the Therapeutic Communities Section of the Association of NGOs. An analysis of the study sample at the beginning of the research project and other information about the study are provided in more detail in the 2008 Annual Report; another analysis will be available by the end of 2011.

6 Health Correlates and Consequences of Drug Use

The state of affairs in terms of infections among (injecting) drug users remained relatively favourable in 2010 – the HIV infection rate was still far below 1%. Seven new cases were reported of HIV-positive persons who may have become infected through injecting drug use. The number of newly reported cases of HCV among injecting drug users has also fallen in recent years, while there was a slight year-on-year increase in the number of HBV infections in 2010. Depending on the characteristics and selection criteria of the sample being studied, the prevalence of HCV among drug users ranges from approximately 20% in low-threshold programmes to 40% in prisons and 70% in substitution treatment. These results, however, need to be interpreted with caution, bearing in mind the possibility of a sampling error – this may be due to diagnostic screening in low-threshold programmes giving already positive cases and the treatment programmes in prisons possibly showing cases examined on suspicion of infection, which may artificially inflate the prevalence rates. The increasing incidence of syphilis among injecting drug users also continued in 2010.

In the long term, there has been a decline in injecting among users of pervitin and opiates, while it remains common among users of Subutex®. The proportion of IDUs among users of heroin and pervitin is approximately 60% of psychiatric outpatient clients and 90% and 80% in the register of drug treatment demands, respectively. According to the data available, the level of risk behaviour (needle sharing) among injecting drug users has declined in the long term.

According to the information from the autopsy registry of forensic medicine departments, the number of fatal overdoses on illicit drugs and inhalants that was identified increased further, reaching 55 in total. In particular, the number of fatal overdoses on inhalants doubled (16 cases); the numbers of fatal overdoses on opiates/opioids and pervitin remained at virtually the same level (19 and 18 cases, respectively). Cocaine was not detected in any of the fatal overdose cases in 2010. Two fatal overdoses with fentanyl detected were reported, the first time this had ever happened in the Czech Republic. In 2010, there was a further increase in the number of indirect drug-related deaths (i.e. deaths from causes other than overdoses, mainly as a result of accidents and suicides) where pervitin was detected, while there was a decrease in those involving THC.

Comparisons with data extracted from the general mortality register show similar long-term trends in the incidence of fatal overdoses in the Czech Republic – a summary of data based on various selection criteria shows that the number of drug-induced deaths resulting from street drugs has been between 30 and 70 cases per year in the Czech Republic in the past 2 years. The rate of fatal overdoses on alcohol (ethanol), based on analogous selection criteria, is approximately ten times higher.

According to traffic police records, the number and proportion of accidents that took place under the influence of alcohol and the number of persons killed in these incidents decreased in 2010 – this positive trend is confirmed by data from the autopsies performed on those killed in traffic accidents and examined by forensic medicine departments. On the contrary, the numbers of accidents caused while under the influence of drugs other than alcohol and of people killed in such accidents are growing; however, the comparison with the data provided by forensic surgeons suggests that the rates are still underreported by the police.

6.1 Drug-Related Infections

6.1.1 Reported Incidence of HIV/AIDS and Viral Hepatitis

In 2010, just as in 2009, there were seven newly diagnosed cases of HIV infection[82] in which the route of transmission may have been through injecting drug use; this means a return to the numbers in the period before 2007[83]. Altogether, 1,522 HIV-positive persons with a permanent place of residence in the Czech Republic were registered as of December 31, 2010; 70 of them are injecting drug users (IDUs) and another 27 are in the mixed category encompassing injecting drug use and homo-/bisexual intercourse. Injecting drug use remains a significantly minor route of HIV infection in the Czech Republic (Státní zdravotní ústav Praha, 2011c; Státní zdravotní ústav Praha, 2011a); see Table 6-1.

[82] In 2009, these included only men, while in 2010, there were 6 men and 1 woman. The age of new cases in the IDU category in 2010 was 19-50 years. These include three residents (from Ukraine, Moldova, and Vietnam); all three were diagnosed as being in the stage of AIDS.

[83] The number of new cases of HIV infection reported each year in the Czech Republic up to 2006 had ranged between two and eight cases among injecting drug users and another one or two cases in the mixed category of injecting drug users and homo-/bisexuals. In 2007, the number jumped to 17 cases and the following year 12 cases were reported of HIV-positive persons who may have become infected through injecting drug use.

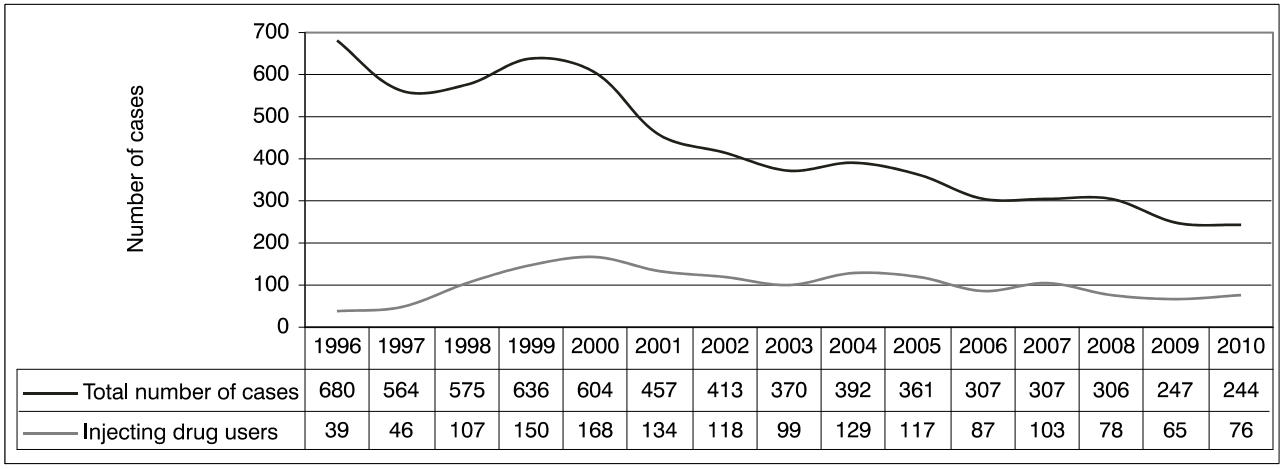
Table 6-1: Number of newly detected HIV cases in the Czech Republic up to 2010 for individual years and according to route of transmission (Státní zdravotní ústav Praha, 2011c)

Route of transmission (risk group)	1985–2004	2005	2006	2007	2008	2009	2010	Total	
								Number	%
Homo-/bisexual intercourse	387	52	54	72	88	103	125	881	57.9
Heterosexual intercourse	239	29	26	28	45	43	37	447	29.4
IDU	33	4	4	12	8	4	5	70	4.6
IDU and homo-/bisexual intercourse	11	1	1	5	4	3	2	27	1.8
Other	37	0	0	0	0	0	0	37	2.4
Not ascertained	29	4	6	4	3	3	11	60	3.9
Total	**736**	**90**	**91**	**121**	**148**	**156**	**180**	**1,522**	**100.0**

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

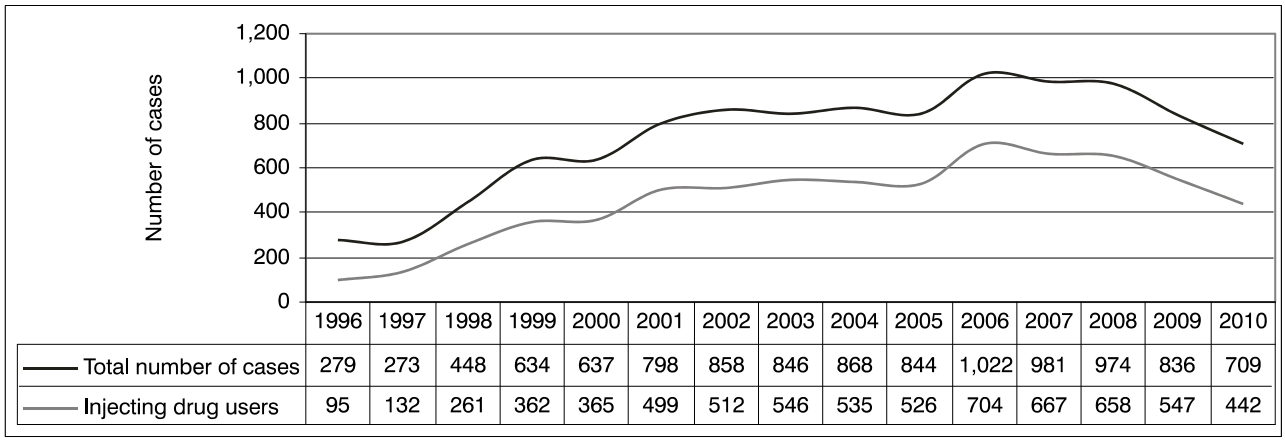
In recent years, the EPIDAT national system of compulsory reporting of infectious diseases has recorded a decrease in the number of newly reported cases of acute viral hepatitis B (HBV, dg. B16) and C (HCV, dg. B17.1 and B18.2), both in the total number of cases and, with minor variations, among injecting drug users (Státní zdravotní ústav Praha, 2011b); see Figure 6-1 and Figure 6-2.

Figure 6-1: Reported incidence of acute HBV among all patients and injecting drug users in the Czech Republic in 1996–2010 (Státní zdravotní ústav Praha, 2011b)



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

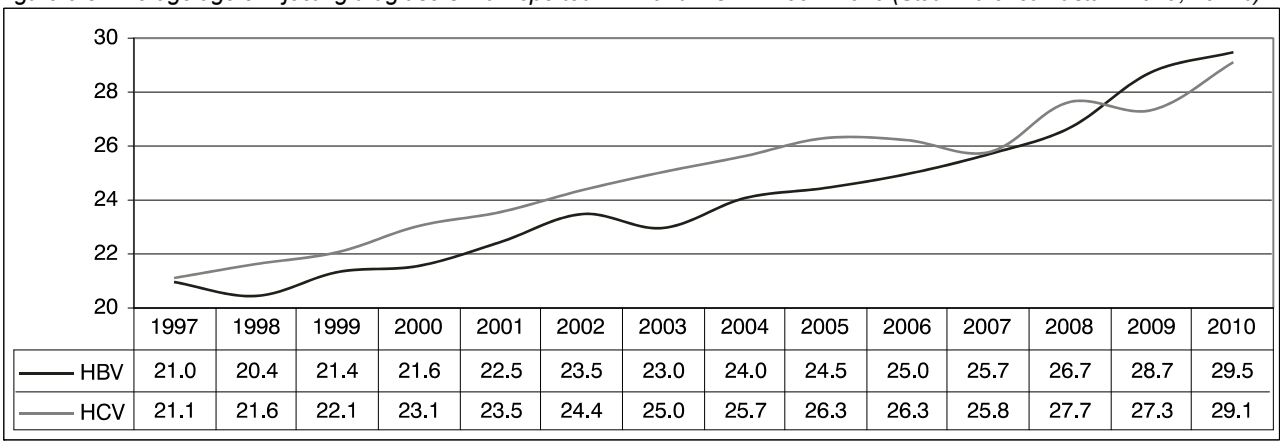
Figure 6-2: Reported incidence of acute and chronic HCV among all patients and injecting drug users in the Czech Republic in 1996-2010 *(Státní zdravotní ústav Praha, 2011b)*



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total number of cases	279	273	448	634	637	798	858	846	868	844	1,022	981	974	836	709
Injecting drug users	95	132	261	362	365	499	512	546	535	526	704	667	658	547	442

In the long term, the average age of injecting drug users with reported HBV and HCV is increasing; see Figure 6-3.

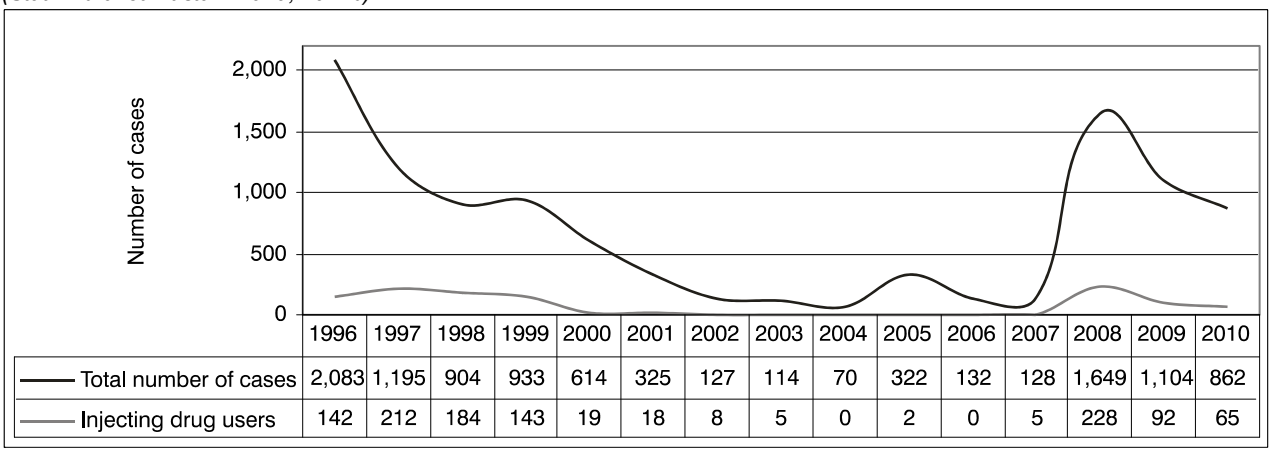
Figure 6-3: Average age of injecting drug users with reported HBV and HCV in 1997–2010 (Státní zdravotní ústav Praha, 2011b)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
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
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

Following the epidemic of viral hepatitis A (HAV, dg. B15) which broke out at the end of May 2008, mainly in Prague, and later spread to Central Bohemia (see the 2008 Annual Report), the increased prevalence of HAV continued in 2010, but the downward trend of HAV is evident (Státní zdravotní ústav Praha, 2011b); see Figure 6-4.

Figure 6-4: Reported incidence of HAV among all patients and injecting drug users in the Czech Republic in 1996–2010 (Státní zdravotní ústav Praha, 2011b)



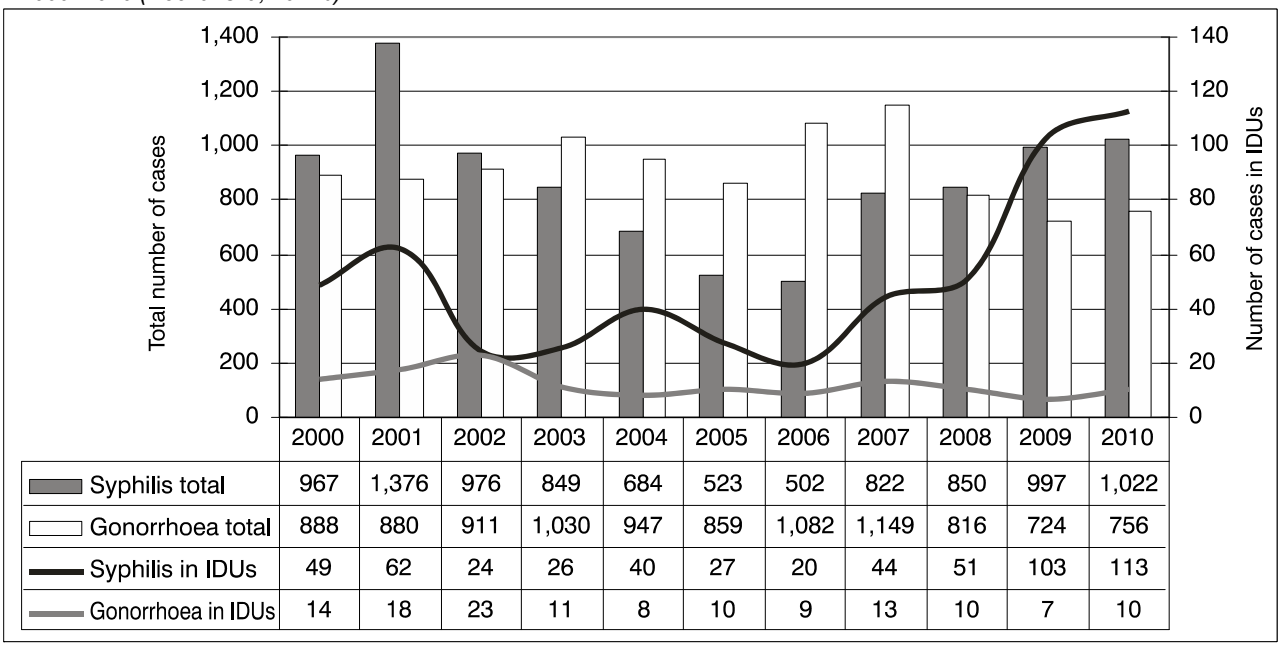
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total number of cases	2,083	1,195	904	933	614	325	127	114	70	322	132	128	1,649	1,104	862
Injecting drug users	142	212	184	143	19	18	8	5	0	2	0	5	228	92	65

6.1.2 Reported Incidence of Veneral Diseases and Tuberculosis

The 2009 Annual Report published data from the National Register of Venereal Diseases for the first time. Compulsory reports are completed for all persons found to have a venereal disease, who died from such a disease, or are suspected to be suffering from or infected with a venereal disease in the Czech Republic. Syphilis (dg. A50 through A53), gonorrhoea (dg. A54), lymphogranuloma venereum (dg. A55), and chancroid (dg. A57) are subject to reporting from all healthcare facilities. Injecting drug use and prostitution have been found to be among the risk factors.

Trends in the number of reported cases overall and among injecting drug users (IDUs) for syphilis and gonorrhoea are shown in Figure 6-5. Since 2006 there has been an evident increase in the number of syphilis cases overall and among IDUs. In 2010, injecting drug users accounted for 11.1% and 1.3% of cases of syphilis and gonorrhoea respectively (Nechanská, 2011b).

Figure 6-5: Reported incidence of syphilis and gonorrhea among all patients and among injecting drug users in the Czech Republic in 2000–2010 (Nechanská, 2011b)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Syphilis total	967	1,376	976	849	684	523	502	822	850	997	1,022
Gonorrhoea total	888	880	911	1,030	947	859	1,082	1,149	816	724	756
Syphilis in IDUs	49	62	24	26	40	27	20	44	51	103	113
Gonorrhoea in IDUs	14	18	23	11	8	10	9	13	10	7	10

In terms of a more detailed distribution of the disease in 2000–2010, early-stage syphilis (dg. A51) accounted for almost 45% of cases, with over two thirds of cases involving injecting drug users. Syphilis in the late stage (dg. A52) was diagnosed in more than 14% of the total number of cases, with just over 7% of cases involving injecting drug users. Congenital syphilis (A50 dg.) was observed only in less than 1% of the total number of cases. As for gonorrhoea, over 88% of cases were diagnosed as acute; almost 82% of acute conditions were associated with IDUs.

In general, sexually transmitted diseases are marked by a significantly higher prevalence among males than females – on average, more than a third higher for syphilis and 2.3 times as high for gonorrhoea in the period under study. Among IDUs, however, the number of females infected with syphilis was higher than that of males (by more than 11%); but gonorrhoea in males was 38% higher than in females. For the period under study, injecting drug use was reported in a greater proportion of syphilis cases in women compared to men by 7.3% of the total number of reported cases in women, while the proportion of men was more than 2.5 percentage points lower.

Data on the prevalence of high-risk behaviour pertaining to the reported cases of sexually transmitted diseases indicate that concurrent prostitution and injecting drug use is relatively common. In 2000–2010, injecting drug use was found in a total of 20.0% of syphilis cases in commercial sex workers and prostitution was concurrently found in 17.9% of injecting drug users (mainly females) (Nechanská, 2011b); see Table 6-2.

Table 6-2: Commercial sex workers (CSWs) and injecting drug users (IDUs) among reported syphilis and gonorrhoea cases, 2000–2010 (Nechanská, 2011b)

Infection	Number of cases reported				Proportion (%)	
	Total	CSWs	IDUs	CSWs and IDUs	IDUs per CSWs	CSWs per IDUs
Syphilis	9,568	499	559	100	20.0	17.9
Gonorrhea	10,042	219	133	14	6.4	10.5

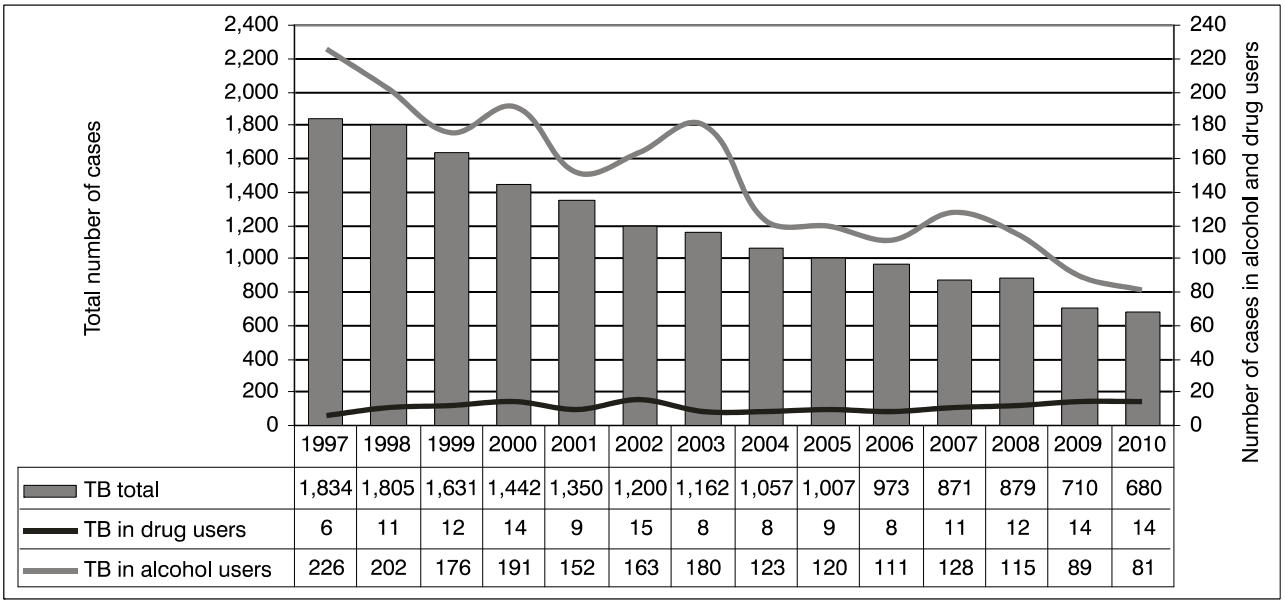
This year, for the first time, the annual report publishes data on the prevalence of tuberculosis (TB, dg. A31), which are drawn from the Register of Tuberculosis. The register monitors people who have been diagnosed with active tuberculosis or other mycobacterioses in the Czech Republic[84] and people screened in groups of active and inactive tuberculosis or other mycobacterioses. In addition to the information related to the disease itself, the mandatory report also contains records of associated circumstances, including whether the patient is a user of drugs other than alcohol (regardless of the route of administration).

Between 1997 and 2010, the number of registered TB cases reported annually decreased 2.7 times. TB of respiratory system was registered in 87% of the total number of reported tuberculosis cases. Men accounted for 63% of the total number of cases. In the period under study, 151 cases of TB among drug users were reported; their number and proportion of the total has increased in recent years; see Figure 6-6. Of the total number of TB cases reported in users of (non-alcohol) drugs, 96% were cases of tuberculosis of the respiratory system. During the period under study, TB was reported in 130 male and 21 female drug users. With the declining trend in the total number of

[84] I.e. infections caused by bacteria of the Mycobacterium genus, which include, in addition to M. tuberculosis, for instance, M. avium complex, M. kansasii, or M. abscessus.

TB cases reported and the growing number of TB cases reported in drug users, the proportion of users of (non-alcohol) drugs has increased during the period under study; by contrast, a downward trend was observed among alcohol users (Nechanská, 2011b).

Figure 6-6: Reported incidence of tuberculosis among all patients and among users of alcohol and other drugs in the Czech Republic, 1997–2010 (Nechanská, 2011b)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
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
TB in drug users	6	11	12	14	9	15	8	8	9	8	11	12	14	14
TB in alcohol users	226	202	176	191	152	163	180	123	120	111	128	115	89	81

The chapter on Responses to Drug-related Health Issues in Prisons (p. 128) provides information about HBV, HCV, and HIV and the treatment of the diseases among prisoners, including drug users.

6.1.3 Prevalence of Infections among Drug Users

A total of 918,855 laboratory tests for HIV were conducted on Czech citizens and residents in 2009, of which 180 (0.20‰) were positive; in this group, 139 were citizens of the Czech Republic and 41 were foreigners with permanent residence in the country (Státní zdravotní ústav Praha, 2011a). 1,050 tests were conducted among injecting drug users (IDUs)[85], with no positive cases. The number of tests conducted among IDUs increased in 2010 after several years of decline, despite a continued absence of saliva tests (Státní zdravotní ústav Praha, 2011c); see Table 6-3.

Table 6-3: Testing of injecting drug users for HIV antibodies in 1994–2010 (Státní zdravotní ústav Praha, 2011c)

Year	Blood tests		Saliva tests		Total	
	Number of tests	Number of positive results	Number of tests	Number of positive results	Number of tests	Number of positive results
1994–1997	1,206	1	895	0	2,101	1
1998	1,034	0	1,124	0	2,158	0
1999	1,101	0	1,219	0	2,320	0
2000	1,090	0	1,001	0	2,091	0
2001	1,208	1	961	0	2,169	1
2002	801	0	735	1	1,536	1
2003	985	1	652	0	1,637	1
2004	1,382	0	227	0	1,609	0
2005	925	1	449	1	1,374	1*
2006	994	1	412	0	1,406	1
2007	845	1	531	1	1,376	2
2008	886	1	477	0	1,363	1
2009	806	1	0	–	806	1
2010	1,050	0	0	–	1,050	0
Total	**14,313**	**8**	**8,683**	**3**	**21,590**	**10**

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

[85] These are cases where 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 becomes known only afterwards that the subject was an injecting drug user. Of the five new HIV-positive injecting drug users in 2010, four were found on the basis of clinical symptoms of the disease and one after examination at the patient's own request. This means that no new HIV-positive cases were detected during testing performed specifically in relation to injecting drug use.

The monitoring of testing for infections among IDUs has been ongoing since 2004 in low-threshold programmes. The 2010 results were collected using an online questionnaire administered in the period from July to August 2010 (Národní monitorovací středisko pro drogy a drogové závislosti, 2011i). A total of 44 low-threshold programmes responded, of which 20 were drop-in centres, 14 outreach programmes, and 10 were services operating both drop-in centres and outreach programmes. The results are shown in Table 6-4. They suggest a very low incidence of HIV, HBV, and HCV among injecting drug users, but assessment should take into account that it is a diagnostic screening, which is probably used to a greater extent by new and therefore less infected clients, and partly these are the results of quick tests. Therefore, the results shown underestimate the true prevalence of infection among drug users and among the clients of low-threshold facilities.

Table 6-4: Results of testing for infections among injecting drug users in low-threshold facilities in 2010 (Národní monitorovací středisko pro drogy a drogové závislosti, 2011i)

Infection	Tested marker*	Type of test material	Number of programmes	Number of tests		Number of persons		
				Total	Positive	Total	Positive	Positive (%)
HIV	anti-HIV	Saliva **	–	–	–	–	–	–
		Capillary blood	18	706	2	494	1	0.2
		Capillary blood serum	5	57	0	52	0	0.0
		Venous blood serum	4	79	0	77	0	0.0
		Total	**27**	**842**	**2**	**623**	**1**	**0.2**
HCV	anti-HCV	Capillary blood	20	743	86	632	77	12.2
		Capillary blood serum	5	201	32	173	31	17.9
		Venous blood serum	5	93	14	91	14	15.4
		Total	**30**	**1,037**	**132**	**896**	**122**	**13.6**
HBV	HBsAg	Capillary blood	13	413	4	346	3	0.9
		Capillary blood serum	3	27	0	23	0	0.0
		Venous blood serum	3	35	0	34	0	0.0
		Total	**19**	**475**	**4**	**403**	**3**	**0.7**
	anti-HBc IgG	Venous blood serum	4	69	0	67	0	0.0
		Total	**4**	**69**	**0**	**67**	**0**	**0.0**
Syphilis	anti-treponema pallidum	Capillary blood	7	380	15	169	7	4.1
		Venous blood serum	2	17	4	17	4	23.5
		Total	**9**	**397**	**19**	**186**	**11**	**5.9**

*Note: * In addition to HBsAg (an antigen indicating acute or chronic active infection), the results of tests for long-lasting antibodies are ascertained. ** Saliva tests have not been available since 2009.*

The results of testing for HCV by region are shown in Table 6-5. When assessing the results and the differences between the regions, it is necessary to take into account the fact that this is not a representative selection of drug users or facilities, but a diagnostic screening, and that the criteria for selection of test clients may differ between the various facilities.

Table 6-5: Results of HCV testing among IDUs in low-threshold facilities in 2010, by programme location (Národní monitorovací středisko pro drogy a drogové závislosti, 2011i)

Region	Number of centres		Number of persons tested		
	Responded to the questionnaire	Tested for HCV	Total	Positive tests	Positive tests (%)
Prague	5	4	172	39	22.7
Central Bohemia	6	5	107	8	7.5
South Bohemia	6	4	94	5	5.3
Pilsen	0	0	0	–	–
Karlovy Vary	2	1	5	1	20.0
Ústí nad Labem	4	4	150	33	22.0
Liberec	1	1	16	3	18.8
Hradec Králové	3	1	9	2	22.2
Pardubice	2	2	81	4	4.9
Vysočina	2	1	12	0	0.0
South Moravia	3	3	105	11	10.5
Olomouc	4	3	100	14	14.0
Zlín	2	0	0	–	–
Moravia-Silesia	4	3	31	2	6.5
Total	**44**	**32**	**784**	**94**	**12.0**

The trend in the number of low-threshold facilities performing tests for these infections and the numbers of tests conducted according to the information provided in the final reports of the projects supported as part of the GCDPC subsidy proceedings are given in Table 7-7 (p. 109) in the chapter on Prevention and Treatment of Drug-related Infectious Diseases.

The data about testing for infections and the results of the tests are also recorded by the Register of Treatment Demands (Studničková and Petrášová, 2011). This information is provided by the clients themselves or is obtained from their files; only tests with known results are included; see Table 6-6. Although they provide limited evidence only, the data indicate a stable and, in recent years, falling prevalence of infections among drug users (in line with the observed trends in new cases of viral hepatitis in the Czech Republic reported in the EPIDAT official register of infectious diseases – see above).

Table 6-6: Results of testing for HIV, HAV, HBV, and HCV among IDUs demanding treatment, self-reported in 2003–2010 (Studničková and Petrášová, 2011)

Year	HIV		HAV		HBV		HCV	
	Total tested	Positive tests %	Total tested	Positive tests %	Total tested	Positive tests %	Total tested	Positive tests %
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

Of the 2,113 people registered in the Substitution Treatment Register in 2010, between 147 and 166 persons were tested for the various infectious diseases under scrutiny, depending on the type of test. HIV prevalence was at 0.6%, HBV prevalence at 54%, and HCV prevalence at 68%. Of the 160 anti-HCV-positive individuals, 131 were tested for direct identification of the HCV virus (HCV PCR-RNA), of whom 66 (50.4%) tested positive, indicating an active ongoing HCV infection (Nechanská, 2011g); see Table 6-7. When interpreting these results, however, it is necessary to take into account the fact that only a small proportion of registered patients were tested for the infections and in many cases the tests were likely to be targeted at people with problems or a suspected infection. Therefore, the results tend to overestimate the true prevalence of infection among substitution treatment patients, as evidenced by, *inter alia*, a higher rate of positive tests among new clients.

Table 6-7: Results of testing for HIV, HBV, and HCV among patients on opiate substitution in 2010 (Nechanská, 2011g)

Infection	Tested marker	All clients			New clients		
		Total tested	Positive	Positive tests %	Total tested	Positive	Positive tests %
HIV	anti-HIV	160	1	0.6	91	0	0
HBV	HBsAg*	166	13	7.8	96	9	9.4
	anti-HBcAg**	147	79	53.7	85	49	57.6
	anti-HBsAg**	160	67	41.9	88	42	47.7
HCV	anti-HCV	160	109	68.1	91	70	76.9

*Note: * An antigen indicating acute or chronic active infection; ** anti-HBcAg are antibodies generated during an acute HBV infection, but lasting even long after recovery; anti-HBsAg antibodies have a similar information value, but also develop after vaccination; when interpreting the results it should be taken into account that these may not be examinations of the same people.*

For 2010, the results of the testing of imprisoned injecting drug users are available (Generální ředitelství Vězeňské služby ČR, 2011d). The sample of prisoners is not representative and repeated tests of the same (positive) person in the various stages of serving a custodial sentence cannot be excluded. Therefore, caution must be exercised in the interpretation and generalisation of the results. Nevertheless, the results indicate a higher rate of infection among prisoners in comparison with available results of studies and monitoring systems aimed at drug users in the community-based facilities – in particular, the prevalence of HIV (even though the number of persons examined is low) is relatively high; see Table 6-8.

Table 6-8: Results of testing for HIV, HBV, and HCV among injecting drug users in prisons in 2010 (Generální ředitelství Vězeňské služby ČR, 2011d)

Infection	Tested indicator		Start of serving prison sentence	Start of remand	In the course of prison sentence
HIV	anti-HIV	Total tested	67	68	912
		Positive	3	4	3
		Positive (%)	4.5	5.9	0.3
HBV	HBsAg*	Total tested	1,790	1,144	1,454
		Positive	194	117	183
		Positive (%)	10.8	10.2	12.6
	anti-HBc IgG **	Total tested	1,644	935	1,210
		Positive	361	249	313
		Positive (%)	22.0	26.6	25.9
HCV	anti-HCV	Total tested	4,776	1,304	1,611
		Positive	1,097	619	704
		Positive (%)	23.0	47.5	43.7

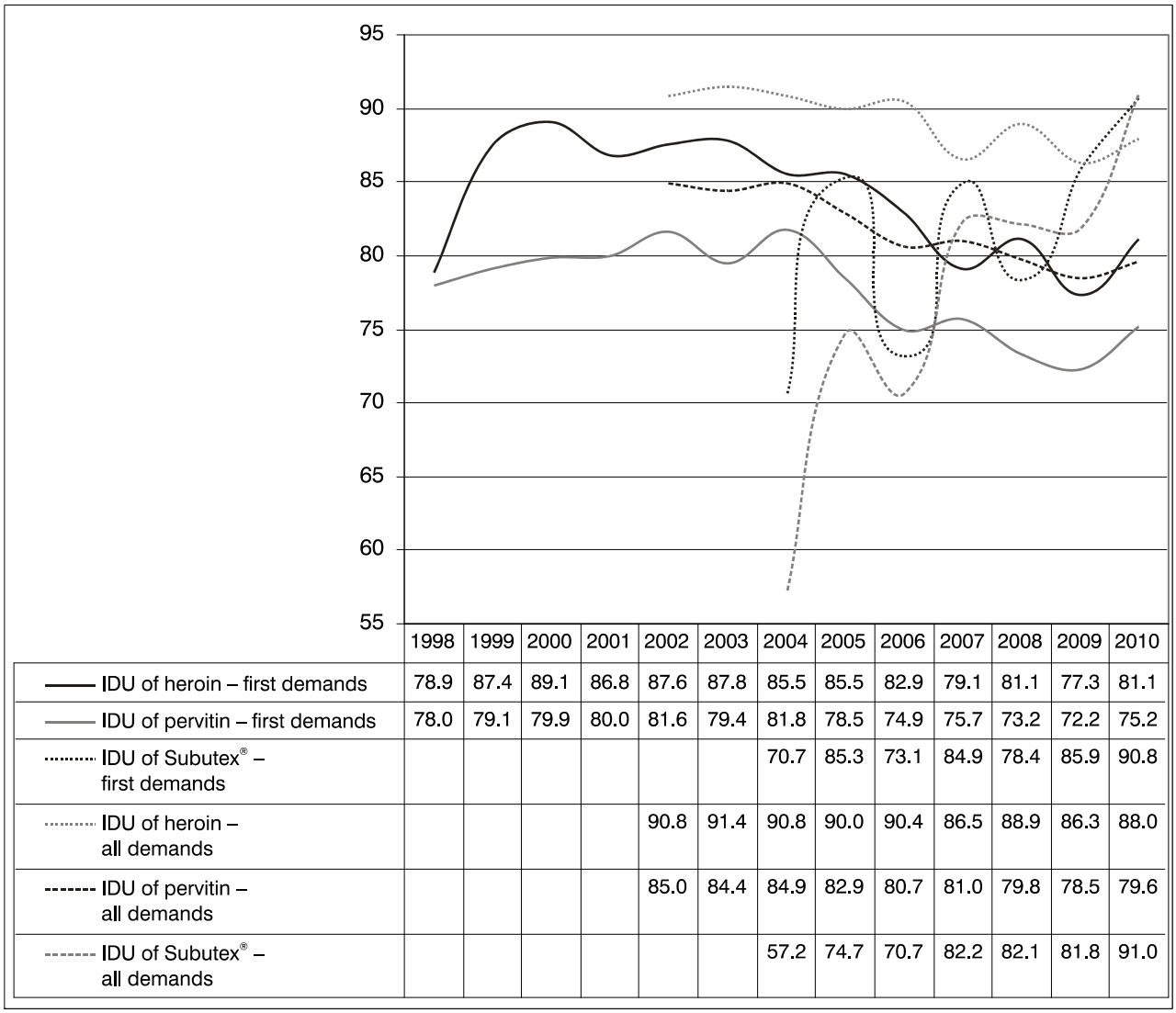
*Note: * An antigen indicating acute or chronic active infection; ** antibodies generated during an acute HBV infection but lasting even long after recovery.*

6.1.4 Risk Behaviour of Drug Users

While there has been a slight decline in the proportion of injecting users among first-time treatment demands in connection with heroin and pervitin use in the long term, the latest available data indicate that this trend may be changing. Subutex® users report a high proportion of administration by injection. In the Czech Republic, cocaine is used almost exclusively by snorting (two out of a total of 23 cocaine users reported injection as the route of administration in their demands for treatment in 2010). No treatment demands related to crack use were registered in 2010 (Studničková and Petrášová, 2011).

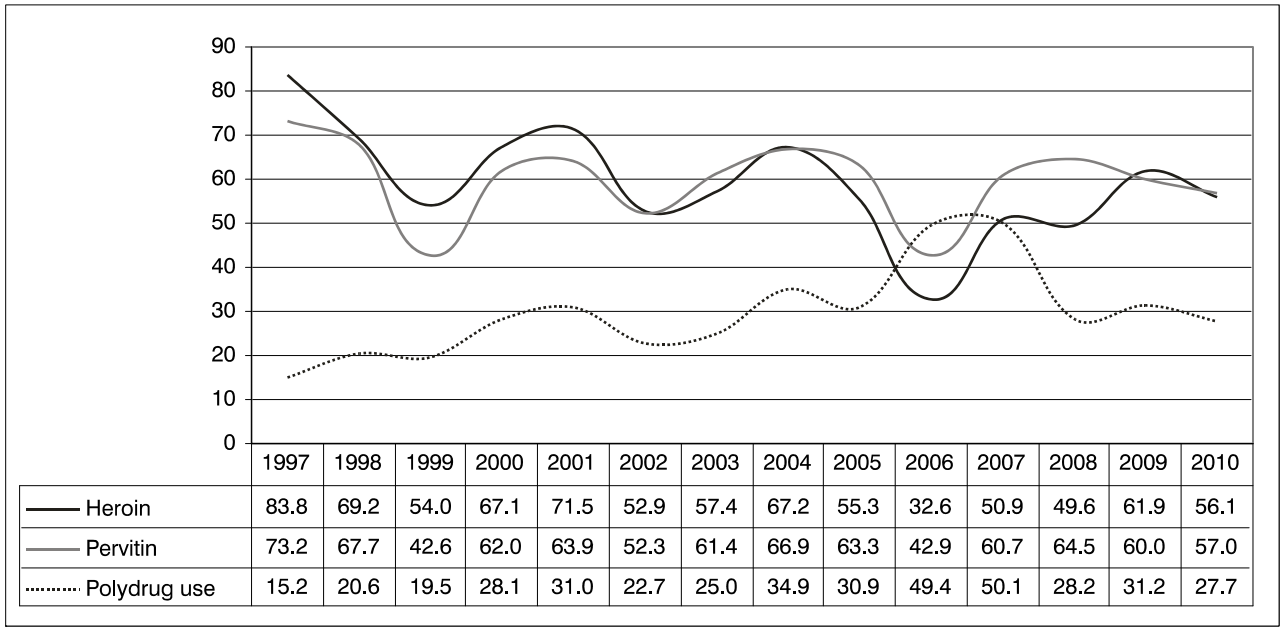
Trends in the proportion of injecting users among patients in outpatient psychiatric treatment are provided in Figure 6-8 (Nechanská, 2011c). The proportion of injecting use among heroin and pervitin users has been decreasing in the long term, and is lower than in the Register of Treatment Demands (Figure 6-7). The long-term rising percentage of injecting drug users among polydrug users (dg. F19) is probably a reflection of the growth in the number of pervitin and opiate users who combine these two drugs together or with other drugs.

Figure 6-7: Proportion of injecting drug use among first-time treatment demands and all treatment demands related to heroin, Subutex®, and pervitin use, in % (Studničková and Petrášová, 2011)



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
IDU of heroin – first demands	78.9	87.4	89.1	86.8	87.6	87.8	85.5	85.5	82.9	79.1	81.1	77.3	81.1
IDU of pervitin – first demands	78.0	79.1	79.9	80.0	81.6	79.4	81.8	78.5	74.9	75.7	73.2	72.2	75.2
IDU of Subutex® – first demands							70.7	85.3	73.1	84.9	78.4	85.9	90.8
IDU of heroin – all demands					90.8	91.4	90.8	90.0	90.4	86.5	88.9	86.3	88.0
IDU of pervitin – all demands					85.0	84.4	84.9	82.9	80.7	81.0	79.8	78.5	79.6
IDU of Subutex® – all demands							57.2	74.7	70.7	82.2	82.1	81.8	91.0

Figure 6-8: Trends in the proportion of injecting heroin, pervitin, and polydrug users treated at outpatient psychiatric facilities, 1997–2010, in % (Nechanská et al. 2011; Nechanská, 2011c)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
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
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
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

It seems that the proportion of injecting users demanding treatment who report sharing needles and syringes is declining in the long term; see Table 6-9.

Table 6-9: Sharing of needles and syringes at any time in the past reported by IDUs demanding treatment in 2002–2010 (Studničková and Petrášová, 2011)

Year	Number of IDUs	Number of sharing IDUs	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

A comparison of needs analyses of low-threshold programme clients in Prague from 2003 and 2010 also shows that there was a decline in the rate of risk behaviour (Šťastná, 2010); for more information see the chapter on Data on Problem Drug Use from Non-Treatment Sources (p. 52). The reported rate of lifetime and current (in the last month) needle sharing fell between these two years. In 2010, all clients except one exchanged used needles for new ones.

6.2 Other Drug-Related Health Correlates and Consequences

6.2.1 Non-Fatal Drug Intoxications

The Public Health Office in Prague collects data about non-fatal intoxications[86]. There are still problems and major regional differences in the system of collecting data which make it complicated to evaluate trends[87]. In 2010 there were 849 cases of non-fatal intoxication with drugs; see Table 6-10.

Table 6-10: Non-fatal drug intoxications in the Czech Republic, 2001–2009 (Studničková and Petrášová, 2011)

Drug	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Pervitin	163	191	149	180	222	231	343	364	187	148
Heroin	285	176	152	179	244	149	190	166	122	162
Methadone	2	6	3	2	10	7	2	1	1	0
Subutex®	–	–	2	12	14	18	32	7	0	0
Other opiates	16	23	22	20	19	21	40	17	42	24
Benzodiazepines	137	89	157	126	153	124	139	113	180	136
Other sedatives, hypnotics	195	137	82	103	88	107	125	135	127	112
Cannabis	63	101	90	84	73	72	127	108	105	102
Inhalants	75	58	69	64	48	28	31	9	33	18
Psilocybin	15	7	4	10	6	5	10	9	7	4
Cocaine, crack	4	2	6	5	7	8	1	7	2	0
Datura stramonium	4	0	0	0	1	0	1	5	2	0
LSD	3	2	3	7	3	5	7	4	13	3
MDMA	15	4	8	3	8	12	12	3	1	2
Other known drugs and pills	182	179	100	92	111	89	124	140	173	137
Other, unknown	24	25	34	65	186	78	71	58	23	1
Total	**1,183**	**1,000**	**881**	**952**	**1,193**	**954**	**1,255**	**1,146**	**1,018**	**849**

6.2.2 Psychiatric and Somatic Co-morbidity of Drug Users

In addition to primary diagnoses, secondary diagnoses are also monitored for patients recorded in the National Register of Hospitalised Patients [88].

[86] This system reports cases of overdoses, as well as other health complications that require emergency hospitalisation. Various health facilities, primarily emergency units, provide reports to the system.

[87] The trends in reported cases are also significantly influenced by changes in the network of reporting facilities (see the 2009 Annual Report). In 2010 there were still problems with reporting in Prague (five cases reported) and other regions (e.g. no cases were reported in the South Bohemia, Hradec Králové and South Moravia regions in 2010).

[88] The primary diagnosis is defined as the primary condition that requires the patient to be hospitalised. The codes for other illnesses that complicate, i.e. impact on and justify the frequency, duration, volume and structure of the care provided and reported, are given as secondary diagnoses. As up to four secondary diagnoses are recorded, it must be noted that one hospitalisation record may be counted by the number of reported secondary diagnoses in up to four chapters of ICD-10.

The incidence of secondary diagnoses among drug users treated for disorders caused by the use of addictive substances (primary diagnosis F10–F19) who were hospitalised in inpatient psychiatric facilities is presented in Table 6-11.

Psychiatric diagnoses, i.e. diagnoses in Chapter V of ICD-10, were the most frequent secondary hospitalisation diagnoses provided for drug users in psychiatric inpatient facilities, which is also implied from the character of the care provided at these facilities. A secondary psychiatric diagnosis was provided in 30% of hospitalisations resulting from the use of alcohol, less than 30% of those resulting from opiate and polydrug use, and nearly 50% of those resulting from the use of stimulants. Diagnoses from the F10–F19 group, disorders related to addictive substance use, were also frequently reported as secondary diagnoses. Other frequent secondary diagnoses were from the group of gastrointestinal and circulatory disorders (Ústav zdravotnických informací a statistiky, 2011c).

Table 6-11: Comorbidity in hospitalisations of addictive substance users in psychiatric inpatient facilities in 2010, in % (Ústav zdravotnických informací a statistiky, 2011c)

Secondary diagnosis by chapter of ICD-10		**Primary diagnosis**									
		F10 – alcohol (n=10,003)	F11 – opioids (n=696)	F12 – cannabis (n=199)	F13 – sedatives / hypnotics (n=306)	F14 – cocaine (n=2)	F15 – other stimulant s (n=1,626)	F16 – hallucinogens (n=9)	F17 – tobacco (n=3)	F18 – inhalants (n=42)	F19 – polydrug use (n=2,476)
I.	Certain infectious and parasitic diseases	0.6	13.5	0.5	1.0	0.0	4.4	0.0	0.0	4.8	4.4
II	Neoplasms	0.4	0.1	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.1
III	Diseases of the blood and blood-forming organs	1.2	0.1	0.5	0.3	0.0	0.0	0.0	0.0	0.0	0.2
IV	Endocrine, nutritional and metabolic diseases	4.3	1.0	1.5	9.5	0.0	1.0	0.0	0.0	7.1	0.6
V	Mental and behavioural disorders	29.9	28.3	79.4	63.1	50.0	48.0	100.0	66.7	14.3	25.6
VI	Diseases of the nervous system	3.4	1.0	1.0	1.6	0.0	0.4	0.0	0.0	0.0	0.8
VII	Diseases of the eye	0.3	0.4	0.0	0.3	0.0	0.1	0.0	0.0	0.0	0.0
VIII	Diseases of the ear and mastoid process	0.2	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
IX	Diseases of the circulatory system	8.5	1.4	0.5	15.0	0.0	0.4	0.0	33.3	0.0	1.5
X	Diseases of the respiratory system	1.6	0.7	1.0	2.9	50.0	0.9	11.1	0.0	0.0	0.7
XI	Diseases of the digestive system	10.9	2.0	1.0	3.3	0.0	0.3	0.0	33.3	0.0	1.7
XII	Diseases of the skin	0.7	0.3	1.5	0.0	0.0	0.4	0.0	0.0	0.0	0.3
XIII	Diseases of the musculoskeletal system and connective tissue	1.1	0.9	0.0	2.9	0.0	0.3	0.0	0.0	0.0	0.2
XIV	Diseases of the genitourinary system	0.7	0.4	0.5	1.3	0.0	0.3	0.0	0.0	0.0	0.2
XV	Pregnancy, childbirth	0.0	0.1	0.5	0.0	0.0	0.1	0.0	0.0	0.0	0.0
XVII	Congenital malformations, deformations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
XVIII	Abnormal clinical findings	0.6	0.4	0.0	0.3	0.0	0.4	0.0	33.3	0.0	0.3
XIX	Injury, poisoning	1.9	0.7	3.0	2.9	0.0	0.7	0.0	33.3	0.0	1.5
XXI	Factors influencing health status	3.0	3.9	23.1	6.5	0.0	10.3	11.1	0.0	4.8	3.2

6.2.3 Drugs and Road Accidents

Since 2003, cases where ethanol and other drugs[89] were detected have been analysed in forensic autopsies of road accident fatalities in the Czech Republic; for more information see the chapter on Drug-Related Deaths and Mortality of Drug Users (p. 95). Active participants in road accidents (pedestrians, cyclists, and drivers) are monitored separately[90].

According to the data reported by forensic medicine departments, 894 persons died in traffic accidents or as a result of traffic accidents in 2010. Of these victims, 505 (57%) were subject to toxicological examination[91], which is a similar percentage as in previous years. The highest proportion of positive tests was detected in the case of ethanol. As far as the three most common non-alcohol drugs are concerned, compared with the previous year there was a decline in the number of positive tests for pervitin and benzodiazepines, but an increase in the number of positive

[89] A test is considered positive for ethanol if the level of ethanol is higher than 0.2 g/kg (Czech Society for Forensic Medicine and Toxicology, 1999), positive for cannabis if THC or its active metabolite is proven (i.e. not THC-COOH, for instance), and positive for inhalants if the autopsy detects substances which do not develop post mortem or are not indicated in some physiological or pathological conditions (e.g. acetone, acetaldehyde, n-propanol, n-butanol).

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

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

tests for cannabis; see Table 6-12. In 2010, there was one case of a driver who tested positive for cocaine. Inhalants were also found in one pedestrian. Results for barbiturates (three cases) and opiates (two) did not exceed 1% (Národní monitorovací středisko pro drogy a drogové závislosti a SSLST ČLS JEP, 2011). Out of the entire group of active participants in road accidents who were killed in 2010, a total of 124 active road users who were killed tested positive for ethanol (of whom 39 were drivers) and 39 (30 of whom were drivers) tested positive for one of the narcotic and psychotropic substances under monitoring.

Table 6-12: Detection of ethanol and other drugs in the bodies of active road users who died in traffic accidents in 2003–2010 (Národní monitorovací středisko pro drogy a drogové závislosti a SSLST ČLS JEP, 2011)

Drug	**Year**	**Category of active road users who died in traffic accidents**							
		Pedestrians		Cyclists		Drivers		**Total**	
		Tested	Positive (%)	Tested	Positive (%)	Tested	Positive (%)	**Tested**	**Positive (%)**
Ethanol	2003	141	51.8	50	40.0	203	32.0	394	40.1
	2004	150	48.7	44	29.5	209	23.9	403	33.7
	2005	148	45.3	35	34.3	198	18.7	381	30.4
	2006	102	55.9	35	37.1	164	26.2	301	37.5
	2007	130	50.8	44	40.9	215	20.9	389	33.2
	2008	139	51.8	40	37.5	202	29.2	381	38.3
	2009	114	50.9	30	16.7	184	25.0	328	33.2
	2010	144	50.0	30	43.3	198	19.7	372	33.3
Stimulants (incl. pervitin and ecstasy)	2003	91	1.1	27	0.0	152	3.3	270	2.2
	2004	109	1.8	23	0.0	170	1.8	302	1.7
	2005	103	1.9	17	0.0	148	0.7	268	1.1
	2006	79	1.3	15	0.0	125	7.2	219	4.6
	2007	107	0.9	27	0.0	223	5.8	357	3.9
	2008	121	3.3	21	0.0	195	9.2	337	6.5
	2009	84	3.6	18	0.0	175	5.1	277	4.3
	2010	97	1.0	16	0.0	172	4.7	285	3.2
Cannabis (active metabolites of THC)	2003	70	2.9	21	0.0	101	4.0	192	3.1
	2004	44	2.3	14	0.0	100	0.0	158	0.6
	2005	54	1.9	11	0.0	94	3.2	159	2.5
	2006	53	11.3	8	12.5	91	4.4	152	7.2
	2007	61	3.3	11	0.0	154	4.5	226	4.0
	2008	60	6.7	13	0.0	130	6.2	203	5.9
	2009	49	4.1	9	0.0	125	1.6	183	2.2
	2010	51	5.9	8	0.0	119	5.9	178	5.6
Benzodiazepines	2003	89	3.4	28	7.1	150	2.0	267	3.0
	2004	109	5.5	23	4.3	172	2.9	304	3.9
	2005	103	2.9	17	5.9	147	4.1	267	3.7
	2006	81	2.5	15	0.0	127	3.9	223	3.1
	2007	114	7.0	30	3.3	223	5.8	367	6.0
	2008	135	5.2	24	12.5	204	2.0	363	3.9
	2009	99	6.1	22	13.6	189	4.2	310	5.5
	2010	114	4.4	18	0.0	197	6.1	329	5.2
Any drug besides ethanol	2003	108	7.4	35	11.4	171	6.4	314	7.3
	2004	117	9.4	26	7.7	181	5.5	324	7.1
	2005	110	8.2	19	5.3	158	7.0	287	7.3
	2006	84	9.5	18	5.6	133	12.8	235	11.1
	2007	122	9.0	30	6.7	233	13.7	385	11.7
	2008	142	10.6	29	10.3	213	12.7	384	11.7
	2009	100	8.0	22	13.6	191	11.5	313	10.5
	2010	124	7.3	21	0.0	205	14.6	350	11.1

Information about the influence of alcohol and other drugs on the rate of road traffic accidents registered by the police is given in Table 6-13. According to these data, in 2010 the number and percentage of drunk driving accidents, as well as the number and percentage of fatalities in drunk driving accidents, fell. In contrast, there was an increase in the number and percentage of accidents which occurred under the influence of drugs, and the number of

fatalities in such accidents also rose. This number is still much lower than the reported results of autopsies and toxicological examinations of road fatalities carried out by forensic medicine departments (see above), even while recognising differing case definitions and data collection methodologies in both sources.

Table 6-13: Road traffic accident statistics in the Czech Republic in 2003–2010 – influence of alcohol and other drugs (Ředitelství služby dopravní policie Policejního prezidia ČR, 2010; Ředitelství služby dopravní policie Policejního prezidia ČR, 2011)

Year	Accidents					Accident fatalities				
	Total	Under the influence of alcohol		Under the influence of pills and other drugs		Total	Under the influence of alcohol		Under the influence of pills and other drugs	
	Number	Number	%	Number	%	Number	Number	%	Number	%
2003	195,851	9,076	4.9	39	0.02	1,319	111	8.5	0	0.0
2004	196,484	8,445	4.5	53	0.03	1,215	59	4.9	1	0.1
2005	199,262	8,192	4.3	60	0.03	1,127	59	5.2	0	0.0
2006	187,965	6,807	3.8	64	0.03	956	42	4.3	1	0.1
2007	182,736	7,266	4.3	78	0.04	1,123	36	3.2	2	0.2
2008	160,376	7,252	4.8	109	0.07	992	80	8.1	1	0.1
2009*	74,815	5,725	8.1	137	0.18	832	123	14.9	6	0.7
2010	75,522	5,015	6.6	165	0.22	753	102	13.5	15	2.0

*Note: * The number of reported accidents fell because from 1 January 2009, the level for the mandatory reporting of accidents to the police increased from CZK 50,000 (€ 1,977) to CZK 100,000 (€ 3,954) in estimated damage.*

Since 2007 the traffic police have tested for narcotic and psychotropic substances using saliva tests as a general detection tool[92]. If the result of the general test is positive, a specialised medical and subsequent toxicological examination must be carried out. In 2007 a total of 2,758 general tests were carried out, of which 347 returned positive (12.6%). These most frequently involved amphetamines (152 cases), cannabis (81), ecstasy (15), opiates (6), and hallucinogens (1). Several drugs at the same time were found in 77 cases. In 2008 a total of 8,511 general tests were carried out, with 794 of these returning positive (9.3%). In 2009, 1,149 cases of the use of narcotic or psychotropic substances and 13,767 cases of alcohol use were found in drivers; in 2010 the corresponding figures were 1,450 and 27,803 cases, respectively (Ředitelství služby dopravní policie Policejního prezidia ČR, 2010; Ředitelství služby dopravní policie Policejního prezidia ČR, 2011).

6.3 Drug-Related Deaths and Mortality of Drug Users

6.3.1 Drug Deaths in the Special Mortality Register

In the Czech Republic, a forensic medical examiner carries out a mandatory autopsy in all cases of sudden death in which the examining practitioner could not determine the cause of death and in all cases of violent deaths (all injuries and poisonings). Since 1998 drug-related deaths (fatal overdoses), and since 2003 also indirect fatalities (with the presence of drugs), have been monitored on a routine basis by means of a special register maintained at all departments of forensic medicine, with close collaboration between the National Focal Point and the Czech Society for Forensic Medicine and Toxicology of the J. E. Purkyně Czech Medical Association. Detailed data for 2010 were obtained from all 13 departments[93], which performed a total of 13,241 autopsies (13,276 autopsies were performed in 2009). Aggregate reports since 2007 have also been obtained from three pathology departments where forensic medical examiners perform autopsies on an irregular basis in accordance with Section 115 of the Criminal Procedure Rules (forensic autopsies); no drug-related deaths were reported by these three facilities for 2010.

6.3.1.1 Fatal Drug Overdoses

In 2010, 194 fatal overdoses on illicit drugs, inhalants, and psychotropic medication were identified (225 in 2009). Of this number, 55 cases fell under the standard EMCDDA selection D for drug-related deaths, i.e. cases of fatal overdoses on illegal drugs and inhalants (49 in 2009), and 139 cases involved psychotropic pills (176 in 2009). The substances which caused the fatal overdoses were successfully identified in all cases in 2010.

A total of 19 cases of fatal overdoses on (illegal) opiates were identified (20 cases in 2009); most were heroin overdoses (13 confirmed or very probable cases). In 13 cases, the opiates were identified alone or together with ethanol (six cases), while in the other six cases opiates were combined with other substances (such as pervitin, MDMA, and pills). Two cases probably involved a fatal overdose on opium (of these, one was in combination with ethanol, the other in combination with pervitin and tramadol). In one case the cause of death was a fentanyl overdose in combination with ethanol (a small amount of fentanyl was also found in another overdose case classified as a pervitin overdose). Methadone was found in two overdose cases: one was in combination with ethanol, while pervitin and benzodiazepines were present in the other case.

[92] DrugWipe (http://www.drugwipe.us) tests are used.
[93] In 2009 data were obtained from 14 departments – data were also reported from the department in Most (Ústí nad Labem region), where there is a forensic toxicology department.

Pervitin was the cause of a fatal overdose in 18 cases (there were also 18 cases in 2009). One of these cases also involved fentanyl, three involved THC, two ethanol, and two psychoactive pills. Sixteen cases (eight in 2009) were fatal overdoses on inhalants (toluene, chloroform, ether, and propane-butane, and one case of death occurred after a 12-year-old boy inhaled cigarette lighter fluid). In addition, two fatal overdoses on synthetic (dance) drugs were reported – one case involved MDMA (ecstasy) with traces of pervitin, the other 4-methylthioamphetamine (4-MTA)[94]. In 2010, as has been the case in the past, buprenorphine was not identified in any fatal overdoses and no fatal overdoses from hallucinogens, THC, or other cannabinoids were reported. In 2010 there were also no reports of fatal overdoses involving cocaine (Národní monitorovací středisko pro drogy a drogové závislosti a SSLST ČLS JEP, 2011); see Table 6-14.

Table 6-14: Fatal drug overdoses in the Czech Republic in 2010 by groups of drugs, age groups and gender (Národní monitorovací středisko pro drogy a drogové závislosti a SSLST ČLS JEP, 2011)

Drug/age group	**<15**	**15–19**	**20–24**	**25–29**	**30–34**	**35–39**	**40–44**	**45–49**	**50–54**	**55–59**	**60–64**	**>64**	**Total**		
													Males	Females	**Total**
Only opiates/opioids (excluding methadone)	0	2	1	1	6	0	2	0	0	0	0	0	11	1	**12**
Only methadone	0	0	0	0	0	0	0	0	1	0	0	0	1	0	**1**
More substances incl. opiates/opioids	0	1	0	2	2	0	0	0	1	0	0	0	5	1	**6**
– methadone	0	0	0	0	0	0	0	0	1	0	0	0	1	0	**1**
Total opiates/opioids	**0**	**3**	**1**	**3**	**8**	**0**	**2**	**0**	**2**	**0**	**0**	**0**	**17**	**2**	**19**
One or more substances, excluding opiates/opioids	**1**	**2**	**4**	**8**	**5**	**6**	**6**	**2**	**1**	**1**	**0**	**0**	**32**	**4**	**36**
– methadone	1	1	2	4	1	1	5	0	1	0	0	0	14	2	**16**
– pervitin	0	1	2	4	4	3	1	2	0	1	0	0	16	2	**18**
– cocaine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
– synthetic (dance) drugs (such as MDMA)	0	0	0	0	0	2	0	0	0	0	0	0	2	0	**2**
– hallucinogens	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Unspecified / unknown	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total illegal drugs and inhalants (EMCDDA selection D)	1	5	5	11	13	6	8	2	3	1	0	0	49	6	**55**
Psychoactive pills	**0**	**0**	**3**	**8**	**5**	**14**	**13**	**26**	**21**	**17**	**11**	**21**	**76**	**63**	**139**
– benzodiazepines	0	0	2	2	3	7	3	10	6	6	4	6	23	26	**49**
Total	**1**	**5**	**8**	**19**	**18**	**20**	**21**	**28**	**24**	**18**	**11**	**21**	**125**	**69**	**194**

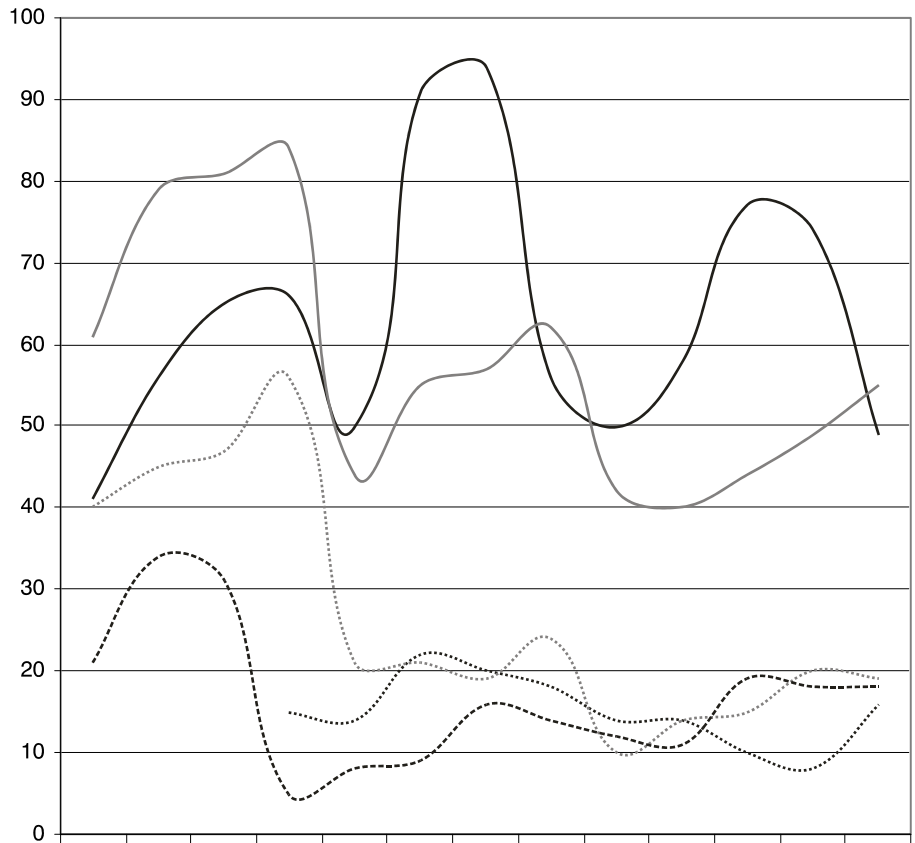
Fatal overdoses on psychotropic pills represent a very heterogeneous category which it would be difficult to evaluate accurately. This is because this category comprises suicidal overdoses, accidental overdoses, and overdoses of undetermined intent, both from pills that were prescribed *lege artis* and from abused medication. In total, 139 cases of overdoses on psychotropic pills were identified in 2010[95] (176 cases in 2009), out of which 49 cases involved benzodiazepine overdoses (74 in 2009) and 36 involved medication containing opiates (24 in 2009).

In 2010 there was a slight year-on-year increase in the number of fatal illicit drug overdoses, especially as a result of the increase in the number of fatal inhalant overdoses, from eight cases in 2009 to 16 cases in 2010; the number of cases of fatal pervitin and heroin overdoses remained essentially the same. The long-term trend is shown in Figure 6-9.

For the first time in the Czech Republic, fentanyl was identified in cases of fatal (illegal) drug overdoses or drug users' overdoses. Although information about the source of the fentanyl was not known at the time of the autopsy (and the fentanyl could have originated from a medication), it is possible that the fentanyl came from the black market (police information about fentanyl seizures in the Czech Republic in the spring of 2011 supports this hypothesis; for more information see the chapter on Drug Markets on p. 131).

[94] This is a very dangerous substitute for ecstasy whose use is associated with the risk of developing serotonin syndrome and death.
[95] The vast majority of pill overdoses are suicidal in nature, most often involving a combination of (several) pharmaceuticals with alcohol.

Figure 6-9: Fatal overdoses from benzodiazepines, illegal drugs, and inhalants, 1998–2010 (Národní monitorovací středisko pro drogy a drogové závislosti a SSLST ČLS JEP, 2011)



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Benzodiazepines	41	56	65	66	50	91	94	56	50	58	77	74	49
Illicit drugs and inhalants total	61	79	81	84	44	55	57	62	42	40	44	49	55
- inhalants				15	14	22	20	18	14	14	10	8	16
- opiates/opioids	40	45	47	56	21	21	19	24	10	14	15	20	19
- amphetamines (pervitin)	21	34	31	5	8	9	16	14	12	11	19	18	18
- cocaine	0	0	0	0	0	0	1	1	1	1	0	0	0
- synthetic (dance) drugs	0	0	0	0	0	1	0	2	0	0	0	3	2
- hallucinogens	0	0	2	0	0	0	0	0	0	0	0	0	0
- cannabis	0	0	0	0	0	0	0	0	0	0	0	0	0
- unspecified	0	0	1	8	1	2	1	3	5	0	0	0	0

Note: Inhalants have been monitored independently since 2001. Data from forensic medicine departments have been available in electronic database form since 2001.

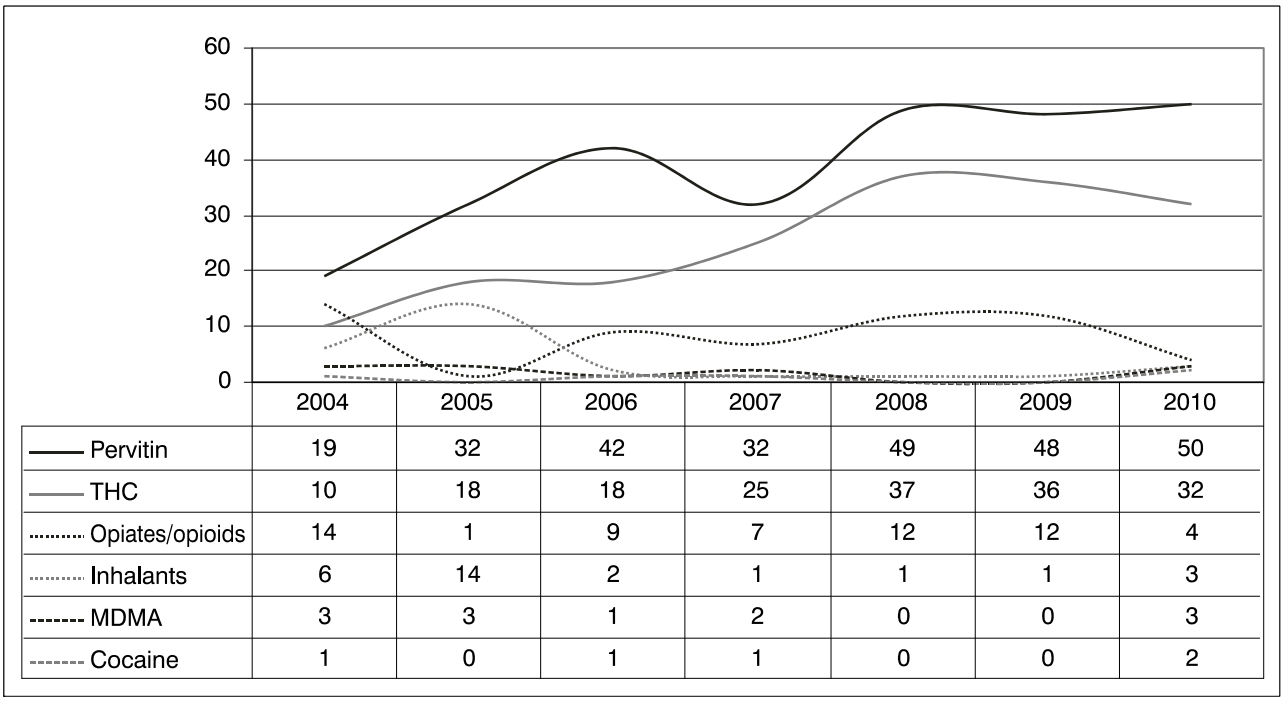
6.3.1.2 Deaths with the Presence of Drugs

Altogether, 117 deaths with the presence of drugs were identified in 2010 (there were also 117 in 2009). Eleven of these cases were due to natural causes, i.e. illness (eight in 2009), 58 cases involved accidents (51 in 2009), 46 involved suicides (47 in 2009), and two were cases of manslaughter or murder (seven in 2009). An overview of the numbers and proportions of selected groups of drugs in the individual groups of deaths in which drugs were present is given in Table 6-15; the trend since 2004 is shown in Figure 6-10 (Národní monitorovací středisko pro drogy a drogové závislosti a SSLST ČLS JEP, 2011). In the long term, a growing number of cases of indirect deaths where pervitin and THC were found are particularly evident, although there has been a slight decline in the case of THC in the past two years. Opioids used in substitution treatment were not found in any cases of deaths with the presence of drugs in 2010.

Table 6-15: Deaths with the presence of drugs detected by forensic medicine departments in the Czech Republic in 2010 by selected groups of drugs and causes of death (Národní monitorovací středisko pro drogy a drogové závislosti a SSLST ČLS JEP, 2011)

Drug	Illness (n = 11)	Accident (n = 58)	Suicide (n = 46)	Manslaughter /murder (n = 2)	Other (n = 0)	Total (n = 117)	Proportion (%)
Pervitin	7	27	15	1	0	50	42.7
THC	5	18	9	0	0	32	27.4
Benzodiazepines	1	9	15	1	0	26	22.2
Other psychoactive pills	0	6	12	0	0	18	15.4
Opiates/opioids	0	2	2	0	0	4	3.4
Inhalants	0	3	0	0	0	3	2.6
MDMA and other synthetic (dance) drugs	0	3	0	0	0	3	2.6
Cocaine	0	0	2	0	0	2	1.7

Figure 6-10: Deaths with the presence of selected drugs detected by forensic medicine departments in the Czech Republic, 2004–2010 (Národní monitorovací středisko pro drogy a drogové závislosti a SSLST ČLS JEP, 2011)



	2004	2005	2006	2007	2008	2009	2010
Pervitin	19	32	42	32	49	48	50
THC	10	18	18	25	37	36	32
Opiates/opioids	14	1	9	7	12	12	4
Inhalants	6	14	2	1	1	1	3
MDMA	3	3	1	2	0	0	3
Cocaine	1	0	1	1	0	0	2

For information on the detection of drugs in the bodies of road accident fatalities see the chapter on Other Drug-Related Health Correlates and Consequences (p. 92).

6.3.2 Drug-Related Deaths in the General Mortality Register

An extract of drug-related deaths from the general mortality register – Information System of Deaths – was presented for the first time in 2010. The register is administered by the Czech Statistical Office[96], which provides the register to the Institute of Health Information and Statistics for further processing and publication[97]. To extract data about drug-related deaths from the death statistics, EMCDDA criteria are used. These are based on selecting the corresponding diagnosis for the cause of death or combined causes and the mechanism of death. As a standard, EMCDDA selection B is used. This is based in selecting deaths where the cause of death is a mental disorder or behavioural disorder caused by illegal drugs and combinations thereof (dg. F11, F12, F14–16, F19) or in cases where there was accidental, intentional, or undetermined poisoning caused by illegal drugs, i.e. a combination of

[96] The Act on Health Services passed in 2011 will fundamentally change the process for sending Certificates of Post-Mortem Examination to and from various institutions (healthcare facilities, the register of births and deaths, and the Institute of Health Information and Statistics), the collection and reporting of diagnoses related to the death, and time limits for reporting. Moreover, several items of data, including the influence of narcotic and psychotropic substances on the death, are added to the report.

[97] In all cases of death in the Czech Republic, the physician diagnosing the death must complete a Certificate of Post-Mortem Examination which, if an autopsy is performed, is augmented by an autopsy diagnosis and sent to the register of births and deaths. At the register of births and deaths, data from the Certificate of Post-Mortem Examination are copied into a Czech Statistical Office form (Report of Death). The Czech Statistical Office then enters this information into the Information System of Deaths database. WHO recommendations for coding the causes of death are applied. In the event that the physician or forensic medical examination department ascertains new facts regarding the cause of death, a change to the Certificate of Post-Mortem Examination is reported to the regional office of the Institute of Health Information and Statistics in Prague, Hradec Králové, Brno, or Ostrava, which passes this on to the Czech Statistical Office.

diagnoses listed under letters X or Y with diagnoses for poisoning caused by the given substance – a narcotic or psychodysleptic drug (dg. T40 and T43.6). In 2010, an alternative selection was made from the death statistics for the first time. In the alternative selection, a combination with a T diagnosis for substances is not necessary for accidental, intentional, or undetermined poisonings caused by narcotics and psychodysleptic drugs (X42, X62 and Y12). The disadvantage of the alternative selection is that without the substance code, no differentiation can be made between the individual types of drugs which cause the fatal overdose.

At the end of 2010, the National Focal Point's working group for drug-related deaths agreed that the National Focal Point and the Institute of Health Information and Statistics would collaborate in comparing individual cases of drug deaths extracted from the special mortality register and the general mortality register in 2009. In the analysis, diagnoses of the causes of death from the Death Certificate information system were added to the data from these registers[98]. Cases from the special register with data from the Information System of Deaths and the Death Certificate information system added served as the basis of the analysis. Data could not be found for seven cases from the special register (out of 49 deaths found in 2009) either in the Information System of Deaths or in the Death Certificate information system, which could be because the Death Certificate for these deaths was not completed or because there are errors in the personal identification number (birth number) or code in the special register. In twelve cases the records were connected and the substances that caused death were identical. In seven cases a different substance was stated in the Information System of Deaths than in the special register, and in 15 cases diagnoses were stated in the Information System of Deaths which did not fall under selection B[99].

The remaining eight cases of death in the special register related to inhalant overdoses. These are not included in selection B. In an effort to bring selection B from the general register as close to selection D from the special mortality register as possible, standard selection B was expanded to include inhalants, i.e. dg. F18 (a mental disorder or behavioural disorder caused by the use of inhalants) and dg. X46, X66 and Y16 in combination with dg. T52, i.e. accidental, intentional, or undetermined poisoning caused by inhalants.

The structure of fatal drug overdoses in 2010 according to the standard and expanded EMCDDA selection B by age, gender, and type of drug is provided in Table 6-16 and trends for deaths by individual drugs are provided in Table 6-17 (Ústav zdravotnických informací a statistiky, 2011b).

Table 6-16: Fatal drug overdoses in the Czech Republic in 2010 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, 2011b)

Drug	**<15**	**15–19**	**20–24**	**25–29**	**30–34**	**35–39**	**40–44**	**45–49**	**50–54**	**55–59**	**60–64**	**>64**	**Total**		
													Males	Females	**Total**
Opiates/opioids	0	3	2	2	1	1	1	0	1	1	1	0	10	3	**13**
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	1	2	3	1	1	0	0	0	0	0	8	0	**8**
Hallucinogens	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Drugs not further specified	0	0	3	1	1	1	0	1	1	0	0	0	7	1	**8**
Selection B (standard)	**0**	**3**	**6**	**5**	**5**	**3**	**2**	**1**	**2**	**1**	**1**	**0**	**25**	**4**	**29**
Inhalants	0	0	2	2	1	3	3	0	2	0	0	0	10	3	**13**
Selection B (expanded)	**0**	**3**	**8**	**7**	**6**	**6**	**5**	**1**	**4**	**1**	**1**	**0**	**35**	**7**	**42**

[98] The Institute of Health Information and Statistics manages and processes this information system to quickly and flexibly select deaths with certain characteristics (e.g. to retrieve death cases for the National Cancer Register), to be able to monitor comorbidities based on cause of death diagnoses, to satisfy the needs of healthcare facilities in updating registers and files, etc. The Certificate of Post-Mortem Examination contains the primary cause of death and previous causes and diseases that directly led to the death, as well as serious pathological findings that were a contributing cause of death and external causes of death.

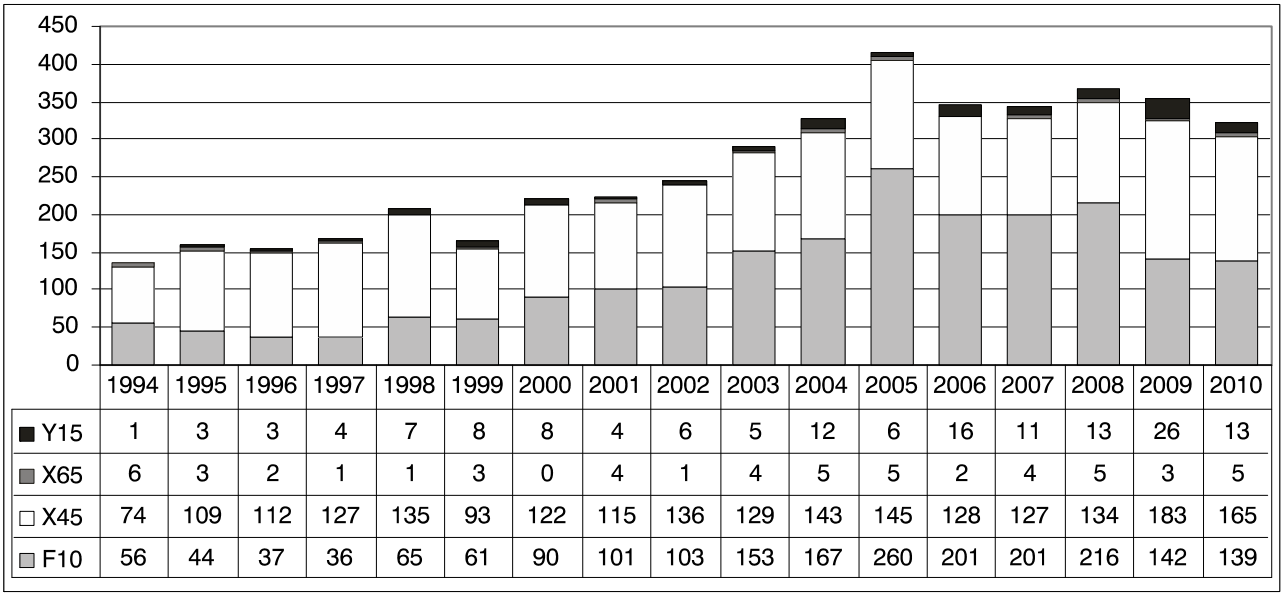
[99] These differences were caused in part by the changes in the diagnoses not being reported to the forensic medicine departments after the result of the toxicological examination was known, and by errors in the cause of death code at the Czech Statistical Office. On the basis of these findings, a recommendation was made to the Czech Statistical Office to check the codes of drug-related deaths in accordance with the International Classification of Diseases instruction manual, which described the procedures for coding poisonings from pharmaceuticals, medications, and addictive and biological substances. The Czech Statistical Office stated that these checks were implemented in the course of 2010. Furthermore, representatives of the Czech Society for Forensic Medicine and Toxicology were acquainted with the results of the analysis and asked to complete the Certificate of Post-Mortem Examination correction reports more thoroughly.

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, 1994–2010 (Ústav zdravotnických informací a statistiky, 2011b)

Year	Opiates / opioids	– methadone	Cannabis	Cocaine	Other stimulants	Hallucinogens	Drugs not further specified	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**

For the comparison, direct drug-related deaths associated with alcohol (alcohol overdoses) were extracted from the Information System of Deaths according to the same criteria as for non-alcohol drugs. Deaths where the primary cause was stated as a mental disorder or behavioural disorder caused by alcohol (dg. F10) or deaths as a result of accidental, intentional, or undetermined alcohol poisoning, i.e. a combination of diagnoses for alcohol poisoning (dg. X45, X65 and Y15) with diagnoses for the toxic effect of alcohol or ethanol (dg. T51.0 and T51.9) were extrapolated. At the beginning of the study period, i.e. 1994–2010, the number of cases rose (from 137 cases in 1994 to 416 cases in 2005) up until 2005, when this figure peaked. In subsequent years there were around 350 cases per year, and in 2010 there were 322 cases identified – about 10 times more than the number of overdoses from all non-alcohol drugs combined (Ústav zdravotnických informací a statistiky, 2011b); see Figure 6-11.

Figure 6-11: Structure of fatal alcohol overdoses in the Czech Republic in the general mortality register, 1994–2010 (Ústav zdravotnických informací a statistiky, 2011b)



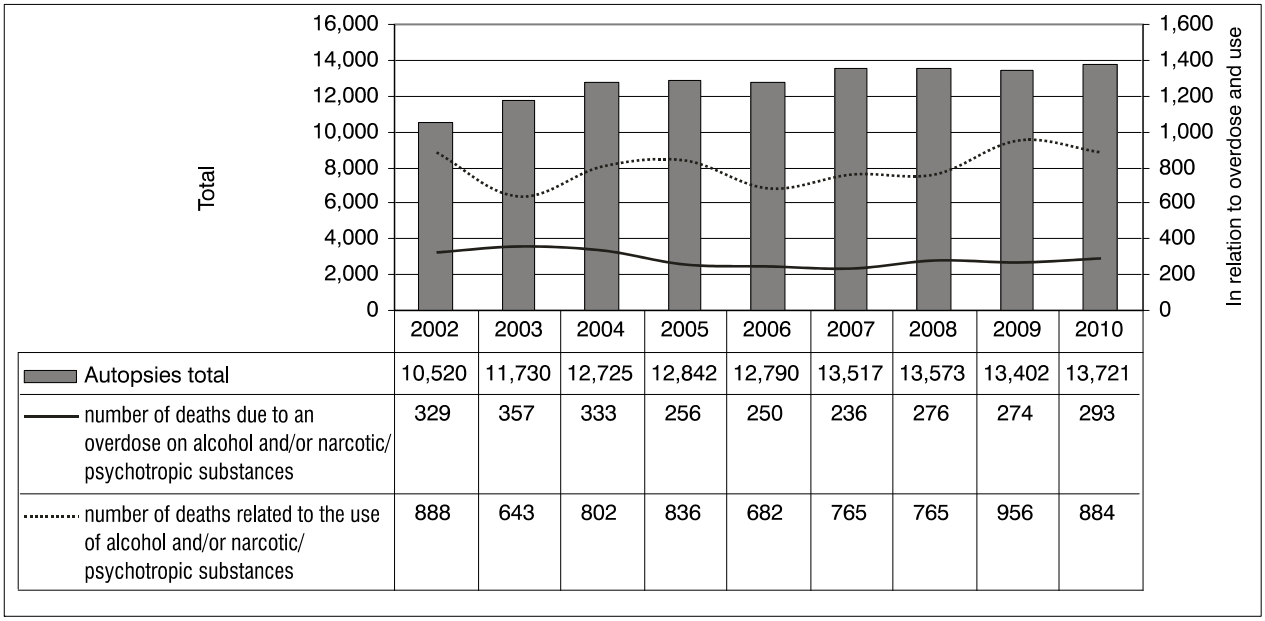
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Y15	1	3	3	4	7	8	8	4	6	5	12	6	16	11	13	26	13
X65	6	3	2	1	1	3	0	4	1	4	5	5	2	4	5	3	5
X45	74	109	112	127	135	93	122	115	136	129	143	145	128	127	134	183	165
F10	56	44	37	36	65	61	90	101	103	153	167	260	201	201	216	142	139

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.

Another source of information on the incidence of drug-related deaths is forensic medicine data sheets, collected by the Institute of Health Information and Statistics within framework Programme of Statistical Surveys of the Ministry of Health. Each forensic medicine department and independent toxicology site at all healthcare facilities completes the datasheet, regardless of who established or operates the facility. The data sheet contains the number of autopsies carried out, broken down by 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 (direct drug-related 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 overdose, such as injury resulting from a fall or traffic accident (indirect drug-related deaths). The datasheet is aggregated – as it is not possible to differentiate individual substances or causes of death in indirect deaths, this information should be considered supplementary to the data that resulted from the extraction of individual cases from the register based on selection criteria and which are presented above. Trends in the overall number of autopsies and number of autopsies for overdoses and in relation to the use of alcohol and/or narcotic and psychotropic substances are provided in Figure 6-12.

Figure 6-12: Number of autopsies carried out at forensic medicine departments in 2002–2010, based on forensic medicine datasheets (Ústav zdravotnických informací a statistiky, 2011e)

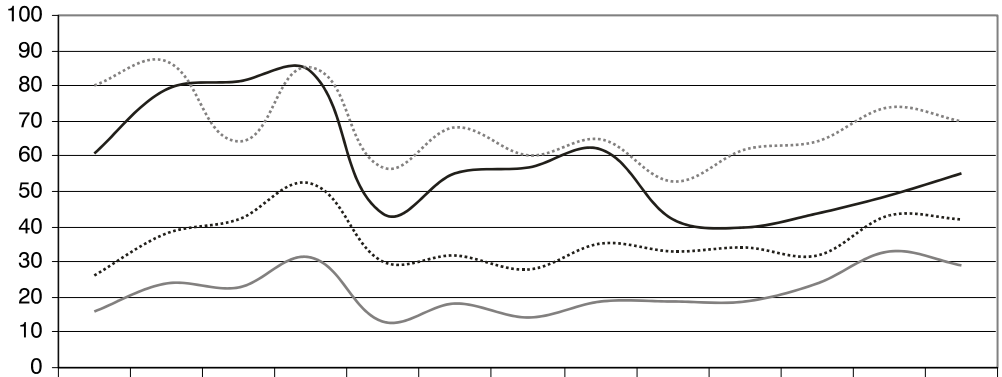


	2002	2003	2004	2005	2006	2007	2008	2009	2010
Autopsies total	10,520	11,730	12,725	12,842	12,790	13,517	13,573	13,402	13,721
number of deaths due to an overdose on alcohol and/or narcotic/ psychotropic substances	329	357	333	256	250	236	276	274	293
number of deaths related to the use of alcohol and/or narcotic/ psychotropic substances	888	643	802	836	682	765	765	956	884

6.3.3 Comparison of the Incidence of Direct Drug-related Deaths Across Data Sources and Selection Criteria

Trends in the number of drug-related deaths according to the standard and expanded EMCDDA selection B and alternative selection in comparison with data regarding fatal illegal drug and inhalant overdoses from the special register of drug-related deaths (selection D) are shown in Figure 6-13. It is evident that at the beginning of the period, the selection D and alternative selection trends are identical. It is also evident that in the past several years the number of deaths under selection D has been falling, nearing the number of fatal drug overdoses in the expanded selection B.

Figure 6-13: Comparison of trends in the prevalence of fatal drug overdoses extracted from the general (GMR) and special (SMR) mortality registers in 1998–2010 (Ústav zdravotnických informací a statistiky, 2011b; Národní monitorovací středisko pro drogy a drogové závislosti a SSLST ČLS JEP, 2011)



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
SMR Selection D	61	79	81	84	44	55	57	62	42	40	44	49	55
GMR Selection B	16	24	23	31	13	18	14	19	19	19	24	33	29
GMR Selection B (extended to include inhalants)	26	38	42	52	30	32	28	35	33	34	32	43	42
Alternative selection from GMR (in part lacking T codes)	80	87	64	85	57	68	60	65	53	62	64	74	70

6.3.4 Mortality of Drug Users

Detailed information on the (overall) mortality rate of drug users and studies that have been conducted in the Czech Republic was provided in the relevant Selected Issue chapter in the 2009 Annual Report.

Another mortality analysis is available for a set of 151 people who, between April 1996 and December 1998, were included in a study focused on risk factors for developing an addiction and gave their consent to being monitored at a later date (Csémy, 1999; Zábranský et al. 2010); for more information see also the 2009 Annual Report. The sample was composed of 65 males and 86 females whose average age was 17.6 years at the time of recruitment into the study and who were predominantly clients of low-threshold facilities in Prague. The mortality rate was found through a comparison with the general mortality register in the Czech Republic (Information System of Deaths) for 1994–2008 (inclusive). In this period, eight deaths were identified; all were males. The annual gross mortality rate reached 0.5% in the overall sample and 1.5% for males. The Standardised Mortality Ratio (SMR)[100] among males was 14.4, with a peak in the 15–19 age group (SMR=60.1). The highest SMR was found in the group of injecting heroin users aged 15–19 (SMR=127.8), while mortality peaked for pervitin users in the group aged 20 to 24. With the exception of gender, no statistically significant predictor of death was found. Most cases of death were concentrated into a very young age and a period shortly after recruitment into the study. With the exception of one suicide by poisoning, all the early deaths were caused by (accidental) drug overdoses (predominantly from heroin, but also pervitin). The findings support the need for the targeted prevention of overdoses and other unnatural sudden deaths among very young male injecting drug users (Zábranský et al. 2011).

The Substitution Treatment Register also includes the death of clients among the reasons for terminating treatment. In 2010 a total of 2,113 people were registered as being in treatment. Deaths were reported for four (Nechanská, 2011g) of these patients, representing an annual gross mortality rate of approximately 1.9‰. Despite the very low numbers, the data since 2000 show a declining mortality trend among registered patients; see Table 6-18. The mortality rate in the register is underestimated because physicians do not report all of their patients' deaths to the register. Studies of the mortality rate for drug users in treatment, comparing data on treated patients in the registers of the Institute of Health Information and Statistics with data in the Information System of Deaths, found that the gross annual mortality rates for patients in substitution treatment were 7.2‰ (Lejčková and Mravčík, 2005; Lejčková and Mravčík, 2007) and 3.5‰ (Zábranský et al. 2009).

[100] The Standardised Mortality Ratio (SMR) is an indicator that expresses the mortality ratio in a study sample to mortality in the general population of the same gender and age; it is similar to relative risk (RR).

Table 6-18: Mortality rate for patients in the substitution register, 2000–2010 (Nechanská, 2011g)

Year	Number of registered patients in treatment	Number of registered patients who died	Proportion of deaths (‰)
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

7 Responses to Health Correlates and Consequences

Harm reduction has been one of the main areas of the Czech drug policy since the beginning. A network of low-threshold facilities and outreach programmes across the Czech Republic forms the supporting system of interventions aimed at harm reduction. Approximately 70% of problem drug users (up to 80% in Prague) are estimated to be in contact with these facilities and programmes.

The number of low-threshold programmes for drug users varies from year to year. Nevertheless, there has been a marked increase in the number of clients in contact with such facilities. There has also been a steady increase in the number of contacts and the quantity of needles, syringes, and other injecting paraphernalia exchanged – nearly 5 million needles and syringes were distributed in 2010.

An increase is noticeable in the number of tests for infectious diseases among drug users who are in contact with the low-threshold services. Nevertheless, the level of testing drug users for infections remains low and it is necessary to continue to place particular emphasis on the higher availability of testing to the clients of the low-threshold services.

There has been an increase in the number of programmes that distribute gelatine capsules as the oral alternative to the injecting application of pervitin. According to the available information, there are at least 30 programmes distributing these capsules in the Czech Republic, in which approximately a quarter of the programmes' clients are involved; nearly 60 thousand capsules were distributed in 2010.

Specific programmes for the reduction of risks in recreational settings were conducted in 2010 by a total of four organisations in five programmes – there appears to have been a slight decrease in the number of interventions performed in recreational settings in 2010.

The treatment of HIV and AIDS patients in the Czech Republic and care for them is provided by seven AIDS centres and is covered by the health insurance system. The problem associated with insufficient funding is to ensure dispensary care and therapy to HIV-positive clients without health insurance, which may also concern injecting drug users.

A questionnaire study was conducted in the spring of 2011 among viral hepatitis treatment centres. One of the findings was the estimate that 39 centres treated injecting drug users (mostly abstinent and only rarely active ones) for HCV in the Czech Republic in 2010.

7.1 Legal Framework, Strategies and Policies for Harm Reduction

In 2010 the Government adopted the National Drug Policy Strategy for the Period 2010–2018 and the 2010–2012 Action Plan. Harm reduction is one of the four pillars (for details see the chapter on National Action Plan, Strategy, Evaluation, and Coordination, p. 9). The Action Plan defines the following areas of activity for harm reduction:

- develop interventions, particularly new ones, to reduce the incidence of infectious diseases, overdoses, and other health-related consequences of drug use among drug users;
- increase the level of testing of drug users for infectious diseases;
- define guidelines for harm reduction services provided in nightlife settings.

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 on Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55). The main educational topics include first aid in the event of an overdose, the risks of polydrug use, and the principles of safe drug use. Most low-threshold facilities also provide counselling in this area via email and the telephone. The facilities have prepared and have available a range of reference materials, some of which are also provided in other language versions.

The regularly updated web portal eDekontaminace.cz focuses on sharing information on harm reduction, including safe use and overdose prevention information[101].

In the Early Warning System for new psychoactive substances, all low-threshold facilities are notified if new drugs or dangerous drugs involving higher health and overdose risks are detected in the Czech Republic (or anywhere across Europe). For example, in 2010 the facilities were notified about the risks of fentanyl[102], and information was also provided regarding the occurrence of new synthetic drugs (legal highs), in particular cathinones (mephedrone).

No other specific activities are being pursued in the Czech Republic with a view to the prevention of overdoses, such as the preventive distribution of opiate antagonists (naloxone) to drug users. Information about counselling and other services provided to drug users upon their release from prison is included in the chapter on Responses to Drug-

[101] http://www.edekontaminace.cz (2011-09-07)
[102] Fentanyl is a high-potency opioid. It was first seized in Slovakia in 2009, which was the immediate reason for notifying the services.

related Health Issues in Prisons (p. 128). Mention should be made of the discussion held in 2010 between the professional public represented by the service providers, the police, and local administration authorities regarding the establishment of a drug consumption room for injecting drug users in the context of tackling the issue of open drug scenes; see also the chapters on Initiatives on the Part of Civil Society and the Professional Community (p. 11) and Problem Drug Use (p. 48).

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

The type and volume of the services vary from one low-threshold programme to another. Nevertheless, the system of quality certification, which is a prerequisite for subsidies from the state budget and from certain regional budgets, guarantees a certain minimum quality of services; for details see the chapter on Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55).

The network of low-threshold facilities comprises low-threshold centres and outreach (streetwork) programmes. In 2010, there were 96 of them in total; see Table 7-1.

Information about the services provided in the low-threshold facilities and about the recipients of such services is mainly available from the final reports drawn up by the facilities for the purposes of the subsidy proceedings of the Government Council for Drug Policy Coordination[103]. The total number of drug users maintaining contact increased again in 2010, to 32.4 thousand individuals, and so did the number of injecting drug users (IDUs) and pervitin users (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j); see Table *7-1*.

The service most commonly used in low-threshold programmes is the exchange of needles and syringes and distribution of paraphernalia, which is understandable, considering the high percentage of IDUs among HR programme clients; see Table 7-2.

In terms of regional distribution, the low-threshold programmes in Prague, followed by those in the Ústí nad Labem and Moravia-Silesia regions, again reported the highest numbers of contacts in 2010. The highest number of individual exchanges in exchange programmes was reported from Prague (approximately 114,000), followed by the Ústí nad Labem (approx. 38,000), Moravia-Silesia (approx. 15,800), South Moravia (approx. 13,300), and Central Bohemia (approx. 11,000) regions (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j). A detailed account of the services reported by the low-threshold programmes in 2010 by region is provided in Map 7-1.

Table 7-1: Clients of Czech low-threshold facilities in 2002–2010 (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Indicator	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of low-threshold programmes	92	93	92	92	90	109	100	95	96
Number of drug users	n.a.	25,200	24,200	27,800	25,900	27,200	28,300	30,000	32,374
– injecting drug users	19,000	16,700	16,200	17,900	18,300	20,900	22,300	23,700	24,500
– pervitin users	12,900	11,300	12,200	12,300	12,100	14,600	14,900	16,000	17,500
– opiate users	8,000	6,100	6,000	6,800	6,900	7,300	8,300	8,900	8,100
– heroin users	n.a.	n.a.	n.a.	n.a.	4,000	4,100	4,600	4,950	4,200
– Subutex® users among opiate users	n.a.	n.a.	n.a.	n.a.	2,900	3,200	3,700	3,950	3,900
– cannabis users	3,400	5,500	4,100	3,600	2,700	2,000	1,700	2,200	1,908
– inhalant users	n.a.	705	560	470	450	390	300	250	324
Average age of drug user (years)	22.0	23.2	23.4	25.0	25.3	26.1	26.4	27.4	27.0

[103] The number of programmes is influenced by the projects submitted by low-threshold facilities for subsidy proceedings, and by the formal differentiation of the individual activities. A low-threshold centre or outreach programme may be both operated and conducted by a single entity within a single project and, in other cases or in other years, they can form two or more separate projects. Despite these influences, the offer and availability of low-threshold services in the Czech Republic have remained stable in recent years.

Table 7-2: Selected services of low-threshold centres in 2004–2010 (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Indicator	2004	2005	2006	2007	2008	2009	2010
Needle/syringe exchange	139,800	249,000	191,000	215,800	217,200	237,800	234,900
Food service	94,700	99,500	97,600	94,100	87,800	108,800	107,700
Hygiene service	34,500	40,900	41,100	40,000	34,800	44,300	56,300
Individual counselling	27,300	25,800	21,900	24,100	21,000	27,800	37,600
Medical attendance	13,500	12,500	10,500	9,400	7,700	10,200	9,700
Crisis intervention	3,000	2,500	1,800	1,600	1,100	1,600	2,400
Group therapy	1,800	1,500	1,500	1,000	1,100	1,300	1,300
Total contacts	317,900	403,900	322,900	338,100	329,500	365,600	396,800

Map 7-1: Network of low-threshold facilities in the Czech Republic in 2010 (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Table 7-3: Selected services provided by low-threshold centres in the individual regions in 2010, extrapolated to the total number of programmes (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Region	Contact	First contact	Needle/syringe exchange	Food service	Hygiene service	Individual counselling	Referral*	Medical attendance	Crisis intervention	Group counselling
Prague	142,185	1,198	113,835	21,711	9,744	5,028	4,342	3,607	236	220
Central Bohemia	18,582	806	10,959	6,028	3,077	1,715	678	124	65	33
South Bohemia	19,987	746	7,686	7,652	2,631	2,833	1,611	271	137	152
Pilsen	20,584	1,109	5,900	6,947	3,133	2,955	3,785	787	208	109
Karlovy Vary	14,715	412	7,027	3,256	3,235	2,865	373	545	31	28
Ústí nad Labem	55,397	2,165	37,959	12,507	5,854	2,179	1,667	885	136	52
Liberec	11,239	397	5,463	4,979	2,388	1,003	482	99	37	26
Hradec Králové	8,382	252	3,406	3,965	2,736	572	172	97	40	1
Pardubice	3,583	146	1,352	493	885	159	199	42	19	0
Vysočina	8,352	325	2,480	5,216	2,463	1,447	362	164	24	25
South Moravia	24,547	826	13,373	9,206	4,549	2,981	753	538	67	155
Olomouc	21,719	1,017	5,542	4,169	2,866	5,351	980	916	127	50
Zlín	10,690	549	4,119	2,033	919	1,286	4,653	294	62	57
Moravia-Silesia	36,879	804	15,815	19,501	11,782	7,253	1,041	1,320	1,214	424
Total	**396,841**	**10,752**	**234,916**	**107,663**	**56,262**	**37,627**	**21,098**	**9,689**	**2,403**	**1,332**

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

Data on the clients of low-threshold facilities from other sources are also provided in the chapter on Data on Problem Drug Use from Non-Treatment Sources (p. 52).

7.3.1.1 Needle and Syringe Exchange Programmes

A needle and syringe exchange component was included in 96 low-threshold programmes in 2010, which is approximately the same number as in the previous years, while the quantity of the material distributed continued to increase in 2010 (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j). A comparison of the number of programmes and the number of needles and syringes supplied in the years 1998–2010 is provided in Table 7-4; the number of needles and syringes distributed in the individual regions is shown in Table 7-5.

According to information available from the final reports, each injecting drug user who visited a low-threshold facility made an average of 10 exchanges in 2010 and received a total of 200 sterile needles and syringes on average. The regional distribution of the needles and syringes provided corresponds with the relative numbers of injecting (problem) drug users; see Map 7-2 (further below) and Map 4-1 (p. 50).

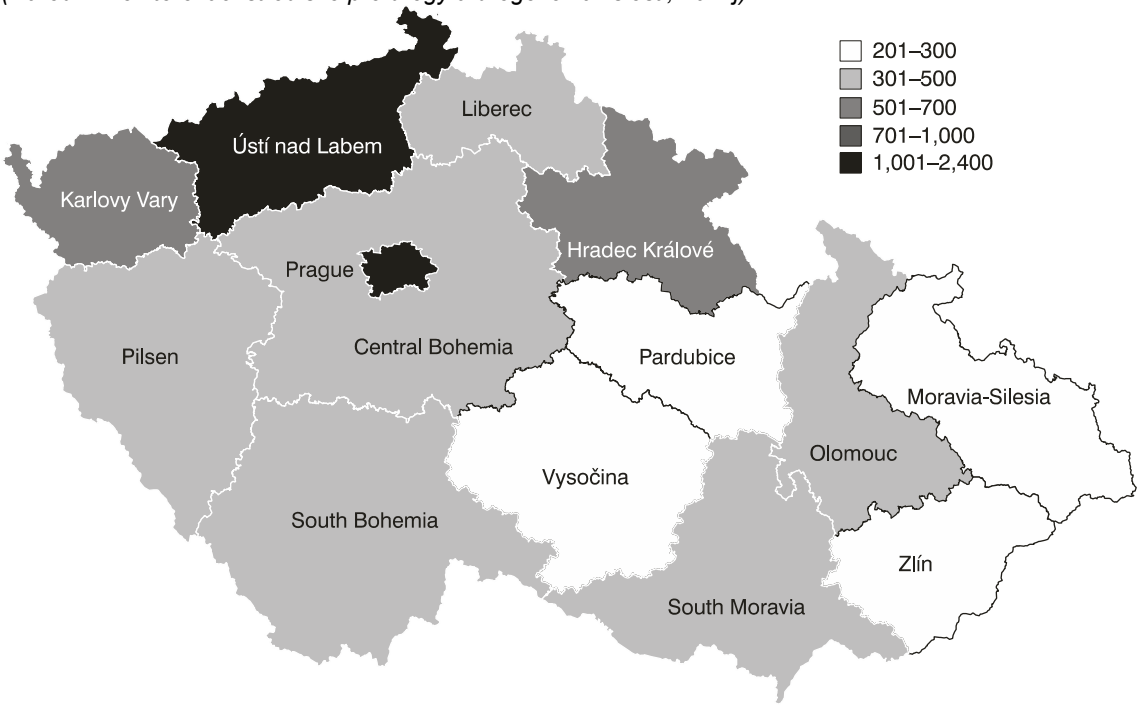
Table 7-4: Exchange programmes in the Czech Republic in 1998–2010 (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Year	Number of exchange programmes	Number of needles and syringes exchanged
1998	42	486,600
1999	64	850,285
2000	80	1,152,334
2001	77	1,567,059
2002	88	1,469,224
2003	87	1,777,957
2004	86	2,355,536
2005	88	3,271,624
2006	93	3,868,880
2007	107	4,457,008
2008	98	4,644,314
2009	95	4,859,100
2010	96	4,942,816

Table 7-5: Number of needles and syringes distributed in the exchange programmes in 2002–2010, by region (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Region	2002	2003	2004	2005	2006	2007	2008	2009	2010
Prague	858,507	979,560	1,210,704	1,697,554	1,850,330	2,071,788	2,060,588	2,130,729	2,130,433
Central Bohemia	12,561	31,682	66,600	110,325	168,220	215,640	309,590	345,214	350,052
South Bohemia	14,883	69,004	102,621	124,454	141,825	212,791	228,872	239,690	183,278
Pilsen	23,221	44,670	88,450	116,611	157,317	189,894	207,938	188,416	190,648
Karlovy Vary	16,608	29,299	35,756	58,680	66,382	83,462	79,834	102,467	141,437
Ústí nad Labem	256,071	262,418	351,561	479,383	612,259	655,882	637,887	678,007	604,191
Liberec	12,273	21,108	33,467	32,800	47,756	63,967	129,903	87,272	129,995
Hradec Králové	22,250	45,089	41,021	86,221	98,269	139,075	173,417	183,186	200,616
Pardubice	23,622	23,330	36,081	38,725	48,144	29,908	52,690	62,541	84,950
Vysočina	11,254	29,363	39,348	61,425	68,682	99,447	65,343	81,127	89,846
South Moravia	134,285	122,137	165,846	173,090	227,833	269,236	264,872	252,145	286,251
Olomouc	21,809	33,832	85,872	96,416	150,024	134,433	137,321	164,699	197,767
Zlín	19,973	11,362	41,977	52,169	69,005	115,744	89,913	111,099	96,330
Moravia-Silesia	41,907	75,103	56,232	143,771	162,834	175,741	206,146	232,508	257,022
Total	**1,469,224**	**1,777,957**	**2,355,536**	**3,271,624**	**3,868,880**	**4,457,008**	**4,644,314**	**4,859,100**	**4,942,816**

Map 7-2: Number of needles and syringes distributed in Czech regions in 2010, per 1,000 inhabitants aged 15–64 (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)



Needle and syringe exchange programmes are complemented by the distribution of aluminium foil for smoking heroin and the distribution of gelatine capsules intended for the oral application of the drug as an alternative to injecting, in particular in the case of pervitin; for more details see the 2009 Annual Report.

The results of a survey which concerned the use of capsules as a harm reduction instrument and was conducted in 2008 among low-threshold facilities and their staff were published in 2011. Emphasis was placed on the potential of capsules to reduce the intensity of injecting use or encourage alternatives to injecting application in motivated (injecting) pervitin users or in those with a damaged venous system, and the potential to contact pervitin users who were otherwise difficult to reach or hidden (Mravčík et al. 2011).

In the monitoring of the tests for infections and their prevention among injecting drug users in low-threshold programmes in 2010 (Národní monitorovací středisko pro drogy a drogové závislosti, 2011i), a total of 43 low-threshold programmes provided their responses (see also the chapter on Drug-Related Infections on p. 83). Thirty (70%) of these programmes conducted a capsule distribution programme, and had issued 56,868 capsules to approximately 24% of their pervitin-using clients (weighted by the number of capsules distributed).

Table 7-6: Information about the gelatine capsule distribution programmes in low-threshold facilities in the Czech Republic in 2008–2010 (Národní monitorovací středisko pro drogy a drogové závislosti, 2008a; Národní monitorovací středisko pro drogy a drogové závislosti, 2010a; Národní monitorovací středisko pro drogy a drogové závislosti, 2011i)

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

In the 2010 monitoring of the testing for and prevention of infectious diseases, the low-threshold programmes generally reported distributing an increasing quantity of needles, syringes and injecting paraphernalia, condoms, and gelatine capsules. Positive changes were mostly reported in client behaviour regarding the principles of safe drug use (Národní monitorovací středisko pro drogy a drogové závislosti, 2011i).

The needs analysis conducted among the clients and staff of the low-threshold services in Prague (see also the chapters on Data on Problem Drug Use from Non-Treatment Sources on p. 52 and Risk Behaviour of Drug Users on p. 90) shows, among other findings, that the high level of adherence of the clients is closely related to the basic service – needle and syringe exchange. Both the staff and the clients considered the free nature of the service crucial. Positive views were also obtained regarding the provision of medical attention and, in general, the availability of counselling in the health care, social, and legal areas. The reported deficiencies of the services included the low capacity of the programmes (in particular, of the contact centres), strict rules or, on the contrary, the absence of clear rules in the contact room (Šťastná, 2010; Šťastná et al. 2011).

The SANANIM civic association launched a project at the beginning of 2010 in which it operates an ambulance within reach of the largest open drug scene near Wenceslas Square and in the *Vrchlického sady* park, where services are provided to drug users; for details see the 2009 Annual Report. The open drug scenes in Prague and the associated issues are also discussed by the chapters on Initiatives on the Part of Civil Society and the Professional Community (p. 11) and Problem Drug Use (p. 48).

7.3.1.2 Testing for Infectious Diseases

The National Focal Point is informed about the extent of testing for infections in low-threshold facilities by the final reports concerning projects supported within the framework of the subsidy proceedings of the Government Council for Drug Policy Coordination. The test results are available from the monitoring of the tests in low-threshold programmes; for detailed information see the chapter on Drug-Related Infections (p. 83). In 2010, 58 low-threshold services offered HIV testing, 59 HCV testing, and 40 HBV testing, and 20 low-threshold facilities offered syphilis testing; see Table 7-7.

Table 7-7: Number of tests for infectious diseases and the number of low-threshold programmes providing tests in 2002–2010 (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Year	HIV		HBV		HCV		Syphilis	
	Programmes	Tests	Programmes	Tests	Programmes	Tests	Programmes	Tests
2002	35	1,158	26	515	33	1,202	2	176
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

A significant drop was observed in 2005–2007 in the number of tests conducted with IDUs, and a decrease was also noted in the number of (low-threshold) facilities providing such tests to drug users. The 2008–2010 data indicate that this negative trend has been reversed and the availability of testing in low-threshold programmes for drug users has improved.

Low-threshold facilities reported contact with a total of 24.5 thousand injecting drug users in 2010. The final project reports from the low-threshold facilities stated that 1,821 HIV tests and 2,134 HCV tests were performed; see Table 7-1 and Table 7-7. Assuming that the tests were performed exclusively on injecting drug users and that no person was tested repeatedly, it can be estimated that the low-threshold facilities conducted HIV tests on 7.4% of their clients and HCV tests on 8.7% of them in 2010. Even though this represents an increase against 2009 (6.7% and 6.3%, respectively), it is only half of the level of testing achieved in 2005 (13.5% and 14.9%, respectively). This low level of testing is also in striking contrast with the potential for testing and the related counselling by the network of low-threshold facilities.

The issue of testing problem drug users in the Czech Republic for infectious diseases is addressed in further detail in the 2009 Annual Report and in a published analysis (Mravčík and Nečas, 2010).

Quite recently, testing for infections by low-threshold facilities was the topic of a final thesis of a student majoring in addictology in the 2010/2011 academic year (Šulcová, 2011). One of the key findings of the thesis points out the unclear legal and methodological framework for providing tests in contact centres for drug users, the inconsistency among the recommendations from the individual ministries, institutions, and funding bodies, and the absence of methodological guidance in the area, which would guarantee a certain minimum standard of the interventions provided in connection with testing for infectious diseases by low-threshold centres.

The clients' history of HIV, HBV, and HCV testing is also monitored in the Register of Treatment Demands. The information contained in these items is mostly self-reported but may also come from the client's documentation or from reports on infection examination as part of the relevant treatment episode. The percentage of injecting drug users demanding treatment between 2002 and 2010 and prior tests for the individual infections is shown in Table 7-8.

Table 7-8: History of HBV, HCV, and HIV testing of all clients – injecting drug users demanding treatment in 2002–2010, (Studničková and Petrášová, 2011)*

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

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

7.3.2 HIV/AIDS and Viral Hepatitis C Treatment

The treatment of HIV and AIDS patients and care for them in the Czech Republic is provided according to the Recommended Procedure for the Comprehensive Care for Adult HIV Patients (Rozsypal et al. 2010) and is organised within the network of seven AIDS centres found in Prague and in the capitals of six former regions but not Central Bohemia. The standard treatment is the administration of various types and combinations of antiretroviral preparations. The problem associated with insufficient funding is to ensure dispensary care and therapy to HIV-positive clients without health insurance, which may also concern injecting drug users. For example, the AIDS centre in Prague provided treatment to only two uninsured patients in 2010. Both patients were HIV-positive pregnant women whose treatment was covered from a sponsor's donation (Staňková, 2011).

In addition to following the standard recommended procedures of the Czech Society for Hepatology and of the Medical Society for Infections of the J. E. Purkyně Czech Medical Association, the prevention and treatment of viral hepatitis in drug users follows the Standard for the Treatment of Viral Hepatitis in Drug Users (Galský et al. 2008); for details see the 2008 Annual Report.

From January to March 2011, the National Focal Point, together with the Czech Society for Hepatology and the Medical Society for Infections of the J. E. Purkyně Czech Medical Association, conducted the collection part of a questionnaire study among the viral hepatitis treatment centres, aimed at HCV treatment (e.g. treatment with the combination of pegylated interferon alpha with ribavirin for 24 or 48 weeks, depending on the genotype of the virus), with the following objectives: mapping (estimating) the extent of the provision of HCV treatment to injecting drug users in the country, mapping the rules and practices for the admission of injecting drug users to HCV treatment in the dedicated centres, describing the factors related to drug use which may affect the treatment of injecting drug users or which are considered relevant by the physicians, and describing any specifics for pervitin and opiate users regarding the availability and provision of HCV treatment to these two most common groups of injecting drug users in the Czech Republic. A total of 76 centres were identified in the Czech Republic, 45 of which (59.2%) responded to the invitation to participate in the survey, and 40 of which (52.6%) filled in the online questionnaire. The preliminary results are currently available (Národní monitorovací středisko pro drogy a drogové závislosti, 2011c).

Abstinence from the use of (illegal) drugs upon the start of treatment is required from all the patients or from most patients in 90% of the centres (the physicians were a little less strict regarding abstinence from alcohol), although an individual approach to the patient was often emphasised. The most frequently specified period of abstinence from drugs and alcohol was six months. Most of the physicians (90%) report using a trial period before the treatment itself in order to test the potential adherence of the patient. The evaluation of the patient's situation regarding drug use is often performed in cooperation with a psychiatrist or an addiction specialist. Half of the physicians reported that they required the involvement of the patient in substitution therapy in the case of opiate users. An addictologist is a permanent member of the therapeutic team in only a few centres; substitution therapy is only rarely provided in the HCV treatment centres. However, over half of the centres work with other healthcare or non-healthcare facilities concerned with the issue of addiction.

The percentage of injecting drug users (IDUs) who are referred to the centre for HCV treatment and whose treatment eventually starts was 60% on average, although there was significant variability among the answers (0–90%). The share of IDUs who complete treatment after being admitted (i.e. the level of adherence) was 80% on average, again with a significant degree of variability among the answers (0–100%). Most physicians saw no difference in the percentage of patients admitted for treatment or in the level of adherence between drug users and non-users and between pervitin and opiate users. Most physicians also did not report any differences between pervitin and opiate users as far as the severity of their hepatological condition, willingness or motivation for treatment, ability to maintain the treatment regime, or risk of relapse were concerned.

It can be estimated on the basis of extrapolating the reasons for non-respondents and of the answers from the respondents that 61 centres treated HCV in the Czech Republic in 2010, 39 of which treated injecting drug users, who were mostly abstinent and only rarely active. An estimated 781 persons were treated for HCV in the Czech

Republic in 2010, of whom 367 were (mostly former or abstinent) injecting drug users (Národní monitorovací středisko pro drogy a drogové závislosti, 2011c).

7.3.3 Programmes Aimed at Drug Use in Recreational Settings

Specific programmes for the reduction of harm in recreational settings were conducted in 2010 by a total of four organisations[104] in five programmes (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j). These programmes established a total of 2,021 contacts (53.0% of them men; average age 22) and the most commonly reported illicit drug used was cannabis (25.5%), followed by ecstasy (16.2%) and pervitin (4.1%). Quality tests were performed on six tablets in total. In comparison with 2009, a decrease can be noted in the number of organisations and programmes (by one and two, respectively), as can a clear drop in the number of contacts – 3,774 contacts were recorded in 2009. In 2003, when the extent of services provided in recreational settings reached its peak, there were 18 active programmes which contacted nearly 5,000 clients. This fluctuation in the availability of services in recreational settings reflects both the amount of funding provided for the implementation of these programmes and the negative political and departmental standpoints regarding ecstasy quality screening tests at dance parties; for details see the 2007–2009 Annual Reports.

One issue of the Zaostřeno na drogy (Focused on Drugs) bulletin addressed the preventive and harm reduction services in recreational settings in 2011 (Saberžanovová and Vacek, 2010). Among other points, it introduces a draft standard of professional competency for this type of service.

The Safer Party Tour project also focused on recreational settings; for details see the chapter on Selective prevention (p. 44).

7.4 Responses to Other Health Correlates Among Drug Users

The treatment of dual-diagnosis drug users in the Czech Republic usually takes place in the network of treatment facilities in consideration of the drug users' specific needs; see the chapter on Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55).

[104] *Podané ruce* association, *Drop-In*, a centre for prevention and treatment, *Prevent* civic association, and the *Kappa-Help* civic association. In 2009 there was also CPPT Pilsen, which discontinued the Dance8 project in 2010.

8 Social Correlates and Social Reintegration

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

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

The number of aftercare facilities increased in 2010 but their capacity and the number of clients did not grow significantly. There was a decrease in the number of places available in sheltered housing. The average age of aftercare clients decreased.

8.1 Social Exclusion and Drug Use

8.1.1 Social Exclusion among Drug Users

Information about social problems among drug users, including those who are members of ethnic minorities, comes from two studies conducted in 2008 and is presented in the 2008 Annual Report. The socio-economic characteristics of treatment demands in connection with drug use are provided in the chapter on Selected Characteristics of Treatment Demands (p. 71).

8.1.2 Drug Use among Socially Excluded Groups

8.1.2.1 Roma Communities

In the Czech Republic, social exclusion mainly concerns Roma communities. The exclusion is the product of the accumulation of social problems; the main factors influencing the social exclusion of Roma include long-term unemployment, low incomes, and either the unavailability or poor quality of housing (Kancelář Rady vlády pro záležitosti romské komunity, 2007). The 2010–2013 Roma Integration Policy was approved in late 2009; for details see the 2009 Annual Report.

Monitoring and evaluation of the situation in Roma communities has been provided in the long term by the Office of the Government Council for Roma Minority Affairs within the framework of the Field Social Workers Support Programme. A total of 48 municipalities were involved in the programme and 66 jobs for field workers were supported in 2010 (Šimíková, 2010).

The field social workers were in contact with 12,377 clients (9,948 persons being over the age of 15 and 2,429 persons under the age of 15) in 2010. Approximately one half of the clients were women. The outreach workers provided their clients with 37,853 contacts. A total of 58% over the age of 15 were long-term unemployed and 3% were illiterate. In terms of the problems addressed, services were most commonly provided in the areas of debt (36%), housing (23%), and unemployment (19%); see Table 8-1. The reporting form on fieldwork changed in 2010. For this reason, problems related to illicit drug use were not monitored in 2010 (Kancelář Rady vlády pro záležitosti romské menšiny, 2011).

Table 8-1: Number of clients provided with the services of Roma field workers in 2006–2010, by problem type (Mravčík et al. 2010; Kancelář Rady vlády pro záležitosti romské menšiny, 2011)

Problem type	2006		2007		2008		2009		2010	
	Number	%	Number	%	Number	%	Number	%	Number	%
Debt	4,477	34.1	5,314	31.9	3,779	28.7	3,722	26.8	5,943	36.4
Unemployment	2,672	20.4	2,916	17.5	2,598	19.8	3,070	22.1	3,067	18.8
Low housing quality	3,362	25.6	3,364	20.2	2,432	18.5	2,408	17.3	3,741	22.9
Problematic tenant/landlord relations	1,847	14.1	1,522	9.1	1,285	9.8	1,413	10.2	1,286	7.9
Insufficient sanitation	1,300	9.9	1,204	7.2	1,282	9.7	1,309	9.4	1,088	6.7
Truancy	907	6.9	716	4.3	1,000	7.6	679	4.9	612	3.8
Usury	277	2.1	320	1.9	696	5.3	218	1.6	143	0.9
Crime	620	4.7	574	3.4	636	4.8	532	3.8	269	1.6
Drug use	457	3.5	391	2.3	344	2.6	291	2.1	–	–
Gambling	268	2.0	302	1.8	323	2.5	236	1.7	142	0.9
Prostitution	63	0.5	39	0.2	51	0.4	25	0.2	24	0.1
Total*	**13,116**	**100.0**	**16,662**	**100.0**	**13,144**	**100.0**	**13,903**	**100.0**	**16,315**	**100.0**

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

According to the Government Council for Roma Minority Affairs, the most commonly reported forms of risk behaviour among socially excluded Roma communities are gambling and drug use. The very low age of the first exposure of Roma children to an illicit drug, attributable, among other factors, to the high prevalence of drug use among their parents, is a major problem. The most widespread (illicit) drugs among Roma drug users include pervitin, heroin, and inhalants (Kancelář Rady vlády pro záležitosti romské menšiny, 2011).

Addictive substance use was a partial focus of the research study called The Quality of Life and the Social Determinants of Health in the Roma in the Czech and Slovak Republics (Davidová et al., 2010). The project resumed the activities of the international research study Sastipen: Health and the Roma Population 2008–2009 (see also the 2009 Annual Report), focusing in particular on how social circumstances (employment, education, place of residence, age, generation, etc.) affect the subjective perception of one's health. The findings show that there is a higher occurrence of risk forms of behaviour among individuals living in socially excluded communities. Within the Roma minority, the Wallachian (Olah) Roma are the most endangered group. The areas involving the highest risk are socially excluded Roma communities in large cities, where drugs are readily available. The most common non-alcohol drugs used include marijuana, heroin, Subutex®, sedatives, and inhalants. The first drug use is largely initiated by a group that spends a lot of time out together, along with relatives and close friends. There is often also a quick transition to injecting use.

In 2007, the government established the Agency for the Elimination of Social Exclusion in Roma Localities. The main objective of the Agency is to support the integration of Roma and translate the national strategies at the local level (Kancelář Rady vlády pro záležitosti romské menšiny, 2011). For details on the Agency see the 2007–2009 Annual Reports.

In 2010 the Agency operated in 13 existing locations in Brno, Broumov, Břeclav, Holešov, Cheb, Litvínov, Most, Přerov, Roudnice nad Labem, and Ostrava, and in the Jeseník and Šluknov regions, as well as in 10 new locations (Bílina, Havířov, Chomutov, Jáchymov, Jirkov, Kutná Hora, Obrnice, Toužim – Teplá, and Trmice). The implementation of 10 situation analyses was initiated in 2010 to survey the situation in the new locations.

8.2 Social Reintegration

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

There are approximately 30 aftercare programmes for drug users in place in the Czech Republic, with the target group of some of the programmes being only alcohol users or only illicit drug users. As of September 2011, a total of 34 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. Sixteen aftercare programmes for (illicit) drug users were subsidised by the Government Council for Drug Policy Coordination in 2010, with detailed information about these programmes being available from the projects' final reports. Thirteen programmes offered their clients sheltered housing and four also provided protected employment.

Altogether, 987 clients (610 of them male) used the aftercare services; 720 (72%) of them used to inject drugs before they entered treatment; 583 (59%) used to use pervitin and 155 (15%) heroin. The total capacity of the facilities offering sheltered housing was 127 places. 25 clients worked in sheltered workshops (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j); see Table 8-2.

Table 8-2: Aftercare programmes subsidised by the Government Council for Drug Policy Coordination in the period 2005–2010 (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Indicator	2005	2006	2007	2008	2009	2010
Number of facilities	20	18	18	18	15	16
Number of aftercare clients	865	904	883	1,041	986	987
Sheltered housing places	118	126	126	283	134	127
Number of clients in sheltered housing	244	235	261	–	–	–
Number of clients in sheltered workshops	59	40	44	25	29	25

Outpatient aftercare was offered by 13 facilities, whose services were used by 494 clients (312 of whom were men), which represents a slight decrease against 2009. While the average age of the clients increased continuously in the period 2003–2009, it went down to 28.3 years of age in 2010. A total of 335 clients (67%) had been injecting drug users prior to the treatment; 286 (57%) had used pervitin and 82 (16%) opiates (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j); see Table 8-3.

Table 8-3: Outpatient aftercare programmes subsidised by the Government Council for Drug Policy Coordination, and their clients in the period 2003–2010 (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Indicator	2003	2004	2005	2006	2007	2008	2009	2010
Number of facilities	8	14	13	10	12	12	11	13
Number of clients	460	444	336	380	389	487	443	494
– injecting drug users	320	307	218	230	236	306	235	335
– pervitin users	210	187	182	216	209	259	246	286
– opiate users	120	115	58	78	69	71	64	82
Average age of clients	26.0	26.6	27.4	26.4	29.3	30.3	30.4	28.3

Thirteen facilities provided intensive aftercare (within a long-term structured programme, typically involving sheltered housing and employment); their total capacity of 269 beds was used by 493 clients (298 of whom were men). The average age of the clients was 28.8 years. A total of 385 (78%) clients had been injecting drug users prior to the treatment; 297 (60%) had used pervitin and 73 (14%) opiates (heroin, Subutex® or methadone). The average duration of the stay of a client in an intensive aftercare programme was 6 months. 163 clients (33%) completed the programme, 87 (17%) dropped out, and 46 (9%) were expelled (Národní monitorovací středisko pro drogy a drogové závislosti, 2011j); see Table 8-4.

Table 8-4: Intensive aftercare programmes subsidised by the Government Council for Drug Policy Coordination, and their clients in the period 2003–2010 (Mravčík et al. 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011j)

Indicator	2003	2004	2005	2006	2007	2008	2009	2010
Number of facilities	14	14	15	16	15	15	12	13
Capacity	321	342	385	365	325	283	316	269
Number of clients	585	562	526	524	494	554	543	493
– injecting drug users	463	404	399	364	360	422	392	385
– pervitin users	245	260	276	304	284	317	329	297
– opiate users	224	184	143	105	104	105	99	73
Average age of clients	24.5	27.0	26.4	27.1	26.6	28.7	29.2	28.8

In addition to the facilities specified above, aftercare services may be provided by other inpatient or outpatient treatment facilities; however, their number and the scope of the services provided are difficult to determine. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups operate on a self-help basis. There are currently 47 AA groups in 34 towns and cities in the Czech Republic[105] and one NA group in Brno[106].

In 2010, the labour and social projects (the so-called labour and social agencies) of established organisations (the SANANIM and *Prev-Centrum* civic associations in Prague, the Christian Help Centre in Pilsen, White Light I. in Ústí nad Labem, and the *PASÁŽ* counselling centre and the *Podané ruce* association in Brno) focused on improving the living situation of former drug users through improving their opportunities on the labour market.[107]. The clients of

[105] http://www.anonymnialkoholici.cz/ (2011-09-01)
[106] http://www.akluby.cz/?page_id=292 (2011-09-11)
[107] The list only includes projects aimed primarily at the users of non-alcohol drugs (active, in treatment, or in aftercare). It must be emphasised that the social reintegration of persons in need is covered by a number of projects, whose primary target group, however,

these agencies can use a wide range of services, from the provision of means for independent work (e.g. internet access) to social and labour counselling and direct intermediation of employment. Also available are, for example, support and preparation for entry onto the labour market for clients serving sentences of imprisonment. The services are intended for clients in need who are unable to manage their problems themselves. There is often a combination of health, social, labour market, drug use and other problems and consequently a demand for multiple types of services at a time. For that reason, most of the service providers offer interventions in the form of coordinated care, applying the case management approach (Matoušek et al., 2003).

The Ministry of Labour and Social Affairs pursues the social protection policy and social inclusion policy for the entire population, and drug users (according to definition of ministry "persons in danger of, or with substance addiction") are one of the target groups. 2010 was the last year the National Action Plan for Social Inclusion for 2008–2010 was in effect[108]. The Ministry of Labour and Social Affairs operates several databases which can assist drug users or helping professionals in obtaining information about the available social support and which also provide statistical information about social services. They include:

- the information portal and database of social prevention services for individuals at risk of social exclusion[109];
- the Register of Social Services Providers – the Register permits a service search according to various criteria, including the target group[110],
- the integrated portal of the Ministry of Labour and Social Affairs – includes all the information regarding social affairs and employment services[111].

does not specifically comprise users of drugs other than alcohol (for details see the Register of Social Services Providers in the Czech Republic – aftercare services and professional social counselling).

[108] http://www.mpsv.cz/cs/9087 (2011-09-01)

[109] https://www.sluzbyprevence.mpsv.cz/ (2011-09-01)

[110] http://iregistr.mpsv.cz/ (2011-09-01)

[111] http://portal.mpsv.cz/ (2011-09-01)

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

Various police sources and information from public prosecutors' offices show that between 2.4 and 2.5 thousand people were prosecuted for drug-related offences in the Czech Republic in 2010. Nearly 2.2 thousand individuals were charged, which corresponds to the long-term percentage of 90% of the persons prosecuted. Nearly 1.7 thousand persons were convicted. 15% of the drug-related offenders were female. The largest proportion of offences (approximately 80%) is associated with the production, trafficking, and selling of drugs.

Offences related to pervitin (approximately 55–70%, depending on the source of the data) and cannabis account for the highest percentage of drug-related crime; the shares of heroin and cocaine are below 5% each.

Prague, Central Bohemia, Karlovy Vary, and Ústí nad Labem are the regions with the highest relative occurrence of drug-related crime.

The number of persons prosecuted for drug-related offences has been increasing in the long term, and there has been an increase in the proportion of people prosecuted for drug possession for personal use. In the long term, there is also a noticeable increase in drug-related offences associated with pervitin and, on the contrary, a decrease in those associated with ecstasy and heroin; the number of cases related to cocaine continues to be relatively low.

1,021 misdemeanours involving the possession of a small quantity of drugs or the cultivation of a small quantity of plants containing a narcotic or psychotropic substance for personal use were recorded in 2010. Most commonly (94%), they involved drug possession; only 6% of the misdemeanours concerned the growing of plants containing a narcotic or psychotropic substance.

In 2010, a total of 117.7 thousand offences were cleared up, 19.6 thousand (16.6%) of which had been committed under the influence of addictive substances, of which alcohol was involved in 17.3 thousand cases (14.7%) and non-alcohol drugs 2.3 thousand cases (1.9%). In both categories, the criminal offence involved was endangerment under the influence of an addictive substance – inebriation.

There were 36 prisons in the Czech Republic in 2010. The very first representative study of drug use among the prison population was conducted in 2010 and showed that, compared to the general population, the level of drug use, including problem drug use, was significantly higher among prisoners. Various services are available to drug users in prison – drug prevention counselling centres, drug-free zones, abstinence-oriented treatment in specialised wings, and opiate substitution treatment with methadone. The care for the imprisoned drug users is complemented by the services provided by non-profit non-governmental organisations.

9.1 Drug-Related Crime

Act No. 40/2009 Coll., the Penal Code (the new Penal Code or new PC), came into force on 1 January 2010, and replaced the previous Act No. 140/1961 Coll., the Penal Code (the old Penal Code of old PC); for details see the chapter on Legal Framework (p. 6). The year 2010 was therefore the first one when the two Codes were applied concurrently. Thus, the statistics include offences defined by both statutory norms. In the area of drug-related crime, they are the following sections:

- Section 187 of the old Penal Code and Section 283 of the new Penal Code: unauthorised production and other handling of narcotic or psychotropic substances and poisons;
- Section 187a of the old Penal Code and Section 284 of the new Penal Code: possession of narcotic or psychotropic substances (for personal use);
- Section 285 of the new Penal Code: unauthorised cultivation of plants containing a narcotic or psychotropic substance (a new provision previously absent in the old Penal Code);
- Section 188 of the old Penal Code and Section 286 of the new Penal Code: manufacturing or possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison;
- Section 188a of the old Penal Code and Section 287 of the new Penal Code: promotion of drug use.

There are several sources of information about drug-related crime in the Czech Republic. They mainly include the statistics of the Police of the Czech Republic, especially the Criminal Statistics Record System and the statistics of the dedicated police unit – the National Drug Headquarters of the Criminal Police and Investigation Service of the Police of the Czech Republic – as well as the statistics of the public prosecutors' offices and court statistics prepared by the Ministry of Justice. Additional data in this area are collected by the Probation and Mediation Service of the Czech Republic and the Prison Service of the Czech Republic.

Individuals arrested or prosecuted for drug-related offences are recorded in the system of the National Drug Headquarters, which only focuses on drug-related crime, and in the police and Ministry of Justice systems, which cover general, i.e. not only drug-related, crime. The data from the above-mentioned sources differ slightly. The differences result from the different reporting practices and discipline, as well as from the methodological differences between the individual reporting systems. For example, such differences include the recording of offences and

offenders at different stages of criminal proceedings[112], different definitions of the cases reported, and different statistical units (individuals, cases, or offences), and double entries of persons in the recorded data (e.g. if a single person has violated multiple drug-related sections of the Penal Code and/or in connection with multiple drug types). However, the non-existence of a uniform record-keeping system for all the institutions involved in criminal proceedings (i.e. the police, public prosecutors' offices, courts, the Probation and Mediation Service, and the Prison Service) is a major disadvantage in this context.

9.1.1 Drug Law Offences

The police data (the National Drug Headquarters database and the Criminal Statistics Record System) for 2010 show a slight increase in drug-related crime while, on the contrary, the data from the Ministry of Justice show a slight decrease in the number of individuals prosecuted and indicted; the number of individuals sentenced for drug-related offences increased; see Table 9-1. The long-term situation is relatively stable but changes can be observed in the structure of drug-related crime by Penal Code section and drug type.

Table 9-1: Number of persons arrested (National Drug Headquarters) and prosecuted (Police, Ministry of Justice), charged with (Ministry of Justice), and sentenced for drug-related offences in 2005–2010, according to the individual information sources (Národní protidrogová centrála SKPV Policie ČR, 2011d; Policie ČR, 2011; Ministerstvo spravedlnosti ČR, 2011a)

Year	Arrested (National Drug Headquarters)	Prosecuted (Criminal Statistics Record System)	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

The structure of the drug-related offences in 2010 is shown in Table 9-2. The biggest share of the offences (approximately 80%) is associated with the manufacturing and trafficking of drugs and dealing in them. Women formed 15% of the individuals prosecuted, charged with, and sentenced for drug-related offences in 2010 (Policie ČR, 2011; Ministerstvo spravedlnosti ČR, 2011a).

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

Table 9-2: Number of persons arrested, prosecuted, charged with, and sentenced for drug-related offences in 2010, by Penal Code (PC) section (Národní protidrogová centrála SKPV Policie ČR, 2011d; Policie ČR, 2011; Ministerstvo spravedlnosti ČR, 2011a)

Indicator (source)	**Section 187, the old PC/ Section 283, the new PC**		**Section 187a, the old PC/ Section 284, the new PC**		**Section 285, the new PC**		**Section 188, the old PC/ Section 286, the new PC**		**Section 188a, the old PC/ Section 287, the new PC**		**Total**	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Arrested (National Drug Headquarters)	2,057	81.5	255	10.1	117	4.6	87	3.4	9	0.4	2,525	100.0
Prosecuted (Criminal Statistics Record System)	1,972	80.9	240	9.8	108	4.4	109	4.5	8	0.3	2,437	100.0
Prosecuted (Ministry of Justice)	1,902	80.0	231	9.7	90	3.8	147	6.2	7	0.3	2,377	100.0
Charged (Ministry of Justice)	1,753	81.5	187	8.7	70	3.3	136	6.3	6	0.3	2,152	100.0
Sentenced (Ministry of Justice)	1,328	80.4	178	10.8	35	2.1	109	6.6	2	0.1	1,652	100.0

Offences related to pervitin accounted for the highest percentage of drug-related crime (approximately 55–70%, depending on the source of the data), followed by cannabis (approximately one third); the proportions of drug-related offences associated with heroin and cocaine were below 5% each. Cannabis accounted for the highest percentage (50–60%) of the offences involving drug possession for personal use, while pervitin was predominant as regards the offences associated with the manufacturing or possession of an article for drug production, which corresponds with the high level of occurrence and number of seizures of illegal pervitin laboratories (see also the chapter on Drug Markets on p. 131); Table 9-3 to Table 9-5.

Table 9-3: Number of persons arrested in 2010, by main drug type and Penal Code section, according to the National Drug Headquarters (Národní protidrogová centrála SKPV Policie ČR, 2011d)

Drug	**Production, trafficking, and selling (Sections 187 and 188, the old PC / Sections 283, 285, and 286, the new PC)**		**Possession for personal use (Section 187a, the old PC /Section 284 the new PC)**		**Promotion of drug use (Section 188a, the old PC /Section 287, the new PC)**		**Total**	
	Number	%	Number	%	Number	%	Number	%
Cannabis	744	32.9	152	59.6	8	88.9	904	35.8
Pervitin	1,293	57.2	69	27.1	1	11.1	1,363	54.0
Cocaine	44	1.9	6	2.4	0	0.0	50	2.0
Heroin	78	3.4	17	6.7	0	0.0	95	3.8
Ecstasy	8	0.4	6	2.4	0	0.0	14	0.6
LSD	1	0.0	0	0.0	0	0.0	1	0.0
Other drugs	93	4.1	5	2.0	0	0.0	98	3.9
Total	**2,261**	**100.0**	**255**	**100.0**	**9**	**100.0**	**2,525**	**100.0**

Table 9-4: Number of persons prosecuted in 2010, by main drug type and drug-related Penal Code section, according to the Ministry of Justice (Ministerstvo spravedlnosti ČR, 2011b)

Drug	Section 187, the old PC/ Section 283, the new PC		Section 187a, the old PC/ Section 284, the new PC		Section 285, the new PC		Section 188, the old PC/ Section 286, the new PC		Section 188a, the old PC/ Section 287, the new PC		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Cannabis	577	30.3	126	54.5	74	82.2	14	9.5	4	57.1	795	33.4
Pervitin	1,126	59.2	84	36.4	4	4.4	126	85.7	3	42.9	1,343	56.5
Cocaine	41	2.2	6	2.6	0	0.0	0	0.0	0	0.0	47	2.0
Heroin	88	4.6	14	6.1	0	0.0	1	0.7	0	0.0	103	4.3
Ecstasy	12	0.6	4	1.7	0	0.0	1	0.7	0	0.0	17	0.7
Other drugs	138	7.3	16	6.9	14	15.6	10	6.8	1	14.3	179	7.5
Total	**1,902**	**100.0**	**231**	**100.0**	**90**	**100.0**	**147**	**100.0**	**7**	**100.0**	**2,377**	**100.0**

*Note: *The data provided in the Total row are not the sum of number or percentage (%) of offences by drug type because certain persons were prosecuted for the violation of multiple drug-related sections of the Penal Code or in connection with multiple drug types; a single person can therefore be included in the statistics several times.*

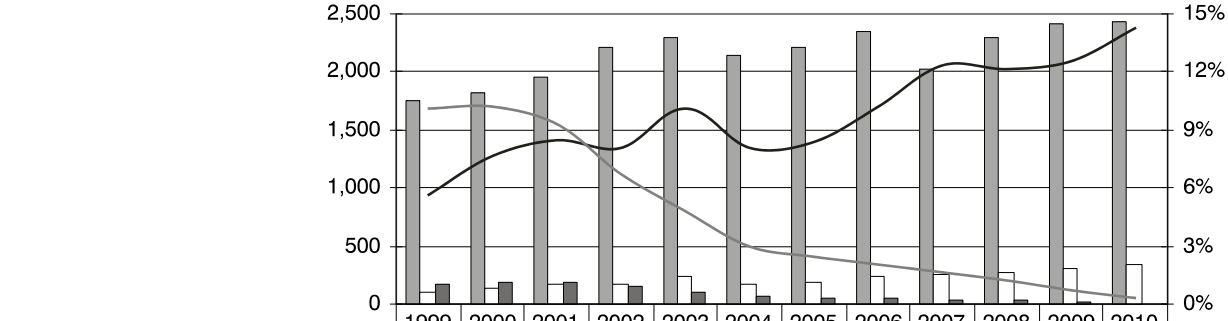
Table 9-5: Number of persons charged in 2010, by main drug type and drug-related Penal Code section (Ministerstvo spravedlnosti ČR, 2011b)

Drug	Section 187, the old PC/ Section 283, the new PC		Section 187a, the old PC/ Section 284, the new PC		Section 285, the new PC		Section 188, the old PC/ Section 286, the new PC		Section 188a, the old PC/ Section 287, the new PC		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Cannabis	501	28.6	97	51.9	58	82.9	14	10.3	3	50.0	673	31.3
Pervitin	1,085	61.9	72	38.5	4	5.7	116	85.3	3	50.0	1,280	59.5
Cocaine	39	2.2	5	2.7	0	0.0	0	0.0	0	0.0	44	2.0
Heroin	84	4.8	13	7.0	0	0.0	1	0.7	0	0.0	98	4.6
Ecstasy	9	0.5	3	1.6	0	0.0	1	0.7	0	0.0	13	0.6
Other drugs	118	6.7	12	6.4	10	14.3	9	6.6	1	16.7	150	7.0
Total	**1,753**	**100.0**	**187**	**100.0**	**70**	**100.0**	**136**	**100.0**	**6**	**100.0**	**2,152**	**100.0**

*Note: *The data provided in the Total row are not the sum of number or percentage (%) of offences by drug type because certain persons were charged under multiple drug-related sections of the Penal Code or in connection with multiple drug types; a single person can therefore be included in the statistics several times.*

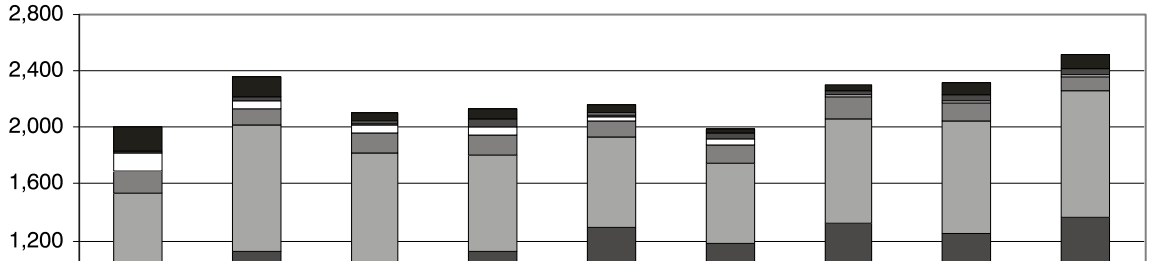
In the long term, there has been an increase in the total number of persons prosecuted for drug-related offences and there has been a continued increase in the proportion of persons prosecuted for the possession of drugs, and a decrease in the number of persons prosecuted for promoting drug use; see Figure 9-1. As far as the individual drugs involved in drug-related crime are concerned, there has been a noticeable long-term increase in the number and percentage of cases associated with pervitin and, on the contrary, a decrease in those associated with ecstasy and heroin; the number of drug-related offences involving cocaine continues to grow but still remains relatively low in absolute terms; see Figure 9-2.

Figure 9-1: Total number of persons prosecuted and the number and percentage of persons prosecuted for drug possession/cultivation for personal use (Section 187a of the old Penal Code/Sections 284 and 285 of the new Penal Code) and for promoting drug use (Section 188a of the old Penal Code/Section 287 of the new Penal Code), 1999–2010 (Policie ČR, 2011)



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of drug-related offences	1,753	1,815	1,952	2,204	2,295	2,149	2,209	2,344	2,023	2,296	2,415	2,437
Section 187a, old Penal Code, Sections 284 & 285, new Penal Code	98	139	166	178	232	173	184	240	250	278	302	348
Section 188a, old Penal Code, Section 287, new Penal Code	177	186	181	149	110	64	53	49	32	28	17	8
Percentage of possession/cultivation for personal use	5.6%	7.7%	8.5%	8.1%	10.1%	8.1%	8.3%	10.2%	12.4%	12.1%	12.5%	14.3%
Percentage of promoting drug use	10.1%	10.2%	9.3%	6.8%	4.8%	3.0%	2.4%	2.1%	1.6%	1.2%	0.7%	0.3%

Figure 9-2: Percentage of individual drug types for persons arrested for drug-related offences in the period 2002–2010 (Národní protidrogová centrála SKPV Policie ČR, 2011d)



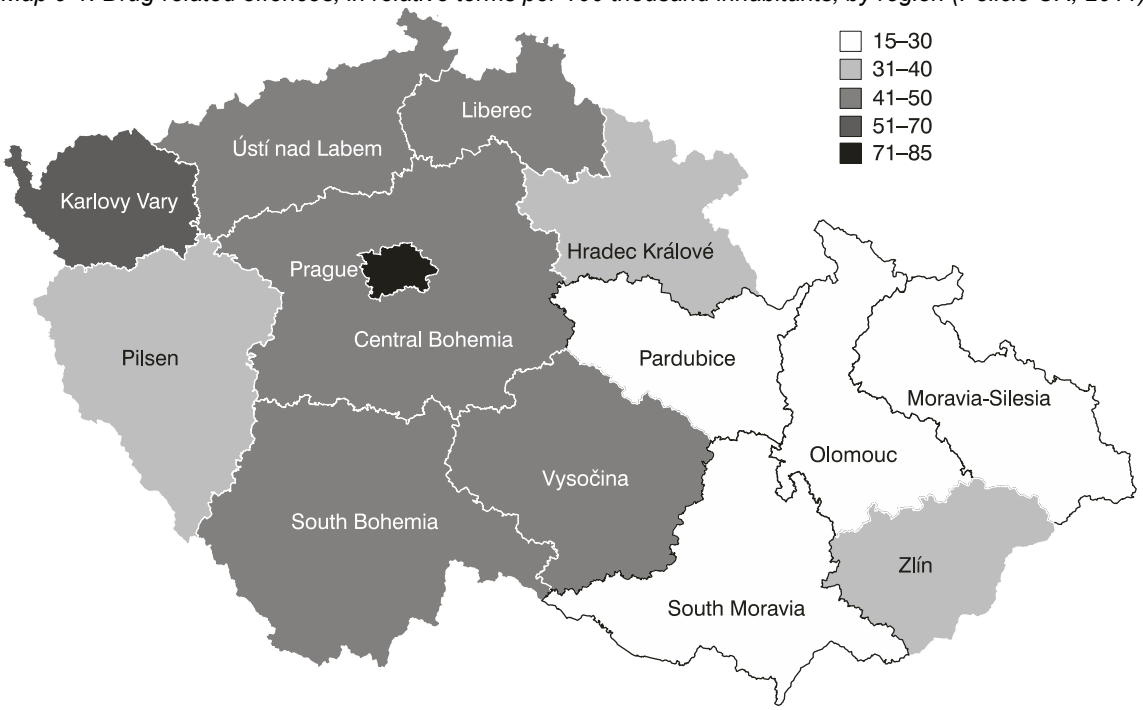
	2002	2003	2004	2005	2006	2007	2008	2009	2010
Other	160	137	59	62	66	30	36	75	98
LSD	4	4	3	9	4	4	2	5	1
Cocaine	10	24	17	50	13	50	23	47	50
Ecstasy	140	66	66	55	35	38	18	5	14
Heroin	157	105	134	145	116	127	151	136	95
Cannabis	748	892	763	682	638	569	746	786	896
Pervitin	781	1,129	1,058	1,125	1,293	1,178	1,320	1,257	1,362

The regions with the highest reported absolute number of drug-related offences and individuals prosecuted in 2010 included Prague, Central Bohemia, Ústí nad Labem, and Moravia-Silesia. In relative terms per 100 thousand inhabitants, the highest occurrence of drug-related crime was reported from Prague and the Central Bohemia, Karlovy Vary, and Ústí nad Labem Regions; see Table 9-6 and Map 9-1.

Table 9-6: Drug-related offences and persons prosecuted for drug-related offences, by region (Policie ČR, 2011)

Region	Drug-related offences			Persons prosecuted for drug-related offences		
	Number	Percentage	Per 100 thousand persons aged 15–64	Number	Percentage	Per 100 thousand persons aged 15–64
Prague	731	23.0	82.1	377	15.5	42.3
Central Bohemia	425	13.4	48.3	379	15.6	43.1
South Bohemia	206	6.5	46.0	155	6.4	34.6
Pilsen	133	4.2	33.2	91	3.7	22.7
Karlovy Vary	146	4.6	66.7	98	4.0	44.8
Ústí nad Labem	281	8.8	47.4	277	11.4	46.7
Liberec	139	4.4	44.8	118	4.8	38.0
Hradec Králové	136	4.3	35.4	95	3.9	24.7
Pardubice	67	2.1	18.6	63	2.6	17.5
Vysočina	173	5.4	48.2	129	5.3	35.9
South Moravia	236	7.4	29.2	191	7.8	23.7
Olomouc	124	3.9	27.6	136	5.6	30.2
Zlín	137	4.3	33.1	109	4.5	26.4
Moravia-Silesia	245	7.7	27.9	219	9.0	24.9
Total	**3,179**	**100.0**	**43.0**	**2,437**	**100.0**	**33.0**

Map 9-1: Drug-related offences, in relative terms per 100 thousand inhabitants, by region (Policie ČR, 2011)



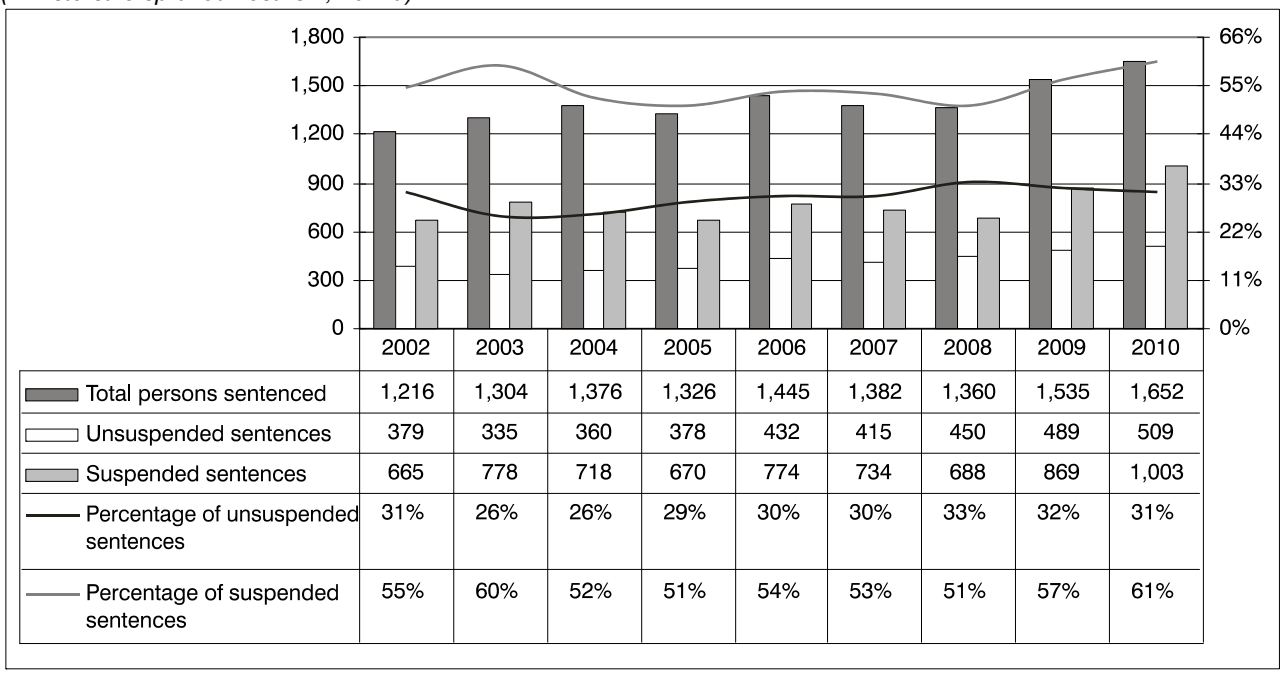
9.1.1.1 Sentences for Drug-Related Offences

In 2010 an unsuspended sentence of imprisonment was imposed upon 31% of the people sentenced for drug-related offences; a higher percentage of unsuspended sentences of imprisonment is apparent in the offences associated with drug production and trafficking; see Table 9-7. The long-term development in the total number of persons sentenced and in the number and percentage of unsuspended and suspended sentences imposed for drug-related offences is shown in Figure 9-3 – a slight increase in the number and proportion of suspended sentences can be noted.

Table 9-7: Sentences and other measures imposed for drug-related offences in 2010, by Penal Code section (Ministerstvo spravedlnosti ČR, 2011a; Ministerstvo spravedlnosti ČR, 2010)

Indicator	Sections 187/283		Sections 187a/284		Section 285		Sections 188/286		Sections 188a/287		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Persons sentenced	1,328	100.0	178	100.0	35	100.0	109	100.0	2	100.0	1,652	100.0
Total unsuspended sentences	440	33.1	27	15.2	1	2.9	40	36.7	1	50.0	509	30.8
– up to 1 year's imprisonment	48	3.6	13	7.3	0	0.0	16	14.7	0	0.0	77	4.7
– imprisonment for 1–4 years	342	25.8	11	6.2	1	2.9	22	20.2	1	50.0	377	22.8
– imprisonment for 5–14 years	52	3.9	3	1.7	0	0.0	2	1.8	0	0.0	57	3.5
– imprisonment for over 15 years	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Suspended sentence	790	59.5	125	70.2	27	77.1	60	55.0	1	50.0	1,003	60.7
House arrest	1	0.1	0	0.0	1	2.9	0	0.0	0	0.0	2	0.1
Community service	47	3.5	10	5.6	5	14.3	6	5.5	0	0.0	68	4.1
Prohibition on undertaking a specific activity	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Fine	10	0.8	4	2.2	1	2.9	0	0.0	0	0.0	15	0.9
Sentence waived	30	2.3	5	2.8	0	0.0	3	2.8	0	0.0	38	2.3
Compulsory treatment	45	3.4	3	1.7	0	0.0	2	1.8	0	0.0	50	3.0

Figure 9-3: Development in the number and structure of sentences imposed for drug-related offences in 2002–2009 (Ministerstvo spravedlnosti ČR, 2011a)



	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total persons sentenced	1,216	1,304	1,376	1,326	1,445	1,382	1,360	1,535	1,652
Unsuspended sentences	379	335	360	378	432	415	450	489	509
Suspended sentences	665	778	718	670	774	734	688	869	1,003
Percentage of unsuspended sentences	31%	26%	26%	29%	30%	30%	33%	32%	31%
Percentage of suspended sentences	55%	60%	52%	51%	54%	53%	51%	57%	61%

9.1.2 Misdemeanours Involving Drug Possession for Personal Use

The possession of a small quantity of drugs for personal use qualifies as a misdemeanour according to Section 30 of Act No. 200/1990 Coll. on misdemeanours – misdemeanours against protection from alcoholism and abuse of other substances. This concerns the unauthorised possession of small quantities of drugs for personal use according to Section 30(1)(j) of the Misdemeanours Act and, effective from 1 January 2010, in connection with Act No. 40/2009, the Penal Code, also the new provision of Section 30(1)(k) of the Misdemearnours Act regarding the unauthorised

cultivation of a small quantity of plants or mushrooms containing narcotic or psychotropic substances for personal use. A fine of up to CZK 15,000 (€ 593) may be imposed upon the perpetrators of each of the misdemeanours.

Effective from 1 January 2009, the Police of the Czech Republic no longer have the jurisdiction in the above-mentioned cases; instead, the jurisdiction lies with the local authorities of municipalities with extended competences. This has caused problems with the collection of data on misdemeanours under the above-mentioned provisions (j) and (k) of the Misdemeanours Act which were committed in 2009 and 2010.[113] The information available for 2010 on the misdemeanours concerned comes from the data collected by the Ministry of the Interior because the standard reporting form for local government authorities was extended (Ministerstvo vnitra ČR, 2011b). The 2009 data were collected especially in cooperation with the Ministry of Health, which used its channels to request a retrospective report from the regional authorities (Národní monitorovací středisko pro drogy a drogové závislosti, 2011g).

A total of 970 misdemeanours involving drug possession for personal use were reported in 2006, and 966 misdemeanours were reported in 2007. The incomplete data available for 2008[114] show 450 cases of misdemeanours, in which 473 persons participated.

752 misdemeanours involving the possession of a small quantity of drugs for personal use were recorded in 2009. One fifth of the perpetrators were minors, and the cases most commonly concerned the possession of marijuana or pervitin or cannabis plants. 1,021 misdemeanours involving the possession of small amounts of drugs or the cultivation of a small number of plants containing a narcotic or psychotropic substance were recorded in 2010. They again mostly concerned adults (85%) and drug possession (94%), with only 6% of the misdemeanours involving the cultivation of plants containing narcotic or psychotropic substances for personal use; see Table 9-8 and Table 9-9.

Table 9-8: Drug-related misdemeanours in 2009 and their breakdown by region, age, and drug type (Národní monitorovací středisko pro drogy a drogové závislosti, 2011g)

Region	**Age**		**Drug**				**Total persons**
	Under 18	Over 18	Cannabis	Pervitin	Other drugs	Cannabis plants	
Prague	6	105	33	29	31	24	111
Central Bohemia	18	64	23	22	6	37	82
South Bohemia	5	36	9	5	2	26	41
Pilsen	3	27	7	0	0	23	30
Karlovy Vary	2	35	17	5	11	11	37
Ústí nad Labem	16	80	49	24	22	16	96
Liberec	6	63	47	5	6	14	69
Hradec Králové	20	10	14	1	2	13	30
Pardubice	12	15	13	2	0	13	27
Vysočina	3	12	4	3	1	8	15
South Moravia	7	32	12	11	2	18	39
Olomouc	18	43	11	11	7	36	61
Zlín	10	25	7	6	1	22	35
Moravia-Silesia	27	52	20	20	5	37	79
Total	**153**	**599**	**266**	**144**	**96**	**298**	**752**

[113] The provision of Section 30 of the Act on Misdemeanours falls within the sphere of the Ministry of Health, which has competence as the higher-instance appeal authority (review of and appeal against administrative decisions) but the data on the misdemeanours handled are provided by the Ministry of the Interior, which uses a dedicated form to collect the data on misdemeanours from the municipalities through the regional authorities, which consolidate the data and send them to the Ministry of the Interior (General Administration Department).

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

Table 9-9: Drug-related misdemeanours in 2010 and their breakdown by region, age, and possession of a narcotic or psychotropic substance (clause (j)) or of a plant containing a narcotic or psychotropic substance for personal use (clause (k)) (Ministerstvo vnitra ČR, 2011b)

Region	Age		Drugs (Section 30(1)(j))	Plants (Section 30(1)(k)	Total number of persons
	Under 18	Over 18			
Prague	4	118	120	2	122
Central Bohemia	28	188	208	8	216
South Bohemia	5	38	35	8	43
Pilsen	10	68	72	6	78
Karlovy Vary	7	47	54	0	54
Ústí nad Labem	27	71	95	3	98
Liberec	4	68	68	4	72
Hradec Králové	20	33	34	19	53
Pardubice	9	18	27	0	27
Vysočina	3	29	31	1	32
South Moravia	14	65	76	3	79
Olomouc	12	42	52	2	54
Zlín	8	29	31	6	37
Moravia-Silesia	6	50	53	3	56
Total	**157**	**864**	**956**	**65**	**1,021**

Note: Unfortunately, the scope and structure of the data collected by the Ministry of the Interior from 2010 on do not enable the misdemeanours to be divided by drug type.

9.1.3 Secondary Drug-Related Crime

The findings of the repeated research conducted by the National Drug Headquarters and the National Focal Point into secondary drug-related crime or those of a questionnaire survey aimed at secondary drug-related crime are provided in the 2009 Annual Report.

The Criminal Statistics Record System again provided data on offences committed under the influence of alcohol and non-alcohol drugs in 2010 (Policie ČR, 2011). In 2010, a total of 117.7 thousand offences were cleared up, 19.6 thousand (16.6%) of which were committed under the influence of addictive substances, of which alcohol was involved in 17.3 thousand (14.7%) cases. As in 2009, the most common criminal offences were endangerment under the influence of an addictive substance, inebriation (9.1 thousand), road traffic accidents caused by negligence (2.7 thousand), voluntary bodily harm, disorderly conduct, damage to property, and assault. A total of 2.3 thousand offences (1.9%) were reported as having been committed under the influence of substances other than alcohol and again most frequently involved endangerment under the influence of an addictive substance, inebriation (1.6 thousand), obstructing justice (193), various types of thefts or burglaries (168), and the unauthorised production of narcotic or psychotropic substances (98); see Table 9-10.

Table 9-10: Criminal offences committed under the influence of addictive substances in 2009–2010 (Policie ČR, 2011)

Year	Offences cleared up	Offences committed under the influence of addictive substances					
		Total		– under the influence of alcohol		– under the influence of other drugs	
		Number	%	Number	%	Number	%
2009	124,543	24,448	19.6	22,192	17.8	2,256	1.8
2010	117,685	19,567	16.6	17,290	14.7	2,277	1.9

9.1.4 Clients of the Probation and Mediation Service

Data for 2010 about the clients of the Probation and Mediation Service of the Czech Republic (PMS) who are drug users had not been made available at the time of the drafting of this Report. In 2009, the PMS recorded a total of 25,851 new clients, 531 (2.1%) of whom were the perpetrators of drug-related crime (both of drug-related offences and of crimes against property committed to acquire the wherewithal for purchasing drugs) – see the 2009 Annual Report.

The 2010 data come from the findings of the pilot project named Verification of the Use of Drug Tests (Non-alcohol Saliva Tests) in the Performance of Probation Supervision of the Clients of the PMS (Probační a mediační služba ČR, 2010b). Implemented by the PMS in cooperation with other institutions, the project ran from August 2007 in the PMS centre in Prague and from January 2009 in other centres in Jihlava, Znojmo, Teplice, Chomutov, Jeseník, Český Krumlov, and České Budějovice. The data collection phase was completed in May 2010. A total of 109 adult and minor clients participated in the project, with adult males prevailing. A court decision included 57 clients in the project; 52 clients participated voluntarily. There were 102 clients whose sentences encompassed probation supervision; educational measures had been imposed upon 6 minors, and 1 client was tested as part of a community service order. The tests detected drug use in 53% of the clients in the first (i.e. involuntary) group and in

37% of the clients in the second (voluntary) group; these results confirmed the assumption that voluntary consent to testing was more likely in clients who can manage their drug problems better or who are more motivated to abstain from drugs. The drugs most commonly detected with the saliva tests included pervitin (56 clients), THC (21), and a combination of pervitin and THC (9). 12 confirmation tests were conducted upon a client's request and the results of the saliva tests were not confirmed in 7 cases. Despite the limitations of the saliva tests, the probation officers considered the tests a useful monitoring instrument and generally agreed that testing built up mutual trust between the client and the officer, which, in turn, improves the willingness of the clients to discuss their drug problem and address it together with their probation officer. The PMS staff also emphasised the fact that the tests offered a more objective assessment of the client's level of risk regarding drug use. The staff implementing the project have proposed the introduction of drug testing as a standard monitoring instrument of the Probation and Mediation Service.

According to the PMS (Probační a mediační služba ČR, 2010a), in 2010 there were a total of 3 probation programmes accredited by the Ministry of Justice that aimed at minors aged 15–18 and focused, among other risk forms of behaviour, on drug-related problems. They were the *Proboš* programme, carried out by the *Renarkon* public service company in Frýdek-Místek, the *Auritus* programme, carried out by the *Tábor* Parish Charity, specifically its *Auritus* centre for people at risk from drugs, and the MOST programme, implemented by the Třebíč branch of the Brno Diocesan Charity. These programmes offered information services, individual counselling, motivational training, and crisis intervention to minors at risk of the use of drugs, especially marijuana.

9.2 Prevention of Drug-Related Crime

In the Czech Republic, crime prevention is within the competence of the Ministry of the Interior[115], which also prepares the 2008–2011 Crime Prevention Strategy; for details see the 2009 Annual Report. The issue of crime prevention also falls within the competence of the Ministry of Education, which is in charge of the prevention of risk behaviour among children and young people; for details see the chapter on Prevention (p. 41).

The specific activities pertaining to the prevention of drug-related crime were mainly conducted by the National Drug Headquarters in 2010. Carried out by the National Drug Headquarters in cooperation with the Czech Chamber of Pharmacists since 2009, the project named I Do Not Support Drug Production aims at preventing the sales of larger quantities of medicinal products containing pseudoephedrine to persons reasonably suspected of being involved in pervitin production. In connection with the detection of illegal large-scale cannabis plantations, in 2009 the National Drug Headquarters also started to cooperate with the representatives of power distribution companies, which can be the first to raise a suspicion of indoor cannabis cultivation on the basis of abnormally high power consumption by a single distribution point or significant losses on the grid in a particular location. The evaluation of the effectiveness of the two above-mentioned projects is not available.

9.3 Interventions in the Criminal Justice System

Even though compulsory treatment and security detention (protective measures) may be included among penalties under criminal law, their nature is rather preventative and they do not express the condemnation of the perpetrators and the level of their guilt; for more details see the 2008 and 2009 Annual Reports. Compulsory treatment is imposed in the institutional or outpatient forms and it is carried out in health care facilities or in prisons; see also the special chapter on Drug-Related Health Policies and Services in Prison (p. 139). Compulsory drug treatment was imposed upon 116 individuals and compulsory alcohol treatment upon 162 persons in 2010. In 48 cases, compulsory drug treatment was imposed for drug-related offences; the other 68 cases were in connection with other criminal offences (Ministerstvo spravedlnosti ČR, 2011a); see Table 9-11.

Table 9-11: Number of persons ordered to undergo outpatient or institutional compulsory drug/alcohol treatment in the period 2004–2009 (Ministerstvo spravedlnosti ČR, 2011a)

Compulsory treatment type	2004	2005	2006	2007	2008	2009	2010
Drug use	161	141	164	139	162	123	116
Alcohol use	190	193	220	232	217	195	162
Total	**351**	**334**	**384**	**371**	**379**	**318**	**278**

In addition to compulsory treatment, other options are also used in the case of drug users as part of diversion from criminal proceedings or alternative sentences. This mostly involves the imposition of a reasonable obligation to undergo treatment; for more details see the 2009 Annual Report.

9.4 Drug Use and Problem Drug Use in Prisons

There were 36 prisons and remand centres (hereinafter referred to as prisons) in the Czech Republic in 2010. The number of prisoners has been increasing in recent years; as of the end of 2010, the Prison Service of the Czech Republic registered a total of 21,900 prisoners[116], with 19,449 persons serving prison sentences, 2,443 awaiting trial

[115] http://www.mvcr.cz/clanek/programy-prevence-kriminality.aspx (2011-09-01)

[116] In relative terms per 100 thousand inhabitants (the prison population rate), there were 207 prisoners in the Czech Republic in 2010. By way of illustration, the 2009 figure in the USA was 743 and in Russia in 2010 it was 582 persons, while in Denmark and Norway it

in custody, and 8 being the inmates of the detention institution in the Brno prison. As of the date specified above, 1,293 prisoners were female. Most prisoners (22%) were serving prison sentences of 1–2 years; the most common age group among the persons sentenced (35%) was 30–40, and most persons were serving their sentence in high-security prisons (49%).

As of the end of 2010, a total of 2,016 drug-related criminal offences according to Sections 187–188a of the old Penal Code or Sections 283, 284, 286, and 287 of the new Penal Code in force from January 2010 were registered among the prisoners; see Table 9-12. However, the total number of prisoners could be lower because a single person may have been sentenced for committing multiple drug-related offences (e.g. there were four people sentenced under Section 285 of the Penal Code, among other charges, in 2010).

Table 9-12: Number of drug-related offences under Sections 187–188a of the old Penal Code and under Sections 283, 284, 286, and 287 of the new Penal Code, respectively, recorded for prisoners at the end of 2008, 2009, and 2010 (Generální ředitelství Vězeňské služby ČR, 2011b).

Drug-related offences	2008	2009	2010
Sections 187/283	1,257	3,073	1,696
Sections 187a/284	127	323	143
Sections 188/286	185	365	145
Sections 188a/287	93	138	32
Total	**1,662**	**3,899**	**2,016**

The level of drug use in Czech prisons in 2010 can be generally estimated on the basis of information pertaining to the results of the examinations of the prisoners and treatment interventions provided to them, urine toxicology screening tests of the offenders, and drug seizures in prisons (Generální ředitelství Vězeňské služby ČR, 2011a).

- general practitioners conducted 421,782 examinations or treatment interventions regarding prisoners in 2010 and reported 10,763 persons (compared to 9,802 in 2009) with drug addiction (including alcohol addiction).
- A total of 19,703 drug tests were conducted among prisoners in 2010, with 358 of the tests being positive after confirmation, and the most common drugs found was pervitin (130 positive tests) and cannabis (THC – 101 tests).
- Scheduled and random drug searches (including those using trained drug-sniffing dogs) were performed in all the prisons. They involved searches of the living quarters, common areas, and workplaces, and checks on correspondence, including packages etc. A total of 115 seizures of non-alcohol drugs were reported; 55 of the cases involved pervitin (a total quantity of 38 grams), 55 marijuana (153.7 grams), and 5 involved heroin (3.4 grams).

9.4.1 Questionnaire Survey of Drug Use among Prisoners

A questionnaire survey of drug use among inmates serving prison sentences was conducted by the National Focal Point in cooperation with the General Directorate of the Prison Service in the autumn of 2010. The data were collected by the *Median Agency* through trained administrators, who were mostly members of the staff of the A.N.O. (Association of Non-Governmental Organisations) Section for Drug Services in Prison dealing with the prevention and treatment of drug addiction. Prior to its launch, the study was assessed and approved by the Ethics Committee of the National Focal Point.

The study was conducted with a sample of 2,000 inmates serving prison sentences, selected from the 19,570 persons imprisoned in all the 36 prisons in the Czech Republic on the sampling date. 1,668 questionnaires were returned, which corresponds to a response rate of 83.4%. In addition to the questions regarding the prevalence of illicit drug use in three retrospective time spans, the questionnaire also contained questions about drug use prior to the start of the prison sentence and drug use during imprisonment, questions identifying problem drug users, the experience of the respondents with drug addiction treatment, and questions identifying risk behaviour associated with the application of the drug, and in addition, a set of demographic questions (gender, age, nationality, education, employment), type of prison, and type of sentence.

A total of 52.2% of the respondents reported a certain experience with an illegal drug in their lifetime; 43.1% of them had used cannabis, 38.5% pervitin or amphetamines, 22.5% ecstasy, 18.0% hallucinogenic mushrooms, 16.7% LSD or cocaine, and 15.1% heroin. Nearly 23% of the respondents reported having used medicines with a sedative effect without a prescription; see Figure 9-4. 22.0% and 8.5% of the respondents had used an illicit drug in the previous 12 months and 30 days respectively; the drug was most commonly cannabis, pervitin and amphetamines, and medicines with a sedative effect obtained without a prescription (Národní monitorovací středisko pro drogy a drogové závislosti and Generální ředitelství Vězeňské služby ČR, 2011).

In comparison with the general population, it shows that the lifetime prevalence of the use of addictive substances is significantly higher among the population serving a prison sentence. This is most apparent in the use of heroin,

was 71 persons in 2010 (Generální ředitelství Vězeňské služby ČR, 2011b). The average prison population rate in the EU was 70-100 persons per 100 thousand inhabitants in 2009 (Valeš, 2009).

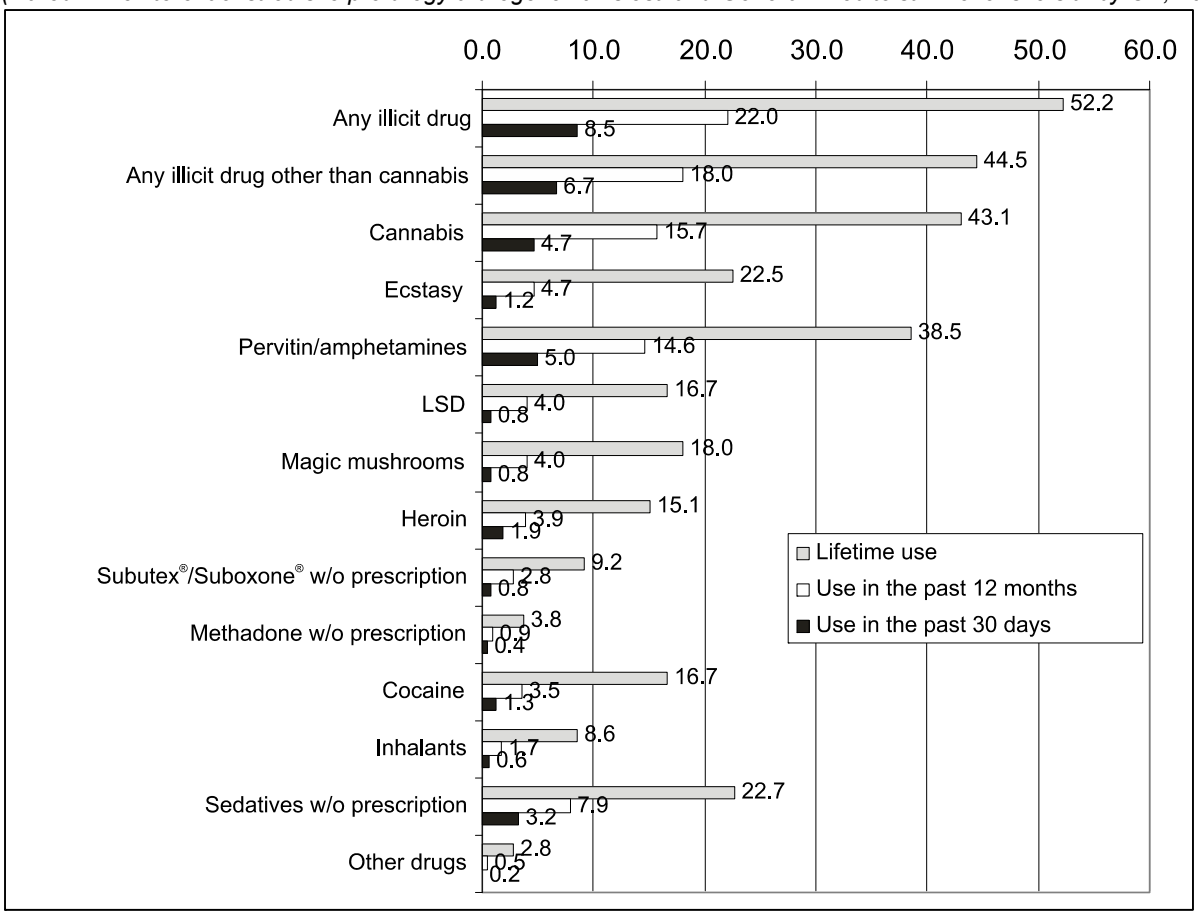
pervitin, and cocaine, where the prevalence among the inmates is a multiple of that among the general population. On the other hand, the prevalence figures are the same or even lower in the case of sedatives, alcohol, and marijuana. Females serving a prison sentence show a generally higher level of prevalence of drug use than females in the general population – in particular in the case of heroin, pervitin, and cocaine.

According to the respondents, pervitin and cannabis (marijuana or hashish) are the most widely available illegal substances in prisons. Almost one third of the respondents described the two drugs as being available. They are followed by alcohol and sedatives without a prescription, which are available according to a quarter of the respondents. Heroin was reported as being available by 18.7% of the respondents and Subutex® or Suboxone® by 14.5% of the respondents. On the other hand, one fifth of the respondents reported that no illegal substances were available in prison.

26.2% of the respondents admitted to using an illegal substance while serving a term in prison. They had most commonly used cannabis (14.5%) and alcohol (14.3%). Pervitin was the third most commonly reported substance (with 12.5%) and the 10% level was also exceeded by sedatives without a prescription (11.6%); heroin and Subutex® were reported by the respondents in 3.8% and 3.1% of the cases respectively.

As far as the risky routes of drug administration are concerned, 31.3% of the respondents reported a history of injecting drug use, with 22.1% of the respondents reporting having injected a drug within the last month before the start of their current prison term. A total of 8.4% of the respondents admitted to having injected a drug while serving a term in prison. 13.4% had shared a needle or syringe previously used by another person, and 6.6% of the respondents admitted to having shared needles or syringes while in prison.

Figure 9-4: Prevalence of the use of addictive substances by the prison population: lifetime, last year, last month, in % (Národní monitorovací středisko pro drogy a drogové závislosti and Generální ředitelství Vězeňské služby ČR, 2011)



6.0% of the respondents had received alcohol addiction treatment and 9.1% other substance addiction treatment prior to the start of their prison sentence. 2.5% of the respondents had been included in methadone substitution therapy, and 3.8% in Subutex® or Suboxone® substitution therapy. Over 43.2% of the respondents had been tested for at least one of the infections being monitored. 28.3% of the respondents had been tested for viral hepatitis type B, 35.0% for hepatitis type C, and 23.9% for HIV. 27.7% of the respondents reported having tested positive for HCV. There were 6 HIV-positive persons in the sample, i.e. 0.4% of the sample and 1.7% of those tested for HIV.

On the basis of the findings of the study, it can be estimated that between one tenth and a quarter of the prisoners show signs of current problem drug use (2–5 thousand people in absolute terms) when starting their prison sentence. The prevalence is thus 20–50 times higher than that of problem drug users in the general population

(approximately 0.5%). However, only approximately a quarter of those who can be referred to as problem drug users when starting their prison sentence are placed in specialised or other dedicated wings such as drug-free zones (Národní monitorovací středisko pro drogy a drogové závislosti and Generální ředitelství Vězeňské služby ČR, 2011).

9.5 Responses to Drug-related Health Issues in Prisons

The information about counselling and treatment interventions for drug users in prison is provided annually by the General Directorate of the Prison Service of the Czech Republic (Generální ředitelství Vězeňské služby ČR, 2011c). The Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2007–2009, the validity of which was extended to the year 2010, was the key document for the implementation of the services for drug users in 2010. In 2011, the General Directorate of the Prison Service adopted the Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2011–2012 (Generální ředitelství Vězeňské služby ČR, 2011a), which builds upon the previous plan, is compatible with the Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2010–2012, and focuses on the following six main areas: (1) primary prevention; (2) treatment and aftercare; (3) harm reduction; (4) supply reduction and law enforcement; (5) coordination and funding, and (6) monitoring, research, and evaluation. Another important document in this area is the Czech Prison Service Development Policy until 2015, which was drawn up in 2005[117].

9.5.1 Drug Prevention Counselling Centres

The services of the drug prevention counselling centres were used by 5,998 prisoners in 2010, i.e. by persons who were provided with at least one intervention (compared to 5,504 persons in 2009). For details on these centres see the section on Drug Prevention Counselling Centres (p. 144) in the chapter on the relevant selected issue.

9.5.2 Detoxification

Detoxification was performed in five prisons in 2010 (the Prague-Pankrác, Prague-Ruzyně, Brno, Ostrava, and Kuřim prisons). A total of 686 persons underwent detoxification (219 persons in 2009), 312 of whom were men, 431 opiate users, 140 pervitin users, and 79 benzodiazepine users. For details on detoxification see the section on Detoxification (p. 144) in the chapter on the relevant selected issue.

9.5.3 Drug-Free Zones

Drug-free zones operated in 33 prisons; in four of them (Kuřim, Příbram, Vinařice, and Znojmo), they were the so-called therapeutic drug-free zones. The total capacity of the drug-free zones was 2,075 and a total of 3,443 inmates served their sentences in them, 87 of whom were expelled for violating the rules; see Table 9-13. A total of 1,562 toxicological screening tests were conducted, 16 of which were subsequently confirmed as positive by the laboratory. For details on the drug-free zones see the section on Drug-Free Zones (p. 143) in the chapter on the relevant selected issue.

9.5.4 Specialised Treatment Departments

Voluntary treatment departments operated in 7 medium-security, high-security, and maximum-security prisons in 2010 (Bělušice, Nové Sedlo, Ostrov, Plzeň, Příbram, Valdice, and Všehrdy). The total capacity of these wings was 300 places, and 437 inmates served their prison sentences in them during the year; see Table 9-13. A total of 362 toxicological screening tests were conducted in the above-mentioned seven prisons, with six of the tests being confirmed by the laboratory as positive.

Departments for court-ordered compulsory drug treatment operated in three prisons in 2010 (Opava, Rýnovice, and Znojmo). Their total capacity of 109 places was used by 128 persons to serve their sentence; see Table 9-13. A total of 107 toxicological screening tests were conducted in the three prisons, with seven of the tests being confirmed by the laboratory as positive.

For details on the specialised treatment departments, see the sections on Voluntary Treatment Departments (p. 143) and Departments for Court-Ordered Compulsory Drug Treatment (p. 143) in the chapter on the relevant selected issue.

[117] Other rules applicable to the drug policy of the Prison Service of the Czech Republic are included in the internal regulations governing the rules, organisation, record-keeping, and forms and methods of addressing various stages of addiction at departments specifically dedicated to the relevant type of dealing with the users of addictive substances.

Table 9-13: Number, capacity, and use of drug-free zones and specialised departments in Czech prisons in 2006–2010 (Generální ředitelství Vězeňské služby ČR, 2011c)

Year	Drug-free Zones			Voluntary treatment department			Departments for court-ordered treatment		
	Number of departments / prisons	Capacity	Persons	Number of departments / prisons	Capacity	Persons	Number of departments / prisons	Capacity	Persons
2006	31	1,665	3,201	6	286	625	3	105	162
2007	35	1,877	3,524	6	258	419	3	114	200
2008	33	1,998	3,646	6	262	422	3	120	206
2009	33	2,057	4,224	7	294	507	3	120	117
2010	33	2,075	3,443	7	300	437	3	109	128

9.5.5 Substitution Therapy

Substitution therapy was provided in 8 prisons out of the total of 10 prisons included in the substitution therapy programme (one prison less than in 2009); the therapy was used by 67 prisoners (the same figure as in 2009). A total of 22 persons terminated substitution therapy in 2010 for various reasons (e.g. breaking the rules, end of their prison term or remand period); see Table 9-14. For details on substitution treatment in prison see the section on Opiate Substitution (p. 144) in the chapter on the relevant selected issue.

Table 9-14: Prisons providing substitution therapy, number of persons in therapy, and average duration of therapy in 2010 (Generální ředitelství Vězeňské služby ČR, 2011c).

Prison	Number of persons	Average duration of therapy in months
Brno	11	11.0
Břeclav	0	–
Kuřim	7	19.5
Litoměřice	10	4.8
Opava	5	6.0
Ostrava	0	–
Prague-Pankrác	15	8.3
Prague-Ruzyně	1	1.0
Příbram	16	6.5
Rýnovice	2	4.0
Total	**67**	**7.6**

9.5.6 Prevention and Treatment of and Care for Infectious Diseases

According to information from the Health Service Department of the Prison Service, a total of 10 persons underwent antiviral HBV treatment, 56 underwent HCV treatment, and 10 underwent antiretroviral HIV treatment in the second half of 2010 (Generální ředitelství Vězeňské služby ČR, 2011d). For additional information about the results of the diagnostic testing for the markers of viral hepatitis and HIV see the chapter on Prevalence of Infections among Drug Users (p. 87).

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

Care for imprisoned drug users was complemented by the services provided by 15 NGOs. They collaborated with 32 prisons in 2010. The Ministry of Justice subsidised five projects, which were carried out by four NGOs (*Podané ruce* association, *Semiramis*, SANANIM, and CPPT) in 2010. In addition to these four NGOs, the *Laxus* and White Light I civic associations were strongly involved in working with drug users. A summary of interventions provided by NGOs and the prisons visited is provided in Table 9-15 (Generální ředitelství Vězeňské služby ČR, 2011c).

9.5.8 Reintegration of Drug Users after Release from Prison

Overdose prevention programmes are only pursued in the form of providing information to the person concerned on their release from prison. Post-penitentiary care and the reintegration of drug users released from prison are also a part of the services provided in the prisons by non-governmental organisations.

Table 9-15: NGOs providing drug services in prison, prisons where these NGOs operate, and number of visits and interventions carried out in 2010 (Generální ředitelství Vězeňské služby ČR, 2011c).

Non-governmental organisation (NGO)	Prisons and remand centres	Number of visits
Semiramis (Nymburk)	Jiřice, Rýnovice, Stráž pod Ralskem, Bělušice, Horní Slavkov, Ostrov (6)	141
Podané ruce (Brno, Olomouc)	Brno, Kuřim, Znojmo, Rapotice, Olomouc, Mírov (6)	303
White Light I. (Ústí nad Labem)	Všehrdy, Teplice, Nové Sedlo, Litoměřice (4)	13
SANANIM (Prague)	Prague-Pankrác and Prague-Ruzyně, Vinařice, Opava (4)	52
Laxus (Hradec Králové)	Hradec Králové, Pardubice, Světlá n/Sázavou, Valdice, Odolov (5)	138
CPPT (Pilsen)	Pilsen (1)	39
6 NGOs listed – total	**26**	**686**
9 additional NGOs	6	21
All NGOs – total	**32**	**707**

10 Drug Markets

Marijuana and pervitin were the two most widely available drugs in 2010, and a trend of cocaine becoming increasingly popular and available was noted. The price and purity of the basic drugs have generally remained stable, even though there have been certain fluctuations in recent years as far as the price (e.g. of cocaine or ecstasy) or purity (e.g. of hashish, ecstasy, or heroin) are concerned.

Most of the marijuana grown was intended for the domestic market. A part of the indoor production of cannabis is well organised and mainly operated by persons of Vietnamese descent. A total of 278 kg of marijuana and nearly 65 thousand cannabis plants were seized, twice the number of cannabis plants seized in 2009. The number of cannabis plantations detected is also increasing – 145 of them were detected.

Pervitin is mainly made by domestic producers in low-volume home-based laboratories. However, large-scale production of pervitin is becoming more common and is mainly run by organised groups of Vietnamese or Albanian descent. Pervitin is mostly made from medicines containing pseudoephedrine, which are mainly imported from Poland. The drug is predominantly intended for the domestic market; a low proportion of the production is intended for export, e.g. to Germany. A total of 21.3 kg of pervitin were seized, the highest quantity in the past 4 years, and 307 cooking labs were discovered.

Cocaine has become an established drug, mainly in the recreational and nightlife settings. Its import and distribution are mainly pursued by West Africans (predominantly Nigerians), in addition to Albanians, Romanians, and Bulgarians. The drugs are smuggled in the body cavities of the couriers (swallowers). The couriers import cocaine directly from South America or from Western European countries. The number of seizures and the quantity of cocaine seized have been increasing since 2008; in 2010 a total of 42 seizures of a total quantity of 14.2 kg of cocaine were reported.

The demand for heroin on the Czech market is satisfied through small shipments (of under 10 kg), which are diluted (most typically with paracetamol and caffeine) before street sale. The purity of street heroin was between 5 and 10%. The quantity of heroin seized and the number of seizures remain stable: 20–40 kg are seized in 50–100 seizures per year.

New synthetic drugs (legal highs) appeared increasingly in the Czech Republic in 2010. They are substances whose effects are similar to those of traditional drugs (pervitin, marijuana, ecstasy, hallucinogens, etc.) but which are not scheduled as illicit substances and, as such, are not subject to the international and national drug control systems. They are imported especially from Asia (China) and mainly include synthetic cannabinoids and cathinone derivatives.

10.1 Availability and Supply

Information provided by the National Drug Headquarters of the Police of the Czech Republic and the General Customs Headquarters (specifically the Customs Drug Unit) represents the basic sources of data regarding the availability, production, smuggling, and distribution of drugs on the territory of the Czech Republic (Národní protidrogová centrála SKPV Policie ČR, 2011b); (Národní protidrogová centrála SKPV Policie ČR, 2011c; Celní protidrogová jednotka , 2011).

The drug market in a specific territory inherently combines domestic production, foreign trade (imports and exports), and consumption. No estimates were made of drug consumption in the Czech Republic in 2010. By way of illustration of the context of the drug markets in 2010, the estimates made in 2008 can be quoted, according to which almost 19 tonnes of cannabis, 4.7 million tablets of ecstasy, and 1 million doses of LSD were consumed in the Czech Republic. 550 kg of cocaine with an average purity of 70% were imported into the Czech Republic and almost 1 tonne of the drug with an average purity of 45% reached the end users. In addition, 4.2 tonnes of pervitin with an average purity of 80% were produced but the drug is usually cut and its purity for street sale or export is reduced to 70%. A total of 4.4 tonnes of the drug are estimated to have been consumed in the Czech Republic. 330 kg of heroin with an average purity of 40% were imported into the Czech Republic but the purity on the market was only approximately 10% and 1.3 tonnes of the drug were consumed on the Czech market; for details see the 2009 Annual Report.

Most of the marijuana grown in 2010 was intended for the domestic market. There has been an increase in the indoor cultivation of cannabis with a high THC content (8–18%) since 2005. It was confirmed in 2010 that a part of the growing operations in large-scale indoor plantations in the Czech Republic is relatively well organised and mainly pursued by persons of Vietnamese descent, who are also active in the area of importing the cultivation technologies, especially from the Netherlands and the United Kingdom. Most of the plantations discovered in 2010 (a total of 145, compared to 84 plantations detected in 2009) were operated by individuals of Vietnamese descent, and most of the production of these large-scale plantations was exported, in particular to Germany and other Western European countries.

Supported by the National Focal Point, the Centre for Addictology conducted the first stage of data collection for the study Marijuana Markets in the Czech Republic – Different Drug Policy Approaches (Běláčková and Zábranský, 2010), which aimed at describing the structure of the marijuana market in the Czech Republic. A total of 61 semi-structured interviews and one focus group were conducted. The research sample consisted of 61 persons, 17 of whom had only used (not grown or sold) cannabis, 27 had been users and growers, 13 had dealing experience, and 4 were police officers or other persons. The findings showed that it was very easy to obtain marijuana for 83% of the respondents[118]. The findings of the study show that the average price of 1 gram of marijuana has dropped in the last decade from CZK 250 (€ 10) to CZK 200 (€ 8), most probably as a result of two factors: the expansion of large-scale plantations organised by persons of Vietnamese descent and the spread of indoor growing at home, the surplus from which is often placed on the market – that means, among other consequences, that the proceeds are lower for marijuana dealers, which is also what was reported by the respondents. The prices and volumes of sales at the individual levels of the market are provided in Table 10-1.

Table 10-1: Structure of the marijuana market – quantities sold and selling prices (Běláčková and Zábranský, 2010)

Respondent category	Quantity sold (g) in a single transaction	Selling price (€) per gram when sold in specified quantity
Indoor grower	200–2,000	3–5
Trafficker	200–500	4–6
Dealer on a closed market	20–500	5–7
Dealer on a semi-open market	1–30	5–8
Dealer on an open market	1–10	8–10

According to the respondents, outdoor cultivation involves a danger of theft, and the growers therefore often switch to indoor cultivation. It is common practice to grow cannabis at another person's place because the cultivation of up to 5 cannabis plants is considered "only" a misdemeanour, and the users thus do not expose those who grow cannabis for them to prosecution. Indoor growers usually covered their costs of cultivation by selling a part of their produce; they most typically used intermediaries, who purchased larger quantities of cannabis so as to minimise the number of contacts with the end user and the inherent risk for the grower. On the contrary, some growers maximised their profit by selling smaller quantities of cannabis directly to the end users. These persons pursued no other criminal activities than the illicit sale of marijuana. The respondents mentioned the possibility of purchasing marijuana on the open drug scene or in certain bars, especially in Prague, but a more common scenario involved a purchase made on a semi-open market, i.e. through an acquaintance or a dealer who had been introduced to the user before and whom the user contacted by telephone. A number of heavy users purchased larger quantities of marijuana and distributed it among their friends and acquaintances with little or no profit. In terms of subjective perception, the quality of marijuana in the period concerned tended to both increase (because of the placing of the surplus of individuals' produce on the market) and decrease (especially in the case of cannabis grown in large-scale plantations, which all the respondents considered low-quality and dangerous to health) (Běláčková and Zábranský, 2010).

Pervitin is made by domestic producers (who are usually also the users), especially in low-volume home-based laboratories – a total of 307 cooking labs were detected in 2010. A trend of relocating the pervitin laboratories from larger cities to more remote areas (e.g. small villages or recreational sites) to reduce the risk of detection has been observed. There is also a trend of increasing high-volume production of pervitin, which is mainly run by organised groups of Vietnamese or Albanian descent.[119]. The pervitin is mainly intended for the domestic market, in which Roma are involved in certain regions (e.g. the South Bohemia, Pilsen, and Karlovy Vary regions). A lesser part of the pervitin production is to be exported; there has been a significant increase in drug tourism by German nationals to North-west Bohemia, where pervitin is produced in large volumes for export purposes, especially by individuals of Vietnamese descent. The price of the drug is EUR 35–40 per gram. In 2010, quantities of over 2 grams of pervitin were seized from 84 persons in Germany, 75 of whom had their permanent residence in Germany and were each exporting 11 grams of pervitin from the Czech Republic on average. Random checks conducted as part of the so-called "veil searches" on the German side of the border resulted in the seizure of approximately 2 kg of pervitin in total (Národní protidrogová centrála SKPV Policie ČR, 2011a); a half-year comparison of the seizures in Germany shows an increase of over 500% in the quantity of pervitin seized in 2010 and 2011 during the same number of checks.

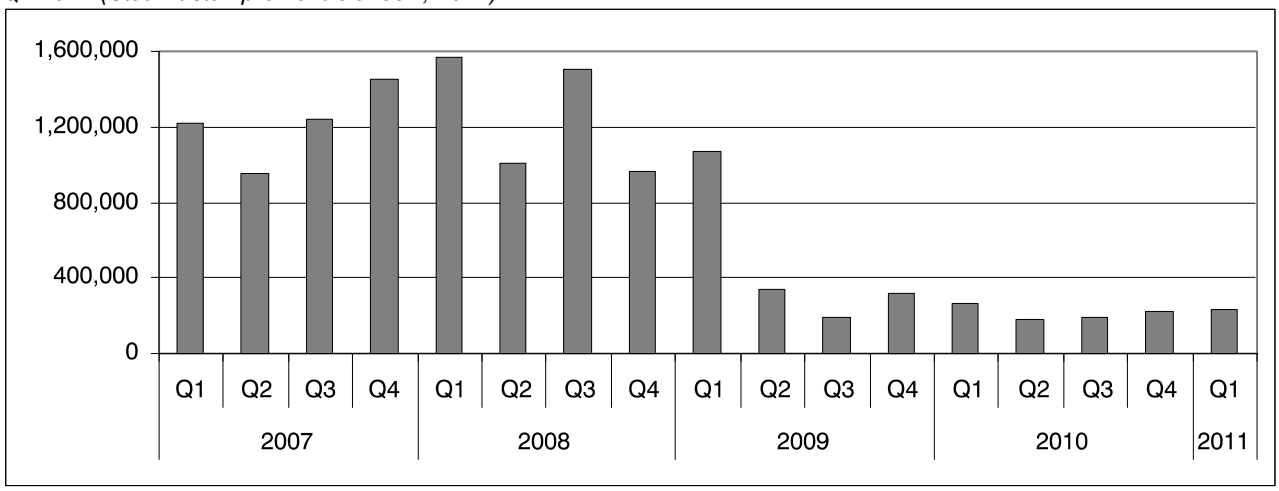
Pervitin is made almost exclusively from medicines containing pseudoephedrine, but ephedrine is regaining its importance. Because their dispensation is controlled in the Czech Republic, medicines containing pseudoephedrine are primarily imported from Poland, where they are purchased in pharmacies near the border. Imports of these

[118] The easy availability of marijuana is reported by 20% of the respondents from the general population and 58% of those who have used the drug in the past year (Běláčková and Horáková, 2011).

[119] Even the 2010 Annual Report of the Security Information Service (BIS) mentions the activities of "organised crime groups originating from the Balkans, especially of ethnic Albanians". According to the BIS, they mainly traffic narcotic and psychotropic substances and their activities are accompanied by attempted money laundering through investments in real estate or by gambling operations. The BIS did not observe a significant increase in the activities of these groups in 2010 – http://www.bis.cz/n/2011-09-07-vz2010cz.pdf (2011-09-08).

medicines from Germany, Slovakia, and Vietnam have also been reported. The reduced sales of medicines containing pseudoephedrine in Czech pharmacies after the control measures were introduced in May 2009 are shown in Figure 10-1.

Figure 10-1: Development of the sales of medicines containing pseudoephedrine in the Czech Republic from 2007 to Q1/2011 (Státní ústav pro kontrolu léčiv, 2011).



The supply of cocaine and demand for the drug has been increasing in the whole of Europe. Cocaine has become a common stimulant in the Czech Republic, in particular in the recreational and nightlife settings in Prague, as well as in other locations, such as Ostrava, where it is mainly distributed by Albanian-speaking persons. Its import and distribution are mainly pursued by West Africans (predominantly Nigerians), in addition to ethnic Albanians, Romanians, and Bulgarians. The drugs are smuggled in the body cavities of the couriers (swallowers). The couriers import cocaine into the Czech Republic, mainly from Western European countries such as the Netherlands, the United Kingdom, Spain, and France, but there has been an increasing number of cases of cocaine trafficking via Greece, Bulgaria, and Romania. Cocaine is often smuggled in postal consignments, where it is concealed in goods in a sophisticated way.

As far as heroin is concerned, the Czech Republic is both a consumer and (especially) a transit country for the drug, according to the National Drug Headquarters. The importation of heroin into the Czech Republic is mainly organised by Kosovo and Macedonian Albanians. The demand on the Czech market is satisfied through small shipments (of under 10 kg), which are diluted (most typically with paracetamol and caffeine) before sale to the end users; the purity of street-level heroin is 5–10%. Tablets of the Subutex® and Suboxone® substitution preparations continue to appear on the black market and compete with heroin; see also the chapter on Opiate Substitution Treatment (p. 60). Trafficking in Subutex® and Suboxone® was reported from South Bohemia, among other regions. Opiates are most commonly trafficked in Prague, where persons from the Roma community are also involved in the distribution of heroin and Subutex®, dealing these substances within this ethnic group. Both ethnic Roma and Vietnamese participate in the distribution of heroin in the South Moravia, Zlín, and Vysočina regions.

According to the available data, ecstasy is not produced in the Czech Republic and is instead imported, mainly from the Netherlands, Poland, and Slovakia. This most commonly involves individual imports of dozens (up to hundreds) of tablets by means of public international surface and air transport. In the Czech Republic, ecstasy is subsequently sold at open-air festivals, in music clubs, and at rock concerts and dance parties. However, ecstasy has become scarcer on the drug market because of the low demand, which is mainly caused by the fact that ecstasy tablets contain mostly mCPP rather than MDMA and its derivatives. Ecstasy is usually imported to the regions by seasonal workers coming to work; this mainly concerns people from Poland and Slovakia. Compared to the previous year, the price of ecstasy tablets dropped significantly, and there have even been cases reported of one tablet being sold for CZK 20 (€ 0,8).

10.1.1 New Drugs on the Czech Drug Scene

An increase occurred in the Czech Republic in 2010 in terms of the occurrence of substances referred to as legal highs, new drugs, new synthetic drugs, or designer drugs (NSDs). They are synthetic substances whose effects are similar to those of traditional drugs (pervitin, marijuana, ecstasy, hallucinogens, etc.) but which are not scheduled as illicit substances and, as such, are not subject to the international and national drug control systems. These NSDs are predominantly imported from Asian countries. They are mostly synthetic cannabinoids, i.e. a group of substances identified as, for example, JWH, HU, or AM, which also occur as a part of herbal mixtures sold as aromatic agents or fumigants (referred to as Spice); there are also cathinones (e.g. mephedrone), phenetylamines (amphetamine or methamphetamine derivatives), piperazines, or herbal extracts with a purposely increased active substance content (e.g. *Salvia divinorum*). NSDs are usually sold through e-shops; a total of 21 web shops offering NSDs in Czech or with a Czech domain name were identified in May and June 2011 (Kmetonyová, 2011). The offer of some of them

was rather bizarre. For example, the website http://mefedron-info.cz/ offered mephedrone as a cleaning agent in addition to drilling systems; see Figure 10-2.

Figure 10-2: Home page of the website http://mefedron-info.cz/ (image from 18 February 2011)

Between the end of 2010 and April 2011, the sale of legal highs also became widespread through bricks-and-mortar shops, which were often combined with e-shops. The drugs were especially sold in larger cities or towns near the Polish border, where the business activities associated with NSDs were moved after the sale of NSDs became controlled in Poland (Národní protidrogová centrála SKPV Policie ČR, 2011b). The businesses presented legal highs as collectables or gifts in order to evade the legislation aimed at controlled substances, consumer protection, or the safety of foodstuffs or other goods whose production and/or sale are regulated by law. The so-called Amsterdam Shop network is a typical representative of such retail outlets; see Figure 10-3.

Figure 10-3: Amsterdam Shops in Český Těšín and Havířov at the end of April 2011 (currently closed)

At the end of March 2011, the Police of the Czech Republic had registered 20 regular stores offering NSDs in 11 Czech towns and cities; they were most commonly found in North-east Bohemia and in the Moravia-Silesia Region (most shops were registered by the police as located in Ostrava, Český Těšín, Opava, and Pardubice). These shops received significant attention from the media, the public and, subsequently, politicians at both the local and national levels, who started calling for swift action against the over-the-counter sale of legal highs. An amendment to Act No. 167/1998 Coll. on addictive substances was quickly prepared, discussed, and passed by the Parliament to extend the list of narcotic and psychotropic substances by 33 new substances (mainly those which belong to the above-mentioned groups of substances detected in the Czech Republic). The amendment came into force on 22 April 2011; for details see the chapter on Legal Framework (p. 6).

A number of studies were conducted in connection with the phenomenon of the occurrence and retail sales of new synthetic drugs (legal highs) in early 2010: a questionnaire survey among the regional and local coordinators and local drug experts regarding the sale of NSDs in regular shops (Národní monitorovací středisko pro drogy a drogové závislosti, 2011a); a questionnaire survey among internet users regarding the use of NSDs and the market practices associated with them (Národní monitorovací středisko pro drogy a drogové závislosti and Median, 2011a); a survey

conducted directly in and near the regular shops which offered the legal highs (Národní monitorovací středisko pro drogy a drogové závislosti and Median, 2011b), and a survey as part of a bachelor's thesis named The Possibilities of Regulating the Market in the So-Called 'Designer Drugs' (Turek, 2011). These studies explored the extent of the use of NSDs among the general population, the practices of the users in the area of the use and purchasing of NSDs, and the opinions of various respondent groups (sellers, customers, local authorities and citizens, and drug experts) regarding the issue of NSDs.

The questionnaire survey conducted by the National Focal Point among 156 coordinators and local experts showed that before April 2011, retail outlets selling legal highs were found in almost all the regions of the Czech Republic except the South Bohemia, Pilsen, and Zlín regions; they were situated in 24 towns and cities, especially in the Moravia-Silesia, Pardubice, and Karlovy Vary regions. The total number reported could reach up to 40 shops in the entire Czech Republic; see Table 10-2.

Table 10-2: Shops selling new synthetic drugs (legal highs) in the Czech Republic in April 2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2011a)

Region	Total number of respondents	Aware of a shop	In cities/towns	Most commonly reported number of shops in the region	Maximum reported number of shops in the region
Prague	6	4	Prague 1, 3	2	2
Central Bohemia	8	1	Mladá Boleslav	1	1
South Bohemia	14	0	–	–	–
Pilsen	1	0	–	–	–
Karlovy Vary	16	8	Karlovy Vary, Kynšperk nad Ohří	2	3
Ústí nad Labem	4	1	Teplice	1	1
Liberec	9	5	Liberec	3	4
Hradec Králové	10	5	Hradec Králové, Náchod	1	3
Pardubice	15	12	Pardubice, Chrudim	2–3	6
Vysočina	0	0	–	–	–
South Moravia	9	3	Brno	2	3
Olomouc	9	7	Olomouc, Jeseník	1	3
Zlín	8	0	–	–	–
Moravia-Silesia	46	35	Ostrava, Český Těšín, Frýdek-Místek, Opava, Havířov, Bohumín, Orlová, Karviná, Bruntál, Třinec, Krnov	1–2	15
Total	155	81	24 cities/towns	17	41

According to the respondents, the shops concerned were mainly of the Amsterdam Shop/smart shop type (89 responses), shops selling growing supplies (13 responses), tobacconist's shops (7 replies), shops selling ethnic goods (5), and other shops (7).

The results found across all the studies showed that legal highs were purchased and used especially by younger people aged 15–35 or even 15–24, who were predominantly experimenters. However, problem drug users were also reported to be among the target groups of the shops. The motivation for the purchase was the ready availability of NSDs and their low price, legality, and the consequent feeling of safety. The customers of these shops mostly used the NSDs they purchased in a group with their friends; they had learnt about the NSDs from their friends or chose them according to the product's name. The NSDs were most commonly sold in powder form or as herbal mixtures (Mefedron, El Padrino, Amsterdam, Rotterdam, and Kokolino were the most common products), but their composition and the concentration of the active substances mostly remained unknown to the customers; see also the chapter on Use of New Synthetic Drugs (p. 32).

The shop assistants in the bricks-and-mortar shops mostly operated as intermediaries who only accepted the money and released the goods. The e-shops provided at least the basic information about the substances and, in approximately half of the cases, also information about the composition and effects of the products. The shop assistants in the regular shops often emphasised the collector's nature of the items being sold, thus waiving any responsibility for any use of the NSD by the buyer. In some cases the shop assistants declared that the products could only be sold to persons over 18 years of age.

The customers were mostly satisfied with the operation of the shops. The prevailing opinion among the customers, the local community, and local authorities was (to a varying degree) that these shops should be regulated or even

shut down by the authorities. The local citizens were rather passive but shared their concerns regarding further developments. The media reported on the situation, which resulted in two effects: promotion (of the sale of NSDs) and prevention (spreading information about their potentially negative effects).

The local authorities and the Police of the Czech Republic mostly only monitored the situation by April 2011 and the Czech Trade Inspectorate ordered the removal of certain products from the market because of their non-compliant identification, but no systematic solution to the uncontrolled sale of NSDs had been found before the coming into force of the amendment to the Addictive Substances Act, i.e. before the most common NSDs became illegal. As early as on the day on which the amendment concerned came into force, the police conducted a large-scale operation against the shops selling NSDs across the entire Czech Republic. Most of the shops, however, had been closed or had suspended their operations by then.

The information obtained by the National Focal Point through a query to the regional and local drug coordinators in August 2011 showed that there were retail outlets offering new synthetic drugs (legal highs) in at least three Czech towns and cities at the time. They were located in Hradec Králové, Trutnov, and Karlovy Vary, where the shops supposedly sold mixtures and supplies for smokers and other gift items and souvenirs and, under the counter, also NSDs. New synthetic drugs (legal highs) were offered in August 2011 by a number of websites, which often stated that the substances were not controlled in the Czech Republic (such as modified mephedrone on the website http://mefedron-info.cz/). There is a reason for concerns that the retail sales of NSDs in the Czech Republic will resume to one degree or another after other NSDs which are not included in the schedules to the Addictive Substances Act are introduced to the Czech market.

Information released by the police in June 2011 suggests[120] that fentanyl was distributed in the Czech Republic (specifically, in the Moravia-Silesia region) in late 2010. It was a white powder, in which fentanyl was cut with paracetamol and caffeine. The mixture was distributed under the name Vlacho, most probably by a group of Wallachian (Olah) Roma. A total of 3 kg of the drug were seized. Two deaths resulting from an overdose with the presence of fentanyl were identified in the Czech Republic in 2010; for details see the chapter on Drug-Related Deaths and Mortality of Drug Users (p. 95). Because of the high potency of fentanyl, its occurrence on the black market is associated with an increased risk of overdose.

10.2 Seizures

The data on drug seizures represent seizures made by the Police of the Czech Republic and the Customs Administration of the Czech Republic (specifically the Customs Drug Unit). Seizures which involved multiple types of drugs are always included separately in the individual drug types; the total number of seizures was therefore lower than the sum of all the seizures by drug type.

Marijuana was the drug that was most frequently seized in 2010. The yearly number of marijuana seizures in the four previous years (2007–2010) was between 550 and 600. A total of 278 kg of marijuana were seized in 2010. A total of nearly 65 thousand cannabis plants were seized in 189 seizures, twice the number of cannabis plants seized in 2009. The number of cannabis plantations detected is increasing; a total of 145 were discovered in 2010 (compared to 84 in 2009). The number of hashish seizures was relatively stable in 2007–2010, reaching approximately 30–40 a year; Table 10-3. In 2010, the Customs Drug Unit reported 80 seizures of marijuana with a total quantity of 37 kg. A half of the seizures were of postal consignments, most commonly being sent via air mail to the United Kingdom or Ireland. The Customs Drug Unit also performed 18 seizures of a total of 0.5 kg of hashish – most of the postal consignments in which the hashish was placed was being sent to the Czech Republic from Spain or the Netherlands by air mail. The largest seizure of cannabis which the Customs Drug Unit performed took place inland – a total of 9 kg of marijuana was hidden in a vehicle travelling from the Czech Republic to Austria.

With 283 seizures, pervitin remains the second most commonly seized drug. Approximately 300–400 seizures annually were reported in the last four years. The quantity of 21.3 kg of pervitin seized in 2010 is the highest figure in the past four years. A total of 307 cooking labs were detected, corresponding with the average of 300–400 labs detected annually in the past four years. The Police of the Czech Republic and the Customs Drug Unit seized large volumes of medicines containing pseudoephedrine, which is the dominant pervitin precursor; the increase is significant (309,176 tablets seized in 2010 compared to 42,285 tablets of medicines containing pseudoephedrine seized in 2009). There was a marked decrease in the quantity that was seized of medicines containing pseudoephedrine which are distributed in Czech pharmacies (Modafen®, Nurofen® StopGrip, Panadol® Plus Grip, Paralen® Plus) and, on the contrary, an increase in the number of seizures of medicines imported from Poland (especially of Sudafed® and Acatar®, which contain 60 mg of pseudoephedrine in a single tablet, i.e. double the amount found in the preparations sold over the counter in the Czech Republic). According to the Customs Drug Unit, the typical pattern of the importing of such medicines is the following: one person purchases larger quantities (of up to several kilograms) of medicines containing pseudoephedrine in Poland, imports them to the Czech Republic, and distributes them to the producers of pervitin. The Customs Drug Unit also seized a significant quantity of ephedrine in

[120] See also http://www.policie.cz/clanek/tiskova-zprava-z-operace-fent.aspx (2011-08-24)

2010 (5835 g of ephedrine and 150 thousand tablets containing ephedrine), i.e. of another important pervitin precursor; see Table 10-3 and Table 10-4.

The number of seizures and the quantity of cocaine seized have been increasing since 2008; in 2010 a total of 42 seizures of a total quantity of 14.2 kg of cocaine were reported. The Customs Drug Unit reported 11 seizures of a total of 13.1 kg of cocaine (compared to 8.1 kg in 2009) smuggled in body cavities (by the so-called swallowers), in garments, luggage, and postal consignments. Cocaine was most often smuggled from South America by air.

As far as heroin is concerned, the number of seizures and the quantity seized remain relatively stable, reaching approximately 50–100 seizures of 20–40 kg annually. The Customs Drug Unit reported two seizures of a total quantity of 10 kg of heroin in 2010, with the largest shipment being transported in luggage by air from Libya via the Czech Republic to Denmark.

Table 10-3: Number of seizures and quantities of main drug types seized in 2007–2010 (Národní protidrogová centrála SKPV Policie ČR, 2011d; Národní protidrogová centrála SKPV Policie ČR, 2011c).

Drug type	2007		2008		2009		2010	
	Number	Quantity	Number	Quantity	Number	Quantity	Number	Quantity
Marijuana (g)	563	122,124	602	392,527	384	171,799	455	277,988
Pervitin (g)	374	5,978	405	3,799	326	3,599	283	21,301
Heroin (g)	96	20,332	105	46,302	73	31,257	61	30,453
Cannabis plants (no.)	46	6,992	69	25,223	117	33,427	189	64,904
Hashish (g)	25	387	30	696	41	12,499	27	9,354
Ecstasy (tablets)	30	62,226	18	16,610	13	198	16	865
Cocaine (g)	38	37,587	24	7,631	26	12,904	42	14,162
LSD (doses)	5	117	5	246	5	142	8	1,218

Table 10-4: Seizures of pervitin precursors, pervitin cooking labs, and pervitin in the period 2007–2010 (Národní protidrogová centrála SKPV Policie ČR, 2011c).

Seizures	2007	2008	2009	2010
Ephedrine (g)	1,185	1,677	6,023	8,152*
Pseudoephedrine (g)	218	–	–	2,179
Modafen® (tablets)	3,480	7,876	840	3,356
Nurofen® StopGrip (tablets)	11,948	21,785	876	0
Panadol® Plus Grip (tablets)	72	17,021	1,224	0
Paralen® Plus (tbl.)	–	–	1,440	144
Acatar® (tablets)	–	–	3,508	26,924
Cirrus® (tablets)	–	–	6	68
Ibuprom® (tablets)	–	–	22,080	551
Sudafed® (tablets)	–	–	12,231	278,133
Cooking labs	388	434	342	307
Pervitin (g)	5,978	3,799	3,599	21,301

*Note: * Plus 15 thousand tablets containing ephedrine.*

The breakdown of the seizures for 2010 by weight shows that almost two thirds of the marijuana seizures involved quantities less than 100 grams, with most of the seizures (153) being of quantities under 15 grams. There were 48 (11%) seizures of quantities exceeding 1 kg each, with 6 seizures being of more than 10 kg each. As far as cannabis plants are concerned, 18 seizures (10%) involved five plants or fewer; seizures of 6–50 plants accounted for 97 seizures (50%); 14 seizures (7%) concerned quantities of over 1,000 plants, and 4 seizures involved over 3,000 plants. For hashish, 81% of the seizures were of quantities less than 50 grams, with the largest seizure being of 8.8 kg. 85% of the pervitin seizures involved less than 50 grams of the drug, mostly (100 seizures) in the category of under 2–10 grams; the two largest amounts of pervitin that were seized weighed 3.2 kg combined. As far as cocaine is concerned, most seizures (11) were of quantities of 11–50 grams, and the largest seizure was of 6 kg of the drug. For heroin, 80% of the seizures involved less than 50 grams each; 3 seizures were of over 1 kg each, and the largest seizure was of 17 kg of heroin. All the seizures of ecstasy (16) were of quantities of 300 tablets or less, with 11–50 tables being seized in the largest number of seizures (7) (Národní protidrogová centrála SKPV Policie ČR, 2011c)

10.3 Price/Purity

Until 2009, information about the prices of the basic types of drugs in the Czech Republic was determined according to estimates provided by the regional headquarters and territorial departments of the Police of the Czech Republic to the National Drug Headquarters. From 2010 on, the information has been based on the prices reported in connection with specific drug offences, provided that the information is available. Drug purity data are only available for a part of the drugs seized and are mostly obtained from the Departments for Forensic and Technical Analyses of

the regional police headquarters on a continuous basis and from the Forensic Science Institute in Prague on an annual basis.

The price and purity of most basic drugs were stable in 2010 despite certain fluctuations in price (e.g. cocaine and ecstasy) and purity (e.g. hashish, ecstasy, and heroin). However, the data provided below have a limited informative value because the number of samples on the basis of which the price and purity figures are determined is rather low in some cases and because the statistical evaluation of the purity combines drug samples from high-volume seizures of a drug with a higher concentration of the active substance with samples of the drug from the street level of the drug market, where the purity is lower; see Table 10-5 and Table 10-6.

Table 10-5: Average and most commonly reported (modus) prices of drugs in 2007–2010 (€) (Národní protidrogová centrála SKPV Policie ČR, 2011d).

Drug type	**2007**		**2008**		**2009**		**2010**	
	Average	Modus	Average	Modus	Average	Modus	Average	Modus
Marijuana (g)	7	4	7	8	8	9	8	10
Hashish (g)	10	8	9	9	10	11	9	10
Ecstasy (tablets)	8	8	8	8	8	9	8	10
Pervitin (g)	43	38	43	38	49	38	51	40
Heroin (g)	42	38	41	38	48	38	51	40
Cocaine (g)	78	76	76	76	73	95	79	79
LSD (doses)	7	8	7	4	8	8	8	8

Note: Prices rounded to €. 2010 average exchange rate was used (1 € = CZK 25.290).

Table 10-6: Average drug purity in 2007–2010, in % (Národní protidrogová centrála SKPV Policie ČR, 2011d).

Drug type	**2007**		**2008**		**2009**		**2010**	
	Number of samples	Average purity (%)	Number of samples	Average purity (%)	Number of samples	Average purity (%)	Number of samples	Average purity (%)
Marijuana	177	4.7	404	5.5	289	8.1	391	7.7
Hashish	2	8.1	5	5.2	3	15.9	8	9.3
Ecstasy*	31	27.4	20	17.5	6	3.4	9	15.3
Pervitin	123	66.4	145	64.3	144	68.1	160	64.4
Heroin	31	17.4	47	22.6	57	16.6	51	24.6
Cocaine	48	49.1	35	43.5	21	33.1	35	27.9

*Note: * The average purity of ecstasy tablets is expressed as the average quantity of MDMA in milligrams in one tablet containing MDMA.*

PART B: SELECTED ISSUES

Selected issues are included in the Annual Report every year. The topics are set by the *EMCDDA* in cooperation with the focal points in the individual Reitox countries with regard to the topics' relevance and the research needs. Since last year all the countries have been required to prepare chapters on at least two selected issues, one of which is mandatory (this year it is the Drug-Related Health Policies and Services in Prison), and one is selected from two options offered. As last year, the Czech National Focal Point has chosen to cover all three selected issues.

11 Drug-Related Health Policies and Services in Prison

This chapter provides an overview of the drug policies and services regarding drug users in the prison system of the Czech Republic in the general context of healthcare for the prisoners, thus complementing the information provided in the regular chapters on Drug Use in the General Population and Specific Targeted Groups (p. 28), Health Correlates and Consequences of Drug Use (p. 83) and mainly Drug Use and Problem Drug Use in Prisons (p. 125) and Responses to Drug-related Health Issues in Prisons (p. 128).

The percentage of drug users is significantly higher in the prison population than in the general population. This mainly concerns the prevalence of so-called problem drug users: while in the general population of the Czech Republic, the problem users account for 0.5% of the adult population, they form an estimated one tenth to one quarter of prisoners; for details see the chapter on Drug Use and Problem Drug Use in Prisons (p. 125).

Problem drug use is viewed from several perspectives in penitentiary practice. Drug use is a health risk that poses a danger not only to the individual concerned but also to their surroundings. It is also a considerable safety risk. Drug use is also seen as a criminogenic risk; it is considered a factor that makes an individual more prone to reoffending after the individual is released from prison. According to the authors of an original Czech tool for the assessment of the risks and needs, drug use among the Czech prison population is also a dynamic risk factor which correlates very significantly to the risk of repeated offending (Buriánek et al. 2010).

The basic data about the Prison Service of the Czech Republic are published annually in the Statistical Yearbook of the Prison Service (Generální ředitelství Vězeňské služby ČR, 2011b). The Prison Service is an armed security force, an administrative authority, and an accounting entity. It is headed by the General Director of the Prison Service, who is appointed and removed by the Minister of the Interior. The Prison Service operates a total of 36 prisons and remand centres, two of which include facilities for security detention (the general term prison is used below). The prisons are headed by governors, who are appointed and removed by the General Director of the Prison Service. Divided into departments and individual units, the General Directorate of the Prison Service is the expert body for the management, organisation, and control of the Prison Service and for supporting tasks in the area of public administration in the prison system. The competence of the departments of the General Directorate includes, among other tasks, guidance and supervision regarding the activities of the specialised sections of the individual prisons and the drafting of internal guidelines.

Remand orders are served both in the conventional cell-based regime and in a mitigated regime. Depending on the level of external and internal security, the prisons where prison sentences are served are divided into four basic types: minimum-security (A), medium-security (B), high-security (C), and maximum- security (D) prisons. In addition to these basic types of prison, there are special prisons for juveniles. Departments with various degrees of security may be established within a single prison. The Health Service provides healthcare to the employees and officers of the Prison Service, as well as to the prisoners. The Health Service includes the following: the Health Service Department of the General Directorate of the Prison Service, the head physicians of the individual health areas (see below), the health centres of the individual prisons, and prison hospitals. The Training Institute of the Prison Service is the agency's educational facility and its objective is to enhance the expertise of the employees and the training of the officers of the Prison Service.

The operations of the Prison Service are governed by the following laws and regulations: Act No. 555/1992 Coll. on the Prison Service and Court Guard Service of the Czech Republic; Act No. 169/1999 Coll. regarding the serving of prison sentences; Act No. 293/1993 Coll. regarding remand; Act No. 129/2008 Coll. regarding the serving of security detention; Decree of the Ministry of Justice No. 345/1999 Coll. laying down the rules for the serving of prison sentences, and Decree of the Ministry of Justice No. 109/1994 Coll. laying down the rules for remand. The Prison Service and Court Guard Service Act specifies certain tasks for the Prison Service concerning healthcare and the way prisoners should be dealt with, in particular:

- provide healthcare to persons on remand or serving their prison sentence or security detention sentence, as well as to the officers and employees of the Prison Service (where needed, ensure specialised healthcare in external healthcare facilities);
- use prisoner management programmes (sentence plans) to affect the persons on remand or serving their prison sentence so as to support an orderly way of life for such persons after their release;

- conduct research in the area of penology and use its findings and scientific knowledge in the execution of remand and imprisonment.

Corresponding with these tasks are the objectives of the Member States articulated in the 2009–2012 EU Drugs Action Plan for the area of prisons:

- provide access to healthcare for drug users in prison;
- develop and implement drug services for people in prison equivalent to services available in the community; particular emphasis is to be placed on follow-up care after release from prison;
- introduce indicators to monitor drug use, drug-related health problems, and the delivery of drug services.

11.1.1 Personnel and Number of Prisoners

In 2010, the Prison Service had 10,447 employees, 6,599 of whom (5,833 male and 766 female) were prison officers and 3,848 were civilians (2,083 male and 1,765 female). The number of employees has been relatively stable in the past 10 years, although a slight decrease has been observed. The proportion of women among the officers is increasing gradually. A trend of the reduction of the number of civilian employees has been noted since 2003. There has been an increase in the level of education achieved by the employees of the Prison Service (approximately 1% of the employees have basic education, 78% have secondary education, and 21% hold a bachelor's or master's degree). The salaries of both the Prison Service officers and civilian employees were reduced across the board in 2011.

The number of prisoners has increased dramatically since the start of 2011. At the end of 2010, there was a total of 21,900 prisoners; the critical limit of 23,000 prisoners was exceeded in the first quarter of 2011. 101% and 117% of the accommodation capacity of the remand centres and prisons, respectively, was being used in June 2011. This development is probably due to the increased number of community service sentences being converted into prison sentences because the former were not properly served and is also attributable to the coming into force of the new Penal Code, which imposes stricter penalties for failure to start serving one's prison sentence on the date specified by the court. It is necessary to remark in this context that this increase in the number of inmates was accompanied by a reduction in the number of staff and that the budget of the Prison Service is being reduced.

11.2 Health Policies and Services in Prison

Both the act regarding the serving of prison sentences and the act regarding remand guarantee prisoners the same extent and conditions of healthcare as those available to all Czech citizens, as laid down by Act No. 20/1966 on public healthcare, subject to the limitations arising from the purpose of the prison sentence or remand. The specifics of the provision of healthcare to people in prison are further detailed by an order of the Minister of Justice, an order of the General Director of the Prison Service, and other internal regulations of the Prison Service. One of the most important specifics is the fact that prisoners are denied the right to the free choice of the physician and healthcare facility.

Healthcare for prisoners is mainly provided by the health centre of the prison where the prisoner is serving their prison sentence or is on remand or by another healthcare facility of the Prison Service – in particular, by the hospitals established in the Prague-Pankrác Remand Centre and in the Brno Remand Centre and Security Detention Facility. In terms of organisation, the prisons are divided into four health areas according to the regions, with a head physician managing each area[121]. In 2010, the Prison Service employed a healthcare staff of 450 persons, 130 of whom were physicians (converted to full-time equivalents). Some members of the healthcare staff, including physicians, are employed part-time or on the basis of a contract for work or contract for services; these physicians work *de facto* in the prison as external staff and do not, for example, participate in providing healthcare to the employees. Some of the physicians are psychiatrists who work in specialised wings where court-ordered compulsory treatment sentences are served and where these physicians provide healthcare aimed at drug addiction treatment. The number of healthcare staff per 1,000 prisoners is not monitored by the Prison Service as a healthcare indicator. With the number of 130 physicians (figure from 2010) per 23,000 prisoners (figure from Q1 2011), there would be less than 6 physicians per 1,000 prisoners.

On the proposal of a physician, a prisoner may be temporarily relocated to another prison to receive the required healthcare. If a prisoner's medical condition requires medical attention which cannot be provided in prison, such care must be arranged through an external facility; in this case, the Prison Service is to provide security or the prisoner's sentence may be interrupted for this period of time.

The provision of healthcare is associated with certain specific obligations on the part of the prisoners. For example, prisoners must not pretend health problems or purposely cause injury to their health. In addition, they must undergo initial, periodical, extraordinary, and pre-release medical examinations to the extent specified by the physician, including the necessary diagnostic and laboratory examinations and vaccination. In addition, the prisoner must

[121] The head physicians provide guidance in the provision of healthcare in their respective health areas, audit the prisoners' medical assessment and temporary incapacity for fork, and supervise the keeping of medical records and log books on behalf of the health insurance authority in their health area, including checks conducted in external healthcare facilities.

comply with the measures determined by the public health protection authorities. The medical examinations must be conducted in such a manner that no employee of the Prison Service who is not a member of the healthcare staff can hear and, unless otherwise determined by the physician, oversee the examination. The healthcare provided to prisoners is covered by the public health insurance system in accordance with Act No. 48/1997 Coll. on public health insurance. The cost of healthcare beyond the mandatory framework is to be covered by the prisoner. In addition, the prisoner must pay the extra costs incurred by the Prison Service in connection with security and transport to a healthcare facility if the person has purposely caused injury to their health or abused the healthcare system by pretending health problems.

The Prison Service also publishes the basic health indicators in its Statistical Yearbook. A total of 421,782 examinations or treatment interventions were reported for 2010 as having been provided to prisoners by general practitioners. A total of 21 HIV-positive prisoners were registered, and 51 cases of tuberculosis were found. At the end of 2009, a total of 1,376 prisoners with chronic hepatitis B were reported, 82% of whom were drug users; hepatitis C was also reported in 3,123 prisoners and drug users made up 87% of this figure (Mravčík et al. 2010). See also the chapters on Prevalence of Infections among Drug Users (p. 87) and Responses to Drug-related Health Issues in Prisons (p. 128).

11.2.1 Drug-Related Health Policies Targeting Prisoners

One of the purposes of a prison sentence is to reduce the likelihood that the individual concerned will continue to use drugs and commit equally or more serious crimes after they are released from prison. The Prison Service thus contributes to the protection of the public, including its protection against drug use-related health risks.

The Prison Service has systematically addressed the issue of imprisoned drug users since 1993, when the document Set of Drug-Related Measures in Relation to the Serving of Prison Sentences or Remand was drafted and became the basis for additional documents determining the drug policy of the Prison Service.

One of the responsibilities of the Ministry of Justice under the National Drug Policy Strategy for the Period 2010–2018 is to provide services in the area of prevention, treatment, and harm reduction for persons addicted to drugs and serving their prison sentence or on remand. The first action plan for the implementation of the Strategy, for the period 2010–2012, sets out specifies tasks for the Prison Service which were also translated into the Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2011–2012 (for details on the National Strategy and on the Action Plan see the chapter on National Action Plan, Strategy, Evaluation, and Coordination on p. 9). They are the following tasks:

- place prisoners indicated for substitution therapy in prisons which provide such treatment;
- unify the system of services provided in accordance with the treatment standards;
- refer drug users to follow-up care in the community after completing their remand period or serving their prison sentence;
- cooperate with community counselling services in the provision of services in prisons;
- distribute harm reduction material in prisons;
- diagnose and treat HIV/AIDS and viral hepatitis in prison;
- collect data regarding drug use, the abuse of medicines containing narcotic and psychotropic substances, and the consequences of the use of such substances among prisoners;
- educate professionals and other drug policy stakeholders.

At the national level, the drug policy of the Prison Service is formulated by the General Directorate of the Prison Service, within which the Imprisonment and Remand Department is the unit in charge of coordinating the drug policy. It is also responsible for the Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2011–2012 and for certain other internal regulations (e.g. the order of the General Director regarding the drug policy of the Prison Service, and the order of the General Director regarding the activities of specialised departments). In coordinating the drug policy, this department cooperates closely with, in particular, the Health Service Department (which is, for example, responsible for the substitution therapy guidelines and the drug monitoring guidelines) and the Prison Service and Court Guard Service Department (which is, for example, responsible for the order of the General Director regarding service cynology). At the level of the individual prisons, the tasks arising from the Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2011–2012 are incorporated into the internal regulations and other documents, with the involvement of drug prevention counselling centres, which are an advisory body of the governor of each prison.

The drug policy of the Prison Service is funded from the state budget chapter dedicated to the drug policy. The situation regarding the entire Prison Service, including its drug policy, was significantly affected by the reduced spending from the public budgets in 2010. A total of CZK 6.5 million (€ 257 thousand) was earmarked for the implementation of the drug policy in 2010, a significant reduction in comparison with CZK 10 million (€ 395 thousand) in 2009. The amount of CZK 2.5 million (€ 99 thousand) was allocated for 2011; see also the chapter on Economic Analysis (p. 6). Because of the cuts in funding, the Drug Policy Action Plan of the Prison Service of the Czech

Republic for the Period 2011–2012 foresees that the level of the drug policy measures achieved will be stabilised and their quality maintained.

11.2.2 Cooperation with Non-Governmental Organisations

NGOs make up the largest group of external providers of drug services in prisons; they operate in 32 of the 36 prisons. There are 15 NGOs involved, six of which provide their services in an intensive form; for details see the regular chapter on Responses to Drug-related Health Issues in Prisons (p. 128). One of the tasks arising for the Prison Service from the 2010–2012 Action Plan is to develop a methodology for the provision of drug services in prison by external providers. The Prison Service is working with the representatives of the A.N.O. Section for Drug Services in Prison to develop this methodology.

11.3 Provision of Drug-Related Health Services in Prison

Whether or not a prisoner is a drug user is identified immediately upon the commencement of their prison term or remand period during the initial medical examination, the procedure for which is defined by Order of the Minister of Justice No. 4/2008 regarding the provision of healthcare to persons on remand or serving their prison sentence, which specifies that, among other data, information about smoking and other habits, in particular alcohol or drug addiction, should be determined as part of the person's medical history. Screening tests are also performed to identify any infectious diseases. Physical somatic examinations then focus on determining any external marks of drug use (needle marks, phlegmona, or phlebitis). This information becomes a part of the medical records, which are available to the healthcare staff and to a clearly defined circle of persons but not to the expert staff members working at the prison wing (psychologist, therapist, special education professional, social worker, educator) who provide or participate in drug-related interventions. Information about drug use by the prisoner is therefore identified again, after the initial medical examination is performed, by such professionals through interviews, on the basis of which a comprehensive report on the offender is prepared[122]. The interviews are conducted separately by a psychologist, a social worker, and a special education professional. Repeated queries by various professionals may help verify the credibility of the information obtained from the prisoner. A prisoner management programme (sentence plan) is prepared on the basis of the comprehensive report; this programme includes its objective(s) and the set of corresponding activities, the performance of which becomes the obligation of the offender. The information that the prisoners provide about their drug use is used in the area of reducing the demand for drugs, as well as reducing their supply. The Prison Service is responsible for observing all the statutory conditions applicable to serving a prison sentence or remand period. It therefore uses the available legal means to enforce the prohibited production, possession, and consumption of alcohol and other drugs by offenders.

The records regarding imprisoned drug users are maintained by the healthcare centre of the relevant prison for the purposes of providing healthcare. Other information about the clients using the drug services is collected centrally at the level of the General Directorate of the Prison Service but each professional centre keeps its own records.[123] Each intervention (both individual and group) provided to a prisoner is entered in the personal records but a general and centralised overview of the interventions provided in the individual professional centres is still lacking. The Prison Service is currently addressing the issue seriously – an instrument is being developed for the keeping of centralised records of the activities and other facts regarding the implementation of the drug policy. However important the various combined statistics are, it is necessary to ensure that the staff delivering the drug-related services in prison are not overloaded with excessive record-keeping tasks and that the records are not kept at the expense of the provision of such services to the offenders.

11.3.1 Services Provided to Drug Users in Prisons

As a standard, the comprehensive report is used to give each prisoner a choice from the options offered by the prisoner management programme. The activities of the management programme are divided into work, educational, special educational, and leisure activities. The prisoner can therefore choose to participate in various regular activities aimed at drug-related prevention, among other factors. These activities are most typically conducted in groups but the individual form is also common. The drug prevention counselling centre is usually in charge of providing the prisoners with information about the individual drug-related activities in the prison concerned.

Services for drug users are predominantly provided through dedicated professional centres, which include specialised wings for court-ordered compulsory treatment and specialised wings where persons with a personality or behavioural disorder caused by substance abuse serve their sentences (voluntary treatment departments); these dedicated treatment departments are therapeutic centres in their nature and they apply the principles of a therapeutic community in their practice. In addition, the specialised professional centres also include drug prevention counselling centres and drug-free zones. Other healthcare services for drug users include substitution therapy and detoxification.

[122] The comprehensive report is the summary of the findings of the psychological, educational and, if applicable, medical assessments and of other available documents regarding the prisoner; the content of the report is confidential.

[123] It is the task for the period 2011-2012 to determine the monitored indicators for clients using the drug services and to set up their integrated records within the Prison Service as a whole.

Detailed information regarding the number and capacity of the individual professional centres and the numbers of clients is provided in the chapter on Responses to Drug-related Health Issues in Prisons (p. 128).

11.3.1.1 Voluntary Treatment Departments

Voluntary treatment departments exist in seven prisons and they are all intended for male inmates. The target group of these departments includes incarcerated problem drug users, who often suffer from a mental disorder. There are also offenders who have been ordered to undergo compulsory treatment by the court. However, their stay here is voluntary – it does not have the status of compulsory treatment. The prisoner needs to prepare a CV and a motivational letter in order to be included in these departments. Some of the clients leave the department before the programme is completed. However, this is not because of any violation of the rules – they are usually released from prison, transferred to another type of prison or to another prison at their own request, etc. Voluntary treatment is conducted through therapeutic programmes inspired by the system of care applied in therapeutic communities. One of the requirements of the programme is the obligation to keep to 21 hours of structured and controlled activities per week, with group therapy being the primary activity (at least 1.5 hours weekly). The therapeutic team usually consists of a psychologist, a special education professional, an educational therapist, a social worker, and an educator. The person responsible for the implementation of the therapeutic programme in a professional fashion is the psychologist, who is the so-called professional guarantor of the programme. These departments are separated from the other wings in the prison, and contact with other inmates is usually limited.

11.3.1.2 Departments for Court-Ordered Compulsory Drug Treatment

Departments of this type exist in three prisons. Compulsory treatment is one of the protective measures which may be imposed by the court either separately or together with a sentence or with a waiver of a penal sentence. There are two basic types of compulsory treatment: outpatient and institutional treatment. If a prison sentence has been imposed on the offender in addition to compulsory treatment, the offender usually undergoes the compulsory treatment after they are admitted to the prison to serve their prison sentence (Section 99(4) of Act No. 40/2009 Coll., the Penal Code). The Prison Service does not currently have the capacity to provide court-ordered compulsory treatment in an institutional form in a dedicated inpatient healthcare facility, and the care provided by the existing wings intended for court-ordered compulsory treatment cannot be considered institutional healthcare according to the opinion of the Health Service Department of the General Directorate of the Prison Service.[124] For that reason, the Ministry of Justice informed the individual courts in 2010 that the Prison Service was not capable of providing the institutional form of compulsory treatment and that the courts therefore should not order compulsory treatment in individual prisons or in the Prison Service in general. Therefore, the clients of these specialised wings now consist of prisoners who have been ordered to undergo institutional compulsory treatment and those who have been ordered to undergo the outpatient form of compulsory treatment, as well as offenders who have not been ordered to undergo compulsory treatment by the court. The treatment programme includes two components. The first component is healthcare, which is provided by the health centre; the second component is the psychosocial part, which is delivered by prison's non-health professionals in cooperation with the head physician of the prison's health centre and in accordance with the instructions of the physician with the relevant medical specialisation who provides healthcare to the prisoner. The psychosocial component of the programme is *de facto* no different from that applied by the voluntary treatment departments described above.

The programme applied by the Opava Prison and Security Detention Facility (separate wings for men and women) is designed for multiple disorders and, unlike the other departments of this type, it therefore also includes and treats persons addicted to alcohol and pathological gamblers.

11.3.1.3 Drug-Free Zones

Drug-free zones constitute separate parts of the prison. Their establishment was inspired by similar facilities abroad[125]. The purpose of drug-free zones is to restrict the contact of persons serving their prison sentence with drugs and lead them to abstinence and a healthy lifestyle, both during and after imprisonment. Inmates are accepted in drug-free zones upon their request, which is evaluated by a committee of prisons' expert staff members. In terms of sentence plan, preference is given to motivation through small rewards[126] in the event that the prisoners follow the rules according to their voluntary commitment rather than to negative motivation through punishment arising from the violation of the rules of the drug-free zone. Naturally, sanctions (such as expulsion from the drug-free zone) are also used in the event of the violation of the rules; it is, however, important that by applying for inclusion in the drug-free zone the prisoner has accepted its rules. Individual counselling, an information service, crisis intervention, and social work are available in all the drug-free zones. There are two types of drug-free zones: standard and therapeutic drug-free zones. Standard drug-free zones are intended both for drug users and for non-users who feel endangered by drugs. Some standard drug-free zones are established exclusively for non-users and focus only on primary prevention. Therapeutic drug-free zones are intended exclusively for drug users, who are motivated during their stay to start voluntary treatment, whether provided by the Prison Service (e.g. in the above-mentioned dedicated

[124] This situation should be remedied by the act on specific health services, currently under preparation.
[125] For example, see http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=57&tab=overview.
[126] For example, such small rewards can include a better environment, more leisure activities, etc.

departments) or by the external providers of drug-related services. All the therapeutic drug-free zones offer their own therapeutic programmes with features of a therapeutic community, which involve, among other obligations, a mandatory 10 hours of structured controlled activities per week. Unlike in standard drug-free zones, the additional services which are guaranteed in therapeutic drug-free zones include group therapy and sociotherapy. Greater emphasis is also placed on the initial assessment of the client's condition.

11.3.1.4 Drug Prevention Counselling Centres

Drug prevention counselling centres exist in every prison. Their purpose is to provide comprehensive activities in the area of prevention and counselling. They are the drug policy advisory body to the governors of the relevant prisons. The members of the drug prevention counselling centres usually include a psychologist, a special education professional, a social worker, an educational therapist, and the head physician of the health centre. The objective of the counselling centre is to coordinate the prison's drug policy, i.e. coordinate the services delivered to drug users by the prison and by external providers, monitor the drug-related situation in the prison, etc. The counselling centres also carry out primary, secondary, and tertiary prevention activities, which include, for example, information about how to avoid contracting an infectious disease.

11.3.1.5 Opiate Substitution Treatment

Substitution treatment was introduced in prisons in 2006, when a pilot project was launched in the Prague-Pankrác and Příbram prisons. Substitution treatment was subsequently extended to eight other prisons. The provision of substitution treatment in prisons follows a special internal regulation (substitution treatment guideline), as well as the generally applicable Substitution Treatment Standard (Ministerstvo zdravotnictví ČR, 2008). Substitution therapy is provided in the outpatient form. The criterion for including a prisoner in substitution treatment is the verified fact that the prisoner has received substitution therapy prior to their imprisonment; prisoners therefore do not start substitution therapy in prison. Another requirement for inclusion is a written agreement. Methadone is the main preparation used for substitution treatment and its cost is covered from the budget of the Prison Service. Persons who have used buprenorphine prior to their imprisonment are not usually switched to methadone; they may continue to use Subutex® or Suboxone® but have to pay for these preparations themselves. The termination of the therapy is based either on the patient's request or on the violation of the therapy rules by the patient. After release from prison, the patient is referred to a substitution treatment programme in the community.

11.3.1.6 Detoxification

Detoxification is a part of healthcare in prison but there is no specific internal standard for detoxification. The decision about the start of detoxification is made by each physician after the assessment of the patient's health status, most usually during the initial medical examination. Detoxification is conducted either in outpatient form in the health centre of the relevant prison, with the inmates allowed to remain in their cells, or (in the more serious cases and on the basis of a physician's decision), the persons are admitted to specialised departments (e.g. the Psychiatric Department of the Brno Remand Centre and Security Detention Facility). Medicines containing buprenorphine, i.e. Subutex® or Suboxone®, or benzodiazepines or neuroleptics are used for detoxification. Detoxification takes 5–10 days on average.

11.3.1.7 Harm Reduction Interventions in Prisons

The existing laws and regulations expressly prevent prisoners from producing, possessing, and consuming alcohol and other drugs. Unlike in the community, drug use is illegal in prisons. A prison is therefore considered an environment where there should be no drugs. The implementation of harm reduction programmes, e.g. those involving needle and syringe exchange, could therefore be viewed as tolerating or even encouraging drug use, i.e. as overlooking disciplinary disobedience and even as the offence of obstructing justice (Section 337 of Act No. 40/2009 Coll., the Penal Code). It is still the case that a Prison Service employee must intervene if a prisoner commits an act of disciplinary disobedience or a crime or if the employee suspects that such acts have been committed (Section 7 of Act No. 555/1992 Coll. on the Prison Service and Court Guard Service); the employee must therefore also intervene if they have a reasonable suspicion that a prisoner possesses needles or syringes or other paraphernalia. It is not entirely clear whether this obligation also concerns the provision of disinfectants for the safer injecting administration of drugs. Another complication for the implementation of harm reduction interventions lies in the provision according to which prisoners are not allowed to possess and distribute documents describing the production and use of addictive substances (Section 28(3)(c) of Act No. 169/1999 Coll. regarding the serving of prison sentences); one of the interpretations of this provision in fact even prevents the distribution of printed harm reduction materials describing procedures for safer drug use. The above-mentioned legal provisions and their interpretations currently hinder or prevent the implementation of harm reduction measures in Czech prisons.

The existing legal framework only enables information to be given or, possibly, disinfectants to be provided for safer drug use. In accordance with the 2010–2012 Action Plan, the Prison Service is going to prepare an analysis of the opportunities for implementing harm reduction interventions. Other, non-specific forms of harm reduction interventions are legally possible, e.g. the provision of free condoms, but the problem in this area is funding; there is

currently no systematic distribution of condoms in prisons but the prisoners may purchase condoms in the prison canteen.

11.3.1.8 Preparation for Release and Post-Penitentiary Care

Preparation for release from prison is mainly performed by social workers. Special care is given to prisoners who have been imprisoned for over three years and who have six months or less until their release. These prisoners can be included in pre-release wings, which exist in all the prisons and which seek to assist the prisoners in creating favourable conditions for an independent way of life after their release and to minimise the risk of reoffending. Among other points, drug users are motivated during the targeted preparation of release to establish contact with an external provider of drug-related services in the community. This effort is supported during conventional imprisonment by the social workers (special approach applies to prisoners receiving care in any of the dedicated departments). It is a noticeable shortcoming that the care provided to the prisoner by the Prison Service and any contact between the client and the Prison Service in fact end with the client's release from prison. This results in the absence of any feedback regarding the client's behaviour after release and it is therefore impossible to address the client's failures or relapses and provide them with additional interventions. Moreover, this also results in the Prison Service missing valuable information necessary for the evaluation of the individual programmes or interventions. There is significant space in post-penitentiary care for further cooperation with NGOs and other institutions in referring the clients to their care. In accordance with the objectives of the 2010–2012 Action Plan, the Prison Service is preparing a draft of the recommended procedures for the systematic referral for aftercare in the community of drug users released after serving their prison sentence.

Other areas which need to be at the centre of attention in the future include the assessment of the risk of overdose after release from prison. There is currently no systematic solution in place to minimise this risk. Even though the topic is addressed as part of the therapeutic programmes delivered by the specialised departments, the entire population of the incarcerated users of drugs, in particular of opiates, is not covered. It would certainly be advisable to consider the use of some of the instruments aimed at overdose risk assessment, and implement the provision of the required interventions to the persons at risk during the pre-release period.

11.3.2 Testing fro Drugs

Testing for drugs is performed both for enforcement purposes (prisoners are not allow to produce, possess, or consume alcohol and other addictive substances – see above) and because the results of the testing are used to estimate the percentage of drug users in the prison population. The prisons conduct urine screening tests and the positive urine samples are sent for confirmation to accredited toxicological laboratories. Drug testing is based on the Guidelines on the Monitoring of Narcotic and Psychotropic Substances, which specify the precise procedures for the methods of testing, recording of the results, selecting the test subjects, etc. The initial medical examination includes as a mandatory component the testing of all persons held on remand and all those about to serve a prison sentence of over four months. In addition, regular random tests are conducted according to specific quotas of the selected persons. These quotas consider whether the prisoners are receiving care from a specialised wing or whether they are on a conventional sentence plan. In the case of the dedicated wings, the number of tests is higher because testing is a part of the treatment. In addition, there is also targeted testing in the event of a reasonable suspicion of drug use.

11.4 Quality of Drug-Related Services in Prison

11.4.1 Service Quality Methodology and Standards

Detoxification constitutes a part of standard health care in prison and follows the procedures *lege artis*. There is no specific standard defined for detoxification and nor is it specifically addressed by any of the guidelines of the Prison Service. As far as substitution treatment is concerned, an internal guideline lays down a special standard, which is based on the generally applicable standard (Ministerstvo zdravotnictví ČR, 2008). In terms of other services, in particular of those which are not included in healthcare, there are at the moment no competency standards of the services for drug users within the meaning of the Certification Standards of the Government Council for Drug Policy Coordination; for details see the chapter on Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55). In prison settings, these standards will be replaced, to a certain degree, by the Guidelines for the Provision of Drug-Related Services in Prison by Non-Governmental Organisations (see above). The standards applicable to the expert departments are specified by the internal guidelines of the Prison Service (see above). These guidelines are based on the Certification Standards of the Government Council for Drug Policy Coordination but they are modified so as to consider the limitations inherent in the circumstances of imprisonment and the staffing situation in the Prison Service. In principle, the general part of the Certification Standards of the Government Council for Drug Policy Coordination is fulfilled by the guidelines of the Prison Service. However, the requirements of the specific part of the Certification Standards of the Government Council for Drug Policy Coordination cannot be fully met in Czech prisons under the current circumstances. For example, in the case of the specialised departments, this concerns the requirement for the programme to be managed by a qualified professional/manager with previous practical experience in a therapeutic community and in group therapy, the requirement for the continuous availability of the services of a qualified therapist or a nurse, the capacity-related requirement for one qualified professional per no

more than 10 clients, etc. This is mainly due to the fact that the dedicated departments are a part of the standard departments and, as such, they are managed by the Prison Term Manager, who is usually not a drug addiction treatment professional. Even though the professional guarantor of the programme ensures the professional quality of the programme and of the individual interventions, they do not have the required powers. There are also several problems that are perceivable in terms of staffing by professionals with previous experience in drug addition treatment. The first problem is the current overall personnel situation of the Prison Service (see above). In addition, even if the position has been established and budgeted for, there is a problem staffing them with qualified persons, and it is even harder to keep such staff because the working environment in prisons is rather specific. The solution to this situation could be to reinforce the staffing of the specialised wings by qualified staff, establish an incentive programme for them, assign additional competences to the professional guarantors of the therapeutic programmes, and support a higher level of these centre's independence of the standard course of imprisonment. Moreover, closer cooperation with NGOs consisting in the more intensive involvement of the staff of the NGOs in the teams of the specialised departments (joint meetings, joint supervision, etc.) could be helpful.

The regulations setting out the minimum standards for these centres and the operating manuals of the individual programmes are some of the evaluation indicators of the quality and efficiency of the services provided by the prison's specialised departments. The fulfilment of these regulations is usually evaluated through regular meetings of the therapeutic programme teams and through supervision of the programmes and teams, which is provided by external supervisors. Finally, the methodological and auditing activities carried out by the General Directorate of the Prison Service must also be mentioned.

Quality is a prerequisite of efficiency, but it is not the only prerequisite. Motivation and work by the client is another precomdition. Thus, a change is the criterion of effectiveness, and the most obvious proof of effectiveness is that the prisoners who have received the drug-related services do not return to drug use and crime after their release from prison. However, there is still a lack of a representative evaluation study which would examine, for example, the influence of undergoing a therapeutic programme on subsequent relapse into drug use or reoffending.

11.4.2 Training of the Staff Members of the Prison Service Providing Drug-Related Services

The qualification requirements regarding the staff members providing services to drug users are the following: a psychotherapist must have completed an accredited self-experience training course in group psychotherapy, with the length of the course being at least 500 lessons; a therapist (conducting mainly individual counselling, group therapy, and counselling) must have completed at least 200 lessons of self-experience training. Moreover, the qualification requirements for the employees providing drug-related services are adequately based on the List and Definitions of Interventions in Drug-Related Services (Národní monitorovací středisko pro drogy a drogové závislosti, 2006). The training of the employees of the Prison Service is supported by the Training Institute of the Prison Service, located in Stráž pod Ralskem. Each newly hired staff member must go through the induction training, which is conducted at the person's place of work; then they must receive follow-up induction training, which is conducted as a basic training course at the Institute. There are currently six types of basic training courses. The professional training of the employees providing drug-related services currently has the form of a range of separate courses, from which the employees may choose or which are recommended to them by their supervisors, e.g. by the HR department of the prison. The director of the Institute decides about the inclusion of an employee in the course. A new system of training is currently being prepared for the employees providing drug-related services. There are several pitfalls in the set-up of this training. Primarily, it is necessary to define clearly what a drug-related service (or the performance of drug-related services) is because the line between specific drug-related services and other interventions associated with the professional management of the prisoners is rather thin in practice. For this reason, there is a lack of exact centralised statistics on the employees providing drug-related services and their qualifications. The Training Institute of the Prison Service plans to perform an analysis of the situation described above in 2012. The findings of the analysis will be used as the basis for the configuration of the systematic training of the employees providing drug-related services.

11.5 Summary of the Main Issues in the Implementation of Drug Policy Measures in Prison

The individual issues are discussed in the relevant sections of this chapter, including the proposals for their resolution; this section provides a brief summary of the issues.

- The drug policy of the Prison Service is adversely affected by the extreme increase in the number of prisoners and the concurrent decrease in the number of staff, payroll cuts, and general budget cuts of the Prison Service, including cuts in the funds earmarked for the implementation of the drug policy. In consequence, it will be difficult to maintain the current level of quality of the drug-related services.
- The long-term absence of a representative epidemiological study aimed at the prevalence of drug use among prisoners was finally rectified in 2010.
- In addition to being used for treatment purposes, the information provided by the prisoner about drug use is also used for enforcement purposes, which may be both demotivating for the prisoners and counterproductive for the implementation of the drug policy, in particular as far as prevention and treatment are concerned.

- An instrument is being developed for the keeping of centralised records on drug users receiving care from the individual specialised centres, their basic characteristics, and the activities (interventions) and other facts regarding the implementation of the drug policy. The Prison Service has lacked records of this type.
- Some of the clients leave the therapeutic programmes before completing them because they are either released on parole or transferred to another type of prison or to another prison at their own request.
- The situation in the area of providing court-ordered compulsory drug treatment as part of serving a prison sentence is currently problematic. It should be remedied by the act on specific health services, currently under preparation.
- Even though drugs are found in prisons in all the developed countries, the Czech public perceive a prison as a drug-free environment, even though there is no doubt about the presence of drugs in them. This opinion and the existing legal framework complicate the introduction of harm reduction measures in prisons.
- There is a lack of feedback regarding the clients' behaviour after their release from prison, which would be useful for the setting-up and evaluation of the drug-related programmes delivered during imprisonment.
- There is no overdose risk assessment in place regarding opiate users; neither are there general interventions aimed at minimising this risk.
- There is no representative study of the efficiency of the drug-related services.
- The systematic training of the employees of the Prison Service providing drug-related services is currently being configured to respond to the previous shortcomings in this area.

12 Drug Users with Children

The aim of this Selected Issue is to provide information about the prevalence of pregnant drug users and those users who are parents of minor children and trends and characteristics pertaining to them, as well as describing specific services designed for such users and their children in the Czech Republic. First and foremost, this chapter deals with addictive substances other than alcohol and those that are illegal.

A pregnant drug user refers to a woman who has used drugs during her pregnancy. For the purposes of this Selected Issue, a drug-using parent means every user who is the parent of a child under 18 years of age, irrespective of whether they currently have custody of the child or whether the child has been temporarily placed in the care of an institution or another person until they are deprived of parental rights or make the child available for adoption. In theory, a child is deemed to be every person up to the age of 18, but, in practice and in relation to the issue under consideration, children of pre-school and school age will be the main age groups referred to.

At a certain stage of their drug careers, some drug users give birth to children, which raises a number of fundamental questions about the future life of such children and their health, safety, and rights. It is common practice that such pregnancies tend to be unintended or unwanted, and often the woman only discovers that she is pregnant after some delay. As a result, mothers carry on using drugs and living in unsuitable socio-economic and hygienic conditions while already pregnant. Following the delivery, newborns may suffer from withdrawal-related problems, which are addressed by specialised healthcare facilities. Drug-using mothers rarely have a good social background to which they could resort with a child after birth. Moreover, their ambiguous attitude to their further drug use complicates their ability to take proper care of the child, which frequently results in interventions on the part of the authorities involved in the social and legal protection of children because of concerns that the child's favourable development may be endangered or disturbed. Some of these children subsequently need to be placed in alternative care. Similar problems also occur when children live with parents who use drugs or in a drug-using environment. Drug-using parents with children are provided with support and treatment by both governmental and non-governmental specialised professional agencies.

12.1 Size of the Problem

Studies investigating the effects and consequences of pregnant women's and parents' drug use on the physical and psychological development of the child mainly fall within the domain of medicine, with a particular focus on the target group of pregnant women in relation to the development of the foetus. The degree of the impact of drug use during pregnancy largely depends on whether the use has involved experimentation, irregular use, or addiction. Occasional users who are aware of the harmful effects of drug use usually abstain during pregnancy. Problem drug users and drug addicts are not able to discontinue their substance abuse; pregnant women often postpone or neglect prenatal care. Studies and practical experience provide enough evidence that parents' drug use affects the child's further development. However, the environment in which children grow up during the early years of their lives, with all its health and psychosocial consequences, plays a significant and often crucial role.

The use of all types of drugs, including alcohol, marijuana, nicotine, and barbiturates and other pills, may have dangerous effects on the course of a pregnancy. The main reason is that, by crossing the placenta, the drug enters the body of the foetus and endangers its healthy development. Similarly, in a breastfeeding woman, drugs may enter the child's body with the mother's milk (Vavřinková and Binder, 2007a).

The studies on the occurrence of neonatal abstinence syndrome (NAS) and other conditions in newborns confirm that the onset and the intensity of symptoms depend on the type of drug, dose, and the time of last use. Evidence shows that withdrawal symptoms are likely to subside rapidly in the children of mothers using heroin, while withdrawal from substitution medication manifests itself later and lasts longer. NAS develops in 50–90% of the children of mothers who used opiates (both illegal drugs and substitution medication) during pregnancy and interferes in a number of organs and regulatory systems (Stará et al. 2009). Alcohol is the most common cause of congenital mental retardation, and even small doses are associated with a higher risk of birth anomalies and lower intellect (Čihař, 2009).

One of the key objectives of postnatal care for drug-using women is the rehabilitation of their family. It has been shown that the success of such rehabilitation is conditioned by ensuring the primary contact between the mother and the child after birth and, where possible, by support from the broader family. The postnatal adaptation of drug-dependent parents' children may be short (with a varying course of NAS). However, it has been suggested that the use of addictive substances during pregnancy has long-term effects which may later manifest themselves in children as hyperactivity, difficulty in concentrating, irritability, speech disorders, slowness, or ADHD. As part of a study carried out at the Children's Centre in Prague (formerly a so-called nursery home), the present psychomotor development, the maturation of the CNS, and health risks in the children of 200 mothers with a history of drug use

were looked into; at the time of the preparation of this Selected Issue the results of the study were not yet available[127].

It has been found that the pregnant woman and the foetus show individual differences in their levels of resistance, or tolerance, to drugs. Clinical signs in newborns and young infants, including the subsequent psychomotor development, do not necessarily correspond to the length of the period for which the mother had been using drugs. Drug-using parents' children show a significantly better long-term prognosis than the children of alcoholic parents, although it is beyond doubt that drugs pose health and social risks. A bad prognosis applies especially to children living in negative social environments with all the related health, social, and psychosomatic consequences. Parents' genetic dispositions (also applicable to alcoholism), including their mental potential, are another factor that influences the development of a child (Lukešová, 2009).

At routine medical check-ups performed at the age of seven by paediatricians, 3752 children from the city of Brno included in a cohort subjected to a longitudinal prospective study of pregnancy and childhood (ELSPAC) were examined for behavioural disorders featuring hyperactivity and significant attention deficits. No behavioural abnormalities were found in 96.5% of the children, one to two out of four abnormalities under observation were identified in 3.2%, and 0.3% of the children, with a significantly higher rate of boys, showed three to four signs of behavioural disorders. In comparison to the children who were found free of any abnormalities, the children with behavioural disorders showed on average a significantly lower birth weight and a smaller head circumference, their mothers were more likely to have a lower level of education, smoke, and have experienced psychological problems in both childhood and adulthood, and their fathers were more likely to have had conflicts with the law. Both prenatal and postnatal exposure to negative family factors, including parents' drug use, have a negative impact on the development of behavioural disorders which may progress in the course of life (Kukla et al. 2008).

Nevertheless, the behavioural disorders featuring hyperactivity and attention disorders observed in drug users' children are caused by a range of risk factors (including genetic, biological, psychosocial, and environmental ones). These observations have also been confirmed by a two-year study entitled Comprehensive Programme of Care for Children of Dependent Mothers, carried out by the SANANIM civic association, with financial support from the *Sirius* foundation, in several of its programmes providing treatment for drug-dependent mothers and their children. 150 children of long-term users of illegal drugs who have used the services of the organisation were included in the study. The children are assessed in terms of four domains (psychomotor development, behavioural disorders, speech development, and morbidity). The aim is to develop a methodological manual for working with the families specified above. The study was commenced in October 2009 and will be concluded in 2011.

A project entitled Sunflower Garden, carried out by the Centre for the Family of the Drop-In public service company in association with the *Meta* association and with support from the Ministry of Education, has been in progress since 2010. Focusing on the occurrence of developmental disorders among children at risk of prenatal exposure to drugs, the project seeks to reduce or eliminate any disadvantage in such children's development.

The substitution treatment of pregnant women is another area of research interest. A three-year prospective study of a sample comprising 47 women dependent on heroin and 60 women in substitution therapy (including 36 on methadone and 24 on buprenorphine) registered for prenatal care was conducted from 2005 to 2007. The women dependent on heroin were statistically significantly younger in comparison to the women in substitution treatment. The study was aimed at surveying the socioeconomic background of pregnant women dependent on opioids and of those in substitution treatment and determining the effect of substitution treatment on the course of pregnancy and childbirth in drug-addicted pregnant women. Substitution was proven to have a generally positive influence on the course of the pregnancy and the health of the foetus and the newborn child. In comparison to both groups of women on substitution, the group of women using heroin recorded a significantly higher rate of unemployment. All the women on buprenorphine substitution, 14 out of the 47 women dependent on heroin, and 32 out of 36 of those on methadone substitution attended the prenatal clinic. The newborns' birth weight was lowest to a statistically significant extent in the group of the women addicted to heroin. The significantly largest number of newborns with symptoms of intrauterine growth restriction was born to the women dependent on heroin. The study confirmed the greater social stabilisation of the women in substitution treatment. In addition, these women's pregnancies were much more likely to be intended and planned, which was reflected in their responsible attitude to prenatal care. The neonatal abstinence syndrome required the longest treatment in women on substitution treatment with methadone. The higher the mother's substitution dose, the more pronounced the withdrawal symptoms in the newborn child. In view of the duration of the neonatal abstinence syndrome in the children of the mothers on methadone substitution, the placement of pregnant women in substitution treatment with buprenorphine appeared to be a more considerate option for the newborns (Vavřinková and Binder, 2007b; Vavřinková and Binder, 2007c).

12.1.1 Data from the Existing Czech Registers

The extent of the problem may also be inferred from the data provided by the register of drug treatment demands, which records whether the drug user shares a home with a child, as well as from the National Register of Mothers at

[127] "Children of Drug-Dependent Mothers" study conducted at the Children's Centre with Comprehensive Care and Supporting Family Therapy of Thomayer University Hospital in Prague.

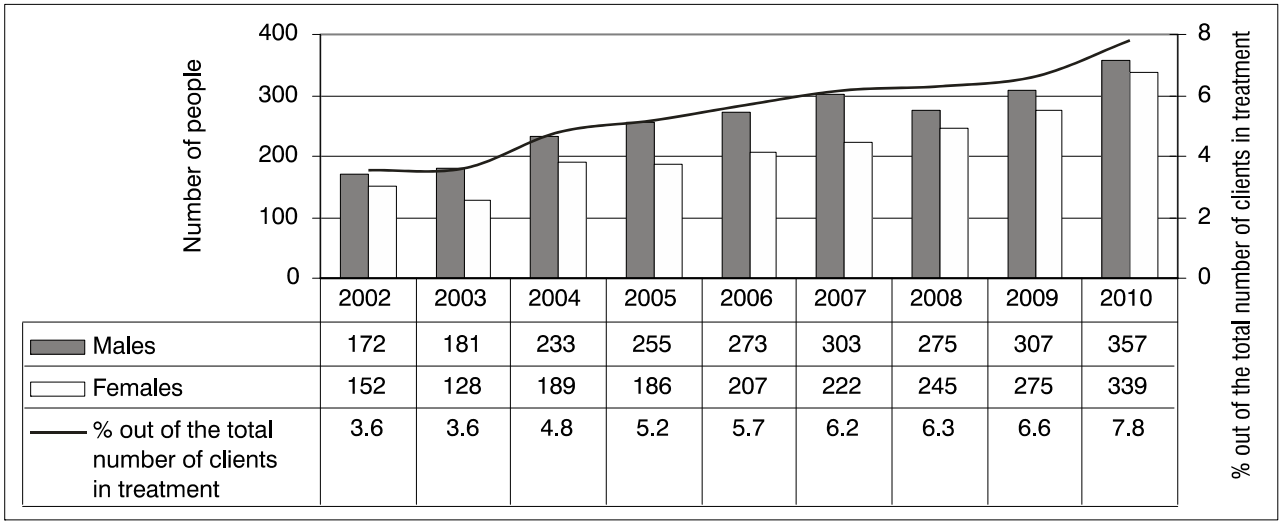
Childbirth and the National Register of Newborns, the purpose of which is to collect data on women's reproductive history, the course of pregnancy and the delivery, and on newborns and their health status and postnatal care, and which also take account of pregnant women's drug use.

Out of the total number of 9005 users reported to the register of drug treatment demands, maintained by the Public Health Service, in 2010, 700 shared a home with children, or with children and a partner (including 357 men and 339 women), with the majority of them being in the 25–39 age category; see Table 12-1 (Studničková and Petrášová, 2011). The proportion of clients living with children is rising: 7.8% of all clients in treatment were living with children in 2010; see Figure 12-1. In 2010 a total of 154 clients were living alone with a child (21 men and 131 women, while the gender of two individuals was not specified), with women accounting for considerably more single parents than men; see Figure 12-2. The percentage of women coming to the treatment centre of their own accord is lower than that of men (approximately 4% lower). On the other hand, women are more likely to be referred to treatment by the social services (Studničková and Petrášová, 2011). These figures, based on the drug treatment demand register, are probably rather underestimated, as they only account for the clients who stated that they lived together with children, or the treatment centre's staff members knew the client's situation and reported the relevant data. It may be assumed that this long-term rise in the number of treatment demands from people living together with children reported to the register results from the real increase in the number of drug users who have custody of children and not from any intensified external pressure on the addressing of the family situation affected by parents' drug use, as approximately 60% of the users demanding treatment report their own decision as the reason for doing so, while a mere 7% report being referred to treatment by the social services, the police, or a court (Studničková and Petrášová, 2011). Additionally, the growing range of services offered to drug-using parents with children, however limited it still is, may be a factor contributing to the rise in the number of the registered cases of drug users from among parents.

Table 12-1: All drug users in treatment living with children, according to gender and age, Czech Republic, 2010 (Studničková and Petrášová, 2011)

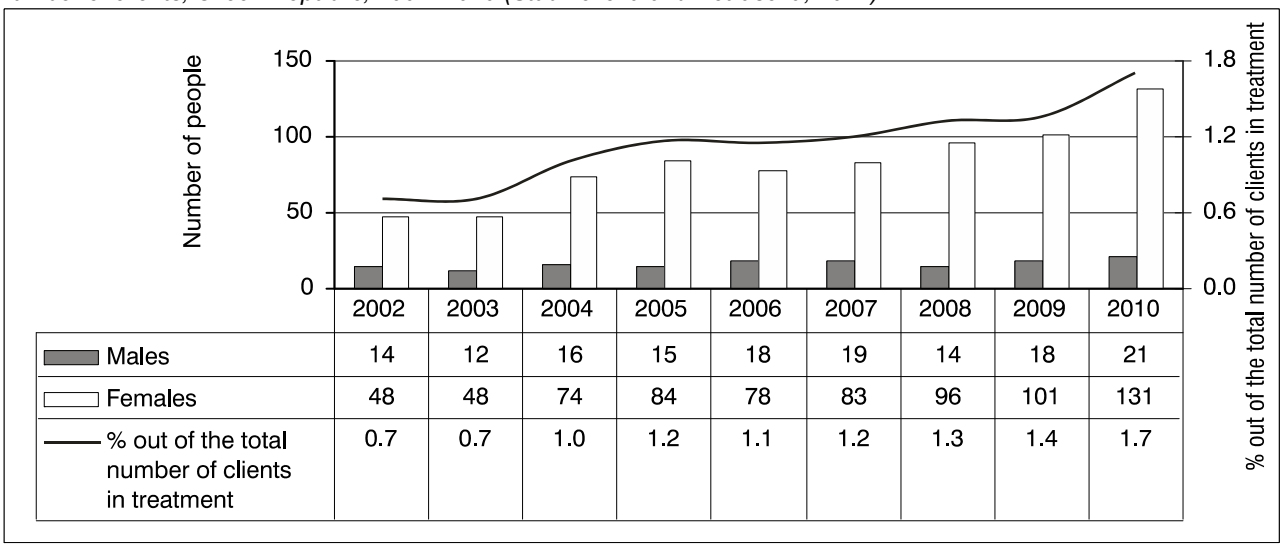
Age groups	Males		Females		Total	
	Number	%	Number	%	Number	%
up to 15 years	0	0.0	0	0.0	0	0.0
15–19 years	4	1.1	6	1.8	10	1.4
20–24 years	29	8.1	52	15.3	81	11.6
25–39 years	273	76.5	248	73.2	524	74.9
40+ years	50	14.0	32	9.4	83	11.9
Unspecified	1	0.3	1	0.3	2	0.3
Total	**357**	**100.0**	**339**	**100.0**	**700**	**100.0**

Figure 12-1: All drug users in treatment living with children, according to gender and proportions in the total number of clients, Czech Republic, 2002–2010 (Studničková and Petrášová, 2011)



	2002	2003	2004	2005	2006	2007	2008	2009	2010
Males	172	181	233	255	273	303	275	307	357
Females	152	128	189	186	207	222	245	275	339
% out of the total number of clients in treatment	3.6	3.6	4.8	5.2	5.7	6.2	6.3	6.6	7.8

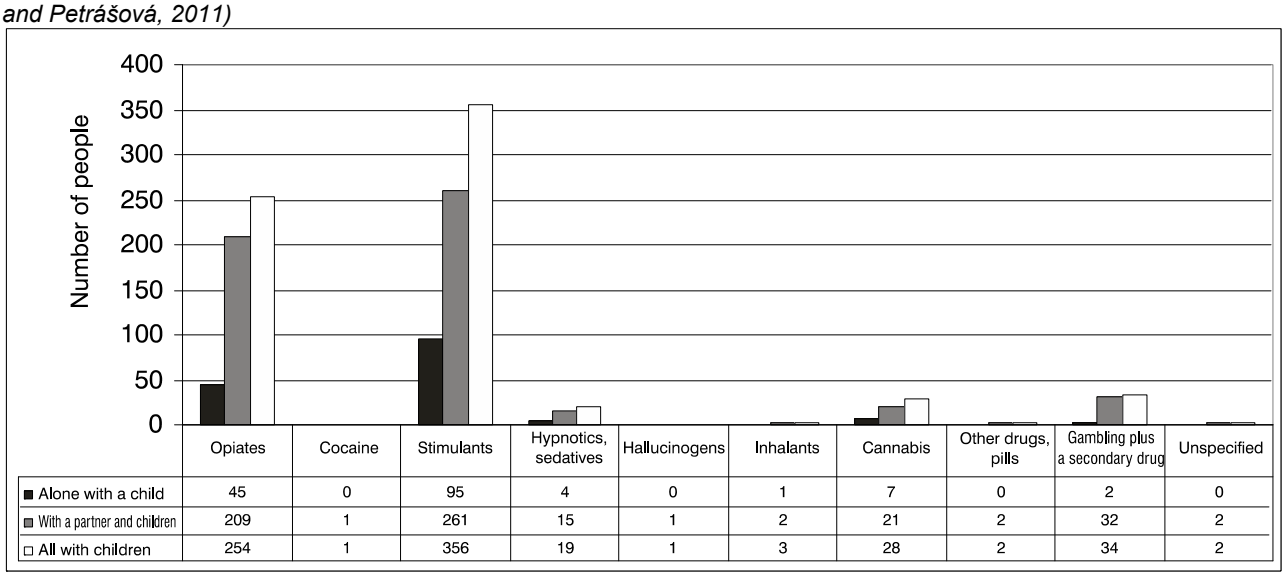
Figure 12-2: All drug users in treatment living alone with children, according to gender and proportions in the total number of clients, Czech Republic, 2002–2010 (Studničková and Petrášová, 2011)



	2002	2003	2004	2005	2006	2007	2008	2009	2010
Males	14	12	16	15	18	19	14	18	21
Females	48	48	74	84	78	83	96	101	131
% out of the total number of clients in treatment	0.7	0.7	1.0	1.2	1.1	1.2	1.3	1.4	1.7

As regards the drug of choice, stimulants, followed by opiates, prevail among drug users with children demanding treatment; see Figure 12-3. Approximately 70% of them are injecting drug users (Studničková and Petrášová, 2011).

Figure 12-3: Drug users in treatment living with children, according to drug of choice, Czech Republic, 2010 (Studničková and Petrášová, 2011)



	Opiates	Cocaine	Stimulants	Hypnotics, sedatives	Hallucinogens	Inhalants	Cannabis	Other drugs, pills	Gambling plus a secondary drug	Unspecified
Alone with a child	45	0	95	4	0	1	7	0	2	0
With a partner and children	209	1	261	15	1	2	21	2	32	2
All with children	254	1	356	19	1	3	28	2	34	2

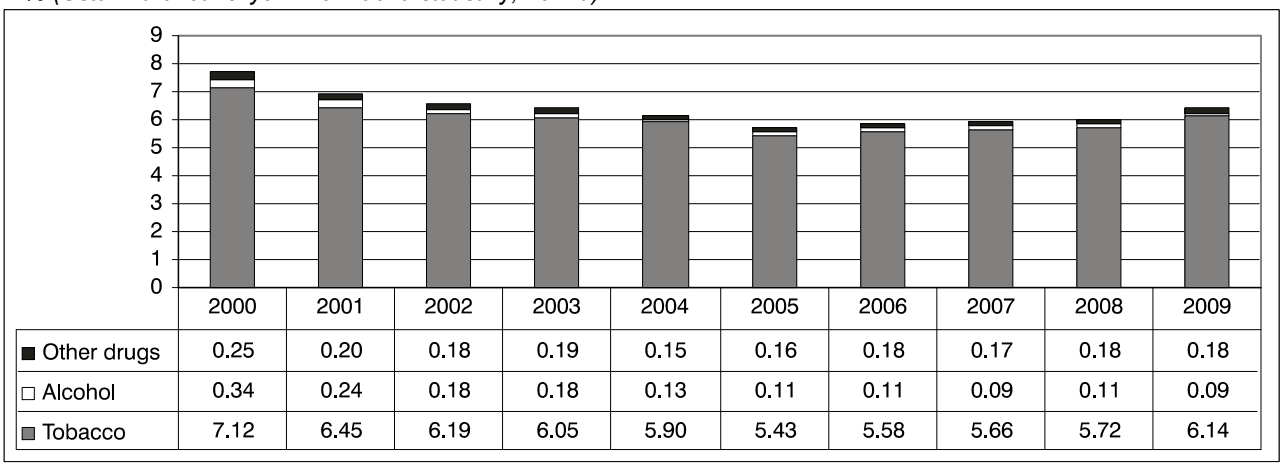
The extent and impact of the problem of substance use in relation to parenting in the Czech Republic may also be derived from the data available from the National Register of Mothers at Childbirth and the National Register of Newborns administered by the Czech Institute of Health Information and Statistics. These registers provide information about the parturient mother, her pregnancy, the delivery, and the child, obtained during the woman's stay in hospital in relation to the delivery or postnatal period. Since 2000 the register of mothers at childbirth has also collected information about addictive substances used by expectant mothers during pregnancy. The use of tobacco (indicated if a woman smoked five or more cigarettes daily at any time during her pregnancy or less than five cigarettes on repeated occasions), alcohol (repeated consumption of spirits or regular use of beer or wine), and other drugs (any, even isolated, cases of drug use during pregnancy) are recorded.

The structure of women recorded as using addictive substances at the time of their giving birth and their average age is indicated in Table 12-2 and Figure 12-4 (Ústav zdravotnických informací a statistiky, 2011d). The average age of the drug users (less than 26) was lower by an average of 3.5 years in comparison to the average age of other mothers at childbirth. This may suggest that the number of women using addictive substances, especially alcohol and other (illegal) drugs, is underestimated in the register. Nevertheless, the proportions of parturient mothers using addictive substances, particularly those other than alcohol, recorded with respect to the region of their domicile correspond to the statistical data on drug users in general. The largest numbers of these mothers are found in the Ústí nad Labem region (26% of the total number of mothers giving birth using other drugs), in Prague, and in the Central Bohemia region (almost a quarter on aggregate); see Figure 12-5. The women who used drugs during pregnancy were more likely to be single (62% and 41% of users of illicit drugs and alcohol respectively) and their level of education was generally lower; women with elementary education accounted for the largest group (50% and almost 37% of users of illicit drugs and alcohol respectively); see Figure 12-6.

Table 12-2: Total number of mothers giving birth and the number of mothers recorded as using addictive substances at the time of their giving birth, including their average age, in the years 2000–2009 (Ústav zdravotnických informací a statistiky, 2011d)

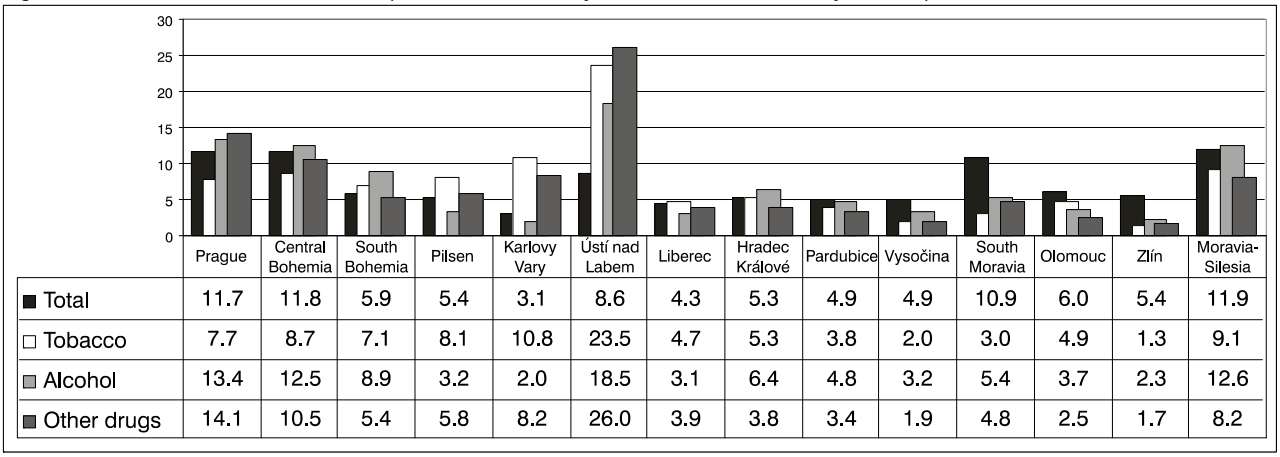
Year	**Mothers giving birth in total**		**Substance-using mothers giving birth**					
			Tobacco		Alcohol		Other drugs	
	Number	Average age	Number	Average age	Number	Average age	Number	Average age
2000	89,562	26.3	6,378	25.0	303	26.2	224	24.4
2001	89,303	26.8	5,764	25.4	217	27.0	176	25.0
2002	91,534	27.1	5,666	25.5	162	27.7	161	24.4
2003	92,387	27.4	5,589	25.5	165	27.4	176	24.1
2004	96,098	27.8	5,669	25.6	124	27.4	140	25.1
2005	100,519	28.1	5,460	25.7	115	27.4	160	25.0
2006	104,129	28.5	5,810	25.8	110	27.0	192	25.2
2007	111,988	28.8	6,339	26.2	104	28.9	189	24.9
2008	117,317	29.1	6,709	26.1	127	27.6	206	25.2
2009	115,984	29.3	7,118	26.3	101	28.3	212	25.4

Figure 12-4: Proportions of substance-using mothers giving birth in the total number of mothers giving birth, 2000–2009, in % (Ústav zdravotnických informací a statistiky, 2011d)



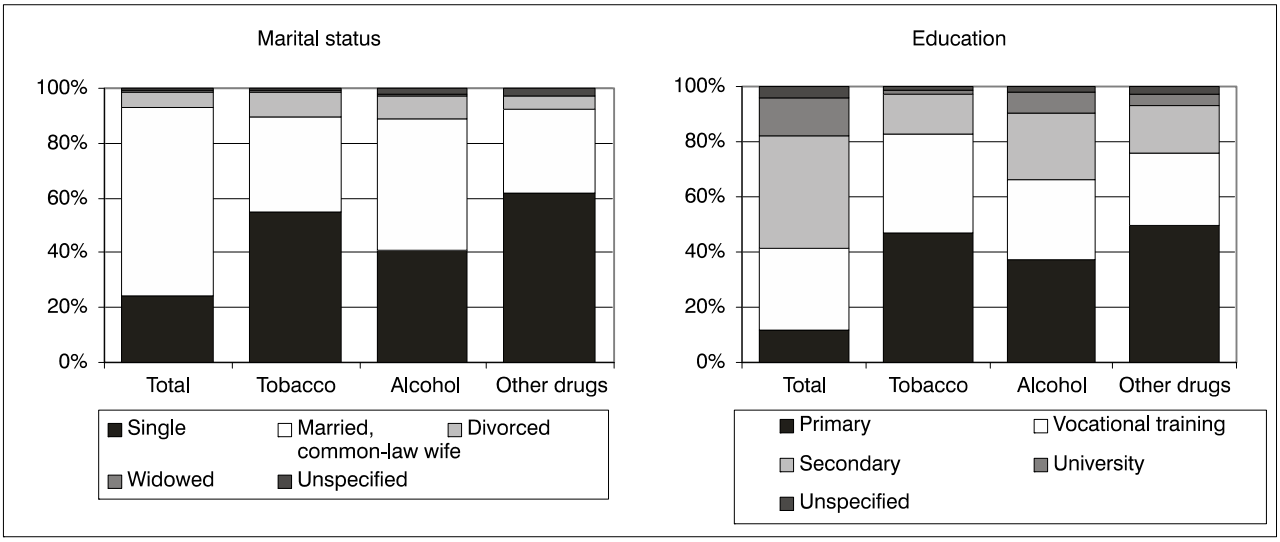
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
■ Other drugs	0.25	0.20	0.18	0.19	0.15	0.16	0.18	0.17	0.18	0.18
□ Alcohol	0.34	0.24	0.18	0.18	0.13	0.11	0.11	0.09	0.11	0.09
■ Tobacco	7.12	6.45	6.19	6.05	5.90	5.43	5.58	5.66	5.72	6.14

Figure 12-5: Proportions of mothers giving birth in total and of substance-using mothers giving birth, according to the region of domicile, 2000–2009, in % (Ústav zdravotnických informací a statistiky, 2011d)



	Prague	Central Bohemia	South Bohemia	Pilsen	Karlovy Vary	Ústí nad Labem	Liberec	Hradec Králové	Pardubice	Vysočina	South Moravia	Olomouc	Zlín	Moravia-Silesia
■ Total	11.7	11.8	5.9	5.4	3.1	8.6	4.3	5.3	4.9	4.9	10.9	6.0	5.4	11.9
□ Tobacco	7.7	8.7	7.1	8.1	10.8	23.5	4.7	5.3	3.8	2.0	3.0	4.9	1.3	9.1
■ Alcohol	13.4	12.5	8.9	3.2	2.0	18.5	3.1	6.4	4.8	3.2	5.4	3.7	2.3	12.6
■ Other drugs	14.1	10.5	5.4	5.8	8.2	26.0	3.9	3.8	3.4	1.9	4.8	2.5	1.7	8.2

Figure 12-6: Structure of the total number of mothers giving birth and substance-using mothers giving birth, according to marital status and education, 2000–2009, in % (Ústav zdravotnických informací a statistiky, 2011d)



An increased incidence of health complications and disorders, including a higher stillbirths rate (the delivery of a dead child), have been recorded among the newborns of substance users; see Table 12-3 (Ústav zdravotnických informací a statistiky, 2011d). After controlling for age, education, marital status, and the individual substances, a statistically significant effect was shown for tobacco, in particular, and for alcohol, in relation to specific complications and disorders. Following the adjustments, the effects of other drugs were not statistically significant.

Table 12-3: Health characteristics of newborns in total and of children born to substance-using mothers, 2000–2009 (Ústav zdravotnických informací a statistiky, 2011d)

Indicator	**Births in total (both live and dead)**			
	Women giving birth in total	Including women using		
		Tobacco	Alcohol	Other drugs
Total number of newborns	1,027,200	61,348	1,553	1,863
Suspect or pathological status of child (%)	14.7	20.1	21.9	26.4
Congenital defect (%)	3.3	3.6	4.4	3.8
Average birthweight (g)	3,306.4	3,051.0	3,051.7	2,991.8
Average gestational age (weeks)	39.2	38.8	38.7	38.4
Treatment in the delivery theatre (%)	12.3	13.9	15.3	15.1
Treatment at the department (%)	3.7	4.3	5.5	5.9
Still births per 1,000 births in total	2.4	4.5	12.4	8.2

12.2 Policies and Legal Frameworks

The 2010–2018 National Drug Policy Strategy does not specifically provide for the issue of drug users' children or parenting. The corresponding 2010–2012 Action Plan for the Implementation of the National Drug Policy Strategy includes only one item that partly addresses the topic of addiction among parents – Action 2.1., "To develop methodological materials – an early intervention manual for educational, health, and social work professionals" – by identifying antenatal clinics, or gynaecologists, as one of the target groups. A number of activities set out in the different domains of the action plan are aimed at minors and children in general, but they are not specifically focused on their parents' drug use.

Other policy and strategy documents falling within the remit of the respective departments of social affairs, health, and education are not much different in this sense. The available information indicates that none of them recognises the existence of a specific high-risk group of children defined by their parents' drug use and, accordingly, they do not identify any objectives or activities focusing on such families. This area is associated with the issue of children exposed to health and social risks in general.

The largest proportion of activities related to care for vulnerable children is pursued by the Ministry of Labour and Social Affairs. These activities are carried out as part of the social and legal protection of children (involving especially legal, methodological, and regulatory activities pertaining to such protection). According to Section 2 of Act No. 359/1999 Coll., on the social and legal protection of children, social and legal protection should apply to all the children present on the territory of the Czech Republic irrespective of their citizenship.

Furthermore, the system of care for children at risk involves the Ministry of Education, Sports, and Youth (the Ministry of Education), which is responsible, in terms of methodological guidance, for the operation of children's homes, children's homes with schools, institutions for juvenile delinquents and children with behavioural disorders

(diagnostic institutions), and rehabilitation institutions. In relation to the National Action Plan to Transform and Unify the System of Care for Vulnerable Children for the Period 2009–2011 (the National Action Plan), the Ministry of Education developed the Framework Policy for the Transformation of the System of Alternative Care in Educational Establishments, which incorporates the objective of reducing the number of children placed in any type of institutional care on a long-term basis, preconditioned by the strengthening of the preventive element of work with vulnerable children and their families and support for the development and availability of the relevant services, including the building of a network of specialised outpatient services featuring professional care centred on children's needs and work with the family system in its entirety.

The National Action Plan conforms to the ongoing process of converting nursery homes and homes for children up to the age of three into children's centres. The purpose of this transformation is to ensure general access to comprehensive, interdisciplinary, and coordinated care primarily focused on the provision of services involving outpatient, semi-outpatient, respite, and immediate care that would be available not only to children without a family background, but to all vulnerable children, including those who are abused either physically or sexually, neglected, exposed to developmental risk, or handicapped, and their families.

The agencies falling within the Interior Ministry's scope of operation are responsible for the detection, investigation, and clearing-up of criminal offences committed by and against children. Children's criminality and criminal offences against children are a major issue within the activities of the Czech Police as a whole and require liaison with other departments and experts. The Interior Ministry's Early Intervention System was launched in 2009. It is used by the police, as well as other entities, such as schools and healthcare facilities, to communicate information about cases of vulnerable or neglected children to the authorities responsible for the social and legal protection of children operating in municipalities with extended competencies (Ministerstvo vnitra ČR, 2011a).

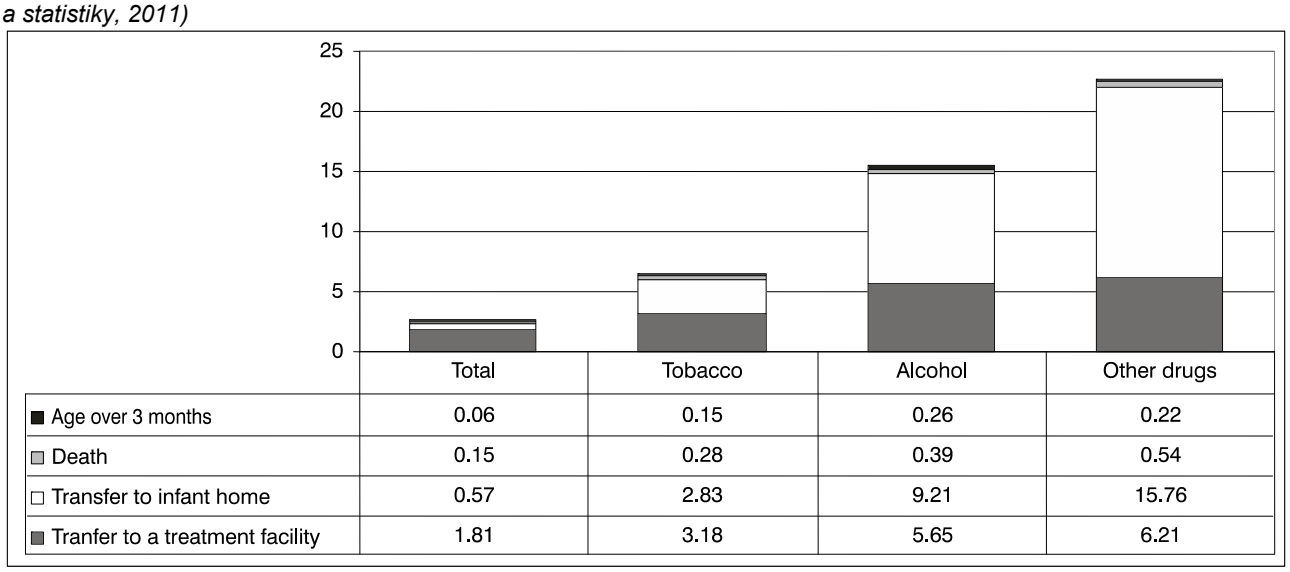
12.3 Responses

12.3.1 Social and Legal Protection of Children

The most frequent occasion on which drug users' children are accounted for is associated with a dependent mother giving birth. The case of a child being born to a drug-using woman is communicated by the hospital staff to a body responsible for the social and legal protection of children (the social services), i.e. mostly the competent department of the local authority of a municipality with extended competencies. This body proceeds to contact the mother and the members of her broader family, if appropriate, and finds out about the circumstances and conditions into which the mother is probably to return with her child. During the mother's and the child's stay in the maternity hospital, the relevant department collaborates with physicians and addiction professionals, which facilitates the exchange and verification of information and the identification of possible solutions. The relevant social workers approach the mothers, or fathers (although often no father is identified), both in the hospital and in the community. If it is concluded that the child's favourable development or their life may be seriously endangered or disturbed, a preliminary injunction is issued at the motion of the body for the social and legal protection of children in accordance with the stipulations of Section 76a of the Civil Procedure Code. The court is obliged to decide about the motion without undue delay, not later than within 24 hours after it has been filed. In the event that a mother shows no interest in her child or is not willing to address her addiction, the child, after being discharged from the healthcare facility, may be placed in an institutional care establishment, an agency for children in need of immediate help, or in the care of an individual. It was found that approximately half of the children who are currently placed in the Children's Centre in Prague were born to parents with a history of drug use.[128] This information is also confirmed by the data from the National Register of Newborns providing details about the end of children's stay at neonatal departments, which show significantly higher rates of referrals to nursery homes for children born to substance users; see Figure 12-7 (Ústav zdravotnických informací a statistiky, 2011d).

[128] Oral communication, Lukešová, a head physician, June 2011.

Figure 12-7: Proportions of the ways of termination of the stay at neonatal departments (other than discharge home) pertaining to newborns in total and those born to women using drugs, 2000–2009, in % (Ústav zdravotnických informací a statistiky, 2011)



	Total	Tobacco	Alcohol	Other drugs
Age over 3 months	0.06	0.15	0.26	0.22
Death	0.15	0.28	0.39	0.54
Transfer to infant home	0.57	2.83	9.21	15.76
Tranfer to a treatment facility	1.81	3.18	5.65	6.21

The preliminary injunction provides the mother with a period of time (mostly three months) within which she has the opportunity to address her situation, particularly by engaging with treatment and expert agencies. In the event that a mother, or parents, are not able to provide child care and parenting because of their drug use, the court rules, on the basis of a motion filed by the social services, that the child be placed in institutional care or in the care of a person close to them (Section 6a of Act No. 359/1999 Coll.). This ruling is often passed in a situation where parents fail to fulfil their obligations ensuing from their parental responsibility or fail to exercise or misuse their rights arising from their parental responsibility and where such circumstances are of such duration and intensity as to exert a negative influence on children's development or (may) cause the children's unfavourable development. The above implies that the law on the social and legal protection of children does not allow for the provision of protection on the grounds of a single event or short-term action. It rather presupposes that such circumstances exist for a period of time that makes it apparent that an appropriate measure needs to be taken to deal with the situation (Section 2, Act No. 359/1999 Coll.).

The pertinent statutory and legislative regulations and guidelines do not currently provide any detailed specifications concerning parents' drug misuse, which leaves considerable space for subjective perception of the level of danger which the situation poses. From the perspective of the law, a child of a drug-dependent mother is viewed as one being abused or neglected. This leads to tricky situations which preclude agreement on whether or not the parents are able to care for their children in view of their drug use. There is no definite specification of the degree and extent of drug use that is detrimental to child care, which leads to inconsistencies in decisions about the provision of social and legal protection to the children of parents whose drug use has been confirmed. This is also upheld by the National Action Plan to Transform and Unify the System of Care for Vulnerable Children for the Period 2009–2011 of the Ministry of Labour and Social Affairs (Ministerstvo práce a sociálních věcí ČR, 2011), which states that the Czech system of working with vulnerable children and families is totally lacking in comprehensive and valid information (both quantitative and qualitative) describing the structure of clients, human and financial resources, and system management. The document also points out that specialised professional services (such as children's psychiatry), in particular, but also regular community services (including counselling and social assistance) are unavailable in some regions. The public administration bodies and other authorities face the following drawbacks in pursuing their activities regarding care for the children of drug-dependent parents:

- the insufficient understanding of the addiction-related problems on the part of the staff members of the bodies responsible for the social and legal protection of children, as well as judges;
- the insufficient methodological guidelines for procedures applied by the bodies responsible for the social and legal protection of drug-using parents' children;
- the inconsistent and unclear procedures for deciding about institutional care and about the resumption of the parents' custody of children who have been placed in institutional care;
- the unclear role, responsibility, and powers of non-governmental organisations working with the clients under consideration;
- the insufficient exchange of information and liaison between the public administration bodies and the organisations catering for the parents and families of vulnerable children;
- the lack of quality data on the occurrence of the phenomena under scrutiny.

12.3.2 Helping Services

Help to children and families at risk of dependency on addictive substances has a long tradition in the Czech Republic. In 1967 a Centre for Children, Young People, and the Family was opened at U Apolináře in Prague. Providing care to children from alcoholic families, the centre was also involved in a number of research studies looking into the effects of parents' alcoholism on children.

The issue of parents' use of drugs other than alcohol has received increased attention in the Czech Republic since the 1990s, which correlates with the rise in the use of non-alcohol drugs in that period and the corresponding growth in the number of children born to drug-dependent mothers or living in families affected by drug use. The first children born to dependent mothers raised a number of questions as to how to address the consequences of such developments for the mothers and their children and how to ensure the professional competences of practitioners working with these clients. A significant moment was the opening of the therapeutic community of the SANANIM civic association in Karlov in the year 2001, which made it possible to provide treatment for dependent mothers (or fathers) together with their children (a total of 115 mothers and 117 children underwent treatment in this facility). Other programmes have been added to the existing treatment options over time.

The national drug policy strategy has not paid much attention to the group of drug-using parents and their children thus far (see above) and interventions targeted at this area are not receiving any special support, for example in the form of subsidy priorities. Several addiction services (mostly outpatient ones), however, have been delivering a range of interventions and programmes to these target groups (mostly pregnant users and dependent parents) for many years.

As part of the preparation of this Selected Issue chapter of the Annual Report, from February to March 2011, the National Focal Point carried out an online questionnaire survey aimed at finding to what degree drug treatment facilities encounter pregnant users, dependent parents, and the children of such users in their practice. The objective of the survey was to identify whether and what services are provided to this target group (Národní monitorovací středisko pro drogy a drogové závislosti, 2011h). The questionnaire was completed by 87 facilities. In view of the fact that the invitation to participate in the survey, with a reference to the questionnaire, was sent from the Help Map application at www.drogy-info.cz, it is impossible to draw conclusions about the representativeness of the survey. Nevertheless, the following information was collected:

- 80 (92%), 65 (75%), and 51 (59%) programmes reported that they meet drug-dependent parents of minor children, drug-dependent pregnant women, and the children of such users, respectively, in their practice. The largest number of clients was reported for the group of drug-using parents (approximately 3600 parents, 320 pregnant women, and 380 children of drug users). The reported numbers are only educated guesses in parts, as approximately only 20% of the services maintain records of these client subgroups (drug-using parents, pregnant users, and children are accounted for by 26%, 21%, and 14% of the agencies respectively).
- The largest numbers of drug-using parents were reported by programmes in Prague, followed by the Ústí nad Labem, Pilsen, and Central Bohemia regions. The largest numbers of drug-using pregnant women were recorded in Prague and in the Ústí nad Labem, Central Bohemia, and Zlín regions. The largest numbers of children of drug users engaged with programmes were reported in Prague again and in the Ústí nad Labem and South Bohemia regions. This is probably related to the fact that the above-mentioned regions have a greater representation of organisations that offer special programmes for the target group under consideration. Disproportions between the data on the number of pregnant women and the number of children were identified in some regions (for example, the Zlín region reported 25 pregnant users but no drug users' children).
- The largest numbers of contacts with drug-using parents and their children were reported by the staff of low-threshold centres and also by outpatient substitution centres and aftercare services. In addition, pregnant users come into contact with outreach workers.
- Special programmes for pregnant users and drug-using parents are offered by approximately 13% of the facilities that were interviewed; similar programmes intended for children are only provided by 7% of the facilities.
- While rather exceptional in the Czech Republic, organisations that provide special services for children of drug-using parents include those providing psychotherapeutic care or family therapy (e.g. the ANIMA civic association, which offers group and individual psychological care to children from families affected by addiction). Of the providers of drug services, special programmes are offered by several organisations, especially the SANANIM civic association, with its Karlov Therapeutic Community (dependent mothers, or fathers, undergoing treatment together with their child), intensive day treatment during which the mother and the child may stay together in a nursery home-type facility or maintain regular contact (Day Care Centre), and the services of the Aftercare Centre providing sheltered housing for mothers with children. In addition, the issue of families at risk of addiction or drug abuse on the part of parents is addressed by Prague's Centre for the Family of the Drop-In public service company, which provides a structured programme for drug-using mothers.
- Specialised services for pregnant users or drug-dependent parents are offered by several programmes in the Czech Republic (approximately 13% of the agencies interviewed). They are, first and foremost, low-threshold drop-in centres and, rather rarely, residential treatment programmes and aftercare programmes. Treatment

- Approximately a quarter of the facilities that were interviewed have developed a certain form of rules or guidelines for work with this target group or its subgroups. They are mostly drop-in centres' manuals specifying how to work with pregnant users or deal with children staying at and entering low-threshold facilities.
- A total of 37 (42%) of the facilities that were interviewed are planning to pay closer attention to at least one of the target groups under consideration in the future; pregnant women were mentioned the most frequently in this respect (38%), followed by drug-dependent parents (33%) and children (29%). The staff members indicated that their greater focus on these target groups is hampered by their limited human and financial resources, the inadequate nature of the liaison with the public administration bodies, and sometimes also clients' lack of interest in the services, but the majority of the respondents showed interest in further information about the issue in question.

12.3.3 Standards of Professional Competency of Services

The services intended for the users of addictive substances that receive funding from the state budget are subject to the system of certification of professional competency of drug services and must comply with the criteria for care set out in the general and specific standards; see the chapter on Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55). The provisions of the general section of the standards include that the patient/client is entitled to contact with their family and/or significant others, if it does not contravene the conditions and restrictions of professional care (Standard 2.6: Patients'/clients' Rights). The specific standards for low-threshold centres and both outpatient and inpatient treatment facilities require that in cases where it is considered necessary clients should be referred to examination for pregnancy and other specialised interventions, as needed. The standards provide no further specifications of client characteristics relevant to the topic of this chapter and make no references to the distinct features of care for pregnant users and drug-using parents of minors. This may be caused by the fact that, at the time of the development of the standards, the issue of pregnant drug users and the children of drug users did not receive adequate attention in the Czech Republic.

13 Cross-border Travel, Drug Use, and Drug Services

This Selected Issue provides a summary of information concerning the issue of cross-border travel and drug use, i.e. so-called drug tourism. Both the publicly available and restricted sources indicate that the phenomenon of drug tourism has not been addressed by any of the relevant institutions. By its nature, drug tourism is an inter- or multidisciplinary topic and is difficult to analyse. The available sources suggest that certain groups of tourists visit the Czech Republic (especially Prague) in search of sex-, alcohol-, and drug-related experiences. There is information (not always accurate) on the internet that describes the Czech Republic (Prague in particular) as a place where drugs and sex services are readily available. The harm reduction programmes have also registered a small number of foreigners among their clients, but these individuals are usually staying in the Czech Republic on a long-term basis and maintain only minimum contact with drug services.

Drug tourism has not been explicitly referred to in any of the sources available. Despite their limited informative value, the existing data sources and registers, in which (self-reported) citizenship or nationality is the main discerning element, may be analysed and interpreted. It may be assumed that drug tourists who come to the Czech Republic for a limited period of time and use drugs during their stay rarely come into contact with typical drug services. If they do seek help, such cases tend to involve responses to acute health problems resulting from the excessive consumption of drugs (including drug overdoses and accidents or injuries). However, there are not enough data to support this assumption (for example, in Prague, foreigners account for 8% of the individuals treated at sobering-up stations). First and foremost, these data reflect the information available from the official health and police registers. Their limitation lies in the fact that they do not account for the residence status (therefore, it is not possible to identify whether a person is a Czech resident or a tourist on holiday). The issue of tourism, or drug tourism, has not been specifically followed and analysed by any entity. It may be assumed, therefore, that the official data do not reflect the phenomenon of the cross-border movement of drug users in its full scope.

13.1 Foreigners in Contact with Treatment and Counselling Services for Drug Users

Data are available from the Czech Institute of Health Information and Statistics, which collects statistical information on inpatient psychiatric treatment, the register of drug treatment demands administered by the Public Health Service, and from the survey focusing on foreigners and services for foreigners carried out by the National Focal Point among providers of drug services.

In the period from 2005 to 2010 foreigners accounted for approximately 1–2% of all the cases of people admitted to inpatient psychiatric facilities in the Czech Republic in relation to disorders caused by drug use (with the exception of alcohol and tobacco, i.e. the F11–F19 diagnoses, excluding F17) (Nechanská, 2011a). In recent years there were 50–100 individuals, of whom approximately half were foreigners from countries outside the EU. The number of hospitalisations of foreigners from non-EU countries has shown a long-term rise. People with permanent residence in the Czech Republic prevail among the foreigners from EU countries, while it is vice versa as regards the individuals from non-EU countries[129]; see Table 13-1. However, the available data make it impossible to distinguish whether these people are illegal long-term residents in the Czech Republic or are staying in the country temporarily (as tourists, for example). Among the hospitalised foreigners, men outnumber women in a ratio of 2–3 : 1 (see Table 13-2); they are mostly people in the 20–29 age category.

Table 13-1: Hospitalisations of foreigners for disorders caused by the use of substances other than alcohol and tobacco (dg. F11–F19, excl. F17) according to their EU affiliation status and Czech Republic residency status, 2005–2010 (Nechanská, 2011a)

Year	Total number of hospitalisations	Including foreigners from EU countries			Including foreigners from non-EU countries			Total number of hospitalisations of foreigners	
		With permanent residence	Without permanent residence	Total	With permanent residence	Without permanent residence	Total	Number	Proportion in all hospitalisations (%)
2005	4,830	24	11	35	3	19	22	57	1,2
2006	5,286	15	21	36	6	24	30	66	1,2
2007	5,497	18	15	33	7	27	34	67	1,2
2008	5,428	30	11	41	7	24	31	72	1,3
2009	5,464	48	7	55	6	33	39	94	1,7
2010	5,356	42	5	47	13	40	53	100	1,9

[129] Foreigners with visas allowing them to stay in the Czech Republic for over 90 days, with special visas, and who have been granted the status of a refugee or an asylum seeker are considered permanent (long-term) residents.

Table 13-2: Hospitalisations of foreigners for disorders caused by the use of substances other than alcohol and tobacco (dg. F11–F19, excl. F17) according to their EU affiliation status and gender, 2005–2010 (Nechanská, 2011a)

Year	EU country		Non-EU country		Total		
	Males	Females	Males	Females	Males	Females	Total
2005	28	6	18	4	46	10	56
2006	32	8	24	6	56	14	70
2007	29	2	30	4	59	6	65
2008	29	4	26	5	55	9	64
2009	38	1	27	12	65	13	78
2010	34	13	37	16	71	29	100

The data from the register of drug treatment demands administered by the Public Health Service suggest that the numbers and the proportions of foreigners among drug-related treatment demands in the Czech Republic between 2005 and 2010 remained relatively stable (Studničková, 2011). The highest rates of treatment demands from foreign citizens were recorded for Slovaks, Ukrainians, Russians, and Vietnamese. Foreigners accounted for a total of about 2% of all treatment demands in the period under study; see Table 13-3.

Table 13-3: Foreigners among all drug treatment demands according to citizenship, 2005–2010 (Studničková, 2011)

Year	Treatment demands in total	Including foreigners from*					Foreigners in total	
		Slovakia	Ukraine	Vietnam	Russia	Others	Number	Proportion in all treatment demands (%)
2005	8,534	65	6	5	3	65	144	1.7
2006	8,366	57	13	3	17	82	172	2.1
2007	8,487	81	9	13	4	100	207	2.4
2008	8,279	68	9	6	8	106	197	2.4
2009	8,763	67	10	8	5	96	186	2.1
2010	9,005	65	13	9	3	71	161	1.8

*Note: * Citizenships reported with the highest frequency. For other countries, no more than three nationals per year were recorded.*

The most commonly used drugs among foreigners in the Czech Republic include pervitin and heroin; intravenous use clearly predominates over other routes of administration; see Table 13-4 and Table 13-5.

Table 13-4: Foreigners among all drug treatment demands according to drug of choice, 2005–2010, in % (Studničková, 2011)

Year	Foreigners in total	Heroin	Pervitin	Cannabinoids	Subutex®	Others
2005	144	27.8	44.4	8.3	2.8	16.7
2006	172	37.8	40.1	7.0	6.4	8.7
2007	207	30.4	44.9	7.7	4.3	12.7
2008	197	36.0	33.5	10.7	7.1	12.7
2009	186	30.1	42.5	11.8	4.8	10.8
2010	161	29.2	41.0	10.6	5.6	13.6

Table 13-5: Foreigners among all drug treatment demands according to route of administration, 2005–2010, in % (Studničková, 2011)

Year	Foreigners in total	Injecting use	Sniffing/snorting	Smoking	Others
2005	144	60.4	13.9	12.5	13.2
2006	172	73.3	11.6	9.3	5.8
2007	207	70.5	10.1	12.6	6.8
2008	197	62.9	9.6	14.7	12.8
2009	186	62.9	10.2	16.1	10.8
2010	161	68.9	5.0	17.4	8.7

The information systems specified above do not enable a more detailed distinction to be drawn between foreigners who are staying in this country on a medium- or long-term basis and tourists who only stay for a short time or come specifically in order to consume drugs (drug tourists).

Presumably, the sources of data about treatment specified above account for drug users from among foreigners who are medium- or long-term residents in the Czech Republic, i.e. individuals who may be referred to as migrants or immigrants rather than tourists.

Other surveys among drug-using foreigners or those concerned with the issue of migration or ethnicity/ nationality/citizenship in relation to drug users in the Czech Republic also confirm that the rate of foreigners in contact with drug services is rather low. The relevant references include publications on substance use among members of

ethnic minorities in the Czech Republic, which also explore the correlations between social exclusion and the development of substance use and address the issue of availability of services for the target group of migrants and ethnic minorities in general (Šťastná et al. 2010). A range of aspects, such as blood-borne diseases, risk behaviour, and social networking, pertaining to Russian-speaking drug users on the Prague drug scene were investigated as part of a sero-behavioural study conducted by the Centre for Addictology (Zábranský and Janíková, 2008). A research project focusing on marginalised groups of migrants in the city of Brno and the surrounding areas sought to analyse specific features of problem drug use with a view to the level of risk of migrants' behaviour and the improvement of the availability of services for this group of drug users (Nepustil and Zajdáková, 2008).

Much information about the health of migrants, their status within the healthcare system, and their health promotion as a part of the process of the integration of foreigners in the Czech Republic was generated by the Healthy Inclusion[130] international project, funded by the European Commission's Public Health Action Programme and implemented in the Czech Republic by the National Institute of Public Health in Prague, and the Migrants and Health[131] conference organised as part of the project in Prague in May 2010.

Although migrants are not to be considered in this Selected Issue, it should be pointed out that they still represent a difficult-to-reach group of drug users. The information that is available on this community in the Czech Republic in terms of drug use is mostly qualitative in nature. This population is poorly mapped and insufficiently linked to the existing services for drug users.

13.2 Foreigners and Drug-related Crime

The crime information systems maintained by the police and the Ministry of the Interior constitute another source of data. In 2010 a total of 313,387 criminal offences were committed in the Czech Republic, and a total of 112,477 individuals were prosecuted in relation to criminal activities. This number included 7,377 foreigners (6.6%), who committed 8,701 offences (2.8%). The police recorded a total of 3,179 drug-related criminal offences, for which 2,437 individuals were prosecuted in 2010. Foreign nationals committed a total of 275 drug offences (8.7%), in relation to which 279 foreigners (11.4%) were prosecuted (Policie ČR, 2011; Ministerstvo vnitra ČR, 2011c). The most frequent offences included the unauthorised production and handling of narcotic or psychotropic substances (205 offences committed and 210 individuals prosecuted) and the possession of narcotic or psychotropic substances or poisons (48 offences committed and 43 individuals prosecuted) and also the unauthorised cultivation of plants containing a narcotic or psychotropic substance (10 offences committed and 16 individuals prosecuted). For comparison, in the year 2009 foreigners committed 215 drug-related criminal offences, with 184 people being prosecuted for such acts. Hence, a certain year-on-year increase in the number of drug offences committed by foreigners in the Czech Republic may be observed. Out of the foreigners from non-EU countries, Ukrainians were prosecuted the most frequently, for offences of endangerment under the influence of an addictive substance – inebriation (249 people), followed by Vietnamese, who were most likely to be prosecuted for the unauthorised production and other handling of narcotic and psychotropic substances and poisons (114 people). Vietnamese citizens were also involved in the unauthorised cultivation of plants containing narcotic or psychotropic substances. Russian citizens were mostly sanctioned for endangerment under the influence of an addictive substance (22 individuals). The Police of the Czech Republic have also recorded foreigners being involved in organised crime pertaining to the sphere of the manufacturing, trafficking, and selling of drugs. People from the Balkans (Kosovo Albanians and inhabitants of the countries of the former Yugoslavia), Nigerians, and Vietnamese are mentioned with the highest frequency (Ministerstvo vnitra ČR, 2011c); see also the chapter on Drug Markets (p. 131).

13.3 Drug Tourism

The picture of the drug tourism situation in the Czech Republic may only be derived from rather sketchy information and references to the issue, mainly supplied by the media. Especially in Prague, drug tourism is often placed in the same context as tourism oriented towards cheap and available alcohol and commercial sex.

Pointing out the high level of availability of drugs and moderate sanctions for drug-related crime, the news server of the *Hospodářské noviny* daily refers to Prague as an equivalent to Amsterdam (Ihned, 2010). The *Idnes.cz* server describes the individual localities where people go to procure different drugs, as well as mentioning sentencing guidelines associated with drugs (Idnes, 2008; Ihned, 2010). Similar information is also provided by the CzechTourism[132] agency, according to which Prague is known to certain groups of respondents as Little Amsterdam.

The National Drug Headquarters has recorded German citizens travelling to the Czech Republic in order to buy pervitin. The available information suggest that, in most cases, this involves recreational users who come to the border areas of the Czech Republic for pervitin, or tourists returning from the Czech Republic with drugs in a quantity not exceeding the personal use threshold. The involvement of the Vietnamese community is often brought up in

[130] http://www.szu.cz/tema/podpora-zdravi/healthy-inclusion (2011-08-31)
[131] http://www.szu.cz/tema/podpora-zdravi/migranti-a-podpora-zdravi (2011-08-31)
[132] CzechTourism is a public agency of the Ministry for Regional Development of the Czech Republic. It was established in 1993 in order to promote the Czech Republic as an attractive tourist destination on foreign markets and, since 2003, also on the domestic one; http://www.czechtourism.cz/ (2011-08-31).

relation to the sale of drugs (mainly cannabinoids and methamphetamine) in the border areas (Národní protidrogová centrála SKPV Policie ČR, 2011b); see also the chapter on Drug Markets (p. 131).

The information collected by means of an e-mail and telephone survey on drug tourism conducted by the National Focal Point among low-threshold programmes for drug users (drop-in centres and outreach programmes) in August 2011 indicates that Slovaks are the foreign nationals who most commonly maintain contact with such services. Russian-speaking clients comprise a relatively large client group too. As reported by one of Prague's drop-in centres, there has been a year-on-year rise in the number of foreigners seeking their services, and there is a clear demand for substitution, detoxification, and long-term psychiatric and psychotherapeutic treatment. As far as the availability of the services is concerned, the absence of health insurance among foreigners indicated for a specific type of treatment intervention poses a problem. The outreach programmes that were interviewed added that Prague, or sometimes also Karlovy Vary, is the main destination (Národní monitorovací středisko pro drogy a drogové závislosti, 2011f).

On the basis of a question aimed at this specific item of information, it was found that foreigners made up 1,011 out of 12,720 individuals (7.9%) treated at the Prague sobering-up station in the Na Bulovce University Hospital in 2010.

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SELECTED DRUG-RELATED WEB PAGES ON THE CZECH INTERNET

The following list provides selected official websites of key institutions concerned with drug-related issues. An exhaustive list of helping organisations is provided in the Help Map application available at drogy-info.cz.

Adiktologie – odborný časopis pro prevenci, léčbu a výzkum závislostí (Addictology – a professional journal for the prevention, treatment of, and research into addiction): http://www.adiktologie.cz/Casopis-Adiktologie.html

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

An application used to register drug-related services and their clients: http://www.drogovesluzby.cz

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

Centrum adiktologie VFN a Psychiatrické kliniky 1. LF UK v Praze (Centre for Addictology, Department of Psychiatry, First Faculty of Medicine of Charles University in Prague and General University Hospital in Prague): http://www.adiktologie.cz/

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

Česká asociace streetwork (Czech Outreach Work Association): http://www.streetwork.cz/

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

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

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

Database of social prevention services: https://www.sluzbyprevence.mpsv.cz/

Drug information server (administered by SANANIM, a civic association): http://www.drogy.net/

Drug counselling service (administered by SANANIM, a civic association): http://www.drogovaporadna.cz/

Drug services in prison (administered by Podané ruce, a civic association): http://www.wezeni.cz/

EXTC – web counselling – prevention of synthetic drug abuse: http://www.extc.cz/

Hygienická stanice hl. m. Prahy, referát drogové epidemiologie (Public Health Office in Prague, Drug Epidemiology Unit): http://www.hygpraha.cz

Information for the staff and clients of outreach programmes and low-threshold centres (administered by SANANIM, a civic association): http://www.edekontaminace.cz/

UN Information Centre in Prague: http://www.osn.cz/

Primary prevention information portal (administered by SANANIM, a civic association): http://www.odrogach.cz/

Safer Party initiative: http://www.saferparty.cz

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

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

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

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

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

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

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

Národní program řešení problematiky HIV/AIDS (National HIV/AIDS Programme): http://www.mzcr.cz/Verejne/Pages/133-narodni-program-reseni-problematiky-hivaids.html; Národní program boje proti AIDS ČR (National Programme for Combating AIDS in the Czech Republic): http://www.aids-hiv.cz/

Národní protidrogová centrála služby kriminální policie a vyšetřování, Policie ČR (Police National Drug Headquarters): http://www.policie.cz/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

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

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

Rada vlády pro koordinaci protidrogové politiky (Government Council for Drug Policy Coordination): http://rvkpp.vlada.cz

Register of social service providers: http://www.mpsv.cz/cs/3880

Sekce terapeutických komunit A.N.O. (Therapeutic Communities Section, Association of NGOs): http://www.terapeutickekomunity.org/

Společnost pro návykové nemoci České lékařské společnosti J. E. Purkyně (Society for Addictive Diseases of J. E. Purkyně Czech Medical Association): http://snncls.cz/

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

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

Ústav zdravotnických informací a statistiky (Institute of Health Information and Statistics of the Czech Republic): http://www.uzis.cz/

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

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

ABBREVIATIONS

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

2007–2009 Action Plan – Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2007 to 2009

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 Report: The Czech Republic – Drug Situation

AT – Alcohol – Toxicomania (AT clinic – a name for an outpatient medical facility dealing with addiction treatment)

Centre for Addictology – Centre for Addictology, Department of Psychiatry, First Faculty of Medicine of Charles University in Prague and General University Hospital in Prague

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

ESPAD– European School Survey on Alcohol and Other Drugs

EU – European Union

GCDPC – Government Council for Drug Policy Coordination

HAV – hepatitis A virus, viral hepatitis A

HBSC – Health Behaviour in School-aged Children survey

HBV – hepatitis B virus, viral hepatitis B

HCV – hepatitis C virus, viral hepatitis C

ICD-10 – International Classification of Diseases, 10th Revision

IDU(s) – injecting drug user(s)

INCB – International Narcotics Control Board

NA – Narcotics Anonymous

NAS – Neonatal Abstinence Syndrome

NFP – National Focal Point (Czech National Monitoring Centre for Drugs and Drug Addiction)

NSD(s) – new synthetic drug(s)

NGO(s) – non-governmental organisation(s)

NSD(s) – new synthetic drug(s)

PC – Penal Code

PMS – Probation and Mediation Service of the Czech Republic

TB – tuberculosis

TC – therapeutic community

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