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2008 NATIONAL REPORT (2007 data) TO THE EMCDDA by the Reitox National Focal Point

„LATVIA”

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

REITOX

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List of Abbreviations

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

Summary

At the moment, the *State Program on Drug Control and Drug Addiction Restriction 2005–08* is topical in Latvia. Bearing in mind that 2008 is the final year during which this program will be in operation, the Drug Control and Drug Addiction Restriction Coordination Council has recognised that the next mid-term policy planning document in the field of drug addiction and reduction in the prevalence of illegal drugs must be based on a complete and comprehensive national policy, which would include an evaluation of the implementation of the National Programme. Accordingly, in order to ensure the continued implementation in 2009 of tasks set by the National Programme, i.e. while the Programme is being evaluated, and when the next mid-term national policy planning document will be in preparation, the Cabinet of Ministers has developed and adopted an action plan for a further year i.e. for 2009.

This year, the National Report consists of 10 Chapters together with a Selected Issue Chapter, in which an in-depth analysis of sentencing statistics is undertaken.

In the area of legislation, relatively few new laws, regulations or amendments were adopted during 2007. The most important of those adopted deal with procedures for the prescribing of medication and for determining/identifying the effect of drugs. More information is available regarding legislative changes and the implementation of the National Programme in Chapter 1.

In 2007, several important studies were undertaken in Latvia: a general population survey on drug abuse prevalence in Latvia; a national school survey was undertaken within the ESPAD 2007 framework, and a study on drug use in recreational places. Information regarding study methodologies and results is compiled in Chapter 2.

At the moment there are several institutions in Latvia which undertake preventive work in the drug field, however, the majority of their activities are characterised by having a campaign-type nature, and frequently, activities in the area of addiction are integrated into broader health promotion activities. Similarly, prevention activities in Latvia are still not being developed for certain target groups based on data acquired during studies. Selective prevention is implemented relatively ineffectively in Latvia's regions overall, there continues to be no unified approach to the implementation of universal and selective prevention activities, and only in rare cases is an evaluation done of the effectiveness of preventive interventions; all of which is mostly explainable by a lack of funding and capacity. More information on universal and selective prevention activities is compiled in Chapter 3.

In 2008, the third wave of a cohort study of drug users in Latvia was undertaken. Based on the results of the cohort study, together with treatment demand and police data, a calculation of problematic drug users has been undertaken utilising the *treatment* and *police multiplier methods*. According to this police multiplier method, the estimated number of problem drug users in Riga is 4757. However, the total number of intravenous drug users according to *treatment multilier* in the

country is not less than 8622, while the number of problem drug users is not less than 9588. More information on the calculations and treatment demand data, as well as characteristics of drug users “on the street” are compiled in Chapter 4.

In 2008, significant amendments were introduced into legislation, which provide that methadone maintenance treatment can be undertaken by any drug addiction specialist having a contract with the Health Compulsory Insurance State Agency. Previously, only one centre, the Riga Psychiatry and Addiction Centre, was authorised to issue methadone. Along with the enlargement of methadone maintenance treatment, an evaluation of substitution maintenance treatment has commenced in Latvia within the United Nations Office on Drugs and Crime project framework. More information may be found in Chapter 5.

In reporting on the number of cases of drug-related deaths, two sources were utilised: data from the Health Statistics and Medical Technologies State Agency of Latvia (GMR) and the Latvia State Centre for Forensic Medical Examination (SR). Data from both institutions are compared over a one-year period. In 2007, 21 drug-related deaths were recorded in Latvia. It must be borne in mind generally that the true number of drug-related deaths could be greater, as an autopsy is not performed in all cases, and a drug overdose is not always recorded as the official cause of death. In 2007, a mortality cohort study among treated drug clients was also conducted.

Injecting drug use is still the most common transmission route for HIV infection in Latvia; on the other hand every year there is an increasing prevalence of HIV among young heterosexual women. In 2007, 350 new cases of HIV infection were registered. Incidence of hepatitis B among intravenous drug users has remained stable since 2006, while incidence of hepatitis C has increased by almost 50% since 2006. Concerns continue to exist that there are many "hidden" patients throughout the country suffering from hepatitis B and from hepatitis C since testing for other infections than HIV is for a charge. More information on drug-related deaths and infectious diseases may be found in Chapter 6.

In 2008, the study by Philip Coffin was published, providing a detailed description of the situation in Latvia with regard to overdosing on drugs. Unfortunately, discussion on this issue is practically non-existent in Latvia, nor is there much information on the prevention of drug-related overdosing. However, the possibility of obtaining treatment in the country, as well as at syringe exchange consultative points, may be regarded as one means by which the number of drug-related fatalities may be reduced. More information on the prevention of overdosing and infectious diseases is compiled in Chapter 7.

Due to a lack of data, social exclusion related to drug use is analysed only in terms of basic indicators: educational level and employment status, which are examined in Chapter 8.

In 2007, there was a significant increase in the number of seizures of illegal drugs, particularly in seizures of methamphetamine and heroin. This may partly be explained by an increase in police activities. However, bearing in mind that since 21 December 2007, Latvia has

joined the Schengen Zone, and as a result, border control is practically non-existent, significant concerns arise that the volumes of illegal drugs circulating in the country would increase, and the fight against the importing and transit of drugs will become more difficult and more complex. The drugs market is described in more detail in Chapter 10.

In order to compile the information on sentencing statistics for the *Selected Issue on Sentencing Statistics*, a cooperation agreement was entered into with the Ministry of Interior Information Centre, which is the manager or holder of many criminal registration systems in which data in relation to offences/offenders in the field of illegal circulation of drugs is collected. Within its competence, the Ministry of Interior Information Centre prepared the extended topic, based on guidelines developed by the EMCDDA. The statistical data in the extended topic report were prepared from the Integrated Ministry of Interior Information System, also utilising data from the State Police Forensic Department on narcotic/psychotropic substances and precursors seized in the city of Riga and across the country in 2007. Statistical data were also compiled in ST11 on registered criminal offences and administrative offences in the field of illegal circulation of drugs, on persons called to criminal or administrative liability, and the basic penalties, and additional penalties imposed upon those persons.

Part A: New Developments and Trends

1. National policy and context

1.1. Legal framework

For several years now Reitox National Focal Point undertakes regular monitoring of legislative documents, identifying changes in the legislation and at the Translating and Terminology Centre website www.ttc.lv. Information is divided into several sections, i.e., legislated documents related to drugs, legislative documents related to alcohol issues, tobacco issues, medications and other spheres (for example infectious diseases, etc).

Drugs

There have been comparatively few changes in the legislative area during 2007, compared with 2006.

On 24 May 2007, the law *"Amendments to the law "On the procedure for the lawful circulation of narcotic and psychotropic substances and medications"* came into force. Section 6 Paragraph 2 of the law is expressed in a new form: "It is permitted to grow cannabis plants (Cannabis sativa subsp. sativa) for the acquisition of fibre and seed, and for other gardening purposes, cannabis plants crops may be sown only in permitted areas (they may not be grown in rooms or covered areas – greenhouses or under plastic sheeting). It is the obligation of the landholder or lawful proprietor to destroy cannabis growing on his land which it is prohibited to grow in accordance with this law".

On 24 July 2007, Cabinet Regulation No. 509 was adopted and came into force: "*Amendments to Cabinet Regulation No. 974 of 30 November 2004 "Doping control regulations*"" (issued in accordance with Section 6, Paragraph five, Clause 4 of the *Law on Sports*) adding several supplementary sections stipulating substances and methods used in doping.

Psychotropic medications

Cabinet Regulation No 435 of 26 June 2007 "Amendments to cabinet regulation No. 175 of 8 March 2005 "regulations on preparation and retention of prescription forms, and regulations on the writing of prescriptions"" (issued in accordance with the *Medical Treatment Law* Section 60 and the law "*Procedure for the Lawful Circulation of Narcotic and Psychotropic Substances and Medications*" Section 36, Paragraph one. The Regulation came into force on 1 October 2007. *Inter alia*, amendments are made which relate to medications containing Buprenorphine, stipulating that such medications may only be prescribed by a drug addiction specialist to a patient to whom Riga Psychiatry and Addiction Centre has issued a therapy program card for Buprenorphine replacement therapy. The drug addiction specialist shall also provide details of the name of the medication prescribed, the dose, and the amount, date of writing prescription and prescription

number on the said card. A prescription for the supply of buprenorphine shall not be written more often than once every two weeks. When writing a prescription for the supply of psychotropic medication and/or narcotic analgesic medication, the physician shall prescribe sufficient medication for a course of treatment of up to one month. As part of the compensation procedure, a drug addiction specialist, psychiatrist, neurologist, or family physician may prescribe sufficient medication for a course of treatment not exceeding three months' duration.

Cabinet Regulation No 220 of 27 March 2007 *"Procurement, storage, usage, stocktaking, and destruction of medications in treatment institutions and social care institutions"* (issued in accordance with the law *"On Pharmaceuticals"* Section 5, Clause 7, and Section 48, Paragraph one, and the law *"Procedure for the Lawful Circulation of Narcotic and Psychotropic Substances and Medications"* Section 37 Clause 4). The Regulation came into force on 4 April 2007 providing the procedure whereby medical treatment institutions and social care institutions obtain, store, and use medications (including medications containing highly dangerous narcotic substances and similar psychotropic substances, which are permitted to be utilised for medical and scientific purposes and which are included on the Latvian Schedule II of controlled narcotic substances; and psychotropic substances, and dangerous psychotropic substances which could be utilised for malicious purposes and which are included in the Latvian Schedule III of controlled narcotic substances, psychotropic substances, as well as a procedure for the stocktaking and destruction of narcotic and psychotropic medications.

Cabinet Regulation No 167 of 3 June 2007 *"Procedure for the advertising of medications and procedure whereby a pharmaceutical manufacturer may lawfully provide free samples of medication to physicians"* (issued in accordance with the law "*On Pharmaceuticals*" Section 5, clause 5, and Section 56; and the law *On Advertising* Section 7, Paragraph two). The Regulation came into force on 3 October 2007, stipulating the procedure for advertising of medications (other than veterinary medications) and the procedure whereby a pharmaceutical manufacturing enterprise may lawfully provide free drug samples to physicians.

Other

Cabinet Regulation No 915 of 18 December 2007 *"Regulations on procedure for meeting costs of testing to determine influence of concentration of alcohol, narcotic or other intoxicating substances"* (issued in accordance with the Latvian Administrative Violations Code Section 258 Part 3). The Regulation came into force on 1 January 2008. It stipulates the procedure whereby a person upon whom an administrative penalty has been imposed shall meet the cost of testing undertaken to determine the effect of the concentration of alcohol, drugs or other intoxicating substances.

Cabinet Regulation No 917 of 18 December 2007 *"Amendments to Cabinet Regulation No 625 of 23 August 2005 "Procedure for testing influence of alcohol, narcotic, psychotropic or toxic substances"* (issued in accordance with the *Medical Treatment Law* Section 60.[1] and the *Law* on

Police, Section 12, Paragraph one, Clause 17. The Regulation came into force on 1 January 2008. Regulation stipulates that: "If the concentration of alcohol in the exhaled air is 0.5 per mille or greater, the cost of such testing in the amount of LVL 11 shall be met by the person being tested." The Regulation also provides a procedure for preparation of a protocol.

On 15 March 2007 the law *"Amendments to the Road Traffic Law"* came into force. Section 28, Paragraph two has been augmented, stipulating that learning to drive a motor vehicle is prohibited if the blood alcohol concentration exceeds 0.2 per mille; or being under the influence of narcotic, psychotropic, toxic or other intoxicating substance or being under the influence of a medication likely to reduce reaction time and attention etc. The law is also supplemented with an explanation of preterm health checks for transport drivers.

1.2. Institutional framework, strategies and policies

1.2.1. Coordination arrangements

The Drug Control and Drug Addiction Restriction Coordination Council (hereinafter "Council") is the coordinating State institution whose main task is to coordinate the operations of State administration institutions, local government and non-government organisations in the controlling of the legal circulation of narcotic and psychotropic substances and their precursors, and the prevention of limitation of illegal circulation and drug addiction. The Council is also responsible for the development, implementation and evaluation of the national programme. Sittings of the Council take place twice a year. (Additional information on the composition of the Council, its functions and main tasks may be found in 2006 and 2007 National Reports).

1.2.2. National program

Currently operating in Latvia is the National Drug Programme 2005–2008. Bearing in mind that this is the final year for operation of this program, the Drug Control and Drug Addiction Restriction Coordination Council, reviewing the issue of planning the future policy for reducing drug addiction and distribution of illegal drugs, acknowledged that the next mid-term policy planning document in the area of reducing drug addiction and distribution of illegal drugs must be based on a total and all-embracing national policy, and would include evaluation of the implementation of the national programme. However, undertaking such an evaluation before the end of the existing national programme's operation would not be completely possible, and therefore its results would only be available in the summer of 2009. In view of the foregoing, the Council decided that to ensure completion of the un-implemented, uncompleted and yet to be completed tasks in the national program continues in 2009, i.e. during the time when the evaluation of the implementation of the national programme is to be conducted, and the next mid-term national policy planning document is to be prepared, it would be necessary to develop and for the Cabinet of Ministers to adopt an appropriate action plan for just one year, namely 2009.

In support of the above-mentioned, in 2008 the Cabinet of Ministers tasked the Ministry of the Interior together with the Ministry of Defence, the Ministry for Education and Science, the Ministry for Children and Family Affairs, the Ministry of Welfare, the Ministry for Regional Development and Local Government, the Ministry of Justice, the Ministry of Finance and the Ministry of Health to prepare and submit in a stipulated procedure to the Cabinet of Ministers an Action plan for the limitation and control of narcotic and psychotropic substances for the year 2009 (Minutes of the Cabinet of Ministers sitting of 30 June 2008 No.44, 36§).

1.2.3. Implementation of policies and strategies

In general the performance activity for tasks in the National Drug Programme during 2007 has improved in comparison with previous years. This is indicated not only by a commendable growth in the number of tasks completed, but also the fact that responsible institutions, in comparison with previous years, have been more active in providing funding for the relevant tasks and have managed to complete or have begun to carry out several tasks even without the allocation of additional funding from the national budget, i.e., as the result of redistribution of funding allocated for the current year.

Guided by the information provided in reports from the responsible institutions regarding tasks still in progress or which for some objective reason have been delayed, it may be concluded that these tasks have retained their relevance and they have not been diminished by developmental trends in the situation with regard to the use of narcotic and psychotropic substances and the prevalence of crime associated with that. Also pointing to this conclusion is the situation that during the operation of the program there has been no amendment or move initiated to withdraw any of the program's tasks.

It must be noted that the majority of the uncompleted tasks under the national programme are still closely related to the allocation of required funding. From all the responsible institutions these measures are only within the responsibility of the institutions subordinate to the Ministry of Justice, Ministry of the Interior, Ministry of Finance, and Ministry of Health.

At the same time it must be acknowledged that on several occasions the initial obstacle to performance of a particular task was not only the lack of allocated funding, but also the provision of a regulatory basis for both performance of the task and obtaining the relevant necessary funding appropriate to the achieving of the aim of this task, e.g., the prevention of drug use, dependence and the reduction of the related harm to health among prisoners (National Drug Programme tasks 16.1.-16.3.).

1.2.4. Evaluation of policies and strategies

All the said impediments to the implementation of the National Drug Programme, as well as other identified problems not directly predicted in the National Drug Programme, but in various publications related to the field of the National Drug Programme (research studies at the Latvian and European Union level, overviews etc) in the field of fighting the spread of illegal narcotic and

psychotropic substances and limiting the dependence on these substances point to the need to undertake serious and in-depth work on the national policies implemented to date (including the programmes of this country) and evaluation of their implementation, so that on the basis of such evaluation an appropriate policy planning document can be developed for the coming year. In addition to the said evaluation, it will also be necessary to provide real and sufficient resources of time and personnel for developing the new policy planning document, while at the same time not interrupting performance of the tasks still remaining to be completed under this programme.

It is anticipated that the said final evaluation of the national programme and development of the new national policy planning document will be undertaken under the leadership of the Council, and will be the main strategic priority for the work of the Council for the period 2008–2009, until the new National Drug Programme is adopted by the Cabinet of Ministers[1].

1.3. Budget and public expenditures

In 2007 the National Drug Programme 2005–2008 received additional supplementary funding for the implementation of activities that needed additional funding besides base expenditures for the first time in its three year history. In 2008 the National Drug Coordinator at the Ministry of Interior initiated data collection on expenditures for the activities in the National Drug Programme (NDP). All ministries and involved partner institutions were asked to state the amount of actual expenditures according to two kinds of expenses: 1) funding allocated through the budget for specific activities in the NDP and 2) funding allocated for some other tasks that are somehow related with the activities in the NDP. These expenses were reported according to two dimensions: 1) allocated supplementary funding for activities and 2) base funding.

The data was summarized according to 1) expenditures for a specific ministry (e.g. expenditures of the Ministry of Health, Ministry of Interior, etc.) and 2) expenditures for specific directions[2] as set out in the NDP.

According to data collected **7.62 million LVL** (around 10.85 million EUR) were allocated for various activities that are fully or partly[3] drug-related in 2007. Of these expenditures 3.05 million LVL (4.34 million EUR) were allocated for expenditures directly related with the activities set out in the NDP, while 4.59 million LVL (6.53 million EUR) were related with some other tasks (which are partly related with the NDP activities (more than half of these expenditures are in the drug supply field in long-term investments in equipment or surveillance systems) *(for details see Tables 1.1 and 1.2 below)*.

[1] Information prepared on the basis of the Informative Report prepared by the Ministry of Interior on implementation of the *State Program on Drug Control and Drug Addiction Restriction 2005–08* in 2007
[2] Four main directions are set out in the National Drug Programme: 1) Coordination, 2) Demand Reduction, 3) Supply Reduction, and 4) Information Analysis, which has been described in detail in previous National Reports.
[3] Partly in a sense that long-term investments in equipment according to some methodologies should not be taken into account when estimating public expenditures. This data collection did not take this consideration into acocunt.

Table 1.1. Expenditures in 2007 for various ministries involved in activities of the National Drug Programme (in LVL; 1 EUR=0.7028 LVL)

		Expenditures for specific NDP activities	Expenditures for other drug-related tasks	**Total**
Ministry of Interior	Allocated supplementary funding	0	0	**2928782.00**
	Base expenditures	179055.00	2749727.00	
Ministry of Health	Allocated supplementary funding	610532.00	0	**886814.37**
	Base expenditures	276282.37	0	
Ministry of Welfare	Allocated supplementary funding	0	0	**428878.62**
	Base expenditures	0	428878.62	
Ministry of Finance	Allocated supplementary funding	0	0	**2005951.38**
	Base expenditures	856358.38	1149593.00	
Ministry of Justice	Allocated supplementary funding	0	0	**112217.80**
	Base expenditures	10741.00	101476.80	
Ministry for Children and Family Affairs	Allocated supplementary funding	0	0	**153900.00**
	Base expenditures	0	153900.00	
Ministry of Defence	Allocated supplementary funding	0	0	**4350.00**
	Base expenditures	4350.00	0	
Ministry of Education and Science	Allocated supplementary funding	872956.04	0	**1101141.83**
	Base expenditures	224468.79	3717.00	
Total	**Allocated supplementary funding**	**1483488.04**	**0**	**7622036.00**
	Base expenditures	**1551255.54**	**4587292.42**	

Source: Ministry of Interior 2008

Table 1.2. Expenditures in 2007 according to four main directions of the National Drug Programme (in LVL; 1 EUR=0.7028 LVL)

	Allocated supplementary funding	Base expenditures	**Total**
1. Coordination	8300.00	33925.00	**42225.00**
2. Demand reduction	1414788.04	1080805.88	**2495593.92**
3. Supply reduction	0	5013026.18	**5013026.18**
4. Information analysis	60400.00	10790.90	**71190.90**
Total	**1483488.04**	**6138547.96**	**7622036.00**

Source: Ministry of Interior 2008

1.4. Social and cultural context

1.4.1. Public opinion of drug use

In Latvia, the most important factors affecting both attitude and awareness of the risk of the use of drugs is the knowledge acquired from various sources of information or by way of personal experience, as well as belonging to various socio-demographic groups (Koroleva, Goldmanis et al. 2008).

Data compiled from the National school survey (aged 13–20) on alcohol and other drugs (Koroleva, Mierina et al. 2007) indicate that the most popular illegal drug in Latvia tried by students

is cannabis. In total, 22% of young people have tried this substance during their lifetime. In the past year, 14% of students, and in the past month 5% of students, had used cannabis.

Analysis of the influencing factors in the study reveals that experimenting with and the use of various narcotic and psychotropic substances is influenced by a very broad subjective and objective range of factors. A most powerful relationship exists between experimenting with drugs and various forms of deviant behaviour and the prevalence of the use of these substances among associates. Drugs are most often tried for the first time among friends in domestic conditions or at private events. At greatest risk of experimenting with and using drugs are those young people in whose family there has been emotional violence or parental indifference, who tend to have thoughts about suicide, or have been subject to social isolation in the school environment. However, the possibility that a young person will try drugs is diminished by close relationships within the family, mutual trust, reasonable control of children by parents, the young person's self-satisfaction, as well as the selection of friends with whom free time is spent.

As evidenced by the 2008 European Commission study (Eurobarometer 2008) on the prevalence of drug use among young people aged 15–24 in EU countries[4] (also including Latvia), the majority of respondents expressed the view that use of any illegal drug creates a great risk. The young people thought that the greatest risk to health was created by the use of heroin (94%), followed by use of cocaine (87%) and use of ecstasy (66%). Regarding risks to health caused by smoking cannabis, 56% of respondents thought the risk was high, 30% said the risk was medium and 9% of respondents thought the risk was low.

However, general population survey on drug abuse prevalance (Koroleva, Goldmanis et al. 2008) indicated that regular cannabis smoking and experimenting with cocaine/crack was regarded as the most risky (in 2008, 68% and 64% of respondents respectively, in 2003, 78% and 72% respectively thought it involved great risk). 56% of respondents thought they were subjecting themselves to great risk by trying amphetamines or ecstasy on one or two occasions, (53% in 2003).

The research data indicate that awareness of the risk increases with increased age. Accordingly, young people aged 15–24 regarded the risk in use of any drug at lowest; while the 45-64 age group saw the greatest risk of use, and women regarded the risks of use of any substance as great significantly more often than men. The greatest differences regarding the question of risk were observable in relation to trying ecstasy among various age groups. Regarding this as very risky were 43% of young people aged 15–24, 59% aged 25–44, and 65% of respondents aged 45–64. The assessment of risk differs among respondents depending on whether or not the respondent has had personal experience with substance use. Those who have such experience, regard risks associated with the use of drugs as lower than those without such experience. Regular smoking of cannabis is regarded as very risky by 71% of respondents who had no experience of

[4] Additional information is available on the Internet: http://ec.europa.eu/public_opinion/flash/fl_233_en.pdf

drug use and by only 49% of respondents who have used drugs. The risks associated with the use of cocaine are rated as great by 68% and 48% of respondents respectively, but the difference in risk assessments associated with trying ecstasy is double – 60% compared to 30%. The research data confirm that those respondents who have friends with drug use experience tend to regard the risks associated with drug use as lower than those respondents who do not have friends with such experience.

The majority of the drug users in society are divided and most often regarded in two categories, as patients and as criminals (Koroleva et al. 2003; Koroleva, Goldmanis et al. 2008). Compared with the 2003 study, the 2007 data indicates that the proportion of inhabitants who regard drug addiction as a disease has reduced. So in 2003, 52% of respondents, and in 2007 38% of respondents regarded drug addicts more as patients than as criminals. However, 25% of respondents in 2003, and 31% in 2007 regarded both dimensions as equal, and only 7% in 2003 and 6% in 2007 respectively regarded drug addicts more as criminals than patients.

Significant differences are observable between respondents who themselves have experience of drug use and those who do not. Those who have at least on one occasion tried drugs significantly more often consider a drug addict to be neither a patient nor a criminal; however, those who have never used drugs tend more often to regard a drug addict as both a criminal and as a patient. Young adults (aged 15-34) more often regard drug addicts as patients (42%); however, older respondents (aged 55–64) significantly more often regard drug addicts as criminals (10%). Youth under age of 24 do not regard the drug addict either as a patient or as a criminal, which indicates a definite attitude and possible lack of knowledge in relation to the expression "drug addict" and the possible consequences of drug use (Koroleva, Goldmanis et al. 2008).

Evaluating their own knowledge level of the consequences of drug use, 32% of respondents regarded them as very well informed, 35% as informed but would wish to know more. 22% of respondents regarded themselves as insufficiently informed. Compared with 2003 (5%), the number of respondents had more than doubled in 2007 (11%), who regarded themselves as very badly informed. It may be concluded from the research data that seeing themselves as "well-informed" respondents were those who had during their lifetime themselves tried or used drugs, and with increasing age, there is a corresponding increase in that proportion of respondents, who regard themselves as badly or very badly informed (Koroleva, Goldmanis et al. 2008). This is explainable by the fact that information in the mass communications media, in the form of purposeful campaigns, specially organised events and promotions, are all directed specifically towards the audience of young people rather than towards the older generation, who are not regarded as a drug use risk group.

Similarly to 2003, the 2007 study indicate that the greatest support in society to the resolution of problems created by drug use is obtained by a repressive approach: various forms of punishment and enforced treatment. The greatest proportion of inhabitants (83%) considers that

drug use is a criminally punishable activity, 68% of respondents are of the view that harsher penalties would deter drug use, 75% support the idea of applying enforced treatment to a drug addicted person, 66% said it was necessary to increase the numbers of treatment and rehabilitation institutions, and 82% of respondents support the idea that while checking drivers' blood alcohol levels, it is also necessary to conduct checks for the presence of drugs in their biological environments.

Overall study data indicate that the main factors which influence opinions and attitude towards both drug uses in society and possible risks, as well as measures to restrict the prevalence of drugs, are age and personal experience in the use of drugs. A more liberal attitude towards drug use in general is characteristic of young people, and they support measures directed towards treatment and assistance to a much greater extent compared to respondents in the 45-64 year age group (Koroleva, Goldmanis et al. 2008).

2. Drug Use in the General Population and specific sub-groups

This chapter discusses results from three studies that were conducted in 2007: 1) general population (aged 15–64) survey on drug abuse prevalence, 2) national school survey (aged 13-20) on alcohol and other drugs that was carried out at the same time with fourth wave of the ESPAD (European School Survey on Alcohol and other Drugs) study, and 3) drug use in recreational places in three cities in Latvia.

Additionally, in 2008 two studies on drug use in the population were conducted: 1) drug use among risk youth in children's homes and boarding schools and 2) second wave of the ECAD (European Cities against Drugs) study "Youth in Europe", which was conducted also in several other regions besides Riga (as compared with 2006 survey). Since analysis for these studies is underway they will be reported in the next National Report.

2.1. Drug Use in the general population

In 2007 the second general population survey (GPS) on addictive substance use was carried out. The study was carried out by the Institute of Sociological Research by the same research team headed by Ilze Koroļeva, as in 2003. The methodology was comparable with that employed during the first GPS in 2003. The net sample size was 4500 aged 15–64, which allows for 1.5 per cent sampling error for all estimates from the whole population, while for all illegal substances – not more than 1.1 per cent. As in 2003, the youngest age groups (15–24) were oversampled. As disproportional sampling strategy was employed, datafile had to be weighted according to age groups, regional distribution and based on inclusion probabilities. Deatiled description of the study is described in the report in Latvian (Koroleva, Goldmanis et al. 2008).

The questionnaire used was based on the EMCDDA developed European Model Questionnaire (EMQ), while the alcohol questions were replaced by several alcohol comsumption measures (Quantity Frequency (QF) and Graduated Frequency (GF)) employed in population surveys worldwide. Additionally, self reported health measures by using the questions provided by the QualityMetric SF-36 v2 were included. The 2007 GPS also included several of the EMCDDA-developed availability module questions, which are discussed in Chapter 10.

Overall, the survey functioned well and results are comparable with those reported in 2003.

According to the data lifetime prevalence for any illegal drugs[5] has increased as compared with the results of 2003 study; in 2007 16.1% (95% CI 15.0–17.2%) of population aged 15–64 reported lifetime use, while 2003 data reveal 12.3% (95% CI 11.3–13.3%) lifetime prevalence. By extrapolating the figures to the general population aged 15–64 (1.5 million), somewhere between 231 and 264 thousand inhabitants have tried any illegal drugs during their lifetime, while 81–102 thousand people have used drugs during the last year.

[5] Any illegal drugs include cannabis, ecstasy, amphetamines, cocaine, heroin or other opioids, and LSD or other hallucinogens.

Drugs have been tried more often by young adults (aged 15–34) and males as compared with older members of population (35–64) or females *(see Table 2.1 below and Standard Table (ST01) on General Population Surveys reported through Fonte)*. Among young adults around every fourth (27.9%) report lifetime use; among males it is two times higher (37.5%) as compared with females (18.1%). Within gender and age groups the highest lifetime prevalence is reported among 15–24–year-old males (41.5%) and 15–24 year old females (19.8%) *(for detailed comparisons see ST01)*.

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

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

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

Cannabis

Most frequently mentioned drug that has been tried by 12.1% inhabitants aged 15–64 is cannabis. Although a small increase as compared with 2003 data can be observed (12.1 and 10.6 per cent, respectively), the confidence intervals of 2003 and 2007 data overlap, which suggests that either cannabis LTP has slightly increased or remained stable as compared with the situation four years ago. About 4.9% percent of the population have used cannabis recently (during the last 12 months), while 1.8% – currently (reporting last 30 days prevalence) *(see Table 2.2)*. Younger respondents (15–34) have tried cannabis significantly more often than older respondents (35–64) (21.7 and 4.6 per cent, respectively).

Table 2.2. Cannabis lifetime (LTP), last year (LYP) and last month (LMP) prevalence in 2003 and 2007 surveys (%)

	LTP	LYP	LMP
15–64			
2007	12.1	4.9	1.8
2003	10.6	3.8	1.8
15-34			
2007	21.7	9.7	3.7
2003	19.6	8.1	3.7
35-64			
2007	4.6	1.1	0.2
2003	4.1	0.7	0.4
Males			
2007	17.2	7.3	3.0
2003	17.6	6.4	3.1
Females			
2007	7.3	2.6	0.7
2003	5.1	1.8	0.8

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

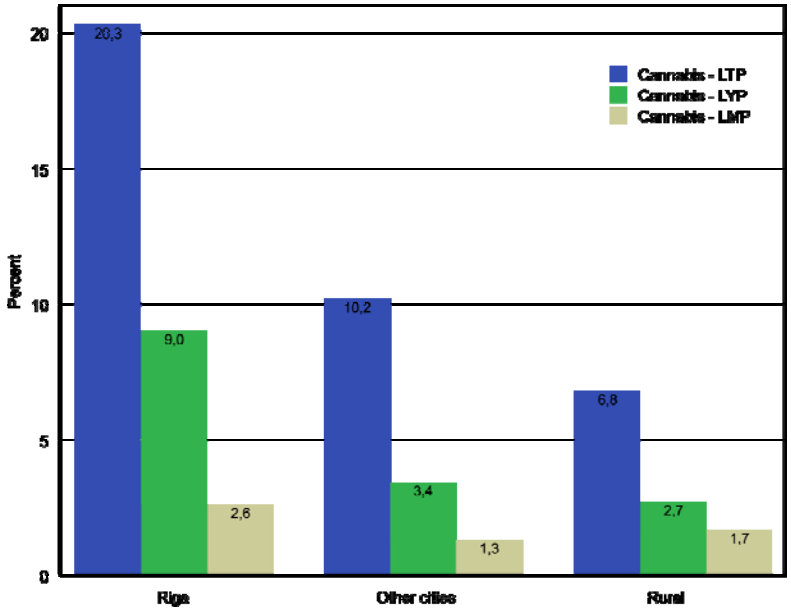
Cannabis is more used among those who live in capital city or other urban areas than those who live in the countryside. According to the level urbanization cannabis has been tried by 20.3% of those living in capital Riga, by 10.2% of those living in other cities, and by only 6.8% of those living in the rural areas *(see Figure 2.1)*. According to the level of urbanization, gender and age:

almost every other (49%) 15–24 year old male living in Riga has tried cannabis,

very fourth (27%) female aged 15–24 living in Riga has tried cannabis,

during last 12 months every fourth (27%) 15–24 year old male and every eight female (13%) living in Riga has tried cannabis (for comparison 15 and 10 percent males and 4 and 3 percent females living in other cities or rural areas have used cannabis during last 12 months).

Figure 2.1. Cannabis lifetime, last year and last month prevalence according to level of urbanization (%)



Source: Koroleva, Goldmanis et al. 2008

Other drugs

After cannabis, the next more prevalent illegal substances are ecstasy and amphetamines followed by cocaine *(see Table 2.3)*. Because of relatively low levels last year or last month use of other drugs, here only lifetime prevalences will be discussed. Detailed figures on last year and last month use by gender and age groups are shown in ST01 in Fonte.

Table 2.3. Lifetime prevalence of various illegal substances by age and gender (%)

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

Source: Koroleva, Goldmanis et al. 2008

Ecstasy

In 2007 the second most prevalent substance after cannabis was ecstasy that has been tried by almost every twentieth inhabitant (4.7%); which is a statistically significant increase as compared with 2003 results where 2.4% had reported lifetime ecstasy use. As with cannabis, also ecstasy is used more often by younger population, by males and by those living in more urban areas of the country:

the highest ecstasy lifetime prevalence is observed among 15–24–year-olds – 13.4% males and 4.8% females as compared with 1.0% males and 0.4% females aged 55–64 have tried ecstasy,

those living in Riga (6.5%) have tried ecstasy more often than those living in other cities (5.2%) or rural areas (2.6%).

Among those who have ever tried ecstasy[6] every fifth (18%) have done it recently (less than a year ago), 17% – 2–3 years ago, while about two thirds (65%) have tried ecstasy for the first time more than four years ago.

Amphetamines

The third prevalent drug in Latvia in 2007 was amphetamines; lifetime prevalence rate in 2007 GPS was 3.3% of population aged 15–64. The profile of amphetamine lifetime users is very similar to that of ecstasy users – those in the youngest age group, males and those living in urban areas are reporting higher lifetime prevalance rates *(see ST01)*.

[6] Only valid answers on age of first use of ecstasy are analysed here; 22% of lifetime users did not reveal age when they tried ecstasy.

Similarly as with ecstasy users, about every fifth (19%) amphetamine user[7] had tried the drug within the last year, 18% – 2–3 years ago, while the majority have tried amphetamines more than four years ago.

Cocaine

Lifetime prevalence rate in 2007 for cocaine has increased as compared with 2003 survey. In 2007 2.3% (95% CI 1.8–2.8%) have reported lifetime use of cocaine, while 2003 survey data suggest that the rate was almost two times smaller – 1.2% (95% CI 0.8–1.6%). Similarly, as observed with cannabis, ecstasy or amphetamines, proportion of those who have tried the drug, is higher among youngest age group (15–24) and males. As compared with lifetime users of cannabis, ecstasy or amphetamines, for cocaine the lifetime use is at the same level between 15–24–year old population and 25–34–year-olds, suggesting that not only teenagers have experience with drugs, but also those in their professional carreer.

2.2. Drug use in the youth population

This subchapter will analyze key trends in drug use form the National School Survey on Alcohol and other Drugs (LaSPAD), which was carried out at the same time as ESPAD 2007 study. As compared with the ESPAD 2007 study where the target group was those born in 1991 (15–16 year olds), the national school survey is realized in a national representative sample of 13–20-year-olds (Grades 7–12 in general education and Course 1–3 in vocational education). As compared with 2003 study, which included also those aged 11–12 (a special shorter version of the questionnaire was developed for this age group), in 2007 study this age group was excluded from the sampling frame due to financial constraints and because of very low levels of drug use as seen in 2003 study.

Because of changes in the ESPAD questionnaire that were implemented in 2007, extra caution needs to be taken when comparing results with previous years' data but these changes are mostly related with alcohol questions.

The results from the national school survey have been published in Latvian and data by age groups were reported in ST02 in Fonte in 2008.

2.2.1. Results from the LaSPAD 2007 study

Key results

Cannabis

22% of students aged 13-20 have used cannabis at least once in their lifetimes, and 11% have done so more than twice. 14% have used cannabis during the last year, and 5% have done so during the last month. Statistically significant differences ($p<0.001$) were observed by gender –

[7] Only valid answers on age of first use of amphetamines are analysed here; 26% of lifetime users did not reveal age when they tried amphetamines.

boys were more likely to report lifetime (29%), last year (19%) or last month (7%) cannabis use than girls were (LTP – 16%, LYP – 9% and LMP – 2% ,respectively) *(see Table 2.4.)*.

Table 2.4. Frequency of lifetime, last year and last month cannabis use by gender among 13–20–year-olds(%)

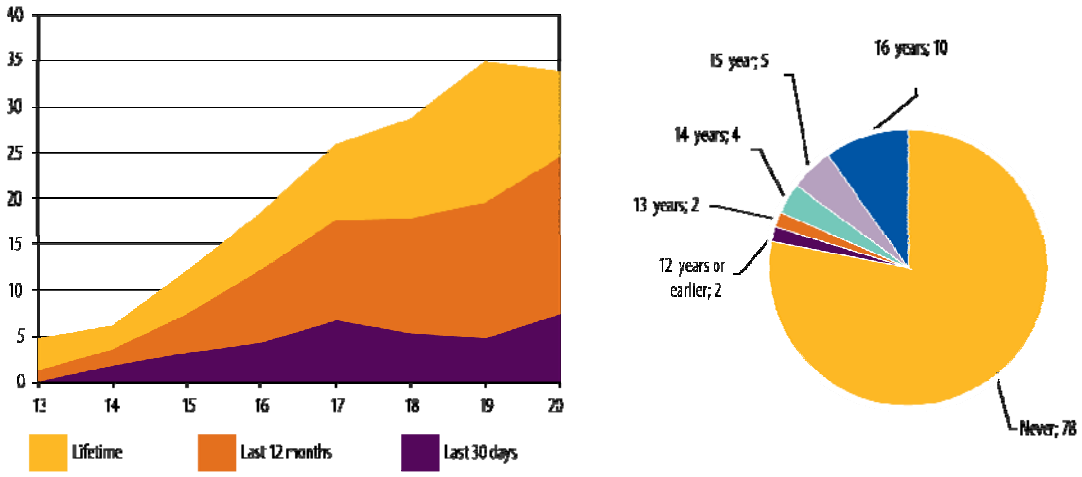
		Never	1–2 times	3–5 times	6+ times
Lifetime	Boys	71	12	6	10
	Girls	84	9	4	3
Last 12 months	Boys	81	10	3	5
	Girls	91	6	2	2
Last 30 days	Boys	93	3	2	2
	Girls	98	2	1	0

Source: Koroleva, Mierina et al. 2007

Lifetime, last year or last month prevalence rates for cannabis among girls were smaller than those observed among boys in all age groups *(see ST02 in Fonte)*.

While only 6% of students have tried cannabis before the age of 14, cannabis use prevalence increases quickly after reaching this age: between the ages of 14 and 19, the fraction of students who have used cannabis increases by 6% per year. By the age of 19, more than one third of all students have tried cannabis *(see Figure 2.2.)*.

Figure 2.2. Cannabis prevalence rates and age of first use (%)



Source: Koroleva, Mierina et al. 2007

Overall, 45% of students report to have had a chance to try cannabis; one half of those have tried the drug, while the other half have refused. Students in Russian-language schools are more likely to have been offered cannabis than are students in Latvian-language schools (52% versus 43%). Consequently, the fraction of students who have tried the drug is also larger among students in Russian schools.

The likelihood to have tried cannabis increases with the level of urbanization *(see Table 2.5.)*. The easy availability of this drug is one of the reasons why cannabis use prevalence is higher among students in larger cities, particularly in Riga.

Table 2.5. Cannabis lifetime, last year and last month prevalence according to level of urbanization among 13–20–year-olds (%)

		Never	1–2 times	3+ times
Lifetime	Riga	71	13	16
	Major cities	75	12	13
	Regional centres	79	10	11
	Other cities	84	8	8
	Rural	86	8	6
Last 12 months	Riga	82	10	8
	Major cities	85	8	7
	Regional centres	86	9	5
	Other cities	89	7	4
	Rural	93	4	3
Last 30 days	Riga	94	3	2
	Major cities	94	3	3
	Regional centres	96	2	1
	Other cities	96	2	2
	Rural	97	1	1

Source: Koroleva, Mierina et al. 2007

Other substances

Cannabis is undoubtedly the most widespread illicit substance among students, but several other substances are also used by substantial numbers of youths. 7% of students have tried amphetamines or ecstasy; 4% have experimented with LSD or other hallucinogens; 4% have taken tranquilizers or sedatives (without a doctor's prescription), and 3% have used magic mushrooms *(see Table 2.6. and prevalence rates by gender and age groups in ST02 in Fonte)*.

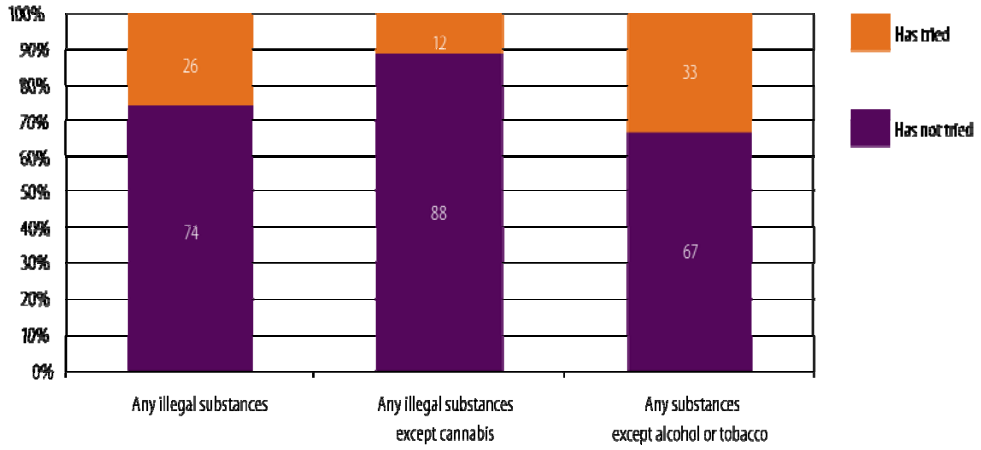
Table 2.6. Lifetime use of various substances among 13–20–year-olds (%)

	Never	1–2 times	3–5 times	6+ times
Tranquilizers or sedative without prescription	95,6	2,8	0,7	0,9
Amphetamines	93,4	3,5	1,2	1,9
Ecstasy	92,5	4,2	1,2	2,1
LSD or other hallucinogens	95,8	2,7	0,6	0,9
Crack	98,3	0,9	0,3	0,4
Cocaine	97,7	1,3	0,3	0,7
Heroin	98,4	0,8	0,3	0,5
„Magic" mushrooms	97,4	1,6	0,4	0,6
GHB	99,0	0,5	0,2	0,4
Anabolic steroids	98,4	0,7	0,3	0,6
Drugs by injection	98,6	0,5	0,3	0,6
Alcohol with pills	90,1	6,8	1,5	1,7
Inhalants	88,0	7,8	1,7	2,5

Source: Koroleva, Mierina et al. 2007

In total 33% of students aged 13–20 have used cannabis or any of the substances mentioned in Table 3, 26% have tried any illegal substances, while 12% have used any illegal substances except cannabis *(see Figure 2.3.)*.

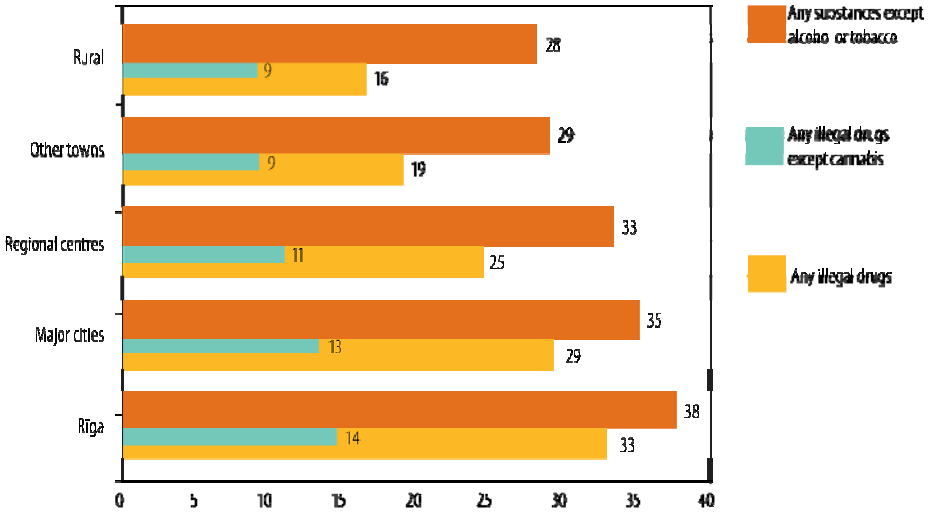
Figure 2.3. Lifetime use of any substances among 13–20–year-olds (%)



Source: Koroleva, Mierina et al. 2007

The types of substances used differ by the size of the community in which students live. Figure 2.4 shows any substance use by level of urbanization. Amphetamines and ecstasy have been tried by significantly higher proportions of residents of Riga (10%) and other large cities (9%) than by other students. On the other hand, small-town and rural residents are more likely than city dwellers to have used inhalants, mostly by sniffing glue. Inhalant use is significantly more prevalent among younger than among older students: the percentage of students reporting to have tried intoxicating themselves in this manner decreases from 14% among 13-to-16-year-olds to 12% among 17-to-18-year-olds, to 9% among 19-to-20-year-olds. The high prevalence of inhalant use in the younger cohorts is responsible for the relatively high overall prevalence of legal drug use among these students. This suggests that future preventive programs and research projects should pay close attention not only to illicit substances, such as amphetamines or LSD, but also to various unorthodox means of intoxication, such as tranquillizers, alcohol plus pills, and inhalants. Ignoring these substances could lead to underestimation of the prevalence of addictive substance use outside of big cities and among younger age groups.

Figure 2.4. Lifetime use of any substances among 13–20–year-olds by level of urbanization (%)



Source: Koroleva, Mierina et al. 2007

Factors influencing drug use.

Exploratory factor analysis and logistic regression analysis were used to identify psychological and environmental factors associated with increased risk of illicit substance use (Koroleva, Mierina et al. 2008). The following risk factors influencing drug use were identified:

- General propensity for deviant behavior:
    - History of criminal activity, such as theft or intentional damage to school property
    - History of using physical violence and being involved in fights
- Suicidal tendencies:
    - Own propensity for suicidal thoughts or history of attempted suicide
    - History of suicide attempts and suicides by relatives or friends
- Tolerating attitude of parents toward the use of addictive substances:
    - Actual parental tolerance toward excessive drinking by their children
    - Expected parental tolerance (as assessed by the children) toward the use of cannabis or ecstasy, as well as toward getting drunk
    - Parents who lack information on and/or are not interested in their children's free time activities
- History of emotional trauma, such as a serious conflict with parents, a break-up with one's romantic partner, or the death of a friend
- Dissatisfaction with life, oneself, one's health, one's relations with peers, or with the family's financial situation
- Social isolation or social discomfort at school: poor or no communication with peers, conflicts with classmates, ridicule by classmates, etc.

2.3. Drug Use among specific groups

2.3.1. Drug use in recreational settings

In 2007 a study on drug use in recreational places was carried by the Institute of Sociological Research. The methodology employed included several data collection methods: 1) analysis of legislation documents, 2) expert interviews with management of recreational places, prevention specialists, and police, 3) quantitative study in three cities in Latvia – Riga (n=420), Liepāja (n=80), Daugavpils (n=100) and 4) a group discussion with youth for development of recommendations was carried out. Based on the results of expert interviews, legislation document analysis and quantitative study recommendations for prevention activities as well as for policy improvements were developed. This chapter will look at the data collected in the quantitative part of the study.

2.3.1.4. Key findings from the quantitative study

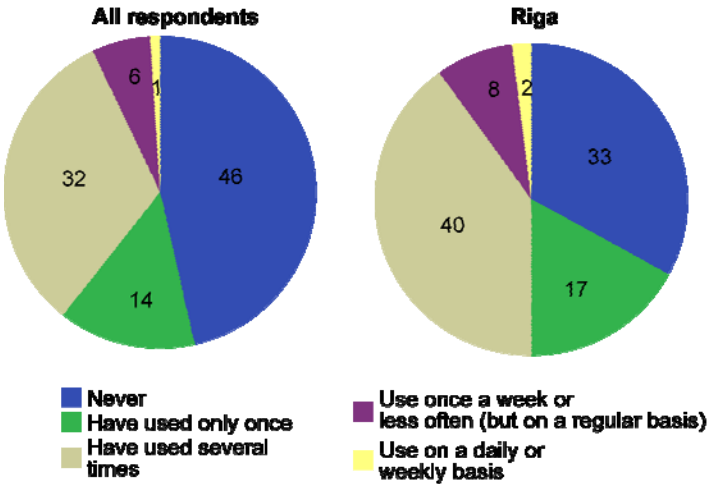
The net sample size was 600 respondents in Riga (n=420), second biggest city Daugavpils (n=100) and third biggest city Liepaja (n=80). In each of the participating cities based on available data s list of recreational places was drawn that was stratified by type and size. The survey was carried out in 29 places, which differed by its size and type (those with three floors playing different music and smaller bar-type settings with a dance floor). The realized sampling strategy gives an insight on use of various substances in recreational places but does not allow generalizing these findings to the youth population.

According to the interviews, the mean age of respondents was 21.5 years (mode 19 years); the proportion of those under 18 was around 6 per cent. Among respondents 53% were males; slightly less than one-half (43%) had secondary level of education, 37% had higher or uncomplete higher education; about one-third of youth were had a full-time enmployment (and were not studying at the same time), about one-third were employed and studying at the same time, while 28% were only studying; majority (77%) of respondents lived with their parents.

According to respondents, drug use among youth in Latvia is rather prevalent – 27% would estimate it as very prevalent and 54% as rather prevalent, while only 18% would estimate it as not prevalent. The perception of drug use among one's friends or acquaintances was at higher level as compared with that in general population – 32% would estimate that none of their friends take drugs, 44% – some of friends take drugs, for 19% about a half of friends take drugs, while for 5% majority of friends take drugs. Tjose aged over 24 would estimate drug use as very prevalent among youth more often as those aged less than 20 or aged 20–23 (39%, 23% and 24%, respectively).

Lifetime any illegal drug use experience was mentioned by 54% of respondents, while among respondents in Riga it was higher (67%) *(see Figure 2.5)*. Males more often than females admitted than they have used drugs at least once (63% and 43%, respectively).

Figure 2.5. Prevalence of any illegal drugs (%)



Source: Koroleva, Kārkliņa et al. 2008

The most prevalent drug used among respondents is cannabis, which was mentioned by 41% (lifetime prevalence). The next "popular" drugs that had been used at least once by respondents were amphetamines (20%), ecstasy (15%) and cocaine (9%). Lifetime, last year and last month drug prevalence rates are shown in Table 2.7.

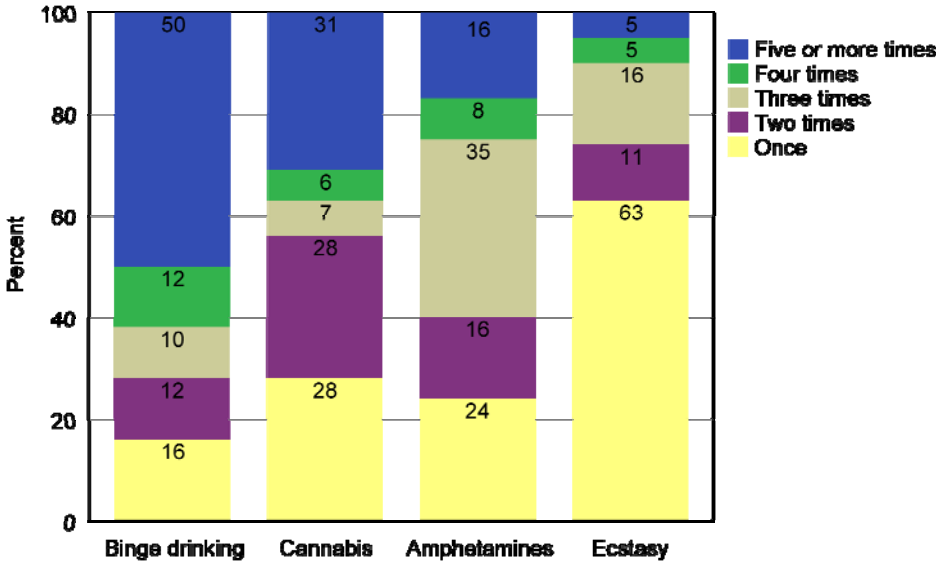
Table 2.7. Lifetime, last year and last month use of various substances among respondents in recreational palces (%)

	Lifetime	Last year	Last month
Binge drinking (5+ drinks in a setting)	53	47	41
Cannabis	41	24	12
Amphetamines	20	13	8
Ecstasy	15	10	4
Cocaine	9	5	2
Alcohol with pills	7	3	1
„Magic" mushrooms	6	3	1
LSD	6	2	1
More than one illegal substance at a time	3	1	1
Other substances	3	1	1
Heroin	2	1	0
Inhalants	1	1	0
Ketamine	1	0	0
Crack	1	0	0

Source: Koroleva, Kārkliņa et al. 2008

The study reveals that 56% cannabis last month users had used cannabis only once or twice during the last 30 days, while 31% had used it five or more times. The study also suggests that use of amphetamines is more prevalent as ecstasy use *(see Figure 2.6)*.

Figure 2.6. Frequency of last month drug use for most often substances (%)

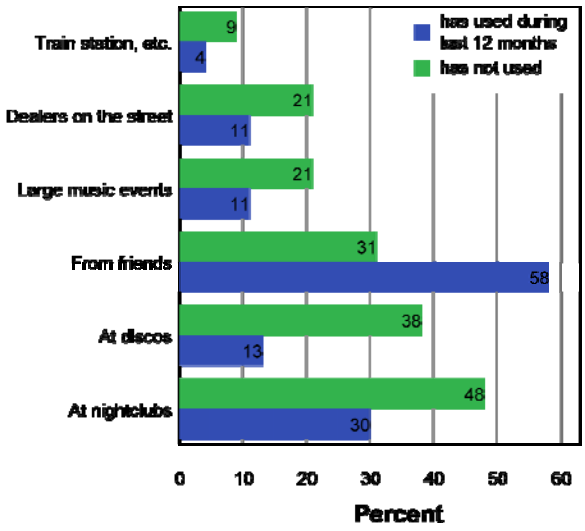


Source: Koroleva, Kārkliņa et al. 2008

Interestingly that perception of places where drugs can be bought according to whether one has used drugs during last 12 months or not. Those with drug use experience would mention that drugs can be bought easily from friends about two times often than those without drug use experience in the last 12 months; while those with no drug experience during last 12 months would more often mention recreational settings or some other places *(see Figure 2.7)*. It is an interesting

observation a further research in this topic would be needed, as the perception for those who are not using drugs themselves is completely different as for those who “are actually in the field”.

Figure 2.7. Perception of places where drugs can be easily bought (%)



Source: Koroleva, Kārkliņa et al. 2008

3. Prevention

The *State Program on Drug Control and Drug Addiction Restriction 2005–08* proposes to ensure development of a long-term prevention program directed towards various target groups. The main emphasis of the newly developed short term drug action plan for 2009 in the area of prevention is on universal prevention with the aim of reducing the commencement of use of narcotic substances among children and adolescents. Also similarly in the State program "State program for improving the situation of children and families in 2007", the main activities in the area of dependence propose improving the qualifications of teachers, training of specialists in various fields, as well as informing the whole of society about the consequences of drug use.

At the moment there are several institutions in Latvia undertaking prevention activities in the area of dependency inducing substances, however, 1) for the most part they are focused on the capital city Riga or sometimes Riga region, 2) the majority of activities are of the campaign type, and 3) often activities in the field of dependence are integrated into broader health promotion activities. Likewise in Latvia prevention activities continued to not be developed for certain target groups based on data obtained from research. In Latvia's regional areas implementation of selective prevention is generally weak, and a unified approach to the implementation of universal and selective prevention activities is lacking, and only in rare cases is evaluation undertaken of the effectiveness of prevention intervention, and for the most part this is explained by a lack of funding and capacity.

3.1. Universal prevention

The major prevention measures in Latvia are for the most part directed towards the target group of young people. Regarded as the major risk group in terms of drug use are children and adolescents aged 9–17, which accordingly is also the main target group for universal prevention interventions in the State. The majority of universal prevention activities are focused on the capital city Riga; they are campaign-like or short term, informative-type activities. Furthermore, efficiency evaluations of universal prevention measures are rarely undertaken in Latvia.

The Ministry of Education and Science Centre for Curriculum Development and Examinations (hereinafter ISEC) is the institution in Latvia responsible for development of the curriculum for primary education and general secondary education. Issues related to health, including addictions, are included in several curriculum standards at the primary and general secondary levels of education. To raise the level of professionalism for teachers involved in health education, in 2007 ISEC organised educational seminars on psychoactive substances, their effect on health, and the negative consequences of their use (official information provided by the Republic of Latvia Ministry of Education and Science Centre for Curriculum Development and Examinations).

In addition, various educational seminars are regularly held throughout the country on the theme of dependence, which are organised not only by state and local government institutions, but also various non-governmental organisations and associations. For the most part, the target group of these activities is young people, their parents and teachers. For example, in 2007 the Public Health Agency organised six seminars on the prevention of drug use for members of parents' support groups and youth support groups. A seminar was organised for school nurses entitled "Recognizing Drug Use among School Pupils and Subsequent Action". Methodological recommendations were developed during the seminar "About the Precocious Child- Identifying Drug Use in Schools".

The Riga Addiction Prevention Centre, is the largest institution in the State to undertake prevention in the area of psychoactive substances, however, its operations for the most part only include Riga and the Riga region, in 2007 continued to organise lectures on dependency prevention issues for school pupils and teachers, parents, students, police and medical staff in schools in the city of Riga. Such lectures were also organised as a paid service for various specialists in other Latvian regions, pupils of schools in other Latvian cities and in a primary boarding school. Similarly in 2007, for methodologically trained specialists (teachers, social workers, social teachers, psychologists, educators from children's homes etc) for work with training programs developed by the Riga Addiction Prevention Centre .

The association "Esi brivs!" [Be free!] which is funded by the gambling industry organised informative and interactive training seminars in 2007 for school pupils and lectures for parents with participation by professional psychologists on reasons for dependency occurring, its consequences, types and signs of dependency, and opportunities of receiving assistance.

The Latvian National Armed Forces (hereafter "NAF") in cooperation with the international temperance club "AVANTE" in 2007 in the training command infantry School, the naval forces training centre, the NAF Headquarters Battalion and Supply Command 3 Regional Supply Centre organised 20 one-day lecture cycles and film screenings on the theme "Dependency Forming Substances and the Dangers of their Use, Possibilities of Prevention". (Official information provided by the Republic of Latvia National Armed Forces).

Based on the program "State program for improving the situation of children and families in 2007", the Ministry for Children and Family Affairs (hereafter BĢLM) implemented an informative campaign entitled "Tāds tu draugiem nebūsi vajadzīgs!" ["Your friends won't want you like that"] on the effects and consequences of addictive substances. As part of this campaign, four video clips were developed on addiction to computers, alcohol, nicotine and drugs, their influence, and the negative effects. The clips were broadcast in December 2007 on several television channels over a two-week period. At the same time materials on addiction prevention were published in several national and regional mass communications media.

In 2007, with collaboration between the Ministry of Education and Science, the Ministry of Health, and the Public Health Agency, amendments were developed to Cabinet regulation No 279 "Procedure for Ensuring Educational Preventive Health Care and Access to First Aid in Educational Institutions", which provide that the head of an educational institution is obliged to organise the development of a plan to limit the use of smoking, alcoholic beverages and other intoxicating substances (official information provided by the Republic of Latvia Ministry for Children and Family Affairs).

In several Latvian city municipalities a restriction in respect of drugs plan has been developed and adopted: since 2001 in Jurmala City the "The Alcohol and Drug Addiction Prevention Programme" has been operating; in 2007 in Jelgava the "Dependency Preventive Measures Plan 2008-2010" was developed and adopted, and in Tukums the "Programme for restricting and preventing the use of dependency inducing substances 2008-2010" was adopted. The main aim of these programmes is, by collaboration between various state and local government institutions, to ascertain and control the situation with regard to the supply and demand of dependency inducing substances, and to provide prevention activities which are related to the popularisation of a healthy lifestyle (Official information provided by the City Councils of Jurmala, Jelgava and Tukums).

The training and informative materials issued as part of universal prevention provide essential information on dependency issues to staff of state and local governmental institutions, public organisations, and all inhabitants.

3.2 Selective prevention

In comparison with universal prevention, in 2007 fewer selective prevention activities were undertaken in Latvia, and for the most part, these involved Riga and the Riga region. There was an observable trend that municipalities which had previously operated in the area of selective prevention, continue to do so at present. It was almost impossible to find activities directly aimed at addiction prevention; for the most part they are activities which are an alternative to beginning the use of addictive substances. The active involvement of new municipalities in the implementation of selective prevention measures has not been observed in Latvia to date; this is explained by a lack of funding and capacity. Similarly explained is the lack of evaluation of the effectiveness of prevention interventions, which continue to be a rare phenomenon in the state.

In 2007 the RAPC continued the project begun in 2006 entitled „Reintegration of adolescents with social behaviour deviations and addiction problems into society”. The project target group was adolescents aged 15–18, with social behavioral deviations, who has one of dependence problems and for whom court or administrative commission applied educational character measure of compulsion: determination of behavioral restriction, with obligation to participate in social correction programme. The aim of the project was to change the behaviour of

the adolescents and their attitude, and promoting a drug-free choice of lifestyle. A day centre was established as part of this project, with the basic aim of working with children, ascertaining their needs, interesting them in cooperating, thereby endeavouring to motivate them to return to school. In 2007 a total of 141 adolescents were addressed; 33 juveniles became permanent clients of the day centre. In 66 cases discussions took place with the clients' parents or guardians. Day centre staff conducted 10 group activities for 94 juveniles, and undertook the practical and theoretical camp leadership training of four forest camp instructors. An evaluation of this project has been undertaken and has been forwarded for placement in the EDRRA database. (Official information provided by RAPC).

In 2007 project was implemented with the aid of EU cofinancing entitled "Step-By-Step". The aim of this project was to motivate members of socially excluded risk groups via various activities, working simultaneously with both the families and the juveniles, becoming involved in the job market, thereby reducing the development of social rejection and the creation of other social problems. In Tukums a young people's social centre continues to operate, which is a sub unit of the family support division, and its aim is to organise suitable use of young people's free time and to promote the prevention of lawbreaking by juveniles within the municipality (official information provided by the city of Tukums Council Social Department).

Under the auspices of the Valmiera City Youth Centre *Vinda* a "help bureau" has been operating since 2001, in which work is performed in the area of social correction with youths under police supervision. In 2007 work continued with children and young people's social risk group integration interest groups and the psychological support group was formed for juveniles and their parents. (official information provided by the Valmiera municipality).

In the city of Ventspils in 2007 the Children's and Youth Support Centre "Nāc līdzi" [come along] provided social and pedagogic persistence to children of "social risk" families, and organised informative-educational events incorporating themes about dependence and a healthy lifestyle.

3.3. Indicated prevention

No new information available.

4. Problem Drug Use and Treatment Demand population

In this section, information is provided on two (of five) EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) main indicators i.e. Problem Drug Use (PDU)[8] and Treatment Demand Indicators (TDI)[9] – problems associated with its introduction and quality of data, together with information regarding problem drug users in terms of research data and in accordance with information available from other data sources.

Comparing treatment indicator data with the situation before 2002, changes to legislation should also be borne in mind, which since 2002 provide that it is possible not to report on patients older than 18 and who have not been diagnosed with a dependency.

4.1. Prevalence and incidence estimates of PDU

Information aPsycquired during the cohort study regarding respondents who have been treated to drug-related problems or who have been tested to drugs can possibly be utilised in estimating the number of drug users utilising the multiplier method. When interpreting the results obtained using the multiplier method, in addition to the fact that respondents have been truthful in their responses regarding treatment or being tested for drugs, it must be accepted that firstly, the treated patient database includes all treated drug users in the whole territory of Latvia, and secondly, the drug testing database includes all positive results in the whole territory of Latvia. However, as indicated by a quality check of data from previous years, neither the first, nor the second, statement corresponds to the real situation, and this must be borne in mind when interpreting these results.

Utilised as the multiplier in the treatment of data is the variable in respondents' treatment during the previous year, or 17% of respondents. The National Report for 2007 (Latvian National Focal Point, 2007) notes that during 2006, no less than 1078 people were treated in addiction treatment institutions in Latvia (443 first-time patients in outpatient institutions and 635 unique patients as inpatients), from whom 733 were intravenous users (55% outpatients and 77% treated respectively), and 815 problem drug users (respectively 68% of outpatients and 81% treated as inpatients).

In accordance with the treatment multiplier, it is estimated that in 2006 in Latvia there had been 4311 intravenous drug users and 4794 problem drug users.

By taking into account that the treated number of patients, for whom information information is not provided to the central database is more than 50%, the number of injecting drug users is not less than 8622, while the number of problem drug users is not less than 9588.

[8] PDU – Problem Drug Use
[9] TDI – Treatment Demand Indicator

Utilised as the multiplier in relation to drug test data is the variable of respondents' were tested or that the fact of drug use was revealed for 21% of respondents. In 2006, positive results were returned from drug tests at the Riga Centre of Psychiatry and Addiction Disorders for 1598 people from whom 999 may be regarded as problem users (biological samples revealed traces of opioids, amphetamines, cocaine, or ephedrine). As the drug testing database includes drug users "captured" mainly from only Riga and its environs, then it would be incorrect to state that this information is applicable to Latvia as a whole. Using this method, the estimated number of problem drug users in Riga is 4757.

4.2. Treatment Demand Indicator

In Latvia there is a strictly delineated boundary between those who fit the SSK–10 criteria on dependence syndrome, abstinence syndrome, abstinence syndrome (with or without delirium), psychotic disturbances, amnesiac syndrome or other psychic and behavioural disturbances (ICD–10 diagnosis F11–F19 categories 2–9), and those who fit the criteria of acute intoxication or excessive substance use (ICD–10 diagnosis F11–F19 0–1 category), which are caused by use of any illegal drug whatsoever. Accordingly, Treatment Demand Indicator data for the most part reflect the prevalence of addiction problems throughout the country, although, to a large extent, the information regarding treatment of the drug problem is incomplete.

All over this chapter two approaches in treatment data analysis are employed: 1) based on ICD-10 diagnosis and 2) based on TDI definition. When interpreting the results, it should be taken into account that a substantial proportion of clients at out-patient treatment centres are not reported (for details see 2005 and 2006 National Reports), and sometimes it is not clear whether changes in the number of treatment clients are related with actual changes or with improvements in registration.

In 2007 and 2008 TDI data was used in two cohort studies: 1) mortality cohort study (which is reported in chapter on drug-related deaths) and 2) a record-linkage study by linking TDI data with data in newborn's registry. For the latter the analysis is still udnergoing and will be reported in the next National Report.

In the following subsections, information is provided on treatment of patients in inpatient and outpatient institutions.

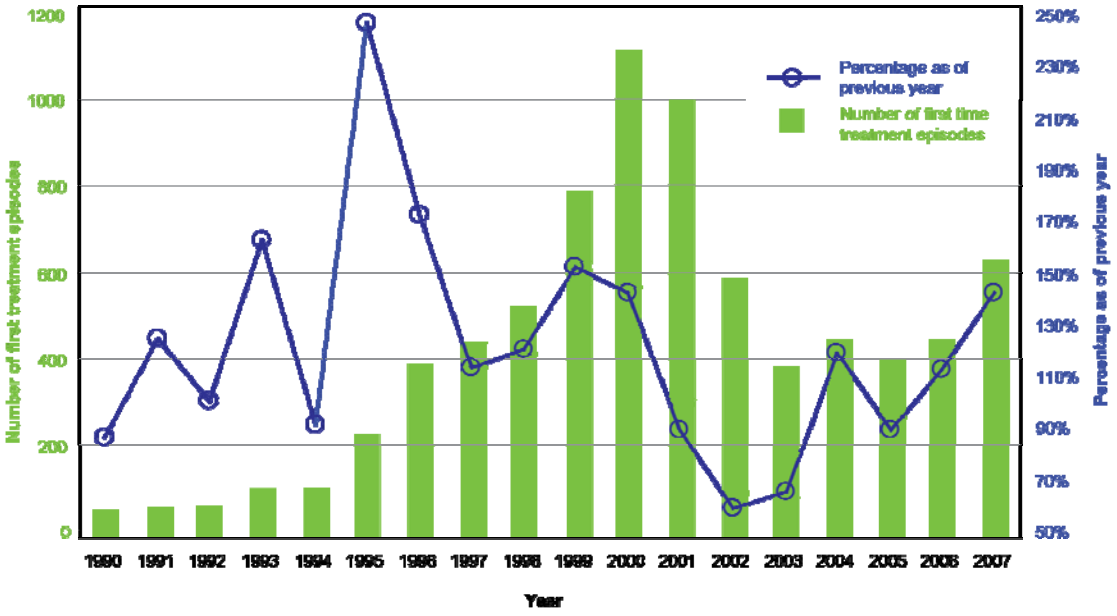
4.2.1. Out-patient treatment

Mainly utilised in this subsection will be data from the Register which, within the framework of the existing systems for patients' record-keeping in Latvia, possibly also includes patients treated at inpatient treatment centres who have not been treated at out-patient centres.

Since the first patient was registered in Latvia in 1976, until December 31, 2007, 8127 patients had been treated to problems due to psychoactive substances other than alcohol and tobacco.

Beginning in 1993/1994, the situation regarding registered patients changed fundamentally in comparison to previous years regarding the low numbers of patients observed in previous years, and each year thereafter a significant increase was observed in the number of patients treated for the first time. The number of patients treated for the first time reached its maximum in 2000 and decreased until 2003, while during the period from 2004 until 2006 it stabilised at the level of approximately 400 patients treated for the first time each year. In 2007, the number of first-time patients registered in comparison to 2006 had increased by 42%[10] *(See Figure 4.1)*.

Figure 4.1. Number of first-time treated patients at out-patient treatment centres and percentage as of previous year

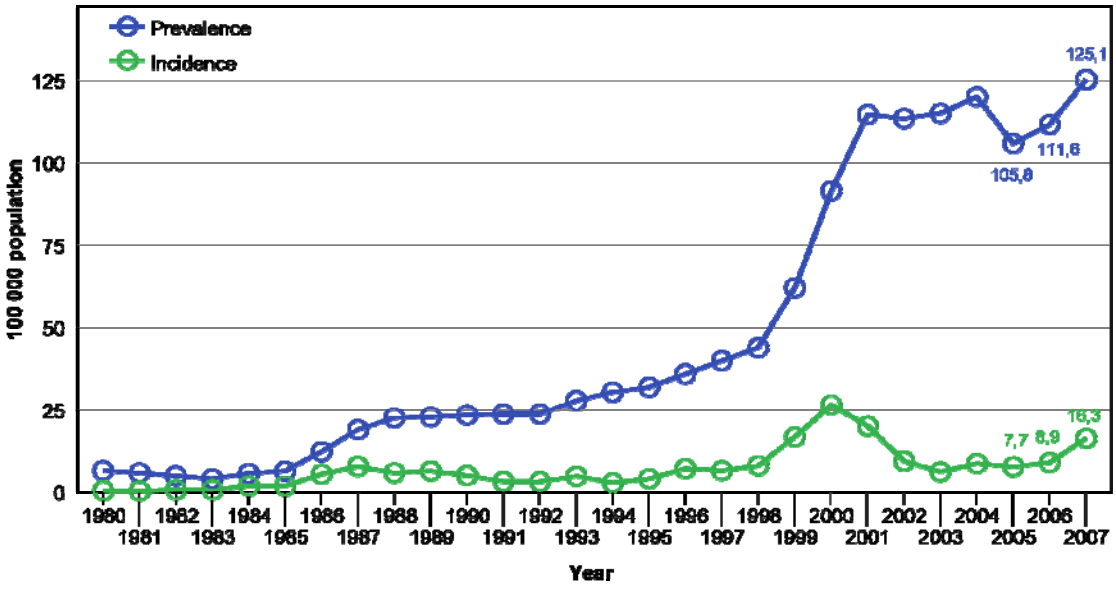


Source: RPAC/HSMTSA, PHA calculations

According to data from the National statistical report[11], 611 new cases were registered in 2007 that were related with dependence, intoxication or harmful use of narcotic and psychotropic substances; of these 372 (16.3 per 100 000 inhabitants) were with a first-time diagnosis of dependence; while the prevalence of dependence syndrome diagnosis at the end of 2007 was 2855 (125.1 per 100 000 inhabitants) *(See Figure 4.2)*. The prevalence rate decrease as seen in the Figure 4.2 in 2005 is related to improvements in data quality, as a result of which several hundred patients registered, but who had not sought assistance for a long time, were "removed" from the register.

[10] According to TDI out-patient data.
[11] There are diferences in number of patients who are reported in the statistical report and those calculated for TDI tabeles, e.g. in 2007 there are 627 first treatments according to TDI, while 611 are reported via statistical report. These diferences are observed because for the national statistical report first treatment episode is according to treatment personnel (usually based on registration system at centre level or according to patient – whether one has been treated or not) ,while for TDI unique personal identifier is used for all reporting treatment centres and it is checked whether there have been previous treatment before or not, based on data reported.

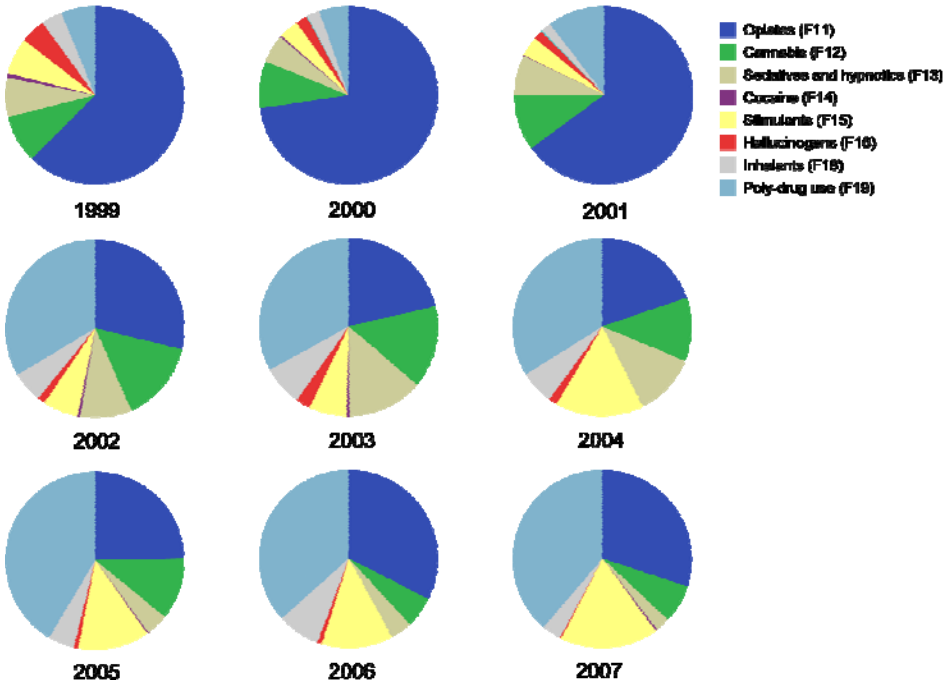
Figure 4.2. Incidence and prevalence of ICD-10 dependence syndrome diagnosis (F11-F19) 1980–2007, per 100 000 inhabitants



Source: RPAC/HSMTSA, PHA calculations

According to ICD-10 diagnosis since 2000 there has been a significant increase of proportion of poly-drug related (ICD–10 F19) and stimulant-related (ICD–10 F15), while those related with opiate use (ICD–10 F11) has decreased. Since 2004/2005 the situation has stabilized and in 2007 39% of diagnosis were poly-drug related, 30 – opiate-related and 18% – related with stimulants *(see Figure 4.3)*.

Figure 4.3. Proportion of various ICD-10 diagnoses (F11–F19) among first-tiem treated clients 1999–2007 (%)



Source: RPAC/HSMTSA, PHA calculations

As compared to a certain stability in the number of first-time treated clients observed since 2004, a significant increase in the number of dependence-related diagnosis was observed in 2007,

for example, in 2006, 205 patients were registered; in 2005 – 174; in 2004 – 201; the same was also observed in the number of patients diagnosed with intoxication or harmful use *(see Table 4.1)*.

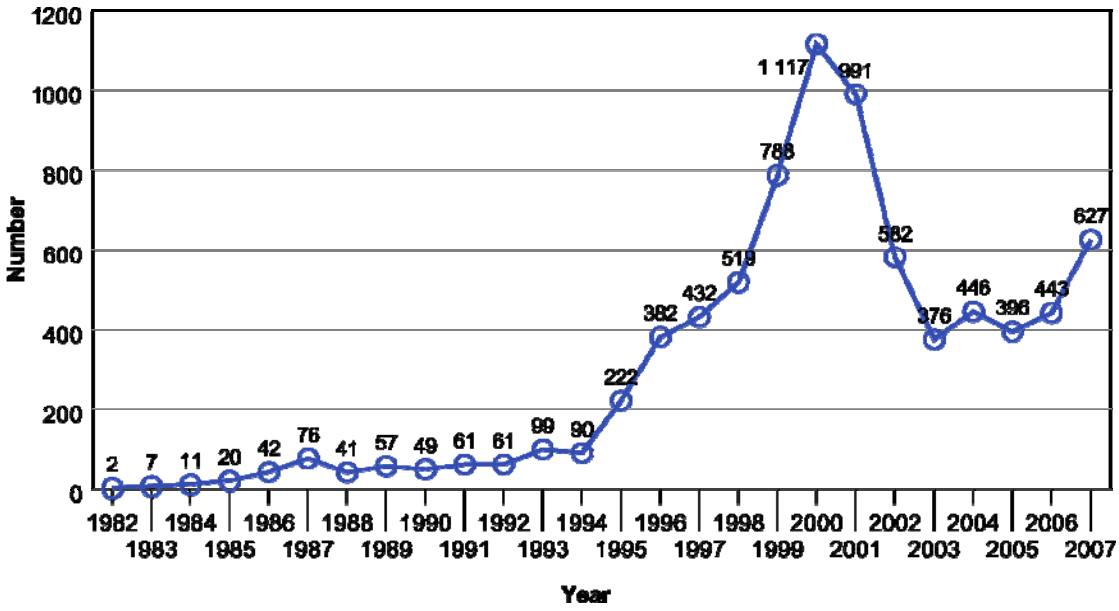
Table 4.1. Number of patients[12] diagnosed for the first time with dependence syndrome or harmful use/intoxication

	2001	2002	2003	2004	2005	2006	2007
Dependence (F11-F19.2-9)	475	220	143	201	174	205	372
Harmful substance use or intoxication (F11-F19.0-1)	456	310	204	224	178	185	239

Source: RPAC/HSMTSA, 2008

According to TDI data, 627 patients were registered for the first time in outpatient institutions in 2007 in Latvia. *(see Figure 4.4 and TDI table provided via Fonte)*; of these 22% or 136 were women. Gender proportion remains practically unchanged in comparison to that observed in 2006, but it has nevertheless slightly decreased in comparison to the increase observed in the proportion of women before 2005 (from 18% in 1997 to 25% in 2005).

Figure 4.4. Number of first treatment clients at out-patient treatment centres



Source: RPAC/HSMTSA, PHA calculations

Among patients treated for the first time in 2007, 38% were Latvians, 54% were Russians, while 8% were members of other nationalities *(See Table 4.2)*, which is significantly different in comparison to officical data from the Central Statistical Bureau, in which it is indicated that 58% of Latvia's population were Latvians in 2007. This situation is difficult to explain, however, as one of the explanations is the fact that prevalence of drug use is higher in Riga and other large cities in comparison to smaller towns or rural areas, and the ratio of non-Latvians in cities is higher than that in smaller towns or rural areas. Nevertheless, the possibility cannot be excluded that there is a higher possibility of social exclusion among non-Latvians which could lead to drug use.

[12] According to National statistical report. It does not always refer to the number of patients, since one and the same individual may have been treated in several institutions, or in one institution one and the same individual may have been regarded as a first time patient for several years.

Table 4.2. Nationality of patients treated for the first time (%)

	2001	2002	2003	2004	2005	2006	2007
Latvians	29	32	28	36	40	36	38
Russians	61	63	68	59	51	57	54
Other nationalities	10	5	4	5	9	6	8

Source: RPAC/HSMTSA, PHA calculations

According to information provided in 2007, the most often indicated means of the patient seeking assistance is the patient's own initiative (43%). 28% of first-time patients visiting a drug addiction specialist have been referred by other treatment institutions (both drug addiction inpatients and other treatment institutions), 14% were referred by family and friends, while 13% were referred by law enforcement agencies *(See Table 4.3)*.

The data indicate that men turn to drug addiction specialists more often than women, as they have been referred by law enforcement agencies (15% and 8% respectively). Such observations are evidence of the fact that the referral system for drug users is fairly unstructured, because in the event of a structured approach, social services and harm reduction programmes would be involved more frequently, which are shown in only three instances or in less than one percent of cases.

Table 4.3. Referring entity for patients treated for the first time (%)

	2001	2002	2003	2004	2005	2006	2007
Patient him/herself	26	15	18	26	29	35	43
Family, friends	22	9	11	14	12	14	14
Treatment institutions	30	63	57	47	48	37	28
Social services	1	1	3	4	1	2	<1
Law enforcement agencies	19	9	6	7	9	10	14
Other or unknown entity	2	3	5	2	1	1	2

Source: RPAC/HSMTSA, PHA calculations

In 2007, 7% of patients treated for the first time were younger than 15, 29% were aged 15–19, 24% – 20–24, 22% were aged 25-29, while 19% of first-time clients were older than 30. The average age of first-time patients in 2007 was 23.7 years (23.8 for men and 23.6 for women) *(see TDI table reported via Fonte)*.

Comparing the situation with that observed in 2000, the data indicates that there is an increase in first time diagnosed patients with drug dependence or excessive use, who are older than 30 years, for example, there were 11% older than 30 years in 2001, while in 2007, it was 19% *(See Table 4.4)*.

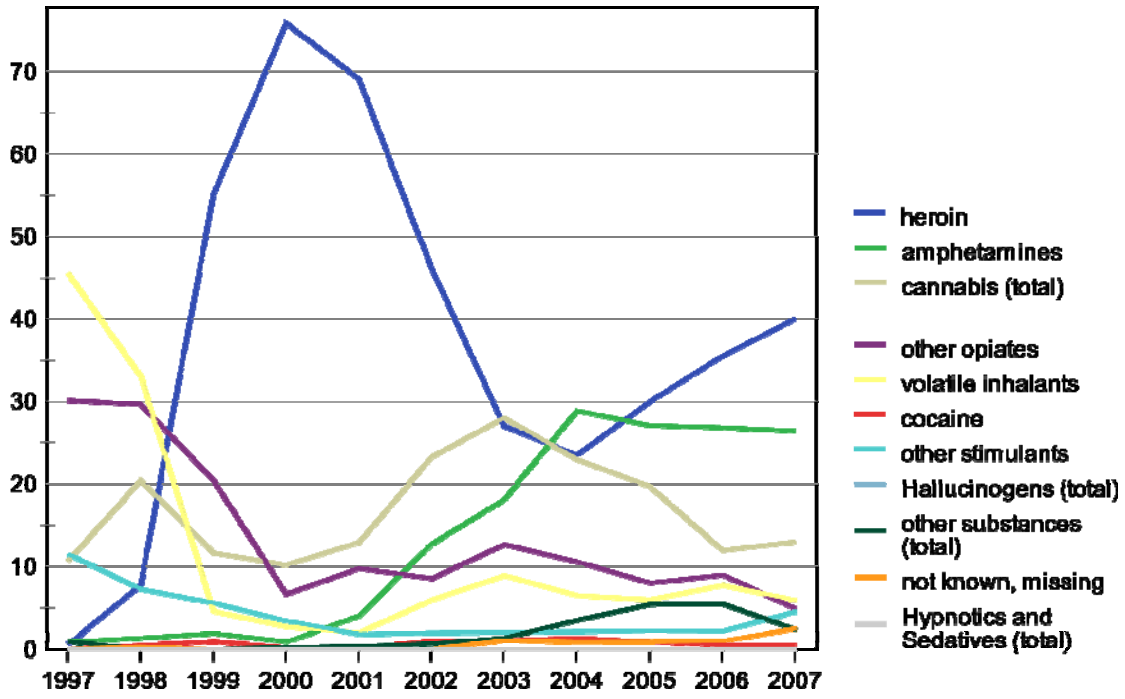
Table 4.4. Age of patients treated for the first time (%)

	2001	2002	2003	2004	2005	2006	2007
Younger than 15 years	7	13	16	12	10	9	7
15–19 years	43	39	47	44	38	33	29
20–24 years	27	22	16	19	21	24	24
25–29 years	12	14	8	10	16	16	22
30–34 years	5	6	7	6	5	8	9
35 years and older	6	7	6	9	10	10	10

Source: RPAC/HSMTSA, PHA calculations

The three most primary drugs mentioned most often among patients treated for the first time in 2007 were heroin (39%), amphetamines (25%), and cannabis (14%). The remaining substance groups are mentioned as primarily used in less than 10% of first-time treatment episodes *(see Figure 4.5)*. In comparison to 2006 data, there is an apparent increase for heroin (by 6%), and cannabis (by 3%) in the ratio of users; the ratio of amphetamine has remained unchanged, while the ratio of other substance users has decreased.

Figure 4.5. Proportion of primary drugs used by first-time clients at out-patient treatment centres (%)



Source: RPAC/HSMTSA, PHA calculations

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

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

problems exceeded the number of patients for whom the primarily-used substance was heroin. Since 2005, the number of patients with problems due to heroin continues to increase, and in 2007 comprised 2/5 of first-time patients;

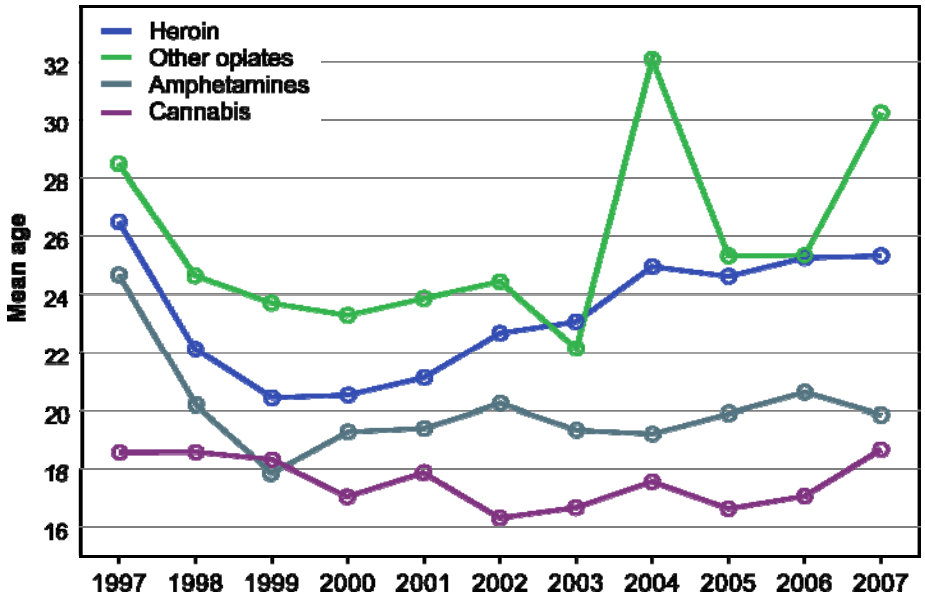
- the number and proportion of patients with problems due to primary cannabinoids is significantly lower in comparison to 2003, but in comparison with 2006 has remained at an unchanged level;
- such substances as hanka and ephedrine, which were popular in the 1990s nowadays are mentioned only in rare cases as the primarily used substance, which could be related to an expansion of the drug market, reductions in drug prices and increased purchasing power of inhabitants, and with that, heroin and industrially manufactured stimulants (amphetamine, methamphetamine) have "pushed out" of the drug market substances that are prepared in domestic conditions (for example, ephedrine or *"hanka"*);
- a significant proportion of young first-time patients (to age 15) mentioned inhalants as the primarily used substance.

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

Analysing substances used in relation to age of first-time registered patients, it may be concluded that patients' age at which they first sought assistance, is different *(See Figure 4.6.)*. Statistically significant differences were observed by substances and by year of treatment for example, the average observed age of a heroin user seeking assistance of the first time in 2007 has increased by approximately 5 years compared to 2000, whereas the age of an amphetamine or cannabis user has remained at a practically unchanged level.

It is difficult to find an explanation for such an observation but it is nevertheless possible that cannabis and amphetamine users are frequently referred to drug addiction specialists by law enforcement agencies (or by "signal" cards), and drug treatment system in Latvia is not very attractive to older amphetamine users. For the average age of "active" drug users see the chapter on PDUs in other sources or the cohort study analysis of drug users (Trapencieris, M. et al, 2007.; Trapencieris M. et al, 2008). It is also possible that enlargement of the substitution therapy in Latvia has encouraged older heroin users to seek treatment.

Figure 4.6. Average age of patients treated for the first time by primarily used substance, 1997 – 2007



Source: RPAC/HSMTSA, PHA calculations

In 2007, the mean age of a heroin user who had sought assistance for the first time was 25.3 years (24.4–26.3 years[13]); users of other opiates: 30.3 (27.4–33.1); amphetamine users: 199 (188 – 210); while the youngest were users of cannabis: 18.7 (16.7–20.7 years). Overall, the mean age of first-time treated women was lower than that of men *(see Table 4.5)*.

Table 4.5. Age of first-time treated users of various substances (%)

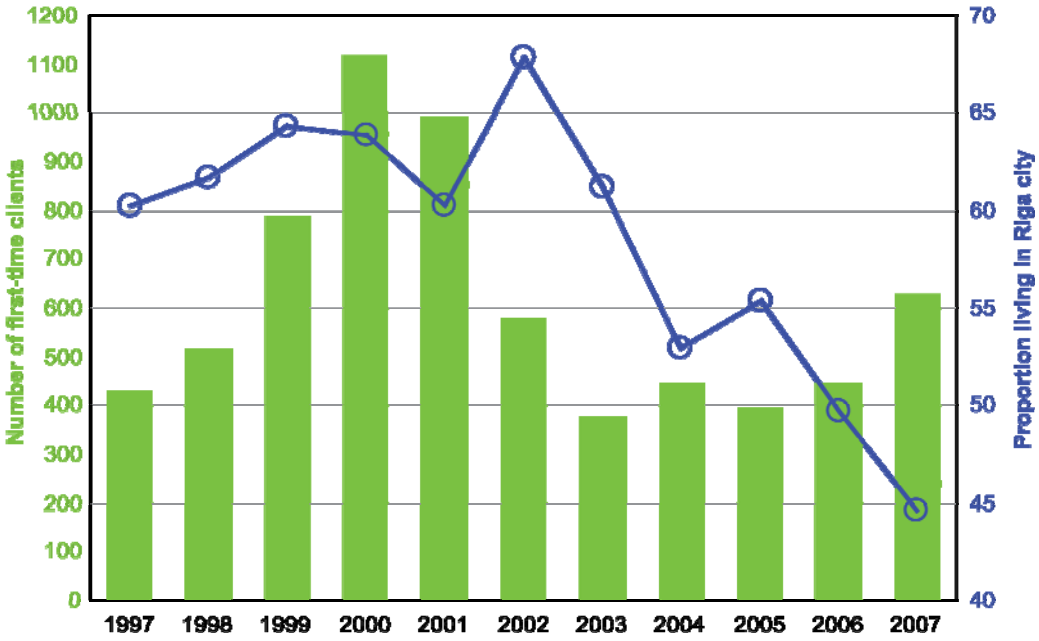
	2006			2007		
	Men	Women	Total	Men	Women	Total
Heroin	26.2	24.3	25.3	26.9	23.7	25.3
Other opioids	28.0	22.7	25.3	26.5	34.0	30.3
Amphetamines	21.8	19.4	20.6	21.7	18.0	19.9
Cannabis	18.6	15.5	17.1	20.6	16.7	18.6

Source: RPAC/HSMTSA, PHA calculations

Treatment data for the 2007 continue indicating a trend that every year, increasingly more first-time patients come from outside capital city Riga, for example, in 2002, 63% of patients treated for the first time lived in Riga, while in 2007, only 45% did so *(see Figure 4.7)*. Such data are evidence of the fact that drug use has spread significantly outside Riga, a conclusion also reached by others (Dia+Logs, 2008).

[13] 95% Confidence Interval

Figure 4.7. Number and proportion of first-time clients living in Riga city



Source: RPAC/HSMTSA, PHA calculations

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

4.2.2. Inpatient treatment

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

A form is filled-in after a patient is discharged from the treatment centre, thus the number of patient treated during reporting year (e.g. 2007) can change slightly until the following year (e.g., 2008 or in some cases 2009) when all registration forms are submitted for those who have begun treatment in long-term programmes or have been admitted at the end of calendar year. Such a reporting system does not fully comply with the UNODC and EMCDDA definitions, and does not provide precise information regarding the number of treated patients for the relevant year.

Additionally, in 2008 a comprehensive quality control by manually checking more than 200 registration forms (about 1/3 of patients treated at RPNC) was carried out for 2007 data. This control allowed for better identification of duplicate cases (full personal data was lacking for several patients), information about missing substances was corrected from treatment history forms, data on those patients with poly-drug use diagnosis (F19) and missing substances was checked very carefully and those with alcohol as primary substance was excluded from TDI data file for analysis. According to data quality control not only 2007 data was corrected, but also several minor changes in previously reported data were done.

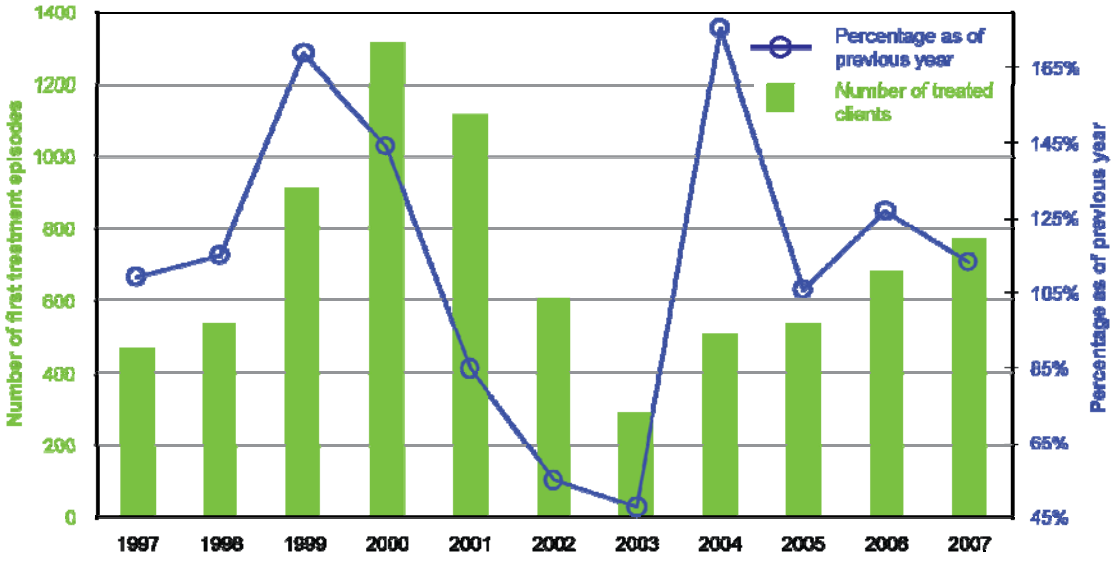
In 2007 in public in-patient treatment centres for addictions that are reporting to the treatment data system there were 17 837 treatment episodes in total, of which 968 (or 5.4%) were drug-related episodes (according to ICD–10 diagnosis F11–F19). During the last ten years (since 1998) there were almost five thousand (4 898) clients treated at in-patient treatment centres in Latvia.

According to these data in 2007 there were 773 clients treated for problems related to drug problems, of which 734 (or 95%) were treated for the first time in their lifetime.

The fact that biggest majority of clients at in-patient treatment centres are first treatments is related with waiting times, which means that for first treatments (which in most cases is detoxification there is no queue, while for consecutive treatment episodes the length could be up to three weeks, thus, according to experts' opinion, drug users sometimes loose the motivation for treatment or would go for anonymous in-patient treatment in some of the private treatment centres (which do not report to treatment system). On the other hand, as previously mentioned, 2007 data analysed does not include clients in the long-term rehabilitation programmes, which are sent in after discharge sometime in 2008. After in-patient treatment people are usually referred to out-patient services close to their place of living.

As compared with 2006 data the number of all treated clients for drug-related problems has increased by 13% *(see Figure 4.8)*.

Figure 4.8. Number of all treated clients at in-patient treatment centres and percentage as of previous year



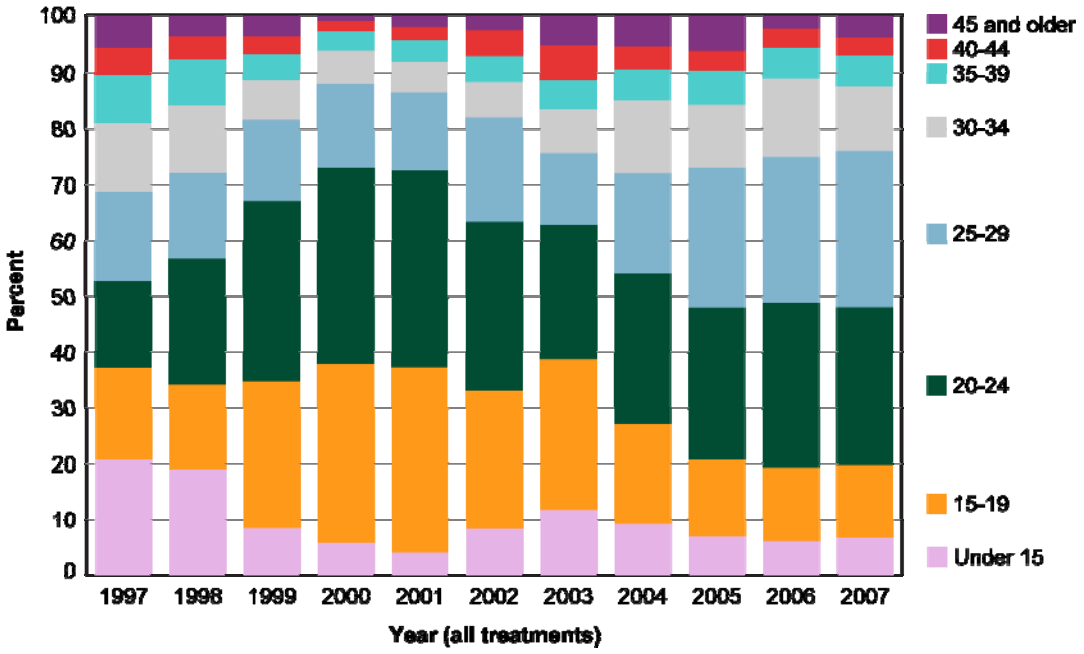
Source: RPAC/HSMTSA, PHA calculations

The median length of drug-related in-patient treatment episode in 2007 was one week (or 7 days), while the most often mentioned (mode) was four days. As compared with 2006 data in has remained about the same (median – 8 days, mode –6 days). As mentioned earlier in this chapter 2007 data does not include long-term treatment, thus the mean days in treatment in 2007 is significantly lower than that observed in 2006 data, 12.1 days and 26.6 days, respectively.

Among all treated clients at in-patient treatment centres in 2007 187 (or 24%) were females, which, as compared with 2006 data, have remained about the same proportion *(see TDI in-patient table reported in Fonte)*.

The mean age for all treated clients in 2007 was 26.02 years, slightly higher for males (26.09) then for females (25.81). As seen in Figure 4.9 about half of the patients (48%) are in the youngest age groups (under 24); and this proportion ahs remained almost unchanged since 2005.

Figure 4.9. Number of treated clients by 5-year age groups

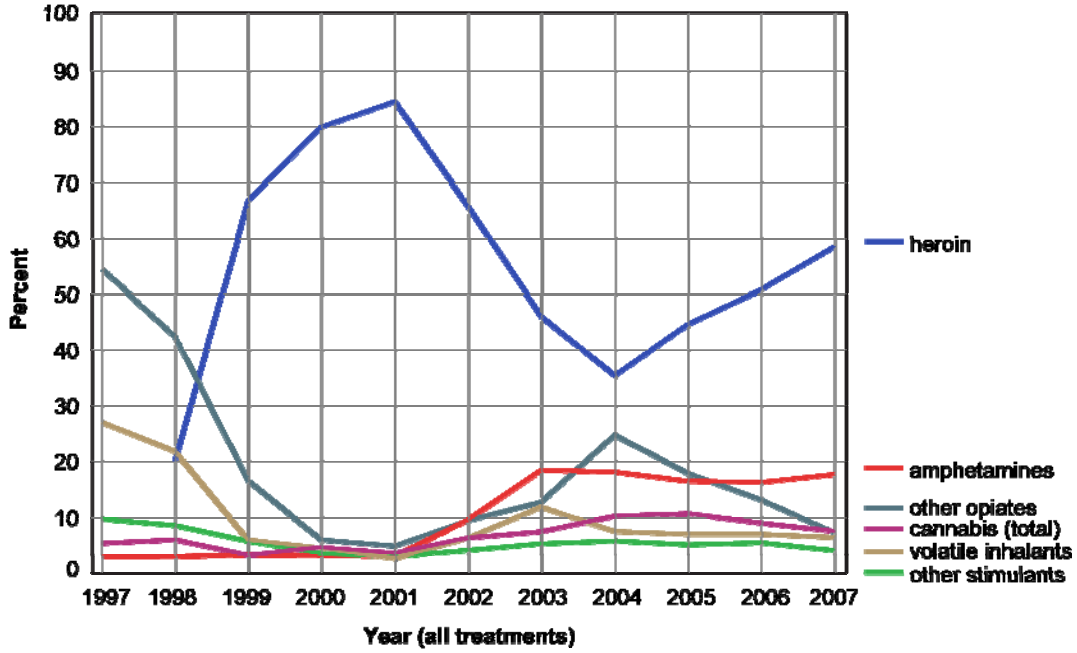


Source: RPAC/HSMTSA, PHA calculations

In 2007 the treatment episode among all treatment clients in 65% of cases was related with the use of opiates[14] (59% heroin-related and 5% – related with other opiates), while for 16% – related with use of amphetamines. In 6% of cases primary drug used was cannabis; the rest of substances or substance groups were mentioned in less than 5% of all treatment clients *(see Figure 4.10 and TDI in-patient table reported in Fonte)*.

[14] Mentioned as primary drug

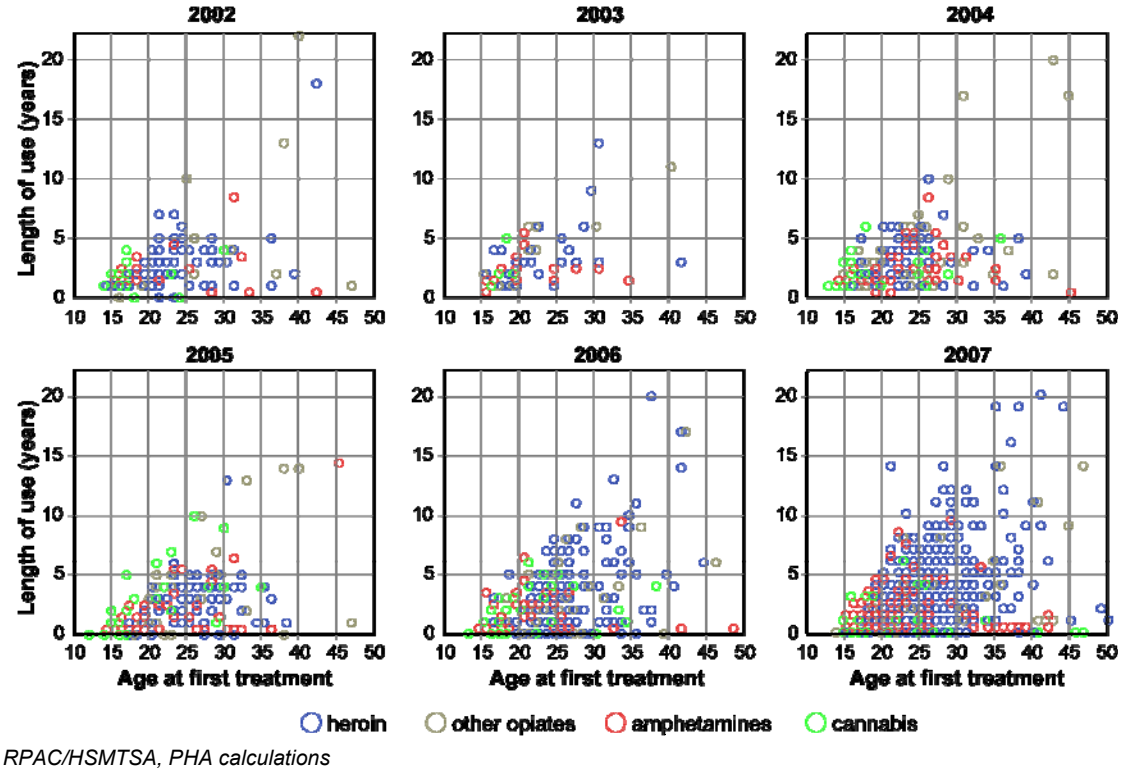
Figure 4.10. Selected primary substances used by All treatment clients at in-patient treatment centres



Source: RPAC/HSMTSA, PHA calculations

Figure 4.11 shows that there i san increase in the lenth of regular drug use before first treatment in the last year as compared with that observed in 2002. Over the last years (2006 and 2007) there are more poeple coming to treatment with much longer history of drug use, e.g. in 2007 more than half of new clients at in-patient treatment centres has five or more years of drug use history, which makes treatment interventions more complicated and cleitns „more severe" as compared with that observed five years ago.

Figure 4.11. Selected primary substances used by first treatment clients at in-patient treatment centres



Source: RPAC/HSMTSA, PHA calculations

4.3. PDUs from non-treatment sources

4.3.1. Drug users' cohort study 2008

Methodology

When commencing the cohort study of drug users in 2006, it was decided to develop it as an open cohort study, surveying those respondents included in previous stages, and supplementing the cohort with new respondents. The study sampling was formed as a modified "snowball" sampling, in which it would be permitted to survey respondents and all[15] their contacts in accordance with the "chain referral" principle (e.g., Atkinson & Flint, 2001). In the event of recruited respondents or their chains ceasing to participate, new respondents are recruited until the necessary number of respondents has been achieved.

In order to compare results of the cohort stage, in addition to the basic questionnaire, a contact page was developed incorporating a respondent code (comprised of gender, initials, and date of birth), which was utilised to determine a respondent's association with a particular questionnaire or range of contacts.

A cohort study of drug users was undertaken in accordance with international practice in such research, which requires a different approach as firstly, the level of trust of drug users is low; secondly, problem drug users are a difficult to reach part of society as they are adept at "hiding", and for other reasons. Therefore, in order to approach this population and to achieve trust, it is necessary for the people involved to be recognized and trusted, in order to provide more reliable results.

The study utilised respondents' contact information acquired in previous cohort study stages in 2006 and 2007, as well as demographic information, to make it possible to identify previous cohort participants. In 2008, according to plan, using a previously developed questionnaire, in which individual sections or indicators had acquired more precise definitions in comparison to the questionnaires utilised in 2006 and 2007, 634 problematic drug users were surveyed. The major benefits of changes to the questionnaire include clearer measurements in several areas/domains (for example, substance use, risky behaviour, etc); however, deficiencies included deterioration in data comparison with observations from previous years.

The core questionnaire developed for the 2006 cohort study included only some of the areas or topics from drug users' lives. Therefore in order to obtain more complete knowledge and more valuable information, in both 2007 and 2008 the questionnaire was expanded, and currently incorporates the following themes: 1) prevalence of drug use, 2) morbidity of blood-transmitted infectious diseases, 3) state of health, 4) degree of addiction and treatment of problems due to drug addiction, 5) family status and social environment, 6) education and employment, 7) risky behaviour and its consequences, 8) coming into contact with law enforcement agencies

[15] In the case of establishing the classic "snowball" selection, from the contact provided by the respondent, only one is selected, with whom contact is attempted, and in the event of a successful contact, only one is selected, and so forth.

Involved in the study were those street and social workers who had participated in the 2007 study. Each survey worker sought access to the drug users recruited during the first and second stages of the cohort study. Bearing in mind that this is the first longitudinal type study among drug users, it is difficult to predict the proportion of previous respondents it will be possible to reach. However, after the significant problems encountered in the second stage of the cohort study when searching for respondents surveyed in 2006 (155 respondents from the first stage of the cohort study were contacted), it may be regarded that the 2008 cohort study was very successful, resulting in almost 400 drug users being surveyed in two stages of the study, while 119 were surveyed across all three stages.

Study Implementation

In the first cohort stage in 2006, 553 questionnaires were accepted as suitable for inclusion in the common data file, 618 questionnaires from 2007, while 634 questionnaires were suitable from the third stage in 2008. In addition to the core questionnaire, in the second and third stages, information was gathered on un-contactable drug users (60 in 2007 and 33 in 2008). Because a small number of cohort participants had indicated in 2007 that they had ceased to use drugs, a different questionnaire was used as part of the 2008 study to also interview those respondents who had indicated they had ceased to use drugs in the previous two stages (n=20).

Additional information was acquired from suitable questionnaires completed by 33 respondents who had participated in one of the previous stages of the cohort study, but had not participated in the 2008 study, and from 20 questionnaires completed by respondents who had ceased to use drugs, however, in accordance with information provided in 2007, 11 cohort participants should still have been in prison. The most often cited reason for an interview not taking place referred to the respondent being in prison (19 respondents for whom this fact was indicated in 2008 and 11 respondents for whom this fact could be deduced from being un-contactable in 2007). Three drug users had died in the period between the second and third stages of the cohort study. These and other reasons for non-participation are reflected in Table 4.6 below.

An analysis of the study results in 2008 utilised the file of data acquired (n=634), as well as the combined three stage data file from the study (n=1225). 119 drug users participated in all three stages of the study, from whom 13 were respondents questioned using the "non-user" questionnaire, however, 398 respondents participated in any two stages (7 using the "non-user" questionnaire).

Table 4.6. Reasons for non-participation

	2007	2008
Responded deceased	6	3
No information on respondent	10	4
Respondent incarcerated	5	19
Respondent moved address elsewhere in Latvia	17	2
Respondent moved abroad	18	1
Respondent did not wish to participate in survey	14	2
Admitted to rehabilitation programme	10	2
Drug use discontinued (non-user questionnaire completed)	N/A	20
Incarcerated (according to information provided in 2007)	N/A	11
Total	80	64

Source: Trapencieris et al. 2008

Results

Profile of drug users

In this section the central socio-demographic identifying data of the 2008 cohort study: respondents' gender, age, nationality, family situation and living environment will be considered, as well as education and employment. In order to better understand these indicators, in individual cases the data are compared with results from the previous stages of the cohort, treatment data, or observations from other studies.

In the 2008 study 64% were men and 36% were women. The ratio of women was slightly higher than in the 2006 and 2007 surveys *(see Table 4.7)*. The gender ratio observed in the cohort study differs from that recorded in other sources, e.g. treatment or police data.

Possible explanations mentioned in the compilation of results from the first stage of the cohort study in 2006, include for example, that the drug treatment model in Latvia is oriented more towards the treatment of men's addiction problems, or women cope more easily with addiction problems, or there might be some bias in treatment reporting system. Regarding police data, possibly, women more rarely commit criminal-type offences and therefore come to the attention of police less frequently than males do (Trapencieris et al. 2007).

Table 4.7. Gender ratio in three waves of cohort study (%)

	2006	2007	2008
Male	68	68	64
Female	32	32	36
Total	100	100	100

Source: Trapencieris et al. 2008

In 2008 the mean age of cohort participants was 29.8 years (median – 28, mode – 27) *(see Table 4.8. below)*.

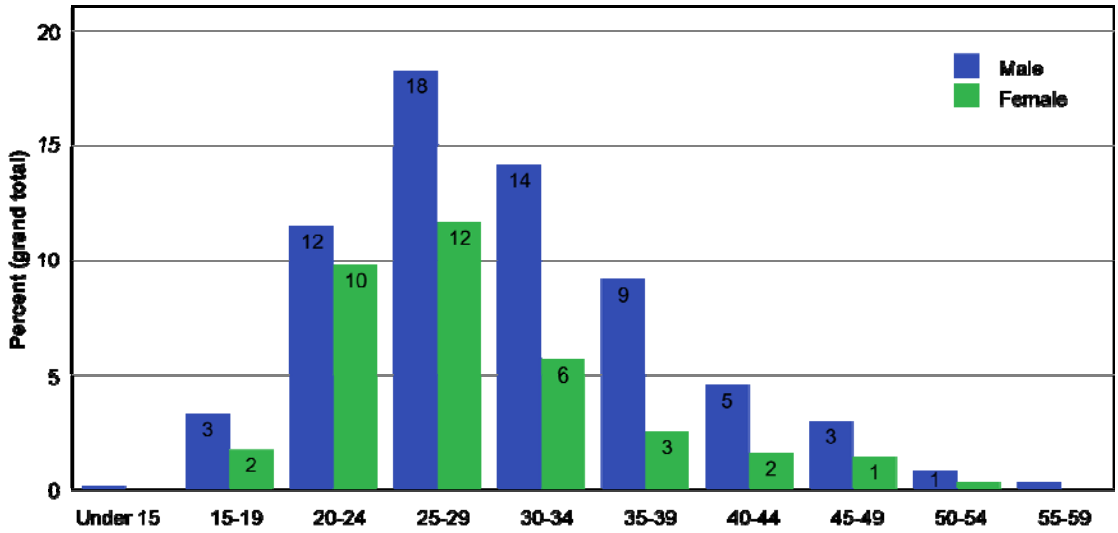
Table 4.8. Age of respondents in three waves of cohort study

	2006			2007			2008		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Youngest	13	15	13	16	16	16	15	17	15
Oldest	57	55	57	58	53	58	58	54	58
Mean age	30.1	29.2	29.8	30.7	29.8	30.4	30.6	28.4	29.8

Source: Trapencieris et al. 2008

In the third stage of the cohort, 21% of surveyed drug users were aged 20–24, 30% – 25–29 years old, 20% – 30–34 years old, 12% from 35 to 39, 6% from 40 to 44, 5% were younger than 19, while 6% were older than 45 *(see Figure 4.12)*. During all three cohort waves there is a small number of drug users who are younger than 19 years, which indicates that a strategy for getting young drug users in the cohort is needed in future, as for these users the reasons for drug use and experience is possibly different from that observed among older respondents.

Figure 4.12. Cohort participants by age and gender (% of all participants)



Source: Trapencieris et al. 2008

Examining the nationality of respondents, a noticeable decrease in the ratio of Latvians has been observed since the first stage of the cohort study: in 2006 every third (33%) respondent was Latvian, in 2007, 27%, while in 2008 only 22% were Latvian *(see Table 4.9)*. As there were no statistically significant differences in terms of belonging to a particular nationality in the reasons for trying drugs, substances used, etc., it is therefore possible that some other circumstances exist (for example, a higher risk of social exclusion, psychological, social, or biological risk factors) why a significantly higher ratio of problematic drug users exists among non-Latvians as compared to general population estimates.

Table 4.9. Distribution of respondents by nationality (%)

	2006	2007	2008	Population data[16]
Latvians	33	27	22	59
Russians	56	63	68	28
Other ethnic minorities	11	10	10	13
Total	100	100	100	100

Source: Trapencieris et al. 2008

Overall, the level of education is significantly lower than that observed in surveys of the general Latvian population, which is also in agreement with the findings of other drug user studies throughout the world; education is frequently the activity that is abandoned because of drug use. Examining the education level of respondents, it may be concluded from the third wave of the cohort study that almost half of respondents (42%) had not acquired secondary education, 33% have acquired secondary education, 19% have acquired vocational education, while 4% have studied in higher education institutions (1% have acquired higher education) *(see Table 4.10)*.

Table 4.10. Level of education across three waves of cohort study

	2006	2007	2008
Primary or less	10	9	8
Primary level of education	19	22	22
Incomplete secondary or vocational education without secondary	12	13	14
Secondary	38	33	33
Vocational	16	17	19
Incomplete higher	4	4	3
Higher	2	2	1

Source: Trapencieris et al. 2008

In comparison to the previous stages of the cohort study, there were no significant differences observed in the overall educational level of respondents in 2008. Discrepancies were also noted in analysing data from individual respondents, when the level of education of a particular respondent has decreased, for example, comparing information provided in the first and third stages of the cohort study. Such discrepancies are observable for every third respondent; however, they are not so pronounced if comparing discrepancies in educational level in the second and third stage *(see Table 4.11)*. A similar situation in terms of discrepancies is also observable in treatment databases, for example in the treatment in- or out-patient data; however reasons for these discrepancies have not been analysed.

[16] According to data from the Central Statistical Bureau for 2007

Table 4.11. Changes in educational level of respondents

	Changes between 2006 and 2008	Changes between 2007 and 2008
Level of education has decreased	33	6
Level of education remains unchanged	33	85
Level of education has increased	34	9

Source: Trapencieris et al. 2008

Similarly to the two previous stages of the cohort study, in 2008 for majority marital status was "single". This was indicated by more than half of respondents (62%, of whom 21% live together with a partner). 16% have divorced, 19% are married (2% married for the second time, 5% married but living separately and 12% married and living together with their spouse), while for 4% the spouse is deceased. No statistically significant differences in gender distribution are observable; nevertheless it was observed that among women, the ratio that is unmarried but live with a partner is greater than in comparison to men (29% and 16% respectively).

The following changes were observed in the family situation between the second and third wave of the study:

- 14 (or 4%) cohort participants have married,
- 5 respondents (1%) indicated their partner had died,
- 18 (5%) had separated or had started living separately from their spouse.
- 9% of surveyed drug users lived alone.
- 41% of respondents had started living together with a partner, parents, or friends, and
- approximately half of those respondents (46%) are presently living together with someone who uses drugs.

According to household composition, 46% of respondents indicated that they live together with a partner, 37% live with parents, 15% with friends or acquaintances, and 19% with children, while 9% of respondents live alone *(see Table 4.12)*.

Table 4.12. Members of respondents' household

	Male	Female	Total
Spouse/partner	41	56	46
Parents	41	29	37
Friends, acquaintances	14	18	15
Children	16	25	19
Live alone	10	8	9
Brother/sister	8	11	9
Other family members	8	8	8

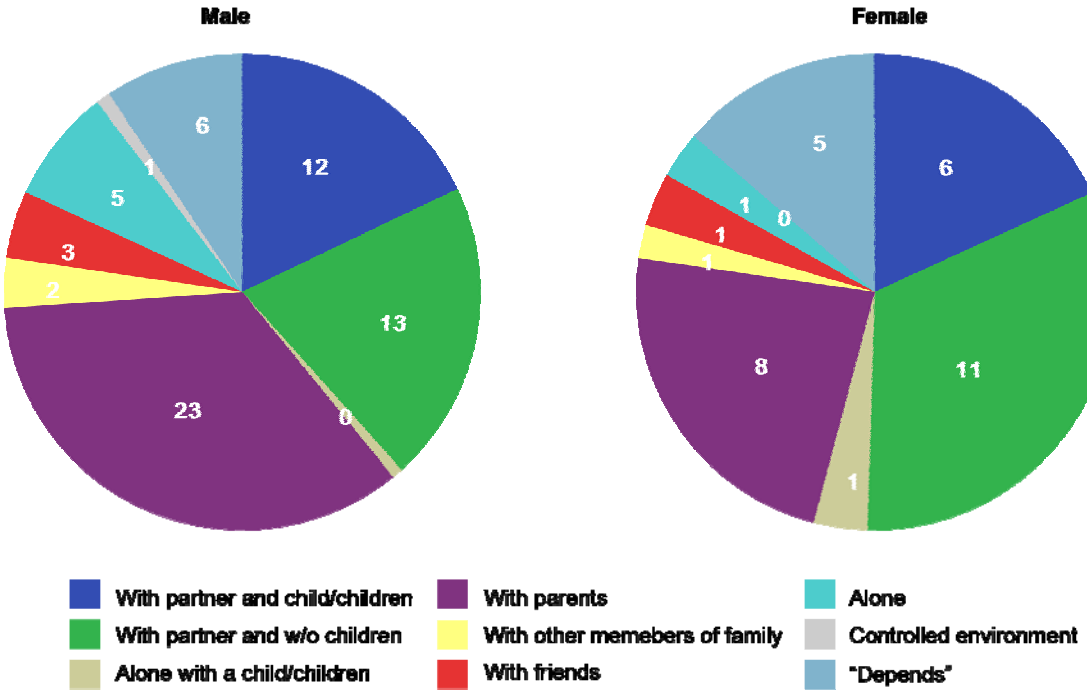
Source: Trapencieris et al. 2008

As in the previous stage of the study statistically significant differences in terms of gender (Sig.=0.05) were observed among drug users, who lived with the spouse/partner, children, or parents: women more frequently indicated that at present they are living with a partner and/or children while men live with their parents. Statistically significant differences in household

composition were observed either in terms of respondents' nationality; non-Latvians significantly more often than Latvians indicated that they lived together with their parents (39% and 29% respectively) or friends and acquaintances (17% and 9% respectively), while Latvians lived together with their brothers or sisters slightly more often than non-Latvians (14% and 8% respectively).

In comparison to the second stage of the study, slightly fewer respondents than previously indicated their place of residence as "it depends", (17% in 2007 and 10% in 2008). Almost every third respondent (30%) usually lived together with their parents, 25% with a partner without children and 18% with a partner and children. Statistically significant differences were observed in terms of respondents' gender: men more than twice as often said that during the past three years they had lived together with their parents, while women lived with a partner and with/without children *(see Figure 4.13)*.

Figure 4.13. Living environment during past three years



Source: Trapencieris et al. 2008

More than half (57%) of drug users lived together with someone who either drinks excessively or uses drugs, and with that, withdrawal from a drug-using environment would be considerably more difficult, particularly for women, who lived together with other users almost twice as often as men (61% and 35% respectively).

Drug initiation and use

Most often, the first substance used (apart from alcohol and tobacco, which were not looked upon in this study) is cannabis that was mentioned by 31% of respondents. The next most frequently mentioned substances were amphetamines (21%), *"hanka"* [17] (10%), heroin (9%), ephedrine (8%), and ecstasy (6%). Other substances mentioned as the first-tried substance were

[17] Home-made opioid from the poppy extract or straws; sometimes in literature referred also as *"kuh"*, *"kuhnarj"*.

mentioned by less than 5% of respondents *(see Table 4.13)*. Notable as significant changes were the rapidly decreasing mentions of *hanka* as the substance first tried, the number of users, and the increasing ratio of stimulant tablets among experimenters.

Table 4.13. Substance first tried (% of respondents)

	Surveyed in 2007	Newly involved in 2008	Total
Cannabis	31	32	31
Amphetamines	20	23	21
Hanka	14	4	11
Heroin	9	10	9
Ephedrine	7	9	8
Ecstasy	7	5	6
Stimulant tablets	3	8	5
Other substances	9	9	9

Source: Trapencieris et al. 2008

For example, according to study results, *hanka* was most often mentioned among older cohort participants, while amphetamine is mentioned most often among younger participants, which points to the fact that during the past 10 years the popularity of *hanka* among drug users has reduced, while the popularity and availability of amphetamine and other "industrially" manufactured substances has increased. These findings are also in accordance with observations in other drug-use related indicators.

As in the previous two stages of the study, the most often mentioned age at which any drug was used for the first time was the same in the first stage in 2006 as well as in the second and third stage in 2008, namely 16 years of age.

Table 4.14 reflects the arithmetic mean age of first trying drugs, and the median age by gender. As there are quite a few respondents who tried individual substances relatively late in life (after age 35), it would be better to utilise the median age rather than average age as that is not directly affected by minimum or maximum age values.

The earliest substance-trying age (by lowest median age) was observed in experimenting with *Cyclodol*, ecstasy and cannabis, whereas the median experimental age for "problem drugs"[18], heroin, hanka, cocaine and amphetamines, was 19 and 20. The lowest age at which respondents had tried one of the substances is 10 years, while the highest is 53 years.

[18] According to the EMCDDA definition, "problem drug use" includes the regular or long-term use of drugs such as opiates, cocaine and/or amphetamines.

Table 4.14. Age at which most often used substance was tried

	Mean age			Median age			Youngest	Oldest
	Male	Female	Total	Male	Female	Total		
Ecstasy	17.6	16.4	16.9	16.5	16	16	13	27
Cannabis	16.9	17.6	17.2	16	17	16	12	35
Cyclodol[19]	17.8	16.7	17.5	16	17	16	13	50
ephedrine	20.1	19.7	20.0	19	18	19	13	53
Cocaine	19.9	20.0	20.0	18.5	20	19.5	16	40
Hanka	20.0	21.1	20.3	20	20	20	13	47
Amphetamines	21.8	20.4	21.3	20	19	19	13	51
Heroin	22.8	21.1	22.2	20	20	20	10	53

Source: Trapencieris et al. 2008

The reason most often given for trying drugs, which was mentioned by every second (52%) cohort participant, was interest or curiosity. The next most frequently given reasons were as follows:

- 10% had used in the company of friends,
- 7% – because friends talked them into it,
- 5% – for company,
- 5% – just because they wanted to,
- 4% – because they did not want to be different from others.

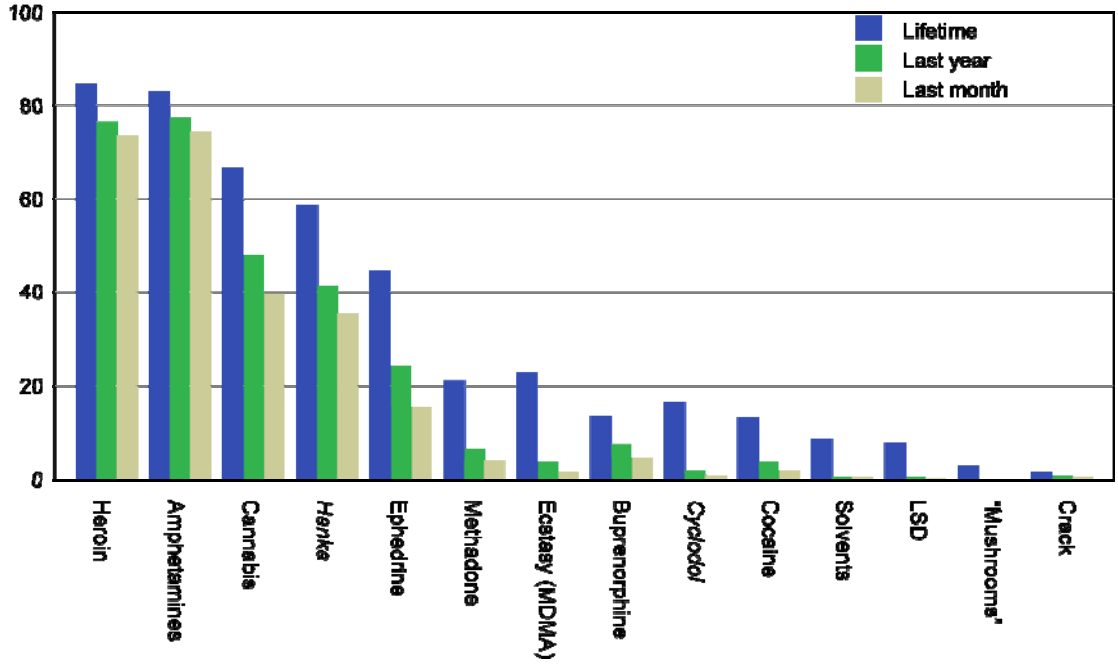
The majority of episodes of trying drugs for the first time took place in company or at some event (85%); some cases also occurred at home (9%), while 2% or 10 respondents indicated that they tried drugs for the first time while in prison.

Substances most often used by respondents are heroin and amphetamines, which had been used during their lifetime by 85% and 83% of respondents respectively, during lifetime, by 76% and 77% during the last year, while during the last month 74% of drug users had used both amphetamines and heroin.

Other substances used (or tried) by cohort participants during their lifetime, listed in descending order, are cannabis (67%), hanka (59%), ephedrine (45%), ecstasy (23%), *cyclodol* (17%), and cocaine (13%). LSD or other hallucinogens, as well as inhalants had been tried by approximately one in ten drug users, while the substances used in substitution treatment (methadone and buprenorphine) had been tried by 21 and 14% respectively of cohort participants *(see Figure 4.14)*.

[19] Active compound -Trihexyphenidyl; it was very popular during 80s and 90s, but still there is a significant proportion of young drug users who take the substance.

Figure 4.14. Drug use during lifetime, during past 12 months, and past 30 days (% of 2008 cohort participants)



Source: Trapencieris et al. 2008

As in the previous two stages of the cohort, it was also observed in the third stage that practically no one of the 2008 cohort participants had used the form of cocaine known as crack, which is very popular in several western European countries and the USA.

There were no observable statistically significant differences in drug use over a lifetime, during the previous year or during the previous month in terms of respondents' gender (Sig.=0.05), other than buprenorphine (during the previous month), cocaine (in their lifetime), ecstasy (during lifetime and previous year), inhalants (in their lifetime) and mushrooms (in their lifetime). Women more often than men had in their lifetime tried cocaine (22% of women in comparison to 8% men), ecstasy (in their lifetime 35% women and 17% men, during the past year 6% and 3% respectively), “mushrooms” (5% women and 2% men) and buprenorphine during the previous month (7% women and 3% men) whereas men– inhalants (11% and 4%).

Statistically significant differences in drug use were observable for amphetamine, ephedrine, ecstasy, heroin, hanka, methadone and LSD used in their lifetime according to age of respondents. Younger respondents had significantly more often mentioned amphetamines, ecstasy and LSD, while older respondents had mentioned ephedrine, *hanka*, methadone and *Cyclodol (see Table 4.15)*.

Table 4.15. Lifetime use of drugs by age (% of 2008 cohort participants)

	Younger than 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	Total
Heroin	100	78	90	82	83	88	90	75	100	100	85
Amphetamines*	100	97	96	84	85	80	59	46	57		83
Cannabis		66	71	64	62	69	77	64	100		67
*Hanka**		28	38	56	66	77	90	79	100	50	59
Ephedrine*		31	28	32	53	73	82	64	71	50	45
Ecstasy*		28	37	29	15	9	8	4			23
Methadone*			13	17	23	39	36	25	86		21
*Cyclodol**		3	10	9	21	28	33	32	43	50	17
Buprenorphine		9	14	14	12	12	26	11	14		14
Cocaine		3	13	14	14	14	18	18			13
Inhalants		9	7	8	7	12	10	18	14		9
LSD*		22	13	6	9	3	5	4			8
mushrooms		6	4	2	4		3	4			3
Crack		3	1	3	2						2

** Statistically significant differences*
Source: Trapencieris et al. 2008

Most used substance

The majority of second and third stage repeat interviewee cohort participants had referred to a substance mentioned in the previous stage as the most frequently mentioned substance. For example, in 2007, 79% had cited amphetamines as the most often used substance and did so again in 2008. A similar situation was also observed among heroin users, for whom this indicator was 77%. The greatest changes were observed in the ratio who continued to use *hanka*: only 42% also continued to use it at most in 2008.

Other substances mentioned as the most often used substance during the past 12 months were mentioned by less than 10 respondents and it is therefore difficult to draw conclusions, although those too are reflected in the table below *(see Table 4.16)*.

According to these calculations, one in four (28%) previously surveyed participants has changed his primary substance. There were no statistically significant differences, neither by gender (p=0.441), age (p=0.414), nor nationality (p=0.518), nor in length of use (p=0.482).

Table 4.16. Substance most often used by cohort participant respondents from cohort stages two and three (% of respondents)

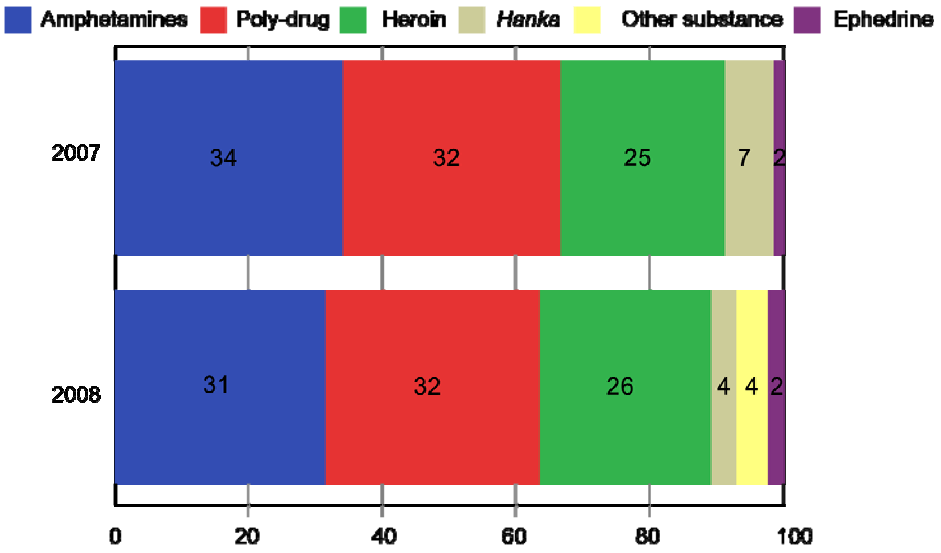
2008 / 2007	Amphetamines	Ephedrine	Heroin	*Hanka*	Methadone	Buprenorphine	Cannabis	*Tramadol*	Number
Amphetamines	79	2	17	1	1		1		164
Ephedrine	25	25	38	13					8
Heroin	16	1	77	4	1				146
Hanka	5		42	50			3		38
Methadone	20		40		30		10		10
Buprenorphine						100			1
Cannabis	33						67		3
Tramadol								100	1
Number	**160**	**8**	**163**	**27**	**6**	**1**	**5**	**1**	371

Source: Trapencieris et al., 2008

It is interesting that statistically significant differences have been observed ($p<0.001$, $r=0.262$) in changing of the favourite drug used for those drug users, who had indicated that they had sought assistance from a drug treatment institution, which would seem to indicate that possibly as the result of treatment received, these users had managed to refrain from using a particular substance, but had turned to using some other drug. Nevertheless it is very difficult to conclude unequivocally as to what this observation indicates. Another observation in relation to changes in the most often used substance is as follows: among those users having a smaller number of points on the *Severity of Dependence Scale* there is a smaller ratio of substitution for substance most often used in comparison to those having more severe signs of dependence ($p<0.001$, $r=0.220$). This observation is possibly explainable by the so-called "honeymoon effect", when users of a particular substance have not fully experienced all the negative consequences associated with use, and therefore do not seek other substances, which could initially provide similar sensations.

According to questions about the injecting substances most often used during the past six months, it may be concluded that approximately two thirds (64%) of cohort participants use only one substance and do not change their preferance, while one third use whatever is most available or also try to achieve various effects caused by use, for example, use heroin to "calm down" after binging with amphetamine. According to these data, 31% of all third stage cohort participants use only amphetamines, while 26% only use heroin *(see Figure 4.15)*. The proportion who would use only *hanka* or ephedrine are very few: 4% and 3% respectively. The most frequently mentioned combination among those indicating that during the past six months they had used more than one substance is amphetamines and heroin.

Figure 4.15. Proportion of users using only one substance in the 2007 and 2008 (%)



Source: Trapencieris et al. 2008

Severity of dependence

In order to determine the degree of severity of dependence in the second stage of the cohort study (in 2007) and the third stage (in 2008), included in the questionnaire was one of the most widely utilised standardised instruments in the world: the *Severity of Dependence Scale ("SDS")*, which is often utilised in studies among drug users, as well as in the clinical environment. SDS has good psychometric qualities (e.g. Gossop et al. 1992; Gossop et al. 1995; Ferri et al 2000; Fatiadou et al. 2004).

As there has been no translation of SDS in Latvian, the 2007 report on results of the study's second wave looks on the psychometric properties of this scale (Trapencieris et al. 2007). According to authors, it may be concluded that the capabilities of the psychometric instrument are good and they may possibly be utilised in analysing data at the individual level, as they reflect the level of dependence severity (Cronbach's alpha for all respondents 0.915).

The SDS questions were asked in both stages of the study in respect of the substance most often used in the past 12 months. The following analysis of severity of dependence includes two drugs most often mentioned by users – amphetamine (n=279) and heroin (n=266), or 87% of participants in the 2008 cohort stage.

As in 2007, the research results from the 2008 study indicate statistically significant differences on SDS scores between amphetamine and heroin users: heroin users have mentioned problems associated with the use of that substance significantly more often than amphetamine users *(see Table 4.17*), which indicates that the use of heroin causes significantly more severe consequences (for example, it is more difficult to stop using, there is less control over using, etc) than use of amphetamine, which is in accordance with observations in world practice on the severity of symptoms caused by the use of heroin and amphetamines.

As significant progress has been achieved in the third stage of the study in recruiting previously surveyed respondents *(see Methodology section)*, the majority of respondents in the 2008 study had been previously interviewed and, without involvement in structured and considered treatment have only "progressed" in terms of dependency symptoms, then it is only natural that significant changes were to be observed in the overall level of dependence severity among cohort participants.

Table 4.17. Amphetamine and heroin user replies to SDS questions

		Amphetamines		Heroin	
		2008	2007[20]	2008	2007
1. Do you think your use of [drug] is out of control?	Never or almost never	20	-8	9	-6
	Sometimes	48	+4	32	-5
	Often	25	+4	44	+7
	Always or almost always	7	0	15	+4
2. Does the problem of missing a fix or dose of [drug] make you anxious or worried?	Never or almost never	18	-6	7	-6
	Sometimes	46	+2	27	-3
	Often	23	+2	37	+2
	Always or almost always	14	+7	29	+7
3. Do you worry about your use of [drug]?	Never or almost never	20	-6	7	-6
	Sometimes	42	0	29	-7
	Often	28	+3	44	+11
	Always or almost always	10	+3	19	+2
4. Do you wish you could stop?	Never or almost never	19	-2	9	-1
	Sometimes	42	+1	27	-5
	Often	23	-7	32	-5
	Always or almost always	17	+8	32	+11
5. How difficult would you find it to stop or go without [drug]?	It would not be at all difficult	29	-1	6	-9
	Fairly difficult	33	-1	23	-3
	Very difficult	31	+7	46	+7
	Impossible	7	-5	25	+5

Source: Trapencieris et al. 2008

Drug treatment

In the second and third stages of the cohort study compared to the first stage in 2006, the range of questions on treatment due to drug problems was expanded. Questions in the survey questionnaire referred to treatment during the lifetime, the previous year, and the previous month, method of treatment (detoxification, inpatient or outpatient treatment, rehabilitation, etc), as well as previous involvement in methadone or buprenorphine maintenance programs, and the longest period for being drug-free.

[20] In comparison to all surveyed cohort participants in 2007, and not only those who were re-interviewed in 2008.

The 2008 study results indicate that 50 per cent of participants had been treated in their lifetime. During the last year, 26% have undergone treatment, while during the last month, 3% of drug users have received drug treatment. In comparison to the 2007 data there has been an increase in the ratio of cohort participants treated during the past year *(see Table 4.18)*.

Table 4.18. Drug treatment experience in 2007 and 2008 (%)

	2007	2008
Lifetime	48	50
During the last 12 months	17	26
During the last 30 days	2	3

Source: Trapencieris et al. 2008

Approximately half (51%) of repeat survey respondents who had been treated in 2008 had also been treated in 2007. In 2008, treatment is slightly less prevalent for newly included respondents than for first-time interviewed respondents in 2007 (22% and 29% respectively).

As observed previously in the 2007 wave, there were no statistically significant differences in terms of respondents' socio-demographic characteristics, other than for lifetime treatment – age of respondents (p=0.002), while for recent treatment, it is less pronounced (p=0.084).

Younger respondents have been treated slightly more frequently during the past year (under 24 and ages 25-29) in comparison to older respondents. This observation is possibly related to the fact that for younger respondents this might have been one of the first treatment episodes in their lifetime, while older respondents have already undergone treatment previously and after not achieving the expected result, place increasingly less reliance on the treatment process and therefore turn to drug treatment institutions less frequently. These results might possibly also indicate that in order to attract older drug users to treatment it might be necessary to offer a wider range of services at the treatment centre, for example, both primary and specialised healthcare, which is topical for older drug users or those who have been using drugs for longer than 15 years.

In comparison to the 2007 data, there is an apparent increase in the number of drug users who have undergone treatment at private treatment institutions, as in 2007, 49% of cohort participants indicated private treatment institutions as institutions in which they had been treated at any time, while 58% indicated so in 2008.

In rehabilitation programmes, as in 2007, slightly more than one third (39%) of patients treated in their lifetime had been treated in rehabilitation institutions.

In comparison to the 2007 data, it was observed that among those who had sought treatment in 2008, the number of treatment episodes had increased. If in 2007 the majority (72%) of patients treated during the past 12 months had been treated once, 21% twice, while 7% had been treated three or more times, then in 2008 52% had been treated once, 31% twice, and 18% three or more times.

5% of respondents treated recently did not wish to reveal the institution in which they had received treatment. The treatment institutions at which cohort participants had been treated most often during the past year were the Riga Centre of Psychiatry and Addiction Disorders (70%) and two private treatment institutions (*Detox* and *Bikur-Holim*) (24%).

As in the second stage of the cohort study, 13% and 3% of cohort participants respectively had been involved in the methadone and buprenorphine programs for some time during their lifetime.

State of health

The 2008 survey questionnaire included questions from which the drug users' state of mental and physical health could be determined. The questions included on health in the cohort study are comparable with data obtained from the survey conducted in 2007 on the prevalence of dependency inducing substances in the general population (Koroleva I. et al, 2008)[21].

According to the cohort study data, 11% of drug users rated their state of health as poor, while 34% rated it as average. In comparison to the general 15–64 year old population self-reported perception of health, the drug users' health is significantly lower *(see Table 4.19)* whereas, if the data is controlled according to age, the health problems are even more serious for the corresponding age group of cohort participants. Similarly to the general state of health, the drug user's mental or physical state of health is lower than that of the population in general.

Such observations accord with those observed throughout the world, and indicate that by turning to primary health care institutions, drug users impose a significantly greater load upon the services in terms of related cost to the state.

In the ideal situation, it might be possible to provide at least primary health care in the range of services offered in harm reducing programs or centres in order to attract new clients, or for "keeping" existing clients in sight.

Table 4.19. Self evaluation of health for drug users and Latvian inhabitants aged 15–64 (%)

	Drug users' cohort	General population (15–64)
Excellent	2	6
Very good	8	18
Good	45	47
Average	34	25
Poor	11	4

Source: Trapencieris et al. 2008

Contact with law enforcement agencies

According to data from the third study wave, during the last 12 months 26% have undergone a drug test on at least one occasion. Almost all drug users returned positive findings (89% of those "checked" or 24% of all cohort participants).

[21] Data on health of population in terms of the SF-36 scale are unpublished to date.

No statistically significant differences were observed either in terms of respondents' gender, nationality, or other socio-demographic indications, other than age (p=0.005), i.e. younger cohort participants (to age 29) had more frequently come into contact with the police, and had as a result undergone a drug test. In comparison to data from the first and second stages of the study, the level of testing for problem drug users in the cohort has remained practically unchanged *(See Table 4.20)*.

Table 4.20. Drug users undergoing testing (%)

	Under 24	25–29	30–34	35–44	45 years and older	Total
2006	23	27	25	16	12	22
2007	30	34	23	7	13	24
2008	28	36	17	18	20	26

Source: Trapencieris et al. 2008

The data also indicate that heroin users are tested more frequently than amphetamine users (32% and 22% respectively). It is interesting that those scoring higher on the SDS are tested more often for drugs, i.e., the average number of points for those not tested is 7.1 while for those tested it is 9.8. This difference is maintained even controlling for more frequently used substances, which is natural, as users with more serious or very serious drug problems due to these substances practically no longer control their use of them *(see Table 4.21)*.

Table 4.21. Mean SDS score (standard deviation) for amphetamine and heroin users

	Amphetamine	Heroin	Total
Tested for drugs	6.1 (3.3)	8.9 (3.6)	7.1 (3.9)
Not tested for drugs	8.6 (4.1)	10.9 (2.8)	9.8 (3.7)

Source: Trapencieris et al. 2008

5. Drug-related Treatment

In 2008, significant amendments were introduced into legislation, which provide that methadone maintenance treatment can be undertaken by any drug addiction specialist having a contract with the Health Compulsory Insurance State Agency. Along with the enlargement of methadone maintenance treatment, an evaluation of substitution maintenance treatment has commenced in Latvia within the UNODC project framework

5.1. Treatment system

The NR for 2005 and 2006 describe the drug addiction treatment system in Latvia and its deficiencies.

5.2. Drug free treatment

No new information available.

5.3. Pharmacologically assisted treatment

The use of Methadone maintenance treatment began in Latvia in 1996, and treatment with Buprenorphine began in 2005. On 9 August 2008 Cabinet Regulation No. 640, "*Amendments to Cabinet Regulation No 429 of 24 September 2002: "Procedures for the treatment of patients dependent on drugs and other toxic substances*"" came into force. Until then, only one centre – Riga Psychiatry and Addiction Centre, was authorised to issue methadone. One of the main points in the amendments provided that methadone maintenance treatment could be provided by a drug addiction specialist who was under contract to the State Agency for Compulsory Health Insurance. This specialist had to ensure that the daily dosage stipulated by the Council of Physicians was administered in the presence of treatment personnel. With these amendments, broadening of the methadone program was made possible.

A slightly different procedure exists in relation to Buprenorphine. Treatment with Buprenorphine is initiated by the Riga Psychiatry and Addiction Centre (inpatient or outpatient). The length of time for which a patient is to remain under observation is decided by the drug addiction specialist and can be up to seven days. Subsequently, a drug addiction specialist (at any other location) may continue replacement therapy, ensuring that the patient receives medication in the presence of treating personnel for at least a further 30 days. After the 30 days, the specialist can write a prescription for the patient to obtain Buprenorphine at a pharmacy. The former Regulation provided that a patient must be under observation for the first period of seven days at Riga Psychiatry and Addiction Centre, the next 30 days – at one of the four major drug addiction hospitals, and only then could the prescription be written.

At present opportunities for access to substitution maintenance treatment have been broadened, although in reality (in relation to the methadone program) are not yet in operation.

In early 2008, thanks to funding allocated within the framework of the UNODC project, evaluation of the replacement therapy program began in Latvia with the aim of ascertaining the present situation in the field of replacement therapy, and in the future broadening the availability of replacement therapy to clients. Evaluation was carried out by staff of the Reitox National Focal Point. A full report will be available in late November 2008. Evaluation included both quantitative and qualitative methodology. The following tasks were undertaken:

- 10 interviews with the leading experts in Latvia on possibilities of broadening the methadone program, problems, models for enlargement, (including at places of imprisonment);
- interviews with six staff members working in substitution maintenance treatment (quality survey (access to staff and replacement therapy centre, therapeutic procedure, client registration system), survey of staff motivation;
- 70 interviews with substitution maintenance treatment clients (55 methadone and 15 Buprenorphine clients);
- interviews with 11 drug users, who are presently not in any substitution maintenance treatment program;
- two separate interviews with centre management on the operation of substitution maintenance treatment and the services offered;

Literature was also analysed for the preparation of the report. Considerable support was provided by experts of the Trimbos Institute, who conducted evaluation of the substitution maintenance treatment in Slovenia in 2006. The structure of the Latvian evaluation report is largely based on the report by experts of the Trimbos Institute. The results of the substitution maintenance treatment evaluation will be presented in the 2009 national report.

6. Health Correlates and Consequences

6.1. Drug related deaths and mortality of drug users

In Latvia, information about fatalities associated with drug use is compiled and analysed by two institutions – the Latvian Health Statistics and Medical Technologies State Agency (hereinafter HSMTSA) and the Latvian State Centre for Forensic Medical Examination (SCFME). Both institutions cooperate, and during the year compare data bases relating to deceased persons. Reflected in the national report will be data provided by both institutions; however, in the EMCDDA Standard Tables *(see ST05 and ST06)* will contain HSMTSA data, which may be regarded as the final result. From next year, it is also planned to provide data from SCFME in the Standard Tables.

Health Statistics and Medical Technologies State Agency data (General Mortality Register)

HSMTSA is a state administration institution under the supervision of the Minister for Health. Its operational aim is, on the basis of information technology and scientific evidence to ensure the acquisition, processing, and analysis of health care information and statistical data *(Cabinet Regulation No 82 of 1 February 2005 "Health Statistics and Medical Technologies State Agency Bylaw")*.

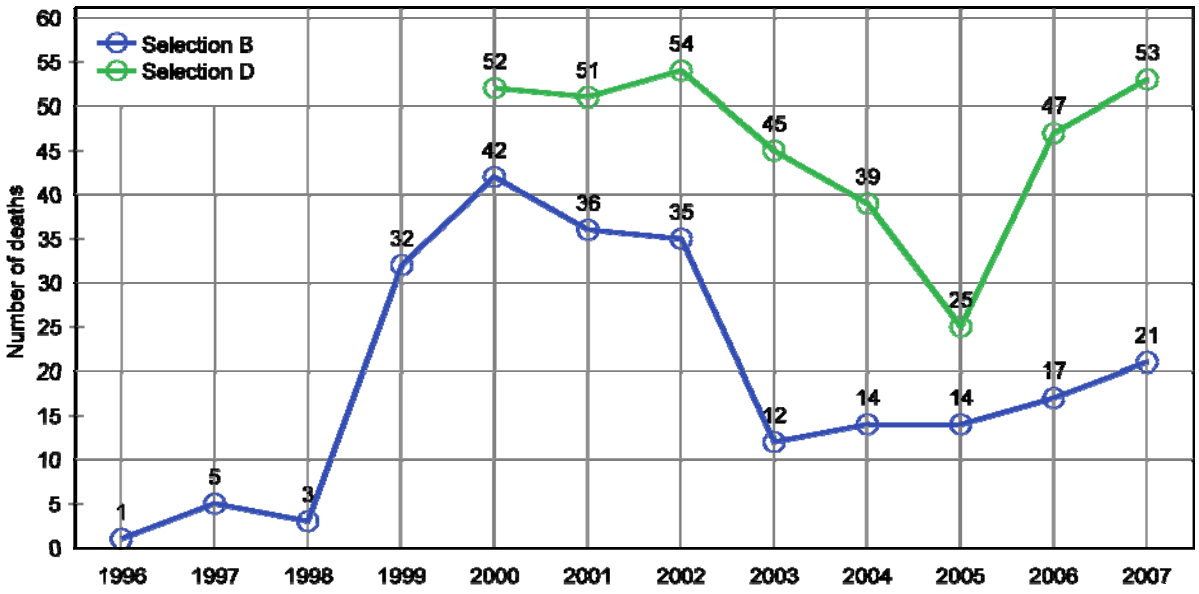
Monitoring Centre for Addiction and the Latvian national focal point maintain close cooperation with the Health Statistics Department, whose main task is to organise the gathering of health and health care statistical information at the national level, processing of information, analysis, and, using the procedure and terminology stipulated in regulatory enactments or agreements, to ensure it is provided to the Republic of Latvia Ministry of Health and the Central Statistical Bureau, as well as international organisations. The basic function of the Department is to ensure the implementation, adaptation, and correct utilisation of international, national economic and local classificators, applicable to health and health care statistics in health care and treatment institutions and to prepare and publish informative and analytical medical and health statistical reports, yearbooks and publications. The department maintains several databases: the Causes of Death data base, Health defense statistics state programme database, the inpatient bed fund, health care indicator database (DPS) and the National Register of Newborns, and also updates the information already held in databases *(HSMTSA, 2008)*. Included in the Causes of Death data base is information about the whole State and it is based on Death Certificates, which are initially sent to the Central Statistical Bureau from every region of the State and after that, monthly to the Health Statistics and Medical Technologies State Agency Department of Health Statistics, which encodes, processes and enters the data obtained into the data base.

During the year the HSMTSA continues to compare data with the State Centre for Forensic Medical Examination, as initially the data of both institutions differ because, when a person dies, the death certificate and possible cause of death is completed immediately, but, if a post-mortem is

performed, the results are received later. If the diagnoses (as initially entered and later revealed) do not match, they are sent for correction. For this reason, the databases of both institutions are regularly compared and the necessary changes are made within them, to the end of the current year.

According to HSMTSA data in 2007 compared with 2006, there is a slight increase in the number of deaths associated with drug use.

Figure 6.1. Deaths associated with drug use 1996–2007 (absolute figures)



Source: HSMTSA, SCFME, SAA

All the deceased persons in 2007 were aged 20–39, and were mostly men. The average age of deceased persons was 29.1 years. Over a 10 year period, the average age of deceased persons has reduced by more than six years. In total in all age groups 18 men and 3 women have died from drug use *(see ST05 and ST06 reported in Fonte)*.

As already mentioned in previous years , the number of persons who have died due to drug use might be much greater, firstly because, analyses were not undertaken in respect of all deceased persons, that would have determined the presence of drugs, and secondly, due to a more rapid dispersion of some substances.

State Centre for Forensic Medical Examination

The State Centre for Forensic Medical Examination is an administrative institution directly subordinate to the Ministry of Health. The operational aim of the SCFME is the undertaking of inquests, scientific research and ensuring postgraduate education in the field of forensic medicine. The main functions of the institution include: undertaking inquests, organising scientific work in the field of forensic medicine, providing consultative assistance in the field of forensic medicine to law enforcement and treatment institutions. SCFME main tasks include: undertaking inquests for physical persons who have suffered harm to life or health, persons who have died as the result of violence or sudden death, as well as undertaking analyses of material evidence and forensic medicine analyses, in the event of suspicions of professional incompetence of treating personnel,

undertaking the prevention of breaches of human rights in the field of forensic medicine, developing the work of scientific research etc (Cabinet Regulation No 776 of 10 September 2004 *"State Centre for Forensic Medical Examination Bylaw"*).

The operation of SCFME is based on its Bylaw, the *Judicial Experts Law* (the aim of the law is to regulate the professional work of forensic experts to ensure objective, lawful and scientifically based forensic examination within the state)[22] and the procedure for forensic medicine examination (*Cabinet Regulation No 51 of 9 February 2001 "Procedure for Conducting Forensic Medical Examinations"*).

SCFME is comprised of the Victims and Suspected Persons Inquest Division, Forensics Division, the Union of Forensic Medicine Clinical Laboratories, the Chemistry and Toxicology Laboratory, the division of Thanatalogy, the Cabinet of Forensic Medicine Commission Medical Inquests, the Division of Latvia's Tissue bank, District and Interdistrict Forensic Medical Inquest Divisions, and the Corpse Biological Materials Archive.

According to data from the SCFME, in 2007 there were registered 22 so-called deliberate fatalities, i.e. death was caused due to drug use (poisoning, overdosing). In 2006, this number was 15, but in 2005 there were 11 deliberate fatalities. In 2007 there were also registered eight accidents (motor vehicle trauma, falls), 4 suicides, 1 murder, 15 cases of non-violent death, while in three cases it was not possible to establish the cause of death because of changes due to decomposition of the corpse. Compared to 2006, the total number of deceased persons in whose biological materials drugs were detected has grown (by six cases). SCFME data also indicate that the majority of deceased cases in 2007 were males aged 20–39.

Table 6.1. Number of deaths in which drugs were detected in the biological materials (including combinations with psychotropic substances) by gender and age in 2007

	15-24	25-34	35-44	45-54	55-64	Total
Men	10	30	9	1	0	50
Women	0	3	0	0	0	3
Total	10	33	9	1	0	53

Source: SCFME 2008

Of the 22 poisoning cases, the majority of deaths were among young people aged 25–29 (20 men and 2 women) *(SCFME, 2008)*.

At present the data of both institutions are not in agreement regarding 23 deceased persons; although the common trend in both registers is an increase in the number of persons deceased due to drugs in comparison to the year 2006. As this is the first increase for a considerable time, it is difficult to determine matters which might influence this factor.

[22] The Law came into force 1 July 2007.

Mortality of drug users in Latvia (cohort study)

In Latvia there are numerous data sources collecting information about those drug users in contact with various institutions, e.g. drug treatment (in- and out-patient), police expertise (those tested positive for drugs), infectious diseases (HIV, hepatitis), mortality data, etc.

Data collection on drug-related deaths In Latvia is carried out by the Health Statistics and Medical Technologies State Agency (HSMTSA) that is responsible for the General Mortality Register. Data collection process and collaboration with the Special Register at the State Forensic Medicine Centre is described in several National Reports on Drug situation in Latvia (e.g., State Addiction Agency, 2006; Public Health Agency, 2007). According to the definition data collected in Latvia refers to the EMCDDA preferred data collection method “Selection B.

According to available statistical data in the period of 1999-2006 there have been 202 drug-related deaths in Latvia. Majority of these deaths (145 or 71%) have been registered between 1999 and 2002, while since 2003 there were 12 to 17 cases registered annually. A number of deaths three times higher between 1999 and 2002 as compared with that recorded in 2003-2006 is related with differences in definition used (EMCDDA Selection D was used between 1999 and 2002 while lately Selection B has been employed) registration system of deaths which counted also those deaths as drug-related where drugs were mentioned in secondary cause of death (State Addiction Agency, 2005, VSMTVA guidelines, 2006).

Among drug related deaths during the last 10 years the mean age at death has decreased by in 6.3 years and in 2006 it was 25.7 years (Public Health Agency, 2007).

In 2006 an open cohort study among injecting drug users was started and the participants are followed-up annually. During the first wave in 2006 555 IDUs were recruited, in 2007 – 614 and in 2008 – 634. The total number of IDUs recruited in the study is 1225, of whom nine persons had died since the first wave. It must be noted that there is a rather large number of persons that were not available at follow-up during the second or third wave, and some of them might have died during three years of follow-up thus becoming unavailable (Trapencieris et al., 2008). Cohort study design has been described elsewhere (e.g. Trapencieris et al., 2007; Trapencieris et al., 2008; Public Health Agency, 2007).

Methodology

A retrospective cohort study design by linking data from two data sources was implemented. One of the sources is out-patient treatment centre database that collects information on those drug users treated. Data collected at out-patient treatment centres is based on TDI protocol developed by the EMCDDA and national and international group of experts, and it includes information on gender, age, substances used, educational level, labour status, etc. The second data source is general mortality registry that records information on died persons according to ICD-10 diagnosis.

The definition of the the cohort of drug users can be defined as those drug users who had entered treatment (for the first time or consecutive episodes) at public out-patient centres between 1999 and 2006 aged 10–44 and having full personal identifier.

Data linkage between two data sources was possible because of a unique personal identifier used in both data sources. Personal identifier was recoded to a sequenced number at the HSMTSA thus not allowing identification of a person by name or any other personal information besides date of birth, gender and initials. As expressed in the definition above the record linkage was done only for those individuals where full personal identifier was recorded at treatment or mortality registers.

The status of all persons in the treatment cohort was checked against the general mortality register, and information about those who had died during the study period (1999-2006) was merged with the treatment database; those with alcohol (F10) or tobacco-related (F17) dependence, intoxication or abuse diagnosis were excluded beforehand.

For each cohort participant person-years were calculated from the first entry date into cohort until date of death or for those who were not present in the general mortality register – until the end of follow-up on December 31, 2006.

Mortality rates were calculated as a fraction of those died and the sum of person years at follow up observed. Mortality rate of drug users with those found in general population of the same age were compared by standardizing the rates. Two methods of standardization were used, while the average eight year (1999–2006) data on population average in Latvia aged 10–49 was treated as standard.

Direct and indirect standardizations were employed:

- the directly standardized mortality rate, which identifies mortality among drug users and not taking into account the age structure of the population, and
- the standardized mortality ratio (SMR) which results from indirect standardization and shows mortality risk among drug users when compared to the general population.

Cohort characteristics

Between 1999 and 2006 5,323 individual aged 11–44 enrolled the treated person's cohort; of these 4,209 (or 79.1%) were males. The mean age at the entrance into cohort was 20.95 years (21.15 for males and 20.16 for females). For slightly less than one half of cohort at the entrance the primary drug of abuse was heroin (2566 or 48.2%), for 722 (or 13.6%) - cannabis, for 503 (or 9.5%) – other or unspecified opiates, for 496 (or 9.3%) - amphetamines, for 452 (or 8.5%) - sedatives or hypnotics, for 218 (or 4.1%) - inhalants or solvents, for 154 (2.5%) - other or unspecified stimulants, for 108 (2.0%) - hallucinogens, for 26 (or 0.5%) - cocaine, while the rest had not reported specific drug of abuse.

In case of consecutive treatment episodes during the time of follow up, primary drug of abuse was taken from the last known treatment episode, thus individuals according to the primary drug for further analysis were as follows: 2592 heroin users, 692 cannabis users, 551 amphetamine users, 490 users of other or unspecified opiates, 424 sedative and hypnotics users, 206 inhalant users, 147 users of other or unspecified stimulants, 100 users of hallucinogens, 95 individuals with no specified substances, and 26 cocaine users. Separate cohorts were drawn and analyzed for those with primary drug of heroin, other opiates and amphetamines at the last known treatment episode. Those with other substances as primary drug of abuse are included in the calculations for the total mortality rates but are not analysed separately here due to small numbers. Cohort characteristics are displayed in Table 6.2 and Figure 6.2.

Table 6.2. Characteristics of the study cohort

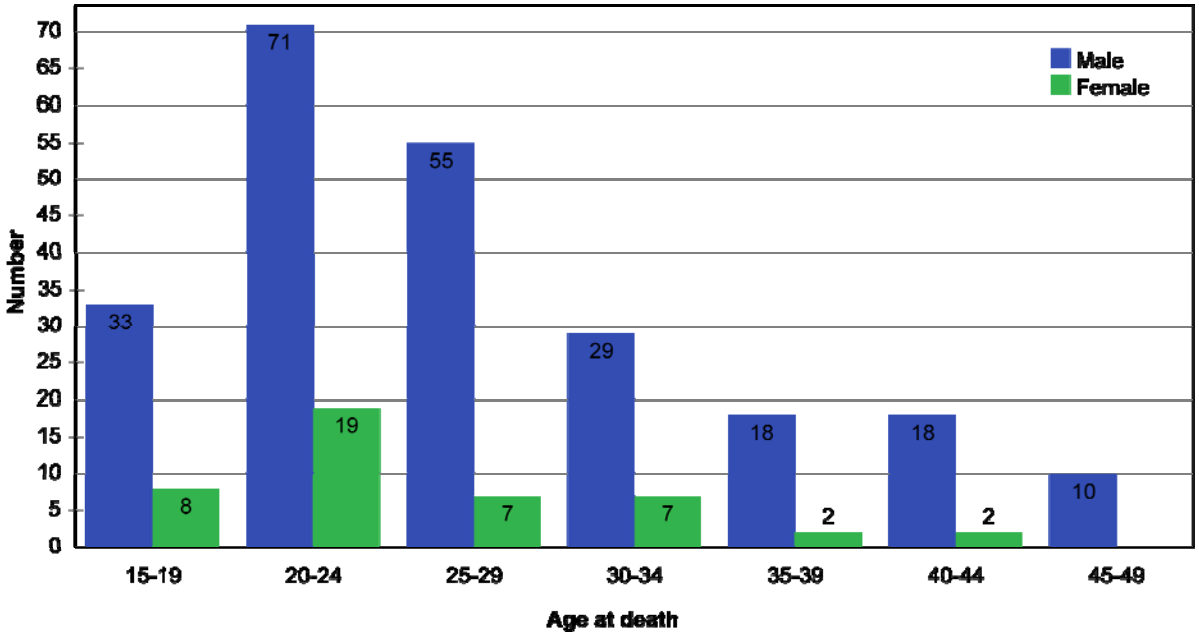
	Male	Female	Total
Total	**4209**	**1114**	**5323**
Mean age	**21.15**	**20.16**	**20.95**
Heroin users			
When entering cohort	2038	528	2566
Last treatment episode	2061	531	2592
Mean age	21.95	20.98	21.75
Amphetamine users			
When entering cohort	377	119	496
Last treatment episode	422	129	551
Mean age	21.02	18.21	20.36
Users of other or unspecified opiates			
When entering cohort	412	91	503
Last treatment episode	397	93	490
Mean age	24.26	23.08	24.03

Source: Trapencieris 2008

Out of 5,323 cohort participants 279 (or 5.2% of all persons enrolled in cohort) had died during the follow-up; among them 234 (or 83.9% of those died at follow-up) were males and 45 (16.1%) females. Majority of them (at follow-up) are classified as heroin users (196 or 70%), followed by users of other opiates (mostly home-made opioid *hanka*) (33 or 12%) and users of amphetamines (13 or 5%). 12 persons who died during follow-up had reported use of sedatives or hypnotics, 11 persons – cannabis, 10 persons – ephedrine, while the rest had reported inhalants or unspecified substances at last known treatment episodes[23]. The mean age at death was 27.08 years; it was higher for males (27.47) than that for females (25.04). About one-third (90 or 32.2%) of all deaths were observed at age of 20–24, followed by age group 25–29 (62 or 22.2%); none of the youngest group of cohort participants had died before age of 15. The age structure by gender at death is reported in Figure 6.2.

[23] TDI data problems that in many cases the diagnosis is not recorded or changed is mentioned in several National Reports and should be taken into account, thus this is being one of the major limitations for the study.

Figure 6.2. Age structure of those died by gender (%)



Source: Trapencieris 2008

Of those died during follow-up for 176 (or 63.1%) the underlying cause of death was external cause (ICD-10 V01-Y98), of which 48 (or 17.2%) had died because of drug overdose. For 13 the main cause of death was an AIDS death (ICD-10 B20-B24), while the most commonly classified main causes of death were related with circulatory system diseases (I codes) – 40 cases, related with diseases of respiratory system (J codes) – 19, digestive system (K codes) – 12 cases. The causes of deaths according to the main ICD-10 groups are shown in Table 6.3.

Table 6.3. Main cause of death

	Number
Total	**279**
External causes of death (V01-Y98)	176
Of those overdose deaths (X41, X42, X61, X62, Y11, Y12)	48
Vehicle accidents (V codes)	15
W codes	18
Assault (X85-Y09)	14
Diseases of circulatory system (I codes)	40
Diseases of respiratory system (J codes)	19
AIDS deaths (B20-B24)	13
Diseases of digestive system (K codes)	12
Malignant neoplasms (C codes)	7
Unattened death (R98)	5
Other deaths (A15, G92, G93, E14, F19)	6

Source: Trapencieris 2008

Within the cohort in 65 cases poisoning by drugs, medicaments and biological substances were mentioned (T36-T50) (except alcohol). The most commonly mentioned was poisoning by other or unspecified narcotics (T40.6) and poisoning by other opioids (T40.2). Poisoning by these and other drugs is displayed in Table 6.4.

Table 6.4. Substances mentioned in cause of death (T codes)

	Number
Total	**65**
Poisoning by other or unspecified narcotics (T40.6)	21
Poisoning by other opioids (T40.2)	19
Poisoning by heroin (T40.1)	4
Poisoning by opium (T40.0)	3
Poisoning by other and unspecified psychodysleptics (T40.9)	2
Poisoning by cannabis (T40.7)	1
Poisoning by psychostymulants with abuse potential (T43.6)	2
Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs (T42)	6
Other (e.g. T50.9, T43.4, T39.3)	7

Source: Trapencieris 2008

Non-standardized mortality (crude) rates

Within the cohort the total mortality rate (crude rate) expressed in person-years (PYs) for eight years of follow-up was 11.29 per 1000 PYs; for males it was slightly higher (11.96 per 1000 PY) as compared with females (8.73 per 1000 PY). No cases of death were observed within the age group 10-14, while the lowest non-standardized mortality rate was within 15-19-year-old drug users (6.66 per 1000 PY), which increases with age and the highest was observed in the 45-49 year old drug users (56.79 PY). Because of relatively small numbers of female drug users who have died during follow-up there are fluctuations in mortality rates within some age groups *(see Table 6.5)*.

Table 6.5. Number of persons died, person-years at follow up and non-standardized mortality rates among gender and age groups

	Number of persons died			Person-years at follow-up			Non-standardized mortality rate		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Total	**234**	**45**	**279**	**19565.59**	**5156.7**	**24722.25**	**11.96**	**8.73**	**11.29**
10-14 y	0	0	0	472.78	133.86	606.63	.00	.00	.00
15-19 y	33	8	41	4958.96	1772.73	6731.68	6.66	4.51	6.09
20-24 y	71	19	90	7015.63	1734.96	8750.58	10.12	10.95	10.29
25-29 y	55	7	62	4140.89	793.97	4934.85	13.28	8.82	12.56
30-34 y	29	7	36	1603.04	383.27	1986.32	18.09	18.26	18.12
35-39 y	18	2	20	771.23	201.45	972.68	23.34	9.93	20.56
40-44 y	18	2	20	461.89	101.55	563.43	38.97	19.70	35.50
45-49 y	10	0	10	141.17	34.91	176.08	70.84	.00	56.79

Source: Trapencieris 2008

The total mortality (crude) rates were higher among those classified as heroin (14.65 per 1000 PY) or other opoid (13.91 per 1000 PY) users as compared with those using amphetamines (8.12 per 1000 PY). Because of small numbers of died amphetamine users further analysis regarding substances at last treatment entry is limited.

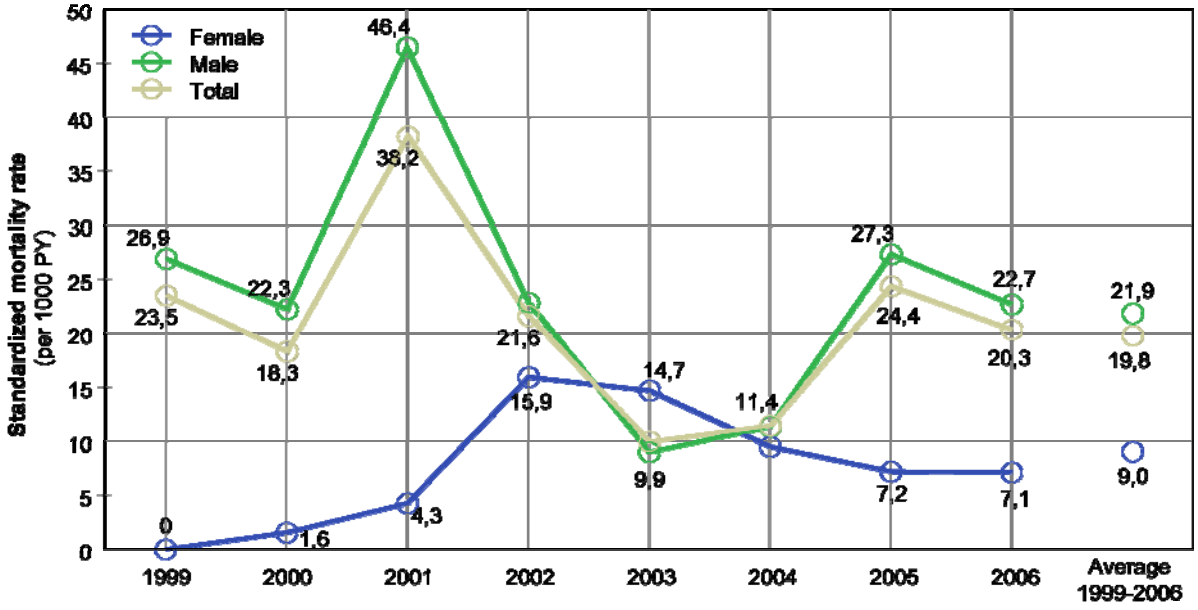
Directly standardized mortality rates

As mentioned above, moving eight-year population average data (1999-2006) was used for standardization for all years of follow-up. Such an approach was assumed to reveal situation better as compared with single year data because of there have been significant changes in demographical situation within the country across years of follow-up.

The directly standardized mortality rate of drug users treated at out-patient treatment centres during cohort follow-up between 1999 and 2006 was 19.80 per 1000 PY; 21.87 per 1000 PY for males and 9.05 per 1000 PY for females. Gender differences were found to be statistically significant.

The highest standardized mortality rate was observed in 2001 at 38.2 per 1000 PY observed, then decreased until 2003 reaching its lowest rate at 9.9 per 1000 PY and increased again until 2005 and has remained somewhat stable in 2006. As seen in the Figure 6.3 standardized mortality rate is dominated by the mortality rate observed in males.

Figure 6.3. Standardized mortality rates at follow-up by gender and year



Source: Trapencieris 2008

Standardized mortality rate changes over time are different between sexes between the years of follow-up. The peak for female drug users in cohort is observed one year later as compared with males, and rate of decrease (in person-years or in percentage points as compared with the preceding year) over the next years of follow-up is not as steep as the one observed within male cohort. But these observations must be interpreted with caution because of small numbers of observed deaths at follow-up, especially among women.

Standardized mortality ratio (SMR)

The standardized mortality ratio (SMR) is used as a risk measure of death among cohort of drug users when comparing mortality with members of general population. The formula used for calculating SMR include number of observed deaths of drug users within whole follow-up, which is

divided by the number of expected deaths within the general population, and the number of person-years of cohort members at follow-up.

The SMR for all drug users in the cohort at follow-up was 7.50 (95% CI 6.65-8.43); this study suggests that the mortality among female drug users is higher than that for males (13.24 and 5.07). SMR and its 95% confidence intervals by gender are shown in Table 6.6.

Table 6.6. Standardized mortality ratios and lowest and highest confidence intervals for males and females during whole cohort follow-up

	SMR	Lowest	Highest
Total	7.5	6.65	8.43
Male	5.07	4.44	5.76
Female	13.24	9.66	17.72

Source: Trapencieris 2008

The SMR for different substance groups was not calculated because of small numbers of cohort members who used other substances than heroin or other opioids at last treatment entry and have died during follow-up.

6.2. Drug related infectous diseases

6.2.1. HIV/AIDS

In Latvia, data on the prevalence of HIV/AIDS is collected and analysed by the state agency "Public Health Agency AIDS and STD Prevention Centre". In 2007 a total of 148 619 blood samples were checked (including state funded, privately conducted tests on blood donors); (153 193 samples in 2006, 119 627 in 2005). 792 tests were used to confirm HIV (698 in 2006, 839 in 2005).

To the end of 2007 there were 3981 cases of HIV infection registered in the State, with 485 persons at the AIDS phase. In 2007 the number of new cases was 350, which had increased by 102 since 2005 (by 51 each year). There is a regular increase in the number of persons at the AIDS phase. In 2007 there were 54 people registered at the AIDS phase, and 28 deceased (in 2006 there were 76 persons registered at the AIDS phase, 25 deceased).

The significant reduction in the number of new HIV cases between 2002-2005 occurred mainly "on account of" intravenous drug users, since an intensive drug addiction harm reduction program had commenced operation, and around the year 2001 large number of drug users were examined who previously had not been tested for HIV, and accordingly a large number of drug addicts infected with HIV was revealed. Consequently, in subsequent years new cases of HIV among drug users were detected much more rarely. It must be borne in mind that the increase in the number of new HIV cases in 2007 does not mean that more people had become infected in that year than in 2005, but rather, that more HIV cases were diagnosed. It is not possible to isolate any single factor to explain the increase in new HIV cases. The situation must be evaluated overall – both on the local and on the regional scale. The prevalence of HIV infection in Latvia is closely

related to similar processes in the eastern European region; it was affected by Latvia's accession to the European Union. In the future, we may possibly expect changes due to changes in the Schengen Agreement (increased migrations of inhabitants etc).

As in previous years the data in 2007 also indicate that there is still a large number of infected persons among intravenous drug users. In 2007, 141 persons were infected with HIV – intravenously using drugs, 126 by way of heterosexual contact, and 15 by homosexual contact; in eight cases a mother had infected a child, and in 60 cases the infection route was not established. New cases of transmission by intravenous drug use have decreased proportionally; however, the sexual transmission proportion has increased.

Table 6.7. Number of cases of HIV infection by transmission groups in Latvia, 1987–2007

Means of transmission	Absolute numbers	Per cent
Intravenous drug use	2515	63.0
Heterosexual contacts	673	16.9
Homosexual contacts	169	4.2
Mother–child	25	0.6
Unknown	599	15.0
Total	3981	100

Source: PHA AIDS and STD Prevention Centre 2008

In 2007 HIV was diagnosed in 233 men and 117 women (in 2006, 186 men, 113 women). The average age of persons in whom HIV infection was detected is 31.8 years for men and 28.8 years for women (PHA AIDS and STD Prevention Centre, 2008).

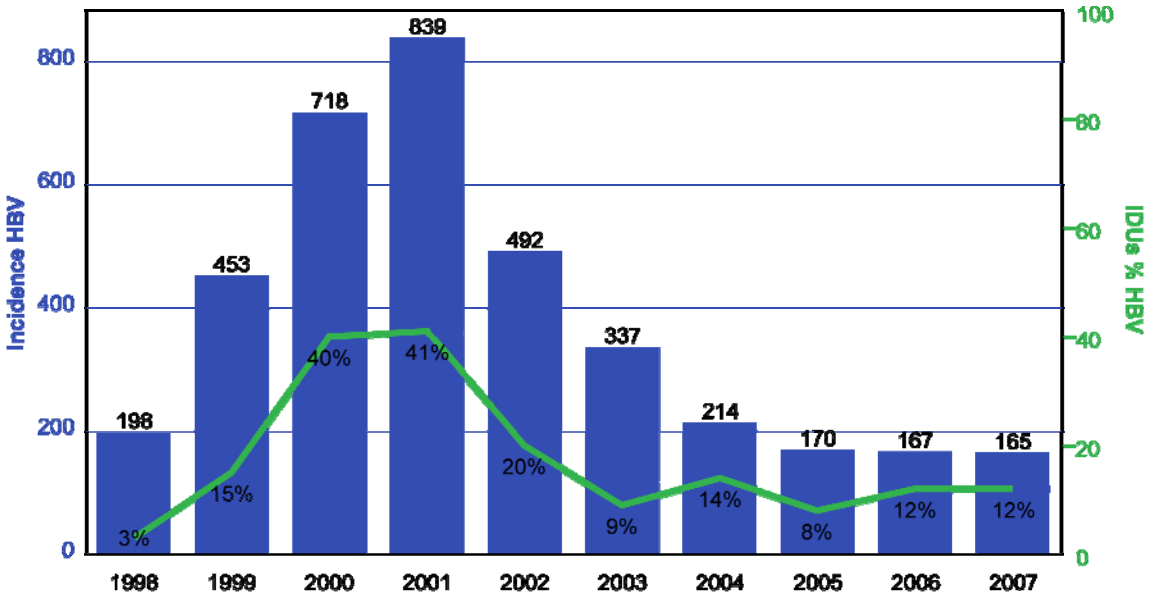
In the third stage of the cohort study (in 2008) it was revealed that the majority of respondents: 89% (total=634) had undertaken a HIV test during their lifetime. Of those who had undertaken the test, 18% indicated that the result had been positive, 6% did not wish to reveal their HIV status, while 1% have not yet been to collect their test results. In 2007 the most recent test for HIV had been positive for 20% of respondents (total =618), who had undertaken the test, in 2006– 14% (n=553). It must be noted that these data may not be precise since they are the product of self reporting and no analyses have been undertaken (Trapencieris et al, 2008.).

Nevertheless it is unequivocally clear that not knowing one's infectious status subjects both the respondents themselves and society as a whole to greater risk and, when planning various activities in the future, it would be necessary to significantly increase the number of tests for both hepatitis and HIV to not less than once a year (or in the ideal case, once every six months).

6.1.1. Hepatitis B/C

At present (since 2001) there is an observable reduction or stabilisation of total cases of both hepatitis B and hepatitis C infection, however, among intravenous drug users there is a significant increase in the number of infectious diseases. At the moment it is difficult to explain this trend unequivocally, since an increase of this magnitude as previously mentioned is seen for the first time since 2001.

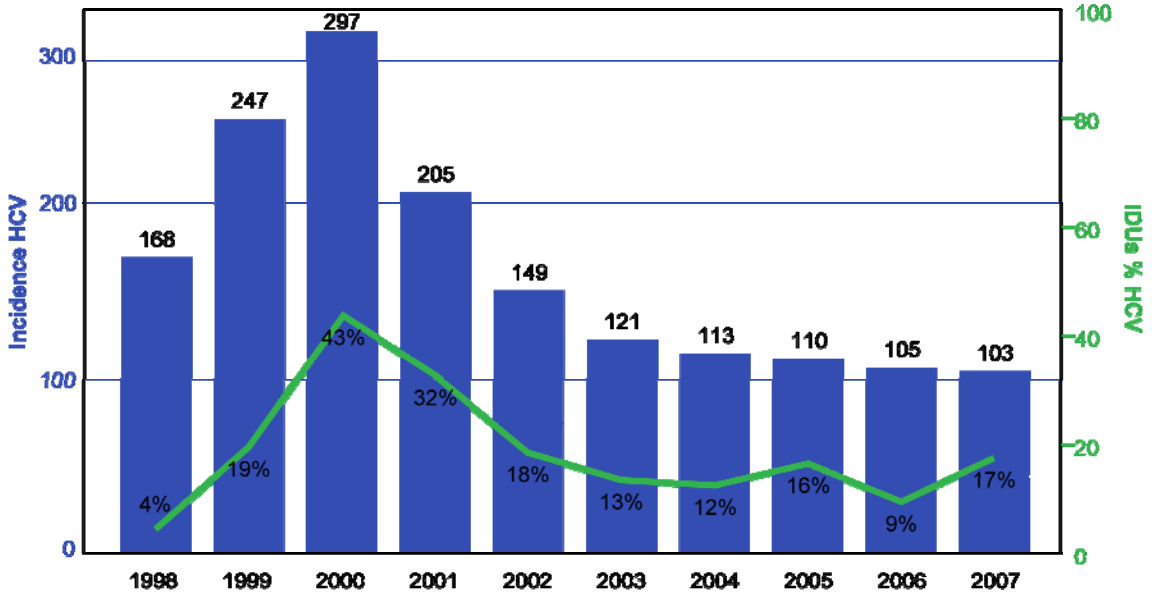
Figure 6.4. Incidence of hepatitis B and proportion of IDUs among notifications data, 1998-2007



Source: PHA Department of Epidemiological Surveillance of Infectious Diseases 2008

An increase is also observable in the number of cases of hepatitis C among intravenous drug users (similar to that of hepatitis B – in this instance an increase was observed until 2000, followed by a decrease).

Figure 6.5. Incidence of hepatitis C and proportion of IDUs among notifications data, 1998–2007



Source: PHA Department of Epidemiological Surveillance of Infectious Diseases 2008

Respondents referred to in the cohort study in the Chapter "Problematic Drug Users" were requested to also reply to questions about morbidity with hepatitis, vaccination, and undertaking tests. The data confirm that 95% of cohort participants (n=634) had not been vaccinated against either hepatitis A or B. 65% also indicated that they had never suffered from these illnesses. 15% noted that they had suffered from hepatitis A, 12% from hepatitis B, 9% were unable to provide any information regarding suffering from these infections.

In the third cohort study wave, there has been a slight increase in the number of respondents surveyed who have undertaken testing for hepatitis (from 61% in 2007 to 65% in

2008). Of those, 18 % are convinced that their test results for hepatitis B is positive, 60% that their test for hepatitis C is positive (Trapencieris et al. 2008). These results should be considered with caution since self-reported data on status of infections is not very reliable measure as compared with serological data.

6.1.2. STDs and tuberculosis

Data on tuberculosis morbidity is gathered and analysed at the state level by the Latvian State Agency for Tuberculosis and Lung Diseases. The operational aim of the Agency is the prevention of tuberculosis and lung diseases and a reduction in the number of cases of tuberculosis illness in the State.

In recent years, morbidity of tuberculosis illness in the State has decreased as has mortality from it, however, it continues to be a topical issue, including among drug users and those persons who suffer from HIV/AIDS.

Table 6.8. Incidence of tuberculosis per 100 000 inhabitants, 2000–2007

	Morbidity per 100,000 inhabitants
2000	70.5
2001	72.9
2002	65.4
2003	63.3
2004	59.0
2005	53.5
2006	49.7
2007	47.2

Source: Latvian State Agency for Tuberculosis and Lung Diseases 2008

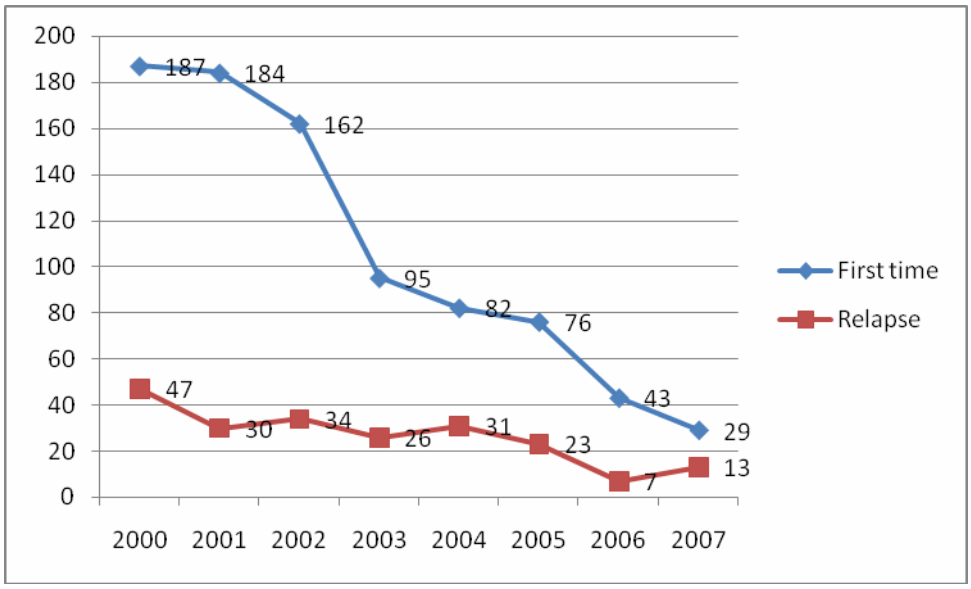
As previously mentioned, mortality from tuberculosis in the period 2000-2007 has also reduced by slightly more than half, i.e. in the year 2000, 300 people died from tuberculosis, while 123 died in 2007 .

Tuberculosis morbidity is also observable among children. It is encouraging that since 2000 the number of children suffering from this disease has reduced almost threefold (144 cases in 2000; 57 cases in 2007).

Tuberculosis in places of imprisonment

Since 2000, tuberculosis morbidity in places of imprisonment has rapidly decreased, among both first-time registered cases and relapsed cases, even though the trend curve changes periodically for relapsed cases,.

Figure 6.4. Diagnosed cases of tuberculosis in places of imprisonment, 2000–2007

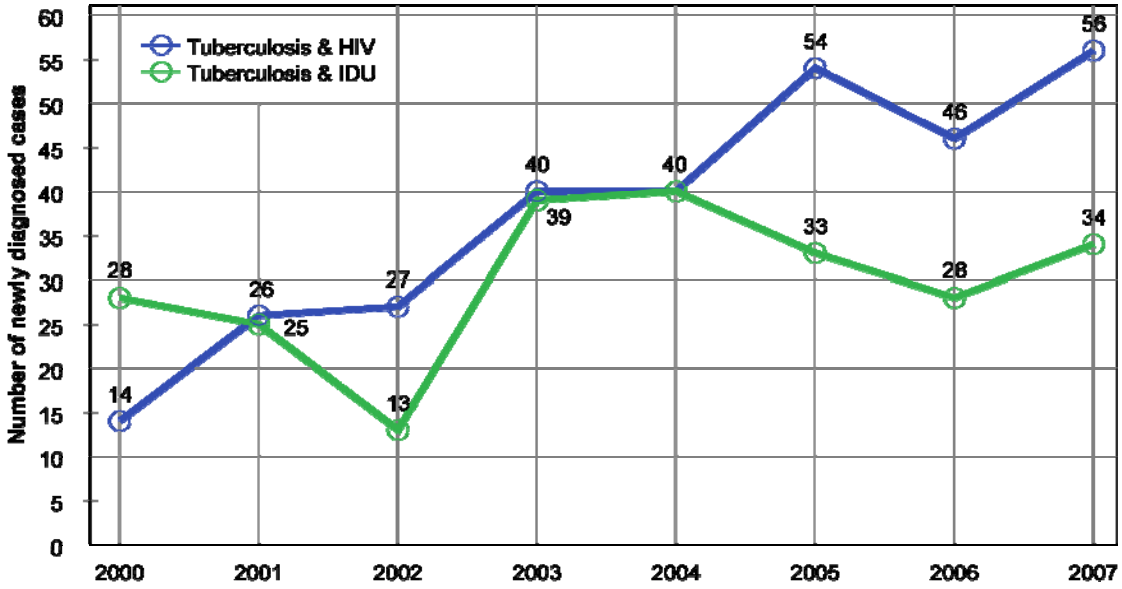


Source: Latvian State Agency for Tuberculosis and Lung Diseases 2008

Most frequently, tuberculosis has been diagnosed in the Riga Central Prison, followed by the prisons at Valmiera and Daugavpils.

The Latvian State Agency for Tuberculosis and Lung Diseases also registers those patients for whom a dual diagnosis has been made i.e. tuberculosis and HIV/AIDS. Contrary to the indicators for places of imprisonment and the general tuberculosis prevalence indicators nationally, the number of patients suffering from both TBC and HIV/AIDS since 2000 is increasing.

Figure 6.6. Number of persons diagnosed with tuberculosis and HIV and IDUs among TBC cases in Latvia



Source: Latvian State Agency for Tuberculosis and Lung Diseases 2008

The Agency's registration forms also show information about whether a patient uses drugs. It must be noted that these indicators do not show any marked trends, as they both increase and decrease periodically. To date, the largest number of tuberculosis patients who use drugs was registered in 2004: 40 persons or 2.9% of the total number of patients suffering from tuberculosis.

The Public Health Agency collects and compiles information not only about HIV/AIDS and hepatitis B/C, but also about other sexually transmitted infections. However this information is not being analysed for the time being in relation to the use of drugs. Nationally in 2007, morbidity from syphilis and gonorrhoea and chlamydia has reduced overall; in 2007, 301 patients were registered with syphilis (483 in 2006), 669 with gonorrhoea (746 in 2006) and 711 with chlamydia (820 in 2006) (PHA, 2008).

6.3. Psychiatric co-morbidity (dual diagnosis)

No data available

6.4. Other drug-related health correlates and consequences

No data available

7. Responses to Health Correlates and Consequences

In 2007 in comparison with 2006, the number of fatalities and user mortality associated with drug use had slightly increased, and with that it is important to consider the possible prophylactic measures that could be undertaken in Latvia in the near future. At the moment there is little being done in this area and information on how users could protect themselves does not reach them to a sufficient extent.

In relation to the prevalence of infectious diseases, there is an observable trend in recent years for the spread of the HIV infection by way of direct heterosexual transmission. In Latvia, all the syringe exchange consultative points are operating successfully, which are primarily those institutions which are able to protect drug users from infection from various infection diseases.

7.1. Prevention of drug related deaths

By the concept of "reduction of fatalities associated with drug use" is meant the direct, i.e. reduction of cases of overdose *(EMCDDA, Aim: drugs, 2004)*. There is practically no discussion of this issue taking place in the country at present, nor is there practically any information available in the country at present on the prevention of drug overdosing (see SQ 23&29). However, it is possible to regard the treatment possibilities offered as one means of reducing the number of fatalities associated with drug use.

Data on overdosing cases associated with drug use is compiled in Latvia by the Hospital "Gailezers", the State Toxicology Centre and the Emergency First Aid Service, as well as the Riga Centre of Psychiatry and Addiction Disorders, which gathers information about the inpatients and outpatients within the centre, including toxicology testing information *(Coffin 2008)*.

In 2008, the research study by Philip Coffin entitled Overdose: A Major Cause of Preventable Death in Central and Eastern Europe in Central Asia: Recommendations and overview of the situation in Latvia, Kyrgyzstan, Romania, Russia and Tajikistan[24] was published. In this study, the Latvian situation with regard to drug overdosing is described in detail, utilising such data sources as the Focal Point National Report, Health Statistics and Medical Technology State Agency and Latvia State Centre for Forensic Medical Examination information, Emergency Medical First Aid Service data, the "Gaiļezers" Hospital, the State Toxicology Centre and the Riga Centre of Psychiatry and Addiction Disorders data.

Emergency First aid is provided free of charge to all Latvian inhabitants, however, a fundamental problem is the users' own fear of calling for assistance. The study indicates that assistance will be sought only in a very critical situation. This is associated with the fact that users

[24] Additional information is available on the Internet : http://www.harm-reduction.org/index.php?ItemId=18541

are afraid that they will be reported to the police, although this is not done in practice *(Coffin, 2008).*

In Latvia, similar to other member states of the European Union, most fatalities from overdosing occur among young men *(EMCDDA, Aim: Drugs, 2004; VSMTV 2008; VTMEC 2008),* and therefore particular attention must be focused on this risk group. Replacement therapy programs have a particular role in the prevention of overdosing from drugs. In Latvia, two replacement therapy medications are available: methadone (free of charge) and subaxone. In the near future it is planned to start using subaksone in place of subutex.

A major role in the reduction of overdosing related to drug use is taken by the AIDS and STD Prevention Centre syringe exchange consultative points, in which social workers inform users about safe use and what to do in the event of overdose (see SQ 23&29).

If particularly dangerous narcotic substances are seized in the country, or information about them is received from other countries, ASEUC as the national focal point transmits the information through its early warning systems for new psychoactive substances to its co-operation partners who pass on the information to their clients, warning of the specific substance and its possible dangerous consequences.

In 2007, 173 cases of overdosing were registered at the State Toxicology Centre. The majority of patients were men who had overdosed on heroin, amphetamines, and other substances which it was not possible to identify *(see Table 7.1.).*

Table 7.1. Cases of drug overdose registered at the State Toxicology Centre in 2007.

Name of substance	Number	
	Men	Women
Amphetamines	23	6
Amphetamines + other substances	13	1
Ephedrine	1	0
Ecstasy	3	1
Heroin	36	5
Heroin + other substances	13	2
Quinine	0	1
Cocaine	2	0
Cannabis	5	2
Cannabis + other substances	0	1
Methamphetamine	4	3
Morphine	3	2
Morphine + other substances	3	0
Natrium oxibuterate	4	0
Unidentified substance	16	6
Combination of unidentified substances	5	1
Opiates	10	1
Total	**141**	**32**

Source: Coffin 2008.

719 calls were made seeking emergency first aid in relation to drug overdosing. Of those, 168 persons were hospitalised. The majority of overdose patients were men aged 25–29. There has recently been an increase in the number of persons poisoned with substances/medications available in Latvia only on prescription (for example, poisoning from *Cyclodol*) *(Coffin 2008)*. A second important problem is poisoning from home-made drugs (ephedrone). Latvian scientists, undertaking a clinical study, revealed a connection between the use of ephedron and the development of the Parkinsonism syndrome among drug users *(Stepens et al. 2008).*

In 2008 a cohort study of drug users (Trapencieris et al. 2008) that was undertaken in Latvia Utilised in this study was contact information for respondents already obtained in 2006 and 2007. At the moment 400 respondents were surveyed in two cohort stages of the study, but in all three stages – 119. In 2008, a total of 634 drug users were followed up (618 in 2007, 553 in 2006). Six respondents died in 2007; three died in 2008, although the cause of death of these persons is unknown (for more comprehensive review of various domains and description of the study see the Chapter "Problem Drug Users" and in study reports published in Latvian).

Thrid wave of the drug users' cohort study (see Trapencieris et al., 2008 and chapter on Problem Drug Use) suggests that 13% of respondents had at least once overdosed on drugs (12% in 2007, 16% in 2006) in 2008. Analysis of the data from the cohort study stages in 2007 and 2008 reveals that every third respondent (34%) of those who indicated that he or she had had at least one overdosing episode within the six months prior to the second stage of the study, had overdosed again during the period prior to the third stage of the study; while 4% of respondents had reported overdosing in both 2007 and 2008 (See Table 7.2):

Table 7.2. Cases of overdosing in the second stage of surveyed respondents, and the third stage of respondents surveyed again (%)

		2008	
		No	Yes
2007	No	78	11
	Yes	8	4

Source: Trapencieris, Snikere et al. 2008.

Of the persons who had overdosed in 2008, 12% had overdosed on amphetamine, 15% on heroin, 16% on hanka and 13% on ephedrine. In comparison with overdosed substances in 2007, the registered differences are not significant other than for overdosing with hanka (in 2007, 4% of surveyed respondents overdosed on hanka).

In 2008, compared with 2007, there is an increase (from 40% to 51%) in the involvement of medical personnel to prevent cases of overdosing, however, there is a slight reduction in the involvement of friends (from 59% in 2007 to 52% in 2008) (Trapencieris et al. 2008).

7.2. Prevention and treatment of drug related infectious diseases

7.2.1. Prevention

Participating in the prevention of infectious diseases in Latvia most often is the Public Health Agency AIDS and STD Prevention Centre, which undertakes and coordinates several projects. The most important of these projects which encompasses the period for 2007 is:

- **"Preparation of law enforcement specialists for work with drug users, utilising the multimedia training method".** The project took place in the period May 2005 until March 2007. The Society Integration Fund-financed project was implemented by the public policy centre PROVIDUS in cooperation with the AIDS and STD Prevention Centre. Within the project framework, 50 regional seminars were held entitled "Police Drugs and AIDS", in which 750 state and local government police officers were prepared for working with drug users. The aim of the training was to improve the contact of police officers with drug users, which carries a high risk of becoming infected with HIV, and to promote awareness of drug-harm producing programmes in Latvia. Modern multimedia training material entitled "Police, Drugs and AIDS" was developed as part of the project, and was utilised at the training seminars.
- **"Development of coordinated and comprehensive HIV/AIDS prevention system for IDU's and transition groups (ENCAP)"** is a project supported by the European Commission in which five countries are collaborating – Latvia, Lithuania, Estonia, Finland and Bulgaria. The project started in 2006, and its aim is to reduce the prevalence of HIV/AIDS and other infectious diseases among high-risk groups and others close to them (for example near relations of intravenous drug users and their sexual partners). The main aim of the project is to enlarge the existing network of state, local government, and non-governmental organisations and institutions with regard to HIV/AIDS prevention work with intravenous drug users and transition groups, involving new co-operation partners in this work. Project tasks include: formation of an international cooperation network, research on the prevalence of HIV and other infectious diseases among intravenous drug users and other related groups, formation of a low threshold cooperation network Centre, developing common indicators, training of low threshold centre personnel and raising the capacity of their staff, public awareness of the importance of the low threshold centre in promoting the reduced prevalence of HIV/AIDS and other infectious diseases. The project report will be published in 2009 and data will be reported in the next National report.
- **"Enlargement of treatment and care possibilities for HIV/AIDS and tuberculosis patients and promotion of prevention of health care system in the Baltic States".** This project is being implemented in Latvia by the World Health Organisation Europe regional bureau in Copenhagen within the framework of the Latvian Ministry of Health Biennial Cooperation Agreement (2006/2007). Its implementation in Latvia is being coordinated by the AIDS and STD Prevention Centre in cooperation with the State Agency for Tuberculosis and Lung

Diseases Latvia. Its main aim is to reduce the prevalence and effect of HIV and tuberculosis in the Baltic states.

The AIDS and STD Prevention Centre administer 13 consultative points in the largest Latvian municipalities. Consultations are provided at these points with social workers and psychologists, clean syringes and disinfectants are issued, contraceptives and informative materials are distributed. It is possible to undertake tests for HIV and hepatitis C. The Centre also administers and coordinates the work of several street social workers who undertake consultative work on the street or in places where users gather, as well as distributing/exchanging clean syringes for used syringes, and distributing disinfectants and contraceptives (see SQ 23 & 29).

Data from Drug users' cohort study 2008

Evaluation of harm reduction programs

In comparison to the second cohort wave (Trapencieris et.al. 2007), the ratio of cohort participants to have ever attended a HIV prevention (or syringe exchange) point has increased to 74%. This observation is natural since respondents who had participated in previous stages of the study were provided with information on the operation of these points and the services offered. Nevertheless if only those cohort participants who were surveyed for the first time in 2008 are considered, no significant differences were observed (61% had visited in 2007; 63% in 2008). No statistically significant differences were observed, either by gender or nationality, but it was nevertheless observed that respondents from some age groups, i.e. older respondents, more frequently indicated that they had at some time visited a HIV prevention point.

In reviewing the regularity of attendance at points during the past six months an increase was observed in the number of visitors who sought help on one or two occasions (32% in 2008 compared to 25% in 2007) and between three and four occasions (32% in 2008 and 24% in 2007), while the ratio of those who had sought help on more than six occasions had decreased, both over the past six months and over the past 30 days *(see Table 4.20)*. When interpreting these results it must be borne in mind that there is an increase in the number of respondents unable to provide a figure for the number of visits.

Table 4.20. Attendance at HIV prevention or "needle exchange" points (%)

	2007			2008		
	Ever	Last 6 months	Last 30 days	Ever	Last 6 months	Last 30 days
Visited services[25]	61	60	50	74	70	48
Proportion of regular clients[26]	N/A	11	18	N/A	4	5
Proportion of respondents unable to indicate number of times	N/A	8	17	N/A	10	22

Source: Trapencieris et al. 2008

[25] Per cent of all cohort participants.
[26] According to attendances for relevant time period (past six months or past 30 days). "Regular" clients may be regarded as those who had attended on more than 20 occasions, or on 4 or more occasions during the t past 30 days (or approximately once a week). Questions on regularity of visits were not put to those who visited points only in their lifetime.

When questioned about the utilisation of services offered by street social workers, 74% of respondents indicated they had utilised these services in 2008 (compared to 81% in 2007).

The most often mentioned services which drug users wished to receive at HIV prevention points were: to undertake analyses of infectious diseases (mostly HIV) (23%), obtain or exchange syringes (15%), to receive various information (9%), or to participate in excursions or recreational events organised at the centre (9%). Slightly less frequently, drug users indicated that they wish to receive moral support and simply to chat (5%); 4% indicated that they wish to consult a psychologist, while nine drug users would willingly participate in courses or training.

Such changes are difficult to explain unequivocally, as overall nationally the resultative indicators from harm reduction programs improved in terms of number of syringes distributed, as well as the number of clients involved, but it is nevertheless possible that syringe exchange programmes do not attract the majority of potential clients, and by increasing their working hours, and/or providing new services or new methods of supplying syringes, theoretically, more clients could be attracted in the evenings, which could in turn effect a reduction in the overall level of syringe use. Worthy of mention as one positive example from the past year is the establishment by the largest harm reduction point in Riga of a mobile unit. However, finance allocated to maintain this unit is far too little to gain the full return from it (for example, the funding allocated for fuel allows it to travel no more than 20 km a day).

Common use of injecting accessories

Based on the cohort study of drug users (2008 stage), it may be concluded that 30% (n=634) of respondents during the past six months had used a common syringe or needle, but if the years 2007 (n=618) and 2008 are compared, then it must be pointed out that this year there is an increase of 13% in the proportion of respondents who had shared the use of other injection accessories (cotton, spoon, etc). By combining it would appear that in 2008, 58% of respondents had shared the use of common injecting accessories. In both previous years, 27% of respondents had never shared the use of common injecting accessories during the past six months. 34% of respondents in the two previous years mentioned, had used common injecting accessories. 24% of respondents had not shared common injecting accessories in 2007 but had shared them in 2008; however, the proportion of respondents who had shared common injecting accessories in 2007 but had not used them in 2008 was 15%.

It was also revealed, that younger respondents more frequently shared common injecting accessories *(see Table 4.21)*.

Table 4.21. Use of common injecting accessories during the past six months by age of respondent (% of replies received)

	Under 24	25–29	30–34	35–44	45 and older	Total
2007	61	46	36	36	25	45
2008	68	65	59	41	32	58

Source: Trapencieris, Snikere et al. 2008

It is an alarming fact, that a proportion of respondents continue risky behaviour, using common injecting accessories for a protracted period, and by doing so, threatening not only themselves but also other users. The fact that common injecting accessories are being used by younger drug users (and the proportion is increasing), indicates the need to focus particular attention on precisely this group. At the moment, parallel to the AIDS and STI Centre administrated syringe exchange points, a mobile unit has been formed – on certain days, a bus travels along a specified route, in which it is possible to exchange syringes, obtain condoms and receive consultations. Unfortunately the funding available does not permit this work to be performed to the necessary extent and quality, since fuel consumption is limited, and in one day the bus can only travel 20 km (Trapencieris et al. 2008).

Risky sexual behaviour by drug users

Risky sexual behaviour is as dangerous a practice as sharing common injecting accessories. It was concluded in the cohort study (2008 stage) that 80% of respondents had engaged in sexual relations within the past 30 days (87% of women and 76% of men). Among those respondents who had engaged in sexual relations within the previous 30 days, there is a greater proportion of women who had had sexual contact with more than three partners, compared to men – 32% and 20% respectively. Engaging in sexual relations with a single partner during the previous month had been 54% of men and 51% of women, but with two partners – 24% of men and 15% of women.

In comparison with the 2007 section of the cohort study, in 2008 there was an increase in that proportion of respondents who had used a contraceptive at the time that last engaged in sexual relations – respectively from 45% to 49%.

The 2008 data reveal that 26% of respondents had during their lifetime engaged in sexual relations for money, drugs, or other material benefits (Trapencieris, Snikere et al. 2008).

7.2.2. Treatment

One of the largest institutions for the treatment infectious diseases is the state agency "Infectology Center of Latvia", which is subordinate to the Ministry of Health. The aim of the centre is to ensure informative support to state institutions and the public and methodological and organisational support to the Ministry of Health in the forming and implementation of infectology policy, providing highly qualified and qualitative specialised medical assistance to second and third level inpatients and outpatients suffering from infectious diseases (including rare and resurgent diseases, HIV/AIDS, sexually transmitted diseases, parasitic diseases), as well as to undertake specific prevention and research in respect of infectious diseases. The main functions of the Centre are as follows:

- provision of medical assistance to patients suffering from infectious diseases,

- ensuring the isolation and treatment of patients suffering from epidemiologically dangerous infectious diseases,
- undertake the functions of a national reference centre in the field of microbiology (including HIV/AIDS and virus hepatitis),
- diagnosis of rarely encountered infectious diseases; introduction of modern technology for the laboratory diagnosis of infectious diseases,
- Undertake prophylaxis of infectious diseases and training of specialists in this field.

At the "Infectology Center of Latvia", multifaceted research studies are undertaken into HIV/AIDS, hepatitis B/C and other fields[27].

7.3. Interventions related to psychiatric co- morbidity

No information available.

[27] Additional information may be found on the Centre website: http://www.infectology.lv/index.php?p=1152&lang=259

8. Social Correlates and Consequences

Due to a lack of data social exclusion related to drug use in this section is analysed only in terms of basic indicators: educational level and employment status. However subchapter will discuss recent data on drug use in prison in Latvia. A study carried out in 2007 in one of the prisons in Latvia (Valmiera prison), as well as data from 2008 cohort study of drug users is analysed.

8.1. Social exclusion

Even though several studies have been conducted in Latvia in the field of social exclusion, this issue has not until now been specifically studied in relation to drug users and drug use. Usually social exclusion and the possibilities of reducing it are related to issues of poverty and their resolution. The most important studies in the field of social exclusion in Latvia were undertaken in 2002 and 2007 – "Identifying risk factors of social exclusion among poor family children" and „Reasons and length of unemployment and social exclusion". Both studies were undertaken in Latvia by the University of Latvia Institute of Philosophy and Sociology.

Although we indicated in the National Report for last year that data available in Latvia do not permit the conducting of an appropriate analysis of social exclusion, it is nevertheless possible to reflect the basic information regarding this issue.

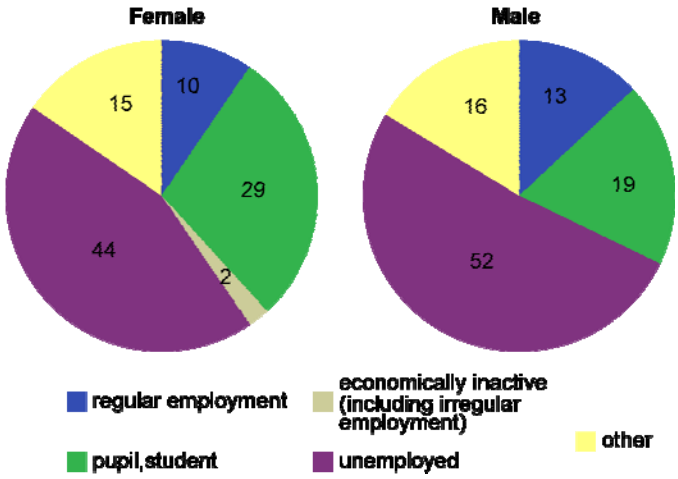
Indicating the complexity of the issue of social exclusion is its definition, that is, social exclusion is a multidimensional phenomenon (Trapenciere, Rajevska et al. 2002), in which several negative aspects are interrelated or causative of each other (EMCDDA 2003). The most frequently interrelated negative aspects are drug use, prostitution, unemployment, low income, poverty, low level of education, diseases, violence, criminality, nonexistent dwelling place, difficult access to health and other services, debts etc (EMCDDA 2003).

As there is a need in the future for a separate qualitative study, in order to analyse social exclusion in relation to drug use, based on the most prevalent dimensions of social exclusion available in the scientific literature (exclusion in terms of employment, economic exclusion, institutional exclusion, isolation as a form of social exclusion, exclusion in terms of culture and spatial exclusion), at the moment, due to lack of data, social exclusion in relation to drug use will be analysed only in terms of basic indicators – education level and employment status.

In 2007, 52321 unemployed persons were registered in Latvia to the end of the year, which is 16623 less than in 2006. The majority of unemployed still comprises women (62%) aged 45 – 54. The majority of all unemployed have professional education (State Employment Agency 2008). This possibly indicates that for the relevant period, the choice of professions was such that at the moment it no longer allows normal entry into the job market with the existing professions in demand. This particularly applies to various manufacturing industries.

In 2007, included in the drug patient register were 627 first-time patients (491 men and 136 women). The majority of those – both men and women, were unemployed at the present time; only 64 men and 13 women were in regular employment.

Figure 8.1. Employment status of first-treated males and females (%)



Source: Riga Psychiatry and Addiction Centre 2008

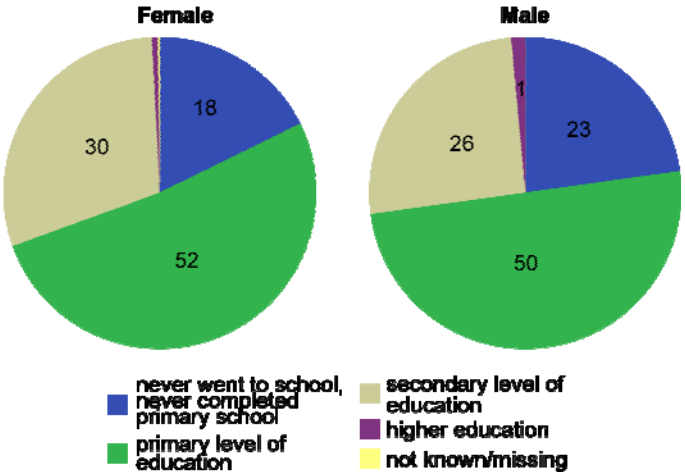
In comparison with 2006, the percentage of unemployed in this group (both for males and females) has remained at stable level, although it still continues at a high level. It must also be noted that the majority of first-time registered patients are pupils or students.

In the third wave of the drug users' cohort study"[28] 20% of men and 34% of women were neither studying nor working; 27% of men and 14% of women had regular and official work, but working without a contract (based on a verbal agreement) were 28% of men and 22% of women. In this study, in a comparison of first-time registered patients, there were few respondents who indicated they were pupils or students; 4% of men and 6% of women respectively. Users most frequently indicated that they worked in building construction: 30%, worked as freight loaders, 7% as salespeople, 6% as security guards, 5% worked doing unqualified work, and 3% worked in prostitution. A further 10% of respondents noted that they did miscellaneous work (Trapencieris et al. 2008).

In relation to the educational level of first-time registered patients, it must be pointed out that the majority had elementary level education or incomplete elementary education. Only five people had higher level education.

[28] Research methodology and documentation are described in the Chapter **Problem Drug Use** and the Treatment Demand population

Figure 8.2. Education level of first-treated males and females (%)



Source: Riga Psychiatry and Addiction Centre 2008

Women more frequently than men had incomplete elementary level education; however men more often than women had secondary level education. Overall, the majority of all patients had only elementary education, which generally conforms to the data from last year.

8.2. Drug related Crime

See Selected Issue on Sentencing statistics.

8.3. Drug Use in Prison

This chapter will discuss recent data on drug use in prison in Latvia. A study carried out in 2007 in one of the prisons in Latvia (Valmiera prison), as well as official data from the Prison Department and data analysis of 2003 study on drug use in prisons that was carried out within the framework of the aforementioned study will be discussed further in this chapter.

Background

Correctional system in Latvia follows progressive prison system. There are 15 prisons in Latvia, including one correctional house for minors (Cēsis) and one prison for female offenders (Iļģuciems) *(see Map 8.1.)*. Out of all prisons there are seven closed regimen prisons (Grīva, Jēkabpils, Jelgava, Valmiera, Matīsa, Pārlielupes, Brasa), two semi-closed regimen prisons (Iļģuciems, Šķirotava), two open regimen prisons (Olaine, Vecumnieki), three custody-type prisons, and one prison from minors. Three of the prisons (Daugavpils, Liepāja and Centrālcietums) contain sections of closed regimen, five prisons (Jēkabpils, Centrālcietums, Daugavpils, Matīsa and Liepājas) – semi-closed regimen, three prisons (Jēkabpils, Iļģuciems and Daugavpils) – open regimen sections, while five prisons (Jelgava, Valmiera, Matīsa, Iļģuciems and Cēsis) – custody type section.

Map 8.1. Prisons in Latvia

Source: Trapencieris, Snikere et al. 2008

RAR study in Valmiera prison

In 2007, in the framework of a four-year UNODC funded project „HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania", a study with an aim of assessing drug use situation in one of the Latvina prisons (Valmiera prison) to develop successful interventions for prevention of HIV/AIDS in this prison.

The main objective of the project is identification of the attitudes and knowledge of prisoners and prison officers regarding narcotic substances and related risks; mapping drug use problems for the long-term planning of activities in the field of drug use and HIV prevention in prisons, including suggestions for the development of appropriate treatment and/or harm reduction programmes.

This study was based on Rapid Assesment and Response (RAR) methodology, which is used worldwide in assessing situation in hard to reach populations (e.g. (Braam et al. 2004; Rhodes et al.1999). This method is a scientifically-led rapid survey method for recording the type, origin and need for action in respect of a recognized or presumed problem, within a short period of time, with limited expenditure and with high practice relevance. It can thus be regarded as forging a "link" between the needs of practice and the methods used by scientific research. RAR makes considerable use of the individual elements or "tools" of social science research, and is essentially qualitative. From the results one can expect that it will provide a clear and relevant depiction of a problem and thus be adequate for the further planning of interventions.

Statistical data on prisoners

According to official statistics, as of 1st January, 2007 there were 6548 inmates in prisons in Latvia; of those 4538 (236 females and 127 minors) were convicted persons. In Valmiera prison the number of convicted persons has remained at the same level as in 2006 but has significantly decreased as compared with 2003–2005 data *(see Table 8.2.)*.

Table 8.2. Number of inmates in Latvian prisons and Valmiera prison, as of January 1 in a given year

	2003	2004	2005	2006	2007
Total number of inmates		8231	7646	6965	6548
Number of convicts		4962	4984	4766	4838
Number of inmates in Valmiera prison		678	678	729	631
Number of convicts in Valmiera prison	686	678	706	599	607

Source: Trapencieris, Snikere et al. 2008

About every other convicted person in Valmiera prison during time between 2004 and 2006 were sentenced for burglaries and theft as their main crime, while about every tenth inmate is sentenced for drug-related crimes; this proportion has remained about the same between 2004 and 2006 *(see Table 8.3.)*. Due to changes in data collection procedures, where all crimes are being reported in not possible to calculate the proportion of main crime against all crimes for 2007 data.

Table 8.3. Number of convicted persons in Valmiera prison according to main crime

	2003	2004	2005	2006	2007
Homicide	85	84	90	79	84
Intentional bodily injury	57	72	78	75	99
Rape	36	39	40	34	58
Theft	253	201	160	134	210
Robbery	168	171	202	182	221
Fraud	6	7	10	5	14
Hooliganism	13	12	16	11	37
Drug-related	24	55	70	51	41
Other	44	37	40	28	192
Total	**686**	**678**	**706**	**599**	**607**

Source: Trapencieris, Snikere et al. 2008

In Valmiera prison about every fourth inmate is aged under 25, while about every second is aged over 30 *(see Table 8.4.)*. As seen in data from other sources and studies conducted around the world, drug abusing risk group is under age of 40 and in majority of cases under 30 years of age, thus it can be estimated that at least 50% of convicted persons in Valmiera prison are in risk for drug abuse.

Table 8.4. Number of convicted persons according to age groups

	2003	2004	2005	2006	2007
18-25	235	186	193	198	143
25-30	133	159	168	124	155
30-40	179	193	201	172	190
40-50	97	102	105	77	87
50 and over	42	38	39	28	32
Total	**686**	**678**	**706**	**599**	**607**

Source: Trapencieris, Snikere et al. 2008

One of the articles in mass media in 2006 mentions that cell phones and illegal substances are brought in regularly inside Valmiera prison either by relatives or persons especially contracted for this purpose. The prison governor calls government officials for necessary changes in legislation to stop any imports of goods into Latvian prisons as, for example, in Estonia and other countries.

Table 4 reveals official data on drugs seized in Valmiera prison. According to this data since 2005 there is decrease in seized quantities of illegal substances (e.g. heroin, amphetamines, cannabis, etc.). On the other hand quantities of seized psychotropic substances (e.g. benzodiazepines, tranquilizers, etc.) have increased.

Table 8.5. Quantity of drugs seized in Valmiera prison, 2003–2007

	2003	2004	2005	2006	2007
Illegal drugs, g	104,32	162,84	443,2	210,1	91,1
Psychotropic substances, g	4,5	6	5	3	263,67

Source: Trapencieris, Snikere et al. 2008

In Table 8.6. known cases of drug use (whenever persons is cought when using drugs or is being sent for blood or urine tests and found positive) in all prisons and Valmiera prison are shown. According to these data number of known cases in 2006 had decreased as compared with 2005 data. According to the legislation one can also refuse to pass these tests and then he gets an administrative fine, will be sent to punishments cell for up to 14 days, and also if one is refusing to pass the drug test it is counted as violation of rules, which is taken into account when deciding on pre-term release from prison. In reality this means: a prisoner who is taking drugs would agree to pass the test only once during calendar year, since when a person is tested positive for drugs during calendar year he would get an administrative punishment, while for the second time it is a criminal penalty and could mean of up to two years extra prison sentence.

Table 8.6. Known cases of drug use in Latvian prisons and in Valmiera prison, 2003-2006

	2005	2006	2007
Prisons in Latvia	255	168	N/A
Valmiera prison	75	21	N/A

Source: Trapencieris, Snikere et al. 2008

Key results from the RAR study

RAR study consisted of three major phases of data collection: 1) semi-structured interviews with inmates (n=10) and staff (n=12), 2) structured interviews with inmates (n=10) and staff (n=10), supplemented by 91 self-completed questionnaires by inmates, and 3) two focus group discussions (one with inmates and other with staff). Based on the gathered information key results are discussed below.

According to information obtained, the most prevalent drug in Valmiera prison is amphetamines, followed by cannabis, heroin and various sedative and tranquilizers. Cannabis usually is used by smoking, as opposed to amphetamines and heroin, which are used by injection.

According to inmates and prison staff, drug use inside prison only reflects what is happening outside prison walls; and indeed treatment (treated persons) and police data (seizures and drug tests) suggest that over the last years amphetamine (and especially methamphetamine) use has increased. In Latvia one should take into account that significant proportion of substance abuse, especially in prisons, is in the form of medicines abuse (both controlled and uncontrolled substances).

According to data about 20% of inmates in Valmiera prison are using legal[29] and illegal substances, and among drug using inmates almost all would use by injection (because it is cheaper). Data suggest that drugs are used on monthly basis (or several times a year) and are rarely used on daily basis because of availability. More drug use is happening during holidays or celebrations, which is partly related to relatively lower control measures during these times.

Number inmates who start drug use (try drugs for the first time during their life) inside prison is relatively small (estimated by prisoners around five per cent) and majority of inmates have drug use experience already before entering prison. More often drugs are being used (and tried for the first time in prison) by younger inmates, those coming from urban areas, those who have financial means or have higher status in prison.

As one of the major reasons for stopping drug use inside prison was mentioned lack of financial means.

According to survey data there are syringes available in Valmiera prison that are used more than once and by more than one inmate. There are several groups of inmates who possess syringe for own use or would lend it to a close circle of very well known people. From the public health perspective situation that one has to use syringe more than once and especially share with other people is high risk behaviour for individual and other people around. Taken this into account one should be using a clean syringe for every injection, otherwise people participating in syringe sharing are at high risk for becoming infected with HIV, hepatitis B/C or other infections, which would lead to higher public and social expenditures in the future.

To reduce the risk of becoming infected by sharing syringes inmates try to use several measures, e.g. if a syringe is used by more than one person and there is knowledge about someone who is infected with HIV/AIDS or hepatitis, those who are infected inject last in the line. Apart from this strategy, syringes are disinfected by boiling water or using domestic chemicals that are sold in the local prison shop. In several countries prisons provide free disinfectants for clean syringes for free, but, according to information obtained, due to financial constraints such strategies have not been implemented in prisons in Latvia.

The level of inmates' knowledge about risks of becoming infected or about measures of protection is high. According to inmates, the most successful intervention inside prison regarding HIV prevention is that one should be open about their infections. The only thing that raises

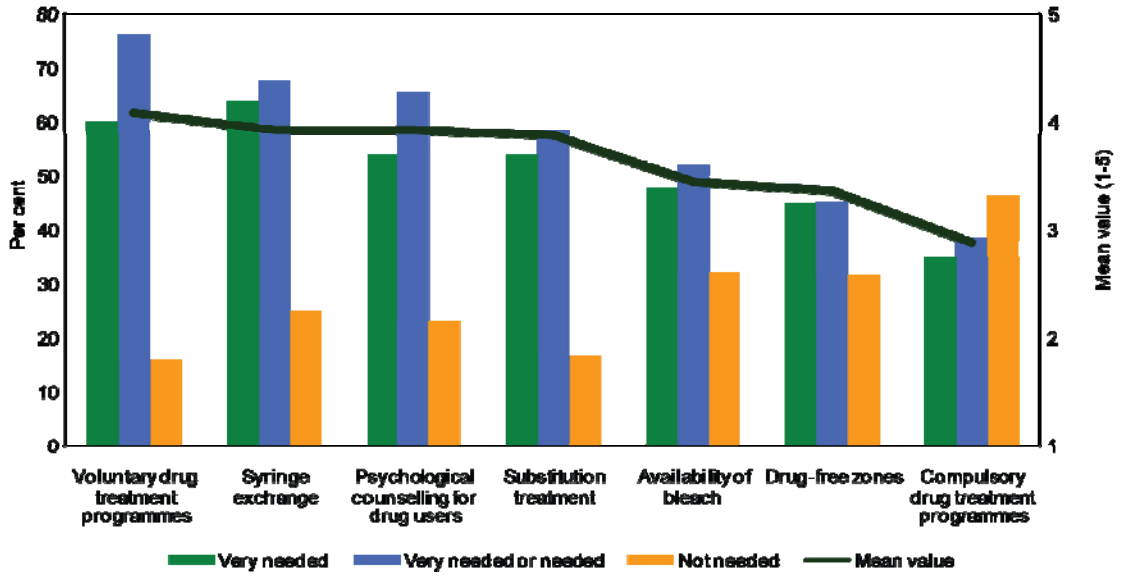
[29] By legal we are referring to substances which are not illegal outside prison, although in prison setting all substances are illegal.

questions is about the knowledge of status of infections and taken into account that HIV/AIDS testing in majority of cases is done only when entering the prison and rarely during the sentence, one cannot be sure about infection.

It should be pointed out that there are activities in prison that raises level of information about HIV and drugs. These activities can be classified as direct (lectures and seminars provided by NGO's) and indirect (information materials that are available at the prison medical department or information stand). Due to irregular funding lectures and seminars held by NGO's are rather scarce in prison system (not only in Valmiera prison) and should be provided more funding and organized more regularly.

According to inmates the most needed interventions for drug users in Valmiera prison would be voluntary drug treatment programmes, followed by syringe exchange, psychological counselling and substitution treatment, which were assessed as very need by more than half of respondents. On the other hand – interventions such as availability of disinfectants, drug free zones or compulsory treatment received less support from inmates *(see Figure 8.3)*.

Figure 8.3. Interventions proposed as needed or very needed by inmates (n=91)



Source: Trapencieris, Snikere et al. 2008

Data on drug use in Valmiera prison from the 2003 Survey of prison inmates

The 2003 survey of prison inmates included a mix of quantitative and qualitative methods (Snikere, Trapencieris, and Vanaga 2003). Qualitative research included in-depth structured interviews with 14 experts from 11 prisons during which information on prison system in Latvia, drug use in prisons, on drug demand and supply reduction and health care in prison as well as some other information was collected.

According to prison officials drug use in Latvia's prison is a very serious issue and is becoming more prevalent with every year since 1997. Drug use in prisons in more concentrated in closed type regimen prisons (or prison sections) or in in investigation-type prisons (or prison sections). Main reasons for drug use in prison were mentioned: firstly, those who have been using

drugs before prison continue their habit inside prison and, secondly, most of the prisoners are not employed or are not involved in any kind of activities inside prison that leads to lots of spare time and consequently drug use. According to prison officials' knowledge, drug users in prison usually are young people (under 25 years of age), with a low level of education, have psychological problems, come from dysfunctional families, and often have been sentenced for drug-related crimes. Until 2003 there were no drug treatment or harm reduction programmes inside prison and several experts expressed willingness to implement drug treatment inside prison.

Several activities that should be implemented inside prison mentioned by prison officials were:

- provision of education for young people and especially for those in high risk groups,
- provide employment for as many inmates as possible,
- establishing drug-free zones inside prison,
- and changes in current drug testing policies have to be made.

Quantitative part included survey of prison inmates (n=2867 – 61% response rate); the self-completion questionnaire included questions on personal drug use experience, drug use patterns, health situation and necessary interventions. Number of persons interviewed in Valmiera prison was 381 (54% response rate).

According to the data about one-half of all inmates lived in cells (with up to 10 people), while another half – in camp type units (with up to more than 60 inmates in one room).

According to the data Valmiera prison in 2003 was the second prison with highest estimate of drug use among cell- or unit mates (on average in prisons in Latvia drug use among cell-mates was estimated to be 17%, while in Valmiera prison – 27%). Among those inmates in Valmiera prison who thought that drugs are used by cellmates 12% mentioned that drugs are being used by all cellmates, 35% – by majority of cellmates, 50% – by just a few cellmates, and 3% – that there is only one cellmate using drugs.

About one-third of inmates in Valmiera prison thought that drugs are not being used inside this prison; from those who thought that drugs are being used inside this prison 44% thought that less than 15% of all inmates use drugs, 25% –more than half of inmates are using drugs in prison, 18% – drugs are being used by less then one third of inmates, while 12% think that drugs are used by less than every other inmate but more than by every third. Statistically significant differences were found out according to respondents' own drug use experience inside prison – those having experience were keener to provide higher estimates of drug use in prison than those without drug use experience inside prison.

Slightly more than one half of respondents (53% among all prison population and 51% in Valmiera prison) have any illegal drug use experience before prison, 38% have been using any illegal drugs during the last 12 month before prison and 29% reported last 30 days prevalence before prison.

31% respondents admitted they had used drugs at least once while in prison, 17% have used drugs during the last 12 month inside prison and 7% – during the last month inside prison. Of those who have used drugs during the last month while in prison slightly less than one-half (43%) have used them less than once a week, 15% – at least once a week, 13% – two to three times a week, while 13% daily.

The most commonly used drugs by the inmates of Valmiera prison before prison and inside prison are shown in Table 8.7. In Latvian context it must be taken into account that a substantial proportion of drug use inside prison is made by abusing sedatives and tranquilizers that are more easily obtainable in prison settings than illegal substances.

Table 8.7. Reported lifetime, last year and last month drug use by inmates in Valmiera prison

	Before prison			Inside prison		
	LTP	LYP	LMP	LTP	LYP	LMP
Cannabis	50	30	21	30	18	9
Heroin	20	15	11	12	6	3
Amphetamines	25	18	13	16	12	7
Ecstasy	19	13	5	11	6	4
Cocaine	14	9	4	6	2	2
Opiates	19	14	8	12	6	3
Sedatives and tranquilizers	36	26	18	25	19	10
Any illegal drug use	**52**	**38**	**30**	**33**	**19**	**11**

Source: Trapencieris, Snikere et al. 2008

Survey data suggest that about every eight (14%) of inmates have injected drugs while serving their sentence – the lowest proportion of injectors being found in female prison (Iļģuciems), in prison for minors (Cēsis prison) and open-type prison in Olaine. In closed regimen prisons injecting experience was mentioned more often than in semi-closed regimen prisons (except Jēkabpils prison). In Valmiera prison 19% of inmates reported injecting experience inside prison.

Since syringe exchange in prison settings in Latvia did not exist in 2003 (and does not exist until now) majority of inmates (86%) who have been injecting inside prison have used unclean (or used before) syringes or needles. Only 28% of inmates (21% in Valmiera prison) who have been injecting are using their own syringe or needle.

The most supported intervention inside prison mentioned by inmates in Valmiera prison was voluntary treatment programmes (86%), followed by treatment instead of punishment (67%), syringe exchange (48%) and methadone treatment (55%). Statistically significant differences were found out according to one's drug use experience inside prison *(see Table 8.8)*.

Table 8.8. Percentage of inmates supporting various interventions according to drug use experience inside prison

	Has drug use experience inside prison	Does not have drug use experience inside prison
Syringe exchange	71	37
Methadone treatment	55	29
Voluntary treatment programmes	93	82
Treatment instead of punishment	68	67

Source: Trapencieris, Snikere et al. 2008

Data from 2008 cohort study of drug users

In order to understand the prevalence of drug use in prisons, in addition to questions in the 2008 cohort study of drug users (Trapencieris et al. 2008) questionnaire regarding respondents' imprisonment, some additional questions was included on their drug use experience while in prison.

According to respondents, a significant proportion (41%) had been imprisoned during their lifetime. In the 2006 and 2007 stages of the study this indicator was 52% and 47% respectively. The consistency of responses provided in the two waves of the study is high ($r=0.890$, $p<0.001$).

According to information in the 2008 survey, 47% of men and 29% of women had been imprisoned during their lifetime ($p<0.001$).

According to information obtained from the supplementary questionnaire, no less than[30] 36 cohort participants or 3% of drug users surveyed during any stage of the cohort had been imprisoned during the 2008 survey.

Of those who had been imprisoned, approximately one in four drug users (22%) had been there within the past three years, 63% after 2000, while 24% did not wish to indicate the year they had last been there.

According to information on drug use in prison, 51% participants in the 2008 cohort, who had been imprisoned, had used drugs while in prison. It is important to mention that among women this ratio is three times lower than among men (20% of women and 61% of men respectively, who had been imprisoned had used drugs). A proportion of respondents (25%) either refused to indicate or did not wish to indicate which substances they had used while in prison, whereas of those who did indicate substances, 29% had mentioned heroin, 26% amphetamines, 8% *hanka*, while 6% mentioned ephedrine. The majority indicated that they had used "everything that was available" (24%) or various other psychotropic substances (20%).

From the public health perspective and developing harm reduction or treatment programmes in places of incarceration in a significant indicator is that 94% of imprisoned drug

[30] No information has been gathered about significant proportion (39%) of respondents surveyed in 2006, 2007 and 2008, and it is therefore possible that some of them are still in prison.

users had done so by means of injection and 82% of drug users in prison and had used a syringes by sharing.

8.4. Social costs

No information available

9. Responses to Social Correlates and Consequences

9.1. Social reintegration

In 2006/2007 Public Integration Foundation conducted two surveys – „Meaning of Force Labor in the Reduction of Social Exclusion“ and „Meaning of Public Activities in the Reduction of Social Exclusion“. In the first one there were analyzed those barriers which do not allow imposing and introducing force labor as a punishment for criminal offenders. From the interviews with the judges it came out that force labor is usually not imposed for persons with addiction problems as it is considered that these persons are not able to realize it (because of lost work skills in general) (Žabko et al. 2007).

Unfortunately though legislation defines also treatment as an alternative to imprisonment, in real life and in practice drug users are almost never sentenced according to this possibility.

In the other survey attention was more paid on under aged persons (juveniles) and on imposement of public activities for them as a compulsory and educational enforcement measure. From the interviews with the judges and employers it came also out that one of the most problematic groups are children with addiction problems and there exist barriers for this kind of punishment – (public activities) for them. Still it was also agreed that for children with addiction problems public activities should come together with compulsory treatment (Žabko et al. 2007).

9.2. Prevention of drug related Crime

No new information available

10. Drug Market

In 2007, there was a significant increase in the number of seizures of illegal drugs, particularly in seizures of methamphetamine and heroin. This may partly be explained by an escalation in police activity. However, bearing in mind that since 21 December 2007, Latvia has joined the Schengen Zone, and as a result, border control is practically non-existent, significant concerns arise that the volumes of illegal drugs circulating in the country could increase. In this section in addition to police data availability of drugs will be discussed according to National school survey data and general population survey data.

10.1. Availability and supply

Perceived availability

School students

In order to determine the availability of illegal drugs among juveniles and Latvian original inhabitants, the PHA undertook several research studies. Data obtained from National school survey 2007 (Koroleva, Mierina et al. 2007), in which the sample group was formed of students from Grades 7–12 of Latvia's general education schools during the 2006/2007 school year, and professional training institution years 1– 3 students (n=9934) aged from 13 - 20, indicate that:

- in the question as to how easily or difficult it would be to obtain cannabis if they wanted to do so, 33% of students replied that it would be fairly easy, 27% thought it would be very difficult and 21% thought it would be impossible to obtain cannabis;
- it is significantly more difficult for younger students to obtain drugs than it is for older students;
- cannabis and other drugs are most readily available to students in Riga;
- Russian stream students (52%) more frequently than Latvian students (43%) have encountered an offer to try cannabis;
- the opportunity for girls to try cannabis has occurred much more rarely (39%) than for boys (51%) (Koroleva, Mierina et al. 2007).

General population

According to general population survey of prevalence of drug abuse in Latvia (Koroleva, Goldmanis et al. 2008), which was conducted in 2007:

- the illegal drug which is most easy to obtain is cannabis;

- any illegal drugs can be more easily obtained by young people up to the age of 29 years, but with much greater difficulty by people over the age of 45, and it seems easier for men to obtain any type of drug more easily than for women
- less than one in 10 (8%) of Latvian inhabitants knows at least one (4%) or more (4%) specific places near his place of residence with drugs can be purchased, although the majority of residents (57% of women and 48% of men) have never heard of any places where drugs can be bought;
- significantly better informed of places where drugs can be obtained are those people who have themselves used drugs during the past year;
- drug trading places are significantly more often known to men (10%) than to women (6%);
- drug distribution places near one's place of residence are more often known to young people (13%) aged 15-34 and only 4% of such places are known to inhabitants aged 35-64;
- comparatively more frequently drug distribution places known to residence in Riga and in other Latvian regions;
- drugs are more readily available if a person has a friend or acquaintance who uses them;
- men (27%) more often than women (15%) and young people significantly more often than old people have a friend or acquaintance who uses drugs (Koroleva, Goldmanis et al. 2008).

Recreational settings

In order to establish the availability of drugs among people attending places of recreation, in 2008 the Public Health Agency conducted a study entitled "Drug Use in Recreation Settings" (Koroleva, Karklina et al 2008). Surveyed in the study were people present at recreational places in Riga, Daugavpils and Liepaja, a total of 600 respondents. Data obtained during this study indicate that the narcotic substances most often by visitors to clubs are cannabis and amphetamine. 63% of club visitors would have little difficulty in obtaining cannabis within 24 hours and 50% could easily or relatively easily obtain amphetamine. As indicated by the research data, drugs can be most easily obtained by those who have themselves at some time used some form of narcotic substances or who have friends or acquaintances that used drugs. This is explainable by the fact that a user will know somebody who distributes these substances, or will know somebody who can provide them. Compared with other Latvian regions it is easiest for visitors to places of recreation in Riga to obtain any type of drug:

Analysing the possibility of acquisition in terms of socio-demographic data: it is easier for men than for women to obtain drugs

- it is comparatively more difficult for young people below the age of 20 to obtain amphetamine than it is for older respondents (37% would find this substance very difficult

or impossible to obtain). This may be explained by the proposition, regular use of drugs is most often commenced after the age of 20; this is also supported by the research data, and thereby the possibilities of obtaining drugs also increase.

- visitors to clubs whose monthly income is less than LVL 200 Ls, comparatively more readily than those whose income is greater than LVL 500 know where to obtain amphetamine, crack, or cocaine.

Surveying club visitors, who during the previous year had used some form of narcotic substance, on places where drugs can be obtained, the following replies were received:

- 29% of drugs were obtained at the home of some other person;
- 23% at a club or discotheque;
- 20% at an event in a private house, apartment or in their own home ;
- 10% in an open public place.

The compiled data indicate that the drugs which are most often obtained at a club or discotheque are ecstasy and amphetamine. However, cannabis is most often obtained in a person's own home or the home of some other person. As admitted by those who visit recreational premises, cocaine is most often obtained at some event taking place in a private house or apartment, which could indicate the prevalence of cocaine use during house parties among certain groups having a higher income level (having regard to its comparatively high retail price).

A different view exists about places where drugs can be most readily obtained is among young people who had either used or not used drugs during the past year. 58% of those who had used drugs thought that they could most easily be obtained from friends; however, those who had not used drugs (48%) thought the easiest place to get drugs was at night clubs and discotheques.

Compiled data regarding awareness of drug point of sale in the vicinity of domiciles indicates that:

- 30% of visitors to clubs knew at least one place (16% of those more than one) specifically where drugs were traded or distributed near their own place of residence (city, district, region);
- 35% knew or had heard that such places existed, but were unable to name one;
- 35% had heard nothing about such drug distribution places near their own place of residence.

Men knew of such places significantly more often (40%) than women (20%). It is natural that those who had used drugs during the previous year were significantly better informed about drug trading points (47% of those knew of at least one such point). Regarding the fact that drug trading places would be a topic of discussion in the circulation of information among visitors to

recreational places, indicates that 21% of those who had never used drugs knew of at least one drug distribution point nearby.

As the research indicates, drugs can be obtained not only on one's own initiative, they are frequently offered even without asking. 58% of people attending clubs admit that they have occasionally been offered drugs free of charge and 42% have received such an offer during the past year, which indicates dealer activity in forming a new range of clients. The statistics differ significantly regarding instances of drugs being offered to men and women. During the past year 53% of men and 44% of women have been invited to obtain drugs. Men have equally often been offered drugs to purchase, or to receive them without charge, whereas women are more frequently offered drugs without charge.

The drug most often (53% of cases) offered free of charge was cannabis; in 11% of cases amphetamine and ecstasy were offered free of charge and in 8% of cases cocaine was offered (Koroleva, Karklina et al 2008).

Police data

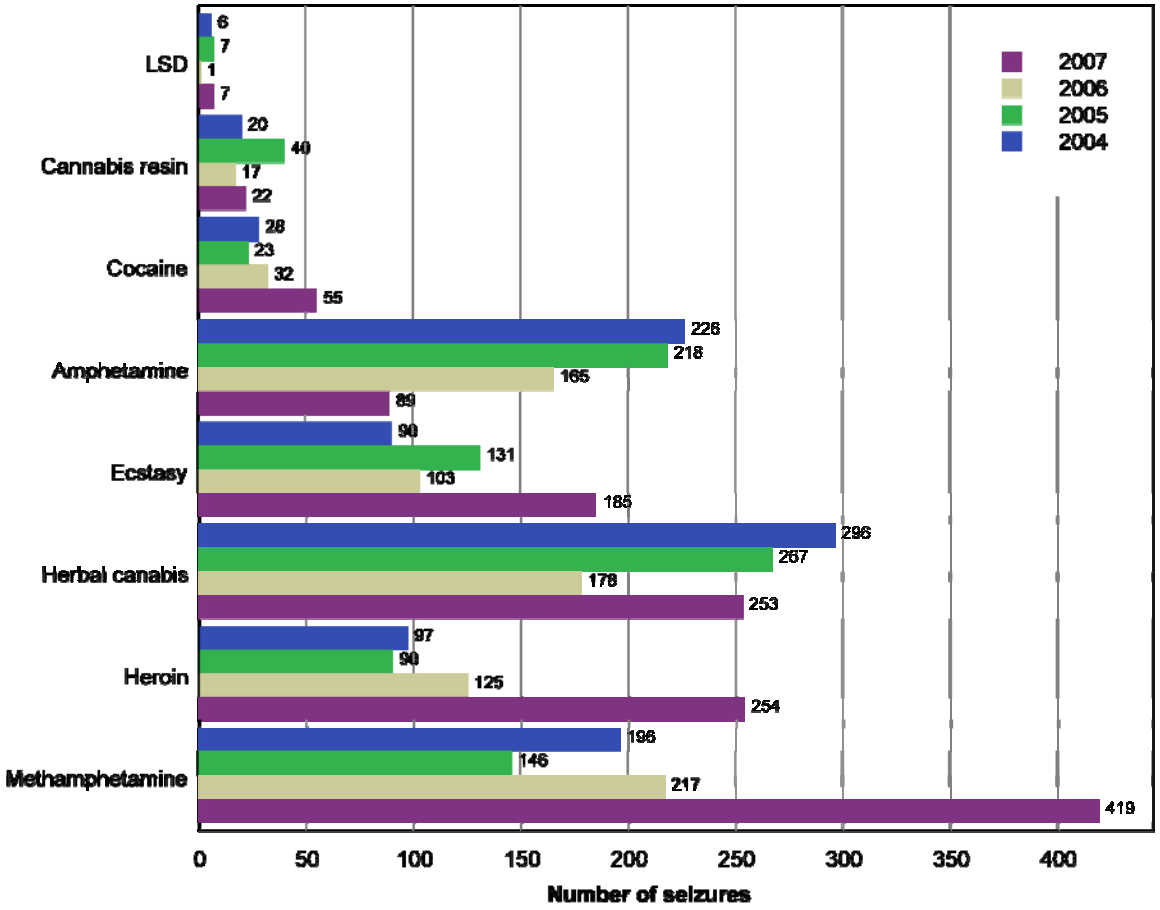
Drugs are brought into Latvia from various countries. Data from Central Criminal Police Department indicates that:

- synthetic drugs are brought into Latvia from EU countries through overland border control points: Lithuania, Estonia, Netherlands, Germany and Poland, mainly utilising motor vehicle transport, including international route buses, and ports, utilising ferry transport lines;
- cannabis is supplied from the Netherlands, Spain and Selangor (Malaysia);
- cocaine is brought into Latvia from Latin American countries (Ecuador or Columbia), utilising sea routes through Russia and Ukraine. The territory of Latvia is also utilised for cocaine transit from South America to Russia and the Scandinavian countries.

10.2. Seizures

One of the illegal drug market evaluation indicators is not the quantity of seized drugs, but the number of seizures which is indicative of a corresponding prevalence of drugs in Latvia. According to Central Criminal Police Department, in 2007, throughout the entire country a total of 1764 (1226 in 2006) seizures of drugs took place (this total includes instances of seizure of a specific substance, regardless of the fact that several seizures have taken place as part of a single criminal case). In the figure provided below may be seen a comparison of number of seizures by year, and substances seized.

Figure 10.1. Number of seizures in Latvia, 2004–2007



Source: State Police Forensic Department 2007

According to the compiled data it may be seen that compared with 2006, the greatest increase has occurred both in the number of seizures of methamphetamine and heroin, and the quantity of substance seized, which is indicative of its continued popularity among users and its increasing illegal circulation.

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

Name of substance	2005	2006	2007
heroin kg	0.004	0.157	1.75
Herbal cannabis kg	25.92	5.9	17.84
cannabis plants kg	N/A	N/A	34.48
Cannabis resin kg	1.55	0.358	0.254
amphetamine kg	3.79	11.03	5.78
methamphetamine kg	3.42	8.12	11.83
ecstasy tab	21937	4600	94753
cocaine kg	0.68	1.12	11.9
LSD stamps	2190	3	146

Source: State Police Forensic Department 2007

Seizures of cocaine have increased in comparison with the previous year, both in terms of number of seizures and quantity seized, which indicates an increase in demand for the drug despite its comparatively high price, most likely among the wealthier recreational users.

Every year, a reduction in the quantity of ephedrine seized has been observed and in 2007, there was no recorded instance of seizure of this substance, which could indicate a reduction of demand for ephedrine among users.

Also in 2007, 1200 tablets were seized of medication not registered in Latvia, with the active ingredient 1-(4-hlorofenil) piperazine, which is utilised not only in treating various forms of depression but also for the purposes of intoxication.

2007 is also prominent due to a significant marijuana growing operation being detected in Latvia. Central Criminal Police Department uncovered two cannabis nurseries in Riga, in an apartment, and in the Kuldiga region, in a domestic outbuilding. The cannabis was cultivated in specially adapted and equipped rooms from which a total of 34.48 kg of cannabis plants was seized.

Bearing in mind that since 21 December 2007 Latvia has joined the Schengen Zone, and as a result, border control is practically non-existent, concerns arise that the volume of illegal drugs in circulation in the country could increase and the fight against important transit of drugs will become increasingly difficult and complex. Of great significance is the cooperation which has formed at the national and international level between law enforcement institutions and effectively continues in the role of reducing the availability of drugs.

10.3. Price and purity

Comparing changes in the price of drugs over a one-year period it is evident that generally these have not particularly changed. In 2007, compared to 2006, the minimum and maximum prices have decreased slightly, but most often encountered price for heroin has increased. There is a slight decrease in both the maximum and minimum most encountered prices for marijuana. For the other indicated substances the price has remained at the previous year's level.

Prices can be influenced by many and various factors: fluctuations in availability, form and quantity supplied level of purity, acquaintanceship between buyer and seller, the region in which the drugs are sold.

Table.10.2. Price comparison of 1 g drugs in 2006 and 2007[31]

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

Source: Central Criminal Police Department 2008 (ST16)

[31] Prices are shown in EUR; at the exchange rate of 1Ls = 0.708 EUR

It is known that for purposes of increasing the volume of drugs, they are mixed with various other substances and with that the quantity of drugs in a particular mixture (referred as purity) could vary. In 2007 in Latvia, no new major trends have appeared in the illegal circulation of drugs. According to data from testing carried out, in some samples the substance mixture has been identified in which the quantity of amphetamine sulphate varied from 2% to 56%, although the most often amphetamine purity level was 32%. However, the purity range of heroin varied from 5% to 78% and most often encountered was 43%; for cocaine it ranged between 4% and 81%, while most often encountered was at 26%. The central active chemical substance in cannabis (delta-9-tetrahydrocannabinol or THC) is not tested for in Latvia *(for details see ST14 in Fonte)*.

Part B: Selected Issues

11. Sentencing statistics

In accordance with its determined competence[32], the Ministry of Interior Information Centre is the manager or custodian of many criminal registration systems in which data has also been collected in relation to breaches of the law/offenders in the field of illegal circulation of drugs. Within its competence, the Ministry of Interior Information Centre cooperates with other institutions which in one way or another are involved in preventing or fighting against breaches of the law and exchanges data with the information systems of these institutions which also hold various types of data in relation to breaches of the law/offenders in the field of illegal circulation of drugs. With that in mind, and observing the Ministry of Interior Information Centre function in the field of processing statistical data[33], Ministry staff, with collaboration with the Reitox National Focal Point, are involved in the compiling of statistical data and describing the methodological aspects in relation to the statistical data requirements of the EMCDDA.

Bearing that in mind, it is nevertheless necessary to note that regardless of the availability of relevant data in information systems, the processing of data in relation to breaches of the law/offenders in the field of illegal circulation of drugs is, for the most part, is done manually, as:

- there are no defined, automatically produced relevant standard reports,
- the information systems are not sufficiently well-connected to produce relevant statistical data automatically,
- the integrated Ministry of Interior information system subsystem ("IIIS") "Persons who have committed Criminal offences" is not yet fully digitalised.

The statistical data included in this Selceted Issue has been prepared from the integrated Ministry of Interior information system subsystems: "Register of Criminal Offences", "Persons who have Committed Criminal Offences" and "Persons Who Have Committed Administrative Offences", also utilising information from the State Police Forensic Research Department data on seized narcotics/ psychotropic substances and precursors in 2007 in the city of Riga and the rest of the country. Similarly, statistical data have been prepared on registered criminal offences and administrative offences related to the illegal circulation of drugs, and on persons facing criminal and administrative liability, and the basic and additional penalties imposed on those persons.

The quality of data in information systems still depends to a great extent on the honesty and accuracy of persons entering/and users providing the information, since completion of several fields in various information systems is not obligatory and therefore it is practically impossible to

[32] Stipulated in Cabinet Regulation No. 526 " Ministry of Interior Information Centre Bylaw" and regulatory enactments which regulate the formation and utilisation of several information systems

[33] For example, Cabinet Regulation No.1008 "Regulations on National Statistical Information Program for 2007"; Cabinet Regulation No. 756 of 4 October 2005 "Regulations on the Register of Criminal Offences"

obtain complete information regarding various aspects to be analysed (for example, whether a criminal offence has been committed while under the influence of drugs).

Making the processing of statistical data considerably more difficult in relation to the requirements for statistical data of the EMCDDA, is the fact that the requirement for data is general by nature, and as a result, it creates the need for careful analysis of data collected in the Republic of Latvia legislative base and information systems in order to provide statistical and methodological responses to the questions included in the requirement.

11.1. Available opportunities within the country[34]

Data is provided in the Table on *usually*/*mainly* utilised ways of reacting to offenders (administrative and criminal) in the illegal circulation of drugs field. (A more detailed description of the sections of the Republic of Latvia *Criminal Law* and the *Administrative Violations Code*, in respect of drugs, is to be found in the Attachment. See *Table 1)*. It must be noted that no particularly specific means of reacting actually exist in the field of illegal circulation of drugs (the same means of reacting are also applicable in relation to other breaches of the law). The reaction methods used depend on the seriousness of the breach of law (administrative offence or criminal offence) and "categories" of offence, for example, confiscation of property is not applicable to the offence of operating a motor vehicle while under the influence of drugs etc.

Table 11.1. Forms of reacting

Type of breach	Forms of reacting		
	State police	Office of Prosecutor General	Court
Personal possession or use	-warning -fine - prohibition/refusal to issue licence for acquiring, storing or carrying a firearm or high-energy pneumatic weapon - referring the matter for criminal investigation	-issuing a complaint -referring the matter to court	- verbal reprimand - administrative arrest - **imprisonment (including suspended)** **-confiscation of property** **-enforced labour** **-fine** **-restriction of rights** **- police supervision**
Production, dealing or trafficking	- conduct operation - prohibition/refusal to issue licence for acquiring, storing or carrying a firearm or high-energy pneumatic weapon - referring the matter for criminal investigation	-issuing a complaint -referring the matter to court	-imprisonment **(including suspended)** **-confiscation of property** **-enforced labour** **- fine** **- police supervision**
Driving after taking drugs	- fine - seizure of motor vehicle drivers license - prohibition on obtaining motor vehicle drivers license for certain period of time - prohibition/refusal to issue licence for acquiring, storing or carrying a firearm or high-energy pneumatic weapon - referring the matter for criminal investigation	- -issuing a complaint -referring the matter to court	- fine - seizure of motor vehicle drivers license - prohibition on obtaining motor vehicle drivers license for certain period of time - administrative arrest - imprisonment **(including suspended)** **- enforced labour**

Source: Ministry of Interior Information Centre 2008

[34] Analysis undertaken based on 2007 statistical data from IIIS subsystems "Persons Who Have Committed Administrative Offences", "Register of Criminal Offences"; and "Persons Who Have Committed Criminal Offences",, and in consideration of the official opinion of the State Police Organised Crime Enforcement Department

11.2. Data collection systems

In Latvia there is no specific information system/systems in which data would be collected only in relation to breaches of the law/offenders in the illegal circulation of drugs. Information on the said breaches of the law/ offenders is registered in a general way in the criminal registration systems and related systems (*See Table 2 attached*). With the aim of improving the operational coordination capability of local and foreign anti-drug institutions and analysis of the prevalence of addiction, and operational planning activities of institutions, on 20 May 2008, the Ministry of Interior Information Centre, as part of the EU Programme: "Prevention of and Fight against Crime" has submitted an application for funding to the European Commission Finance Committee for the project "Development of a geographical-analytic system to restrict the illegal circulation of drugs" As part of the project, it is proposed to provide a graphic and geo-spatial linkage for the combination of data contained in various information systems, linking various types of information both among themselves, and together with cartographic information, identifying zones of increased risk, undertaking other wide-ranging operations essential for analytic work and ensuring opportunities for an effective exchange of information in the field of drug prevention/combating among member states of the European Union.

11.2.1. Mutual linkage of Information Systems

A situation has arisen historically that in Latvia, criminal registration systems were formed and developed independently of each other, and their mutual linkages have been relatively weak. In 2002, development was commenced of the Integrated Ministry of Interior System and its progressive introduction into use (via individual subsystems) was begun in 2004. The Integrated Ministry of Interior System subsystems have a unified data-searching interface and analogous solutions for the entering of data. Measures have been introduced to avoid the duplication of data entered in subsystems, and a unified primary data (for example personal information) storage solution has been applied.

The introduction of the Integrated Ministry of Interior System does not however mean that all subsystems are mutually integrated at the moment to a level sufficient that Integrated Ministry of Interior System data extraction/representation is possible for any mutual link, which is exactly why work is continuing on developing and improvement of mutual links between the subsystems, and improvement of signal systems (for example, authorised users of one subsystem are automatically informed if relevant information is entered in another subsystem: example.g. relevant users of the "Register of Weapons" subsystem are informed if information is entered on the subsystem "Persons Who Have Committed Administrative Offences" or "Persons Who Have Committed Offences" subsystems regarding an offence committed by the owner/holder of a weapon, for which offence prohibition/refusal to issue licence for acquiring, storing or carrying a firearm or high-energy pneumatic weapon is a possible penalty). Work is continuing not only on the improvement of mutual links between the subsystems of the Integrated Ministry of Interior System, but also on

improvements to links between the Integrated Ministry of Interior System and the information systems of other agencies.

The Ministry of Interior Information Centre has commenced work on development of a data warehouse solution, thereby broadening the prospect of conducting data analysis (including the establishment of integrated statistical reporting) possibilities. Work is also in progress on the development of a criminal process support system, ensuring the possibility of processing related data much more efficiently and ensuring better opportunities for statistical analysis.

Table 11.2. Mutual links between Information Systems

IS name	Integrated Ministry of Interior System subsystem "Electronic Journal of Events"	Integrated Ministry of Interior System subsystem "Register of Criminal Offences"	Integrated Ministry of Interior System subsystem "Persons who have Committed Criminal Offences"	Integrated Ministry of Interior System subsystem "Persons who have Committed Administrative Offences"	Integrated Ministry of Interior System subsystem "Property Search"	Integrated Ministry of Interior System subsystem "Register of Weapons"	Court Informative System	Road Traffic Police Register
Integrated Ministry of Interior System subsystem "Electronic Journal of Events"		XO	O	O	X	-	-	O
Integrated Ministry of Interior System subsystem "Register of Criminal Offences"	XO		XO	-	O	-	O	-
Integrated Ministry of Interior System subsystem "Persons who have Committed Criminal Offences"	O	XO		O	O	XO	O	O
Integrated Ministry of Interior System subsystem "Persons who have Committed Administrative Offences"	O	-	X		-	X	O	X
Integrated Ministry of Interior System subsystem "Property Search"	X	-	-	-		X	-	-
Integrated Ministry of Interior System subsystem "Register of Weapons"	-	-	XO	X	X		-	-
Court Informative System	-	O	O	O	-	-		-
Road Traffic Police Register	O	O	O	X	-	-	-	

Source: Ministry of Interior Information Centre 2008

X-link already exists

XO – link exists but will be strengthened and improved in the future

O – link to be developed in the future

- – no link

11.2.2. Characterisation of statistical data reporting

In accordance with Section 13 of Cabinet Regulation No. 1008 of 12 December 2006 "Regulations for State Statistical Information Program 2007", the Ministry of Interior information Centre (utilising the Ministry of Interior information system subsystem "Register of Criminal Offences" and the subsystem "Persons Who Have Committed Administrative Offences") provides reports containing the following information (individual information on offenders in relation to offences/offenders in the field of illegal circulation of drugs is not included in the reports):

Table 11.3. Statistical Reports Produced

Information content	Responsible institution, source of information	Periodicity	Method of acquiring informati on	Total output
Statistical information prepared to satisfy regular requirements from international institutions				
Registered number of criminal offences, including offences involving violence and crimes against property – *UNICEF, UN* requirement	Ministry of Interior	Annual	Full survey	Total in Latvia
Number of criminal offences detected, divided by age and gender of offenders – *UNICEF*, *UN* requirement[35]	Ministry of Interior	Annual	Full survey	Total in Latvia
Number of juvenile offenders facing criminal liability, divided by type of crime (murder, rape, robbery etc) – *UN*, *UNICEF* requirement	Ministry of Interior	Annual	Full survey	Total in Latvia, by gender
Number of juvenile victims of crimes, divided by type of crime (murder, rape, robbery etc) – *UN*, *UNICEF* requirement	Ministry of Interior	Annual	Full survey	Total in Latvia, by gender
Statistical information prepared regularly in accordance with requirements of domestic users				
Registered number of criminal offences and their detection, divided by type of crime (murder, rape, robbery etc)	Ministry of Interior	Annual	Full survey	Total in Latvia, by Cities and Districts of Republic
Number of persons charged with criminal offences, divided by types of crime	Ministry of Interior	Annual	Full survey	Total in Latvia, by Cities and Districts, by age and gender
Registered number of administrative offences	Ministry of Interior	Annual	Full survey	Total in Latvia, by Districts

Source: Ministry of Interior Information Centre 2008

A statistical data report from the data of the Integrated Ministry of Interior Information System subsystem "Register of Criminal Offences" (observing the need for user institutions to have statistical data) is prepared every month. Data in the report on registered criminal offences are depicted in ascending order (i.e.: for one month, for two months etc). Information on types of criminal offence is compiled in accordance with the *Criminal Law*, both in terms of which group they belong to, and in terms of specific sections of the Law (statistics in terms of paragraphs and clauses of the Law are not produced at the moment). Information on decisions taken in criminal processes already begun is compiled in accordance with the *Criminal Procedure Law*.

The criminal statistics data produced by the Ministry of Interior Information Centre (most important indicators, including Sections of the *Criminal Law*, regarding criminal offences in the area of the illegal circulation of drugs, including the "Criminal offences in relation to narcotic

[35] Here and henceforth - observing the fact that law enforcement agencies have not for the time being been able to define an opinion as to the moment from which a criminal offence may be regarded as solved, the Ministry of Interior no longer provides statistical information on the number of criminal offences

substances") is published annually on the website of that institution (http://www.ic.iem.gov.lv). Central Statistical Bureau each year publishes data provided by the Ministry of Interior Information Centre (main indicators) in a statistical Yearbook.

11.2.3. Registered statistics unit characterisation

In accordance with Cabinet Regulation No. 756 of 4 October 2005 "Regulations for the Register of Criminal Offences", in the Integrated Ministry of Interior Information System Subsystem "Register of Criminal Offences" are included criminal offences, criminal processes begun, and persons who have committed criminal offences.

- The number of criminal offences is comprised of criminal processes begun in the reporting period (during one calendar year) and registered episodes within the criminal process framework, subtracting those criminal processes completed during the reporting period (during one calendar year) (in relation to which no criminal offence has occurred or it is not part of a series of criminal offences) and the number of registered episodes within them. A criminal offence is included from the moment a criminal process is initiated in respect of a possible criminal offence;
- Episode: a criminal offence which itself is comprised of individual criminal offences and is neither continued nor an element of an extended series of criminal offences; several criminal offences which comprise conceptual aggregation, may be depicted as one episode, independently of the number in the series of criminal offences[36];
- criminal offences committed by a person are counted from the moment that the person is charged with the offence, when a private prosecution is begun against the person, when a criminal process regarding a criminal offence committed by some other person is listed in separate record keeping, and it is not related to another criminal process already begun, or when the criminal offence is committed in the interests of a legal person.

11.2.4. Registration of statistical data in relation to repeat offending

To the criminal offence characterising data in the integrated Ministry of Interior information system subsystem "Register of Criminal Offences", additional data is entered on whether a person who has committed a criminal offence had previously committed a criminal offence, but statistical data are not gathered or compiled on what type of offences were previously committed (whether a criminal offence of the same or another type was committed). If a criminal process has begun in respect of a criminal offence, it is counted in the reporting period (during one calendar year) regardless of the real date a criminal offence was committed (e.g., if a criminal offence is committed in December 2006 but the criminal process in relation to that offence is begun in February 2007, then the criminal offence is counted in the information system for 2007). If the

[36] Definition provided by Republic of Latvia Office of the Prosecutor General

offence qualifies under several sections of the Criminal Law (in the event of conceptual aggregation), then the total of registered offences will be registered as one offence (e.g., in the total registered offences in relation to the illegal circulation of drugs will be shown the real number of offences, for, regardless of the number of applicable sections of the law, the number of individual offences will be totalled). If analysis is undertaken of the applicable sections, then the offences will be classified according to the relevant sections, and thereby the number of offences will increase proportionally to the number of applicable sections.

11.2.5. Registration of statistical data in relation to multiple sanctions

The basic penalties and additional penalties imposed on persons are registered in the Integrated Ministry of Interior Information System subsystem "Persons Who Have Committed Criminal Offences". Penalties imposed on persons are registered in the Integrated Ministry of Internal Affairs Information System subsystem "Persons Who Have Committed Administrative Offences" are. As a result, if several penalties are imposed on a person in respect of one and the same offence, information regarding all penalties imposed will be counted in the relevant information systems.

11.3. Data collected

See description of data included in information systems attached at *Table 3*.

11.3.1. Description of cases which are finalised and have been accorded the status "No Further Action Required"

The staying of a criminal process is regulated by Section 378 of the Criminal Procedure Law, and staying of proceedings in an administrative matter is dealt with in Chapter 28 of the Administrative Procedure Law; however, these laws do not anticipate the suspending of criminal/administrative proceedings due to an offender voluntarily commencing treatment. With that in mind, such data are not gathered and registered.

In 2007, not one case was registered in which a decision had been made in accordance with Section 378 Paragraph 1, Clause 1 of the Criminal Procedure Law:

"Suspension and Renewal of Criminal Proceedings"

(1) A person directing the proceedings shall suspend criminal proceedings, if all the procedural actions that are possible without a suspect or accused have been performed, and if:

1) the suspect or accused has contracted an illness that is an obstacle, for a longer term, to the performance of procedural actions with the participation of such person, and such contraction of the illness has been certified by a conclusion issued by a medical institution;".

11.3.2. Registration of a case in the event of a criminal investigation if a person is released from penalty due to commencing voluntary treatment

Information is collected and compiled for instances when persons have commenced voluntary treatment for drug addiction. Depending on that, for a person who has committed an offence (this mainly applies to cases of using drugs, when criminal process has been initiated), if the person has commenced voluntary treatment, prosecuting institutions take that into account in finalising criminal processes, relieving the person from criminal liability. But this practice is only applied if the criminal offence committed bears the signs of a criminal offence but harm sufficient to attract criminal punishment has not been created. In some cases a suspended punishment will be imposed on a person and this person will become a client of the Probation Service37.

11.3.3. Registration of orders for treatment in cases involving alcohol and drug use

The legislation does not anticipate the inclusion of information in the criminal registration systems on orders for treatment in cases of alcohol and drug use. Having regard to that, such data are not gathered and registered.

11.3.4. Registration of results of driving a motor vehicle under the influence of alcohol and drugs

Information on committed criminal offences and administrative offences is counted in a unified procedure irrespective of the type of offence committed.

In compiling information on penalties imposed for driving a motor vehicle while under the influence of alcohol or drugs, data are not shown in the system which records penalties imposed on a person, which would separately depict the circumstances in which the vehicle was driven. The data characterising the criminal offence (the circumstances in which the offence was committed, motive etc) are recorded in the Ministry of Interior Information Centre Integrated Information System (IIIS) subsystem "Register of Criminal Offences". However, penalties imposed on a person are compiled in the said system's subsystem "Persons Who Have Committed Criminal Offences". The IIIS subsystems are not completely interconnected.

In relation to administrative offences pursuant to Section 149.[15] of the Latvian *Administrative Violations Code*, data on the committing of offences while under the influence of alcohol or drugs is separately registered in the IIIS subsystem "Register of Administrative Offences", as such a distribution is presumed by Section 149.[15], Paragraph five, and Section 149.[15], Paragraph seven of the *Administrative Violations Code*.

To facilitate the acquisition of data from various systems which hold information about criminal processes in progress in respect of criminal offences, preliminary work is in progress at present to develop a new system: the Criminal Process Support System.

[37] Information source: specialised prosecution services from various areas

The aim of the system being developed is to provide support to investigating institutions, staff of the Prosecutor's Office and other staff who participate in the criminal process. This system is to provide support for the guidance of the criminal process and the compiling of information associated with the process in the pre-court investigation, prosecution, and court proceedings stages. A two-way exchange of information with the Court Information System is proposed for the system.

After implementation of the system, the acquisition of data from various mutually unrelated or partly related systems will be facilitated.

Bearing in mind the above, statistical data on penalties imposed on persons who have driven a motor vehicle while under the influence of drugs are in part manually acquired.

11.4. Available results

Information regarding the description of the criminal offence (place, time, motive, in what condition of intoxication or under the influence of what substance the offence was committed) is collected in the IS "Register of Criminal Offences", while in the IS "Register of Persons Who Have Committed Criminal Offences" information is collected regarding penalties imposed on persons, and that contains no separate details by which those persons who had driven a motor vehicle while under the influence of drugs could be selected. Therefore, information on the conviction of persons for driving under the influence of drugs was obtained from the IIIS "Register of Persons Who Have Committed Criminal Offences" partly by manual means.

11.4.1. Driving under influence of drugs

In 2007, 54 persons who had driven a motor vehicle while under the influence of drugs were called to criminal liability *(see Table 11.4)*. Of those 54 persons, 40 – were prosecuted; in relation to eight persons the criminal process begun was remitted to court via general procedure; for two persons criminal process was remitted to court via extraordinary procedure, two persons' criminal process was remitted to court via abbreviated process, while for two persons a different approach was used and is not described in detail here.

Of 54 persons (of which five persons were aged 15–20, 13 persons – 20–25 years old, 23 persons – 25–30 y.o., 9 persons – 30–35 y.o., 3 persons – 30–40 and one persons was aged 45–50) called to criminal liability because of “drugged-driving”, 22 persons were charged, of whom: community service (or enforced labour) as a basic penalty was adjudged for 7 persons (from 50 hours to 200 hours), deprivation of liberty (or a term of real imprisonment) was adjudged for 6 persons (between 13 months and 2 years), suspended sentence was imposed on 4 persons (term of probation ranged between 10 and 24 months), a monetary fine as a basic sentence was imposed on four persons (sums ranging between LVL 480–840), and police supervision was imposed on 1 person (for a period of one year). An additional sentence – confiscation of driver's license (ranging from 16 months up to 4 years) – was imposed on 20 persons.

Table 11.4. Driving under influence of drugs and actions taken

Called to criminal liability	54
Procecuted	40
Charged, of which with a basic sentence:	22
Community service (forced labour)	7
Deprivation of liberty (real-term imprisonment)	6
Suspended sentence	4
Monetary fine	4
Charges were cleared	1
Additional sentence – confiscation of driver's licence	20

In respect of persons called to administrative liability pursuant to Section 149.[15], Paragraph five, of the *Administrative Violations Code*, a fine was imposed on 205 persons, administrative arrest was imposed on 203 persons, confiscation of driving licence was imposed on 204 persons, and administrative arrest was imposed on 203 persons.

In respect of persons called to administrative liability in accordance with Section 149.[15], Paragraph seven, of the *Administrative Violations Code*, a fine was imposed on 155 persons, administrative arrest was imposed on 143 persons, and confiscation of driving licence was imposed on 129 persons.

11.4.2. Data and results regarding court decisions related to the use and possession of drugs[38]

The total registered number of criminal and administrative offences in 2007 was 4270, of which 1393 were according to Section 253 of the *Criminal Law*; 511 – according to Section 253.[2], Paragraph one of the *Criminal Law*, and 2366 were according to Section 46 of the *Administrative Violations Code*.

In 2007, 3282 persons were called to both criminal liability and administrative liability for the use and possession of drugs, which includes 870 persons called to criminal liability pursuant to Section 253 of the *Criminal Law*, 329 persons pursuant to Section 253.[2], Paragraph one of the *Criminal Law*, and 2083 persons called to administrative liability pursuant to Section 46 of the *Administrative Violations Code*.

In 2007, 166 persons were charged for criminal offences committed during the year pursuant to Section 253 of the *Criminal Law (see Table 11.5)*. Of these, deprivation of liberty as a basic sentence was adjudged for 162 persons, of which 117 – were adjudged with suspended sentence (with parole periods ranging between one and three years). Police supervision as an additional penalty was imposed on 33 persons (the periods of police supervision ranged between 1

[38] The *Criminal Law* s.253, s.253.[2], Paragraph one; *Administrative Violations Code* s.46. Statistical data prepared from IIIS subsystems "Register of Criminal Offences"; "Persons Who Have Committed Criminal Offences", "Persons Who Have Committed Administrative Offences"

and 3 years). Enforced labour was imposed as a basic penalty on 2 persons (a total of 80 hours). A monetary fine was imposed as a basic penalty on 2 persons (LVL 840 and LVL 1200). An additional penalty of confiscation of property was imposed on 13 persons. An additional penalty: limitation of rights was imposed on 4 persons.

In 2007, the sentence most frequently adjudged for criminal offences committed pursuant to Section 253 of the *Criminal Law* was deprivation of liberty. Only in 19.9% of cases was police supervision also imposed. Of the basic penalties enforced labour was imposed in only two cases i.e. in 1.2% of the total number of cases where a basic penalty was imposed. Of the basic penalties, only in two cases was a monetary fine imposed i.e. in 1.2% of the total number of cases where a basic penalty was imposed.

In 2007, in 97.6% of cases when imprisonment was imposed on a person, in 72.2% of cases, the punishment was imprisonment on parole. A real term of imprisonment was only served in 25.4% of cases.

In 2007, 131 persons were charged pursuant to Section 253.[2], Paragraph one of the *Criminal Law (see Table 11.5)*. Of these, deprivation of liberty a basic penalty was adjudged for 109 persons or in 83.2% of cases (suspended sentence was adjudged for 38 persons or in 34.9% of cases). A monetary fine was imposed as a basic penalty on two persons, while community service (ranging from 60 to 280 hours) as a basic penalty was adjudged for 20 persons or in 15.3% of cases.

Confiscation of property as an additional penalty was adjudged for seven persons or in 5.3% of cases. Limitation of rights (ranging between one and five years) was imposed as an additional penalty on 6 persons or in 4.5% of cases. Police supervision (ranging between one and three years) was imposed as an additional penalty on 14 persons.

Table 11.5. Number of persons charged in 2007 according to use/possession without purpose of selling[39]

	Section 253	Section 253[2] §1
Charged, of which with a basic sentence:	166	131
Deprivation of liberty, of which	162	109
Suspended sentence, of which	117	38
Police supervision	33	14
Community service	2	20
Monetary fine	2	2
Additional sentence – confiscation of property	13	7
Additional sentence – limitation of rights	4	6

Pursuant to Section 46 of the *Administrative Violations Code*, administrative penalties were imposed on 1980 persons. In accordance with section 239 of the *Administrative Violations Code*, record-keeping was finalised in respect of 36 persons, and administrative arrest was imposed on

[39] Criminal Law Section 253, Section 253[2] §1

100 persons. Warnings were given to 40 persons; other corrective measures were imposed in respect of 9 persons; monetary fines were imposed in the remaining cases.

11.4.3. Data and results regarding court decisions associated with drug-dealing, trafficking or production of drugs[40]

In 2007 the total number of registered criminal offences and administrative offences was 458, of which 33 criminal offences were registered pursuant to Section 190.[1] of the *Criminal Law*, 407 criminal offences were registered pursuant to Section 253.[1]of the *Criminal Law*, 18 criminal offences were registered pursuant to Section 253.[2], Paragraph two of the *Criminal Law*. No criminal offences pursuant to Section 256 of the *Criminal Law* were registered in 2007.

Pursuant to Section190.[1] of the *Criminal* Law, in 2007, 13 persons were called to criminal liability; of those, 10 persons were charged. Deprivation of liberty was adjudged for 3 persons (the periods of imprisonment imposed ranged between two and four years); a monetary fine (the amount imposed ranged from LVL 600 to LVL 1200) was imposed as a basic penalty on 3 persons; community service was as a basic penalty was adjudged for four persons. An additional penalty of confiscation of property was imposed in one case *(see Table 11.6)*. .

Table 11.6. Number of persons charged with use/possession without purpose of selling[41]

	Section 190[1]	Section 253[1]	Section 253[2] §2
Charged, of which with a basic sentence:	10	82	3
Deprivation of liberty, of which	3	80	3
Suspended sentence, of which	0	23	0
Police supervision	0	21	0
Community service	4	1	0
Monetary fine	3	1	0
Additional sentence – confiscation of property	1	36	0
Additional sentence – limitation of rights	0	0	0

In 2007, pursuant to Section 253.[1] of the *Criminal Law*, 238 persons were called to criminal liability. 82 persons were charged pursuant to Section 253.[1] of the *Criminal Law*. The basic penalty of deprivation of liberty (imprisonment between one and two years) was imposed on 80 persons (for 23 persons suspended sentence was adjudged ragning between one and three years); community service was imposed on one person for a period of 120 hours; a monetary fine was imposed on one person in the amount of LVL 720. An additional penalty, confiscation of property was imposed on 36 persons or in 43.9% of cases. Police supervision was imposed as an additional penalty on 21 persons or in 25.6% of cases.

In 2007, pursuant to Section 253.[2], Paragraph two of the *Criminal Law*, 23 persons were called to criminal liability, with 3 persons being charged. Imprisonment was imposed as a basic

[40] The *Criminal Law* s.190.[1], s.253.[1], s.253.[2], Paragraph two, s.256. Statistical data prepared from IIIS subsystems "Register of0 Criminal Offences" and ","Persons Who Have Committed Criminal Offences"
[41] Criminal Law Section 253, Section 253[2] §1

penalty in 3 cases; in one case, the penalty imposed was with parole for one year. Terms of imprisonment ranged between 7 months and 5 years. As an additional penalty, police supervision was imposed on one person for a period of three years.

11.4.4. Data and results regarding court decisions associated with other offences in the field of illegal circulation of drugs[42]

In 2007, the total number of registered criminal offences and administrative offences was 569, of which one criminal offence was registered pursuant to Section 250 of the *Criminal Law*; five – pursuant to Section 251 of the *Criminal Law*; two – pursuant to Section 252 of the *Criminal Law*; 60 criminal offences were registered pursuant to Section 262 of the *Criminal* Law. No criminal offences were registered pursuant to Section 249 or 255 of the *Criminal Law*

17 administrative offences were registered pursuant to Section 46.[1] of the *Administrative Violations Code*; 201 administrative offences were registered pursuant to 149.[15], Paragraph five of the *Administrative Violations Code*; 154 administrative offences were registered pursuant to Section 149.[15] Paragraph seven of the *Administrative Violations Code*.

4 persons were called to criminal liability pursuant to Section 251 of the *Criminal Law*; 1 person was convicted and sentenced to imprisonment for a period of five years, with confiscation of property and police supervision to two years.

54 persons were called to criminal liability pursuant to Section 262 of the *Criminal Law* for driving while under the influence of drugs.

Information regarding the description of a criminal offence (place, time, motive, under what degree of intoxication or under the effect of what substance had the offence been committed) is collected in the IS "Register of Criminal Offences ", while in the IS "Persons Who Have Committed Criminal Offences" information is collected on penalties imposed on persons, and contains no extra details by which those persons could be selected who have driven motor vehicles while under the influence of drugs.

11 persons were convicted pursuant to Section 309 of the *Criminal Law* in 2007. Imprisonment was imposed on 10 persons; confiscation of property was imposed as an additional penalty on two persons; police supervision was imposed an additional penalty on 3 persons (for periods between 1-2 years); a monetary fine of LVL 720 was imposed on 1 person as a basic penalty. For 10 persons, in respect of whom imprisonment had been imposed, the sentence was suspended on parole for 7 persons or in 70% of cases. The periods of parole imposed ranged between 1-2 years.

17 persons were called to administrative liability pursuant to Section 46.[1] of the *Administrative Violations Code*; of those, and administrative penalty was imposed on 8 persons,

[42] The *Criminal Law* s.249, 250, 251, 252, 255, 262, 309, *Administrative Violations Code* s.46.[1], s.149.[15] Paragraph five, and Paragraph seven. Statistical data prepared from IIIS subsystems""Register of Criminal Offences ", "Persons Who Have Committed Administrative Offences", "Persons Who Have Committed Criminal Offences"

but in relation to two persons, record-keeping was finalised in accordance with Section 239 of the *Administrative Violations Code*.

198 persons were called to administrative liability pursuant to Section 149.[15] Paragraph five of the *Administrative Violations Code*; of those, administrative penalties were imposed on 188 persons.

153 persons were called to administrative liability pursuant to Section 149.[15] Paragraph seven of the *Administrative Violations Code*; of those, administrative penalties were imposed on 149 persons, record-keeping in respect of one person was finalised in accordance with Section 239 of the *Administrative Violations Code*.

11.4.5. Number of offenders (in relation to illegal circulation of drugs), in respect of whom, in relation to each type of drug, different means of disposing of the case had been applied (good behaviour bond, penalty, case finalised)

At the moment it is not possible to provide data on the number of offenders in respect of whom different means of disposing of the case had been applied, in relation to the type of drug involved.

After development of the Criminal Process Support System, a means of acquiring information will be facilitated; this is necessary for the criminological research and analysis of data.

11.5. Court Administration data

Court Administration (CA), which was established in 2004, is a direct administrative organization of the Minister of Justice. One of its aims is to provide statistical data on court operations (for aims and available data see http://www.ta.gov.lv).

According to available data from the website of Court Administration two aspects in relation with drug-related[43] criminal offences will be analysed in this subchapter: 1) length of examined drug-related cases in courts and 2) number of charged persons. Data aggregation level does not allow distinguishing between different types of offences, e.g. use/possession and drug-dealing/trafficking for the number of examined cases.

11.5.1. Length of examined cases

According to CA data in 2007 713 drug-related cases were examined in Courts of First Instance. Of these the majority (78% or 562) were examined in less than three months, 89 cases – between three and six months, 38 – between six and 12 months, while 24 cases took more than one year of examination *(see Table 11.7)*. The length of a drug-related case examination in Courts of First Instance as compared with other cases in 2007 was slightly quickier, e.g. 73% of all cases at First Instance as compared with 78% of drug-related cases that were examined in less than three months. It can be observed that the length of drug-related case examination in courts has

[43] According to Sections 248.; 249.; 251.; 253.; 256 of the Criminal Law, which excludes some of the Sections of Criminal Law as described in detail in Attachment Table 1 and in text in previous chapters of this Selected Issue.

become quicker over the years, e.g. in 2004 only 53% of cases were examined in less than three months' time, in 2005 – 59%, in 2006 – 69%.

Additionally, in 2007 there were 82 cases in Courts of Appeal, for which the majority of cases was also examined in less than three months and the number of cases has gradually decreased since 2005.

As compared with 2006 data the number of examined cases in Courts (First Instance or Appeal) has increased by 28% but has decreased with that observed in 2005 and 2004. The workload of Courts of First Instance in relation to proportion of drug-related cases has not much changed over the last four years – in 2004 6.5% of cases were drug-related, in 2005 – 7.0%, in 2006 – 5.2%, and 6.6% in 2007.

Table 11.7. Length of examined cases in 2007

		Less than 3 months	3–6 months	6-12 months	12-18 months	18-24 months	24-30 months	30-36 month	Over 36 months	**Total**
2007	1st Instance	562	89	38	16	2	1	2	3	**713**
	Appeal C.	72	7	3	0	0	0	0	0	**82**
2006	1st Instance	361	81	52	14	7	4	1	4	**524**
	Appeal C.	74	9	8	1	1	1	0	0	**94**
2005	1st Instance	479	181	113	27	5	2	1	4	**812**
	Appeal C.	125	25	10	4	0	0	0	0	**164**
2004	1st Instance	424	159	118	52	22	12	5	6	**798**
	Appeal C.	88	25	8	2	0	0	0	0	**123**

Source: Court Administration

11.5.2. Number of persons charged

According to Court Administration data 554 persons were charged for drug-related crimes in 2007; the number of persons is higher as compared with 2006 data (498) but lower as compared with 2005 (605) or 2004 (718) data. There is a decreasing trend in proportion of women charged for drug-related crimes – in 2004 23% of all persons charged for drug-related crimes were women, whilst in 2007 – only 15.2%. On the other hand, the number of persons with previous criminal records has increased since 2004 – 30.2%, 45.8% in 2005, 46.0% in 2006, while it has slightly decreased in 2007 (42.4%).

There is no clear trend over the last four years regarding basic sentence. The lowest ratio of a basic sentence leading to real-term imprisonment was observed in 2005 (42.6), while the highest – in 2006 (51.0); at the same time the lowest ratio of suspended sentences was observed in 2006, while the highest – in 2007 *(see Table 11.8)*. In 2005 as compared with other years' data there was almost twice as high ratio of a basic sentence of community service (11.4% in 2005, 7.4% in 2004, 6.8% in 2006 and 6.5% in 2007).

Table 11.8. Ratio of basic sentences for charged persons (% of all drug-related charged persons)[44]

	2004	2005	2006	2007
Imprisonment	44.3	42.6	51.0	43.5
Fine	1.5	3.5	2.8	1.6
Community services	7.4	11.6	6.8	6.5
Suspended sentence	45.5	43.0	39.6	48.4

Source: Court Administration

According to Court Administration data among those who were imprisoned for drug-related charges in 2007 about one-third (35%) received a sentence between one and three years, while 29% – between five and ten years *(see Table 11.9)*.

Table 11.9. Length of imprisonment time for those adjudged with deprivation of liberty (% of those imprisoned)

	2004	2005	2006	2007
Less than one year	11.3	12.0	11.0	14.0
1–3 years	46.9	44.6	27.6	34.7
3–5 years	26.7	19.0	27.9	22.4
5–10 years	15.1	24.0	33.1	28.9
10–20 years	0.0	0.4	0.4	0.0

Source: Court Administration

[44] Total sometimes do not add to 100 per cent because a few cases are sentences differently, e.g. in 2004 nine cases received sentence of being sent to treatment, while a few other cases over the years are dismissed.

Attachment. Table 1. Comparative table: Republic of Latvia *Criminal Law* or *Administrative Violations Code* "drug-related" sections v. EMCDDA Offence type

EMCDDA offence	Republic of Latvia *Criminal Law*/*Administrative Violations Code* (AVC) section
Drug-related use/ possession for personal use	**Section 253. Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances** *[18 May 2000; 25 April 2002; 17 October 2002]* (1) For a person who commits unauthorised manufacture, acquisition, storage, transportation or conveyance of narcotic or psychotropic substances without the purpose of selling such substances, the applicable sentence is deprivation of liberty for a term not exceeding five years, with or without confiscation of property, and police supervision for a term not exceeding three years. (2) For a person who commits the same acts, if commission thereof is repeated or in a group of persons pursuant to prior agreement, or by a person who has previously committed theft of narcotic or psychotropic substances, or such have been committed regarding large amounts of narcotic or psychotropic substances, the applicable sentence is deprivation of liberty for a term of not less than five and not exceeding ten years, with or without confiscation of property and police supervision for a term not exceeding three years. **Section 253.[2] Unauthorised Manufacture, Acquisition, Storage, and Sale of Narcotic and Psychotropic Substances in Small Amounts and Use of Narcotic and Psychotropic Substances without a Physician's Designation** (1) For a person who commits unauthorised acquisition, or storage in small amounts of narcotic or psychotropic substances without the purpose of sale thereof, or who commits use of narcotic or psychotropic substances without a physician's designation, if commission thereof is repeated within a period of one year, the applicable sentence is deprivation of liberty for a term not exceeding two years, or community service, or a fine not exceeding fifty times the minimum monthly wage. **AVC Section 46. Illegal Acquisition or Storage in a Small Amount of Narcotic and Psychotropic Substances and Medicinal Products, as well as Substances, which May Be Used for the Illegal Production of Narcotic and Psychotropic Substances (Precursors), or the Use of Narcotic and Psychotropic Substances without Prescription by a Doctor** *[23 October 2003]* In the case of the illegal acquisition or storage in a small amount of narcotic or psychotropic substances or medicinal products, including substances, which may be used for the illegal production of narcotic or psychotropic substances (precursors), without the aim of selling them, as well as the use of narcotic or psychotropic substances without prescription by a doctor – a fine in an amount up to LVL 75 or administrative arrest for a period of time up to 15 days shall be imposed. 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 this section. The amount of illegally traded narcotic and psychotropic substances and medicinal products, including substances, which may be used to produce narcotic and psychotropic substances (precursors), which is to be recognised as small is specified in Annex 2 to the Law on the Procedures for the Coming into Force and Application of the Criminal Law.
Drug-related dealing/ trafficking/ production	**Section 190.[1] Movement of Goods and Substances the Circulation of which is Prohibited or Specially Regulated across the State border of the Republic of Latvia** *[17 October 2002; 28 April 2005; 21 June 2007; 13 December 2007/2]* (1) For a person who commits the moving of narcotic or psychotropic substances or the source materials (precursors) for the preparation of such substances, alcohol or other alcoholic beverages, as well as radioactive or hazardous substances, goods of strategic importance or other valuable property, explosives, weapons and ammunition across the State border of the Republic of Latvia in any unlawful way, the applicable sentence is deprivation of liberty for a term not exceeding ten years or community service, or a fine not exceeding one hundred times the minimum monthly wage, with or without confiscation of property. (2) For a person who commits the same acts, if the commission thereof is repeated, or where committed in a group of persons pursuant to prior agreement, or if such is committed on a large scale, the applicable sentence is deprivation of liberty for a term of not less than five and not exceeding twelve years, or a fine not exceeding two hundred times the minimum monthly wage, with or without confiscation of property. (3) For a person who commits the same acts, where committed in an organised group, the applicable sentence is deprivation of liberty for a term of not less than eight and not exceeding fifteen years, with confiscation of property, and with police supervision for a term not exceeding three years. **Section 253.[1] Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances for the Purpose of Sale and Unauthorised Sale** *[17 October 2002]* (1) For a person who commits unauthorised manufacture, acquisition, storage, transportation or conveyance of narcotic or psychotropic substances for the purpose of sale, or who commits unlawful sale of narcotic or psychotropic substances, the applicable sentence is deprivation of liberty for a term of not less than five and not exceeding ten years, with or without confiscation of property and police supervision for a term not exceeding three years. (2) For a person who commits acts the same acts, if commission thereof is repeated or in a group of persons pursuant to prior agreement, or by a person who has previously committed theft of narcotic or psychotropic substances, the applicable sentence is deprivation of liberty for a term of not less than five and not exceeding twelve years, with or without confiscation of property and police supervision for a term not exceeding three years. (3) For a person who commits the same acts, if commission thereof is in an organised group, or such have been committed regarding large amounts of narcotic or psychotropic substances, as well as commits sale of narcotic or psychotropic substances to minors, in educational institutions or the territory thereof, in restaurants, cafeterias, bars, places of public recreation or holiday events, the applicable sentence is deprivation of liberty for a term of not less than eight and not exceeding fifteen years, with confiscation of property and police supervision for a term not exceeding three years. **Section 253.[2] Unauthorised Manufacture, Acquisition, Storage, and Sale of Narcotic and Psychotropic Substances in Small Amounts and Use of Narcotic and Psychotropic Substances without a Physician's Designation** *[17 October 2002]* (2) For a person who commits unauthorised sale of narcotic or psychotropic substances in small amounts. the applicable sentence is deprivation of liberty for a term not exceeding three years, or custodial arrest, or community service, or a fine not exceeding eighty times the minimum monthly wage.

Drug-related use and trafficking	N/A
Other types of offences	**Section 249. Violation of Provisions Regarding the Production, Acquisition, Storage, Registration, Dispensation, Transportation and Conveyance of Narcotic and Psychotropic Substances** *[12 February 2004]* (1) For a person who commits violation of provisions regarding the production, acquisition, storage, registration, dispensation, transportation or conveyance of narcotic or psychotropic substances, the applicable sentence is deprivation of liberty for a term not exceeding three years, or custodial arrest, or community service, or a fine not exceeding fifty times the minimum monthly wage, with or without deprivation of the right to engage in specific employment for a term not exceeding three years. (2) For a person who commits the same acts, if such have been committed repeatedly or by a group of persons pursuant to prior agreement, the applicable sentence is deprivation of liberty for a term not exceeding five years or community service, or a fine not exceeding eighty times the minimum monthly wage. **Section 250. Unauthorised Dispensation of Narcotic and Psychotropic Substances** *[25 April 2002]* For a person who commits issuing of prescriptions where not medically necessary, or illegal issue of other documents for the obtaining of narcotic or psychotropic substances, or who commits dispensation of narcotic or psychotropic substances without a prescription or other document or with knowledge that a prescription or other document is fictitious or issued illegally, if commission of such acts is for purposes of acquiring property or for other personal interests, or if commission of such acts is repeated within a one year period, the applicable sentence is deprivation of liberty for a term of not less than one and not exceeding five years, with deprivation of the right to engage in specific employment for a term not exceeding five years. **Section 251. Inducement to Use Narcotic and Psychotropic Substances** *[25 April 2002]* (1) For a person who commits inducing use of narcotic or psychotropic substances, or providing premises for using such substances, the applicable sentence is deprivation of liberty for a term of not less than one and not exceeding five years. (2) For a person who commits the same acts, if commission thereof is repeated or with regard to a minor, a mentally ill person or a person undergoing treatment for addiction to narcotics, or with regard to a person financially or otherwise dependent on the guilty party, or if other substances have been added to narcotic or psychotropic substances as enhance their effect, the applicable sentence is deprivation of liberty for a term of not less than three and not exceeding eight years. (3) For a person who commits inducing use of narcotic or psychotropic substances, if their use has caused serious consequences, the applicable sentence is deprivation of liberty for a term of not less than eight and not exceeding fifteen years. **Section 252. Administering of Narcotic and Psychotropic Substances Against a Person's Will** *[25 April 2002]* (1) For a person who commits administering of narcotic or psychotropic substances to another person or of adding such substances to the food or drink of another person against the will of such person or without his or her knowledge, the applicable sentence is deprivation of liberty for a term of not less than three and not exceeding eight years. (2) For a person who commits the same acts, if other substances have been added to the narcotic or psychotropic substances as enhance their effect, the applicable sentence is deprivation of liberty for a term of not less than five and not exceeding ten years. (3) For a person who commits acts provided for in Paragraphs one or two of this Section, if such have been committed against a minor or by using force, or threats of force, or have caused serious consequences, the applicable sentence is deprivation of liberty for a term of not less than eight and not exceeding fifteen years. **Section 255. Manufacture, Acquisition, Storage, Transportation, Conveyance and Sale of Equipment and Substances (Precursors) Intended for Unauthorised Manufacture of Narcotic and Psychotropic Substances** *[25 April 2002; 21 June 2007]* (1) For a person who commits manufacture, acquisition, storage, transportation or conveyance of equipment, devices, objects, materials or substances (precursors) intended for the unauthorised manufacture of narcotic or psychotropic substances, the applicable sentence is deprivation of liberty for a term of not less than one and not exceeding three years. (2) For a person who commits the same acts, if such have been committed for the purposes of sale of such equipment, devices, objects, materials or substances (precursors), or who commits sale of equipment, devices, objects, materials or substances (precursors) intended for unauthorised manufacture of narcotic or psychotropic substances, the applicable sentence is deprivation of liberty for a term of not less than three and not exceeding ten years, with or without confiscation of property or with or without deprivation of the right to engage in specific employment for a term of not less than two and not exceeding five years. (3) For a person who commits the acts provided for in Paragraphs one or two of this Section, if such has been committed in a group of persons pursuant to prior agreement, the applicable sentence is deprivation of liberty for a term of not less than five and not exceeding ten years, with confiscation of property or deprivation of the right to engage in specific employment for a term of not less than two and not exceeding five years. **Section 256. Unauthorised Sowing and Growing of Plants Containing Narcotic Substances** *[25 April 2002; 12 February 2004]* (1) For a person who commits unauthorised sowing or growing of plants containing narcotic substances, if commission thereof is repeated within a one year period, the applicable sentence is deprivation of liberty for a term not exceeding two years or community service, or a fine not exceeding fifty times the minimum monthly wage. (2) For a person who commits unauthorised sowing or growing of plants containing narcotic substances, over a large area, the applicable sentence is deprivation of liberty for a term of not less than one and not exceeding five years, with or without confiscation of property. **AVC Section 46.[1] Violation of Specified Procedures in Pharmaceutical Activity** In the case of violation of regulations related to the manufacture, production or distribution of narcotic and psychotropic medicinal products, as well as substances, which may be used for the illegal production of narcotic or psychotropic substances (precursors) – a fine in an amount from LVL 100 and up to LVL 500 shall be imposed on natural persons, and a fine in an amount from LVL 1000 and up to LVL 10 000 shall be

imposed on legal persons, with or without the confiscation of the relevant medicinal products or precursors. In the case of the distribution of medicinal products that are not registered or prohibited in the Republic of Latvia – a fine shall be imposed on the distributor – for a natural person from LVL 100 and up to LVL 500, but for a legal person from LVL 1000 to LVL 5000, with the confiscation of the relevant medicinal products.

AVC Section 149.[15] Driving of a Vehicle under the Influence of Alcohol or Narcotic or other Intoxicating Substances

(Paragraph five) In the case of driving of a vehicle or instructing to drive a vehicle, under the influence of a narcotic, psychotropic, toxic or other intoxicating substances – a fine shall be imposed on the driver of the bicycle and moped in an amount of LVL 60, for the driver of a vehicle, who was driving a bus, an administrative arrest shall be imposed for a period from 10 up to 15 days, a fine shall be imposed in an amount of LVL 500 with the suspension of the D category driving licence for a period of 5 years with the suspension of the driving licence for other vehicles for a period of 2 years, but for the driver of other vehicles an administrative arrest shall be imposed for a period from 10 up to 15 days, a fine shall be imposed in an amount of LVL 500 with the suspension of the driving licence for a period of 2 years.

(Paragraph seven) In the case of the use of an alcoholic beverage, narcotic or other intoxicating substances after a traffic accident, as well as after the vehicle is stopped at the request of a police officer, until a test that establishes the concentration of alcohol or determines the influence of narcotic or other intoxicating substances or until release from such a test –

for a driver who does not possess a driving licence (where the driving licence has not been obtained pursuant to the prescribed procedures or has been suspended), an administrative arrest shall be imposed for a period from 10 up to 15 days, a fine shall be imposed in an amount of LVL 500 and a prohibition on obtaining a driving licence for a period of three years shall be imposed. In respect of a bicycle and moped driver a fine shall be imposed in an amount of LVL 60, and in the case of a driver, who was driving a bus, an administrative arrest shall be imposed for a period from 5 up to 10 days, a fine in an amount of LVL 400 shall be imposed with the suspension of the D category driving licence for a period of 5 years with the suspension of the driving licence for other vehicles for a period of 1 year, but for the driver of other vehicles an administrative arrest shall be imposed for a period from 5 up to 10 days, a fine shall be imposed in an amount of LVL 400 with the suspension of the driving licence for a period of 1 year.

Attachment. Table 2. Information systems, containing information on offences/offenders in the field of illegal circulation of drugs [45]

No	IS name	Legal basis for establishment and operation of IS	IS manager	IS custodian	Functions/tasks/objectives	Nature of information held	Institutions which primarily register information
1	Integrated Ministry of Interior System subsystem "Electronic Journal of Events"	The law *On Police*	State Police	Ministry of Interior Information Centre	To ensure the unified movement of registered information to authorised users in State police structural units in real time and to ensure the integration of registered information with relevant subsystems in the integrated Ministry of Interior Information System. Ensure access to registered information by authorised staff of other law enforcement agencies	Information received by units of the State police from the entire territory of the Republic of Latvia on criminal offences and other breaches of the law, and on persons who have committed the offences, and on events which threaten the security of persons, the public, or the State (accidents, fire disasters, catastrophes, natural disasters and others)	State Police
2	Integrated Ministry of Interior System subsystem "Register of Criminal Offences"	• ***The Official Statistics Law***; • *The Criminal Law*; • *Criminal Procedure Law* I; • Cabinet Regulation No. 756 of 04.10.2005, "Regulations on the Criminal Offences Register"	Ministry of Interior Information Centre	Ministry of Interior Information Centre	Ensure the movement of information necessary for criminal procedures, by undertaking processing of data for criminal processes in progress, detected criminal offences and persons who have committed criminal offences	Information on criminal processes in progress (criminal cases initiated) and detected criminal offences throughout the State, as well as criminal cases received from abroad in which the pre-court investigation will be conducted in the Republic of Latvia (number of criminal offences, their nature, prevalence, place where criminal case initiated, date). Physical and legal persons who have committed criminal offences, in whose interests criminal offences had been committed by physical persons (who have been charged, the criminal case has been forwarded to court, number of persons, the description, personal information, qualification of criminal offence). Results of criminal process (criminal case) results of pre-court investigation (important decisions taken during criminal case; date of decisions). Criminal process (criminal case) direction	• State Police Prosecuting institutions • investigating institutions • Courts
3	Integrated Ministry of Interior System subsystem "Persons who have Committed Criminal Offences"	• *Punishment Register Law* • Cabinet Regulation No. 687 "Procedure and amount of information to be provided for the Punishment Register, and information available from the Punishment Register. Ministry of Interior	Ministry of Interior Information Centre	Ministry of Interior Information Centre	Ensure a unified record-keeping system for persons who have committed criminal offences	Information on physical persons in the Republic of Latvia who : • have been arrested, • are suspects, • have been charged, • have been convicted, • have been acquitted, • against whom the criminal process is finalised; • legal persons in respect of which enforced sanctions have been imposed; • legal persons registered in the Republic of Latvia, non-citizens of Latvia, foreigners resident in Latvia, having permanent resident status • stateless persons and refugees who have committed criminal offences in other countries	• Investigating institutions • Prosecuting institutions • Courts; • Latvian Prison Administration • Latvian President's Chancery Clemency Service • State and local government institutions holding information necessary to compile the Punishment Register; • Competent foreign institutions
4	Integrated Ministry of Interior System subsystem "Persons who have Committed Administrative	• *Punishment Register Law* • Cabinet Regulation No. 687, "Procedure and amount of information to be provided for the Punishment Register, and	Ministry of Interior Information Centre	Ministry of Interior Information Centre	To ensure a unified system of records in respect of persons who have committed administrative offences	Information on administrative offences, administrative penalties imposed, and their enforcement	

[45] Operative information systems not included

No	IS name	Legal basis for establishment and operation of IS	IS manager	IS custodian	Functions/tasks/objectives	Nature of information held	Institutions which primarily register information
	Offences"	information available from the Punishment Register. Ministry of Interior Order No. 613 of 17.09.2002 approved the establishment of the "Filtrs" information system and its user instruction					
5	Integrated Ministry of Interior System subsystem "Property Search"	Ministry of Interior Order No. 125 of 23 February 2001 approved the "Instruction for the establishment and utilisation of the "Mantas" information system".	Ministry of Interior Information Centre	Ministry of Interior Information Centre	Facilitate the search for property (thereby facilitating the detection of criminal offences), collecting and maintaining unified and comprehensive information on property being searched for within the Republic of Latvia and abroad	Information on property which has been stolen, found, confiscated or lost, including confiscated drugs	• State Police other law enforcement agencies (including foreign)
6	Integrated Ministry of Interior System subsystem "Register of Weapons"	• *Law On the Handling of Weapons*, • Cabinet Regulation No. 167 of 15.04.2003 "Record-keeping procedure for firearms and high-energy pneumatic weapons", • Cabinet Regulation No. 226 of 25.06.1997 "Listing of State secrets"	Ministry of Interior Information Centre	Ministry of Interior Information Centre	To ensure the unified, computerised inventory of fire arms and high energy pneumatic weapons held by physical and legal persons (other than National Armed Forces)	Information on -weapons registered and available for sale in the Republic of Latvia, and weapons imported into the Republic of Latvia, exported from the Republic of Latvia, or in transit through the Republic of Latvia ; - owners of weapons (holders) and their registered (declared) and legal addresses; - all types of weapons permits and special permits (licences), including the annulment of permits, e.g.., involved in breach of the law; - control collection of bullets and shells from control firings undertaken with single barrel firearms; - address where weapons kept and addresses to where they are to be sent	• Ministry of Interior system institutions, including State Police, • Constitutional Protection Bureau, • Prosecuting institutions, • Corruption Prevention and Combating Bureau, • Bank of Latvia Protection Board, • State Revenue Service, • Ministry of Justice Latvian Prison Administration • local government police institutions, • merchants who trade in the handling of weapons
7	Court Informative System	• Law *"On Judicial Power"*; • Cabinet Regulation No. 582 of 28.08.2007 "Regulations on procedures for the establishment, maintenance and utilisation of a Court Informative System, and the minimum amount of information to be stored".	Ministry of Justice	Courts administration	To automate the courts' record-keeping cycle, ensuring registration of data on cases, its processing, maintenance, transmission, and availability, creating the opportunity of rapidly checking the pace of progress on cases, efficient exchange of necessary information (data), between the courts and institutions of the justice system; automating the preparation of statistical reports, and ensuring the exchange of data via an automated regime with other State Information Systems	Information on civil cases, criminal cases, and materials reviewed during criminal procedures, administrative cases, and administrative violation cases.	Courts
8	Road Traffic Police Register	• *Law "On Police"* • *Punishment Register Law,* • *Road traffic Law,* • Cabinet Regulation No. 477 of 26.08.2003 "Regulations on record-keeping in relation to road traffic accidents, and those injured or killed in them", • Ministry of Interior Internal Instruction No. 22 of	State Police	State Police	Ensuring the unified collection and maintenance of information, and the efficient and precise utilisation of this information in accordance with existing legislation	Information on breaches of the Road traffic legislation registered by the State police, and road accidents	State Police (Road traffic police)

No	IS name	Legal basis for establishment and operation of IS	IS manager	IS custodian	Functions/tasks/objectives	Nature of information held	Institutions which primarily register information
		30.12.2003 "Work organisation of the Road traffic police" • State Police Order No. 289 "Approval for the establishment of an information searching complex on the "CPR-SQL" platform, together with user instruction".					

Source: Ministry of Interior Information Centre

Attachment. Table 3. Data held in information systems

No	Name of IS	Data groups									Information directly related to offence/offender in the illegal circulation of drugs
		Offender's data (e.g. arrested, suspect, charged, convicted, etc. (e.g. name, surname, person code, address etc)	Involved persons' data (e.g. victim, witness, owner/ holder of weapon etc) (e.g. name, surname, person code, address etc)	Qualification of offence committed (e.g. pursuant to APC or criminal law section, paragraph, clause etc)	Administrative or criminal penalty imposed	Data on process (administrative/criminal direction)	Data on court process	Detailed information regarding offence or event (e.g. circumstances of offence, weapons etc)	Information on drugs seized	Departmental data (e.g. process numbers, details of institutions involved, details of officials involved etc)	
1	Integrated Ministry of Interior System subsystem "Electronic Journal of Events"	X	X	X	-	X	-	X	X	X	- type and description of offence (e.g. circumstances, initial qualification, time, address, short description) - description of persons involved (including arrested, victim, submitter etc.) (personal data, state of health, identifying marks etc.) - substances seized
2	Integrated Ministry of Interior System subsystem "Register of Criminal Offences"	X	X	X	-	X	-	X	X	X	- information on criminal proceedings - detailed information on criminal offences committed - information on persons against whom criminal proceedings have been initiated
3	Integrated Ministry of Interior System subsystem "Persons who have Committed Criminal Offences"	X	-	X	X	X	X	-	-	X	- information on persons who had been arrested within the Republic of Latvia, - are official suspects, charged, convicted, - acquitted of criminal offences, - against whom criminal process is finalised; - Latvian citizens, non-citizens, foreigners having Latvian residence permit, stateless persons and refugees who have committed criminal offences in other countries - direction of criminal process - sureties imposed - penalty imposed
4	Integrated Ministry of Interior System subsystem "Persons who have Committed Administrative Offences"	X	-	X	X	X	-	X	X	X	- information on administrative offences committed, administrative penalties imposed -implementation of administrative penalty -persons who have committed administrative offences
5	Integrated Ministry of Interior System subsystem "Property Search"	-	X	-	-	-	-	-	X	X	-information on substances seized (weight, form,) - information on submitter (e.g. a person representing an organisation at whose property stolen drugs were located)
6	Integrated Ministry of Interior System subsystem "Register of Weapons"	X	X	X	X	-	-	-	-	X	- information on persons (owners/holders of weapons), from whom the licence to purchase, store, or carry firearms or high-energy humanity weapons has been withdrawn
7	Court Informative System	X	X	X	X	X	X	-	-	X	- data on the person being prosecuted or called to administrative liability - information on decision - information on penalty or additional penalty imposed - information on other enforced corrective measures imposed -- indications whether a criminal offence was committed under the influence of drugs.

		Data groups									
8	Road Traffic Police Register	X	X	X	-	X	-	X	-	X	- detailed information on road traffic offences - information on persons who have committed road traffic offences - information on penalties imposed in respect of Road traffic offences

Source: Ministry of Interior Information Centre

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Standard Table 15	Composition of tablets sold as illicit drugs	Fonte
Standard Table 16	Price in Euros at street level of illicit drugs	Fonte
Standard Table 18	Overall mortality and causes of deaths among drug users	e-mail
Standard Table 24	Access to treatment	Fonte
TDI data (in- and out-patient)		Fonte
Structured Questionnaire 27 (I&II)	Treatment programmes (part I) Quality Assurance treatment (part II)	Fonte
Merged Structured Questionnaire 23 & 29	Prevention and reduction of health-related harm associated with drug use	Fonte