European Monitoring Centre for Drugs and Drug Addiction

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CENTRE FOR DISEASE PREVENTION AND CONTROL OF LATVIA

2014 NATIONAL REPORT (2013 DATA) TO THE EMCDDA by the Reitox National Focal Point

LATVIA

New Development, Trends

Reitox
2014

Foreword

2014 National Report is one of the national annual reports compiled by the National Focal Points in the European Information Network on Drugs and Drug Addiction (REITOX) which is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The national reports form the basis for the EMCDDA's annual drug report. The national reports are compiled in accordance with the guidelines provided by the EMCDDA.

The Latvian National Report discusses recent developments and research data. The sections that describe the drug situation during the past year (drug experimentation, high risk drug use, health and social correlates and consequences, availability and supply of drugs) are linked with discussion on related societal interventions (prevention, treatment, harm reduction, social reintegration and control). Each section begins with background information on the subject and the latest data is discussed in the subsections.

Head of Addiction Monitoring Division Aija Pelne (Centre for Disease Prevention and Control of Latvia) wrote Section 3 and Subsections 5.1. and 5.2. Mārcis Trapencieris (University of Latvia Philosophy and Sociology Institute) wrote Sections 2 and 4 and Subsection 5.3. Anda Karnīte (Assistant Professor at Riga Stradiņš University) wrote Subsections 6.2. and 7.2. Agnese Zīle-Veisberga (expert at the Ministry of the Interior of the Republic of Latvia) wrote Sections 9 and 10. We thank them warmly.

The report was compiled and the remaining sections written by Ildze Redoviča and Linda Sīle at the Latvian Reitox National Focal Point, which operates at the Centre for Disease Prevention and Control of Latvia.

Research data and comments from experts on different areas of the drug issue were used in drafting the report. We thank all the experts for their contribution and comments.

The report has been approved by the Deputy Director of Centre for Disease Prevention and Control of Latvia / EMCDDA Management Board member Dr. Dzintars Mozgis and the director of Centre Mrs. Inga Šmate.

The National Report is available electronically on the website of the Centre for Disease Prevention and Control of Latvia in Latvian and English.

The EMCDDA Report is available electronically on the EMCDDA website (www.emcdda.europa.eu) in Latvian and English.

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
UN	United Nations
APANS	Outpatient Service Payment Settlement System
ART	Antiretroviral treatment
CDPC	Centre for Disease Prevention and Control
CL	Criminal Law
CSB	Central Statistical Bureau of Latvia
ECAD	European Cities Against Drugs
ECDC	European Centre for Disease Prevention and Control
EDDRA	Exchange on Drug Demand Reduction Action
EC	European Commission
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMN	Epidemiological Monitoring Network
EU	European Union
ESPAD	European School Survey Project on Alcohol and Other Drugs
GMR	General Mortality Register
GPS	General Population Survey
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immuno-deficiency Virus
HPP	HIV prevention point
HRDU	High-risk drug use
HSV	Amogenital herpes virus
GDP	Gross domestic product
ICD-10	International Classification of Diseases (10th revision)
IDU	Injecting drug use
MoES	Ministry of Education and Science
NHS	National Health Service
NPS	New psychoactive susbstances
LaSPAD	National School Survey on Alcohol and Other Drugs
LAVC	Latvian Administrative Violations Code
LIC	Latvian Infectology Centre
LMR	Latvian Mortality Register
MDMA	Ecstasy
CM	Cabinet of Ministers
NFP	National Focal Point
NGO	Non-governmental organisation
ONAP	Organized Crime Enforcement Bureau
PDU	Problem drug users
PLHIV	Patient living with HIV
PREDA	Patient Register Data
PWID	People who injext drugs
WHO	World Health Organisation
RDS	Respondent driving sample
RAKUS	Riga East Clinical University Hospital
REITOX	European Information Network on Drugs and Drug Addiction
RPNC	Riga Psychiatry and Addiction Centre
SDS	Severity of Dependency Scale
SMR	Special Mortality Register
SP	State Police

SRS	State Revenue Service
STI	Sexually transmitted infections
TB	Tuberculosis
TDI	Treatment Demand Indicator
THC	Tetrahydrocannabinol (delta-9-tetrahydrocannabinol)
UNODC	United Nations Office on Drugs and Crime
VTMEC	Latvia State Centre for Forensic Medical Examination

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Summary

National Policy Background

During 2013 and in the first half of 2014, several significant regulatory enactments were adopted and came into force—laws and regulations of the Cabinet of Ministers or amendments thereto that directly or indirectly deal with drugs.

As informed previously, on 14 March 2011, the Cabinet of Ministers approved the Guidelines for the Containment and Control of Narcotic and Psychotropic Substances and the Prevalence thereof for the Period from 2011 to 2017. The Guidelines aim to reduce the availability of illicit narcotic and psychotropic substances, the acceptability of their use to the society and the harm substance use causes to the population by improving the quality and efficiency of health care services rendered to drug users.

To achieve the goals set in the Guidelines, four main courses of action have been put forward: 1) prevention of drug addiction and drug abuse, 2) health care of addiction patients and drug users, 3) reduction of drug supply, and 4) policy coordination and information gathering and analysis. These courses of action comprise measures for the coordination and monitoring of implementation of which an interdisciplinary course of action has been envisaged, namely, policy coordination and collection and analysis of information. In the summer of 2014, a mid-term evaluation of performance indicators of the Guidelines was carried out.

Drug Use in the General Population and Specific Targeted Groups

In the spring of 2013, a methodological study was carried out in Latvia in accordance with ESPAD methodology (a survey project for European schools regarding alcohol and other narcotic substances). This study has been already described in the previous National Report, and currently no newer data or study results are available.

The primary objective of the methodological study was to determine whether and to what extent the answers of students differ depending on whether the fill-in questionnaire form is completed in the conventional manner (as a printed copy) or electronically. However, as the sample group for the study was selected as a representative sample of 14–16 year-olds from Latvia, it provides an insight into the prevalence of alcohol, tobacco and drug use in this target group, and, although the data should be interpreted with caution, it is comparable with the findings of previous ESPAD studies. The methodological nuances of the study and drug use prevalence rates in three age groups ascertained by surveying students have been described in this section.

In 2013 a study was first performed in Latvia where women in postnatal period were surveyed to establish the prevalence of addictive substances (tobacco, alcohol, narcotic and psychotropic substances) during pregnancy, women awareness of and attitude towards the impact of use of the mentioned substances on the health of the baby and course of pregnancy, as well as to learn the opinion of women about substance prevention measures.

Within the study, 602 women in postnatal period, who were hospitalised in Riga Municipality company SIA “Rīgas Dzemdību nams” (“Rīgas Dzemdību nams” is the largest delivery assistance institution in Latvia), were surveyed.

Prevention

Course of action “Competence Development” of the Latvian National Development Plan for 2014 to 2020 envisages that by 2020 all children and young people have to be provided with high-quality primary and secondary education, as well as access to activities outside of formal education, while

course of action “A Healthy Person who is Able to Work” focuses on premature death and loss of ability to work and the relationship between the causes thereof and various health risks, including smoking and risky drinking. Within the framework of this course of action, one of the tasks to be completed is prevention of addictive substances and processes.

In 2013 and the first half of 2014, many activities were carried out as comprehensive preventative action, and it can be observed that local government involvement is showing a tendency to increase. For example, the Ministry of Health of the Republic of Latvia established a network of health contact persons at municipalities in April 2014. In total, 86 municipalities appointed or delegated their contact persons. Selective prevention activities are carried out not only in Riga, but regionally as well. The indicated prevention is not common in the country. Significant initiatives have been implemented in the field of environmental prevention, especially in limiting alcohol consumption.

It has to be emphasised that in most cases, prevention activities in the country are not based on examples of the best practice; usually only a quantitative evaluation is carried out, and assessment of the effectiveness of preventative intervention is provided in very few cases.

In 2013, only one (in 2012—three) media campaign was organised at the national level to reduce the number of drunk drivers of vehicles. No drug awareness campaigns were carried out in 2013.

High Risk Drug Use

Improvement in medical data quality that had been achieved in recent years was continued in 2013, which allows identifying the number of treated drug users more precisely, thus providing opportunities to estimate the number of drug users more accurately. The number of drug users in the high risk drug user category in Latvia in 2012/2013 was estimated by using the treatment multiplier method.

The estimates show that in 2012/2013, there were approximately 15,416 high risk drug users in Latvia, or 11.3 per 1000 population aged 15-64.

Drug-related Treatment: Treatment Demand and Treatment Availability

According to the statistical report data, there were 421 (or 20.9 per 100,000 people) first-registered cases, i.e., patients to whom a diagnosis related to drug use (F11–F19, except for F17) had been established for the first time. The diagnosis was related to addiction syndrome or psychoses in 188 cases. In 2013, the diagnosis established most often for the first-registered patients was related to poly drug use (F19): 34.5% of the first-registered cases in 2013, followed by diagnoses related to use of opioids (F11: 12.4%), stimulants (F15: 15.7%) and cannabinoids (F12: 31.4%). Sedative-related diagnoses (F13) have been established in 2.9% patients, while inhalant related diagnoses (F18) have been identified in 1.7% patients; only five patients have a cocaine-related diagnosis (F14). There have been no diagnosis related to hallucinogens (F16) established in first-registered patients in 2013.

According to the new treatment definition, 1543 drug users have received treatment in 2013, out of who 555 have received assistance for the first time in their lives. There is an increase in the number of first-treated patients in comparison to 2012At the end of 2013, 424 patients underwent treatment on long-term pharmacological opioid addiction treatment programmes, of whom 328 patients were on the methadone treatment programme, and 96 patients were on the buprenorphine programme. In comparison, at the end of 2012, there were 278 patients on the methadone program and 77 patients on the buprenorphine programme.

Health Correlates and Consequences

By 31 December 2013, a total of 5,867 HIV cases were registered in Latvia (including 1,354 persons diagnosed with AIDS). Out of HIV infected persons who had been registered, 1169 have died. It means that the general prevalence of HIV is 234.7 per 100,000 in Latvia at the end of the reporting year.

As per HIV incidence, it is concluded that this indicator has experienced gradual growth in 2013. And namely, this epidemiological indicator is 16.9 per 100,000 population (n=340) in the reporting year, while it was 16.7 (n=339) in 2012 and 14.5 (n=299) in 2011. Thus, the gradual increase in the HIV incidence, which is observed starting from 2010, is present also in the reporting year.

Regarding the modes of HIV transmission, the trend described in previous years—increase in the proportion of HIV cases transmitted heterosexually—continue to grow also in 2013. This mode of transmission is responsible for one-third of incidences (36.8%, n=125) (in 2012, the proportion of heterosexually transmitted cases was 33.0%). The second most common mode of HIV transmission is by using contaminated injecting equipment, in total 22.6% (n=77) have been transmitted by this mode (27.7% in 2012). In 2013, 10 new-borns (or 2.9%) have inherited HIV infection from the mother.

There is no specific information on STI's among drug users available. In general the rates of chlamydiosis are still growing. In 2013 there were 100,8 cases per 100 000 population recorded (in 2012 – 85,5 cases per 100 000 population). The rates of gonorrhoea and syphiliss have decreased slightly as well as the incidence of anogenetal herpes virus.

There were 11 deaths from drug overdose recorded in 2013, which is six cases less than in 2012 and equals the result of 2011. Out of all death in 2013, one was woman and ten—men. The age of the deceased woman was 34, while the average age of deceased males—30.7 years. The overall mean age of persons deceased due drug overdose was 31 years. The youngest recorded deceased was aged 23, while the oldest was aged 40.

Out of all cases accidental poisoning (ICD-10 codes: X41 and X42) was recorded in nine cases, while in two cases the intention of the person is unknown (Y11 and Y12). In two cases the death was caused by the overdose of heroin (T40.1); in one case by the overdose of morphine (T40.2); in one case by the overdose of methamphetamine (T43.6); in one case by the overdose of hallucinogens (T40.9), while in six cases the substances were unspecified.

Responses to health correlates and consequences

Programs for the pharmacological treatment of opioid-dependent patients have an important role in preventing drug overdose. At the end of 2013, methadone cabinets were working in 10 towns. Buprenorphine replacement therapy is available at nine towns in Latvia.

An important role in reducing the number of overdose cases is also played by the HIV prevention points, which also operate as needle exchange consultative points, where staff informs users about safe use and what to do in the event of a suspected overdose. In 2013, 18 HIV prevention points operated in 15 municipalities in Latvia.

In total, 341,421 syringes and 82,443 needles were distributed in 2013, which is more than in the previous year (311,188 syringes and 81,354 needles). At the same time, the number of returned used injecting equipment (syringes and needles) has slightly increased—from 331,136 in 2012 to 335,346 in 2013.

By the end of 2013 70.6% (n=4142) of all HIV infected persons registered in Latvia are present also at Riga Eastern Clinical University Hospital's (RAKUS) registry (as described in previous reports

RAKUS centrally provides the health care and treatment services for people living with HIV). In 2012 this rate was 69.6%. It means that sustainably one third of persons approved to be HIV positive have never sought specialized HIV care. Among the persons registered at RAKUS slightly more than a half are drug injectors (52.3%; n=2249).

Social Correlates and Social Reintegration

Social exclusion and addiction issues are multi-dimensional; they can mutually both reinforce and affect one another. Unfortunately, in Latvia there have not been any studies on social exclusion problems among drug users, therefore, the data used in the present report only partially reflects the actual situation. The two key aspects that were used in the report in relation to the social exclusion of drug users were the rates of employment and education of these persons. The analysis is based on data about the drug-addicted patients treated in in-patient clinics, as well as data about users who participated in the cohort study in 2013.

The issue of social reintegration is by nature as vast and complex as the issue of social exclusion, and in fact it has yet to be acknowledged that the issue of social reintegration in relation to drug users has never been a primary issue at the national level among other socially-excluded groups of people. All in all, social reintegration in Latvia operates on a very low level, and often the term “reintegration” is confused with the term “rehabilitation”, which both are two different things.

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

Total number of drug related offences has remained stable during a couple of last years. Again the number of administrative offences has increased by 25,7% if compared to 2012, but the number of criminal offences has decreased by 40,1%. This is due to amendments in Latvian Administrative Violations Code (LAVC). Most popular drugs involved are methamphetamine, herbal cannabis and the group of so called “other drugs” which includes new psychoactive substances (NPS), sedatives, opiates and other.

In 2013 1002 persons were charged with various criminal offences related to illegal drug supply. Still as the person can be accussed with more than one section the total number of persons per cases is higher.

Drugs and driving is still a significant problem. Each year about 60% of drivers reffered to examination are established to be under influence of narcotic substances.

Use of drugs in prison settings stays stable according to the available data.

Drug Markets

The well-developed infrastructure of roads, air traffic, rail road, and marine transport in combination with other external factors is one of the aspects facilitating drug trafficking of drugs. Thus, the territory of Latvia is mainly used for the transit of narcotic substances and substances for the internal market come from the transit for the most part.

Data of the State Police on the seizures of narcotic substances show that substances are most often seized inside the country. In 2013, 97% of substance seizers were performed inside the country (83%—by the State Police, 13%—by the Prisons Administration, 1%—by Riga Municipal Police), but 3% of seizures fell within the competence of Customs Criminal Board of the State Revenue Service (on boarders, at the airport, at ports, etc.).

According to the data provided by the Forensic Service Department of the State Police, 2607 seizures of narcotic substances, psychotropic substances and precursors were performed in

2013, which is 6.5% more than in 2012 (n=2438); this suggests of increase in the illegal circulation of narcotic substances on the national level.

Analysis of the number of narcotic substances seizures revealed that the new psychoactive substances have returned to the leading positions in 2013, first time after their entry into the illegal market in 2008. In 2013, 819 seizures of new psychoactive substances were carried out, which accounts for 31.4% of the total confiscations performed in the state, which is 64.7% more than in 2012 (n=289). The remarkable increase in the number of seizures of new psychoactive substances is related both to the growth in the number of sales points and the intensified attention of national law enforcement institutions paid to the control of new psychoactive substances in 2013.

The next most popular substance confiscated in 2013 is methamphetamine. In total, 667 seizures of methamphetamine have been carried out in 2013, accounting for 25.6% of the total number of seizures, which is 10.6% less than in 2012 (n=746). Marijuana completes the top three confiscated substances in 2013. In 2013, marijuana (dried) was seized in 412 cases, which is 15.8% of all confiscations performed in the state. In addition, 31 times non-dried marijuana was seized, this result is closely related to the number of discovered marijuana farms (18 farms). In the list of substances confiscated most often in 2013, heroin takes the fourth place—288 cases, which is 11.1% or 32.6% less than in 2012 (=427). At the same time, amphetamine circulation has been comparatively stable over the years. The substance is not very popular in the market. Amphetamine was seized 77 times (3% of the total number of seizures) in 2013—3.9% less than in 2012 (n=74).

Part A: New Developments and Trends

1. Drug Policy: Legislation, Strategies and Economic Analysis

1.1. Legal Framework

In 2013 and the first half of 2014, a number of important legislative enactments related to policy for reducing drug distribution were adopted and came into force in Latvia. Several introductions to law should be underlined especially: the system of controlling the substances according to the basic principles of the generic system, imposition of a temporary ban on new psychoactive substances, which is performed by the Centre for Disease Prevention and Control of Latvia, as well as the amendments to the Criminal Law providing for a punishment of persons performing unauthorised activities with substances under a temporary ban.

Laws and Cabinet Regulations

On 10 October 2013, the Parliament (Saeima) adopted the Punishment Register Law. The Law came into effect on 1 January 2014 and its goal is to establish a unified register of persons that have committed criminal offences and administrative violations, in order to facilitate prevention and disclosure of these offences, and of the control of execution of the punishment imposed and rights restricted. The law lays down that the Punishment Register shall be maintained and administered by the Information Centre of the Ministry of the Interior, but the information contained therein shall be of restricted access.

On 14 February 2013, the Saeima adopted Amendments to the Law "On the Procedures for the Coming into Force and Application of the Criminal Law". The amendments came into effect on 23 April. Along with the amendments, a completely new procedure for the control of substances has been adopted in Latvia. Namely, substances are subject to control according to the basic principles of the generic system, which means imposing of ban on several related substances simultaneously. Corresponding amendments were made also to the Cabinet Regulation No. 847 of 8 November 2005 "Regulations regarding Narcotic Substances, Psychotropic Substances and Precursors to be Controlled in Latvia". The Law was renewed in 11 July 2014 by including new generic groups and widening the former groups. The aim of all these activities was to subject to the control as many actual substances available in the illegal circulation as possible.

In addition to the introduction of the new generic system, a decision on the necessity to introduce another mechanism for controlling the new psychoactive substances was made. As a result, Amendments to the Law "On Procedures for the Legal Trade of Narcotic and Psychotropic Substances and Medicinal Products" were adopted on 17 October 2013 and came into force on 14 November 2013. The amendments give a new definition of the term "new psychoactive substance" stating that it is a new narcotic substance in a pure form or preparation that has not been registered according to the Single Convention on Narcotic Drugs of 30 March 1961 and may cause health damage similar to the substances listed in the Schedules I, II, or IV of the mentioned Convention, or a new psychotropic substance in a pure form or preparation that has not been registered according to the Convention on Psychotropic Substances of 21 February 1971 and may cause health damage similar to the substances listed in the Schedules I, II, III, or IV of the mentioned Convention. Section 4, Paragraph two, includes now a norm which defines that the Centre for Disease Prevention and Control of Latvia may take a decision regarding imposing a ban or restriction on the manufacturing, acquisition, storage, transportation, forwarding or distribution of the new psychoactive substances or their preparations that are not included in the lists of narcotic substances, psychotropic substances and precursors to be controlled in Latvia, but regarding which information has been received from the Early Warning System or a conclusion of a forensic expert institution regarding new psychoactive substances has been received, for up to 12 months from

entering into force of the decision. The decision shall enter into force on the next day after it is published in the Official Gazette “Latvijas Vēstnesis”. The amendments also provide that a natural or legal person shall hand over the new psychoactive substances or their preparations, circulation of which is either banned or restricted with a decision of the CDPC, to the State Police within three working days after the decision enters into force. The amendments to the Law bring some changes also to other chapters, namely, Chapter 4, 5, 6, 7, and 8. Section 4, Paragraph four, of the Law regulates that storage of the new psychoactive substances or their preparations, circulation of which has been banned or restricted with a decision of the CDPC, shall be ensured by the State Police or investigation authority that has seized the new psychoactive substances or their preparations within the framework of criminal proceedings, while Paragraph five states that if the new psychoactive substances are included in any of the lists of the narcotic substances, psychotropic substances or precursors to be controlled in Latvia, the investigation authority shall take a decision regarding destruction of these substances or their preparations. The execution of this obligation shall be secured by the State Police. If the new psychoactive substances are not included in the lists of the narcotic substances, psychotropic substances or precursors to be controlled in Latvia, the State Police or investigation authority shall take a decision regarding returning of these substances or their preparations to the owner. Finally, the amendments also rule that the decision of the CDPC can be appealed at the Ministry of Health according to the procedure prescribed by the Administrative Procedure Law; however, appeal shall not suspend the decision. Until August 2014, the CDPC had issued a temporary ban on 24 new psychoactive substances, majority of which belongs to the synthetic cannabinoids group.

Additional control mechanism was applied in 9 April 2014, when Amendments to the Criminal Law entered into force; these amendments expressed Section 248.1 in the following wording: “Unauthorised Manufacture, Acquisition, Storage, Transport, Forwarding for Purposes of Sale and Sale of New Psychoactive Substances or their Preparations”. Amendments to the Law define that for a person who commits manufacture, acquisition, storage, transportation or forwarding for purposes of sale and sale of new psychoactive substances or their preparations circulation of which is banned or restricted the applicable punishment is deprivation of liberty for a term up to two years or temporary deprivation of liberty, or community service, or a fine and with a police supervision for a term up to three years. But for the same activities if substantial harm has been caused thereby the applicable punishment is deprivation of liberty for a term up to five years, or community service and with a police supervision for a term up to three years. Amendments to the Law were necessary to punish those persons who perform illegal acts with substances that are subject to temporary ban, as the previous experience shows that administrative punishments in this area are ineffective.

Amendments to the Latvian Administrative Violations Code that were adopted on 20 December 2012 and entered into force on 1 April 2013 puts Section 46 in new wording and provides for an administrative liability for illegal acquisition or storage in a small amount of narcotic and psychotropic substances, as well as substances, which may be used for the illegal production of narcotic and psychotropic substances (precursors), or the use of narcotic and psychotropic substances without prescription by a doctor. Currently it is stated that in the case of the illegal acquisition or storage in a small amount of narcotic or psychotropic substances without the aim of selling them, as well as the use of narcotic or psychotropic substances without prescription by a doctor a warning shall be issued or a fine in an amount up to EUR 280 shall be imposed. Also for the illegal acquisition or storage in a small amount of substances, which may be used for the illegal production of narcotic or psychotropic substances (precursors), without the aim of selling them a warning shall be issued or a fine in an amount up to EUR 280 shall be imposed. Amendments to the Law also define that when applying the administrative punishment for the violation laid down in the Article 46, Paragraph one, of this Law, the person shall be warned in writing about criminal liability if he or she illegally acquires or stores in a small amount narcotic or psychotropic substances or uses narcotic or psychotropic substances within one year after the administrative punishment is imposed. At the same time, a person, who has handed over a small amount of narcotic and psychotropic substances or medicinal products, as well as substances, at his or her disposal, which may be used for illegal production of narcotic or psychotropic substances (precursors), which were obtained or

stored without the aim of selling them, or who has voluntarily attended a medical treatment institution for medical assistance in relation to the use of narcotic and psychotropic substances without a doctor's prescription, is exempt from the administrative liability regarding the actions intended by Section 46.

Amendments to the Latvian Administrative Violations Code of 29 May 2013 added Paragraph three to Section 46, which defines liability for persons who refuse to undergo a medical examination to establish the influence of narcotic and psychotropic substances. In such cases a fine in the amount up to EUR 280 shall be imposed.

On 3 July 2014, new Amendments to the Latvian Administrative Violations Code came into force by adding Section 45.4 "Provision of Premises for Unauthorised Manufacture, Storage, Transport, Forwarding and Sale of New Psychoactive Substances and their Preparations". The law establishes that in the case of provision of premises at a movable or immovable property possessed by the person for the unauthorised manufacture, storage, transport or sale of new psychoactive substances or their preparations, if it has been committed within one year after the person has been informed in writing about the unauthorised manufacture, storage, transport or sale of new psychoactive substances or their preparations at the particular property, a fine in the amount from EUR 280 to EUR 700 shall be imposed on natural persons, but for legal persons—from EUR 1400 to EUR 7100.

On 1 February 2013, Cabinet Regulation No. 47 "Pharmacovigilance Procedures" came into force. The aim of the Regulation is to perform analysis of the drug reactions to medicinal products for human use. The Regulation establishes that a healthcare professional or pharmacist shall report to the State Agency of Medicines or marketing authorisation holder of the medicinal product on the suspected adverse drug reactions, in order to ensure an effective functioning of the pharmacovigilance system. The new Regulation provides for the pharmacovigilance procedures, including rights and obligations of a healthcare professional, pharmacist and patient, obligations of marketing authorisation holder of the medicinal product, obligations of the State Agency of Medicines, pharmacovigilance monitoring and other important aspects (www.likumi.lv).

1.2. National Action Plan, Strategy, Evaluation and Coordination

National Action Plan and Strategy

Guidelines for the Containment and Control of Narcotic and Psychotropic Substances and the Prevalence thereof for the Period from 2011 to 2017 (hereinafter—the Guidelines) is a medium-term policy planning document. It includes measures the aim of which is to ensure and continue implementation of a planned national action policy for the containment and control of illegal narcotic and psychotropic substances and the prevalence thereof.

The Guidelines were drawn up and will be assessed according to the regulating legal acts: Cabinet Regulation No. 1178 of 13 November 2009 "Regulation for Development and Impact Assessment of Planning Documents" (hereinafter—Cabinet Regulation No. 1178) and Cabinet Instruction No. 19 "Procedures for the Initial Impact Assessment of a Draft Legal Act" (hereinafter— Cabinet Instruction No. 19). These are the main legal acts that regulate development, implementation and assessment of national policy planning documents. They provide for the criteria for setting policy goals, carrying out the initial impact assessment of policy, identifying the results and indicators of policy and action, as well as for establishing the necessary tasks and elements that should be included in the final assessment.

The Guidelines were drawn up as an integrated document and included the description of the situation and formulation of problems, policy and action tasks and indicators for reaching the targets set, as well as plan of measures and the estimated financing for the implementation of the policy.

The goals of the Latvian Guidelines:

- to reduce the acceptability of the use of illicit drugs to the society;
- to reduce the harm illicit drugs causes to the population;
- to reduce the availability of illicit drugs.

To achieve the three goals set in the Guidelines, four main courses of action have been put forward:

- prevention of drug addiction and drug abuse (2 policy results, 4 action results, 10 measures);
- health care of addiction patients and drug users (2 policy results, 7 action results, 15 measures);
- reduction of drug supply (2 policy results, 7 action results, 12 measures);
- action policy coordination and information gathering and analysis—an interdisciplinary coordination action to provide for the implementation of all courses of action (16 measures).

The authorities stipulated as having responsibility for implementation of the tasks set in the Guidelines are the Ministry of the Interior, Ministry of Education and Science, Ministry of Welfare, Ministry of Health, Ministry of Justice, National Armed Forces, State Police, Prisons Administration, State Revenue Service, Centre of Health Economics (currently: Centre for Disease Prevention and Control of Latvia) and Drug Control and Drug Addiction Restriction Coordination Council. Ministries, institutions subordinate to the ministries, municipal and non-governmental organisations shall be involved in the implementation of the Guidelines.

The tasks set in the Guidelines are mainly related with activities that have to be performed within the framework of allocated State budget means. Additional financing within the Guidelines has been provided for capacity-raising activities, for example, improvement of the forensic laboratory equipment of the State Police for identifying narcotic substances.

Implementation and Evaluation of National Action Plan and Strategy

Two evaluation measures (mid-term and ex-post evaluation) have been planned for the monitoring of implementation of the Guidelines. The Ministry of the Interior prepared and submitted the mid-term evaluation to the Cabinet of Ministers in the summer of 2014. The ex-post evaluation of the Guidelines must be submitted until 1 July 2018.

The procedure for the evaluation of the implementation of Guidelines has been established in accordance with Cabinet Regulation No. 1178 and Cabinet Instruction No. 19. The mid-term evaluation is a process evaluation basically and performs the function of monitoring and identifying the drug addiction situation. The main objectives of the mid-term evaluation will be to monitor the procedure of implementing the Guidelines and to identify their strengths and weaknesses, the changes that should be made to the activities, for example, improving the actions, removing or adding new actions. During the mid-term evaluation, also the level of policy and action results was considered, namely, if the planned indicators and their results have been achieved.

The planned evaluation questions are: to what extent the established goals have been reached and to what extent the related activities have been implemented? What are the most important results? Do the performance indicators of policy and actions correspond to the planned results? Are the identified national problems related to narcotic substances still topical? Are all tasks included in the Guidelines action plan topical?

In general, quantitative data will be mainly used in the evaluation. The most important data sources for performing the evaluation are the information provided by the state institutions and organisations directly involved in the implementation of the national programme, information in the possession of the Council Secretariat, results of the drug addiction studies carried out during the operation of the national programme, information systems and statistical data of various institutions, as well as expert discussions on the results of implementation of the national programme.

Currently, the ex-post evaluation of the Guidelines has been planned as an impact evaluation of policy, which will be performed by those implementing the policy. An accurate evaluation methodology will be developed after the mid-term evaluation is completed.

Coordination Arrangements

In drug policy coordination the highest authority is the Drug Control and Drug Addiction Restriction Coordination Council (hereinafter—the Council) chaired by the Prime Minister. The members of the Council are the competent ministers and official representatives from the State Revenue Service, the State Police and the Deputy Director of the Centre for Disease Prevention and Control of Latvia. The Council is a coordinating state institution, the main task of which is to coordinate governmental agencies, municipalities and non-governmental organisations in their efforts to control the circulation of narcotic and psychotropic substances and precursors and to prevent and restrict their illegal circulation and drug addiction. The Council is also responsible for national programme development, implementation and evaluation. Council meetings are held when necessary.

A responsible body of the coordination of the implementation of the Guidelines is the Council Secretariat. The functions of the Secretariat are performed by the representative from the Ministry of the Interior, who is also the National Drug Coordinator. In 2014, the National Drug Coordinator was changed. The board has set up three working groups:

- prevention and restriction of the prevalence of narcotic and psychotropic substances, treatment and rehabilitation of drug addicts;
- supply reduction group;
- information analysis working group.

Council working groups' main objective is to monitor the situation in the country and to submit proposals on the priority courses of action, necessary normative enactments and policy planning documents to the Council. These working groups are not responsible for the implementation of the Guidelines.

2. Drug Use in the General Population and Specific Targeted Groups

Drug use in the general population is one of the five key EMCDDA epidemiological indicators. It reflects the prevalence of drug use among population aged 15–64 years. This indicator incorporates the conducting of regular representative population surveys using a range of questions approved by EU experts (EMQ—European Model Questionnaire), which has been extended by the addition of questions of interest to the Member States.

Latest developments in the indicator at both the national and the international level include the necessity of obtaining additional information about intense drug use habits and drug availability. Likewise, the issue of data reliability is becoming increasingly more topical among researchers in recent years due to the rising non-responsiveness levels, so is the need for methodological studies using new ways of collecting data, such as conducting surveys via the Internet and the capability of generalising the surveys.

In the spring of 2013, a methodological survey using ESPAD methodology was carried out in Latvia. The primary objective of the methodological study was to determine whether and to what extent the answers of students differ depending on whether the fill-in questionnaire form is completed in the conventional manner (as a printed copy) or electronically. However, as the sample group for the study was selected as a representative sample of 14–16 year-olds from Latvia, it provides an insight into the prevalence of alcohol, tobacco and drug use in this target group, and, although the data should be interpreted with caution, it is comparable with the findings of previous ESPAD studies. The methodological nuances of the study and drug use prevalence rates in three age groups ascertained by surveying students have been described in this section.

2.1. Drug Use in the General Population

Studies on Prevalence of Drug Use

In Latvia to date, there have been three large-scale representative studies (in 2003, 2007 and 2011) which permit the tracking and monitoring of prevalence of drug use among the population. These studies were conducted on population aged 15–64 years and were conducted in accordance with the EMCDDA recommended methods, thus allowing the results obtained from Latvia to be compared with the situation in other EU states to a large extent. In accordance with these methods, the survey questions on drug use were measured in three time periods—during lifetime, during past year and during past month. In addition to the questions about the prevalence in use of various substances, the range of issues studied also included questions about attitudes and values, availability of drugs, etc. (EMCDDA, 2002).

The first large-scale survey took place in 2003; while the second and the third studies conducted using comparable survey methodology took place in 2007 and 2011 respectively. The target sample size exceeded more than 4500 respondents (4534 in 2003, 4500 in 2007, and 4493 in 2011), also allowing the prevalence of a relatively small phenomenon in the general population to be measured with a sufficiently high degree of accuracy. Reports of all these studies have been published as separate reports and are available in hard and soft copy (Goldmanis et al., 2003; Koroļeva et al., 2008 and Sniķere et al., 2012).

Outlined below in this section are the main prevalence indicators for use of any illicit drug[1], comparing the results of the 2003, 2007 and 2011 studies by key age and gender groups (see Table 2.1.).

In general, 14.3% of Latvian residents aged 15–64 years have tried some form of illicit drug during their lifetime. Relatively much fewer inhabitants had used illicit substances within the past year (recent use) or past month (current use): respectively 4.4% and 1.8%. A reduction in drug use is evident in comparison with 2007. The number of inhabitants experimenting with drugs has decreased by 1.8% (from 16.1% to 14.3%); the number of recent users—by 1.7%, and the number of current drug users—by 0.4%. Thus, drug use indicators have returned to approximately the 2003 level.

According to data from the Central Statistical Bureau, currently in Latvia there are approximately 1.4 million (1,384,502) inhabitants of working age. According to the results obtained, it can be generalised that in Latvia 198,000 people have tried drugs. The sampling error in this case is 1%, i.e. it can be argued with a 95% probability that 13.3–15.3%, or 184,000–212,000 Latvian inhabitants have tried illicit substances at least once in their lives.

During the past year, approximately 61,000 inhabitants had used drugs (compared with 92,000 in 2007). The sampling error in this case is 0.5%. This means that it can be argued with 95% confidence that 53,000–69,000 or 3.8 to 5.0% of the population had used drugs during the past month in 2011 compared with 5.4–6.6% of the population in 2007 and 4.0–5.2% of the population in 2003.

Drugs had been used during the past month by 1.8% of 15–64 year-olds, or about 25,000 (± 6,000) inhabitants. T-test results confirm that the reduction in drug use since 2007 may also be considered statistically significant.

Table 2.1. Proportion of recent and current users who have tried any drug, 2003, 2007 and 2011 (%)

	Lifetime prevalence	Last year prevalence	Last month prevalence
15–64 year-olds			
2011	14.3	4.4	1.8
2007	16.1	6.1	2.2
2003	12.3	4.6	2.2
15–34 year-olds			
2011	22.9	8.2	3.2
2007	27.9	11.9	4.2
2003	21.9	9.7	4.7
35–64 year-olds			
2011	7.8	1.5	0.7
2007	6.8	1.6	0.7
2003	5.3	0.9	0.5

Source: Sniķere et al., 2012

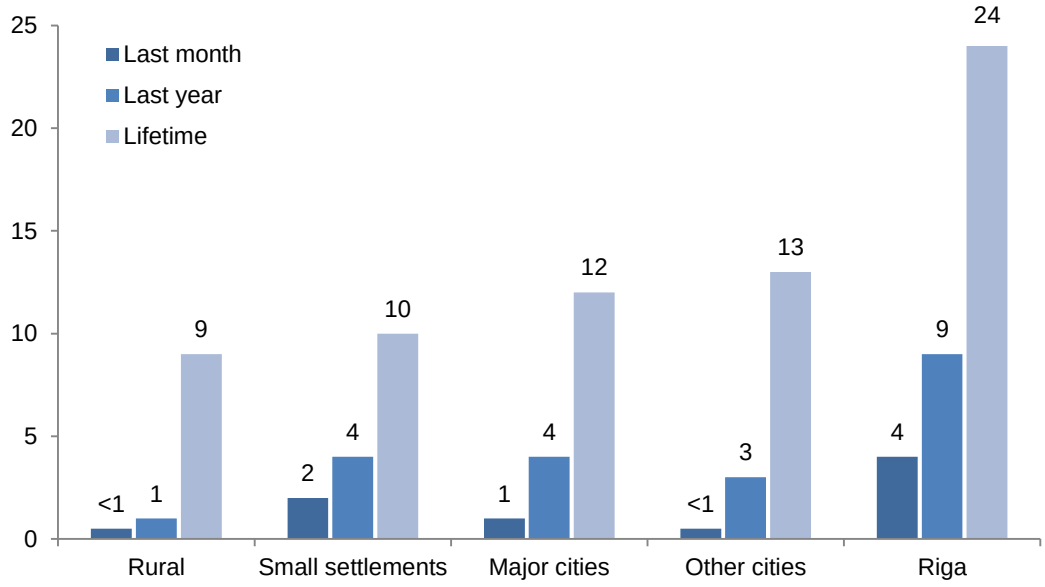
Although the total quantitative indicators suggest that use of several narcotic substances is decreasing in Latvia, there is a risk that they may have been replaced by new substances or substances not listed in the Schedule of Prohibited Substances hitherto. As stated in the EMCDDA 2011 European Drug Report, although the drug situation in Europe is stable, qualitative changes do exist. New psychoactive substances are emerging, such as the new synthetic cannabinoids;

[1] Marijuana/hashish, ecstasy (MDMA), amphetamines, cocaine, heroin and/or other opioids, LSD and/or other hallucinogens

mephedrone, “Spice” and other intoxicating plant mixtures are becoming more widespread (EMCDDA, 2011).

As in the 2003 and 2007 studies, in 2011 the persons most commonly trying and using drugs are those living in Riga: a total of 23.7% of them had tried drugs, 8.9% used drugs during the past year, and 3.9% of the population aged 15–64 years had done so in the past month, (see Figure 2.1.). In other cities, 12–13% have tried drugs, 3–4% have used them during the past year, which is almost 50% less than found for the general population of Riga. The number trying drugs in the smaller towns is slightly lower (10%), but the number using drugs during the past year is similar to what it is in the major cities. In rural areas the number of drug users is significantly lower: only 9% had tried them, and only 1% of the population aged 15–64 years had used them during the past year. These results confirm the need to pay particular attention to combating the spread of drugs in Riga, where the indicators for drug use among young people are of particular concern. In Riga, drugs have been tried by one in every two (51%) males aged 15–34 years. It must also be noted that since 2007 the numbers trying drugs in various urbanised areas have steadily declined.

Figure 2.1. Lifetime, last year, last month prevalence rates of any illegal drugs, by level of urbanisations (%)



Source: Sniķere et al., 2012

As in previous years, significant differences are observed between the genders: men have tried drugs nearly three times more frequently (21.1%) than women (8.02%). During the past year, 6.2% of men and 2.7% of women had used drugs. It must however be noted that the differences in rates between the genders have decreased since the previous survey; drug use has significantly decreased within the men’s group, while indicators for the women’s group are relatively stable.

Drugs were most commonly tried or used during the past year and past month by young people aged 15–34 years (see Table 2.2.): 23% have tried drugs, 8% have used them during the past year and 3% have used them during the past month. Drug use is rare among those aged 35 and over: although 8% have tried drugs, only 1.5% have used them in the past year and 0.7% during the past month. Importantly, the reduction in trying and using drugs has occurred among the younger age group, in which the number trying drugs decreased by five percentage points and the number recently using drugs by four percentage points (from 12% to 8%).

The largest number trying drugs for the first time is observed among men aged 15–34 years: 31% of men and 15% of women in this age group have tried drugs; 11% of men and 5% of women had used them during the past year.

Table 2.2. Proportion of recent and current users who have tried any drug, relative to gender and age (%)

	Lifetime prevalence	Last year prevalence	Last month prevalence
15–64 year-olds			
Men	21.1	6.2	2.7
Women	8.0	2.7	0.9
Total	14.3	4.4	1.8
15–34 year-olds			
Men	31.0	11.1	4.4
Women	14.6	5.2	1.9
Total	22.9	8.2	3.2
35–64 year-olds			
Men	12.9	2.2	1.4
Women	3.4	1.0	0.2
Total	7.8	1.5	0.7

Source: Sniķere et al., 2012

As in previous years, the most commonly used illicit drug is marijuana or hashish; 12.5% of the population have tried it. After marijuana the next most popular drug is ecstasy (tried by 2.7%), amphetamines (2.3%), cocaine (1.5%) and various opioids (1.1%). LSD, other hallucinogens, and heroin are rarely encountered substances; they have been tried by less than 1% of the population (see Table 2.3.).

Table 2.3. Distribution of illicit drugs tried during lifetime, by gender and age in 2011 (%)

	15–64 year-olds			15–34 year-olds			35–64 year-olds		
	M	*W*	*T*	M	W	T	M	W	T
Any drugs	21.1	8.0	14.3	31.0	14.6	22.9	12.9	3.4	7.8
Any drugs, except for marijuana/hashish	7.8	3.4	5.5	11.4	5.6	8.5	4.7	1.8	3.2
Marijuana or hashish	18.7	6.7	12.5	28.0	12.7	20.4	11.0	2.5	6.5
Ecstasy	3.9	1.6	2.7	6.5	2.4	4.5	1.9	1.1	1.5
Amphetamines	3.6	1.0	2.3	5.4	2.3	3.9	2.1	0.2	1.1
Cocaine	2.0	1.0	1.5	2.6	1.7	2.2	1.5	0.5	1.0
Heroin	1.1	0.1	0.6	1.5	0.1	0.8	0.8	0.0	0.4
Other opioids	1.5	0.6	1.1	2.4	1.0	1.7	0.8	0.4	0.6
LSD	1.1	0.4	0.7	1.9	0.6	1.3	0.4	0.3	0.3
Other hallucinogens	0.9	0.2	0.5	1.4	0.2	0.8	0.4	0.2	0.3
Inhalants	2.7	0.5	1.5	3.9	0.8	2.3	1.7	0.3	1.0
Spice	3.7	1.4	2.5	6.1	2.7	4.4	1.6	0.5	1.0

Source: Sniķere et al., 2012

Cannabis

As elsewhere in Europe and the world, in Latvia marijuana and hashish are the illicit substances most widely used by the general population. According to EMCDDA estimates, more than 78 million, or nearly a quarter (23%) of the working age population of Europe (15–64 years) have tried marijuana or hashish at least once during their lifetime and this is not significantly different from

2007 indicators (EMCDDA, 2011). In Latvia too, the proportion of first time users of marijuana has not changed significantly in comparison with 2007. In total, 12.5% have tried marijuana or hashish; however, the number of recent users has decreased slightly, and is practically back at the 2003 level. In 2007 marijuana had been used by 4.9% in the past year, while only 4.0% had done so in 2011. T-test results confirm that the reduction is statistically significant at the 95% confidence level.

A similar slight decrease is seen in the number who had used marijuana during the past month—from 1.8% to 1.6%. In this case, the number of users is small and does not support the argument that the difference is statistically significant.

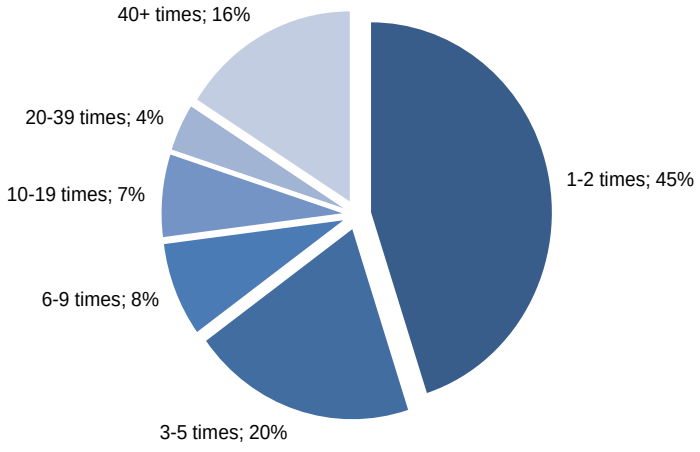
Table 2.4. Proportion of recent and current users who have tried marijuana, 2003, 2007 and 2011 (%)

	Lifetime prevalence	Last year prevalence	Last month prevalence
15–64 year-olds			
2011	12.5	4.0	1.6
2007	12.1	4.9	1.8
2003	10.6	3.8	1.8
15–34 year-olds			
2011	20.4	7.4	2.9
2007	21.7	9.7	3.7
2003	19.6	8.1	3.7
35–64 year-olds			
2011	6.5	1.4	0.7
2007	4.6	1.1	0.2
2003	4.1	0.7	0.4

Source: Sniķere et al., 2012

Almost half (45%) of those who used marijuana or hashish during the past year indicated that they done so once or twice (see Figure 2.2.). However, one in five (20%) had used marijuana 20 or more times during the past year, i.e. more often than once a month. Overall, the number of such regular marijuana smokers comprises 0.8% of the working age population.

Figure 2.2. Frequency of cannabis use during past 12 months (% of persons reporting last year cannabis use)



Source: Sniķere et al., 2012

Marijuana has been tried more often by men (18.6%) than women (6.7%). It is worth noting that, compared to 2007, marijuana use has declined among men, while among women it has remained practically unchanged. Men had also used cannabis more often during the past year (5.5% compared with 2.5% of the women's group).

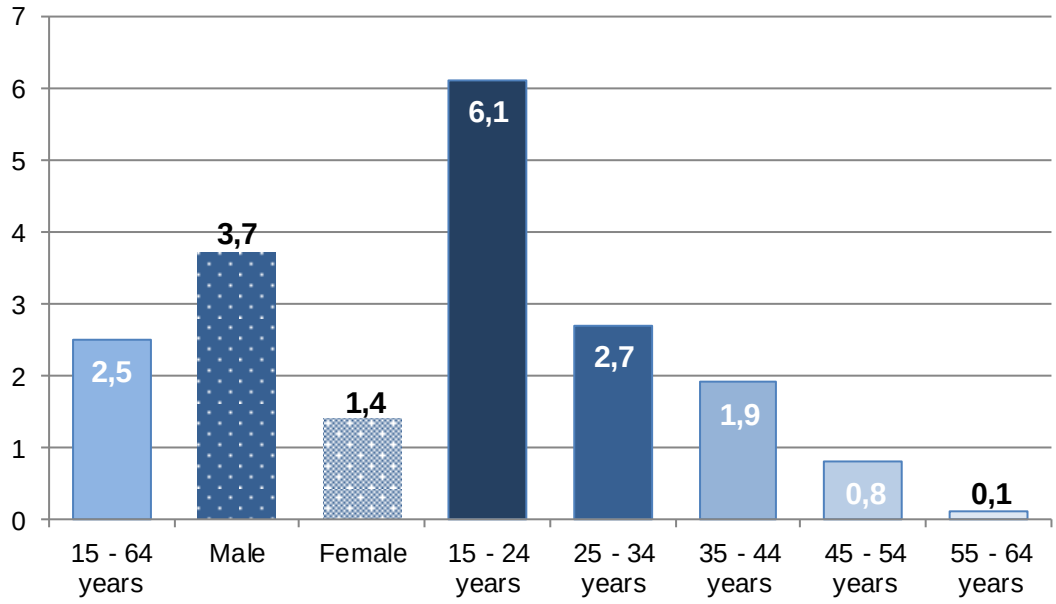
Younger respondents aged 15–34 have tried marijuana significantly more often (20.4%) than those aged 35–64 years (6.5%), and they have used it significantly more often during the past year. Overall, 7.4% of the population aged 15–34 years have used marijuana during the past year, and 2.9% have done so within the past month.

Spice and Other Smoking Mixtures

Survey respondents were asked if they had ever tried intoxicating smoking blends/incense (such as the so-called "Spice" group mixes or "Alarama"). The results show that such mixtures have been tried by 2.5% of the population aged 15–64 years, including 3.7% of men and 1.4% of women.

Most often, such mixtures had been tried by young people aged 15–24 (6.1%). With increasing age, the popularity of such substances declines (see Figure 2.3.). Such mixtures were tried most often by those whose income is very low—less than LVL 80 per family member (3.8%), but they are also relatively popular among the highest income groups. As with all drugs, smoking blends/incense are much more common in Riga (tried by 5.5%) than elsewhere in Latvia (tried by less than 2%).

Figure 2.3. Lifetime prevalence of Spice products, % by various age groups



Source: Sniķere et al., 2012

Age of Trying Drugs

The drug which is tried earliest in life is the inhalants. It is not illegal, it is easy to get, and so for children this form of intoxication is the most accessible. In general, 40% (compared with 55% in 2007) had tried inhalants before reaching the age of 16 years. After the age of 18 this type of intoxication is rarely tried (see Table 2.5.). Perhaps this can be explained by the fact that at 18 years of age, other intoxicating substances such as cigarettes become available.

Also tried relatively early on are marijuana, opioids, various hallucinogens, as well as new psychoactive substances not listed in the Schedule of Illicit Substances, the so-called "new drugs": at least 34% of the population had tried them before reaching the age of 18 years. Amphetamines

are usually (56%) tried by the 19–25 age group, but before then in only 33% of cases. Cocaine is usually tried even later—usually (44%) by 21–25 year olds.

Table 2.5. Age at which drugs tried (%)

	Cannabis (n=467)	Ecstasy (n=107)	Amphetamines (n=84)	Cocaine (n=61)	Opioids (n=37)	LSD or other hallucinogens (n=44)	Inhalants (n=61)	Other psychoactive substances (n=94)
Less than 16 years	8	6	3	5	6	8	40	12
16 years	12	9	5	<0.1	11	19	21	14
17 years	14	9	16	12	21	6	17	12
18 years	14	22	9	5	7	10	4	5
19 years	12	14	14	12	19	7	4	10
20 years	10	14	20	6	20	1	7	11
21–25 years	21	21	22	44	4	36	2	20
26–30 years	5	5	6	14	11	9	<0.1	7
Over 30 years	4	1	4	3	2	5	4	10

Source: Sniķere et al., 2012

2.2. Drug Use in the School and Youth Population

ESPAD Methodological Study

In the spring of 2013 (April to May), a methodological study was carried out in Latvia in accordance with ESPAD methodology (a survey project for European schools regarding alcohol and other drugs).

The primary objective of the methodological study was to determine whether and to what extent the answers of students differ depending on whether the fill-in questionnaire form is completed in the conventional manner (as a printed copy) or electronically. However, as the sample group for the study was selected as a representative sample of 14–16 year-olds from Latvia, it provides an insight into the prevalence of alcohol, tobacco and drug use in this target group, and, although the data should be interpreted with caution, it is comparable with the findings of previous ESPAD studies. The methodological nuances of the study and drug use prevalence rates in three age groups ascertained by surveying students have been described in this section.

In addition to the survey of students, a school administration survey was also carried out, within the framework of which principals of Latvian schools or their representatives were asked to evaluate their experience with computerised questionnaires or assessment of academic achievement, and questions were asked about research among students, addiction prevention and the needs of the school. A detailed report on the findings obtained in the school administration survey is available on the website of the Centre for Disease Prevention and Control of Latvia (Pētersons et al., 2013).

Methodology

The sampling frame of studies included a number of young people who were born in a specific year (1997). Within the framework of the 2013 study, the data is also representative of students one year younger (born in 1998) and one year older (born in 1996). The sample of the study was designed as a single-stage stratified cluster probabilistic sample with the school class designated as the sample unit, a principle that was applied successfully in the ESPAD studies carried out in Latvia in 2003, 2007, and 2011.

The sampling frame was designed in accordance with the data at the disposal of the Ministry of Education and Science as of the beginning of academic year 2012/2013 when a total of

46,111 students were enrolled in 2828 classes at the level of Form 8 to Form 10. As in the studies carried out in Latvia in the previous years, the sampling frame did not include special education classes and/or schools for children with severe mental and/or physical disabilities, for whom completing a standard questionnaire could be problematic. In total, the sampling frame consisted of 2411 classes in 666 schools, and, according to the Ministry of Education and Science statistics, 42,634 students were studying in those schools.

The sampling frame was stratified according to the form (grade) level (Forms 8, 9, and 10), teaching language (Latvian and non-Latvian) and the urbanisation level (Riga and each of the nine major cities constituted separate strata, while the rest of the country's territory was stratified according to the status of the area (urban or rural) in each of the five regions and the three ranks of the development indices). A total of 114 strata were established and their sizes were calculated in accordance with the Ministry of Education and Science statistics on students in academic year 2012/2013.

In accordance with the estimated number of classes that need to be included in the sample, such classes were selected at random from the entire list of classes the inclusion probability of which is proportional to the number of students in the class. A total of 231 classes were selected.

The fieldwork of the study was carried out from April to May 2013. Overall 161 comprehensive schools agreed to participate in the study, with a total of 178 classes of students surveyed. Refusals were received from 42 secondary education establishment principals (53 classes); however, the sampling method used did not envisage for a replacement of those classes. Considering the number of school refusals and the imprecise information regarding class size and student absenteeism, the sample size was in practice 3071, of which 1060 studied in Form 8, 1126—in Form 9, and 871—in Form 10.

On the day of the survey, of the schools/classes that had agreed to participate in the survey, 241 students (164 boys and 127 girls) were absent from school for various reasons and they were not interviewed.

The estimated non-response rate at schools and in classes that had agreed to participate in the survey is 7.8% of all the students, while the estimated non-response rate at class level is 23% (due to school refusal to participate in the study, mainly due to the heavy academic workload). Nine students refused to participate in the survey in a total of six form levels.

Students in a class were divided into two groups in alphabetical order according to the class register: one group was instructed to complete the questionnaire electronically in the school's computer room, while the other group completed printed out questionnaires as in other LaSPAD studies (Survey Project on Students in Latvia regarding Alcohol and Other Narcotic Substances).

Probability of inclusion in the sample was calculated for each sampling unit (class), and these were used when weighting the data. Given the uneven level of non-response by gender and regional dimension, the data from the study was weighted according to division by gender within the strata, as well as according to the inverse probability of a student being included in the sample. Data from the additional survey was weighted in a class dimension by gender and the manner of how the questionnaire was completed.

For data analysis, responses provided by 14–16 year-olds (born from 1996 to 1998) were used (n=2896; unweighted data), of which 925 were born in 1998 (14 years old), 1062 were born in 1997 (15 years old) and 909 were born in 1996 (16 years old).

Within the framework of the 2013 study, survey questionnaires were completed by 3071 students, of which 1551 completed them in paper format and 1506 completed them using a computer. For data

analysis such questionnaires were used in which gender and the appropriate age were indicated (students born in 1996, 1997, and 1998), namely, 2896 questionnaires.

Table 2.6 shows specific characteristics of students. The data shows that there were no significant differences between the students who completed the questionnaire in the printed format and those who completed them using a computer.

Table 2.6. "Objective" indicators characterising students, %, by format of how the questionnaire was completed

	P&P (%)	CASQ (%)
Average marks (p=0.5774)		
8>	10.0	11.3
5–8	79.2	77.7
<5	10.8	11.1
Financial condition (p=0.0245)		
Better than that of others	56.7	61.4
Approximately the same as that of others	33.7	31.2
Worse than that of others	9.6	7.4
Family type (p=0.2373)		
Both parents	57.6	61.1
Father+stepmother, mother+stepfather	13.7	11.8
Single parent	21.6	20.6
Other	7.2	6.5
Activities in free time (% every/almost every day)		
Plays computer games	29.7	31.2
Is active in sports	48.2	48.4
Reads books for own enjoyment	8.9	10.7
Goes out in the evening	4.5	5.5
Other hobbies	29.0	28.6
Kills time aimlessly	23.8	25.5
Surf son the Internet to use up free time	63.9	64.9
Parents always know, where the student spends Friday nights	57.3	57.0

Source: Trapencieris et al., 2013

The main indicators characterising the prevalence rates of substance use in comparison to the previous ESPAD studies are outlined in this section. However, the indicators must be interpreted very carefully, as the sample sizes in each of the age groups achieved in the 2013 study is about two times smaller than those in the studies conducted in 2003, 2007, and 2011; moreover, half of the students filled in the questionnaires using a computer, while the other half filled in questionnaires in paper format, which theoretically could affect the findings.

Unlike for legal addictive substances (tobacco, alcohol), whose prevalence rates seem to have dropped considerably since 2011, the prevalence of the most commonly used illegal substance, marijuana/hashish, has slightly decreased or has remained at the same level (see Table 2.7).

The data from 2013 shows that over the past 12 months, marijuana/hashish has been used by 18% of the 15-year-old boys and 12% of the 15-year-old girls (14% total). These figures, just as those that show the rate of trying the substance, have slightly decreased compared to 2011, but care must be taken when interpreting the data due to the different sampling error values and the methods used. The proportion of current marijuana/hashish users, namely, those who have used this substance within the last 30 days, has not changed substantially compared to the proportion in

2011, when 6% of the young people admitted to marijuana use in the last 30 days, while in 2013 the figure was 7% of the 15 year-olds.

Table 2.7. Lifetime prevalence of trying marijuana/hashish in the ESPAD cohort of students by gender, 1995–2013, %

	Boys	Girls	Total
Lifetime prevalence of marijuana/hashish			
1995	8	3	
1999	22	12	17
2003	21	13	16
2007	24	13	18
2011	29	19	24
2013	24	19	21

Source: Trapencieris et al., 2013

Data from the 2013 study shows that the second most frequently used substance (after marijuana/hashish) is the so-called Spice group products, which have been tried by 15% of the 15-year-olds in their lifetime (in comparison, in 2011, the figure was 11%). What is interesting is that, unlike the 2011 study data, the data from the 2013 study do not point at statistically significant differences by gender (it has been used by 16% of the boys and 13% of the girls).

Relatively few school-age young people have used various synthetic stimulants (amphetamines, ecstasy) in their lifetime (2–4%), as has been found in other ESPAD studies.

Although the proportion of young people using various inhalants has decreased in comparison to 2011, the figure still remains high—18% of the young people in the ESPAD cohort have tried inhalants in their lifetime (equally many boys and girls).

2.3. Drug Use in Pregnant Women

In 2013 a study was first performed in Latvia where women in postnatal period were surveyed to establish the prevalence of addictive substances (tobacco, alcohol, narcotic and psychotropic substances) during pregnancy, women awareness of and attitude towards the impact of use of the mentioned substances on the health of the baby and course of pregnancy, as well as to learn the opinion of women about substance prevention measures.

Within the study, 602 women in postnatal period, who were hospitalised in Riga Municipality company SIA “Rīgas Dzemdību nams” (“Rīgas Dzemdību nams” is the largest delivery assistance institution in Latvia), were surveyed.

The proportion of users of narcotic and psychotropic substances among pregnant women is relatively low (0.3%). Majority of women (92.2%, n=555) points out that they have never used the mentioned substances. Overall, 6.8% (n=41) women reveal that they have tried some substances several times during the lifetime, but that they have stopped using these substances long time before the pregnancy (see Table 2.8.).

The data obtained in the study suggests that one in ten women (9.5%) have smoked during the pregnancy, but slightly less than one fifth of women (17.3%) has used alcohol during the pregnancy.

Although healthcare professionals have asked almost all women surveyed (92.4%) about the use of addictive substances during the pregnancy, only every second women has received information about the hazards of smoking and impact of use of alcohol or narcotic and psychotropic substances. Moreover, almost half (40.7%) of the smoking women, largest portion (89.6%) of women using

alcohol and all women drug-users surveyed had not been suggest to stop using the addictive substances.

Table 2.8. Number and proportion of women whose narcotic or psychotropic substances use habits have changed over the lifetime

Change of habits	n	%
I have never used narcotic or psychotropic substances	555	92.2
I have used several times in my life, but stopped using some time before the pregnancy	41	6.8
I have used regularly, but stopped using some time before the pregnancy	1	0.2
I have used narcotic or psychotropic substances, but stopped using during the pregnancy	5	0.8
I tried to stop using, but I am still using	0	–
I did not try to stop using	0	–
Total	602	100.0

Source: Evija Dompalma-Linuža et al., 2014

Although women can name a number of child development or pregnancy disorders that can be caused by the use of tobacco products or alcohol, the respondents show certain difficulties in distinguishing the impact caused by separate addictive substances, namely, the hazards of smoking and hazards of using alcohol. Women have poorer knowledge about the impact of narcotic and psychotropic substances on the pregnancy and child development, and in most cases they answer that the child will have general development disorders (36.2%) or avoid giving a specific answer (35.1%), for example, by indicating that the child will have “all possible problems and disorders”.

Internet (93.7%), television (84.2%) and healthcare specialists (83.1%) are mentioned by the women as the most convenient information channel for transmitting information on the hazards caused by the use of addictive substances during the pregnancy. However, examples of other countries and the interviews conducted show that information on the impact of addictive substances must be adapted for the target group. For example, drug users might better understand the information provided directly by a specialist (healthcare specialist, social worker) or another drug user, instead of the Internet or television.

The study concludes that it is necessary to improve the communication of healthcare specialists monitoring pregnancy and pregnant women so that the women would trust the doctor and inform the doctor on their addictive substances use habits. It is also necessary to improve the knowledge of doctors about the national treatment programmes and methods suitable for those pregnant women who would like to stop using addictive substances. Professional medical associations should consider the necessity of organising professional development study courses on motivating women to stop using addictive substances, as well as to weigh up the possibilities of drafting guidelines for work with pregnant women using various addictive substances.

3. Prevention

Course of action "Competence Development" of the Latvian National Development Plan for 2014 to 2020[2] envisages that by 2020 all children and young people have to be provided with high-quality primary and secondary education, as well as access to activities outside of formal education, while course of action "A Healthy Person who is Able to Work" focuses on premature death and loss of ability to work and the relationship between the causes thereof and various health risks, including smoking and risky drinking. Within the framework of this course of action, one of the tasks to be completed is prevention of addictive substances and processes.

The Public Health Guidelines for 2014–2020[3], as a mid-term policy planning document that have been drafted in accordance with the National Development Plan 2014–2020, European policy framework and strategy "Health 2020" of the World Health Organisation, as well as the priorities of the European Union funds for 2014–2020 planning period, marks new development goals and directions of action with the view to maintain, improve and restore the health of the inhabitants of Latvia, especially people who are subject to the risk of social exclusion and poverty, over the next seven years. One of the sub-goals of this draft normative enactment provides for reducing the risk of premature death caused by non-communicable diseases by reducing the negative impact of risk factors on the health.

Section 15 of the Law "On Local Governments"[4] stipulates that it is a function of the local government to provide access to health care, as well as to promote a healthy lifestyle and sports among the population.

Overall, several positive conclusions can be drawn from the prevention programmes implemented by the municipalities. First, the network of municipal health contact persons established by the Ministry of Health should be mentioned (on 1 April 2014, 86 municipalities had appointed their contact persons), as well as the work undertaken in order to create the National Healthy Municipalities' Network. The goal of the network is to facilitate exchange of best practices, experience and ideas among municipalities and to provide them with a methodological support in solving various issues related to public health and health promotion, including drug addiction prevention, on the local level. On 1 April 2014, there were 27 municipalities in the network. Both projects are being implemented in order to make the public health issue, including addiction prevention measures, No. 1 in the municipalities.[5]

In 2013, many activities were carried out as comprehensive preventative action, and it can be observed that local government involvement is showing a tendency to increase. Selective prevention activities are carried out not only in Riga, but regionally as well. Target groups of the selective prevention activities: students with social or learning problems, children and young people from socially disadvantaged families, young offenders. The indicated prevention is not common in the country.

It has to be emphasised that in most cases, prevention activities in the country are not based on examples of the best practice; usually only a quantitative evaluation is carried out, and assessment of the effectiveness of preventative intervention is provided in very few cases.

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[2] Approved with Decision of the Parliament (Saeima) of 20 December 2012 (available on: http://www.pkc.gov.lv/images/NAP2020%20dokumenti/20121220_NAP2020_Saeim%C4%81_apstiprin%C4%81ts.pd)

[3] Available on: http://likumi.lv//doc.php?id=269591

[4] Available on: http://www.likumi.lv/doc.php?id=57255/

[5] Information Report "On the Implementation of the "Guidelines for the Containment and Control of Narcotic and Psychotropic Substances and the Prevalence thereof for the Period from 2011 to 2017" from 2011 to 2013" (unpublished data).

In 2013, a national scale mass media campaign was organised with an aim to reduce the number of drunk drivers and the number of traffic accidents. No drug awareness campaigns were carried out in 2013.

Definition

In already 1994, the Institute of Medicine (the USA) has suggested describing prevention of addictive substances use by using terms different from the general health care terminology, namely, **universal, selective and indicated** addiction prevention.[6] A new term "environmental strategies" has been suggested by the EMCDDA in 2011 to refer to the environment where people make their choice of using or not using addictive substances.

The prevention activities carried out in Latvia have been described in accordance with the mentioned classification.

Data Collection Methods

Information on specific prevention activities is derived, first, from the data provided by the state institutions that are directly or indirectly involved in prevention, second, from the information on the operation of non-governmental organisations, local government (municipality) and state institutions published by the media.

In order to clarify the situation in addictive substances prevention and also to promote mental health and suicide prevention activities in municipalities in 2013, in the spring of 2014, professionals of the CDPC sent questionnaires to 109 municipalities and 9 city municipalities asking to provide answers and to send out a set of questions about the prevention activities for school environment carried out at schools in the municipality.

In order to better identify the selective addiction prevention activities carried out at municipalities, questions about the selective prevention strategies and activities in risk families were clarified. The set of questions regarding the prevention of addictive substances in municipalities consisted of eleven questions which enabled the respondents both to select corresponding answers and to express their comments replying to the open questions. By using questions in which the respondent has to specify prevention activities for addictive substance use in target groups, we tried to find out whether the municipalities are implementing universal, selective and indicated prevention of addiction. The last six survey questions that addiction and mental health promotion have in common were asked to find out the vision of municipalities about their "strengths", "weaknesses", opportunities and solutions when implementing the above mentioned prevention activities, as well as potential threats in the future.

A separate set of questions was added to the questionnaire for schools; schools, however, were asked a question regarding an action plan that envisages actions if the school found out that there were addictive substances or suspected that students used, stored or distributed addictive substances. Schools were asked about issues integrated into curriculum subjects that are directly or indirectly related to addictive substance prevention (with an option to select one of the choices offered or to report on other activities), informative events organised by the schools dealing with various issues related to addictive substance problems (with an option to select one of the choices offered or to report on other measures), as well as about parent meetings/evenings held at the school, guest lecturers invited to participate in the activities, etc. All the questions were analysed both quantitatively by calculating the proportion (%) of the municipalities and schools that had responded and qualitatively by summarising the opinions sent in by the municipalities.

[6] More information on: http://www.emcdda.europa.eu/html.cfm/index1568EN.html

As a delimitation of the scope of interpretation of the findings of the survey, the first point to be discussed is the potentially different understanding of the respondents about the concept of prevention of addictive substance use. The respondents were also offered specific examples of addictive substance use prevention activities and possibility to learn the best practices of addictive substances prevention in European countries; however, also in this case, the activities can be interpreted in different ways, which could cause a bias in the gradation by proportion of the municipalities that responded in which such activities were carried out. Second, it should be taken into consideration that only 53% of the municipalities provided answers, which suggests that the findings show the situation only in these municipalities. Third, when interpreting the findings in terms of how they concern schools, it must be taken into consideration that responses were received from only 21% (176, n=832) of the schools.

At the end of the survey, 62 replies were received from the municipalities (53%, n=118), compared to 86 replies (or 72%) in 2013 and 74 replies (63%) in 2012. The section of the questionnaire addressed to schools was completed by 176 schools (21%, n=832).

3.1. Environmental Prevention

Environmental prevention aims to transform the physical, cultural, social and economic environment in which people make their choices. Complementing the information on environmental prevention to restrict the use of alcohol and tobacco provided in the 2012 National Report (CDPC, 2013), it should be pointed out that new policy initiatives were initiated in 2013.

In 2013, amendments to legislation were submitted to the Cabinet of Ministers providing for ban of sale of electronic smoking devices or the so-called e-cigarettes and the e-liquid used in these devices starting from 1 January 2015. Electronic cigarettes, which entered the European market first in 2007/2008, have gained an increasing popularity also among people in Latvia, especially the young people. Applying legislative norms to electronic cigarettes has been practised also by the European legislators—after discussions lasting more than a year they managed to agree on the amendments to the EU Directive 2001/37/EC “On the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco products”, which obligates the Member States to introduce the new provisions into their laws during the coming years. The adopted changes provide for the introduction of several legislative norms that will strengthen the tobacco control policy in each Member State. These changes will apply to the content, packaging, use of tobacco, plant mixtures and nicotine-containing products, as well as other important fields of tobacco control in all the EU Member States.

The price is the most important factor determining availability of tobacco products. Last year, the Saeima adopted amendments to law providing for gradual raising of the excise duty on cigarettes to comply with the EU requirement regarding harmonisation of the minimum price of cigarettes in all Member States. Until June of 2018, the tax rate per 1000 cigarettes has to increase up to EUR 97, from the current EUR 85.6. The extension of the time frame for raising the prices in Latvia, where the set minimum price should be reached in 2016 already, suggest that the legislators hesitate to use one of the most efficient tools for cutting the demand for tobacco products (Mārtiņsone et al., 2014).

Several amendments to legal acts in the field of drug prevention were made in 2013 and 2014 to fight the phenomenon of using new psychoactive substances. On 23 February 2013, amendments to the Law “On the Procedures for the Coming into Force and Application of the Criminal Law” and amendments to the Cabinet Regulation No. 847 of 8 November 2005 “Regulations regarding Narcotic Substances, Psychotropic Substances and Precursors to be Controlled in Latvia” came into force; thus, a new system was introduced to the schedule I of narcotic and psychotropic substances to be controlled in Latvia—control of substances according to the generic system, which includes both the identified and the unidentified new psychoactive substances.

On 14 November 2013, amendments were made to the Law "On Procedures for the Legal Trade of Narcotic and Psychotropic Substances and Medicinal Products", Section 4, Paragraph two, states now that: Centre for Disease Prevention and Control of Latvia may take a decision regarding imposing a ban or restriction on the manufacturing, acquisition, storage, transportation, forwarding or distribution of the new psychoactive substances or their preparations that are not included in the lists of narcotic substances, psychotropic substances and precursors to be controlled in Latvia, but regarding which information has been received from the Early Warning System or a conclusion of a forensic expert institution regarding new psychoactive substances has been received, for up to 12 months from entering into force of the decision. The decision shall enter into force on the next day after it is published in the Official Gazette "Latvijas Vēstnesis". Thus, a new temporary ban of new psychoactive substances was introduced to Latvia.

To continue, also amendments to the Criminal Law coming into force on 9 April 2014 should be mentioned. The Criminal Law was added with Section 248.[1] providing for a criminal punishment for persons who manufacture, acquire, store, transport, forward for purposes of sale or sale new psychoactive substances or their preparations circulation of which is banned or restricted. The applicable punishment in these cases is deprivation of liberty for a term up to two years or temporary deprivation of liberty, or community service, or a fine and with a police supervision for a term up to three years. For the same activities if substantial harm has been caused thereby the applicable punishment is deprivation of liberty for a term up to five years, or community service and with a police supervision for a term up to three years (www.likumi.lv).

3.2. Universal Prevention

In basic education, health education matters for students in Forms 1 to 9 have been included in the curriculum of the subject "Social Sciences".[7]

Health education issues have also been included in the curricula of other subjects of basic education, namely, "Natural Sciences", "Biology", "Domestic Science and Technologies", "Physical Education".

In comprehensive secondary education, the subject "Health Studies" has been established as one of the optional subjects for students in Forms 10 to 12 within the mandatory curriculum of comprehensive secondary education programmes.[8]

Currently, the subject "Health Studies" has not been established as the optional or mandatory curriculum of vocational education programmes. In 2013 when examining the Information Report "On including the subject "Health Studies" in the curriculum of general secondary and vocational education programmes" prepared by the Ministry of Health, the Cabinet of Ministers[9] considered the necessity of including the health education module in vocational secondary education programmes starting from academic year 2015/2016.

Findings of the CDPC survey on municipalities show that most of the regional and city municipalities, namely, 84% (54 municipalities) that responded to the questionnaire, are implementing disease prevention and health promotion activities (80 regional and city municipalities in 2012). In total, 75% of the surveyed municipalities (48 municipalities), compared to 67 municipalities in 2012, had included or was going to include prevention and health promotion activities in the municipal development plan or other binding documents; while 14 major city and

[7] Cabinet Regulation No. 530 of 6 August 2013 "Regulations On the State Basic Education Standard, Basic Education Subject Standards and Basic Education Program Samples".
[8] Cabinet Regulation No. 281 of 21 May 2013 "Regulations Regarding the State General Secondary Education Standard, Subject Standards and Sample Education Programmes".
[9] Minutes of the Cabinet of Ministers of 24 September 2013 (available on: http://www.mk.gov.lv/lv/mk/mksedes/saraksts/protokols/?protokols=2013-09-24).

regional municipalities (23%), compared to 17 municipalities in 2012, had designed programmes (plans) that focus on limiting and preventing addictive substance use.

Findings of the CDPC survey on municipalities show that most of the regional and city municipalities, namely, 93% (80 municipalities) that responded to the questionnaire, are implementing prevention and health promotion activities; in 79% (67 municipalities), implementation of preventive and health promotion activities was included or was going to be included in the municipal development plan or other binding documents; while 17 major city and regional municipalities (20%) had designed programmes (plans) that focus on limiting and preventing addictive substance use.

Slightly more than half of the municipalities or 59.7% (37 municipalities) (65 municipalities in 2012) answered in the affirmative to the question “Are any activities being carried out in your municipality that focus directly on limiting the prevalence of addictive substances and/or processes?”; 32.3% of municipalities have not performed such activities in 2013, but 8% have not provided a specific answer (see Table 3.1.).

Table 3.1. Number of municipalities that have reported on activities carried out in 2013 for the prevention of addictive substance use

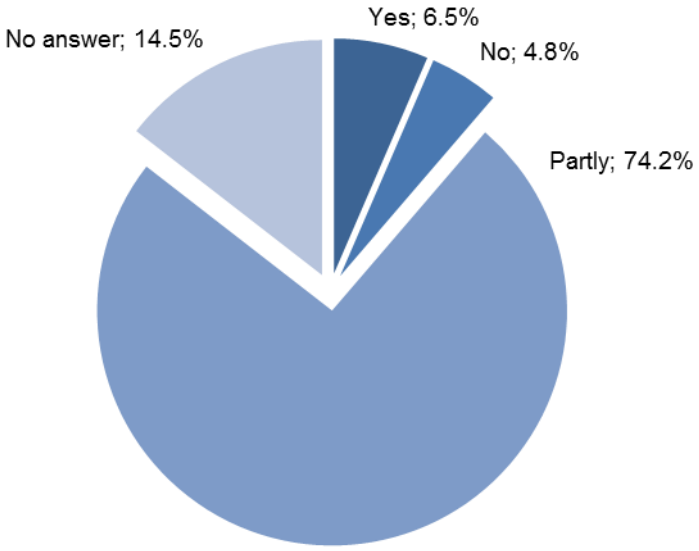
Activities in 2013	Number of municipalities	%
Alternative activities outside school (sports, hobby groups, art school, music school, et.)	51	82%
Activities for risk group families (families with problems related to addiction, long-term unemployment, violence)	49	79%
Training for various groups of people or specialists	36	58%
Support measures for families (meetings of parents outside education institutions, support groups, parent NGOs patrolling at entertainment venues, sales points of new psychoactive substances)	35	56%
Youth centres, support groups where addiction prevention measures are carried out (for example, classes for students, youth support groups, leadership training, summer camps)	34	55%
Preparation of publications, information materials	19	30%
Other (public events, campaigns, etc.)	12	19%

Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013

The findings of the municipality survey show that the municipalities are critical of what has been achieved in prevention of addictive substance use and in promotion of mental health.

The answers to the question “Do you think that the activities carried out in your municipality for addiction prevention, promotion of mental health, prevention of mental disorders and suicides attain the desired outcome?” attest to that. Only 6.5% of the municipalities answered in the affirmative, the majority (74.2%) of the municipalities indicated that the result was only partially achieved, while 4.8% believe that the result has not been achieved (see Figure 3.1).

Figure 3.1. Breakdown of the answers given by the municipalities (% of the ones that responded) to the question "Do you believe that the activities carried out in the municipality for the prevention of addictive substance use and for promotion of mental health achieve results?"



Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013

In total, 88.6% of municipalities have answered the survey question about the "strengths" of municipalities in realisation of the set of activities with regard to the prevention of addictive substance use, and promotion of mental health, prevention of mental disorders and suicides. The majority of the municipalities pointed out goof cooperation of specialists and institutions and team work. Comparing the number of times when the cooperation and team work have been mentioned as "strength" and "weakness", it is concluded that most often cooperation between specialists and institutions is well-approved. Some of the most popular "strengths" are good leisure possibilities (including sport, culture activities, infrastructure) and prevention measures carried out at education institutions. Prevention activities organised at schools is the third most often mentioned intervention.

Table 3.2. "Strengths" of municipalities in implementing addiction prevention, promotion of mental health, prevention of mental disorders and suicides by number of replies

Opinion	How often mentioned (number)
Good cooperation of specialists and institutions, team work	19
Good opportunities (including infrastructure for sports and culture activities) for spending free time	13
Prevention measures at education institutions	10
Active social service division, well-developed social services	7
Good cooperation with NGOs, active NGOs	7
Availability of professional specialists, consultations	7
HIV and addiction prevention points	5
Medical treatment services, including Minnesota programme and methadone programme	3
Various support groups	3
Day-time centres organising various activities	3
Availability of social rehabilitation programmes for work with addiction patients	2
Psychologist	2
Availability of financial assistance for providing treatment of addiction patients	1
Social worker specialised for social work with people with suicidal thoughts	1
Support from municipality administration	1
Active municipal police	1
Good infrastructure for carrying out activities	1
Health promotion specialist at the municipality	1
Small municipality able to identify and solve problems quickly	1
The only Youth Initiatives and Health Centre in Latvia	1
No gambling or computer games rooms	1
Social rehabilitation and motivational programmes for people with functional disorders and mild mental disorders	1
Approved long-term planning document providing for addiction prevention and mental health promotion measures	1
High professionalism and long experience of public health specialists	1
Continuing education programmes for teachers provided by training and information sector	1
Regular study in order to evaluate efficiency of prevention programmes	1

Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013

In order to establish what were the reasons why municipality activities have not been efficient enough and have not covered all target groups, answers to the question about the "weaknesses" of municipality in the implementation of the set of actions for the addiction prevention, promotion of mental health, prevention of mental disorders and suicides were analysed. In general, 75.8% of all municipalities that answered have provided some shortcomings.

Table 3.3. "Weaknesses" of municipalities in implementing addiction prevention, promotion of mental health, prevention of mental disorders and suicides by number of replies

Opinion	How often mentioned (number)
Lack of specialists and human resources	17
Lack of financial means	10
Lack of regulatory framework (programmes, plans, strategies, guidelines) or their drawbacks on the municipal level	9
Negative and passive attitude and lack of understanding of people	7
Lack of regulatory framework (programmes, plans, strategies, guidelines) or their drawbacks on the national level	4
Lack of support groups at the municipality	4
There is no position of health promotion coordinator	4
There is inefficient or no inter-institutional cooperation	2
There is restricted or no availability of psychiatrist, narcologist	3
There are inactive or no NGOs	2
Lack of information and information exchange	2
High level of unemployment	2
There are no half-way-homes, community flats	2
Insufficient availability of training for specialists	2
Insufficient cooperation with general practitioners	2
There is no psychological support service, crisis centre	1
Few seminars for specialists	1
Low remuneration of specialists	1
No day-time centre services for patients with mental disorders	1
Lack of statistical data for planning activities	1
Municipality has other priorities	1
Insufficient variety of information activities	1
Voluminous and tense work for social workers, social teachers and psychologists at schools	1
Lack of special centres	1
Poor cooperation with psychiatrist	1
Specialists insufficient knowledge	1
Insufficient use of innovative prevention measures (e-consultations)	1

Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013

Analysis of answers to the open questions show that the problems identified most often are: first, lack of specialists and human resources; second, financial problems, therefore some municipalities stress the need for establishing a position for health promotion coordinator which would be paid for by the state; third, lack of a regulatory framework or deficiencies on the municipal level. Passivity of people, insufficient understanding of some issues and sometimes even negative attitudes are mentioned as the risk factors for the implementation of health promotion and prevention activities.

Table 3.4. New possibilities or solutions that could promote implementation of activities for addiction prevention, promotion of mental health, prevention of mental disorders and suicides by number of replies

Opinion	How often mentioned (number)
Attraction of the State and other funding	12
Attraction of specialists and human resources	10
Implementation of various campaigns on the national level, educating society	8
Implementation of projects	6
Improvement or drafting of regulatory framework (programmes, plans, strategies, guidelines)	6
Establishment of a position for a State-supported health promotion coordinator	6
Establishment of support groups	4
Facilitation of inter-institutional cooperation	3
Strengthening and engagement of NGOs	2
Courses for specialists	2
More active participation by the general public	2
Improvement of legislation	2
Methodological support from the Ministry of Health/CDPC, as well as engagement of regional CDPC employees	2
Development of social care and rehabilitation	2
Provision of psychologist's services	1
Establishing the subject "Health Studies" as mandatory in the education programmes	1
Free specialists' consultations in the public space	1
Provision of school support personnel and engagement of it in the health promotion	1
Improvement of cooperation between general practitioners/psychiatrists	1
Development of multi-discipline approach to solving of public health problems	1
Establishment of crisis centre	1
Political support for health promotion ideas	1
Reduction of employment	1
Establishment of youth initiative centres	1
Work with risk groups	1
More active voluntary work	1
Development and provision of methodology for evaluating activities	1
More targeted work	1
Establishment of prevention points	1
Purchasing of outsourced lectures or events	1
Establishment of day-time centres	1

Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013

The question "What new opportunities or solutions could promote the implementation of measures for prevention of addictive substance use, promotion of mental health, and prevention of mental

disorders and suicides?" was posed in the survey. Overall, 77% of municipalities have provided different possibilities or solutions.

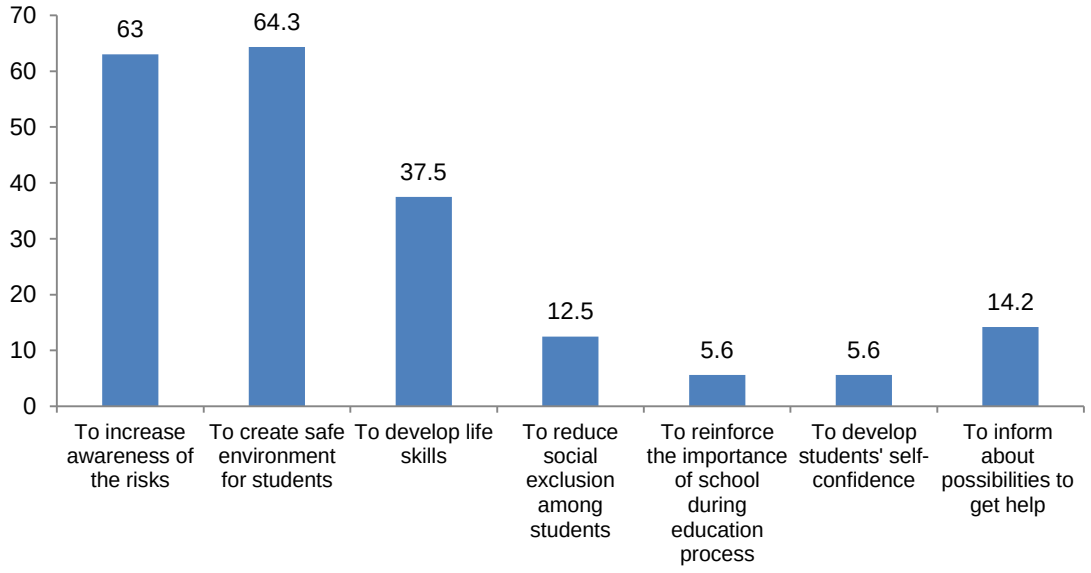
The most important solution, to the mind of municipalities, is attracting financing, which could enable municipalities to hire additional prevention specialists. Other often mentioned solutions are carrying out information campaigns and educating the society.

Table 3.4. presents also other opportunities and solutions mentioned by the municipalities by frequency.

In universal prevention at school (school-based drug prevention), in most cases, prevention activities were based on an informative approach by improving the knowledge of students about the harmful effects of the substances on health and social risks of substance use.

In the CDPC survey, the schools were asked to "Mark two most important priorities the school is trying to attain by implementing prevention measures".

Figure 3.2. Schools (% of the schools that responded) that have answered the question "Mark two most important priorities the school is trying to attain by implementing prevention measures"



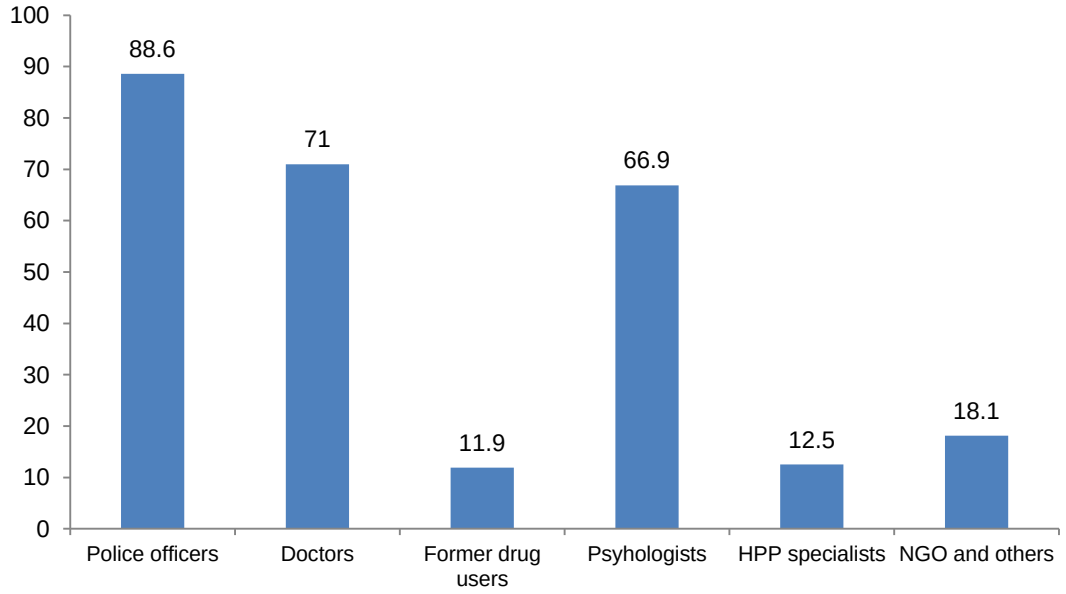
Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013

In schools, majority of activities in the framework of restricting addictive substance use have been discussions (lectures) during class meetings with the participation of various specialists—doctors, police officers, NGO representatives (see Figure 3.3.).

Within the methodological study "Use of alcohol, tobacco and drugs among students" (Trapencieris et al., 2013) conducted by the CDPC in 2013, a school administration survey was also carried out; one of the main tasks of this survey was to identify the issues related with health education and addiction prevalence at school. The electronic survey form was filled in by 292 principals or their authorised representatives of schools (36%, n=809).

Approximately half of school administration representatives regard their knowledge about drug use as good and nearly one-third classify their knowledge as average. There was a comparatively small number of school administration representatives (less than 10%) who think that they have poor understanding about drugs and their impact on the society.

Figure 3.3. Schools (% of the schools that responded) that invite the indicated guest lecturers to implement prevention activities



Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013

Table 3.5. Evaluation of personal knowledge about signs suggesting of drug using, %

	Very good	Rather good	Average	Rather poor	Very poor
About general characteristics, distribution of drugs and impact thereof on the society	11	50	31	7	<1
About signs suggesting that student, possibly, has used /is using drugs	4	51	36	7	1
What to do if there is suspicion that student has used /is using drugs	19	49	27	4	<1

Source: Trapencieris et.al., 2013

Overall, 56% of school administration representatives are in full agreement or simply agree that subject “Social Sciences” provide the students with the necessary knowledge and skills related with various lifestyle habits. However, more than a half (57%) of the respondents considers that schools should undertake a more active role in strengthening healthy lifestyle habits.

Despite the comparative studies show not only a high prevalence of addictive substance use among students but also lack of knowledge about the impact of unhealthy lifestyle habits on the health, which could be consequences of the shortcomings in the health education curriculum and lack of prevention measures, slightly more than half of school administration representatives (52%) do not agree with the statement that teachers lack information and methodological materials about the impact of addictions and other lifestyle habits on the health of an individual.

At the same time, there are considerably fewer school administration representatives who think that teachers are already overloaded with works in the study process and thus cannot devote additional attention to addiction prevention and promotion of healthy lifestyle habits among students. Two in five or 40% of the respondents do not support additional engagement of teachers in strengthening healthy lifestyle habits in students.

Speaking about specialists who could be the most efficient ones in developing students’ individual skills with regard to addictive substances, representatives of school administration mention the class teacher as the most appropriate specialist. In total, 28% schools have marked the class teacher as

the most suitable one from all specialists listed, while 17% schools have ranked the class teacher in the second place, but 19% schools think that class teacher is the third most appropriate specialist.

Young leaders are also often regarded as specialists that could develop knowledge and skills in students with relation to issues related with addictive substances prevention. Overall, 22% of representatives of school administration find young leaders to be most suitable for the work with young people, and 17% schools regard them to be the second most appropriate ones. Teachers of social sciences are regarded as appropriate for work with young people in discussing issues connected with healthy lifestyle and addiction prevention less often—only one in ten school administration representatives ranks the social science teacher in the first place among other specialists. Still, 18% of schools find teacher of social sciences to be the second most appropriate specialist.

Other teachers and representatives of NGO are regarded to be less suitable specialists in addiction prevention issues, as 28% of schools have left the NGO representatives in the last place.

Table 3.6. Evaluation of addiction prevention initiatives, by importance (% of the schools that responded)

	1st	2nd	3rd	4th	5th	6th	7th	8th	9th
Seminars, discussions, training organised by addiction prevention specialists	34	19	16	12	9	8	2	1	0
Meetings with people who have suffered (receive treatment) from using addictive substances	19	19	12	12	6	11	9	8	0
Movies or videos on the mentioned topics	16	24	22	15	17	5	3	0	1
Interactive study materials	13	15	24	20	14	9	6	2	0
Courses for raising qualification	7	4	6	14	10	25	18	14	0
Guidelines prescribing actions in case of suspicion about use of addictive substances among students	6	12	13	12	23	14	13	6	2
Informal education programme at school	4	5	4	5	7	8	22	35	2
Brochures or other information materials	0	2	4	9	14	20	27	26	4
Other	0	0	0	0	0	0	0	10	88

Source: Methodological survey "Use of alcohol, tobacco and drugs among students", 2013, CDPC

The Cochrane systemic reviews suggest that use of alcohol in children reduces both in the short- and long-term in the result of family-based universal interventions (Foxcroft et al., 2011).

The results of the survey organised by the association "Esi brīvs!" ("Be free!")[10] and carried out by the "TNS Latvia"—a market, public opinion and media research agency in Latvia—show that majority of parents (92.4%) think that even more often should education institutions discuss facts that use of alcohol can foster development of addiction.

Schools that participated in the CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013 indicate that also parents are engaged in comprehensive prevention action by organising parents' meetings/evenings.

[10] Information available on: http://www.esibrivs.lv/uimg/19_08_2014_Relize.pdf

Table 3.7. Schools (% of the schools that responded) that indicated that the mentioned addiction-prevention related issues have been included in the agenda of information days in 2013

Topic	Information days (project weeks, competitions, exhibitions) are organised at school on these topics (% of the schools that responded))
Problems related to narcotic substance use	79.5%
Problems related to use of other addictive substances (tobacco, alcohol)	86.9%

Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013

In total, 71.0% of schools that participated in the CDPC survey indicated that they organise parents meetings /evenings about the effects of using tobacco and alcohol, and 57,9% of schools organised discussions with parents about the effects of narcotic substance use (see Table 3.8.).

Table 3.8. Schools (% of the schools that responded) that indicated that they organise parents' meetings /evenings about the topics specified

Topic	Parents meetings /evenings are organised at school (% of the schools that responded)
About the effects of narcotic substance use	57.9%
About the effects of using other addictive substances (tobacco, alcohol)	71.0%

Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013

Within the CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013, schools were asked the question "Taking into consideration the Cabinet Regulation No. 277 of 23 March 2010 "Procedures for Preventing Health Care and Emergency Assistance in Educational Institutions": If there is an action plan that envisages actions if the school found out that there were addictive substances or suspected that students used, stored or distributed addictive substances?".[11]

Overall, 88% of schools answered in the affirmative and gave an explanation action plan has been included as a section in the School Regulation or executed as an internal normative enactment.

3.3. Selective Prevention in At-risks Groups and Settings

In order to find out whether selective prevention activities were carried out in the municipalities in 2013, the CDPC survey questionnaire posed the following question: "Are activities for reducing and preventing addictive substance use organised for the following social groups?"

Practice of foreign countries suggests that school psychologist who has received additional training for work with addiction problems and at-risk young people can be involved in the organisation of selective and indicative prevention measures in school environment. Due to this reason, the methodological study "Use of alcohol, tobacco and drugs among students" (Trapencieris et al., 2013) carried out by the CDPC in 2013 identified also the resources of Latvian schools and involvement of psychologists in the school work. Majority (64%) of school administration representatives indicated that school psychologist works with students by assisting them in solving various problems related to the study process, peer relations, and behaviour. Only 5% of school administration representatives have pointed out that school psychologist only works with those students who have certain learning difficulties. However, taking into account that presence of education psychologist at school is not mandatory; there are a number of schools where such specialist does not work at all. According to the information provided by school administration

[11] Information available on: http://www.likumi.lv/doc.php?id=207125&from=off.?

representatives, almost one third of general education institutions (30% of schools) do not have an education psychologist.

Table 3.9. Municipalities (% of the municipalities that responded to the survey questions) that implement addiction prevention activities for specific target groups

Target audience of the prevention activities	Number of municipalities	%
Students with social or learning problems	39	62.9
Children and young people from socially disadvantaged families, including children whose parents have addictive substance use related problems	33	53.2
Offenders (young people)	27	43.5
Young people who leave school without graduating	22	35.4
Young people from socially disadvantaged environment	21	33.8
Children and young people in social care homes and children's homes	16	28.5
Other target groups (parents of young people of risk group, etc.)	11	17.7
People who frequent entertainment venues	9	14.5
Ethnic groups (for example, Roma)	9	14.5
Young people without permanent place of residence, who often spend night outside home, stray	8	12.9

Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013

Within the CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2013, schools were asked the question "Indicate which services of school support specialists are provided at the school?" Psychologist has been mentioned as one of the main support specialists (90.8%), followed by a social teacher (79.5%), a special teacher (44.8%), but 6.8% of schools that responded indicated services provided by a speech therapist and nurse.

Students with social and learning problems and young offenders are the two most important target groups for selective prevention intervention. The main attention of selective prevention measures is paid to setting standards, restructuring of the environment, motivation and skills, and taking of decisions.

Summary of the CDPC survey results reveal that two most popular target groups for prevention measures are: students with social or learning problems (62.9% of municipalities that responded), and children and young people from socially disadvantaged families, including children whose parents have addictive substance use problems (53.2% of municipalities that responded) (see Table 3.9.).

In order to improve specialists' professional knowledge and skills in social correction, addiction prevention and work with children with addiction problems and behavioural disorders, as well as to improve the practical skills that would allow for more efficient professional support in work with children, the Latvian Association of Local and Regional Governments in cooperation with the State Inspectorate for Protection of Children's Rights drafted guidelines for specialists working at state and municipal institutions for work with children with addiction problems and behavioural disorders and organised a conference in 2013.[12]

3.4. Indicated Prevention

The target of indicated prevention is those children who are prone to experimentation by smoking, drinking alcohol, using illicit narcotic and psychotropic substances, including those who have occasionally used these substances, but have not yet been diagnosed with addiction.

[12] Information available on: http://www.bti.gov.lv/lat/metodiska_palidziba/vadlinijas_/

Analysis of addiction prevention policy implemented by 10 European countries, which was performed by the association "Latvian Association of Addiction Psychologists" (Antone, 2013), suggests that each country chooses its own priority measures for addiction prevention, for example, the universal and selective. The second direction chosen by the countries often is selective and indicated prevention.

Indicated prevention methods include individual work with people who have behavioural or psychological problems that could indicate that these persons might start using psychoactive substances in the future. This type of prevention has rarely been used in Latvia for a couple of years, because it requires consistent input of work and providing a stable flow of funds every year, and professional experts are required who could implement these programmes. To some extent, programme development is hindered by the separated funding models for treatment and prevention, namely, treatment is paid by the state, but funding for prevention is mostly sourced from municipality and foreign projects. The priority types of addiction prevention in Latvia are universal and selective prevention.

3.5. National and Local Media Campaigns

A systemic overview of the efficiency analysis of anti-drugs campaign indicates that there are no solid evidence on their efficiency, and they may even have an opposite result in some cases (Werb D. et al., 2011).

In 2013, the Road Traffic Safety Directorate, in cooperation with the Ministry of Transport and the State Police, organised the campaign "Ja dzer, tad nebrauc!" (If you drink, then don't drive!) in order to reduce the number of persons who use to drive vehicle under the influence of alcohol and narcotic substances and decrease the number of traffic accidents. The campaign was also supported by SIA "Statoil Fuel & Retail Latvia", insurance company "ERGO" and producer of beverages "Aldaris".

Within the campaign, drivers and other participants of traffic were addressed with video and audio promotions, environmental advertisements, as well as a public funeral feast of drunk drivers. During the campaign, the Traffic Police intensified their patrols.[13]

The annual social campaigns most often act against drunk drivers, but those using drugs are only mentioned in mass media when providing additional information about the current and planned actions performed by the State Police during these campaigns. At the same time it should be noted that within the international project "Driving Under Influence of Drugs, Alcohol and Medicines" or "DRUID", which concluded in 2012, it was concluded that inclusion of drug prevention issues in social campaigns against drunk drivers may turn out to be inefficient, as it might "address", for example, smokers of marijuana, while users of other substances will not pay any attention to it. It was also concluded that prevention campaigns should be addressed to particular risk groups depending on the substance used (Schulze H. Et al., 2012.). Environmental campaigns in municipalities remain quite popular; as an example, a campaign organised in Riga to honour the WHO World No Tobacco Day can be mentioned. During this campaign, young people encouraged smokers to change their cigarette for a carrot.

Those interested in the campaign were offered psychotherapy consultations for treating tobacco addiction. All inhabitants of Riga could make sure about the hazards of smoking by measuring the breath carbon monoxide and performing the lung function test for free. The youth team of the European Commission anti-smoking campaign "Ex-smokers are Unstoppable" introduced the interested persons to a free interactive programme for giving up smoking "iCoach", which is a

[13] Information available on: http://www.csdd.lv/lat/noderiga_informacija/preses_relizes/2013/?doc=1974

powerful tool assisting in discarding the addiction. This interactive tool is available both on the Internet and as a mobile application for smart-phones.[14]

Within the EC campaign “Ex-smokers are Unstoppable” (www.exsmokers.eu), the Ex-smokers Day was celebrated in Riga, Latvia, and all other EU Member States to attract public attention to issues related with giving up smoking, During the event, everyone could participate in various activities and show their support to healthy lifestyle without smoking. The future doctors from the Latvian Medical Students Association calculated the body mass index, measured blood pressure and pulse before and after physical activity and informed on the impact of smoking on the body and quality of life. Also trainers of “City Fitness” participated in the event and offered various exercises, assisted in drafting individual training programmes, informed on healthy and balanced nutrition and training opportunities. The event was supported also by several well-known people who do not smoke or who have quitted smoking.[15]

[14] Information available on: http://nra.lv/latvija/riga/95811-riga-notiks-pasaules-diena-bez-tabakas.htm
[15] Information available on: http://apollo.tvnet.lv/zinas/ceturtdien-svetki-bijusajiem-smeketajiem/613029

4. High Risk Drug Use

According to the EMCDDA definition, high risk drug use (HRDU) includes the regular use of heroin and other opiates, cocaine and/or amphetamines and/or drug use by injection. This is one of the five EMCDDA key epidemiological indicators and as the data mining methods used in the indicator are implicit, the quality of estimates is directly related to data acquired from other indicators, such as the treatment demand indicator data or data on infectious diseases associated with drug use, etc.

Previously this indicator was called problem drug use (PDU).

4.1. Prevalence and Incidence Estimates of HRDU

Taking into consideration the specific features of the data available, indirect estimates of high risk drug users in Latvia are mainly performed according to treatment, police and mortality rate methods, which are among the methods recommended by the EMCDDA for estimating the number of drug users. To apply the multiplier methods, two types of data are required:

1) number of drug users captured in a data source, for example, drug users treated within a year or “caught” by the police.
2) the percentage of the drug users that have indicated that they have sought assistance (or have been caught) within a specific time period, for example, a year, in one of the data sources about which information has been obtained. Such information can mainly be obtained by surveys among high risk drug users.

The main drawback of the multipliers method is the fact that this method does not allow identification of the limits of the credibility interval errors that can arise both by not including data on individuals in the data source to be researched, or if the percentage of drug users that have approached the provider of the relevant services that was identified within the framework of the study is imprecise, etc. Elsewhere in Europe, the capture-recapture method is used, which provides limits of error in the estimated number of drug users. This method envisages that several types of data with the same identifier should be combined, for example, data consisting of gender, initials and date of birth information, thus looking for overlaps among three or more data sources and, by using log-linear regression methods, the most credible mathematical model showing the data is identified. There have been several attempts in Latvia to use this method, but in most cases it was not possible to estimate the number of problem drug users.

Previous estimates of drug user numbers performed in Latvia and the methods used therein have been described in the national reports for 2010 and 2011 (Health Economics Centre, 2010).

The number of unique drug users treated in 2012 was identified by using the number of treated drug users in three databases: 1) PREDA, 2) APANS database of the National Health Service, and 3) the SPANS database of the National Health Service. In total, the databases of three treatment institutions identified **1836** unique high risk drug users (or **1985**, if assuming that also users of several substances (diagnosis F19) are high risk drug users), whose primary drug is opiates or amphetamines and who received out-patient or hospital assistance in 2012. The proportion of drug users (0.1191) who have received any drug-related assistance (see also the chapter “Treatment”) over the last 12 months, which was gained in the result of cohort study of 2013 was used as a multiplier.

The estimates show that in 2012/2013, there were approximately **15,416** high risk opioids or amphetamines users in Latvia, or **11.3** per 1000 population aged 15-64. Assuming that also drug users with diagnosis F19 are high risk drug users, it has been calculated that in 2012/2013 there were **16,667** high risk drug users in Latvia, or **12.2** per 1000 population aged 15–64.

The main drawback of these estimates to be pointed out is the fact that the method used does not allow estimating credibility intervals in a precise manner, therefore, the reliability of the estimates is subject to a large extent to the quality of treatment data and the findings of the study.

The treatment multiplier methods were also used for calculating the number of injecting drug users (IDU). However, there are several important delimitations with regard to this data, therefore, the actual number of IDU could be higher. Below there is a list of treatment data limitations, which do not allow for an accurate calculation of IDU number and are related also to the calculation of the number of opioids and amphetamines:

- a number of drug users, who have been included among those having received treatment within a year, have been entered into the PREDA database several years ago. Thus, it is possible that both the primary substance and the manner of using it have changed. It is hard to estimate the impact of this nuance on the calculations of the number of injecting or high risk drug users;
- the manner of using has not been specified in a large number of entries. For example, the manner of use has not been indicated for 39 opioid users and 60 users of amphetamines in 2012. In addition, 35 entries do specify neither the substance nor the manner of use. The possible impact on the estimates of the number of drug users could be 570 injecting drug users, approximately;
- detailed information (for instance, manner of use) about a considerable number of treated drug users has not been included in the PREDA Register, and the National Health Service (NHS) databases only contain the diagnosis. In total, 187 patients with diagnosis F11, 102 patients with diagnosis F15 and 140 patients with diagnosis F19 have been registered in the NVD databases but not in the PREDA system. The possible impact on the estimates of the number of drug users could be 2600 injecting drug users, approximately.

Taking into consideration the above assumptions, it was calculated that there were **7983–12,699** injecting drug users, or 5.9–9.3 per 1000 population aged 15–64, in 2012/2013.

4.2. Data on HRDUs from Non-treatment sources

Cohort Study of Drug Users

Cohort study on drug users in Latvia was initiated in 2006, and in 2013 it was carried out for the seventh time (Trapencieris et al., 2014). The methodology of the study envisages interviewing one and the same drug users, so that it is possible to assess changes that can be observed in Latvia, for example, in terms of substances used, employment, risk behaviour, etc. In total, in the seven stages of the study 1439 drug users have been recruited and interviewed, of whom 30 were interviewed in seven stages of the study, 132 in six stages, 183 in five stages, 141 in four stages, 141 in three stages, 155 in two stages, and 657 drug users were interviewed merely in one stage of the study. In 2013, an emphasis was put on recruiting drug users with shorter drug career in addition to interviews with already recruited and interviewed drug users, in order to understand the trends and changes in drug users' behaviour in Latvia better. As a result of this strategy, 70 drug users have been included in the cohort for the first time.

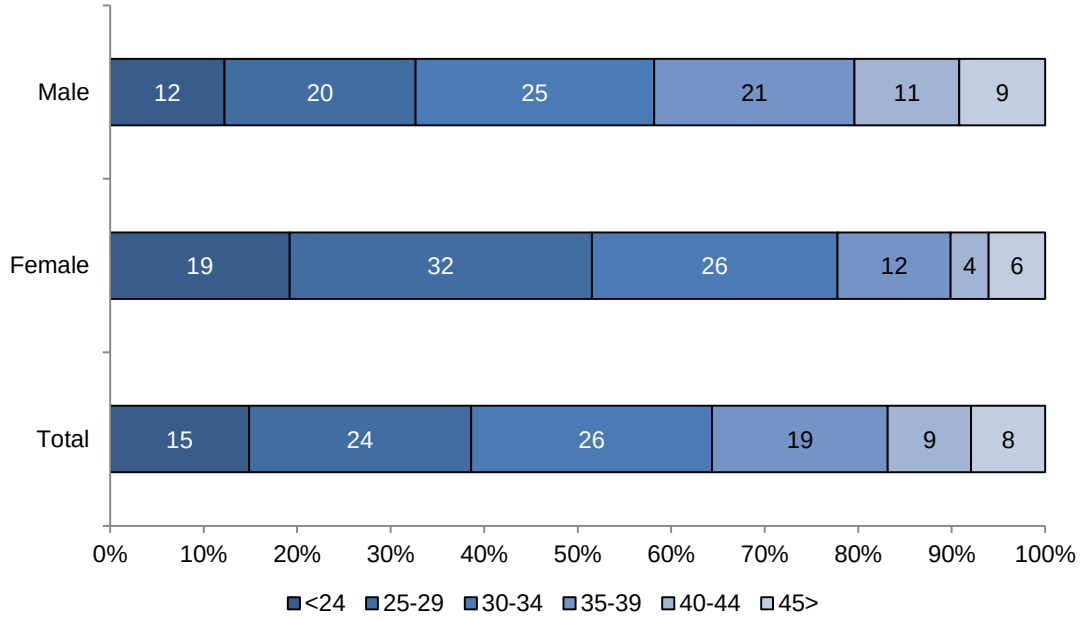
Socialdemographics

The data of the study indicate that the percentage of women among everyday drug users is approximately 30–33 per cent. The majority of surveyed drug users live in Riga or its surroundings. The average age of drug users is 32.7 and, as interviews with one and the same drug users are conducted year on year, the average age is increasing (the average age of 70 drug users recruited for the first time in 2013 is 22.8 years).

The average age of the interviewed drug users is 32.7 (median 32 years, standard deviation 7.97) in 2013.

In the seventh stage of the cohort study, only 1.1% of the interviewed drug users were less than 19 years old, 13.4% were 20-24 years old, 24.0% were 25–29 years old, 25.5% were 30–34 years old, 18.5% were 35–39 years old, 9% were 40–44 years old, and 8.3% were over 45 years old. In 2013, if compared to 2012, the number of respondents aged 20–24 has increased; this is related to the strategy aiming to include in the cohort new respondents with little short career of drug use (see Figure 4.1.).

Figure 4.1. Age of the cohort study participants in 2013, %



Source: Trapencieris et.al., 2014

When looking at the nationality of the respondents, it can be observed that only slightly more than one fifth (23.5%) of respondents are Latvian, although the proportion of Latvians among all inhabitants of Latvia is higher. Majority of respondents (just below two thirds) are Russian and almost one in ten (8.5%) belong to other nationalities.

Table 4.2. Nationality of the respondents, %

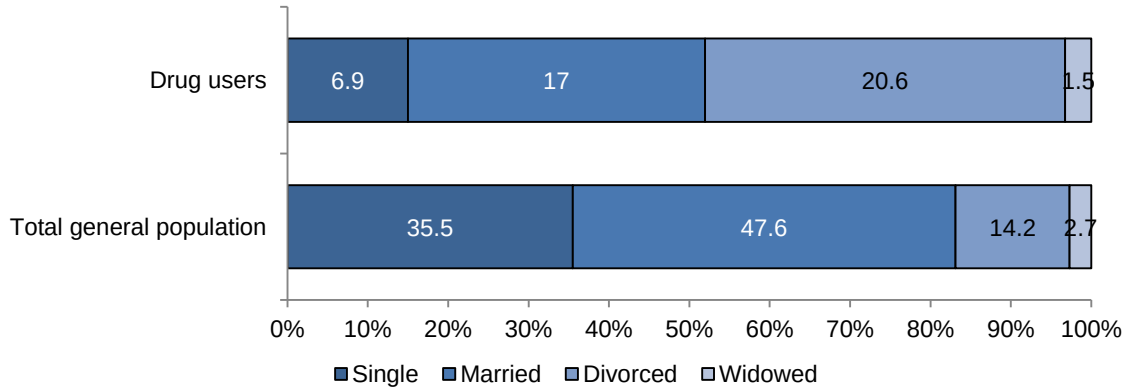
	2006	2007	2008	2009	2010	2012	2013	2013, data of CSB
Latvians	33.0	25.8	21.0	21.9	23.1	21.8	23.5	61.1
Russians	55.5	63.8	69.4	68.3	67.5	68.3	68.0	26.2
Other	11.5	10.4	9.6	9.8	9.4	9.9	8.5	12.7

Source: Trapencieris et.al., 2014

Of other minority nationalities, the number of Roma respondents is the highest among drug users, which notably exceeds the number of drug users in this ethnic group in comparison with other minority nationalities.

Likewise as in the previous stages of the cohort study, the respondents interviewed in 2013 are also single according to the marital status they indicated. Approximately two thirds (60.2%) of the respondents indicated this, and 27.6% indicated that they live together with a partner. Overall, 20.6% of the drug users are divorced; 12.4% are married (of which 0.8% have married repeatedly); 4.6% are married, but live separately; and 1.5% of the respondents reported being widowed.

Figure 4.2. Marital status among drug users in comparison with 20–59 year-olds in the general population, %



Source: Trapencieris et.al., 2014

According to the breakdown of the household, approximately a fifth (21.1%) of the respondents live alone, 52.3% of the respondents indicated that they live with a partner or spouse, 21.9% with children, approximately one third (33.4%) with parents. Comparatively more rare respondents have indicated that they live together with siblings (8.5%), friends or acquaintances (9.8%) or other family members (10.0%).

As it had been analysed in the previous stages of the study, statistically significant differences based on respondents' gender could be observed among those drug users who live with a spouse/partner, children and parents: the women more frequently indicated that they currently live with a partner and/or children, while the men more frequently indicated that they live with a partner and/or parents (see Table 4.3).

Table 4.3. Marital status of drug users (who they live with) by gender, %

	Total	Men	Women
Lives alone	21.1	23.4	16.4
Spouse, partner	52.3	48.4	60.5
Children	21.9	15.8	34.7
Parents	33.4	38.4	22.9
Siblings	8.5	8.6	8.2
Other family members	10.0	10.3	11.1
Friends, acquaintances	9.8	8.3	12.9

Source: Trapencieris et.al., 2014

In 2013, more than one fifth (23.7%) of the interviewed drug users indicated that they live together with a person abusing alcohol, but approximately one in three (33.4%) respondents live together with a someone using drugs. Another 9.5% of drug users live together with a person abusing alcohol and using drugs. In comparison to the study of 2012, a decrease is observed in the

proportion of respondents who live together with a drug user: from 39.7% in 2012 to 33.4% in 2013. Also it should be marked that there are more women (47.3%) than men (25.4%) a household member of who uses drugs. By regions, the respondents surveyed in this cohort stage both in and outside Riga have indicated that they live together with a drug using person more often than last year (40% in and 38.5% outside Riga in 2012, compared to 33.8% in and 31.5% outside Riga in 2013).

In the 2012 survey questionnaire, questions regarding drug users' children were included. The survey data shows that two in three (34.3%) of the interviewed drug users have minor children, while every second user (61%) lives together with his or her child (one or several). The women, more often than men, indicated that they have children, 49% and 27%, respectively. Likewise, the women, more often than men, indicated that they live together with their child or children, 77% and 48%, respectively.

5. Drug-related Treatment: Treatment Demand and Treatment Availability

5.1. Strategy and Policy

There have occurred no material changes in the treatment policy for addicted patients in 2013.

On 30 September 2014, the Cabinet of Ministers approved the Public Health Guidelines for 2014–2020, as a mid-term policy planning document that have been drafted in accordance with the National Development Plan 2014–2020, European policy framework and strategy "Health 2020" of the World Health Organisation, as well as the priorities of the European Union funds for 2014–2020 planning period; these Guidelines marks new development goals and directions of action with the view to maintain, improve and restore the health of the inhabitants of Latvia, especially people who are subject to the risk of social exclusion and poverty, over the next seven years.

One of the sub-goals of this draft normative enactment provides for reducing the risk of premature death caused by non-communicable diseases by reducing the negative impact of risk factors on the health.

In order to implement this sub-goal, it is necessary to continue implementation of a single policy for reducing the use of and addiction to various addictive substances (tobacco products, alcohol, narcotic substances (including new psychoactive substances)) in the population by raising society's knowledge about the harmful impact of these substances on the health, by restricting advertising and availability, drafting legal framework for regulating the distribution of new tobacco products and other products containing other addictive substances.[16]

On 17 December 2013, the Cabinet of Ministers approved Regulation No. 1529 "The Procedure for Organising and Financing Health Care"[17] (hereinafter—Cabinet Regulation No. 1046); the Regulation is basically an updated version of the former Cabinet Regulation No. 1046 of 19 December 2006 with a more optimal structure, and the new Regulation does not provide for any significant changes in the procedure of organising and financing of the health care services provided for drug users at out-patient and in-patient clinics paid from the State budget[18].

Guidelines for the Containment and Control of Narcotic and Psychotropic Substances and the Prevalence thereof for the Period from 2011 to 2017[19] indicate that treatment of drug addicted patients in Latvia is organised generally according to the narrower understanding of the term "treatment". According to the definition adopted by other EU Member States, treatment includes structured interventions by using special medical and/or psychosocial techniques aimed at reducing or eliminating the use of illicit narcotic substances. Thus, for example, also HIV prevention points (low-threshold service centres), consultations planned within the treatment (at the social or State Probation Service, for instance), as well as consultations within the HIV/AIDS patient treatment system are services available in drug addiction treatment.

In Latvia, treatment of drug addicted patients is regulated by the Medical Treatment Law and a special procedure for treating patients addicted to alcohol, drugs, psychotropic and toxic substances,[20] which explains the procedure of pharmacotherapy in detail.

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[16] Available on: http://tap.mk.gov.lv/lv/mk/tap/?pid=40330161&mode=mk&date=2014-09-30
[17] Available on: http://www.likumi.lv/doc.php?id=150766
[18] Available on: http://likumi.lv/doc.php?id=263457
[19] Available on: http://polsis.mk.gov.lv/LoadAtt/file57284.doc
[20] Available on: http://likumi.lv/doc.php?id=243233

At the same time, it has to be remembered that issues related with health care of prisoners have been included in the Prison Infrastructure Development Concept (Cabinet Instruction of 12 February 2013 No. 50). In addition, within the of the two related programmes of the Norwegian Financial Mechanism 2009–2014, Reform of Latvian Correctional Services and Police Detention Centres and A New Unit at Olaine Prison, it has been planned to establish a new unit in the territory of Olaine Prison for the treatment and re-socialisation of prisoners with addiction problems; the project includes also training of personnel in the work with prisoners with addiction problems.[21]

5.2. Treatment Systems

In 2013 State-funded out-patient services were ensured by a narcologist, who is a directly accessible specialist and who provides healthcare services to patients (diagnoses ciphered as mental and behavioural disorders due to psychoactive substance use (F10–F19) or habit and impulse disorders (F63.0) in accordance with the International classification of Diseases ICD-10). Narcologist works at special psychiatry centres, out-patient clinics of regional multi-profile hospitals, specialised single-profile drug addiction clinics, out-patient clinics of local multi-profile hospitals, health care centres.[22]

In our country treatment of addiction patients is also provided by private institutions (secondary multi-profile health care clinics, etc.) and private narcologist's practices. If a patient has recourse to a private doctor, all expenses related to the treatment must be paid at a patient's own expense.

State-funded in-patient narcological treatment is provided with the use of beds of narcological profile,[23] located in specialised psychiatry centres, regional multi-profile hospitals, as well as in other medical institutions.

It must be emphasised, that drug users, to whom emergency medical aid is provided, for example, in case of drug overdose (ICD-10 diagnosis groups, basically T40–T43, as well as sometimes F10–F19), in most cases are hospitalised in university hospitals, regional multi-profile hospitals and local multi-profile hospitals, where specialised beds of narcological profile may not be available.

Out-patient Psychosocial Intervention

Out-patient psychosocial interventions in Latvia are ensured by narcologists in cooperation with assistant nurses. Particular institutions have also created multi-discipline teams including also psychologists in addition to the mentioned specialists.

The number of treatment personnel has remained stable. According to the data of Register of Medical Practitioners and Medical Treatment Support Persons of the Health Inspectorate, in 2013 addiction treatment aid was provided by 94 narcologists working at 110 out-patient and in-patient clinics. In 2012, such aid was provided by 91 doctors at 97 clinics. (L.Šulca et al., 2013.)

Judging by the number of narcologists working in contractual relationship with the National Health Service from 2007 to 2012 (see Table 5.1.), it is concluded that this number is comparatively stable.

[21] Information Report On the Implementation of the "Guidelines for the Containment and Control of Narcotic and Psychotropic Substances and the Prevalence thereof for the Period from 2011 to 2017" from 2011 to 2013" (unpublished data)

[22] Definitions of terms available in the "Programme for the Development of Out-patient and In-patient Health Care Service Providers", Cabinet Order No. 1003 of 20 December 2000

[23] Including detoxification beds, Minnesota programmes, the motivation programme, medical rehabilitation. Diagnoses ICD-10: F10–F19

Table 5.1. Narcologists working in contractual relationship with the NHS in the years 2007–2013

	2007	2008	2009	2010	2011	2012	2013
Narcologists (natural persons)	65	77	75	72	68	69	69

Source: National Health Service, 2013

Specialists in private narcological institutions, which do not have contractual relationships with the National Health Service, also provide out-patient narcological aid in our country.

Narcological services provided by the narcologists who have contractual relationships with the National Health Service are paid with fixed monthly payments if 0.5 of the amount of work is reached, in other cases the treatment episode tariff is applied.

According to the data provided by the National Health Service, 18 treatment institutions and 26 narcologist's practices received financing according to an estimate in 2013. In 2013, the National Health Service financed 24.5 full-time positions of narcologists and 27.75 full-time positions of assistant nurse, according to the estimate. While the treatment episode tariff was applied for narcologists working at 31 treatment institutions providing drug addiction treatment (L. Šulca et al., 2013).

In accordance with the National Health Service data, the total number of out-patient narcological visits (diagnoses ciphered as mental and behavioural disorders due to psychoactive substance use F10–19 in accordance with ICD-10) in 2013 was 46,900 visits (in 2012—49,959, in 2011—38,437, and in 2010—36,522 visits), while the number of unique patients was 9748 (in 2012—11,853, in 2011— 2,781). The average number of out-patient visits per one unique patient in 2013 was 4.8 visits (in 2012—4.2, in 2011—3.0 visits and in 2010—2.94visits).

Health problems related to alcohol addiction, abuse or to intoxication were diagnosed for 76.5% of all unique patients (F10 diagnosis group in accordance with ICD-10), while diseases related to narcotic or psychotropic substance intoxication, abuse and addictions (diagnosis groups F11–19 according to ICD-10) were diagnosed for 23.5% of such patients. Unique patients by gender: 77.9% of patients are men and 22.1% of patients are women.

Motivating intervention, cognitive behavioural therapy, supporting therapy for solving of social issues etc. are applied in the course of out-patient psychosocial intervention.

Out-patient narcological aid is a service available for the patients in Latvia both with regard to the geographical scope and the number of specialists.

However, multi-discipline teams are partially provided with methadone only in the long-term pharmacotherapy, and where there are no such programmes it is not possible to engage also, for example, a psychologist for working with other patients. Specialists emphasise the need for a multi-discipline team of professionals in providing narcological aid to out-patients.

It shall, nevertheless, be mentioned that only about 10% of drug users (from the high risk drug users) use the State-paid narcologic treatment services.

One of the key reasons for this problem is the high stigmatisation of narcological patients, which is still high. In addition, addicted patients are stigmatised by not only the society but also specialists, medical practitioners, including narcologists. So, in the treatment process there are situations when the addiction diagnosis serves as a punishment or tool for intimidating the patient by limiting the right to receive driver's license, permit to bear weapons, etc.

Another factor or reason is the fact that addicted patients are subject to patient fee, unlike, for example, psychiatric patients (CDPC, 2013).

In accordance with the Cabinet Regulation of 31 October 2006 No. 899 “Procedures for the reimbursement of expenditures for the acquisition of medicinal products and medicinal devices intended for out-patient medical treatment”, the list of medicinal products to be compensated from the State budget includes medicinal products that are used for treatment of children with mental and behavioural disorders due to use of psychoactive substances provided that particular preparations (with 100% compensation) are prescribed for these children. In accordance with the National Health Service data, the number of unique patients-children, who received compensated medicinal products for the particular diagnoses (diagnosis groups F11; F12.; F13; F14; F15; F18; F19 according to ICD-10) was 105 (in 2012—28), while a little amount of financial resources compensated from the State budget was used for treatment of children—EUR 1558.2 (in 2012—LVL 300) (National Health Service, 2013).

In-patient Psychosocial Intervention and Detoxication

In case of acute emergency situations related to use of addictive substances (basically, T40–T43 diagnosis groups, and sometimes F10–F19 according to ICD-10), medical aid is provided by hospitalising such patients not only in medical centres where beds of narcological profile are available, but also in university hospitals, regional multi-profile hospitals, as well as local multi-profile hospitals, where specialised beds of narcological profile are not available.

The Database of Hospital Bed Utilisation of the Centre for Disease Prevention and Control of Latvia provides information regarding utilisation of hospital beds only in relation to healthcare institutions, which are identified as institutions that provide medical services of narcological profile (Sate-funded services as well as private services for diagnosis groups F10–F19 according to ICD-10).

In 2013 the average number of beds of narcological profile was 232 (249 in 2012), including beds designated for detoxication, Minnesota programme, motivation and medical rehabilitation. Within the last five years, the number of narcological profile beds decreased from 387 beds in 2008 to 232 beds in 2013. These services were provided by 9 healthcare institutions. 198 beds were funded from the State budget, while other beds were located in private healthcare institutions.

The average number of days spent at institution by 1 patient has decreased from 5.4 days in 2008 to 4.1 days in 2013, which suggests that majority of patients arrive at an in-patient clinic for detoxication only and do not continue treatment within motivation or Minnesota programmes, mandatory treatment programme for children or medical rehabilitation.

In our state, due to circumstances of limited financing, generally detoxication is provided with the use of narcological profile beds.

In-patient psychosocial intervention includes treatment of patients in medical institutions of in-patient type, starting with short-term in-patient programs (Minnesota and motivation programmes) up to therapeutic communities.

In accordance with data provided by the National Health Service information system (as of 20.10.2014), the number of hospitalisations for drug-addicted patients (diagnosis group F10–F19 according to ICD-10) in all hospitals, which have contractual relationships with the National Health Service, was 10,280 hospitalisation cases in 2013 (11,638 in 2012), of which 9689 hospitalisation cases or 94.3% were based on diagnoses related to alcohol use (diagnosis group F10 according to ICD-10), and 591 hospitalisation cases or 5.7% (602 in 2012) were based on diagnoses related to use of narcotic and psychotropic substances (diagnosis group F11–19 according to ICD-10).

Analysing the National Health Service data concerning patients with mental and behavioural disorders, the number of unique patients treated within the framework of Minnesota and motivation programmes is relatively small: in 2013 there were 287 unique patients (395 in 2012) treated within the Minnesota programme, while 33 unique patients (23 in 2012) were treated within the motivation programme. The mentioned facts show evidence of possible limited accessibility of this service.

Social rehabilitation for children and adults with mental and behavioural disorders due to use of psychoactive substances is financed by the Ministry of Welfare on the basis of regulations prescribed by the Social Services and Social Assistance Law, in accordance with the procedure specified by the Cabinet Regulation No. 914 of 6 November 2006 "Procedures, by which persons addicted to psychoactive substances receive social rehabilitation services, and requirements for social rehabilitation service providers".

In accordance with data provided by the Ministry of Welfare, in 2013 resources in the amount of LVL 56.048[24] were used for social rehabilitation of adult persons addicted to psychoactive substances, while LVL 57.072 were used in 2012, LVL 53.856 in 2011 and LVL 44.080 in 2011. In 2013 social rehabilitation services were received by 19 adult persons (in 2012—by 10 persons, in 2011—by 14 persons and in 2010—by 15 persons).

In 2013 resources in the amount of LVL 93.716 were used for rehabilitation of children addicted to psychoactive substances, while resources in the amount of LVL 141.011 were used in 2012 and LVL 297.450 were used in 2011. Social rehabilitation services were received by 40 children in 2013 (52 children in 2012 and 56 children in 2011).

5.3. Access to Treatment

Similarly to the national reports of previous years, this section describes Treatment Demand Indicator (TDI) data and data reported by drug-related assistance providers. The sub-sections deal with:

historical information spanning the period from 1980ies according to information on F11–F19 (except for F17 (tobacco)) diagnosis collected in the national statistical report;

information on the drug users who have received treatment gathered in the APANS and SPANS databases of the National Health Service;

data according to more exact and EMCDDA-appropriate definitions that have been obtained by combining the information in PREDA and APANS databases, thus identifying the situation in the drug-related addiction treatment more precise than in previous years.

In 2011, targeted works were commenced to prepare for changes in the data collection form (register card) and structure used in the treatment indicator; in 2012, working groups held numerous meetings during which a new data collection card was elaborated together with experts; the card was approved by the Cabinet of Ministers (Cabinet Regulation No. 746). The new data collection card entered into force on 1 January 2013.

Data gathered with the new data collection form allows for a more accurate monitoring of this field and richer data analysis. Moreover, the planned changes in the card and updated definitions will provide more information to policy makers and planners, as well as experts for the evaluation of treatment process and argumentation of the necessity to implement knowledge- and evidence-based measures.

[24] 1 LVL=1,42 EUR

Detailed data on each registered patient with addiction diseases is collected in Latvia starting from 1997, when this register was established. The register card initially included social and demographic information on the patient (gender, age, nationality, profession, education, place of residence, family status, description of living conditions), information on the diagnosis, substance use (substances used, frequency of use, career of drug use, manner of using), as well as manner how the diagnosis was established, and the result of doctor's visit. The changes made in the new data collection system pursuant to TDI Protocol 3.0 provide for an updated treatment definition, more clear criteria for dates marking the beginning and end of treatment episodes, as well as new and updated variables, for example, information on children, internationally comparable education levels (pursuant to ISCED), assistance received during a visit, more detailed information on alcohol use, including high-risk alcohol abuse, use of several substances simultaneously, injecting careers and sharing of injecting equipment, as well as testing for blood-borne infectious diseases. The data of the first year after the changes are comparable to the information gathered in previous years, to a large extent; however, the more exact definitions and decline in the number of clients entered into the PREDA system, if compared to data of 2012 and 2013, suggest of: 1) more objective statistical data, or 2) systemic problems in data provision. The section of patient-reported outcome, which is filled-in after the treatment, has been re-included in the PREDA system and will allow for the evaluation of the impact of various treatment programmes on the improvement of quality of patient lives, as well as for a more efficient planning of treatment programmes, in the future. Additional innovation in the PREDA system provides that data is provided by not only narcologists working at out-patient clinics, but also specialised in-patient treatment institutions.

The information on diagnosis contained by the PREDA system is included in the annual reports by the CDPC and submitted to the Central Statistical Bureau.

Statistical Report Data

According to the statistical report data, there were 421 (or 20.9 per 100,000 people) first-registered cases, i.e., patients to whom a diagnosis related to drug use (F11–F19, except for F17) had been established for the first time; overall, the diagnosis was related to addiction syndrome or psychoses in 188 cases (9.3 per 100,000 people) (Centre for Disease Prevention and Control, 2013).

In 2013, the diagnosis established most often for the first-registered patients was related to poly drug use (F19): 34.5% of the first-registered cases in 2013, compared to 41.9% in 2012. Diagnosis F19 is followed by diagnoses related to use of opioids (F11: 12.4% (12.5% in 2012)), stimulants (F15: 15.7% (16.8% in 2012)) and cannabinoids (F12: 31.4% (25.1% in 2012)). Sedative-related diagnoses (F13) have been established in 2.9% (4.9% in 2012) patients, while inhalant related diagnoses (F18) have been identified in 1.7% (1.1% in 2012) patients; only five patients have a cocaine-related diagnosis (F14). There have been no diagnosis related to hallucinogens (F16) established in first-registered patients in 2013.

Treatment Demand Indicator Data

The information collected in the PREDA system in Latvia previously did not match the treatment definitions used by the EMCDDA and recognised internationally, in addition the State did not gather information on drug users treated within a year; therefore, targeted actions have been performed for more than two years already to ensure that combination of information of two databases (PREDA and APANS) gives a more precise definition of a treated patient. As a result of combining the information collected in these databases, the number and characteristics of drug users treated within 2007–2012 were identified in 2012, according to TDI definition. The new data collection system allows gaining information about the treated patient from the PREDA system; however, in order to calculate the number of patients who have participated in long-term treatment programmes (for more than a calendar year), several data sources (PREDA, APANS, and SPANS) are combined. In addition to the data quality improvements described in the chapter previously and more exact definitions, when interpreting data and trends it has to be taken into consideration that

the data of 2007–2012 does not include the drug users treated in in-patient clinics, while data for 2013 do include information from in-patient clinics.

The quality control of PREDA data of 2013 revealed that PREDA system does not include detailed information on 977 drug users (785 in 2012 and 984 in 2011) treated within a year by narcologists at the expense of the State budget. Since this number is quite remarkable (concerning approximately one in three patients), it is necessary to introduce various mechanisms in the future allowing acquisition of more complete information for the PREDA system as it is used for policy and service planning and monitoring of the situation.

According to the new treatment definition, 1543 drug users have received treatment in 2013 (2187 in 2012), out of who 555 (402 in 2012) have received assistance for the first time in their lives. The collected data shows that there is an increase in the number of first-treated patients in comparison to 2012 (by 153 patients or 38.1%; in 2012, the increase was only 16 patients or 4.1%), while the number of patients treated within a year has dropped by 644 patients or 29.5% (compared to the increase of 177 patients or 8.8% in 2012). Trends in changes in the number of patients treated within a year and for the first time are illustrated in Table 5.1.

Table 5.1. Dynamics of patients treated within a year, for the first time, and previously, 2007–2013, in absolute numbers

	2007	2008	2009	2010	2011	2012	2013
Treated within a year	1594	1952	1816	1962	2010	2187	1543
Treated for the first time	331	386	290	311	386	402	555
Treated previously	1263	1566	1526	1651	1624	1785	988

Source: Centre for Disease Prevention and Control of Latvia, 2014

Overall, 123 or one in four (22.2%) patients treated for the first time in 2013 was woman (in 2012: 95 or 23.6%). Since 2007, the trend in the number of first-treated women is stable and stays within 22–24%, except for 2008, when only 18.7% of first-treated patients were women (see Table 5.2.). The proportion of women who have received treatment within a year is similar: 341 women or 22.1% (457 women or 20.9% in 2012) have been treated by a narcologist in 2013.

Table 5.2. Proportion of women treated within a year, for the first time, and previously, 2007–2013, %

	2007	2008	2009	2010	2011	2012	2013
Treated within a year	22.3	19.4	20.3	20.5	20.7	20.9	22.1
Treated for the first time	23.3	18.7	23.1	24.4	23.1	23.6	22.2
Treated previously							22.1

Source: Centre for Disease Prevention and Control of Latvia, 2014

In 2013, the average age of patients treated for the first time was 24.5 (standard deviation (SD): 9.9 years) (in 2012 it was 26.4 years); there are no remarkable differences by gender— 24.9 years for men and 25.4 years for women (in 2012: 26.4 years for men and 26.5 year for women) (see Table 5.3.). Generally, the patients treated within a year are 3–4 years older than first-treated patients, and there is a tendency for the average age of patients to increase since 2007; however, the average age of patients has slightly decreased in 2013 if compared to that of 2011 and 2012.

Table 5.3. Average age of patients treated within a year, for the first time, and previously, 2007–2013, by gender

	2007	2008	2009	2010	2011	2012	2013
Treated within a year							
Total	27.7	27.8	28.5	29.2	30.1	30.0	28.6
Men	27.6	27.8	28.5	29.1	30.0	30.1	30.9
Women	27.8	27.9	28.6	29.4	30.6	30.0	28.9
Treated for the first time							
Total	25.5	26.1	26.1	28.3	27.7	26.4	24.5
Men	25.5	25.9	25.9	27.0	27.9	26.4	24.3
Women	25.5	27.2	26.8	32.0	27.1	26.5	24.9
Treated previously							
Total							31.0
Men							28.6
Women							31.1

Source: Centre for Disease Prevention and Control of Latvia, 2014

In total, 9.0% (7.2% in 2012) of the first-treated patients were younger than 15 years; 32.6% (26.1% in 2012) were 15–19 years old; 29.5% (16.9% in 2012) were 20–24 years old; 18.6% (19.2% in 2012) were 25–29 years old; 16.4% (13.2% in 2012) were 30–34 years old; 12.6% (8.7%) were 35–39 years old; but 13.9% (8.7% in 2012) were older than 40 years (see Table 5.4.). Data of the last four years shows that there is an increase in the number and proportion of the first-treated patients who are older than 40 years, but in 2013 there is a remarkable growth in the number of drug users representing the youngest age group (up to 15 years).

Table 5.4. Patients treated for the first time by age, 2008–2013, %

	2008		2009		2010		2011		2012		2013	
	n	*%*	n	*%*	n	*%*	n	*%*	n	*%*	n	*%*
Younger than 15	20	*5.2*	20	*6.9*	18	*5.8*	18	*4.7*	29	*7.2*	50	*9.0*
15-19 year-olds	61	*15.8*	56	*19.3*	60	*19.3*	88	*22.8*	105	*26.1*	164	*32.6*
20-24 year-olds	115	*29.8*	77	*26.6*	57	*18.3*	68	*17.6*	68	*16.9*	103	*29.5*
25-29 year-olds	99	*25.6*	68	*23.4*	66	*21.2*	80	*20.7*	77	*19.2*	91	*18.6*
30-34 year-olds	46	*11.9*	35	*12.1*	44	*14.1*	62	*16.1*	53	*13.2*	70	*16.4*
35-39 year-olds	21	*5.4*	15	*5.2*	29	*9.3*	29	*7.5*	35	*8.7*	40	*12.6*
40 and more year-olds	24	*6.2*	19	*6.6*	37	*11.9*	41	*10.6*	35	*8.7*	37	*13.9*
Total	386	*100*	290	*100*	311	*100*	386	*100*	402	*100*	555	*100*

Source: Centre for Disease Prevention and Control of Latvia, 2014

Overall, 4.1% (2.0% in 2012) of the patients treated within 2013 were younger than 15 years; 16.6% (16.0% in 2012) were 15–19 years old; 13.2% (12.2% in 2012) were 20–24 years old; 21.3% (22.9% in 2012) were 25–29 years old; 22.3% (22.5% in 2012) were 30–34 years old; 11.4% (11.5%) were 35–39 years old; but 6.1% (12.8% in 2012) were older than 40 years (see Table 5.5.).

Table 5.5. Patients treated within a year by age, 2008–2012, %

	2008		2009		2010		2011		2012		2013	
	n	*%*	n	*%*	n	*%*	n	*%*	n	*%*	n	*%*
Younger than 15	44	*2.3*	33	*1.8*	28	*1.4*	27	*1.3*	44	*2.0*	64	*4.1*
15-19 year-olds	275	*14.1*	275	*15.1*	320	*16.3*	287	*14.3*	351	*16.0*	256	*16.6*
20-24 year-olds	461	*23.6*	353	*19.4*	306	*15.6*	262	*13.0*	266	*12.2*	203	*13.2*
25-29 year-olds	563	*28.8*	503	*27.7*	546	*27.8*	541	*26.9*	501	*22.9*	328	*21.3*
30-34 year-olds	289	*14.8*	325	*17.9*	345	*17.6*	428	*21.3*	493	*22.5*	344	*22.3*
35-39 year-olds	143	*7.3*	147	*8.1*	187	*9.5*	209	*10.4*	251	*11.5*	176	*11.4*
40 and more year-olds	177	*9.1*	180	*9.9*	230	*11.7*	256	*12.7*	281	*12.8*	172	*6.1*
Total	1952	*100*	1816	*100*	1962	*100*	2010	*100*	2187	*100*	1543	*100*

Source: Centre for Disease Prevention and Control of Latvia, 2014

Comparing the data of 2013 and 2012, the proportion of first-treated patients who live outside Riga has decreased. In 2011, 46% of first-treated patients lived in Riga, the proportion decreased in 2012 to 42% and then again rose in 2013 to 48%. The highest proportion of patients who live in Riga was in 2002; since then both the number and proportion of first-treated drug patients who live outside Riga have increased year by year. Analysis of data about the patients treated within a year shows that the number and proportion of patients living in Riga is higher (56%) in 2013 than in previous three years, when the proportion of patients living in Riga was practically stable (41%–43%), while the proportion in 2013 is considerably lower than in 2007 (49%).

Data of 2012 on the primary substance among the first-treated patients show that the primary substance used most often is cannabinoids (272 patients or 49.0%, compared to 107 patients or 26.6% in 2012), unlike the previous years when the primary substance mentioned most often was amphetamines. The next most “popular” primary substance is amphetamine/methamphetamine (111 patients or 20.0%, compared to 107 patients or 26.5% in 2012). Heroin has been mentioned as the primary substance by 81 first-treated patients or 14.6% (61 patients or 15.2% in 2012). Other substances have been mentioned comparatively rarer—by less than one in ten patients.

Overall, 23 patients or 4.1% (compared to 41 patients or 10.2% in 2012) have primary used other opioids (mainly home-produced preparations containing poppy or the so-called ”hanka”), 21 patients or 3.8% (compared to 14 patients or 3.5% in 2012)—sedative-hypnotic substances, seven patients (13 patients in 2012)—inhalants, four patients (two patients in 2012)—cocaine, three patients (five patients in 2012)—other stimulants, except for amphetamine/methamphetamine, three patients (also three patients in 2012)—LSD or other hallucinogens, and two patients (one patient in 2012)—ecstasy (or MDMA). The primary substance has not been identified for 26 patients or 4.7% (39 patients or 9.7% in 2012), while it has not been indicated for two patients (seven patients in 2012). For more detailed information see Fonte (in total, 60 detailed tables on treatment process TDI_LV_2014_01).

Data of 2013 (similarly to the information about 2012) about the primary substance among patients treated within a year shows that the substance mentioned most often is heroin (472 patients or 30.6% in 2013, compared to 789 patients or 36.1% in 2012), unlike the first-treated patients, while amphetamine/mehtamphetamine has been primary used by 222 patients or 14.7% (compared to 426 patients or 19.5% in 2012). Various cannabinoids as a primary substance has been indicated by 411 patients or 26.6% (compared to 314 patients or 14.4% in 2012), while other opioids (except for heroin) have been primary used by 311 patients or 20.2% (compared to 250 patients or 11.4% in

2012). Other substances or their groups have been mentioned by less than one in ten patients. Table 5.2. illustrates the proportion of patients treated within a year by primary substance used.

Table 5.2. Patients treated within a year by primary substance, 2007–2013, %

	2007	2008	2009	2010	2011	2012	2013
Heroin	49.5	46.0	42.8	40.4	39.8	36.1	30.6
Amphetamines	12.9	15.2	16.7	18.7	18.9	19.5	14.7
Other opiates	13.2	12.5	12.6	12.1	12.2	12.9	20.2
Cannabinoids	7.7	8.8	10.5	11.4	11.5	14.4	26.9
Other substances	6.1	5.9	6.4	5.8	6.2	7.1	0.4
Sedatives	4.4	4.4	4.7	5.8	5.4	5.0	2.9
Inhalants	4.6	4.4	4.0	4.0	4.1	3.3	0.7
Now known	1.6	2.8	2.4	1.9	1.9	1.8	2.5

Source: Centre for Disease Prevention and Control of Latvia, 2014

Treatment data suggests that users of various substances have different age of first-treatment and different length of time between starting using the substance and turning for assistance to a treatment institution. For example, users of inhalants have first received treatment earlier than users of other substances—average 13.3 years according to data 2013 (13.9 years in 2012). Considerably later the first treatment has been received by users of cannabinoids (20.2 years compared to 21.1 years in 2012), users of amphetamines (26.6 years compared to 27.5 years in 2012), users of heroin (30.2 years compared to 30.4 years in 2012), but the oldest first-treated addicts are those using other opioids who receive first treatment in 33.4 years (31.8 years in 2012).

Observations of the last few years suggest that the age of first treatment rises for users of practically all substances. Such tendency might indicate that drug users involve in the treatment system only when the drug addiction problems are rather serious, and that the treatment system is not able to perform early identification of young drug users when it is comparatively easier, possibly, to treat them.

Social and Demographic Indicators

Nationality

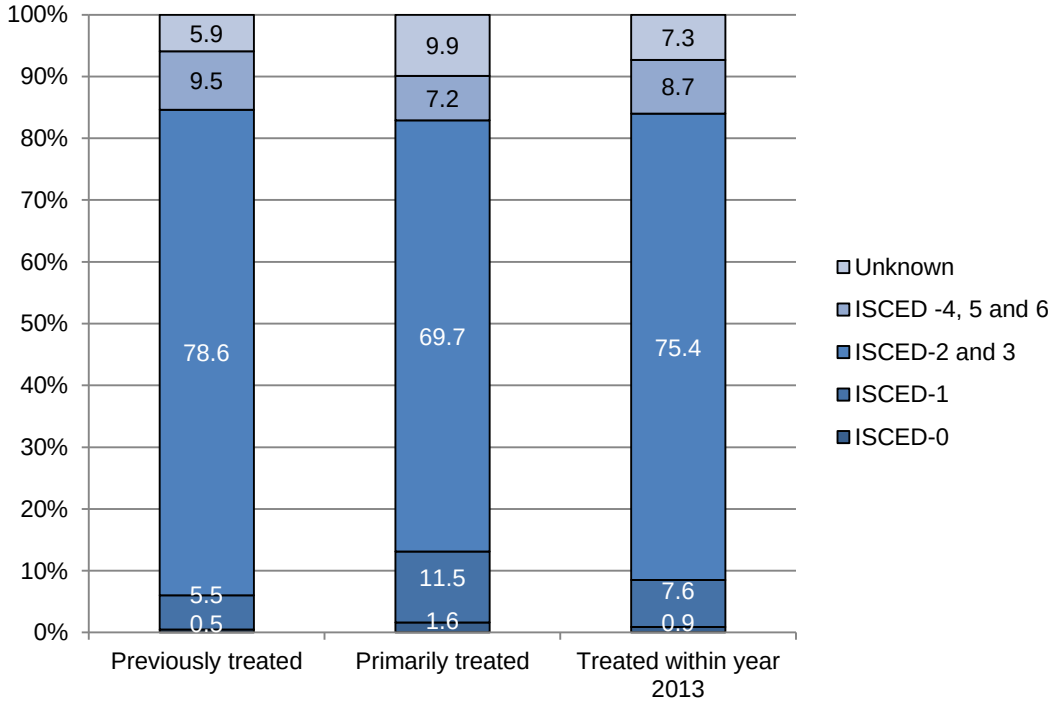
Approximately one third (35.2%) of drug users treated in 2013 are Latvians, about one half (50.6%) are Russian speaking, one in ten (10.2%) drug users have not provided information on their nationality, but 7.6% of drug users treated in 2013 represent other nationalities.

Among those first-treated patients whose nationality has been indicated, the proportion of Latvians is bigger than among previously treated patients (44.6% and 30.8% respectively).

Education

In total, 1.6% of first-treated drug users have not attended the school or have studied for less than six years (ISCED level 0), 11.5% of patients have studied for 6–9 years (ISCED level 1), 69.7% have secondary education (ISCED levels 2 and 3, which include both completed and uncompleted secondary education and vocational secondary education), while the highest education (ISCED levels 4, 5, and 6, which include completed and uncompleted highest education or vocational education after graduation from a secondary education establishment) has been acquired by 7.2% of patients. The education level has not been indicated for 9.9% or 55 of the first-treated patients.

Figure 5.1. Level of education of first-treated patients, patients treated in 2013 and previously,

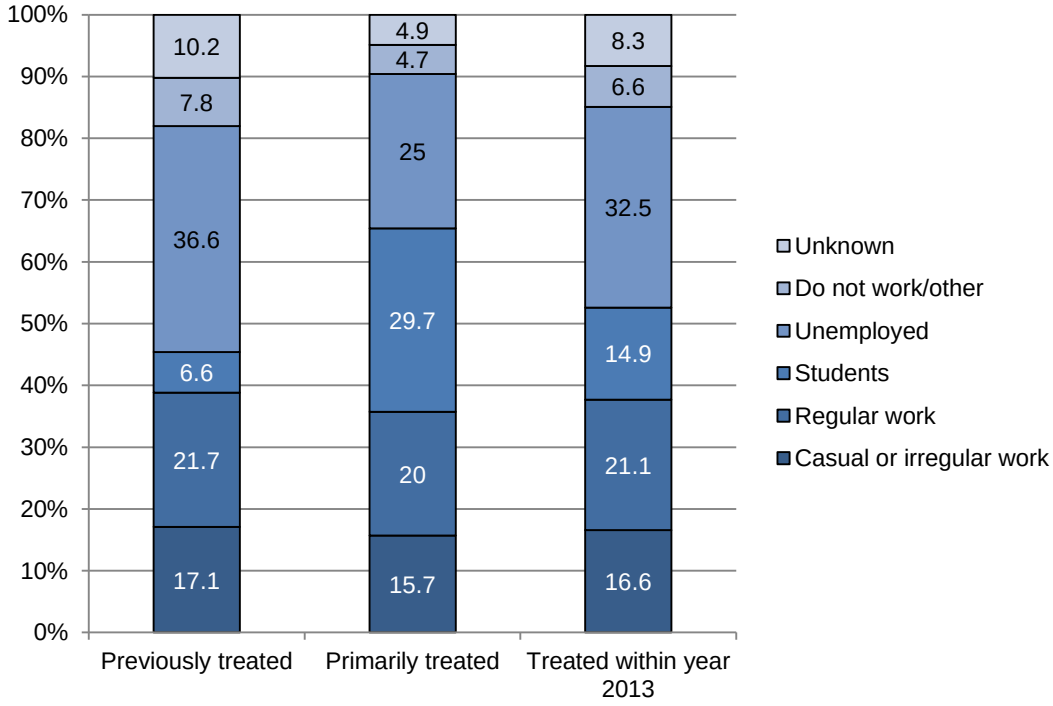


Source: Centre for Disease Prevention and Control of Latvia, 2014

Economic Activity

In general, 15.7% of first-treated patients (17.1% among those treated previously) have casual or irregular work, 20.0% (21.7% among those treated previously) have regular work, 29.7% (6.6% among those treated previously) are students, 25.0% (36.6% among those treated previously) are unemployed and receive or do not receive unemployment benefit, 1.8% (3.6% among those treated previously) do not work (pensioners, unemployed persons, disabled persons, etc.), 2.9% (3.9% among those treated previously) have indicated other employment status, while the employment status has not been mentioned for 4.9% (10.2% among those treated previously) of first-treated patients.

Figure 5.2. Status of employment of first-treated patients, patients treated in 2013 and previously, %

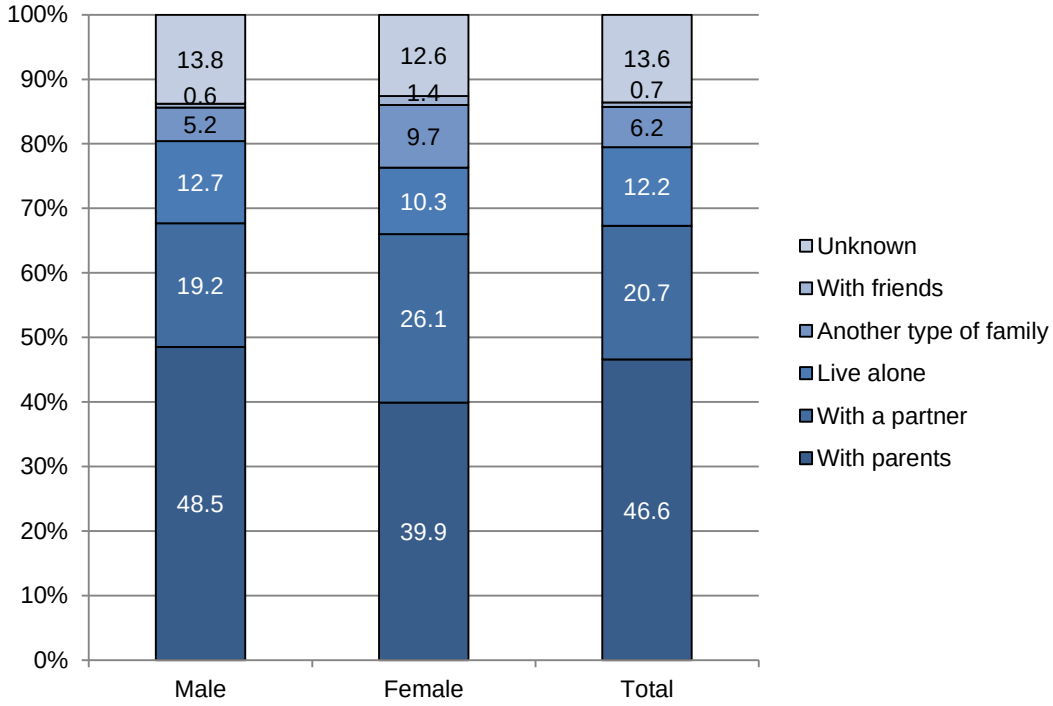


Source: Centre for Disease Prevention and Control of Latvia, 2014

Family Status

According to the information gained in 2013, 46.6% or 719 of patients treated within a year live together with parents and/or siblings, 20.7% (320 patients) live with a partner and with or without children, 12.2% (188 patients) live alone, but 6.9% (107 patients) have another type of family model (with friends, with a partner and friends, in extended families, are single mothers/fathers, etc.); information on the family status has not been provided for 13.5% or 209 patients. Men live together with parents more often than women (48.5% and 39.9% respectively), while women more often live together with partner with or without children (261% of women and 19.2% of men).

Figure 5.3. Family conditions/status of patients treated in 2013 by gender, %



Source: Centre for Disease Prevention and Control of Latvia, 2014

According to the data contained by the PREDA card, information on children has not been indicated for a large portion of patients (769 patients or 49.8% of those treated within a year), while 18.9% (292 patients) live together with children.

Profile of Users of heroin and amphetamines

This chapter includes information on the profile of users of the two most popular drugs—heroin and amphetamines. The information is based on the data provided by treatment data collection systems.

Heroin

Treatment data (PREDA) shows that 3448 unique patients have been registered (have received treatment) since 1997 for whom heroin has been indicated as the primary substance in the first registration (treatment) episode. The largest number of primary users of heroin has been registered in 2000 (777 patients), but the number and proportion of primary heroin users among all patients is decreasing over the last years

The average age of primary heroin users treated in 2013 was 31.1 years (SD 5.9) (compared to 30.3 years in 2012, SD 6.1). The average age of treated men was slightly higher than among women, respectively 31.4 years (SD 5.6) and 30.2 years (SD 6.6). The youngest heroin user who received first treatment in 2013 was aged 16, while the oldest was aged 60.

In 2013, there were 23.7% women and 76.3% men among the first-treated heroin users, while the proportion of women among all registration cases was 20.8%.

Table 5.3. Proportion of women primary using heroin treated within a year, for the first time, and previously, 2007–2013, %

	2007	2008	2009	2010	2011	2012	2013
Treated within a year	22.8	19.5	20.5	20.7	21.1	20.3	23.7
Treated for the first time	21.4	19.7	25.2	17.2	19.0	18.0	28.4
Treated previously							22.8

Source: Centre for Disease Prevention and Control of Latvia, 2014

A bit more often than one in two (56.8%) heroin users first treated in 2013 (57.4% in 2012) had an opiates-related diagnosis (ICD-10 F11), while others (42,6%) had a diagnosis related to poly drug use (ICD-10 F19). As shown by Table 5.4., the majority of first-treated heroin users have been diagnosed with addiction.

Table 5.4. Groups of diagnosis and proportion of diagnoses related to addiction syndrome among first-treated primary heroin users in 2007–2013, %

	2007	2008	2009	2010	2011	2012	2013
F11	69.9	71.9	69.9	79.6	56.8	57.4	56.8
F19	30.4	28.1	30.1	20.4	43.2	42.6	43.2
Total	100	100	100	100	100	100	100
including proportion of addiction-related diagnoses	98.8	98.9	93.5	93.6	92.6	91.8	96.7

Source: Centre for Disease Prevention and Control of Latvia, 2014

An absolute majority (97.5% of the first-treated and 97.7% of previously treated) of heroin users treated in 2013 are injecting drug users. Similar situation with regard to heroin use was also in previous years. Each year there are some users who have indicated that they use heroin by smoking or snorting, although this number is small, for example, 3 patients in 2012, no one in 2011, and 2 patients in 2010).

According to PREDA data on 2013, 63.0% of first-treated heroin users use the substance every day, 2.5%—4 - 6 days a week, 7.0%—2–3 times a week, 1.2%—once a week, but 23.5% of the first-treated patients have not used heroin over the last 30 days.

Table 5.5. Frequency of heroin use in first-treated heroin users in 2007–2013 by gender, %

	2008		2009		2010		2011		2012		2013	
	M	F	M	F	M	F	M	F	M	F	M	F
Has not used within the last 30 days	0.0	0.0	0.0	0.0	0.0	3.3	5.2	12.5	2.6	0.0	25.9	17.4
Once a week or rarer	0.8	0.0	0.7	0.0	4.4	6.5	2.6	6.3	5.2	0.0	0	4.4
2–6 times a week	7.6	5.6	4.9	5.7	13.0	29.0	20.8	6.3	20.8	16.7	13.8	8.7
Every day	84.9	91.7	90.9	88.6	77.2	61.3	62.3	68.8	71.4	72.2	60.3	69.6
Not indicated	6.8	2.8	3.5	5.7	5.4	0.0	9.1	6.3	0.0	11.1	0.0	0.0

Source: Centre for Disease Prevention and Control of Latvia, 2014

Overall, 37.0% of the primary heroin users first-treated in 2013 have first tried this substance in 15–19 years, but 32.1%—in 20–24 years. Nearly one in ten (9.9%) patients has first used it for the first time until the age of 15 years or in 25–29 years, while 7.4%—in 30 years or later. Comparison of the age when heroin has been used first among first-treated patients and those treated previously shows that there is a tendency for the age of first-time use to increase, for instance, 52.7% of previously treated patients have tried heroin in 15–19 years, but 20.7%—in 20–24 years. In 2013, the average age of starting using heroin was 21.5 years among first-treated primary heroin users (SD 5.6) and 19.9 years among previously treated users (SD 4.5). The average time span until heroin user has commenced the current treatment is 8.6 years (SD 5.5) for first-treated heroin users.

Amphetamines

Treatment data (PREDA) shows that 1596 first-treated patients have been registered (have received treatment) since 1997 for whom amphetamine or methamphetamine have been indicated as the primary substance in the first registration (treatment) episode. The largest number of primary amphetamine/methamphetamine users was registered in 2008 (186 patients). When speaking about Latvia, it has to be taken into consideration that often drug users are not able to indicate whether they use amphetamine or methamphetamine (hereinafter “amphetamine” is mentioned).

The average age of primary amphetamine users treated in 2013 was 27.1 years (SD 7.4) (compared to 27.5 years in 2012, SD 7.7). The average age of asking for help among treated women was less than among men: 24.7 years (SD 6.5) ad 28.0 years (SD 8.0) respectively. The youngest amphetamines user who received first treatment in 2013 was aged 13, while the oldest was aged 55.

There were 29.1% of women and 70.9% of men among the primary amphetamine users treated in 2013. Table 5.6. reflects the division of first-treated primary amphetamine users by gender since 2007.

Table 5.6. Proportion of women primary using amphetamine treated within a year, for the first time, and previously, 2007–2013, %

	2007	2008	2009	2010	2011	2012	2013
Treated within a year	21.8	20.6	22.8	22.3	22.4	24.4	29.1
Treated for the first time	27.3	20.7	23.3	27.5	29.8	29.9	27.0
Treated previously							31.0

Source: Centre for Disease Prevention and Control of Latvia, 2014

Approximately two thirds (67.6%) of amphetamine users first treated in 2013 had a stimulants-related diagnosis (ICD-10 F15), 31.5% of the first-treated ones had a diagnosis related to poly drug use (ICD-10 F19), and others (0.9%) had a diagnosis related to cannabinoids. As shown by Table 5.11., approximately half (47.8%) of the amphetamine users first treated in 2013 have been diagnosed with addiction, but this proportion has been very fluctuating since 2007.

Table 5.7. Groups of diagnosis and proportion of diagnoses related to addiction syndrome among first-treated primary amphetamines users in 2007–2013, %

	2007	2008	2009	2010	2011	2012	2013
F11		1.1			1.9		
F12							0.9
F14		2.2					
F15	60.6	57.6	48.0	60.0	48.1	63.6	67.6
F19	39.4	39.1	52.0	40.0	50.0	36.5	31.5
Total	100	100	100	100	100	100	100
including proportion of addiction-related diagnoses						39.3	47.8

Source: Centre for Disease Prevention and Control of Latvia, 2014

About two thirds (67.0%) of amphetamine users are injecting drug users, 10.1% (13.1% in 2012) use it by eating or drinking, 18.1% (26.2% in 2012)—by snorting, 3.1%—by smoking, while 1.8% (10.3% in 2012) of primary amphetamine users have not indicated information on the manner of use. The proportion of drug users injecting amphetamines in 2012 was 50.5%, while it was 46.2% in 2011, 47.5% in 2010, 64.4% in 2009, 73.9% in 2008, and 71.2% in 2007.

According to PREDA data on 2013, 14.4% (9.4% in 2012) of the first-treated amphetamine users use amphetamines every day, 30.6% (30.8% in 2012) use amphetamines 2–6 days a week, 27.9% (29.9% in 2012)—once a week, but 27.0% (15.9% in 2012) have not used the substance over the last 30 days.

Clients in Long-term pharmacotherapy using opioids

A positive tendency of 2013 and the previous years is that there is an increase observed in the number of methadone programme clients; however, tha changes with regard to the geographical scope have not been observed. Amendments made to legal acts in 2011 provide that methadone programme is continued also for prisoners. Despite the changes of latest years, the number of patients treated within methadone (and buprenorphine) programme still is the lowest among the EU Member States both in absolute numbers and among the general population or number of users of opioids.

By the end of 2013, there were 424 patients treated within long-term pharmacological treatment for opioid dependence programmes, of whom 328 patients were in the methadone programme and 96 patients were in the buprenorphine programme. To compare with, 278 patients were in the methadone programme and 77 patients were in the buprenorphine programme by the end of 2012.

At the end of 2013, methadone cabinets were working in 10 towns. Buprenorphine replacement therapy is available at nine towns in Latvia.

In Latvia the methadone programme was launched in 1996, while the buprenorphine programme was launched in 2005. In spite of the fact, that the methadone programme was launched practically in-parallel with similar activities in various Western- and Eastern European countries (e.g., in France the methadone programme was launched in 1995, in Norway it was launched in 1998, in Belgium—in 1994), development of this programme was limited. In accordance with the information gathered by EMCDDA, currently the highest percentage of opioids users, who are treated within pharmacological treatment programmes, (approximately 70% of users) has been observed in Norway, while in Latvia the lowest percentage of such patients has been observed (approximately 2-3%) (according to EMCDDA, 2013). In those countries, where a significant number of opioids users are treated, there are various strategies designated for lowering of social expenses, which may occur as a result of drug use. The strategies are as follows: 1) State-funded buprenorphine programme has been established, 2) pharmacotherapy programmes have been implemented as a part of primary health care, and 3) heroin replacement therapy programmes have been implemented.

6. Health Correlates and Consequences

Drug-related infectious diseases and drug-related deaths and mortality of drug users are two most essential indicators presenting extensive information concerning drug-related health correlates and consequences. During the past three years, there have not been observed any major changes in prevalence of HIV. The lack of such changes might be explained by the presence of needle exchange consultative points, which play an important role in reduction of spread of infectious diseases. At the moment one of the greatest issues is the changes of HIV transmission route; previously HIV was mainly acquired through injecting drugs while at present it has changed to heterosexual transmission route.

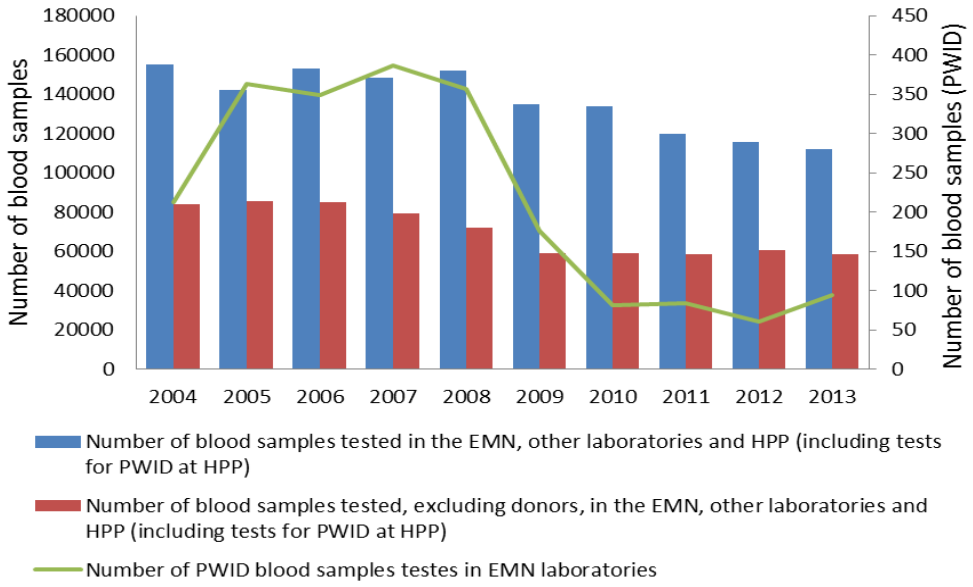
Drug-related mortality is a complex phenomenon, which accounts for a considerable percentage of deaths among young people in many European countries. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), in collaboration with national experts, has defined an epidemiological indicator with two components at present: deaths directly caused by illegal drugs (drug-related deaths) and mortality rates among high risk drug users.

6.1. Drug-related Infectious Diseases

HIV/AIDS

The number of tests for HIV in Latvia in 2013 matches the general tendency of decline observed over the last 10 years. Namely, 112,028 blood samples were tested for HIV in the reporting year (compared to 115,744 in 2012) in the Epidemiological Monitoring Network (EMN) and other laboratories, as well as HIV Prevention Points (HPP). Except for the mandatory tests performed for blood donors, 58,302 tests for HIV have been performed in the reporting year, which is also less than in 2012 when 60,491 tests were performed. The number of tests carried out for persons injecting drugs has slightly increased: there were 94 such tests performed in the reporting year, while information just on 61 cases has been received in 2012. The declining tendencies of the aforementioned statistical indicators confirm the need for active and continuous campaigns to be carried out in the country.

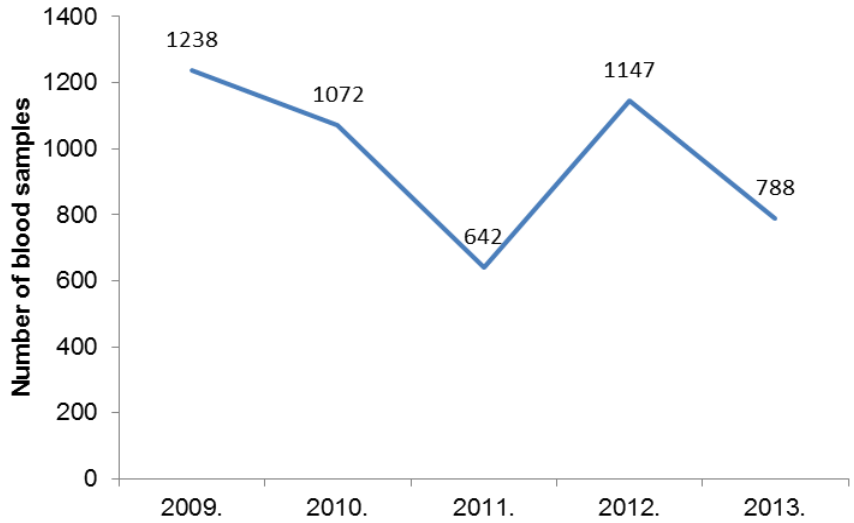
Figure 6.1. Total number of blood samples and number of IDU blood samples tested for HIV in Latvia, last 10 years (2004-2013)



Source: Centre for Disease Prevention and Control of Latvia, 2014

At HPP in 2013, rapid HIV test was done for 788 injecting drug users, which is slightly below the number of 2012 when rapid test was performed for 1147 persons, but still exceeded the result of 2011 when 642 IDU were tested. As mentioned in the last year's report, these differences in the number of rapid tests performed by HPP (see Figure 6.2.) can be explained with the biobehavioural and cohort studies of IDU population; these studies are carried out in the country periodically with the help of HPP.

Figure 6.2. Number of IDU who have been rapid-tested for HIV at HPP in Latvia over the last five years (2009–2013)

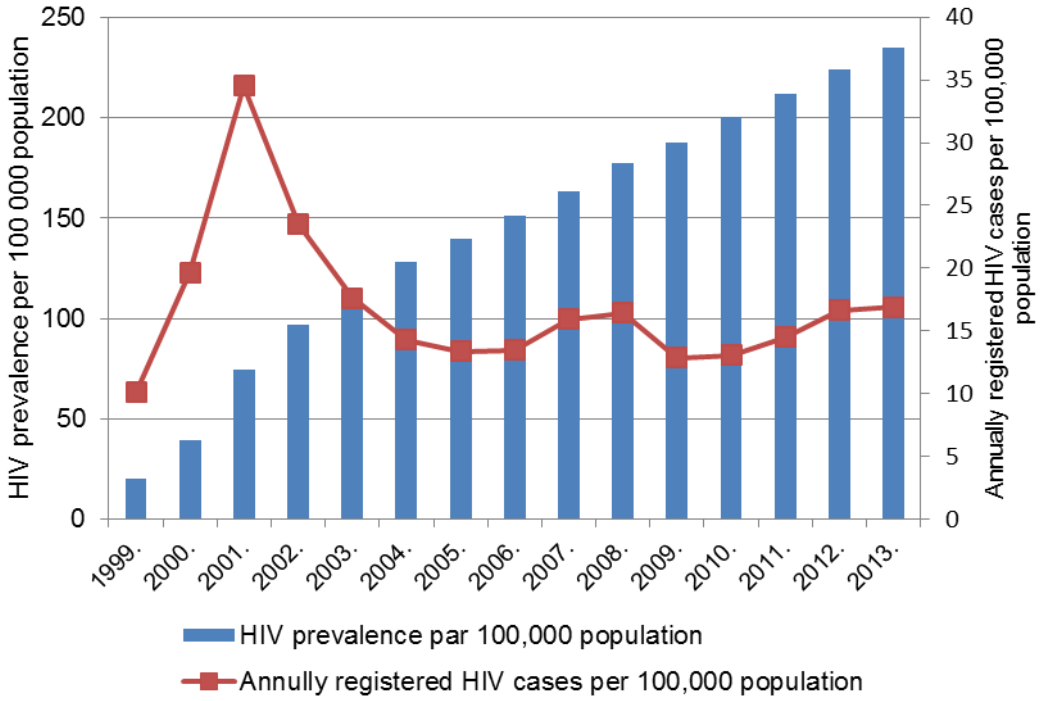


Source: Centre for Disease Prevention and Control of Latvia, 2014

Regarding to the number and proportion of persons tested for HIV in prisons in 2012, the stable decrease has been observed also in this reporting year. According to the report published by the Latvian Prison Administration in 2013, the proportion of prisoners tested for HIV in 2013 was 40% (n=2237/5604), which is less than in 2012 when 42% (n=2676/6352) of persons in penitentiary institutions were tested, and also less than in 2011 when 46% (n=3077/6685) of prisoners were tested. Therefore, promotion of tests for HIV in Latvia is topical not only for the general population but also for prisoners.

By 31 December 2013, a total of 5,867 HIV cases were registered in Latvia (including 1,354 persons diagnosed with AIDS). Out of HIV infected persons who had been registered, 1169 have died. It means that the general prevalence of HIV is 234.7 per 100,000 in Latvia at the end of the reporting year. To compare: the prevalence of HIV in 2012 was 223.7 per 100,000 population and 212.0 per 100,000 population in 2011 (see Figure 6.3.).

Figure 6.3. HIV prevalence (per 100.000 people) and annually registered HIV cases (per 100.000 people) in Latvia, last 15 years (1999–2013)



Source: Centre for Disease Prevention and Control of Latvia, Central Statistical Bureau, 2014

Regarding the HIV incidence rate (if annually registered cases are assumed to be incident cases, similarly to reports of previous years), it can be concluded that it has showed a slow increase in 2013. And namely, this epidemiological indicator is 16.9 per 100,000 population (n=340) in the reporting year, while it was 16.7 (n=339) in 2012 and 14.5 (n=299) in 2011 (see Figure 6.3.). Thus, the gradual increase in the HIV incidence, which is observed starting from 2010, is present also in the reporting year.

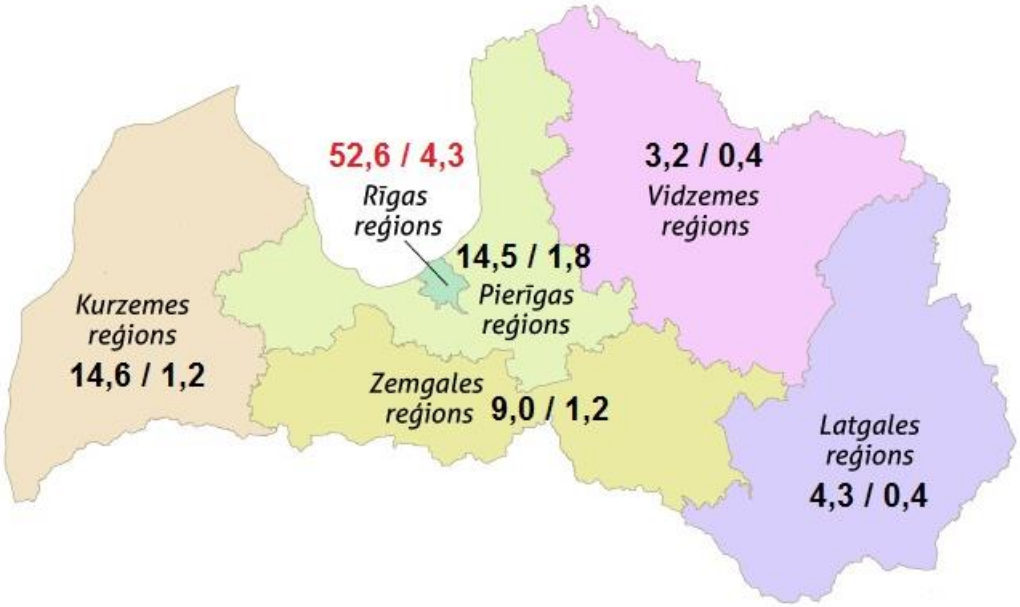
In 2013, the highest HIV incidence rate is for people aged 35–39 years (46.4 per 100,000 population), the second higher rate is among those aged 30–34 years (45.8 per 100,000 population). Speaking about the relation of HIV incidence and gender, it is concluded that the rate is twice as low for women (12.6 per 100,000 population) compared to men (22.0 per 100,000 population) in 2013. Among women, the highest incidence rate (41.2 per 100,000 people) is in a younger age group (30–34) than among men, where the highest incidence rate (55.6 per 100,000 population) is in the age group 35–39.

It must be noted that the proportion of women who are diagnosed with HIV grows year from year. For example, 34.4% of all first-registered HIV cases in 2011 were women, in 2012 this rate was 35.6%, but in 2013 it grew even more reaching 40.3%. This division by gender corresponds to the below-described “popularity” of HIV transmission via heterosexual contacts in Latvia.

Regarding the HIV prevalence, regional differences, which were already noted in the previous year’s report, can be observed in Latvia also in the current reporting year. Riga remains the region with the highest prevalence (52.6 per 10,000 population), in comparison to the whole country. Vidzeme Region shows the lowest HIV prevalence—3.2 per 10,000 population. The same is also true for HIV incidence in the reporting year. Also this indicator has been the highest in Riga Region—4.3 per 100,000 population, and the lowest in Vidzeme and Latgale Regions (0.4 per 100,000 population) (see Figure 6.4.). Explanations for these peculiarities were given in the

previous report already, namely, these can be differences in socioeconomic conditions and drug use habits between the regions.

Figure 6.4. HIV prevalence in regions of Latvia by the end of 2013 and HIV incidence in 2013 (per 10,000 people)



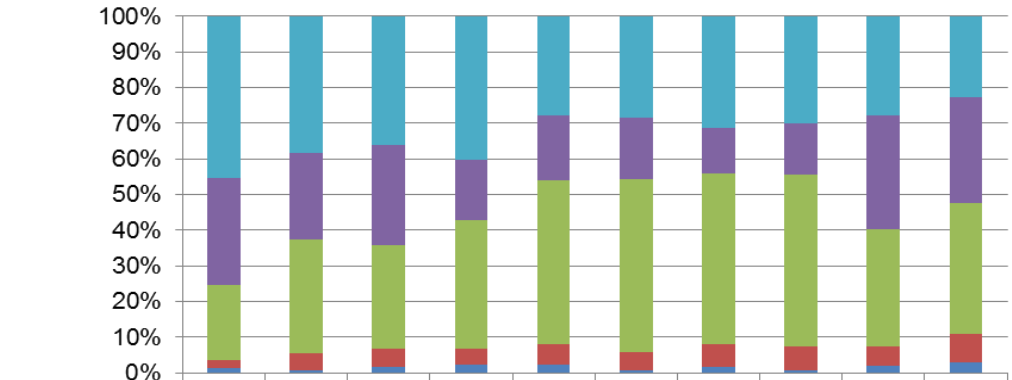
Source: Centre for Disease Prevention and Control of Latvia, Central Statistical Bureau, 2014
Map: NeoGeo.lv, http://neogeo.lv/?p=16656 (visited on 31.10.2014)

With regard to AIDS incidence in Latvia, there is no new information on the reporting year within the European context. The recent materials published by the European Centre for Disease Prevention and Control (ECDC) suggest that Latvia takes the leading position with regard to the results of this epidemiological indicator (6.8 per 100,000 population), while the European average is 0.9 per 100,000 population (ECDC, 2013). This fact reconfirms the previously mentioned need for promoting testing for HIV so that it was possible to diagnose the infection sooner and start a more successful treatment of HIV infection thus delaying the AIDS stage and prolonging the life of HIV positive people.

Regarding the modes of HIV transmission, the trend described in previous years—increase in the proportion of HIV cases transmitted heterosexually—continue to grow also in 2013. This mode of transmission is responsible for one-third of incidences (36.8%, n=125) (in 2012, the proportion of heterosexually transmitted cases was 33.0%). The second most common mode of HIV transmission is by using contaminated injecting equipment, in total 22.6% (n=77) have been transmitted by this mode (27.7% in 2012) (see Figure 6.5.). In 2013, 10 new-borns (or 2.9%) have inherited HIV infection from the mother.

In the reporting year a positive fact is observed: the rate of registered HIV incidences for which the transmission mode is unknown has slightly decreased. In 2013 this proportion was 29.7% (n=101), while in 2012—31.9%. Since this reduction is small, it has to be stressed that improvements in the quality of registering HIV and AIDS cases in the country are still needed.

Figure 6.5. Distribution of annually registered HIV cases (in absolute numbers and per cent) by mode of transmission, last 10 years (2004–2013)



	2004.	2005.	2006.	2007.	2008.	2009.	2010.	2011.	2012.	2013.
PWID	147	115	108	141	100	78	86	90	94	77
Unknown	97	72	84	59	65	48	35	43	108	101
Heterosexual	68	96	87	127	164	133	131	144	112	125
MSM	7	14	15	15	21	14	18	20	18	27
MTCT	4	2	5	8	8	2	4	2	7	10

Source: Centre for Disease Prevention and Control of Latvia, 2014

As mentioned in the previous report already, slightly more than half of the total number of HIV-infected individuals registered in the country had acquired this infection via drug injection, namely, 51.9% (n=3034) of all cases registered by the end of 2013. Of them 762 individuals are diagnosed with AIDS and 759 have died. The majority (75.9%, n=2309) of the total number of HIV infections acquired via drug injection have been established for individuals residing in Riga.

The previous report states that men account for the majority of cases (68.1%) acquired through drug injection and newly registered in 2012. This proportion is even higher in 2013 and reaches 76.6% (n=59/77). The highest rate of cases transmitted via drug injection in 2013 was for persons aged 25–29 and 30–34 (19.5%, n=15), which is similar to the result of previous years. Two thirds (67.5%, n=52) of cases transmitted via drug injection have been diagnosed for people living in Riga, while no HIV infection transmitted in such way has been established in Latgale and Vidzeme Regions.

According to observations, the proportion of cases diagnosed in prisons (in relation to the total number of first-registered HIV infections annually) is declining over the last three years. While in the past it could be declared that there is a stable tendency in the country of each fifth HIV case to be diagnosed at prisons, then only one in ten of cases (12.7%, n=43) is actually diagnosed at prisons in 2013 (see Table 6.1.). It could, however, be related to the tendency of the number of tests performed at penitentiary institutions to decrease, as described at the beginning of this chapter.

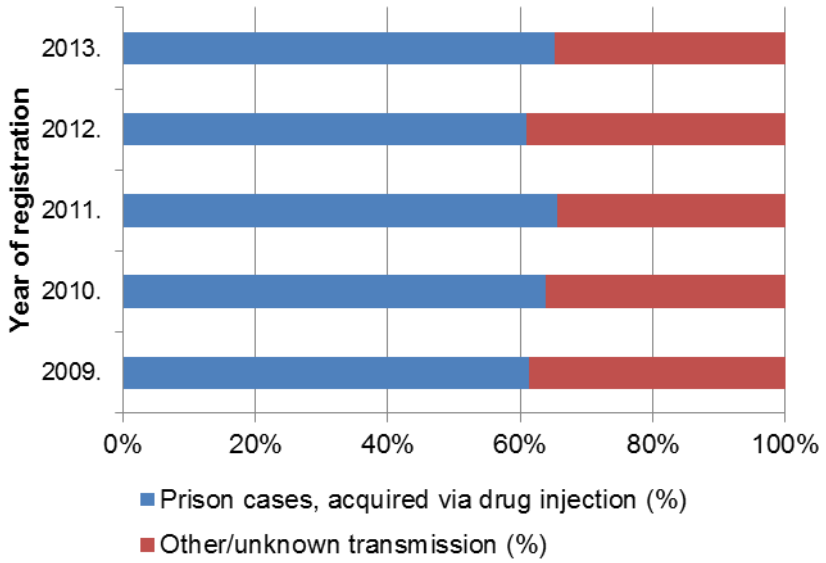
Table 6.1. Number of total annual HIV incidences in the country and the cases registered (in absolute numbers and %) at prisons over the last 6 years (2008–2013)

Year	2008	2009	2010	2011	2012	2013
New cases in prisons	70	44	47	67	59	43
All cases annually registered in the country	358	275	274	299	339	340
Proportion (%) of cases diagnosed in prisons among all annually registered cases	19.6	16.0	17.2	22.4	17.4	12.7

Source: Centre for Disease Prevention and Control of Latvia, 2014

The tendency of drug injection route to be the leading manner of transmitting HIV at prisons continues also in 2013 (see Figure 6.6.). Namely, 65.1% (n=28) of cases have been transmitted with this manner in the reporting year. For a comparison: 61.0% of HIV cases registered at prisons had been transmitted via drug injection in 2012.

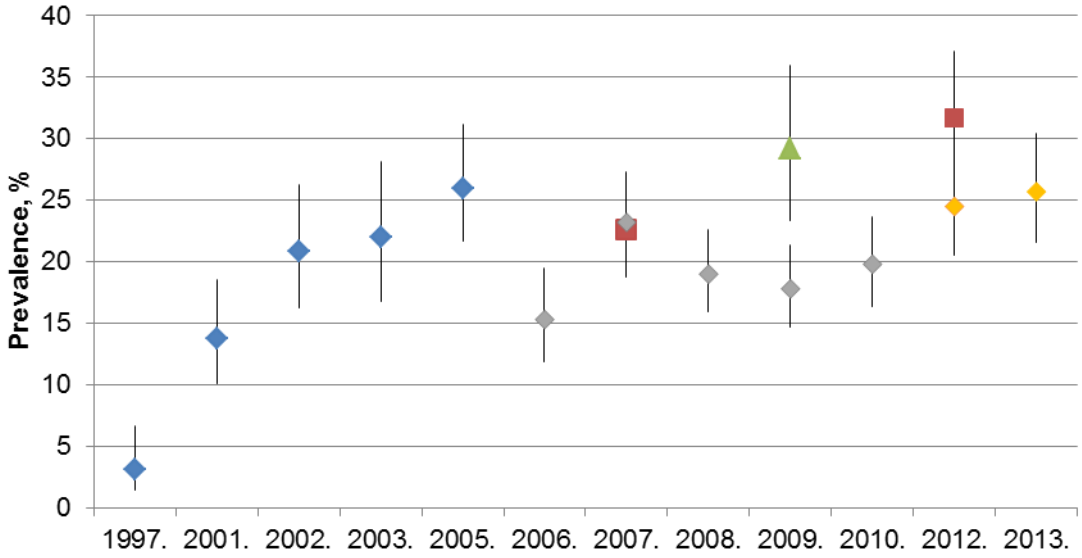
Figure 6.6. Proportion of cases acquired by drug injection from total number of HIV cases annually registered among prisoners, last five years (2009–2013)



Source: Centre for Disease Prevention and Control of Latvia, 2014

Combining the graph published in the report of previous year representing the HIV prevalence among IDU in different studies with the data of the study carried out in 2013, it can be seen that this epidemiological indicator shows a growing tendency among IDU population. For example, comparison of the HIV prevalence among the IDU cohort of 2012 and 2013 reveals that the proportion is slightly growing—24.5% and 25.7% respectively (see Figure 6.7.).

Figure 6.7. HIV prevalence among injecting drug users (results of various studies carried out in Latvia in 1997–2013)



Source: ECDC, 2011; Centre for Disease Prevention and Control of Latvia, 2014; Tuberculosis Foundation of Latvia (TUBIDU study), 2014

In 2013, there was one HPP less in Latvia than in 2012. And namely, 19 HPP in 16 towns in Latvia provided harm reduction activities (including rapid HIV test) in the reporting year. Overall, the rapid HIV test was performed for 788 IDU by the HPP network in the reporting year. A reactive result was found for 9.4% of persons (n=74), which is only half of the 2012 result, when reactive result was found for one fifth of IDU (20.3%) (see Table 6.2.). The fluctuations in the proportion of reactive cases can be explained with the impact of studies carried out in IDU population periodically, as described in the beginning of the chapter, since the profiles of IDU who are every-day clients of HPP and IDU who are attracted to a HPP to carry out rapid test within a study differ.

Table 6.2. Number and proportion of reactive HIV test results among IDU tested in HPP (2010–2013)

Year	2010	2011	2012	2013
Number of persons tested	1072	642	1147	788
Number of reactive test results	68	72	233	74
Proportion (%) of reactive results among tests performed (%)	6.3	11.2	20.3	9.4

Source: Centre for Disease Prevention and Control of Latvia, 2014

Table 6.3. shows the reactive results of rapid HIV tests for the last three years stratified according to demographic, social and behavioural factors. It can be concluded that tendencies of reactivity of HIV test, for example, in relation to age or injecting career, are quite variable over several years. However, there are two stable trends: first, the HIV test has been reactive for women more often than for men in all three years studied; and second, HIV test is reactive more often for IDU using opioids than for IDU using another primary drug (see Table 6.3.). These two tendencies suggest of particular IDU target groups where prevention and harm reduction activities should be carried out especially actively.

Table 6.3. Number and proportion of reactive HIV test results among IDU tested in HPP according to gender and age (2011–2013)

		2011		2012		2013	
		n	%	n	%	n	%
Gender	Male	46/437	10.5	145/788	18.4	48/542	8.9
	Female	26/204	12.7	88/359	24.5	26/246	10.6
Age	<25 years	10/172	5.8	13/144	9.0	7/107	6.5
	25-34 years	-	-	125/575	21.7	45/423	10.6
	>34 years	-	-	94/424	22.2	21/254	8.3
Injecting career	<2 years	-	-	4/49	8.2	1/18	5.6
	2-4 years	-	-	10/95	10.5	13/89	14.6
	5-9 years	-	-	44/205	21.5	7/101	6.9
	10+ years	-	-	111/503	22.1	22/319	6.9
Primary drug	Opioids	-	-	102/452	22.6	32/266	12.0
	Other than opioids	-	-	42/321	13.1	13/191	6.8
Incarceration experience	Has	-	-	73/349	20.9	16/211	7.6
	Does not have	-	-	-	-	58/577	10.1

Source: Centre for Disease Prevention and Control of Latvia, 2014

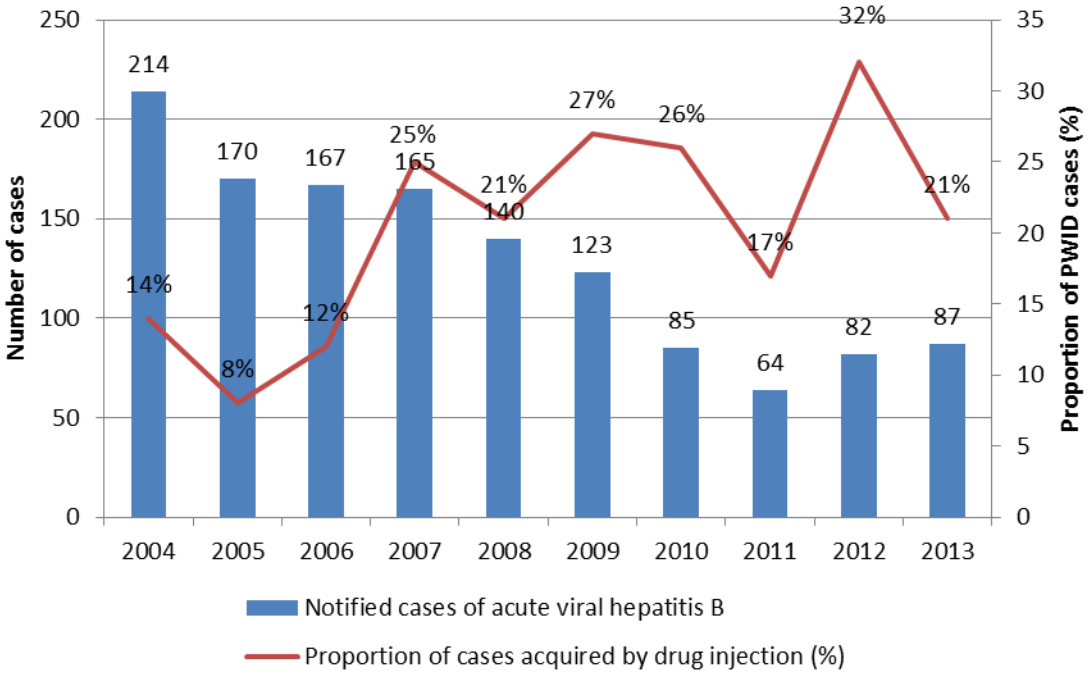
Hepatitis A/B/C

The number of registered cases of hepatitis A virus (HAV) in 2013 is almost similar to that of 2012—12 and 11 cases respectively. There are no increasing tendencies or outbreaks observed. There is no information that any of the HAV cases notified in the reporting year is diagnosed among IDU. Out of all registered cases, 10 have been male and only 2 have been female. Infection is more often diagnosed for individuals aged above 35 (n=6), and only 2 cases have been registered in the age group 25–34 and 4 cases for young people aged up to 24 years.

Also the number of registered cases of acute HBV has remained close to the numbers of 2012, and the infection has been established in 87 and 82 persons respectively (see Figure 6.8.). During the reporting year, only 18 (or 21%) out of all 87 cases have been established in persons who inject drugs (PWID), which is less than in 2012 when 32% of cases were in PWID and remind rather of the 2011 results when drug injection has been indicated as the manner of transmitting HBV in 17% of cases (see Figure 6.8.). It should be pointed out that the interpretation of the fluctuations in this proportion is limited by the proportion of cases with unidentified route of transmission, which is still high (32% of cases (n=28) in 2013). Measures for facilitating completeness of information entered into the register of hepatitis cases should be carried out in the country.

Out of 18 cases when acute HBV has been acquired via drug injection, 12 (or 66.7%) have been in men. Most often the infection is diagnosed in persons aged up to 24 years (44.4%, n=8) and 25–34 (38.9%, n=7). Only 3 cases of acute HBV have been established in individuals aged above 35 (see Table 6.4.).

Figure 6.8. Number of annually notified cases of acute hepatitis B (in absolute numbers) and proportion (%) of cases acquired via drug injection, last 10 years (2004–2013)



Source: Centre for Disease Prevention and Control of Latvia, 2014

Table 6.4. Proportion of annually notified cases of acute hepatitis B acquired via drug injection by age, last 5 years (2009–2013)

Year	Age group			Total number of cases
	<25 years (%)	25-34 years (%)	>35 years (%)	
2009	57.6	33.3	9.1	33
2010	68.2	31.8	0	22
2011	45.5	54.5	0	11
2012	30.8	50.0	19.2	26
2013	44.4	38.9	16.7	18

Source: Centre for Disease Prevention and Control of Latvia, 2014

The number of people with chronic HBV has also remained on the same level as last year, namely, 76 cases identified in 2013 and 73—in 2012. Drug injection by using contaminated equipment as the route of transmission has been identified only in three out of the total 76 cases. However, like every year also in relation to 2013 it has to be stressed that transmission route is unknown in the

majority of cases (82.9%, n=63). All three cases of chronic HBV identified in PWID are male. Two cases have been established in people aged 25–34 and one in the age group above 35 years.

During the reporting year at HIV prevention points, tests for HBV have been performed for 562 IDU, which is less than in 2012, when HBsAg rapid tests were performed for 985 PWID. The higher number of tests in 2012 can be explained with the previously described studies carried out within PWID population. In 2013, reactive test result was for 2.1% (n=12) persons, which slightly exceeds the result of 2012 (1.6%).

It should be noted that similar conclusion has been made also in the IDU cohort study of 2013, where a positive HBV test result was identified in 3.0% of PWID, compared to the 2.4% in 2012 (Trapencieris et al., 2014).

As seen from Table 6.5., tendencies of stratified HBV prevalence indicators are not stable in 2012 and 2013, however, both years show similar numbers in relation to the age and gender of PWID, namely, the indicator of men slightly exceeds that of women (2.2% and 1.9% respectively in the reporting year), and the HBV prevalence increases as people grow older (from 1.4% aged up to 24 to 2.5% PWID aged above 35 during the reporting year).

Table 6.5. Number and proportion of reactive HBsAg rapid test results among PWID tested in HPP according to social, demographic and health-habit factors (2012–2013)[25]

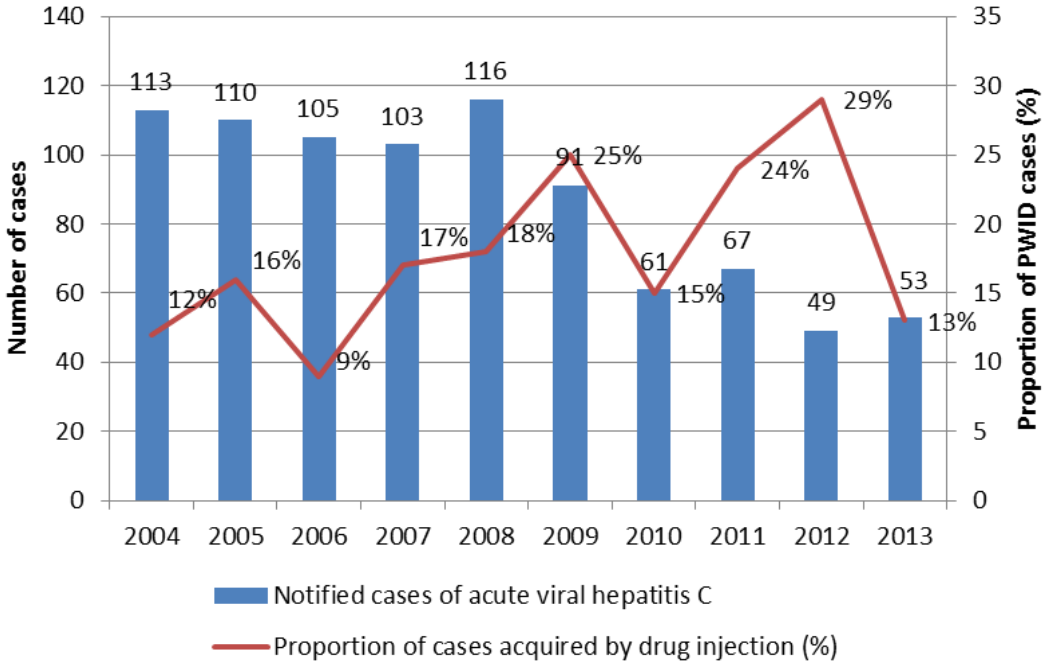
		2012		2013	
		n	**%**	**n**	**%**
Gender	Male	14/686	2.0	9/402	2.2
	Female	2/299	0.7	3/160	1.9
Age	<25 years	0/89	-	1/72	1.4
	25-34 years	8/508	1.6	6/289	2.1
	>34 years	8/385	2.1	5/198	2.5
Injecting career	<2 years	0/33	-	1/13	7.7
	2-4 years	1/69	1.4	1/49	2.0
	5-9 years	2/173	1.2	0/43	0
	10+ years	11/455	2.4	5/200	2.5
Primary drug	Opioids	4/383	1.0	3/143	2.1
	Other than opioids	8/267	3.0	2/124	1.6
Incarceration experience	Has	-	-	3/110	2.7
	Does not have	-	-	9/452	2.0

Source: Centre for Disease Prevention and Control of Latvia, 2014

Looking at the number of notified cases of acute viral hepatitis C (HCV) in 2013, a similar conclusion to that of HBV infection can be drawn, namely, the number of cases registered has remained similar to that of last year: the infection has been diagnosed in 53 and 49 people respectively (see Figure 6.9). Of the 53 cases mentioned, only 7 (13%) were acquired via drug injection, which is less than in 2012 when nearly 29% of cases were acquired via drug injection, however this result is close to that of 2010 when this route of transmission was identified in 15% of cases (see Figure 6.9.). The mechanism of transmission has not been established in 22.6% (n=12) of registered acute HCV cases in 2013.

[25] The sum of numbers in denominators may differ between the analysed factor groups (gender, age, injecting career, primary drug, incarceration experience) due to unknown/missing information about some of tested persons

Figure 6.9. Number of annually notified cases of acute hepatitis C (in absolute numbers) and proportion (%) of cases acquired via drug injection, last 10 years (2004–2013)



Source: Centre for Disease Prevention and Control of Latvia, 2014

All 7 registered cases of acute HCV in PWID have been male. Slightly more often (57.1%, n=4) this infection has been diagnosed in young people (aged up to 24), compared to older PWID (above 35) where this proportion is 42.9% (n=3) (see Table 6.6.).

Table 6.6. Proportion of annually notified cases of acute hepatitis C acquired via drug injection by age, last 5 years (2009–2013)

Year	Age group			Total number of cases
	<25 years (%)	25-34 years (%)	>35 years (%)	
2009	34.8	52.2	13.0	23
2010	44.4	33.3	22.2	9
2011	43.8	43.8	12.5	16
2012	35.7	50.0	14.3	14
2013	57.1	0	42.9	7

Source: Centre for Disease Prevention and Control of Latvia, 2014

The number of chronic hepatitis C infection in the reporting year is lower than in 2012, the infection has been established in 1221 and 1361 people respectively. The total number of registered cases during the last 5 years has been variable and both upward and downward tendencies have been observed (1268 cases in 2011, 1052 in 2010, 1271 in 2009).

Drug injection as a route of transmission has been identified in 16.5% (n=201) of all cases in 2013, and this result slightly exceeds the one of 2012, when this transmission has been identified for 11.4% of people. However similarly to all previous years, the interpretation of this data is limited by the high proportion of HCV cases with unidentified mechanism of transmission—there were 810 or 66.3% such cases in 2013.

The information available on the HCV rapid tests (HCV-Ab testing) performed in HPP shows that 522 IDU have been tested in the reporting year. Due to the already mentioned studies carried out in the PWID cohort, the number of people tested in 2012 was higher (see Table 6.7.), but the proportion of reactive test results is similar in both years—70.1% and 74.2% respectively.

The results of HCV prevalence acquired in IDU cohort studies of 2013 and 2012 are higher—83.7% and 83.3% respectively (Trapencieris et al., 2014). However, it should be stressed that the profiles of people for whom HCV test has been performed within the studies and those who are tested within the routine activities of HPP are different. Namely, cohort study shows all PWID whose HCV test has been positive, while the annual results of HPP suggest more of the first-registered infections, as the rapid testing is not performed for those HPP clients who are already known to be HCV positive.

Table 6.7. Number of HCV tests among IDU in HPP, number of tested IDU and proportion of reactive HCV test results (absolute number and %) in Latvia (2009–2012)

Year	2010[26]	2012	2013
Number of persons tested	279	1031	522
Number of reactive test results	159	765	366
Proportion (%) of reactive results among tests performed (%)	57.0	74.2	70.1

Source: Centre for Disease Prevention and Control of Latvia, 2014

Table 6.8. shows the stratified results of HCV reactivity among PWID tested in HPP. It can be observed that in the reporting year and 2012 several similar tendencies remain, namely, higher proportion of reactive results is higher among males (71.6% in male and 67.1% in female in the reporting year). It is also observed that as the injecting career grows so does the proportion of positive HCV test results: from 18.8% of PWID with injecting career of less than 2 years to 79.5% PWID with career of more than 10 years, in 2013. It is also seen that the infection is more "popular" among IDU using opioids than those injecting other substances (80.1% and 52.4% respectively in 2013).

Table 6.8. Number and proportion of reactive HCV-Ab rapid test results among PWID tested in HPP according to social, demographic and health-habit factors (2012–2013)

		2012.		2013	
		n	%	n	%
Gender	Male	542/713	76.0	252/352	71.6
	Female	223/318	70.1	114/170	67.1
Age	<25 years	60/121	49.6	35/84	41.7
	25-34 years	396/506	78.3	222/290	76.6
	>34 years	305/400	76.3	108/147	73.5
Injecting career	<2 years	18/45	40.0	3/16	18.8
	2-4 years	49/84	58.3	35/70	50.0
	5-9 years	126/178	70.8	56/74	75.7
	10+ years	371/445	83.4	147/185	79.5
Primary drug	Opioids	304/383	79.4	137/171	80.1
	Other than opioids	190/301	63.1	76/145	52.4
Incarceration experience	Has	-	-	116/132	87.9
	Does not have	-	-	250/390	64.1

Source: Centre for Disease Prevention and Control of Latvia, 2014

Tuberculosis

In 2013, the incidence of first-registered tuberculosis (TB) in Latvia is 38.3 cases per 100,000 population (or 776 cases, in absolute numbers). This result is lower than last year (2012), when it was 42.8 cases per 100,000 population (n=880). However, it is almost similar to the

[26] The information for 2011 is not included in the tabele as it was available only on the number of provided tests not persons.

incidence registered in 2011 (38.0 per 100,000 population). So, it can be claimed that no sudden changes can be identified with regard to incidence of tuberculosis over the last three years.

During the reporting year, the situation with regard to incidence of TB in relation to age has not changed: TB has been diagnosed most often in individuals aged 35–44 years (61.3 per 100,000 population, n=169). Similarly to previous years, also in 2013 TB is diagnosed more often among men than women (53.6 and 38.3 per 100,000 population, respectively).

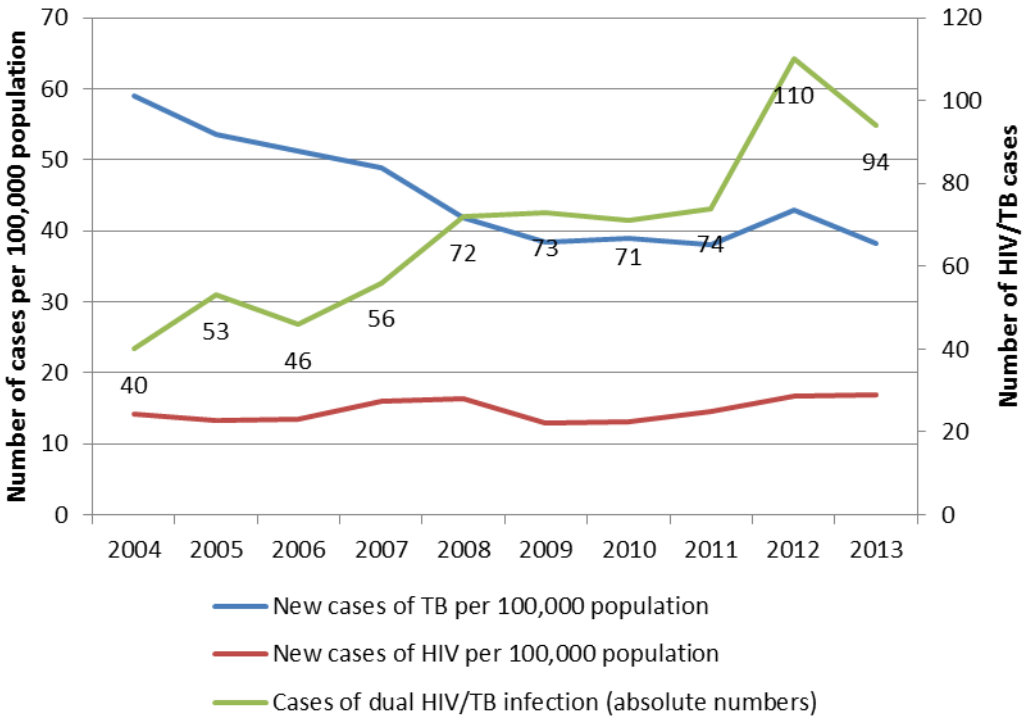
The number of TB relapses remained comparatively stable in 2013. And namely, the result is almost similar to that of 2012, i.e. 4.7 per 100,000population (or 96 cases). Also relapses are diagnosed more often in persons aged 35–44 years (9.8 per 100,000 population) and more often among men (8.7 per 100,000 population) than women (1.4 per 100,000 population).

Figure 6.10. shows that there is a small decrease in the number of dual HIV/TB infection cases in Latvia in 2013. During the reporting year, there have been 94 such cases, while 110 cases have been reported in 2012. This reduction corresponds to the described decline in TB incidence in 2013.

The number of multi-resistant TB cases is gradually decreasing in the country: from 92 cases in 2011 and 101 cases in 2012 to 66 cases in 2013. Also the number of extensively drug-resistant TB has not experienced a sharp growth over the last years: 13 such cases have been registered in 2013, 16 cases in 2012 and 14 cases in 2011.

Out of all first-time TB cases registered in 2012, 41 (or 5.3%) have been identified among drug users, which is similar to the previous two reporting years (6.5% in 2012 and 5.8% in 2011). Out of the mentioned TB cases among drug users, the majority is male (n=37). The infection is most often diagnosed in persons aged 25–34 (n=16) and 35–44 (n=14).

Figure 6.10. Number of annually registered first-time TB and HIV cases per 100,000 population and number of cases of dual HIV/TB infection in Latvia, last 10 years (2004–2014)



Source: Centre for Disease Prevention and Control of Latvia, 2014

Out of all cases of dual HIV/TB infection, one in three (31.4%) cases are established among drug users. This proportion is slightly below the results of previous years: 43.0% in 2012 and 51.4% in 2011.

At the beginning of 2014, the results of respondent-driven sampling (RDS) survey[27] carried out among PWID in 2012 (within the TUBIDU project), which was mentioned in the last year's report, were published (Karnīte et al., 2014). As mentioned in the last year's report, symptoms typical for TB (coughing up blood and/or cough lasting more than 2 weeks) are marked by one in three or 27.0% of IDU. With regard to this indicator, Latvia takes the leading position among other study member states. For example, only 10.7% of PWID in Estonia and 20.6% in Lithuania had such symptoms.

Study about the awareness of TB established that there are false opinions among PWID regarding the transmission of this infection. For instance, only 69.4% of respondents in Latvia knew that TB cannot be transmitted via sexual contacts. Only 24.1% of IDU knew that TB cannot be acquired by sharing meal with a TB patient. And just 24.8% of PWID knew that they cannot get tuberculosis by sharing one cigarette with a TB patient.

At the beginning of 2014, a journal listed in the science citation index (Rüütel K. et al., 2014) published a scientific article on prevalence of latent TB among PWID in Estonia and Latvia. In the study, the data of the previous RDS survey carried out in Latvia in 2007 was used. One of the most important study results in relation to Latvia is the fact that IDU located in prison are three times more likely to acquire latent TB (OR 2.75, 95% credibility interval 1.62–4.68).

Thus, both the results of TUBIDU study and the mentioned international publication confirm the need for paying urgent attention to the issues of acute TB in Latvia: it is necessary to educate PWID on TB questions, stress the need for performing TB testing for PWID as a high-risk group. Given this context, a special attention should also be paid to prevention and harm reduction activities in the penitentiary institutions of Latvia.

Sexually Transmitted Infections

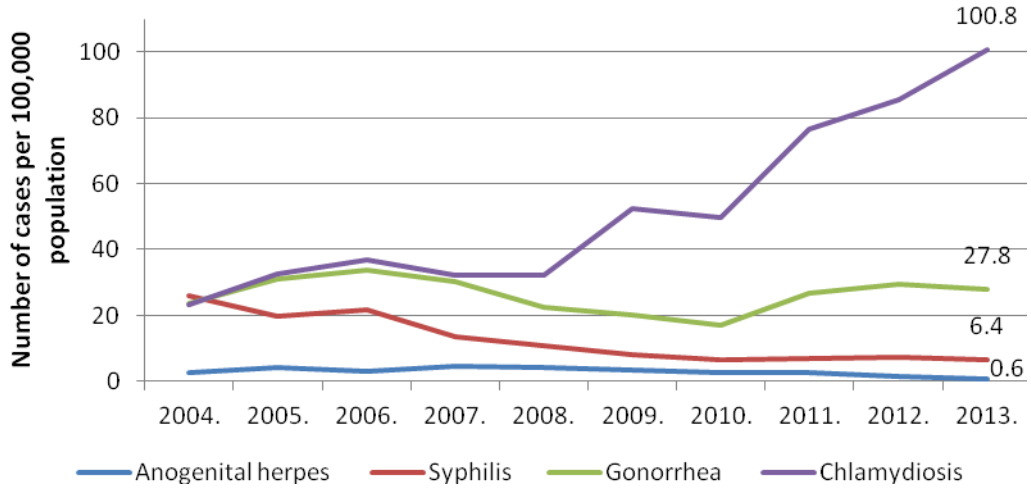
Regarding the chlamydiosis the tendency observed in previous years has continued in 2013, i.e. the rates are growing - in 2012 there were 85.5 cases per 100,000 population recorded, whereas in 2013 this figure has reached 100.8 cases per 100 000 population (see Figure 6.11).

Figure 6.11 shows that the incidence of gonorrhea in the reference year is somewhat diminished – from 29.6 cases per 100,000 population in 2012 till 27.8 cases in 2013. Also the recorded incidence of syphilis has decreased slightly – from 7.2 cases per 100,000 population in 2012 till 6.4 cases in 2013. Also the incidence of anogenital herpes virus (HSV) infection has decreased - in 2012 there 1.5 cases per 100,000 population were registered, whereas the rate in 2013 was 0.6 cases per 100,000 population.

There is no specific information available, how many of these cases of sexually transmitted infections are diagnosed among drug users.

[27] Full report of the international survey in Latvian (including an additional chapter with data specific for Latvia) is available on: http://balthiv.com/noderiga-informacija/petijumi

Figure 6.11 Number of annually registered cases of anogenital herpes, syphilis, gonorrhoea and chlamydiosis infection cases in Latvia per 100,000 population, last 10 years (2004-2013)



Source: Centre for Disease Prevention and Control of Latvia, 2014

Looking at the syphilis data from the routine testing in HPP network (immunochromatographic screening test for the qualitative detection of antibodies of isotypes IgG, IgM, IgA against *Treponema pallidum*) it can be seen that in 2013 a reactive test result was observed for 18 PWID out of 736 tested ones (i.e. 2.4%). In 2012 the rate was higher - 4.2%.

Table 6.9 shows the stratified proportions of reactive syphilis test results among tested PWID. Comparing 2012 and 2013, it can be concluded that none of the factors contain sustainable trends in subgroups. For example in 2012 the reactivity of syphilis test was higher among males, whereas in 2013 – among females. To assess time trends of reactivity in the case of fluctuating data the observation requires a longer time period.

Table 6.9 Number and proportion of reactive syphilis rapid test results among PWID tested in HPP according to sociodemographic and behavioural factors (2012-2013)[28]

Variable		2012.		2013.	
		n	%	n	%
Gender	Male	26/317	8.2	5/497	1.0
	Female	16/676	2.4	13/239	5.4
Age	<25 years	1/102	1.0	0/96	0
	25-34 years	18/510	3.5	11/390	2.8
	>34 years	23/378	6.1	7/246	2.8
Injecting career	<2 years	2/36	5.6	0/14	0
	2-4 years	5/79	6.3	0/72	0
	5-9 years	6/180	3.3	1/88	1.1
	10+ years	26/463	5.6	13/301	4.3
Primary drug	Opioids	17/376	4.5	8/228	3.5
	Other than opioids	20/281	7.1	3/163	1.8
Imprisonment ever in lifetime	Yes	-	-	8/190	4.2
	No	-	-	10/546	1.8

Source: Centre for Disease Prevention and Control of Latvia, 2014

[28] The sum of numbers in denominators can differ between characteristics (gender, age, injecting career, primary drug, imprisonment) because of the missing information in some cases

6.2. Other Drug-related Health Correlates and Consequences

Non-fatal Overdoses and Drug-related Emergencies

Until 2011 there were no data on non-fatal drug-related overdoses compiled for the whole situation of Latvia and there was only an analysis of those overdose cases which required hospitalisation and were treated in the Riga Eastern Hospital (RAKUS) Toxicology and Sepsis Clinic.

On the basis of Amendments (Cabinet Regulation No. 1005 of 27 December 2011, Riga) to Cabinet Regulation No. 746 of 15 September 2008 "Procedures for the Development, Supplementing and Maintenance of Registers of Patients who are Ill with Certain Diseases", there were changes implemented in the Trauma/injury reporting form. The form was supplemented by part B, which comprises data on poisoning in accordance with ICD-10 code: T36.0–T65.9; the card of trauma, injury and poising cases has come into effect on 31 December 2011. In 2012 and 2013 twenty in-patient facilities provided data for the trauma register (see Table 6.10.).

Table 6.10. Number of overdose cases by gender, 2005–2013[29]

	Men	Women	Total
2005	130	39	169
2006	161	60	221
2007	146	40	186
2008	n.a.	n.a.	n.a.
2009	110	33	143
2010	40	6	46
2011	49	12	61
2012	64	15	79
2013	64	16	80

Source: Register of Patients who are Ill with Certain Diseases or have Traumas or Injuries, 2014; Riga Eastern Hospital (RAKUS) Toxicology and Sepsis Clinic, 2012

Similarly to previous years the majority of 80 patients treated in 2013 were males—64 (80%). The average age for overdosing drug users was 28 years (in 2012 it was 26.9, in 2011 it was 25.0; in 2010—26.2); the youngest was aged 13 years (in 2012—14, in 2011—15; in 2010—14) and the oldest was aged 85 years (in 2012—54, in 2011—60; in 2010—51).

Stimulants was involved in 21 treated overdose cases, for majority of which the most common overdose substance was amphetamine—15 cases. Cannabinoids were involved in 17 treated overdose cases, opioids—in 17 cases for majority of which the most common overdose substance was heroin and tramadol—7 cases both. In 2013, also overdose of the new psychoactive substances (the so-called Spice) was identified in 11 cases.

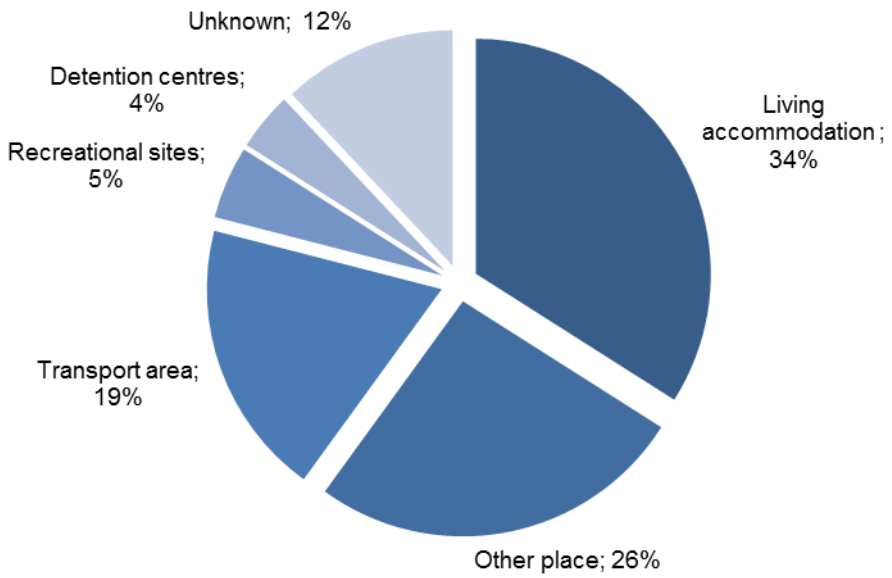
The average age of patients overdosing marijuana and hashish was 23.6 years while for overdose of stimulants—27.4 years; the greatest average age of overdosing patients was 39.6 years, which was observed among overdose cases of opiates. The smallest average age is among young people who have overdosed the new psychoactive substances (21.8 years).

In 2013, in addition to the mentioned substances, there have been 10 cases when the narcotic substances have not been identified, as well as cases of overdosing cocaine, hallucinogens and other substances.

[29] The 2005–2009 data relate to the number of substances, not the number of patients, i.e. several substances might be indicated for one patient, and data for this period also include cases of poisoning in which only medications are mentioned

The most commonly reported place where the overdose occurred was living accommodation (27 cases) while in 15 cases overdose took place in transport area.

Figure 6.11. Distribution of overdose cases by the site of occurrence, 2013



Source: Register of Patients who are Ill with Certain Diseases or have Traumas or Injuries, 2014

The majority of cases were classified as deliberate self-harm—35 cases; unspecified intention—30 cases; undeliberate self-harm—8 cases; other and unspecified—7 cases.

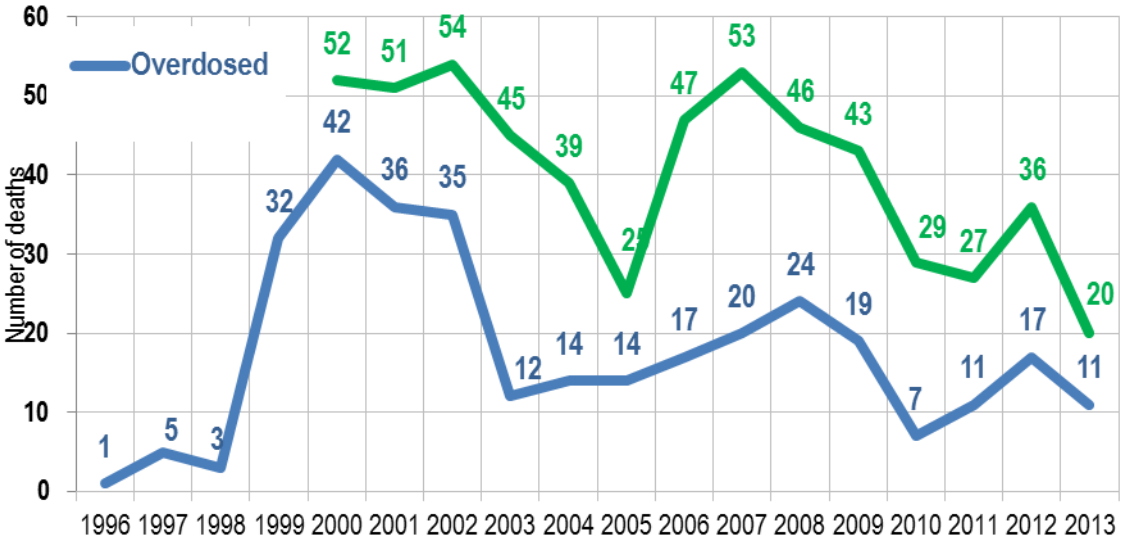
6.3. Drug Related Deaths and Mortality of Drug Users

Information on deaths in Latvia associated with drug use is collected and analysed by two institutions: 1) the Centre for Disease Prevention and Control of Latvia (CDPC) is responsible for maintaining the database on causes of deaths (the General Mortality Register (GMR)), and (2) the Latvia State Centre for Forensic Medical Examination (VTMEC) which maintains a special register of data on deceased persons (the Special Mortality Register (SMR)).

The CDPC-administered General Mortality Register database includes information for the entire country and is based on death certificates which are initially forwarded from all registry offices (data is entered into the Mortality Register) to the CDPC, which encodes, processes and enters the data collected into the database and performs analysis. However, the main operational objective of the other centre—the Latvia State Centre for Forensic Medical Examination—is the conducting of medical inquests.

The two institutions cooperate and during the year compare their databases of deceased persons, as initially the data of both institutions may differ due to the fact that when a person dies, the death certificate and a possible cause of death are written immediately, but if an autopsy is performed on the deceased, the results are received at a later date. If the diagnoses (as originally recorded and as later revealed at autopsy) do not coincide, they are referred for correction.

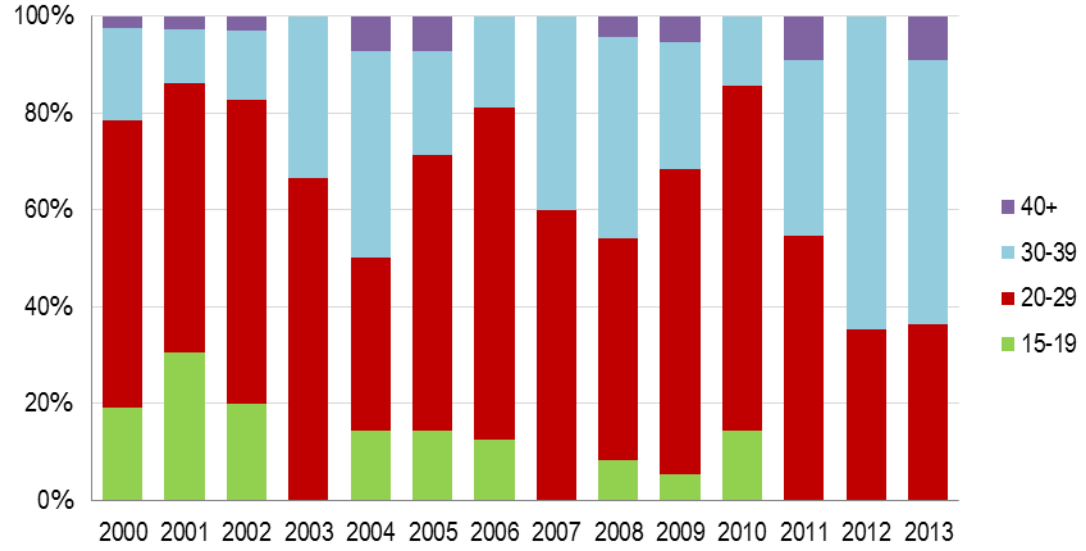
Figure 6.12. Deaths due to drug use 1996–2013 (absolute numbers)



Source: Centre for Disease Prevention and Control of Latvia, 2014; Latvia State Centre for Forensic Medical Examination, 2014

There were 11 deaths from drug overdose recorded in GMR 2013, which is six cases less than in 2012 and equals the result of 2011. Out of all death in 2013, one was woman and ten—men. The age of the deceased woman was 34, while the average age of deceased males—30.7 years. The overall mean age of persons deceased due drug overdose was 31 years. The youngest recorded deceased was aged 23, while the oldest was aged 40.

Figure 6.13. Distribution of persons who have died due to drug overdose by age, 2000–2013, (%)



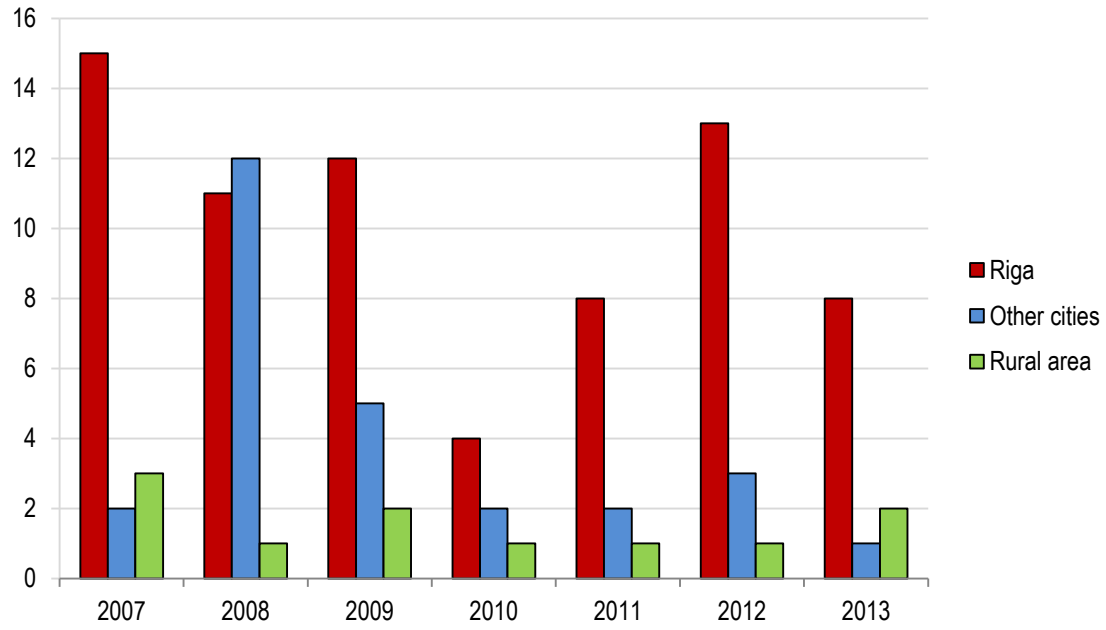
Source: Centre for Disease Prevention and Control of Latvia, 2014

The analysis of age of deceased persons in structural dynamics shows that from 2000 the most of recorded deceased persons are aged 20-29. The years 2004, 2012 and 2013 can be mentioned as exceptions since during that time the most of recorded persons deceased due drug overdose were 30-39 years old, which is the second most common age group of the deceased. A positive trend has been noted—a small decrease in number of young persons who have deceased from overdose; moreover, there has not been any case of death registered in the age group 15–19 over the last three years. A number of deceased who are older than 40 years are relatively small (only 0-9% of all deceased during the past years).

Out of all cases accidental poisoning (ICD-10 codes: X41 and X42) was recorded in nine cases, while in two cases the intention of the person is unknown (Y11 and Y12). In two cases the death was caused by the overdose of heroin (T40.1); in one case by the overdose of morphine (T40.2); in one case by the overdose of methamphetamine (T43.6); in one case by the overdose of hallucinogens (T40.9), while in six cases the substances were unspecified.

Often in addition to the overdosed narcotic substance the presence of other drugs is detected in the body of a deceased. In 2013 the following additional narcotic substances were detected in the bodies of deceased: phenobarbital and clonazepam.

Figure 6.14. Distribution of death cases due to drug overdose by regions, 2007–2013



Source: Centre for Disease Prevention and Control of Latvia, 2014

The analysis of overdose cases from geographical perspective (place of residence of a deceased) shows that in 2013 the majority of the death cases were observed in Riga (eight cases), while the remaining cases—in other cities and rural areas.[30] Such trend has been maintained for several years. One of the exceptions is 2008 since during that year the majority of such death cases were recorded in other cities outside Riga. Another exception was year 2007 when more death cases occurred in rural areas instead of other cities. Data about the place of death suggests of the topicality of this problem in the capital even more—in 2013, the death had occurred in Riga in 10 cases out of the total 11 deaths (in one case the place of death is unknown).

According to VTMEC data, eight deaths from drug overdose were recorded in 2013 (6 men and 2 women), the youngest of which was of age 25, but the oldest—40. In previous years, VTMEC reported on largest number of overdose deaths: there are 19 such cases registered in 2012 and 15—in 2011.

Of the overdose deaths recorded in 2013, 4 were due to poisoning by opiates and in four cases poisoning occurred by stimulants. In addition to the overdose narcotic substances there were other drugs detected in the body of the deceased: alcohol, benzodiazepines, clonazepam, phenobarbital .

[30] Distribution in accordance to the Classificator of Administrative Territories and Territorial Units, CSB

According to VTMEC there were cases when the cause of death was not related to overdose, however, the aforesaid drugs were discovered in the biological environments of the deceased. In 2011 in addition to overdose cases there were 11 cases when narcotic substances were found in the biological environments of the deceased; in 2012 there were 17 such cases, but in 2013— 12 cases. Of all the persons deceased in 2013 whose death was related to an overdose, or where drugs/psychotropic substances were found in the biological environments of the deceased, the youngest was aged 26 years (22 years in 2012), while the oldest deceased was aged 61 years (49 years in 2012).

In 2013, in addition to drug overdose according to the EMCDDA definition (Selection B), three persons died from overdosing of psychotropic benzodiazepines (ICD-10 code T42.4) (in 2012 there were 12 such cases) and one person died from overdosing of unspecified psychotropic medicinal products. Out of all deaths there were three women and one man; the youngest recorded deceased was aged 24, while the oldest was aged 84. Out of these cases, two (both women) were classified as deliberate poisoning (cause of death X61: Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified).

The actual number of deaths from overdose in the country might be much higher compared to the gathered statistical data. In 2013 it was calculated that there were 15,416 problematic drug users in Latvia, the largest part (9298) of which uses opioids; while this year's statistics show that there were only 11 death cases related to drug overdose.

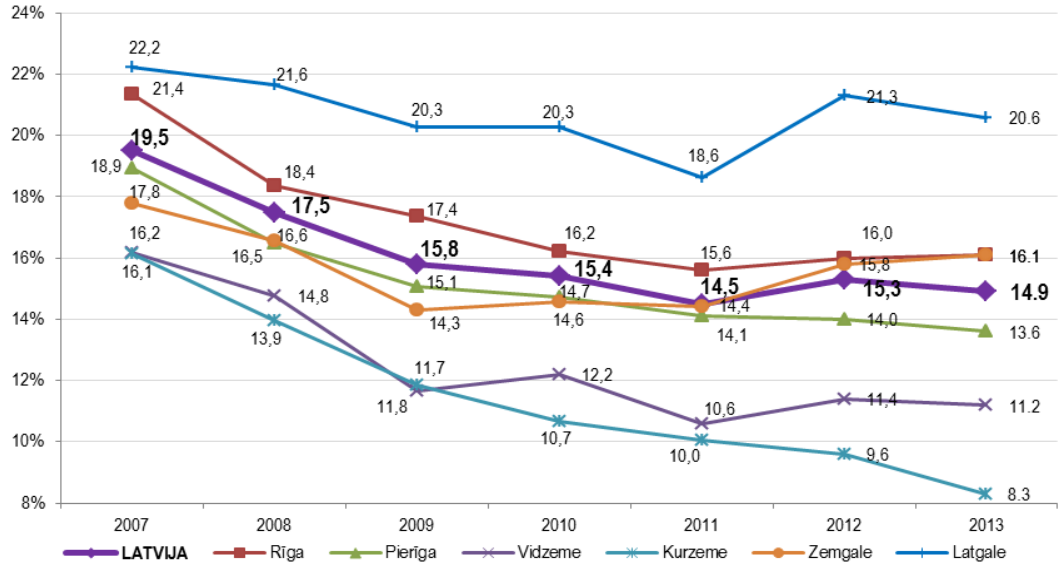
Table 6.11. The number of deceased due to drug overdose

Year/Country	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Estonia	45	86	36	98	57	68	81	67	133	101	123	170	
Latvia	36	35	12	14	14	17	20	24	19	7	11	17	11
Lithuania	35	33	40	38	31	62	72	60	68	51	45	73	

Source: Centre for Disease Prevention and Control of Latvia, 2013

Not all problems that are related to the registration of drug-related deaths are caused by the impossibility to reveal presence of some substances due to their specific characteristics or lack of special equipment that would allow determining presence of some new substances. Also the decreasing number of autopsies is an important factor.

Figure 6.15. The proportion of performed autopsies from the total number of the deceased distributed by regions, 2007–2013 (%)



Source: Centre for Disease Prevention and Control of Latvia, 2014

7. Responses to Health Correlates and Consequences

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

The human immunodeficiency virus (HIV) infection control programme for 2009-2013 provides for a training/informing of the staff of HIV prevention points (HPP) and Prison Administration and NGO representatives on the prevention of drug overdose, as well as distribution of informative material. During the reporting year, no special workshops on drug overdose have been organised for the staff of HPP and prisons and representatives of NGO, these issues have been integrated in the agenda of workshops about HIV prevention ("Motivational Interview with Injecting Dug Users" and "Participation of Patients in ARV Therapy").

The HIV prevention points also operate as needle exchange consultative points, where staff informs users about safe use and what to do in the event of a suspected overdose.

Programs for the pharmacological treatment of opioid-dependent patients have an important role in preventing drug overdose. At the moment methadone clinics are operating in 10 Latvian cities (Riga, Jelgava, Liepaja, Kuldiga, Jurmala, Tukums, Olaine, Salaspils, Rezekne, Daugavpils). By the end of 2013, 424 patients were being treated in long-term pharmacological treatment for opioid dependence programmes, of whom 328 patients were in the methadone programme and 96 patients were in the buprenorphine programme. To compare with, 278 patients were in the methadone programme and 77 patients were in the buprenorphine programme by the end of 2012. Although there is a positive tendency with regard to the number of patients addicted to pharmacological opioids, it is still not enough, taking into consideration that there are 15,416 high-risk drug users in Latvia according to estimates.

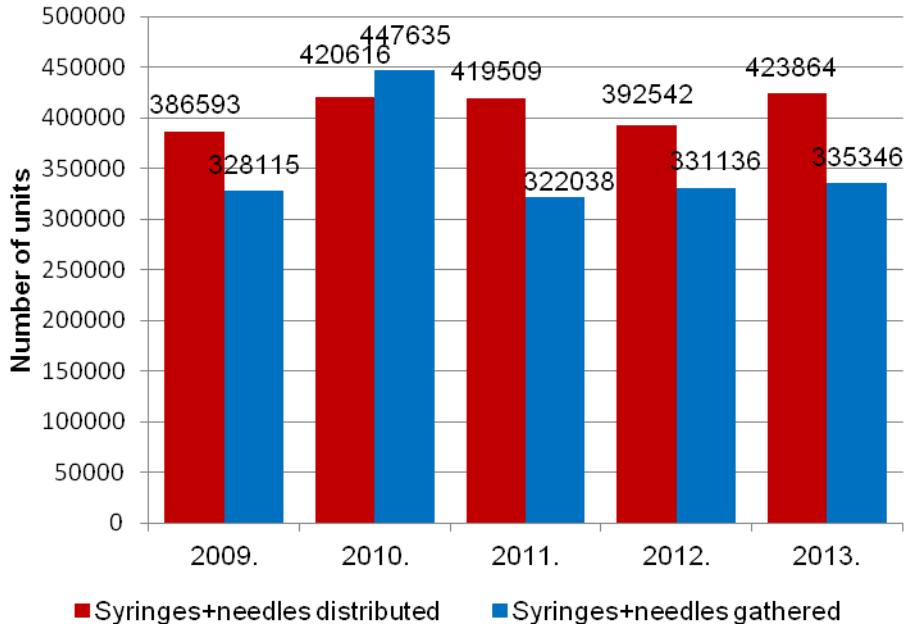
7.2. Prevention and Treatment of Drug-related Infectious Diseases

Prevention

In 2013 the number of HIV prevention points (HPP) in Latvia has slightly grown. In 2012 there were 18 HPP operating while in 2013 – 19 points are providing the services. Three HPP out of 19 are taking place in the capital city Riga. The number of HPP carrying out mobile services remained the same as in 2012, i.e. the services are provided by three points. Services of outreach workers in 2013 are available in eight HPP (comparing to 2012 when the mentioned activity was carried out in seven HPP). So it can be said that the outreach services are broadening gradually. Number of clients attending the HPP program is slightly increasing – from 2,261 in 2012 till 2801 in 2013.

The mentioned information is in concordance with the increase of the number of syringes and needles distributed and gathered in 2013. In the reporting year 341,421 syringes and 82,443 needles were distributed (comparing to 2012 when 311,188 syringes and 81,354 needles were distributed by HPP). The number of used syringes and needles collected in 2013 is 335,346 comparing to 2012 when 331,136 have been gathered (see Figure 7.1.). Despite the larger number of distributed units of injecting paraphernalia in 2013 still the coverage of the mentioned service in the country is unsatisfactory – 34.0 syringes per drug injector per year (assuming that the number of PWID in 2012/2013 was 10,034 (according to Trapencieris et al, 2014).

Figure 7.1. Number of syringes and needles distributed and gathered at HIV prevention points in Latvia, last 5 years (2009-2013)



Source: Centre for Disease Prevention and Control of Latvia, 2014

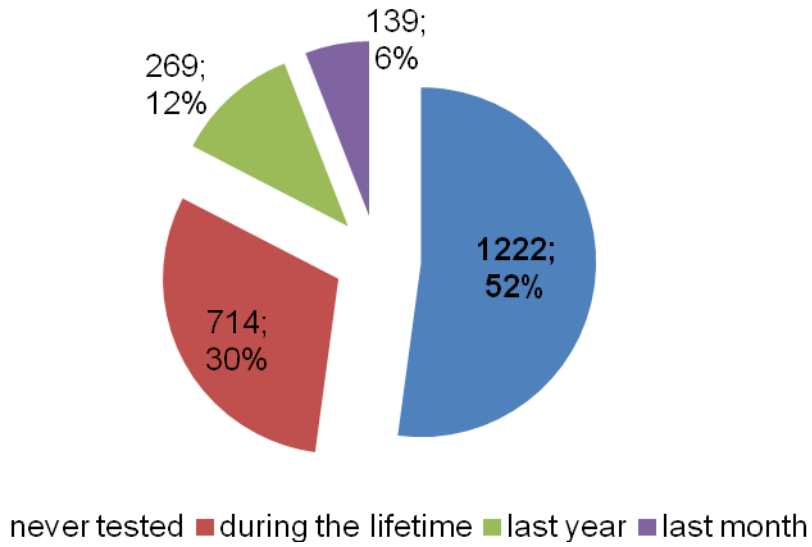
These data are again in concordance with the high rates of needle sharing clarified in studies carried out among PWID. For example the last wave of Latvian PWID cohort study is showing that largest part – 71.1% of drug injectors have shared needles or syringes during the lifetime. Within last year the needles are shared by one fifth of PWID (20.9% in the wave of 2012 and 20.5% in the wave of 2010). Although in the last wave (in 2013) only 11.3% of drug injectors are reporting the needle sharing within last year (Trapencieris et al, 2014). Whether this decreasing tendency will be sustainable or just a phenomenon of one wave must be observed in the next phases of the study.

It must be added that in 2013 there were also 90,894 condoms distributed to PWID via HPP which makes 9.1 condoms per drug injector per year. This rate cannot be considered as high and satisfactory.

According to the cohort study only one half of the drug injectors have used condom during the last intercourse (55.7% in the wave of 2010, 49.6% - in 2012 and 58.6% in 2013) (Trapencieris et al, 2014).

It can be concluded that even the coverage of needle exchange and other harm reduction services has slightly increased as well as the rates of risky behaviour among PWID is diminishing there is still a lot of space for improvements. This can be said also about the coverage of HIV and HCV testing activities in the country. As it was mentioned already in the chapter of this report on the HIV prevalence and incidence rates in the country, the number of tests performed is decreasing annually. The unsatisfactory level of testing among drug users in Latvia is shown also by data from a new source of information available since 2013, i.e. the registry of narcological patients. Since 2013 in the registration form of a narcological patient new variables are included which should be asked to the patient and filled in by the respective doctor. I.e. questions on whether the patient has ever undergone HIV and HCV testing and if the answer is positive – what was the approximate time of the last test. The data base of 2013 contained information on 7,297 patients. It can be seen in Figure No 7.2. that less than a half (48%) of patients have ever undergone HIV testing.

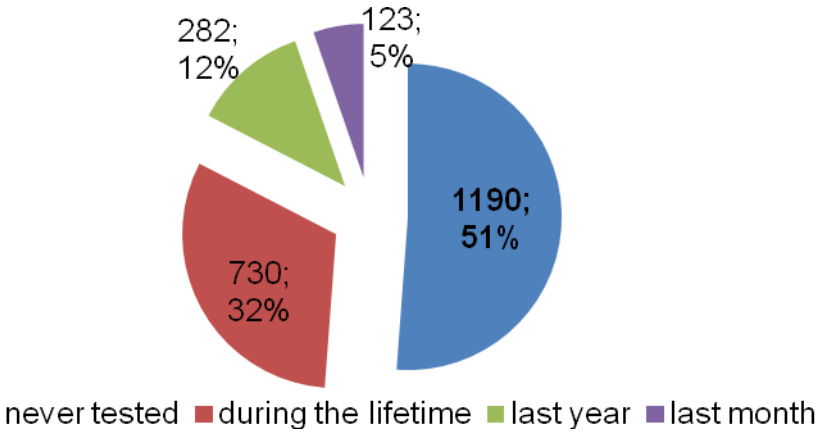
Figure 7.2.Number and percentage of narcological patients tested for HIV (2013 data)



Source: Centre for Disease Prevention and Control of Latvia, 2014

The same can be concluded about HCV testing rates – only 49% of narcological patients have undergone this testing ever in lifetime (see Figure 7.3.)

Figure 7.3. Number and percentage of narcological patients tested for HCV (2013 data)



Source: Centre for Disease Prevention and Control of Latvia, 2014

It must be admitted that large part of reporting forms contained missing information regarding the mentioned testing variables, i.e. the information is missing for 68% (both – HIV and HCV testing) of patients. It could be explained by the recent implementation of the amendments of the reporting form and that the medical staff need time to accept these changes. Nevertheless the doctors should be trained and motivated to fill in the forms in a more complete manner.

Treatment and care

Similarly to the previous year by the end of 2013 70.6% (n=4142) of all HIV infected persons registered in Latvia are present also at Riga Eastern Clinical University Hospital's (RAKUS) registry (as described in previous reports RAKUS centrally provides the health care and treatment services for people living with HIV). In 2012 this rate was 69.6%. It means that sustainably one third of

persons approved to be HIV positive have never sought specialized HIV care.

Among the persons registered at RAKUS slightly more than a half are drug injectors (52.3%; n=2249).

Around 17% (n=819) of all persons living with HIV in Latvia by the end of 2013 (n=4,698) received antiretroviral therapy (ART). Out of all persons receiving ART slightly less than one half are persons who inject drugs. The amount covered by the state for ART is increasing annually as it can be seen in Table 7.1.. Dividing the amount by the number of patients receiving ART it can be seen that the average ART cost per patient per year is also increasing (from 4,686 EUR in 2011 to 6,042 EUR in 2013).

Table 7.1. Number of people living with HIV and receiving antiretroviral treatment and the amount covered by state for antiretroviral therapy per year, 2010-2013

Year	2010	2011	2012	2013
Number of PLHIV receiving ART	645	747	862	819
Costs of the anti-retroviral therapy (EUR)	2,885,165	3,500,781	4,105,039	4,948,371

Sources: Riga Eastern Clinical University Hospital, 2014; National Health Service, 2014

In the reporting year the number of patients using the decentralized services of HIV care introduced in Latvia in 2010 still is very low – by the end of 2013 only 11 PLHIV were visiting infectologists outside Riga (in 2012 – 13 patients were visiting regional doctors). Thus it can be said that the system of HIV care in the country is still highly centralized.

In 2013 still no changes have been introduced in the country regarding the ART guidelines for asymptomatic HIV patients. I.e. the CD4 cells threshold for initiation of the therapy was still 200 cells / mm^3. Thus it can be concluded that Latvia remains the country with a highly limited access to ART.

Also the situation with the ART for prevention of vertical transmission is alarming – only around one half of the pregnant females are starting the therapy on time (from the 14^{th} week of gestation). I.e. in 2013 there 61 HIV positive females were registered at RAKUS as pregnant and only 31 of them started the ART on time (49 versus 26 in 2012 and 48 versus 23 in 2011).

Regarding the treatment of HCV no significant changes were introduced in 2013, i.e. despite the active advocacy campaigns carried out by patient organizations the compensation rate payable by the state still remains 75%.

As well in relation to the system of tuberculosis care and treatment no specific changes in Latvia are identified in 2013. As it is mentioned already above in the report, there was RDS study among drug injectors carried out in 2012 in frame of the TUBIDU project. One aim of the study was to identify the barriers to health services PWID are facing in Latvia. Speaking about the obstacles for receiving TB related services no systemic issues are identified. The identified barriers to access services are more related to the lack of personal knowledge or motivation, not to organisational or socio-economical issues. For example, out of those PWID who are never been tested for TB and who were asked to identify the reasons for that, 30% replay that they didn't know where such kind of investigations can be undergone, 15% answered that they didn't have time to undergo the testing.

It means that it is necessary to inform PWID on the available TB screening, care and treatment services on regular basis. This should be the daily routine also of the work of HPP.

8. Social Correlates and Social Reintegration

Social exclusion and addiction issues are multi-dimensional, they can mutually both reinforce and affect one another. Unfortunately, until this moment in Latvia there have not been a separate study on social exclusion problems among drug users, therefore, the data used in the present report only partially reflects the actual situation. The two key aspects that are used in this chapter in relation to the social exclusion of drug users were the rates of employment and education of these persons. The analysis is based on data about the drug-addicted patients treated in in-patient clinics, as well as data about users who participated in the cohort study in 2013 (7th stage cohort study). Similar analysis in relation to the social exclusion of drug users has been performed also in previous years.

According to EMCDDA social reintegration consists of three pillars: housing, education, and employment (EMCDDA, 2004). The issue of social reintegration is as extensive and difficult as the issue of social exclusion and unfortunately it has to be admitted that the issue of social reintegration of drug users has never been prioritised on the national level compared to social reintegration of other groups. All in all, social reintegration in Latvia operates on a very low level, and often the term "reintegration" is confused with the term "rehabilitation", which both are two different things. Unfortunately, it has to be concluded that drug users in Latvia have poor possibilities for not only reintegration but also rehabilitation, and this is true both for adults and children.

8.1. Social Exclusion and Drug Use

In total, 93,321 unemployed persons were registered with the State Employment Agency of Latvia in 2013, which is 10,731 people less than in 2012 (n=104,052 unemployed) and 36,975 people less than in 2011. Out of the unemployed persons registered in 2013, a bit more than 33,000 were long-term unemployed with the average career as unemployed approaching three years. Of all reported unemployed persons 56% were women and 44% were men in 2013. Most of unemployed persons had vocational or secondary education. The highest rate of unemployed women and men is in the age group 45–54 years, followed by the 35–44 year-olds (State Employment Agency, 2014).

In 2013, 328 people (271 male and 57 female) have undergone treatment at in-patient clinics for drug users. A year ago, 195 patients (154 male and 41 female) were treated. In 2013, 116 out of 328 were unemployed/job-seekers; 85 were reported as students or pupils; 40 were reported as employed persons and 50 were reported as having part time job; 37 were involved in other activities. The analysis of education level of those treated in in-patient facilities shows that 40 persons had incomplete elementary education, 130 had elementary education or vocational basic education, 38 persons had professional qualifications, 109 persons had secondary or vocational secondary education, while the highest (tertiary) education was acquired only by 6 persons; the education level was unknown for 5 persons. The general trend is that persons who have been treated in in-patient facilities during 2013 had low level of education in most of the cases, which does not promote their successful inclusion in the labour market.

One of the most extensive instruments for analysis of social exclusion in Latvia is cohort study which has been conducted since 2006. In 2013 the seventh stage of cohort study was already carried out. During these 7 stages 1439 drug-users have been surveyed, out of which 30 have participated in all stages of the study. The questionnaire of cohort study includes several important topics: spread of drug use, incidence of infectious disease, quality of life of drug-users, severity of addictions, treatment, family status and environment, education and employment, risky behaviour and its consequences, health, contact with law enforcement agencies, etc.

Of all participants/respondents, who took part in cohort study during 2013, 67.9% were men and 32.1% were women. A similar proportion of genders was also seen in previous years. The mean age of drug-users was 32.7 years. Only 1.1% of the interviewed drug users were less than 19 years

old, 4% were 20-24 years old, 24% were 25–29 years old, 25.5% were 30–34 years old, 5% were 35–39 years old, 9% were 40–44 years old, and 3% were over 45 years old.

Overall, 69% of respondents were Russian-speaking, while 23.5%—Latvian-speaking. Also this proportion is similar year from year. More than a half of respondents (60.2%) indicated that they were not married, while 27.6% specified that they were living together with a partner. Overall, 20.6% of the drug users are divorced; 12.4% are married; 4.6% are married, but live separately; and 1.5% of the respondents reported being widowed. Slightly more than a fifth (21.1%) of the respondents live alone, 52.3% of the respondents indicated that they live with a partner or spouse, 21.9% with children, approximately one third (33.4%) with parents. Comparatively more rare respondents have indicated that they live together with siblings (8.5%), friends or acquaintances (9.8%) or other family members (10%).

In total, 23.7% of the interviewed drug users indicated that they live together with a person abusing alcohol, but 33.4% respondents live together with someone using drugs; 9.5% of drug users live together with a person abusing alcohol and using drugs. This is a factor preventing change of the living environment, reduction of the social exclusion and facilitation or start of a successful reintegration in the society.

As it was already mentioned, two of the most important dimensions of social exclusion are level of education and employment. The seventh stage of the cohort study reveal that the average level of education of drug users is below the average level of education in Latvia. In total, 23.3% of respondents indicated that they had elementary education and 6.1% of respondents had incomplete elementary education. These both indicators account for nearly one third of all the respondents. Another 12.3% of respondents had incomplete secondary education or vocational education without secondary education. More than a half of the respondents or 54.1% noted that they had secondary education or professional qualification, while 4.4% indicated that they had highest (tertiary) education or incomplete highest (tertiary) education. It is interesting to note that the education level of younger drug-users is lower than of older drug-users; it might be explained by the differences in the system of education before and after the restoration of independence of Latvia. In short, secondary or at least elementary education was mandatory previously, but after the restoration of independence gaining of education is voluntarily.

Taking into account the overall low level of education of drug users, it is concluded year by year that it is directly related to the possibilities of finding and keeping a job. Even more, the specifics of habits of respondents “demands” spending additional time and resources for acquiring narcotic substances and, possibly, their preparation and use. Overall, 23.3% of respondents noted that they were unemployed and were not studying (35.9% in 2012); 34.9% had a contractual employment (worked officially) and paid taxes; 28.8% of respondents had unofficial employment; 1.7% of respondents stated that they were studying, while 11.4% of the surveyed persons specified other kind of activity. There is a general positive trend—since 2007 the overall number of officially employed drug-users has increased.

There are more employed (including officially) among men than women (37.1% and 30.2% respectively). The largest differences by gender are among people who do not work—women are unemployed nearly twice as often as men (37.9% and 16.4% respectively). There are also less unemployed people among Latvians than other nationalities, including Russians (19.4% and 24.3% respectively).

The average monthly income of respondents surveyed in 2013 was LVL 400 or approximately EUR 569. For a comparison, the average wage in Latvia in 2013 was EUR 716 gross. Within the study it is concluded that monthly income of drug users has increased over the last years. The most of respondents noted that they acquired their income from work, their partner, family or friends. In total, 15.7% of respondents indicated that they acquired income from selling drugs; 23.5% mentioned theft as the main source of income, while 16.7% of respondents stated that they

acquired income from social benefits. Overall, 30.8% of surveyed women specified that they engaged in prostitution.

Even though we might assume that drug-users are socially excluded in terms of receiving social help or being informed about such help, the cohort study does not confirm such assumption. In general, 71.9% of surveyed drug-users indicated that they were informed about places where they can receive social aid; 35.3% have requested such help, while 16.9% of drug-users are currently receiving help. This indicator has not essentially changed since 2010. Thus, it can be concluded that the work of social employees and services is organised comparatively actively in the country.

It might also be assumed that drug-users feel socially excluded or are socially excluded due to their social status, however the cohort study of 2009, 2012 and 2013 (where the respondents were asked to put themselves in the society, 1 being the bottom of the society and 10 being the top of the society) do not confirm such assumption; moreover, starting from 2012, the self-evaluation has become optimistic. It was discovered that 3.3% of respondents believed they belonged to the top of society (marked 8–10); 71.3% marked 4 to 6 (mid level of the society), while 12.3% of the surveyed drug-users believed they belonged to the bottom of the society marking 1-3.

Another dimension of social exclusion is health condition of a person. Overall, 51.8% of the respondents rated their health condition as “excellent” or “good”, 42.7% as “fair”, while 5.5% as “poor”. Most of respondents (95.6%) have a family doctor. The surveyed drug-users were also asked to evaluate the severity of their dependence in accordance to SDS (Severity of Dependence Scale). Compared to the users of amphetamine, the users of heroin pointed out drug-related health problems and severe consequences more often.

Although respondents were asked to answer question about HIV infection and HBV/HCV, the answers not always matched the actual result obtained by using rapid tests. Namely, people sometimes did not indicate that they are HIV or HBV/HCV positive, possibly, due to not knowing that. The cohort study revealed that one in four (25.7%) of drug users is HIV positive, 83.7% has HCV, 3%—HBV, but two respondents have syphilis. Persons who have been imprisoned were infected more often.

An important role in reducing of social exclusion among drug-users is played by their treatment, rehabilitation, and social reintegration. According to the responses of drug-users, 11.9% drug-users have received an addiction treatment during the past year, which is 2.3% less than a year before. In total, 40.3% of respondents have received addiction treatment during their lifetime, most often it has been detoxication, which is followed by treatment provided by a drug specialist. They also stated that in order for social rehabilitation to be successful it should be free, provided by qualified specialists who have a respectful attitude towards their patients and the treatment should not be connected to any religion. The last factor was indicated by 33% of respondents of the study of 2012 (Trapencieris et al., 2012).

8.2. Social Reintegration

The issues concerning social reintegration and rehabilitation are the responsibility of the Ministry of Welfare of the Republic of Latvia. Providing social rehabilitation services is regulated by the Cabinet Regulation No. 914 of 6 November 2006 “Procedures, by which persons addicted to psychoactive substances receive social rehabilitation services, and requirements for social rehabilitation service providers”.

The said arrangements establish the procedures by which the adults addicted to psychoactive substances (alcohol, narcotic, toxic or other addictive substances) and drug-dependent children and children abusing psychoactive substances receive State-funded rehabilitation services, in order to make these persons stop using psychoactive substances thus improving their physical and mental health and facilitating their return to valuable life. The said arrangements provide that drug-

dependent children shall be entitled to State-funded rehabilitation services after completion of a full treatment and motivational course at a treatment centre or after completing a course of treatment prescribed by an addiction specialist. The course of social rehabilitation for a child is relevantly of three, six, twelve, or eighteen months' duration. The services can be obtained repeatedly, and may also be received after the child has attained the age of 18 provided no more than six months remains to course completion. With regard to adult persons, the Regulation stipulates that persons addicted to psychoactive substances are entitled to State-funded social rehabilitation services after receiving a full course of treatment. The services may be received repeatedly, but not more frequently than once every two years. Social rehabilitation services may be received by adult persons for up to 12 months.

Availability of social rehabilitation has not changed over the last few years—every year the State pays for social rehabilitation of 64 children and 10 adults. In 2013, only one institution provided services to children—teenager rehabilitation community "Saulrīti", but starting from 1 August 2014 there is another rehabilitation institution—the social rehabilitation centre "Upe", which has been established by the association "Ģimenei un veselībai" (For family and health) and can accommodate up to 14 children. Unfortunately, the places for children are often not used, for example, only 56 teenagers received the services in 2011, 52 children used this possibility in 2012, but in 2013 this number is even lower—40 children and teenagers (NR, 2013). It can be explained with the inefficient mechanism for channelling teenagers into programmes facilitated by the weak cooperation between institutions and disinclination of parents to involve teenagers in treatment and rehabilitation programmes.

A positive fact is that on 6 May 2014 the Cabinet of Ministers approved allocation of EUR 62,657 for the rehabilitation of teenagers addicted to psychoactive substances, which means that additional 10 beds can be paid every month. This decision will improve the availability of treatment and can be valued approvingly. At the same time it should be stressed that larger number of beds paid by the State should be ensured also in the coming years by paying the mandatory treatment programme for minimum 100 minors per year, as the statistical data shows that 169 teenagers were treated for abuse of psychoactive substances and intoxication, and 24 teenagers received addiction treatment.

In 2011, 14 adults received a State-paid rehabilitation, in 2012 there were 10 persons and in 2013—19 persons (NR, 2013). It should be noted that the aforementioned children and adult social rehabilitation institutions are State institutions, but besides these, there are also a variety of non-governmental organisations engaged in activities e.g. in the form of an established commune. Overall, information is held regarding nine such non-governmental organisations that deal with addiction treatment, and in fact—social reintegration in its different forms and meanings — "Apziņas ekoloģija", "Kalna svētību kopiena", "Neatkarība balt", "Dieva ģimene", "Akrona 12", "Reto Cerība", and "Lapaiņi". The number of these organisations has increased significantly during the last years. The organisations do not receive any financing from the State, but some of them cooperate with municipalities, State Probation Service, attract the EU funding, etc. Estimates show that such centres accommodate more than 100 people during a year (NR, 2012). The study of 2012 on State institutions and non-governmental organisations providing social rehabilitation services for drug-users shows that most of non-governmental organisations can be characterised as organisations carrying out re-socialisation work, providing support for drug-users, and teaching drug-users to live without drugs and to establish relationships with people who are not involved in drug-use. Most of such organisations are connected to religion and use only work therapy. Some of these organisations are directed by former drug-users, and they do not provide help of trained professionals.

According to the data provided by the Ministry of Welfare, in total LVL 57,072 (EUR 81,206.14) of State budget means had been used for the social rehabilitation of adults addicted to psychoactive substances in 2012, while in 2013 the sum amounted to LVL 56,048 (EUR 79,749.12). In total, LVL 141,011 (EUR 200,640.58) in 2012 and LVL 93,716 (EUR 133,345.85) in 2013 have been used for rehabilitation of children addicted to psychoactive substances.

Also in 2013 only two state institutions were authorised to provide rehabilitation services to adult persons: the VSIA “Slimnīca “Ģintermuiža”” and Riga Centre of Psychiatry and Addiction Disorders (NR, 2012).

In November 2912, the State Employment Agency started offering the 12-step Minnesota programme for long-term unemployed who are addicted to narcotic substances or alcohol, as a support measure for addicted unemployed. The project has been planned for two years with the total budget of LVL 148,000 (EUR 210,585.03). It is projected that approximately 480 unemployed will engage in the project. Its aim is to give a possibility for the unemployed to treat alcohol addiction and narcotic and psychotropic substances addiction by joining the 12-step Minnesota programme, thus promoting elimination of obstacles to finding a job sooner. The project is opened for registered unemployed persons starting from 18 years of age who have held the status of an unemployed person for at least 3 months or who are unemployed for less than 3 months but have not worked at least 6 months before that. Only people who have received a conclusion from an addiction specialist regarding addiction to alcohol, narcotic or psychotropic substances are eligible. The treatment is 28-days long, during this period the State Employment Agency covers the patient’s fee in the amount of EUR 7.11 per one treatment day (for those unemployed persons who are not exempt from the patient fee pursuant to normative enactments), as well as daily expenses for accommodation and catering in the amount of EUR 13.37. Within this project, the unemployed person can receive psychologist or psychotherapist’s consultations, considers the opportunity to participate in other active employment activities, receives support for job seeking and starts looking for a job and integrating into the labour market. The treatment is provided by SIA “Akrona 12”, VSIA “Slimnīca “Ģintermuiža””, Riga Centre of Psychiatry and Addiction Disorders, who have contractual relationships with the National Health Service on providing addiction treatment following the Minnesota programme (State Employment Agency, 2014).

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

Information on the registered administrative and criminal offences, and individuals involved therein has been acquired from the Information Centre of the Ministry of Interior. Data on person sentenced has been acquired from the Court Information Systems (see Table 9.1). To acquire information on drug-related criminal offences by drug type, two databases had to be combined - the Register of Criminal Offences, the Examination Registration System LupaPro 2010. This statistics is not annually reported by any of institutions and is prepared only within the frame of the National Report.

Table 9.1. Information sources on offences and criminal offences related to illegal circulation and use of narcotic substances

Institution in charge	Information systems
Information Centre of the Ministry of Interior	Electronic event log Search of belongings Persons having committed administrative offence Register of criminal offences Persons having committed a criminal offence
Court Administration	Court Information System
State Police Forensic Service Department	Examination Registration System LupaPro 2010

Source: Information Centre of the Ministry of Interior, 2013

Data from the Information Centre on drug-related criminal offences is updated and supplement with new information constantly, therefore data was not frozen at certain moment in order to get permanent information. Considering that the procedures contained in the statistics are frequently continued, the statistical data, according to the same criteria, if requested at different time points, may vary. Since 2014 new approach was introduced, namely on every 6th date of months existing data is frozen in order to have unchangable and comparable information. Meanwhile also work on data quality is proceeding.

Summarizing data on violation of drug-related articles[31], the statistics cover the most significant drug-related articles regulated in the Latvian Administrative Violations Code (hereinafter referred to as LAVC) and Criminal Law (hereinafter referred to as CL), which are divided into three categories (see Table 9.2 and Table 9.3):

1. Use and storage of drugs for personal needs — group “Use and possession”;
2. Illegal circulation of drugs with purpose to sell — group “Illegal supply”;
3. Various criminal offences, for instance, misuse of prescribed medicines, inducing drug-use, precursors trafficking — group “Other”.

In Latvia, both administrative and criminal liability is provided for use and supply. Administrative liability is foreseen for provisions in relation to possession, cultivation in small amounts and use of narcotic substances for personal use, though, if the individual repeats the offence within one year, criminal liability shall be applied (see Table 9.2).

[31] Clauses of the Latvian law on drugs selected in accordance with — Mežulis D., Judins A. (2009). *Narkotisku un psihotropo vielu noziedzīgas aprites kvalifikācija*. Riga, Police Academy of Latvia

Table 9.2. Clauses of LAVC on violation of provisions regarding circulation and use of narcotic substances

Category	Clause of LAVC	Transcript
Use and storage	**Article 46**	Was amended in 2013. Illegal acquisition or storage in a small amount of narcotic and psychotropic substances, or the use of narcotic and psychotropic substances without prescription by a doctor Illegal acquisition or storage of precursors without intentions to sell Refusal from testing on drugs
	Article 103[2]	Unauthorised sowing and growing of plants containing narcotic substances (in small amounts). Was deleted from LAVC in 01/04/2013.
Other	**Article 46[1]**	Violation of provisions regarding manufacturing, production, or dissemination of narcotic and psychotropic medications and precursors

Criminal liability has been provided both for recurrent use and storage and various more severe criminal offences in relation to smuggling, trade, etc. Table 9.3 lists and transcripts clauses of CL on violation of regulations related to circulation of narcotic substances, classifying them in groups — “use and storage”, “illegal circulation”, and “other”.

Table 9.3. CL clauses on violation of regulations in relation to circulation and use of narcotic substances

Category	Caluse of CL	Transcript
Use and storage	Section 253	Unauthorised manufacture, acquisition, storage, transportation and forwarding of narcotic and psychotropic substances substances without the purpose of selling such substances
	Section 253², Part One	Unauthorised acquisition, storage and sale of narcotic and psychotropic substances in small amounts and unauthorised use of narcotic and psychotropic substances without a physician’s designation
Illegal circulation	Section 190¹	Smuggling
	Section 253.1	Unauthorised manufacture, acquisition, storage, transportation and forwarding of narcotic and psychotropic substances for the purpose of sale and unauthorised sale
	Section 253², Part Two	Unauthorised sale of narcotic or psychotropic substances in small amounts
	Section 256	Unauthorised sowing and growing of plants containing narcotic substances
Other	Section 249	Violation of provisions regarding the production, acquisition, storage, registration, dispensation, transportation and forwarding of narcotic and psychotropic substances
	Section 250	Issuing of prescriptions where not medically necessary, or illegal issue of other documents for the obtaining of narcotic or psychotropic substances
	Section 251	Inducement to use narcotic and psychotropic substances
	Section 252	Administering of narcotic and psychotropic substances against a person’s will
	Section 255	Manufacture, acquisition, storage, transportation, forwarding and sale of equipment and substances (precursors) intended for unauthorised manufacture of narcotic and psychotropic substances

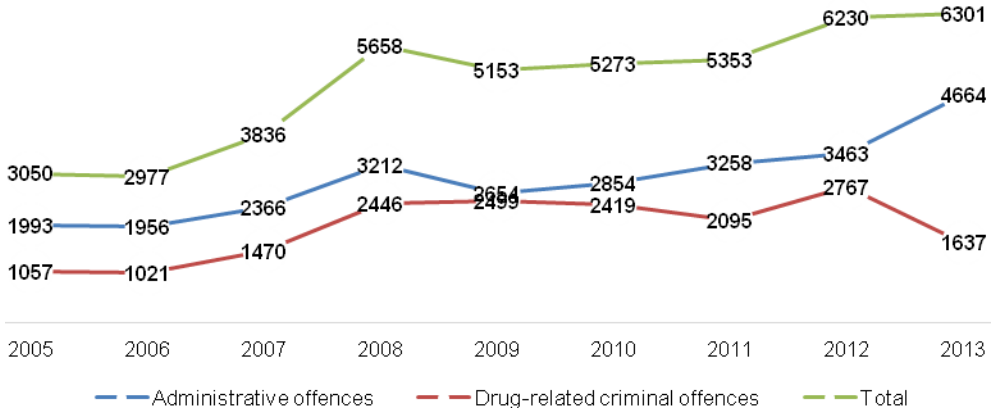
9.1. Drug- related crime

It shall be noted that the summarized statistics allows acquisition of information on violation of the law on narcotic substances only, while, in general, no data have been summarized, which reflect the situation in relation to psychopharmacologic crimes (committed under the influence of narcotic substances), system crimes (committed to ensure smuggling and trade of narcotic substances) and economic offences, committed to acquire money to buy a dose.

9.2. Drug law offences

Total number of offences, comparing to 2012, has remained stable, however, significant changes in the number of registered administrative and criminal offences was observed (see Figure 9.1). Number of registered administrative offences increased by 25.7%, while the number of registered criminal offences decreased by 40.1% (see Figure 9.1). Such trend is explained with the new amendments to the LAVC section 46. Previously it was stated that that drug use or possession in small amount is an administrative liability with accordance to the LAVC section 46. If a person commits the same offence within one year, criminal liability is foreseen. The amendments didn't change the system but now in case of use or possession in small amounts an administrative warning is issued stating that person will be penalised according to Criminal Law if the same offence is committed one more time within 12 months. At this stage only administrative warnings were issued in 2013, which is why significant decreased in the number of criminal offence for drug use and possession was observed in 2013.

Figure 9.1. Number of registered administrative offences and criminal offences related to circulation and use of narcotic substances in 2005–2013

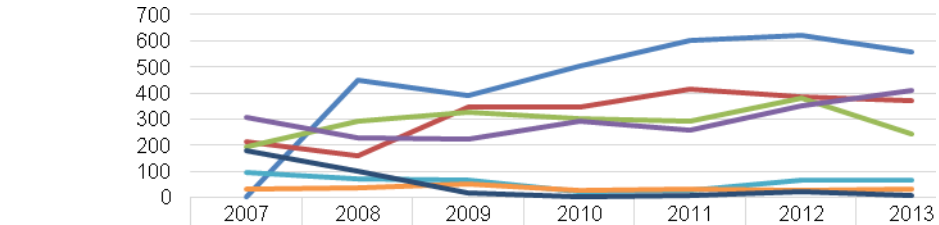


Source: Information Centre of the Ministry of Interior; 2013

When describing registered criminal offences related to narcotic or psychotropic substances, it may be concluded that the three most frequently involved substances are metamphetamine, herbal cannabis, and group of "other" drugs (see Figure 9.2). Under the column other NPS, sedatives, opiates and other drug groups are included.

In general, data on the registered criminal offences correspond with the police data on illegal circulation of narcotic substances and reflect the illegal market in the country. Furthermore, it shall be noted that minor difference may be observed in charges on use and storage and illegal circulation of narcotic substances. For instance, offences in use and storage most frequently involve herbal cannabis, metamphetamine, and heroine, while illegal circulation crimes most frequently involve herbal cannabis, metamphetamine, and "other" substances.

Figure 9.2. Number of registered administrative and criminal offences by narcotic substance in 2007–2013[32]



	2007	2008	2009	2010	2011	2012	2013
methamphetamine	1	449	391	505	601	620	555
herbal cannabis	216	161	348	346	415	385	371
heroin	196	291	327	302	293	380	243
other	308	229	224	294	258	351	412
amphetamine	96	73	68	21	27	68	67
cocaine	33	35	52	28	31	29	33
MDMA	180	103	18	5	9	22	9

Source: Information Centre of the Ministry of Interior, 2007–2013; data from the State Police Forensic Service Department, 2007–2013

Administrative Offences

Since 2009, the number of administrative offences in general has remained stable. Comparing to previous year, the number of registered administrative offence protocols has increased by 25.7% from 3458 in 2012 to 4664 in 2013 (see Table 9.4). Basically, those are registered protocols under Section 46 of LAVC, consequently, for use and/or possession of narcotic substances in small amounts. Only few events have been registered, which may be referred to unauthorized seeding of plants and cultivating thereof in small volumes, or violation of regulations on circulation of prescribed medicines.

Table 9.4. Number of registered administrative protocols in relation to circulation and use of narcotic substances in 2005–2013

	2007	2008	2009	2010	2011	2012	2013
Number of administrative offences	3906	4147	2668	2878	3271	3458	4664

Source: Information Centre of the Ministry of Interior, 2013

In total in 2013, administrative offence protocols were issued to 4664 individuals. From these, 4.4% (n=209) were in proportionally is the same as in 2012, when 110 young people (4.2%) were inflicted a penalty. Majority of penalised persons were males (86.3%, n=4028).

The most frequent type of punishment for administrative offences was a fine. In 2013, the administrative punishment was inflicted in 93.3% (n=4353) of cases. In total in 13 (0.2%) cases administrative arrest was applied; in 203 cases a warning was issued, while measure of constraint of educational nature was applied in 2 cases. Most of the administrative offences were committed by Latvians (98.6%; n=4600) followed by Russia's citizens (n=30), Lithuanians (n=11) and Estonians (n=8). Also one or two administrative protocols were issued to citizens of the Netherlands, Germany, Azerbaijan, Tajikistan and Brazil.

[32] See ST11_2013_LV_1

Criminal Offences

Comparing to 2012, proportion of the registered crimes in relation to circulation and use of narcotic substances has significantly decreased in 201 and compose is 3.44% of all crimes registered in the country (see Table 9.5). This trend mainly can be explained with amendments in LAVC, which came into force in April 2013 and has been already explained in section 9.2 of this chapter.

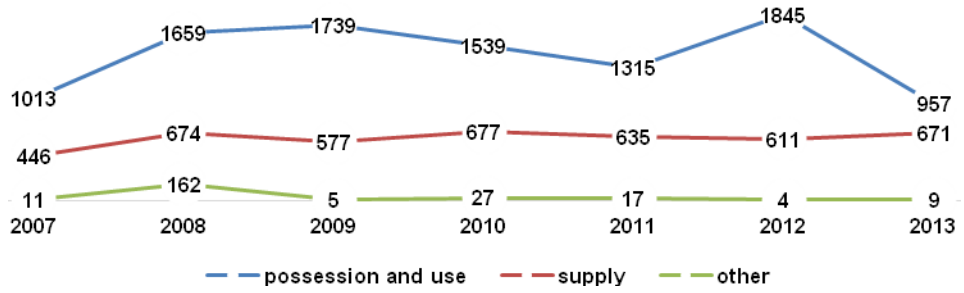
Table 9.5. Number and proportion of criminal offences in relation to circulation and use of narcotic substances of all offences registered in the country in 2005–2013

	2006	2007	2008	2009	2010	2011	2012	2013
Number of criminal offences in the country	62328	55620	57475	56748	51108	50469	49758	47561
Criminal offences related to circulation of narcotic substances	2493	1469	2493	2322	2241	1953	2574	1637
Proportion (%) of all reg. crimes in the country	1.64%	2.64%	4.33%	4.09%	4.38%	3.86%	5.17%	3.44%

Source: Information Centre of the Ministry of Interior, 2005–2012

The effect of the amendments can be easily observed in the figure 9.3. Namely the number offence related to use and possession has significantly, decreased by 48.1%, meanwhile the number of supply and trafficking offences as well as other type of drug offences is stable. Presumably the number f use and possession crimes will reach previous level in 2014.

Figure 9.3. Registered crimes related to use and storage of narcotic substances for individual use, illegal circulation and other, 2007–2013



Source: Information Centre of the Ministry of Interior, 2007–2012

Analysing this trend more in depth, it is visible that decrease in possession and use offences is related to CL section 253.2 part one, where registered offences dropped from 1151 in 2012 to 282 in 2013. Also significant drop has been observed for CL 190.1 or smuggling section (110 cases in 2012 and 79 cases in 2013) and 253.2 Part Two or dealing in small amounts (33 cases in 2012 and 14 cases in 2013). With respect to other sections situation is very similar to previous years (see Table 9.6)

Table 9.6. Number of registered crimes pursuant to CL sections in 2009–2012

	CL clause	*2009*	*2010*	*2011*	*2012*	*2013*
Use, possession	Section 253	447	516	500	694	675
	Section 253², Part One	1292	1023	815	1151	282
Illegal supply	Section 190¹	99	158	135	110	79
	Section 253.1	451	496	474	578	559
	Section 253², Part Two	27	22	23	33	14
	Section 256	0	1	3	4	19
Other	Section 249	1	1	2	0	0
	Section 250	2	24	0	1	4
	Section 251	1	0	1	1	1
	Section 252	0	0	0	0	2
	Section 255	2	0	0	2	2
	Total	2322	2241	1953	2574	1637

Source: Information Centre of the Ministry of Interior, 2013

Accused individuals

In 2013, 1002 persons were charged with various criminal offences related to illegal drug supply, thus making 1.6 offences per person. But one person can be accused with more than one section, therefore in the analysis below the total number of persons per cases is higher (total sum of the case is 1170).

Majority or 59.4% (n=696) persons have been charged with drug use and possession without purpose of trade. In total, 40.2% (n=471) persons have been charged with illegal trafficking crimes, where majority refer to circulation with purpose of trade and trade (see Table 9.7).

Majority of the convicted persons were males – 82.1% (see Table 9.7). 23 juveniles have been charged with various criminal offences, which makes 2.1% of all accused persons in total. For comparison — total juvenile proportion in administrative offences made 4.4%

Table 9.7. Persons accused in 2013 pursuant CL sections

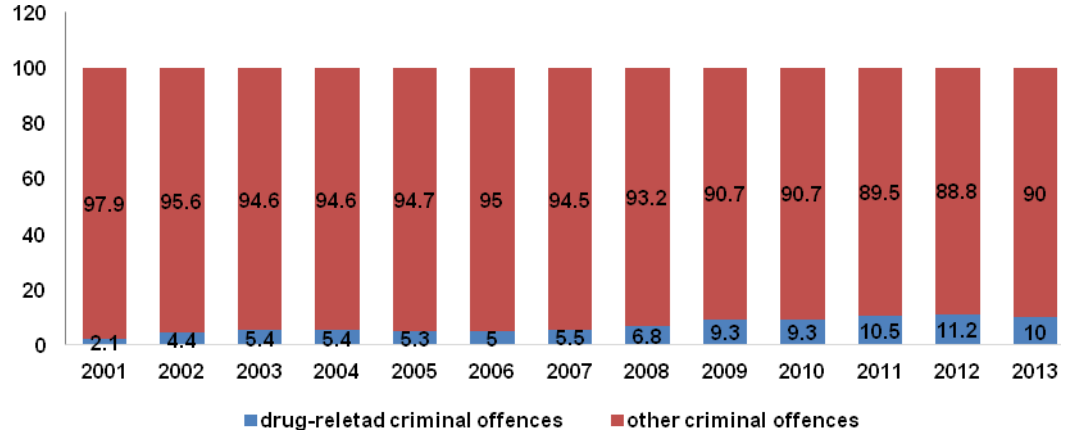
Type	Clause of CL	Males	Females	Adults	Minors	Total
Use, possession	Section 253	444	80	511	13	524
	Section 253², Part One	144	28	168	4	172
Illegal supply	Section 190¹	29	3	32	0	32
	Section 253.1	317	98	407	6	415
	Section 253², Part Two	6	0	6	0	6
	Section 256	17	1	18	0	18
Other	Section 249	0	0	0	0	**0**
	Section 250	0	0	0	0	**0**
	Section 251	1	0	1	0	0
	Section 252	0	0	0	0	0
	Section 255	3	0	3	0	3

Source: Information Centre of the Ministry of Interior, 2013

Convicted persons and penalties applied

In addition, the Central Statistical Bureau summarises information on individuals convicted with trade, production or storage of narcotic substances (see Figure 9.4).

Figure 9.4. Proportion of individuals convicted with trade, storage and production of narcotic substances to all convicted persons in 2000–2013 (%)

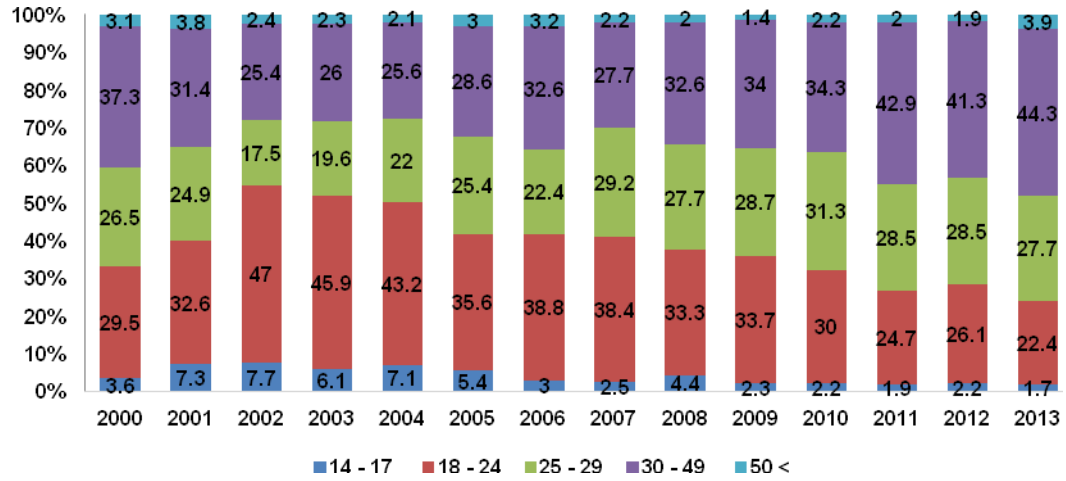


Source: Central Statistical Bureau, 2000–2013

It shows that from all convicts in 2013, 10% of persons were convicted with drug sections (see Figure 9.4). It shall be noted that since 2008, increase in proportion of convicts may be observed, which may be due to the fact that in 2007 and 2008, number of registered crimes increased (see Table 9.4), which were brought to court in several years.

Analysis of convicted persons by age (see Figure 9.5) shows that most of the drug related offences are committed by male in age from 30 to 49, but minors and adults over 50 years in these crimes are involved significantly less, e.g, 1.7% of all convicted persons were minors and 3.9% adults over 50.

Figure 9.5. Convicted persons for drug-related criminal offences by age groups (%)



Source: Central Statistical Bureau, 2000–2013

In terms of applied punishment the situation during the latest years has remained unchanged, and convicts most frequently are being convicted with imprisonment or suspended with or without

probation period. Individuals convicted for use (CL Section 253[2] Part One) most frequently were convicted with community service or their matters are terminated. In turn, to those convicted for smuggling and trade of narcotic substances (CL Section 190[1] and Section 253[1]), imprisonment or suspended imprisonment is usually applied (see Table 9.8). It shall be noted, if a person is charged with more severe criminal offences, the statistics only include punishment for these more serious criminal offences, without separating punishment specifically for drug related sections, therefore there might be statistical deviations.

Table 9.8. Penalties applied pursuant to CL sections in 2013 (in absolute figures)

Section	Imprisonment	suspended	community service	Fine	Medical measures of constraint	Terminated or the individual acquitted
Section 253	324	133	108	5	0	37
Section 253², Part One	51	8	33	0	0	80
Section 190¹	12	8	4	6	0	1
Section 253.1	353	203	2	1	0	3
Section 253², Part Two	11	10	4	1	0	0
Section 256	5	2	0	0	0	1
Section 249	0	0	0	0	0	0
Section 250	0	0	0	0	0	0
Section 251	1	1	0	0	0	0
Section 252	1	0	0	0	0	0
Section 255	0	0	0	0	0	0

Source: Information Centre of the Ministry of Interior, 2013

9.3. Other drug- related crime

Driving under the influence narcotic substances

Drivers of vehicles suspected of the use of narcotic substances are referred to examination to the Alcohol, narcotic and psychotropic substance examination department of the Narcological Aid Service of Riga Centre of Psychiatry and Addiction Disorders. In total 334 persons – drivers - were brought to the centre for testing, and in 187 cases the result was positive (State Police, 2013). Each year, 60% of drivers referred to examination are established to be under the influence of narcotic substances, for instance, in 2012, in 166 (63.35%) of 262 drivers the test has been positive, and in 2011, in 162 (60.9%) of 266 drivers narcotic substances have been established in blood.

In total in 2013 the first instance regional courts received 159 cases under LAVC article 149.[15] Part 5 (driving under influence of narcotic and psychotropic substances), which is more than in previous years - in 2012 – 114 cases; in 2011 – 112 cases.

Criminal liability is provided for driving of vehicle with no driver's licence when under the influence narcotic drugs, however, statistics is summarised along with offences committed when under the influence of alcohol, consequently, no summarisation of data has been made, how many of these events are related to driving vehicle when under the drugs influence.

9.4. Prevention of drug- related crime

Prevention of crimes related to narcotic substances is integrated into daily activities of police, the Customs, the Latvian Prison Administration, and municipal police. Most often measure in prevention of crimes related to narcotic substances are raids and patrols in the most dangerous places of the city, attendance of festivals and other mass events by police. Besides this in 2013 several crime prevention projects have been implemented, which both directly and indirectly apply to reduction of number of drug-related crimes.

Anonymous reporting on illegal alcohol, cigarette, and narcotic substance trade spots

In June 2012, a project was commenced, when people could anonymously report on illegal alcohol, cigarette, and narcotic substance trade spots, entering the respective address into the specific interactive map of Latvia on the Internet. Until mid of 2013, reports on 1500 illegal trade spots have been received. The highest activity was observed during the first two months, when population had made 1007 marks on illegal alcohol, cigarette and narcotic substance trade spots in the map (mostly, those of the so-called “legal narcotic substances”). Majority of marks in Riga — 606, Latgale — 122, Zemgale — 110 (Ministry of Interior, 2012).

Juvenile support information system

In 2010 the Information Centre of the Ministry of Interior, with financial support from the EU Crime Prevention and Reduction, established the Juvenile Support Information System, where law enforcement institutions, social institutions, municipalities, educational institutions, and other institutions working with juveniles may report on risk behaviour of a juvenile, for instance, a committed administrative and criminal offence, including in relation to illegal circulation and use of narcotic substances. Thus, within the system, exchange of operative information and cooperation between the involved law enforcement, social, educational institutions is encouraged to prevent early juvenile crime, including in relation to illegal drug related crimes. Although, implementation of the system in the country was provided for 2012, actual implementation occurred in 2013 (*Nepilngadīgo personu informācijas atbalsta sistēmas anotācija*, 2012).

Prevention Strategy of the State Police

At the beginning of 2014 a prevention Strategy of the State police was developed. All together it includes 5 main directions of actions – reduction of violence, security of property, drug demand reduction, safe internet, traffic safety. Under the direction addressing drug situation, most of the actions are informative and awareness rising focusing on one target group – juveniles. Besides this the strategy also focuses on the improvement of the cooperation of services education, treatment and social work.

9.5. Interventions in the criminal justice system

Alternatives to prison

Section 59 Part Four of the CL provides that a court may release a person, who has committed a criminal offence or a less serious crime due to alcoholism, narcotic, psychotropic addiction or toxic substance addiction, from serving a punishment, if this person has agreed to medical treatment for alcoholism, narcotic, psychotropic addiction or toxic substance addiction. The punishment shall be served if the person has not commenced undergoing the medical treatment within the time specified by the court or, after this, has avoided the medical treatment. Treatment costs shall be covered by the convicted person. This practice is almost never applied, and this type of punishment has been applied only in few events during recent years.

9.6. Drug use and problem drug use in prisons

To 31 December 2013, in total 5139 prisoners and convicts remained in 11 prisons of Latvia which is 15.9% less than in 2012. Data on drug use in prisons is provided both by operative registers of prisons and the study conducted in 2010. Operative register accounts individuals, on whom clear indications have been received on drug use. The number of registered drug users has decreased but the proportions remains at the same level as previous year, namely, in 2011 — 904 individuals (13.8%), in 2012 — 910 individuals (14.9%) and in 2013 – 720 individuals (14%) (Table 9.9).

Table 9.9. Number and proportion of individuals convicted for illegal circulation and use of narcotic substances, and number and proportion of registered users in prisons in 2007–2013

	Total number of prisoners to 31 December of each year	In operative register as users of narcotic substances	
	number	number	%
2007	6548	529	8.1
2008	6873	745	11.4
2009	7055	881	12.5
2010	6780	862	12.7
2011	6561	904	13.8
2012	6117	910	14.9
2013	5139	720	14

Source: Latvian Prison Administration, 2007–2013

Furthermore, the Latvian Prison Administration summarises information on identified events of drug use, as well as on prisoners making injections of narcotic substances. In 2013 in total 1621 cases of drug use in prisons were registered, of which 918 were related to intravenous use. For comparison, in 2012, 1894 cases of drug use were detected, of which 1218 were in relation to intravenous use (the Latvian Prison Administration, 2012–2013).

Responses acquired during the study conducted in prisons in 2010 illustrate that approximately each third (31.8%) prisoner has used drugs at least once. Most frequently, prisoners use in prison herbal cannabis and/or hashish (24%), amphetamines (19%), sedatives and tranquilisers (18%). Approximately each tenth (10.1%) has used cocaine, 7.6% — ecstasy, 5.5% — various opiates (Sniķere et. al., 2010)[33].

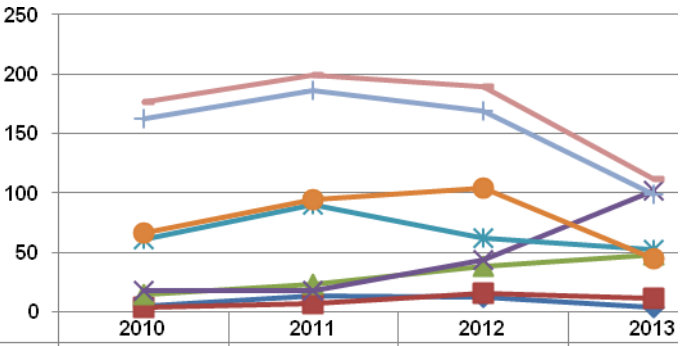
Expropriation of narcotic substances

In 2013 in prisons were registered 473 drug and NPS seizures, which is 25.4% less than in 2012 (n=634), which was caused by significant decrease in number of prisoners. The most frequently seized substance was metamphetamine (24%), followed by NPS (22%) and sedatives (21%) (see Figure 9.6). In general it may be concluded that seizure data comply with data from 2010 study.

Compared to 2012 significant increase of NPS seizures can be observed. Among NPS the most frequently seized substance was synthetic cannabinoid AKB48F (n=27), followed by AKB48B, UR-144, XLR-11, STS-135 and other cannabinoids. Also one seizure of 25B-NBOMe/25H-NBMe blotter, and 2 tablets of mCPP.

[33] See ST12_2011_LV_01

Figure 9.6. Number of seizures of narcotic substances carried out in prisons in 2010–2013



	2010	2011	2012	2013
cannabis resin	5	14	12	4
amphetamine	4	7	16	11
other	15	23	38	48
NPS	18	18	44	102
herbal cannabis	61	90	62	52
heroine	66	94	104	45
sedatives and tranquillisers	162	186	169	99
methamphetamine	177	199	189	112

Source: Data from the State Police Forensic Service Department, 2012–2012

Comparing to previous years, number of heroin seizures and seized quantity has significantly decreased (in 2013 – 45; in 2012 - 104), (see Figure 9.6. and Table 9.10) but instead number of buprenorphine (n=30), fentanyl (n=2) and carfentanyl (n=7) seizures increased and all together reached 39 cases. Decrease can be observed also in cases of amphetamine, cannabis resin and methamphetamine (see 9.17 Table)

Table 9.10. Quantity of several narcotic substances expropriated in prisons in 2010–2012 (g)

	2011	2012	2013
Methamphetamine	1056.55 g	1380.16 g	852.47 g
Heroine	53.71 g	100.28 g	25.18 g
Herbal cannabis	448.80 g	252.49 g	229.09 g
Amphetamine	12.34 g	76.21 g	39.67 g
Cannabis resin	65.35 g	48.84 g	6.47 g

Source: Data from the State Police Forensic Service Department, 2010–2012

In 2013 in total 99 seizures (21%) have been carried out, which resulted in seizures of 1362.35 g and 2739 tablets of various sedatives and tranquilisers; for comparison, in 2012, 169 seizures and seized amount composed 1680.75 g and 5172 tablets. In general, within this group, benzodiazepines, in particular, clonazepam-containing substances and pills (n=91) are most freaquently seized, followed by few seizures of diazepam, phenazepam, oxazepam, and alprozalom.

9.7. Responses to drug- related health issues in prisons

In general, primary and secondary healthcare is available in prisons, including addiction specialists. However, considering medical technologies of treatment, drug addiction treatment opportunities in prisons are limited. In 2012 treatment possibilities were extended, introducing opioid substitution therapy in prisons. Currently, pharmacotherapy is offered to those clients only, who have started it before imprisonment and one cannot involve in the programme when in prison. In 2012 in total 14 prisoners and in 2013 11 prisoners continued therapy in the imprisonment (Latvian Prison Administration, 2013).

Furthermore, in two prisons — women prison *Iļģuciems* and Cēsis Correctional Facility for Juveniles —— Minnesota 12-step programme was implemented. Additionally Riga Central Prison arranges anonymous meetings for drug addicts.

The project "Establishment of a new prison block in Olaine prison, including construction and training of staff" will be implemented in the frame of Programme LV08 "Reform of the Latvian Correctional Services and Police Detention Centers" of the Norwegian Financial Mechanism. Implementation of the project will last starting from 18 September 2013 till 30 April 2016

Within the framework of the first activity several sub-activities for prison staff will be carried out, with a goal to improve their knowledge about the specifics of work with addicts. Within the framework of the second activity there will be developed a technical project and construction work of the new center for addicts there will be carried out in the Olaine prison area.

Implementation of resocialization measures for prisoners with addiction problems will be carried out within the framework of the third activity and will be implemented in all prisons of Latvia. Activities will be implemented in cooperation with NGOs, the Latvian Prison Administration will carry out HIV/AIDS prevention programme, sport and leisure activities, create library and infrastructure for e-environment for implementation of education programs and access to actual legislation.

In 2012 prisoners' possibilities to receive general health care services were improved. Prisoners were provided the possibility to receive consultations, medical examination and treatment with specialists of treatment institutions outside prisons. In cooperation with the National Health Service of the Ministry of Health, physicians working at prisons could provide out-patient treatment to prisoners by using compensated medicines and medicinal products. In total in 1 cases in-patient treatment was provided and 242 out-patient treatment was provided in 2013.These improvements contribute to prevention and treatment of infectious diseases related to narcotic substances, which mostly was related to emergency help.[34]

Prevention and treatment of infectious diseases

In accordance to the information from the Latvian Prison Administration, approximately 8.5% of prisoners in 2013 were HIV-positive. In total 454 HIV-positive events were registered. It shall be noted that there are several factors to explain the decrease in the number of registered HIV-positive events: total number of tests carried out has decreased in general (in 2013 - 2 237 in 2012 — 2767 tests; in 2011 — 3077 tests).

Table 9.11. Registered cases of HIV, AIDS and tuberculosis in prisons in 2008–2013

	2008	2009	2010	2011	2012	2013
HIV infection	621	612	657	702	509	454
AIDS	103	101	120	120	152	107
Tuberculosis	103	106	81	79	116	n.i.

Source: Latvian Prison Administration, 2008–2012

More in depth analysis on HIV, HCV in among prison inmates please see in Chapter 6.

In 2013 in prisons, 15 death occurrences were registered, of which in 10 events were due to health issues (oncologic, cardiovascular disease, AIDS and AIDS with tuberculosis), while in 3 events from suicide and 2 events from homicide.

[34] Project description available on: http://norwaygrants.tm.gov.lv/en/2009-1014/news/the-pre-defined-project-establishment-of-a-new-prison-block-in-olaine-prison-including-construction-1

For the prevention of dissemination of infectious disease, such measures as testing for infectious disease and organisation of information programmes and lectures are taken, but no measures like syringe exchange or distribution of condoms are applied to reduce risks.

Preventive measures for the use of narcotic substances and reduction of hazard

In general preventive measures on drug use are implemented on a regular basis by carrying out checks in prison cells and parcels. Annually approximately 150 express tests on drugs are obtained in order to have rapid results. In 2013 in 114 cases tests were positive. No specific measures are taken to prevent overdosing of narcotic substances in prisons or after release from prisons.

Reintegration of drug users after release from prison

In accordance with amendments to the Sentence Execution Code, which become valid from 2012, the convicted individual is assessed of individual risks and needs and development and implementation of resocialization plan. Degree of risk of the convicted individual to commit a recidive is assessed, and based upon results thereof; resocialization plan has to be developed. This had not been a mandatory requirement before.

Resocialization of convicted individuals with narcotic, psychotropic or other psychoactive substance addiction is carried out in accordance with the general programme of re-socialization, which is formed of two parts:

- Social behaviour corrective measures including motivation and work with priority groups;
- Rehabilitation of convicted persons, which is basically carried out through general, professional and interest education programmes, employment, arrangements of spare time, and development of household skills.

Resocialization flow is divided into two parts — individuals with psychoactive substance addiction and individuals with no psychoactive substance addiction. It means that if an individual is established any addiction issues, he/she is involved into the same programmes as all prisoners, but, in addition, he/she is referred to motivation programmes involving issues on disengaging from narcotic substance addiction, as well as, by developing an individual re-socialization plan, opportunity to refer the individual for rehabilitation is assessed. Former prisoners are among clients of several Christian organisations functioning in accordance with principles of therapeutic community.

Table 9.12. Involvement of prisoners in re-socialization programmes

	Number of programmes implemented	Number or prisoners involved	Number of individuals having completed the programme
2010	37	2528	2097
2011	31	1205	995
2012	23	714	504
2013	13	481	334

Source: Latvian Prison Administration, 2010–2012

Since the number of prisoners has significantly decreased and individual re-socialization plans are developed, provided resocialization programmes and number of participants in them have decreased (see Table 9.12).

Along with re-socialization programmes in imprisonment also educational and employment programmes are implemented. In 2013, 1629 (29% of all prisoners) prisoners were involved in educational programmes: general education — 597 individuals; professional education — 684;

higher education programmes — 7 prisoners. In total, at the end of academic year 2011/2012, 75 prisoners acquired elementary education; 31 prisoners — secondary education; 727 prisoners — professional education. It shall be noted that number of prisoners involved in educational programmes has decreased, namely, in 2013, 1 629 individuals involved, while in 2012 — 3375 individuals.

Prisoners are employed in economic services, as well as positions formed by merchants. Prisoners in open-type prisons were employed outside the territory of the prison. In 2013, 1179 prisoners were employed compared to 1224 employed prisoners in 2012, in 2011- 1224 prisoners, while in 2010 — 1210 prisoners were employed.

10. Drug Markets

The data collected by the Chemical Investigation Division of the Forensic Bureau of the Department of Criminalistics of the State Police in relation to seizures of narcotic substances, psychotropic substances, precursors[35] and new psychoactive substances[36] in Latvia were the most important sources for the analysis of illegal drug market. In addition, the reports prepared by the Organised Crime Prevention Department of the Main Criminal Police Department of the State Police, report prepared by the Customs Criminal Board of the State Revenue Service concerning illegal circulation of drugs in Latvia, as well as the annual report of the Prison Administration have also been used. The market analysis is also based on the information provided by the Consular Department of the Ministry of Foreign Affairs on the Latvian nationals arrested in foreign countries for trafficking of narcotic substances, official press releases provided by law enforcement institutions, as well as the information about the topicalities regarding illegal drug market available in foreign resources. In addition, the analysis of drug market uses also the data of the study "Use of Drugs at Entertainment venues in 2012", which summarises information about the views of respondents in the availability of narcotic substances (Koroļeva et al., 2013).

10.1. Availability and Supply

The well-developed infrastructure of roads, air traffic, rail road, and marine transport in combination with other external factors is one of the aspects facilitating drug trafficking. Thus, the territory of Latvia is mainly used for the transit of narcotic substances and substances for the internal market come from the transit for the most part. Taking into account the role of the EU Member States (mainly Lithuania, Poland, Belgium, and the Netherlands) in the supply of synthetic drugs, as well as the connections of the organised crime groups of Latvia with the organised crime structures in the EU and third countries, it is not very likely that synthetic substances are going to be produced in Latvia in large amounts.

Despite the aforementioned, there is a stable growth of number of facts regarding marijuana farms in Latvia. Namely, 7 such farms have been established in 2007, but in 2013—already 18. Marijuana is usually grown for distribution in the local market or individual use, and only in one case it was intended for distribution in a foreign market (Estonia) (the State Police, 2013).

Distribution of Narcotic Substances

The operational activities of the State law enforcement institutions and the information gained during the pre-trial investigation allows identification of the most popular routes for import and transit of narcotic substances in 2013. In this regard it has to be emphasised, that this information does not mean that the country of export is also the country of origin (manufacture).

Synthetic narcotic substances (methamphetamine for the most part) are mainly transit substances, although a part of them remain in the country for local consumption. They are imported into Latvia mainly from the Western Europe countries (the Netherlands, Belgium), Lithuania and Poland. Part of the production is forwarded to Russia, Scandinavian countries and Estonia (the State Police, 2013).

Marijuana is usually imported into the country or transported as a transit product through the territory of Latvia from the Western Europe countries (the Netherlands, the United Kingdom) and also Lithuania and Spain. Part of the production is forwarded to Russia, Scandinavian countries and

[35] Hereinafter—narcotic substances, except when it i neccessary to specify the substance in separate cases

[36] The group of new psychoactive substances included also substances that belong to the groups of synthetic cannabinoids, cathinones, piperazines, phenylethylamines and other new psychoactive substances. Both substances that were and were not subject to control at that moment have been included in the statistics.

Estonia. It should be added that the production harvested in one of the marijuana farms discovered in 2013 was intended for sale in the Estonian market (the State Police, 2013). In addition, the information possessed by the national law enforcement institutions suggests that marijuana that is exported to Russia is, possibly, grown in the territory of Latvia. It should be added that in April 2013, two citizens of the Republic of Latvia were arrested for smuggling of narcotic substances at the border crossing-point "Suwalki" on the Polish–Lithuanian border and 2 kg of marijuana were seized from them (SRS Customs Criminal Board, 2013).

Heroin is basically imported from Central Asia with the use of overland transportation through Ukraine, Belarus, then Lithuania, as well as through the Russian Federation territory and then through Estonia. Part of the production is forwarded to Scandinavian countries and EU Member States (the State Police, 2013).

Seizures of large amounts of hashish are related to the transporting of this substance to other countries by using Latvia as a transit country. The substance is usually transported from other countries, mainly the Northern Africa (Morocco), through Spain and Latvia as transit countries and then to the Russian Federation. This conclusion was also confirmed in 2013, when a car was stopped at the border crossing-point "Grenctāle" on the Lithuanian–Latvian border in January 2013 and during the customs control hashish in the amount of 104.5 kg was found in it. It had been intended to use Latvia as a transit country for transporting the hashish to the Russian Federation (SRS Customs Criminal Board, 2013).

Cocaine is also basically a product in transit, which is transported from the South American countries (usual transit countries are Spain, the United Kingdom, the Netherlands, France, Belgium and Germany). Most often the production is forwarded to Russia, Scandinavian countries and Estonia (the State Police, 2013).

New psychoactive substances are imported into Latvia mainly from China. The production is then forwarded to Russia, Ukraine, Belarus and Scandinavian and Western Europe countries (the State Police, 2013). In addition to the aforementioned, the tendency topical in 2013 is related to the fact that in majority of cases senders of psychoactive substances are individuals from Chine, regarding whom information from international risk information network has already been received with regard to their connection with drug-containing courier parcels sent to the Russian Federation, Ukraine, Greece, Azerbaijan, Nigeria and other countries. The accompanying documents usually state that the parcel contain a chemical substance, for example, "disodium dihydrogen pyrophosphate" (fluoromethamphetamine 4-FA, which is banned in Latvia), "sample of antioxidant 1010" (1-benzylpiperazine, 1,4-dibenzylpiperazine, 1-[3-(trifluoromethyl) phenyl] piperazine, which is also banned in Latvia), "clean powder" (4-methylethcathinone, which is also banned in Latvia). The indicated value of packages usually is USD 5–10. As addressees of these parcels both natural and legal persons may be indicated. But the persons who are engaged in distribution and smuggling of new psychoactive substances import these substances with a car through the internal border of the Republic of Latvia by using the absence of regular customs control and thus reducing the possibility of discovering the parcels to minimum. At the same time it should be noted that in April of 2013, two citizens of the Republic of Latvia driving a car were arrested at the border crossing-point "Grenctāle" on the Lithuanian–Latvian border, as mephedrone (975 g, 2022 pills), two guns, and 150 cartridges were found during the customs control. During a sanctioned search, 255 g of hashish were seized at the place of residence of one of the arrested individuals (SRS Customs Criminal Board, 2013).

The data possessed by the law enforcement institutions suggests that illegal circulation of narcotic substances in Latvia, as well as organisation of smuggling of substances to be controlled in Latvia is mainly performed by local organised criminal groups, which collaborate with organised criminal groups located in the EU and third countries (the Russian Federation, Belarus, Ukraine, Southern American countries, etc.). In addition to the aforementioned, Latvia is used as a transit country for smuggling of narcotic substances also by organised criminal groups of other countries. The cultural ties and possibilities to use the Russian language shared by representatives of organised criminal

groups in Latvia, Russia, Lithuania, Estonia and other former Soviet Republics is a factor facilitating trafficking of narcotic substances. It has been observed, that criminal groups working in Latvia are multinational (some groups include Latvians, Lithuanians, Russians, Germans, Estonians) and their activities are multi-criminal, that is, their illegal interests include not only illegal circulation of narcotic substances but also other areas of criminal offences, for example, laundering of proceeds from crime, smuggling of excise goods, car thefts (the State Police, 2013).

It should also been added that within the competence of SRS Custom Criminal Board, criminal proceedings against 39 persons, who smuggled narcotic substances, were initiated in 2013. Out of them, 19 were nationals of Latvia, 8—of Lithuania, 3—of Estonia, 3—of Germany, 2—of Israel, 2—of Russia, 1—of Malaysia, and 1—of Nigeria (SRS Custom Criminal Board, 2013).

In addition to the aforementioned, one of the characteristics of the market is that citizens of Latvia usually engage in smuggling of narcotic substances as couriers. In total, 34 Latvian citizens were arrested abroad for smuggling of narcotic substances in 2013 (see Table 10.1.). Majority of arrests have taken place in the European Union (19 persons in total: Poland—5 persons, Sweden—5 persons, one individual was arrested twice, Austria—3 persons, Germany—2 persons, France—1 person, Lithuania—1 person, the Netherlands—1 person), territory of the Russian Federation (5 persons), Southern America (Peru, Argentina, Brazil—4 persons), Turkey (3 persons), Norway (2 persons), Aruba (1 person) (Ministry of Foreign Affairs, 2013).

Table 10.1. Information received by the Consular Department of the Ministry of Foreign Affairs of the Republic of Latvia concerning the number of citizens of Latvia, who have been arrested for trafficking and illegal circulation of narcotic substances in 2009–2012 (in absolute numbers)

	2009	2010	2011	2012	2013
Number of citizens of Latvia	**32**	**55**	**71**	**29**	**34**

Source: Ministry of Foreign Affairs of the Republic of Latvia, 2013

Further there are some information on citizens of Latvia arrested abroad. In May of 2013, a citizen of the Republic of Latvia was arrested at Charles de Gaulle Airport in Paris (France), who transported cocaine from the Southern Africa (Argentina) to Europe; the target country in this case was Latvia. In the body of this person, 94 capsules with cocaine (total weight 1155 g) were found. To continue, in August of 2013, 2 citizens of the Republic of Latvia were arrested in Rovaniemi (Finland) by Finnish law enforcement authorities for smuggling of narcotic substances. In this case, 375 pills of Subotex were seized. And in July of 2013, 2 citizens of the Republic of Latvia were arrested at Bromma Airport in Stockholm (Sweden), thus terminating smuggling of 40 kg of Catha edulis into the territory of Sweden (the State Police, 2013).

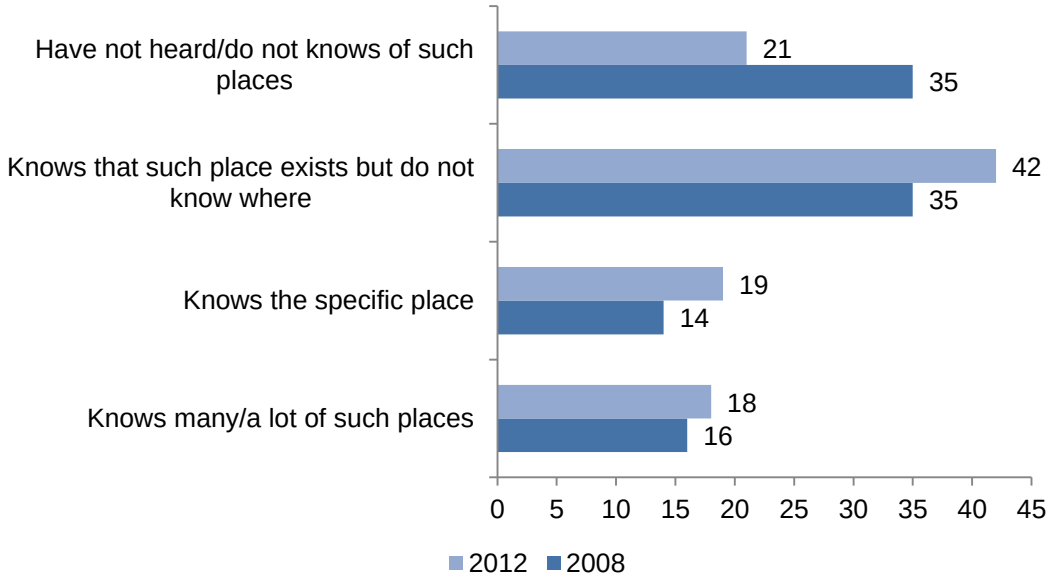
Availability and Supply

Respondents of the study “Use of Drugs at Entertainment venues in 2012” were asked how easy or hard it is to acquire various narcotic substances within 24 hours. Visitors of entertainment venues indicated that it is “extremely” easy to purchase such substances as Spice (47%), marijuana (37%) and amphetamines (12%). Among substances that are “impossible” to be purchased heroine (35%), crack (31%) and cocaine (34%) were mentioned most often.

Within the study, the respondents were also asked about sales points of narcotic substances near their home. A conclusion was drawn that awareness of young people about the existence of such sales points has increased considerably over the last four years. Approximately four in five (79%) visitors of entertainment venues at the largest cities in Latvia know or at least suspect that there are such places in their city. In 2008 only two thirds (65%) of the young people surveyed had such information (Koroļova et al., 2013). However, it should be pointed out that part of these points of

sale could be related with the new psychoactive substances, the number of sales points of which had increased at the moment of the study in 2012 (see Figure 10.1.).

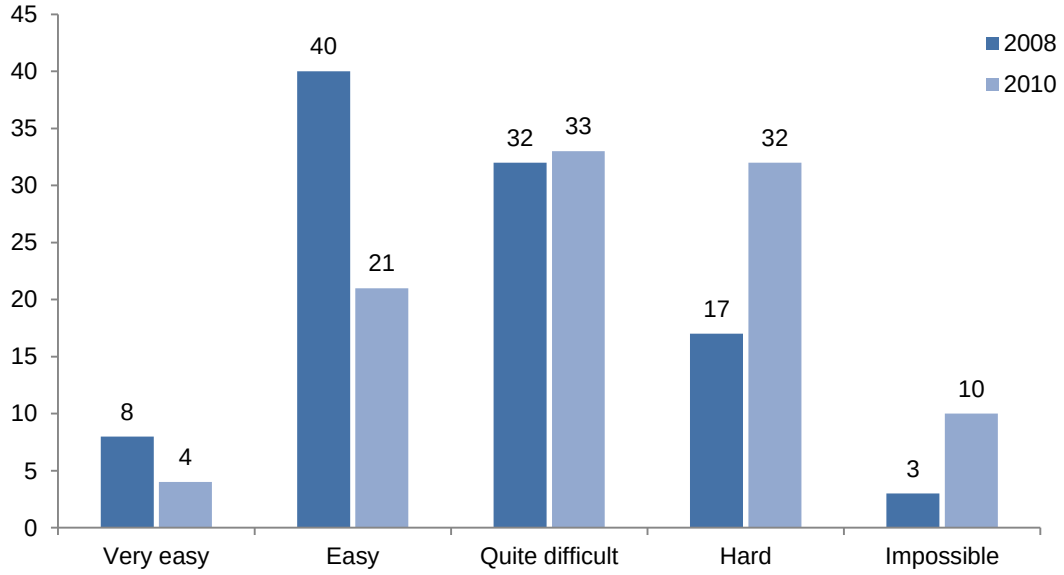
Figure 10.1. Awareness about points of sale of drugs near home (%)



Source: Koroļeva et al., 2013

The respondents were also asked how easy or hard it is to purchase narcotic substances at night clubs. In comparison to 2008, almost twice as less respondents admitted that it is easy or very easy to purchase drugs at clubs, while 42% of young people surveyed thought that purchasing of addictive substances at bars, night clubs and other night entertainment venues favoured by young people would be hard or even impossible (see Figure 10.2.). The greatest changes in this regard were observed for entertainment venues in Riga (Koroļeva et al., 2013).

Figure 10.2. Opinion about how easy it is to purchase drugs at entertainment venues favoured by young people (%)



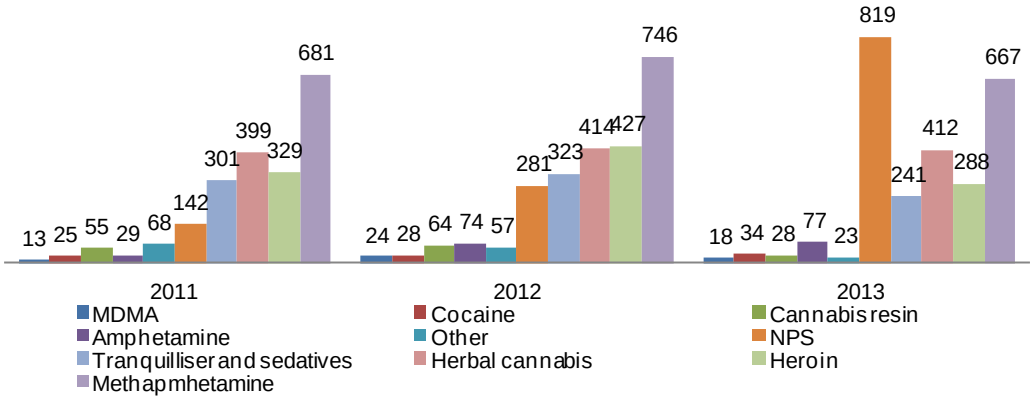
Source: Koroļeva et al., 2013

10.2. Seizures

According to the data provided by the Forensic Service Department of the State Police, 2607 seizures of narcotic substances, psychotropic substances, NPS and precursors were performed in 2013, which is 6.5% more than in 2012 (n=2438); this suggests of increase in the illegal circulation of narcotic substances on the national level (see Figure 10.3.).

It should be mentioned that data of the State Police on the seizures of narcotic substances show that substances are most often seized inside the country. Namely, in 2013, 97% of substance seizers were performed inside the country (83%—by the State Police, 13%—by the Prisons Administration, 1%—by Riga Municipal Police), but 3% of seizures fell within the competence of Customs Criminal Board of the State Revenue Service (on boarders, at the airport, at ports, etc.).

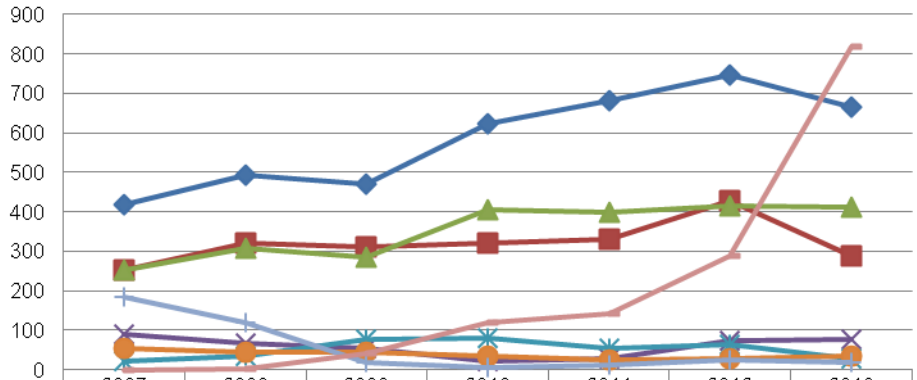
Figure 10.3. Number of seizures of narcotic substances, psychotropic substances, NPS and precursors in 2011–2013



Source: Forensic Service Department of the State Police, 2014

Analysis of the number of narcotic substances seizures revealed that the **NPS** have gained the leading positions in 2013, first time after their entry into internal market in 2008. Methamphetamine which had been in the first place for several years changed its position in the structure of seized substances in the country. Namely, in 2013, 819 seizures of NPS were carried out, which accounts for 31.4% of the total seizures performed in the state, which is 64.7% more than in 2012 (n=289). It should be noted that both substances that were and were not subject to control at that moment, have been included in the statistics of NPS seizures. The remarkable increase in the number of seizures of NPS is related both to the growth in the number of sales points and the intensified attention of national law enforcement institutions paid to the control of NPS in 2013 (see Figure 10.4.).

Figure 10.4. Number of seizures of narcotic substances, psychotropic substances and NPS in 2007–2013[37]



	2007	2008	2009	2010	2011	2012	2013
Methamphetamine	419	494	469	624	681	746	667
Heroin	254	322	312	322	329	427	288
Herbal Cannabis	253	309	284	406	399	414	412
Amphetamine	89	66	54	21	29	74	77
Cannabis resin	22	34	76	81	55	64	28
Cocaine	55	46	44	34	25	28	34
MDMA	185	118	19	5	13	24	18
NPS	0	3	42	120	142	289	819

Source: Forensic Service Department of the State Police, 2014

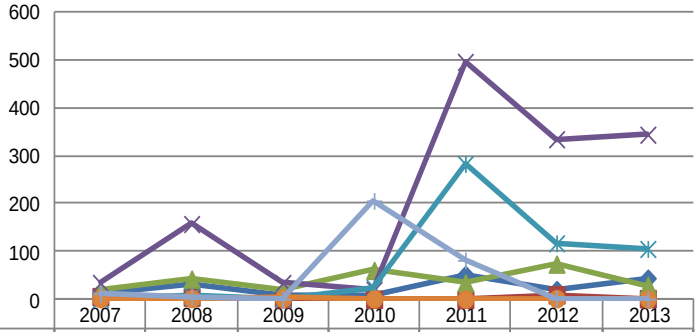
The next most popular substance seized in 2013 is **methamphetamine**. In total, 667 seizures of methamphetamine have been carried out in 2013, accounting for 25.6% of the total number of seizures, which is 10.6% less than in 2012 (n=746). The amount of substances seized accounted for 44.33 kg (see Figure 10.3.). It should be marked that in 2013, 276 seizures (or 41.4% of methamphetamine seizures) were up to 1 g, which can be intended to individual use. While in 7 seizures (1.1%) the amount exceeded 1 kg. However, it cannot be claimed that the drop in the number of methamphetamine seizures suggests of changes in the drug use habits and replacing of "traditional" substances with new ones.

Herbal cannabis completes the top three seized substances in 2013. This substance takes firm positions in the illegal market of Latvia for several years already, and the fluctuations in the amount of substance seized are related to the discovering of cannabis cultivation sites and trafficking in large amount. Thus, in 2013, herbal cannabis was seized in 412 cases, which is 15.8% of all seizures performed in the state; the total amount of herbal cannabis seized is 29.19 kg. In addition, 31 times cannabis plants were seized, which is closely related to the discovered 18 cultivation sites. In total, 344.4 kg of cannabis plants were seized. In 2013, 123 cases (29.9%) of herbal cannabis seizures were with amount up to 1 g, and 155 cases (37.6%) with an amount of 1–5 g. That is, 67.5% of herbal cannabis seized was intended for individual use and distribution in the retail market. While 5 seizures of herbal cannabis (1.2%) were with amount exceeding 1 kg.

In the list of substances seized more often in 2013, **heroin** takes the fourth place—288 cases or 32.6% less than in 2012 (=427), which is 11.1% of all seizures performed in the state. It should be added that in total 0.719 kg of heroin was seized in 2013. At the same time it should be pointed out that 62 seizures (21.5%) of heroin up to 0.1 g were performed in 2013 and 161 seizures (56%) were with 0.1–1.0 g of the substance; thus it can be concluded that 77.5% of seized heroin was intended for individual use and distribution in the retail market. Overall, 25 seizures (8.7%) of heroin were related to amount from 5–100 g of the substance.

[37] See ST13_2014_LV_1

Figure 10.5. Amount of some narcotic substances confiscated from 2007 till 2013 (kg)[38]



	2007	2008	2009	2010	2011	2012	2013
Methamphetamine	11.83	32.27	7.89	8.26	52.2	20.47	44.33
Amphetamine	5.78	4.8	1.29	0.11	0.1	9.43	1.57
Herbal cannabis	17.84	42.44	17.88	60.68	34.28	73.85	29.19
Cannabis plants (kg)	34.48	157.52	34.28	19.96	496.67	334.93	344.4
Cannabis resin	0.25	6.88	1.45	23.83	282.9	117.29	105.46
Heroin	1.75	1.75	2.14	1.12	0.44	1.39	0.719
Cocaine	11.9	5.15	0.44	206.06	81.49	1.07	0.575

Source: Forensic Service Department of the State Police, 2014

At the same time, amphetamine circulation has been comparatively stable over the years. The substance is not very popular in the market. Amphetamine was seized 77 times (3% of the total number of seizures) in 2013, compared to 74 seizures in 2012. In 2013, 1.57 kg of amphetamine was seized in total. It should be pointed out here that seizures when both amphetamine and methamphetamine are found in the same mixture of substances have not been included in the number of seizures of neither methamphetamine nor amphetamine (11 such seizures were registered in 2013).

In 2013, cannabis resin was seized 28 times (64 times in 2012). In total, 105.46 kg of resin was seized, as smuggling of this substance was intercepted on the Lithuanian–Latvian border in January of 2013. Also the number of seizures of cocaine is small: 34 seizures in 2013, which is 6 seizures less than in 2012 (28 cases); the total amount seized in 2013 was 0.575 kg.

Ecstasy/MDMA continues disappearing from the structure of the illegal market—18 seizures of total of 60 pills have been performed in 2013. In 2012, 847 pills were seized in 24 seizures, to compare with. In addition, two seizures of coca leaves and two seizures of hallucinogenic mushrooms were performed in 2013.

It should be also added that tranquillisers and sedatives are put in one separate group. Their number is quite stable over years: 241 seizures (9.2% of all seizures in the country) have been performed in 2013. In total, 2.08 kg of the substance and 6271 pills were confiscated.

Overall, 87 seizures of synthetic, semi-synthetic and natural opiates were performed in 2013: 26 seizures of carfentanyl[39], 4 seizures of fentanyl, 34 seizures of buprenorphine (8.75 g, 17 pills), 8 seizures of methadone, 1 seizure of codeine, 2 seizures of partly-acetylated opium, 8 seizures of poppy straw, 2 seizures of morphine and 1 seizure of opium-containing substances. In 2012 in total 67 seizures of such opiates were carried out.

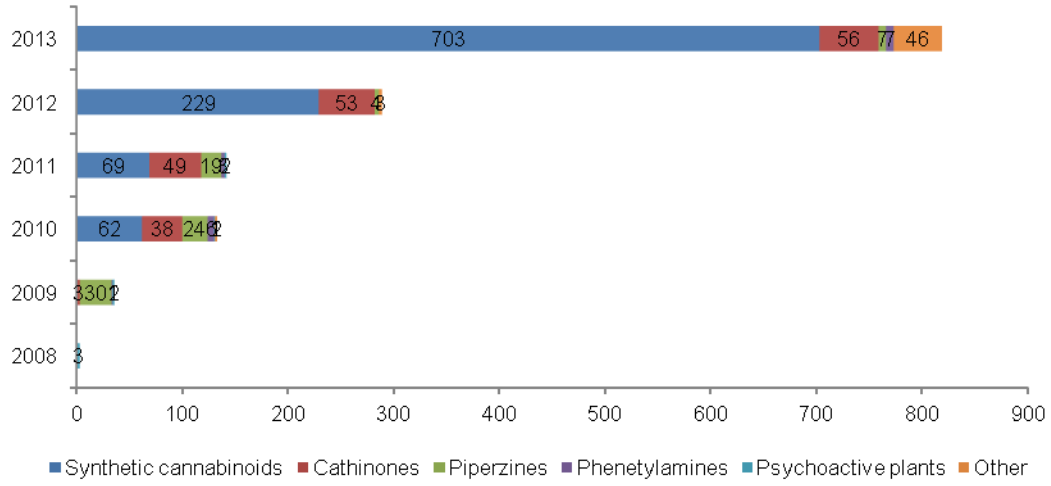
New Psychoactive Substances

As a result of legislative initiatives, the system of controlling the narcotic substances, psychotropic substances and precursors to be controlled in Latvia according to the basic principles of the generic system came into force in February 2013, but in November 2013 a new temporary ban of NPS was introduced in Latvia. In this relation, it is pointed out that temporary ban was placed on 6 new

[38] See ST13_2014_LV_1
[39] Carfentanyl has been included in the statistics of new psychoactive substances

psychoactive substances in 2013 (5F-AKB48, AB-FUBINACA, AKB48, 5F-PB-22, AM-2201 indazolecarboxamide analogue, 25I-NBOMe) and their preparations.

Figure 10.6. Number of seizures for NPS, in 2008–2013



Source: Forensic Service Department of the State Police, 2008–2013

The general amount of NPS in 2013 consists of synthetic cannabinoids (85.8%, n=703), cathinones (6.2%, n=56), phenethylamines (n=7), piperazines (n=7), arylalkylamines (one 6-APB/6-APDB seizure). Among the largest seizures, seizure of 2022 tablets of mephedrone on the Latvian–Lithuanian border should be mentioned and seizure of 245 paper blotters of the substance 25I-NBOMe, while the synthetic cannabinoids have mainly been confiscated in small amounts (see Figure 10.6. and Table 10.2.).

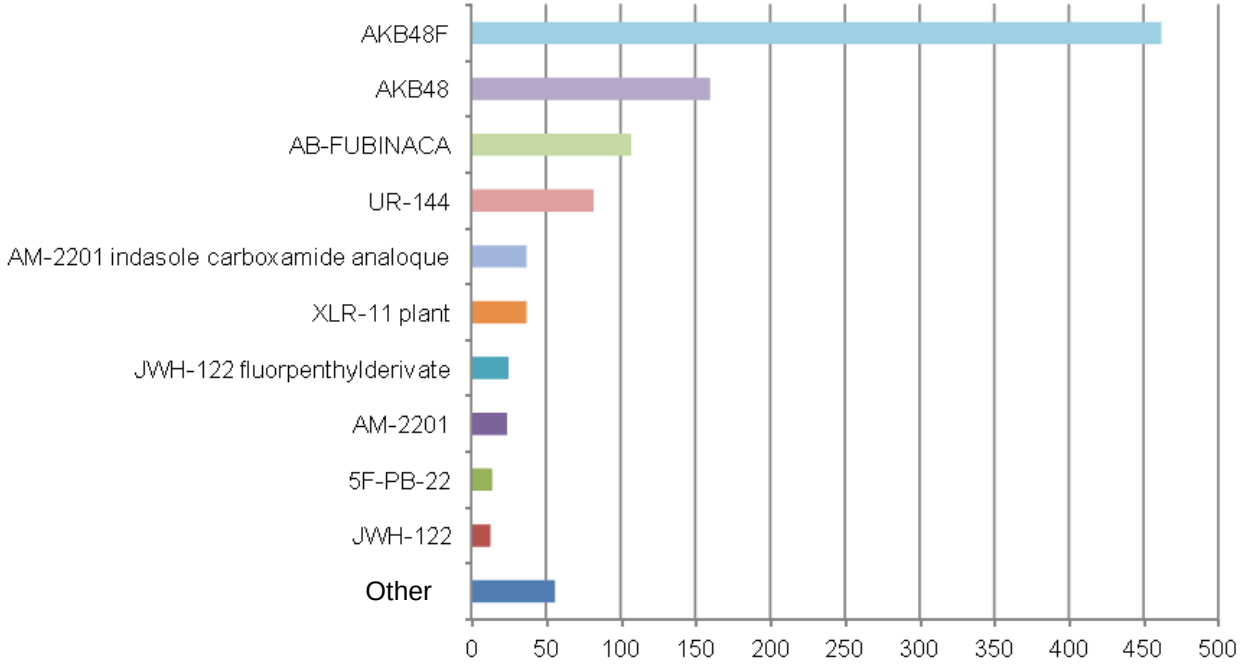
Table 10.2. Amount of seized NPS in 2010–20123 (kg/tab./paper slips)

		2010	2011	2012	2013
Synthetic cannabinoids	powder	4.8 kg	0.009 kg	0.004 kg	0.139 kg
	plant mixtures	3.07 kg	7.92 kg	2.99 kg	7.94 kg
Cathinones	powder	24.5 kg	5.92 kg	5.8 kg	1.09 kg
	tablets	6	0	0	2022
Piperazines	powder	0.015 kg	0.59 kg	0	0.049 g
	tablets	627	118	310	5 pills
Phenylethylamines	powder	0	0.54 kg	0	0.050 kg
	tablets	12	8	0	0
	blotters	0	0	0	245

Source: Forensic Service Department of the State Police, 2014

When analysing seizures of separate substances, it has to be mentioned that AKB48F takes the leading positions (n=462, 56.4%) among all seized NPS in 2013, followed by AKB48 (n=160, 19.5%), AB-FUBINACA (n=107, 13.1%), UR-144 (n=82, 10%), AM-2201 indazole carboxamide analogue (n=37, 4.5%), XLR-11 (n=37, 4.5%), JWH-122 fluorpenthylderivate (n=25, 3.1%), AM-2201 (n=24, 2.9%), 5F-PB-22 (n=14, 1.7%) and JWH-122 (n=13, 1.6%) (the State Police, 2013) (see Figure 10.7.).

Figure 10.7. Number of some seizures of some synthetic cannabinoids in 2013



Source: Forensic Service Department of the State Police, 2014

It should be added that as a result of intensifying the measures carried out by the law enforcement authorities in the field of restricting circulation of NPS, the number of the respective sales points has decreased from more than 70 points of sale at the beginning of 2013 to 50 points of sale in December 2013.

However, an important risk factor the role of the Internet with regard to circulation of NPS should also be highlighted. The Internet resources not only give the possibility to learn about the types and projected impact of the NPS but also provide persons with unlimited possibilities to order them; these possibilities are actively used in supporting illegal activities.

Medical Preparations Containing Narcotic and Psychotropic Substances

When examining the market of medical preparations containing narcotic and psychotropic substances, it is concluded that violations of the regulations for their distribution are not characteristic of Latvia; however, medical preparations containing narcotic and psychotropic substances are seized every year. Still, the number of these substances has reduced, if compared to 2012. In 2013, 241 seizures of medical preparations were performed in the country, which is 25.4% less than n 2012 (n=323). In total, 2.08 kg of substance and 6271 tablets were seized in 2013. In general, 59% of medical preparations have been seized within the competence of the State Police, 40%—by the Latvian Prison Administration, and 1%—by the Customs.

In 2013, the general amount of medical preparations containing narcotic and psychotropic substances consisted of benzodiazepines (n=192, 79.7%), followed by prescription opiates (n=36, 14.9%), mixture of barbiturates and benzodiazepines (n=7, 2.9%), as well as trihexifenidilo (n=4, 1.7%) and zolpidem (n=1). In addition to the aforementioned, one seizure of barbiturates was performed in 2013 (the State Police, 2013).

Discovered Plantations for Production of Cannabis

In 20123, there have been **18** cannabis cultivation sites discovered. In eight of these events, the plants were placed indoors, in seven cases the plantations were placed in greenhouses, while in four other events it was placed outdoors. Totally, 14,220 plants were seized in connection with cannabis cultivation indoors, while 359 plants were confiscated from outdoor sites; in total, 344.4 kg of plant mass was seized.

Table 10.3. Number of cannabis cultivation sites and confiscated amount from 2007 till 2013

	2007	2008	2009	2010	2011	2012	2013
Cannabis cultivation facts	3	3	3	8	9	7	18
Seized plants (kg)	34.48	157.52	34.28	19.96	496.67	334.93	344.4

Source: The State Police, 2014; Forensic Service Department of the State Police, 2007–2013

Speaking about special equipment used for ensuring the growing process, it is noted that growing without any special equipment has been performed in 14 cases, in some cases usual lamps or natural light, and fertilisers have been used (in greenhouses (n=6), in special premises (n=4), outside (n=4)). Special equipment has been used in 5 cases (in special premises (n=4), in greenhouse (n=1)). Mainly men have been engaged in cultivating (10 people aged 20–30, 3 people aged 30–40, and 3 people aged 40–50).

Analysis of cannabis cultivation sites reveals that usually it is grown for distribution in the local market and for individual use; expert to a foreign market (Estonia) had been planned in only one case. In addition, the fact that Internet resources are used for starting the growing (purchasing seeds and learning information about growing and using cannabis was confirmed once again. The growing tendency of cultivating cannabis is clearly related to the popularisation of issues related to the circulation of the substance in mass media, including questions about decriminalisation[40] of use, and availability of cannabis growing information in the Internet resources, which can facilitate the increase in the level of interest of persons not related with the criminal environment and their involvement in the mentioned illegal activities (the State Police, 2013).

Precursors

In 2013, 8 seizures of precursors have been registered in the criminal proceedings held in the record-keeping of the State Police. For example, gamma-butyrolactone[41] (in amount of 69.056 g and 5495 ml) has been confiscated in 2013. Note: the seizures were not related to the discovered laboratories of synthetic narcotic substances in 2013.

In 2013, the fact of distributing the pre-precursor of methamphetamine—nitropropene (phenyl-2-nitropropene)—via company registered in Latvia was detected. In relation to this case, law enforcement authorities of the United Kingdom, based on the information provided by the State Police of Latvia regarding import of nitropropene (phenyl-2-nitropropene) from Latvia to the United Kingdom, organised surveillance; as a result 2 laboratories were discovered in January 2013 from which narcotic substances, a large amount of chemicals and equipment for manufacturing narcotic substances were seized (the State Police, 2013).

10.3. Prices and Purity

Prices

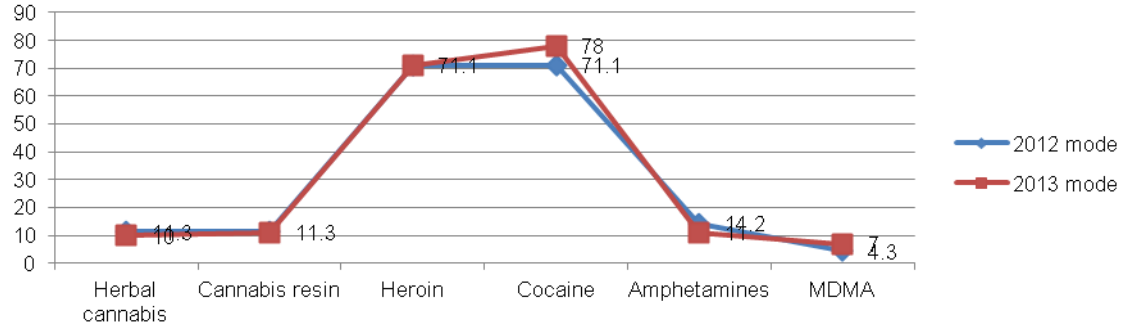
Estimation of prices of drugs in Latvia are based on the operative information sources available to Organized Crime Prevention Department of the Main Criminal Police Department and five regional departments of the State Police. In reply to the need for higher quality of data, a new framework for data collection on drug prices in retail and wholesale was developed in 2013; on the basis of this framework, also the information possessed by the structural units of the State Police about the prices of narcotic substances on the national level in 2013 was collected.

Analysis of drug prices did not reveal any significant changes in the illegal market of Latvia. Similarly to the previous years, differences are observed between Riga and regions of Latvia. For example,

[40] http://manabalss.lv/marihu-nas-dekriminaliz-cija/show, http://www.ventasbalss.lv/forum/view/21958 etc.
[41] Included in the statistics of new psychoactive substances

the typical (mode) price of methamphetamine and amphetamine per gram is EUR 11 in Riga Region and EUR 17 in regions; one gram of herbal cannabis costs EUR 10 in Riga and EUR 14 in regions; the average price of heroin is EUR 71 per gram in Riga and EUR 100 per gram in regions; while the average price of 1 gram of cocaine is EUR 78 in Riga and EUR 100 in the major cities (see Figure 10.8.).

Figure 10.8. Typical prices of narcotic substances 2012–2013 (g/EUR)[42]



Source: Organised Crime Prevention Department of the State Police, 2014

The analysis of prices for narcotic substances indicates stable price for herbal cannabis (2012 mode: EUR 11.3; 2013 mode: EUR 10), stable typical price for cannabis resin (2012 mode: EUR 11.3; 2013 mode: EUR 11), as well as practically unchanging typical price for heroin (2012 mode: EUR 71.1; 2013 mode: EUR 71) in the illegal market.

The typical price for cocaine was EUR 78 in 2013, but the typical price in 2012 was EUR 71.1. In this case a conclusion can be drawn that these differences in the price for cocaine can be explained with small sample size. The varied data was potentially affected by the changes in the methodology of summarising prices, which were reflected in the structure of the collected data. In addition to the aforementioned, consultations with the officials of the operational structures of the State Police confirmed that no new tendencies have been observed in 2013 with relation to drug prices. Similar situation is observed also with regard to changes in the typical price for amphetamines. In case of ecstasy/MDMA, it has to be noted that the substance is not highly-demanded in the illegal market and the fluctuating prices depend on the particular source of information. In addition to the mentioned, the changing prices were also affected by Latvia joining the Euro Zone in 2014; in the result of this fact sale of substances was performed both in lats and euro (also by taking into account different approaches to price conversion in the illegal market) (the State Police, 2013).

Also the sixth and seventh stage of high risk drug user cohort study included a question about the price of narcotic substances at the retail level (Trapencieris et al., 2013 and 2014). The respondents answered an open-ended question where they had to indicate the measurement unit and the respective price. The answers provided mention such measurements as “half-a gram” and “gram”, “dose”, “half-a-dose”, “20 cubics”, “30 cubics”, “čeks”, “half čeks” (čeks – heroin street dose), etc. All the prices and measurement units provided were converted to price per gram. A note: only those measurements that could be converted to grams were included in the estimation, for example, the measurements “dose” and “half-a-dose” were not taken into account, since it is impossible to establish whether “dose” is expressed as half-a-gram or gram.

While the price range for cannabis and amphetamines was irrelevant, the price range for heroin was considerably larger, as the price per one gram of heroin was often indicated to be equal to one (0.1 g) of heroin. It can be actually concluded that this estimation is an indicative price per gram and for a more exact estimation, the conversion rules must be reconsidered.

[42] See ST16_2014_LV_1

Table 10.4. Data on prices of drugs (g/EUR) obtained within the study[43]

	2012				2013			
	sample	min	max	mean	sample	min	max	mean
Marijuana (g)	92	3.56	71.14	14.62	45	4.26	34.14	13.91
Heroine (g)	233	7.11	142.29	119.15	138	14.23	142.29	121
Amphetamine, methamphetamine (g)	287	7.11	19.92	13.56	194	5.70	17.07	13.51

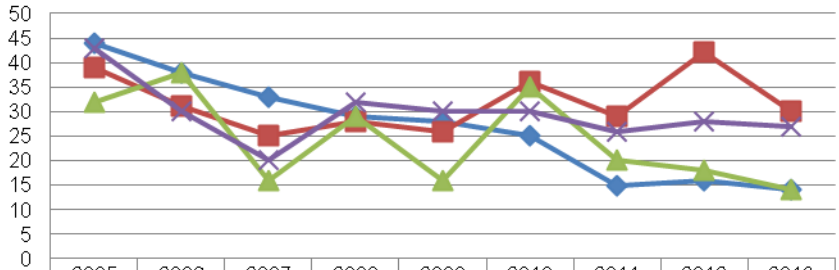
Source: data from Trapencieris et al., 2013 and 2014, calculation by A. Zīle–Veisberga

Purity

Drug purity in Latvia is analysed within the competence of the Forensic Service Department of the State Police. Although the gas chromatography method is applied during expert investigation, it must be pointed out that the THC level is not determined in cannabis products.

The structure analysis of narcotic substance purity indicates stable average purity of heroin. It is important to note that the average purity of heroine after the drop in 2011 has not increased. The fluctuating level of purity of cocaine and amphetamine can be explained with the small sample size which is becoming more stable in case of amphetamine due to the growing number of seizures. In addition, the average purity of methamphetamine almost does not change over years (2011—26%, 2012—28%, 2013—27%). It has to be noted that the average purity of methamphetamine is higher than the average purity of amphetamine, without any changes over several years, and that there is a gradual decrease in the average purity of amphetamine compared to the baseline of 2010 (35% in 2010, 20% in 2011, 18% in 2012, and 14% in 2013) (see Figure 10.9.).

Figure 10.9. Average purity of various drugs from the year 2005 till 2013 (average purity, %)[44]



	2005	2006	2007	2008	2009	2010	2011	2012	2013
Heroin	44	38	33	29	28	25	15	16	14
Cocaine	39	31	25	28	26	36	29	42	30
Amphetamine	32	38	16	29	16	35	20	18	14
Methamphetamine	43	30	20	32	30	30	26	28	27

Source: Forensic Service Department of the State Police, 2014

It should be added that drugs are generally mixed with the following substances: heroin is diluted with lactose (the additives are caffeine, dextromethorphan, ibuprofen). Cocaine is diluted with lactose and glucose and the additives used are lidocaine, phenacetin, caffeine, benzocaine. Amphetamine is diluted with lactose and glucose by adding caffeine. And also methamphetamine is diluted with lactose and glucose by adding caffeine (Forensic Service Department of the State Police, 2014).

[43] See ST16_2014_LV_2
[44] See ST14_2014_LV_1

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