# Annual Report

## The Czech Republic

## 2011 Drug Situation

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

# Annual Report
# The Czech Republic
# 2011 Drug Situation

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Annual Report: The Czech Republic – 2011 Drug Situation

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## SUMMARY

The development and enforcement of the national drug policy is the responsibility of the Government of the Czech Republic. Its main advisory and coordination body for drug-related issues is the Government Council for Drug Policy Coordination (GCDPC), which met four times in 2011.

The National Drug Policy Strategy for the Period 2010–2018 and its first action plan for the period 2010–2012 are in effect. The interim evaluation of the action plan concluded that 52 out of the 84 activities under evaluation (62%) have been completed and that the implementation of the action plan was affected by the lack of financial resources. Both the Government and its Council for Drug Policy Coordination dealt with the issue of the funding of the drug policy repeatedly in 2011.

A new Penal Code has been effective in the Czech Republic since 2010, and the Government passed two regulations determining greater-than-small quantities of narcotic or psychotropic substances and plants or mushrooms that contain them in order to provide further guidance on the implementation of the new legislation. The evaluation of these regulations conducted in 2011 revealed no major difficulties in their application on the part of the bodies involved in criminal proceedings. The subsequent amendments to the regulations were limited to the specification of names and the inclusion of new substances and quantities in the list. As regards the regulation applicable to plants and mushrooms containing drugs, the THC content was to be newly related to the upper sections of the plant rather than the plant as a whole. Plants containing derivatives of tryptamine and mescaline, i.e. exotic plants and cacti, were deleted from the list.

In response to a massive increase in the supply of new synthetic drugs recorded in late 2010, Act No. 167/1998 Coll., on addictive substances, was amended in the spring of 2011; 33 new substances were added to its schedules. A law on the criminal liability of legal entities and on proceedings against them was adopted in 2011. In addition to individuals (natural persons), an innovation is that corporate entities may also be prosecuted for drug offences involving the manufacturing and selling of drugs according to this legal norm. A new body of health regulations was adopted as part of the health care reform. A major part of this material became effective in April 2012.

Public expenditure on drug policy amounted to a total of CZK 563.8 million (€ 22,933 thousand) in 2011. This sum included CZK 341.9 million (€ 13,908 thousand) (60.6%) provided from the state budget and CZK 221.9 million (€ 9,025 thousand) made available from local budgets – regions contributed CZK 157.0 million (€ 6,387 thousand) (27.9%) and municipalities CZK 64.9 million (€ 2,638 thousand) (11.5%). In comparison to the previous year, the total expenditures dropped by 10.1% (national and regional budgets showed a decline of 8.0% and 18.9% respectively, municipal expenses earmarked for drug policy rose by 4.5%). It was the very first time that such a year-on-year decrease in these expenditures had been experienced; the drop is even more pronounced when one controls for inflation. A decline was observed in expenditures earmarked for all categories of services. The most dramatic cuts were observed in the funding of sobering-up stations (by 22.9%) and law enforcement (by 10.6%). Subsidies to support primary prevention, harm reduction programmes and treatment were reduced by 11.8, 8.1% and 6.2% respectively. In 2011 drug prevention programmes and drug services received significant financial support to the tune of almost CZK 100 million (€ 4,067 thousand) from the European Social Fund. The termination of this European source of funding may cause an outage of financial support for services in the upcoming years.

Treatment, however, is mainly covered by health insurance: an estimated CZK 1,633 million (€ 58,821 thousand) was spent on medical treatment associated with the use of psychoactive substances in 2010 (the latest year for which relevant data are available), including CZK 1,173 million (€ 42,252 thousand) and CZK 459 million (€ 16,533 thousand) incurred by health insurers in relation to the treatment of users of alcohol and those of drugs other than alcohol, respectively.

The year 2011 experienced the culmination of public and professional discussions on the issue of making cannabis available for medical use and the respective legislative changes were drafted. Because of some civil society initiatives, in particular, the issue of the legalisation of cannabis for medical use is often confused with the legalisation of cannabis in general. Czech society shows an increasing level of acceptance of the use of cannabis-based substances. There is a rising proportion of people who disagree with the criminal prosecution of cannabis users, including those who use cannabis for medical purposes and those who cultivate it for their personal use. Nevertheless, the perceived availability of illegal drugs, including cannabis, has been declining among young people.

The level of drug use among the general Czech population remains stable, and the evidence even indicates a decline among young people, which may be considered a very positive trend. The adult population questionnaire surveys carried out in the past three years show that the most frequently used illegal drug is cannabis (23–34%), followed by ecstasy (4–10%), hallucinogenic mushrooms (4–9%), and LSD (2–6%). While the ESPAD survey has indicated a declining trend in the prevalence of the use of pervitin (methamphetamine), heroin, ecstasy, and hallucinogenic mushrooms among 16-year-olds in the long term, the year 2011 also recorded such a decline for cannabis for the first time.

Key documents pertaining to the primary prevention of drug use among young people were reviewed in 2011. In particular, the Standards of Professional Competency of Providers of School-based Primary Prevention and the

Certification Rules were updated, a recommended structure and scope for the Minimum Prevention Programme, the key strategic document providing for the school-based prevention of risk behaviour, were developed, and examples of prevention programmes representing good practice were compiled. The available information indicates that there are approximately 90 specialised providers of specific drug prevention services of various types in all the Czech Republic.

The year 2011 recorded another slight increase in the number of problem drug users estimated on the basis of data provided by low-threshold programmes; the mean estimate reached 40.2 thousand people, including 38.6 thousand injecting drug users. This increase may be attributed especially to pervitin users (30.9 thousand), while opiate users showed a further decline in their numbers (to 9.3 thousand). Although these trends should be interpreted with caution, given the possibility of systematic error in the input data, the general picture indicating a rise in the number of pervitin users and a drop in that of opiate users appears true. In addition to pervitin, heroin, and buprenorphine, the seasonal use of raw opium obtained from poppy fields and an increase in the use of medicinal products containing fentanyl and morphine have been recorded among problem drug users. For the first time after many years, “braun” labs were uncovered in the Czech Republic. “Braun”, an opiate drug containing derivatives of codeine and morphine, was widespread in communist-era Czechoslovakia, where it was manufactured in home labs using medicines with a codeine content.

Traditionally, the highest rates of problem drug users, as well as of opiate users, are reported from Prague and the Ústí nad Labem region, where, as in other Bohemian regions, the injecting use of buprenorphine is particularly widespread. A special project involving the estimation of the number of problem drug users for 2011 was undertaken in Prague using the capture-recapture method and drawing on data about the overlap between clients of low-threshold programmes. The resulting figure of 8 to 10 thousand individuals basically confirmed the estimates produced by the multiplication method.

The information from the register of autopsies carried out by forensic medicine departments shows that the number of fatal overdoses on illicit drugs and inhalants declined significantly in 2011 to a total of 28 cases identified, which was especially due to a drop in the number of fatal overdoses on opiates/opioids, from 19 to 6 cases, and on inhalants, from 16 to 4 cases. The number of cases of fatal overdoses on pervitin remained almost unchanged. Fatal overdoses on other illegal drugs are still very rare. 162 cases of fatal overdoses on psychotropic medication were detected in 2011. According to the data extracted from the General Mortality Register, fatal overdoses on alcohol (ethanol) show a rate of approximately 330 cases per year. As in the previous years, pervitin and cannabis were the most likely illegal drugs to be detected in connection with indirect drug-related deaths (i.e. deaths from causes other than overdoses, mainly as a result of accidents and suicides, with the presence of drugs) examined by forensic medicine departments.

The relatively favourable situation concerning the occurrence of infections among injecting drug users continued in 2011; HIV seroprevalence remains below 1%, although not all the sources of data are consistent in reporting such low levels. Seven new cases of HIV-positive people who contracted the infection through injecting drug use were identified. The number of newly reported cases of viral hepatitis C (HCV) among injecting drug users rose in the last year, while the number of viral hepatitis B (HBV) remained the same as that recorded in 2010. The prevalence of HCV among drug users ranges from approximately 20% in low-threshold programmes to 40% in prisons and up to 70% among drug users in substitution treatment; however, these results should be judged with caution, as they originate from various screening or assessment monitoring systems and are likely to be biased by a sampling error.

The past three years witnessed a marked increase in the number of tests for infectious diseases carried out among drug users in contact with low-threshold services, with testing for syphilis showing the highest year-on-year increase. There has also been a long-term rise in the number of contacts with IDUs and the amount of injecting equipment and paraphernalia exchanged; over 5 million hypodermic needles and syringes were distributed in 2011 as part of the operation of 99 low-threshold programmes. Programmes for the distribution of gelatine capsules as an oral alternative to the administration of pervitin by injecting continue to develop. In the Czech Republic, the treatment of people with AIDS, including injecting drug users, is provided at seven AIDS centres, and the treatment of viral hepatitis is available at approximately 75 dedicated centres, with about half of them also catering for injecting drug users. The number of individuals receiving treatment for HCV while serving a prison sentence increased significantly in 2011.

A questionnaire survey entitled the Drug Services Census 2012, involving 255 different facilities and programmes, was conducted in order to create an inventory of services intended for drug users. In 2011 the Public Health Service’s Register of Treatment Demands listed a total of 273 facilities, with 205 actively reporting data. They include a wide range of social, health, educational, and religious establishments that provide various low-threshold, outpatient, and residential services. Approximately 250 facilities, excluding prevention programmes, may be considered as constituting the core of Czech drug services.

Stimulant users (64.9%), with pervitin being the drug of choice for most of them, have long predominated among those demanding treatment. As in the previous years, the second largest group among all treatment demands comprised opiate/opioid users (19.3%), while cannabis users ranked second among first treatment demands

(18.6 %). An aging of the population demanding treatment is apparent; their average age in 2011 was 27.4 years. Women continue to account for a little less than one third of treatment demands. While the data from the Register of Treatment Demands indicate a long-term downward trend in the rate of injecting among pervitin users (77% in 2011), the injecting use of heroin is on the rise (90%), and this route of administration is also common among problem users of buprenorphine.

There was an increase in the number of users of drugs other than alcohol admitted to inpatient psychiatric facilities. This rise may be attributed to patients admitted for disorders caused by the polydrug use and use of stimulants other than cocaine; the number of hospitalisations for disorders caused by opiate/opioid use has dropped.

At least one substance user was reported by 454 providers of outpatient mental health services, including 50–70 facilities that may be considered as specialising in clients with addiction issues. The network of outpatient services as a whole recorded a year-on-year decline in the number of alcohol users, as well as patients seeking help with the use of substances belonging to the three largest groups of non-alcohol drugs, i.e. opiates/opioids, stimulants other than cocaine, and polydrug use. The number of patients recorded in the substitution treatment register grew again; there were 2,290 of them in 2011. In 2011, for the first time ever, psychiatrists and general practitioners reported annual aggregated figures for people in substitution treatment; a total of 4,092 patients were reported.

The Register of Social Services includes 34 aftercare programmes for drug users. However, the 2012 Drug Services Census indicates that aftercare services are provided by a much larger number of programmes of various types. Social work and support services intended to facilitate the social reintegration of drug users are provided by tens to hundreds of facilities; such services mainly involve assistance with housing, employment, and debts.

Since 2007 the total number of drug-related criminal offences has been on the rise and their share of the reported volume of offending is also growing. In 2011 approximately 2.8 thousand individuals (1.2% of all offenders) were prosecuted for drug-related criminal offences, which mostly involved the production, trafficking, and selling of pervitin and cannabis. 2.5 thousand people were charged. Final court sentences were imposed on 1.9 thousand people, 41% of whom had no previous convictions. The most common sanction imposed was a term of suspended imprisonment. As in the previous year, women accounted for approximately 15% of those prosecuted, charged, and sentenced for drug-related offences. The highest rates of drug offending per number of inhabitants were registered in Prague and the Vysočina and Karlovy Vary regions. A total of 1,169 misdemeanours of the unauthorised handling of drugs, mostly involving the unauthorised possession of drugs for personal use, were dealt with in 2011.

According to the official police data, 16% of all the criminal offences that were cleared up had been committed under the influence of addictive substances, with alcohol being involved in 90% of the cases. Estimates of secondary drug-related offences were made again for 2011: drug users are estimated to have committed 33.4% of the offences that were reported and 28.5% of those selected criminal offences (especially those against property) that were cleared up (mostly thefts).

In 2011 an estimated 18.2 tonnes of cannabis, 4.6 tonnes of pervitin, 1.2 tonnes of heroin, 870 kg of cocaine, 4.6 million tablets of ecstasy, and a million doses of LSD were consumed in the Czech Republic.

The domestic production of cannabis is estimated to have amounted to almost 16 tonnes, with an estimated little less than three tonnes of cannabis being imported from abroad. Indoor cultivation of cannabis with a THC content of 12–20% predominated. The Police of the Czech Republic discovered 165 plantations in 2011. The involvement of people of Vietnamese descent in the large-scale cultivation of cannabis and the distribution of marijuana has grown. In 2011 441 kg of marijuana, 63 thousand cannabis plants, and 2.4 kg of hashish were seized in the Czech Republic.

In the Czech Republic, pervitin (methamphetamine) is mostly manufactured in small home labs; the police detected 338 such operations in 2011. Medicinal products containing pseudoephedrine, especially imported from Poland, are used as the main precursor of pervitin. The pervitin market in northwest Bohemia has gained significance as a result of the growing demand for this drug on the part of German nationals. The year 2011 registered 304 seizures of pervitin, involving a total amount of 20 kg, in the Czech Republic.

The Czech heroin market is supplied by means of small shipments. It is estimated that 375 kg of heroin with an average purity of 25% were imported into the Czech Republic in 2011. The purity of the diluted heroin distributed among end users was around 8%. The total number of seizures and the quantity of the heroin seized have fallen significantly; while there were 61 seizures, involving a quantity of 30.5 kg, in 2010, only 34 seizures, involving a quantity of 4.7 kg of heroin, were recorded in 2011. 44 cases of cocaine seizures, involving a total quantity of 16.1 kg, were reported.

35 new psychoactive substances were intercepted in 2011, 21 of which appeared in the Czech Republic for the first time. The substances seized in the largest quantities included the cathinones mephedrone (58 kg) and methylone (1.8 kg) and the synthetic cannabinoid JWH-122 (2 kg). The new psychoactive substances were marketed by means of e-shops and regular brick-and-mortar shops. Since the ban on these substances introduced in April 2011, their sale through retail outlets has been dramatically reduced, but they can still be obtained via the internet.

Traditionally, this annual report includes three chapters on selected issues; this year they address residential treatment for drug users in the Czech Republic, the recent trends in drug-related public expenditures and drug services with a view to the current financial crisis, and urban drug policies.

There are two models of residential drug treatment in the Czech Republic: one involves treatment in specialised units of inpatient healthcare facilities, i.e. mental institutions and hospitals, the other treatment in therapeutic communities. Both approaches overlap in certain aspects of their philosophy (such as abstinence-oriented treatment) and provide their patients and clients with a basically similar range of services and professional interventions. Another important common feature lies in their structured programme, which not only involves a fixed timetable within which the services and interventions are incorporated, but also a set of rules that the treatment follows. Another converging characteristic may be seen in the principles of a therapeutic community, which are also applied to a greater or lesser extent by the specialised units of treatment institutions and hospitals. The differences between these two models are mainly determined by their respective historical development, which, to a great degree, influenced the position of the services within the system of care, the ways they are funded, the structure of their clients, and the ways in which their quality is assured and checked.

The purpose of the second selected issue is to describe the impact of the current financial crisis on expenditures earmarked for drug policy and the provision of drug services in the Czech Republic. Analysis of the relevant data shows that restrictive measures had an effect on the drug policy (in terms of funds available to governmental portfolios, regional authorities, and service providers) in 2010 and, especially, in 2011. Subsidies provided from the state budget which are used to fund the majority of prevention, counselling, and low-threshold drug services were reduced in both years (by up to 10% in 2011). While in 2010 local government bodies allocated 10% more financial resources for the drug policy than in the previous year, by 2011 the crisis had taken its toll even at this level, as documented by a 13% year-on-year decrease in drug policy-labelled expenditures. Although no consistent approach to the setting of priorities can be identified across the governmental portfolios and regions, the cuts within the drug services segment affect, first and foremost, primary prevention services, information and research projects, and any new projects. The most common response of the regions to the limited supply of funding intended to subsidise drug services is an overall cutting down on money for all the services. The network of local drug services has been retained thus far and no massive closing-down of programmes and services has been experienced.

The last chapter on a selected issue provides a brief outline of the institutional background and nature of drug policies in the three largest Czech cities: Prague, Brno, and Ostrava. Traditionally, the regional and local drug policies stem from the national drug policy strategy. Those local governments that have their drug policies defined in a special document, such as a drug policy or action plan, can formulate measures aimed at addressing the drug use-related problems at the local level in a more focused, comprehensive, and coordinated manner. Out of the cities under consideration, this applies to Brno and Prague. In Ostrava, the drug policy is built into the scheme of community planning. While underlining the social aspect of the issue, such an approach may result in the drug activities being rather fragmentary and difficult to coordinate.

## PART A: NEW DEVELOPMENTS AND TRENDS

### 1 Drug Policy: legislation, strategies, and economic analysis

A new Penal Code has been effective in the Czech Republic since 2010, and the Government passed two regulations determining greater-than-small quantities of narcotic or psychotropic substances and plants or mushrooms that contain them in order to provide further guidance on the implementation of the new legislation.

An evaluation of these regulations was conducted in 2011. Its results showed that no major difficulties were encountered in their application by the bodies involved in criminal proceedings. However, certain changes in the regulations were recommended with a view to their practical application. The respective amendments were adopted in 2011. They involved the specification of the names of certain substances, the definition of greater-than-small quantities of additional substances for which such quantities had not been determined, and the inclusion of new substances in the list. The regulation applicable to plants and mushrooms containing drugs was amended to the effect that the content of THC in cannabis should be considered in relation to the upper sections of the plant rather than the plant as a whole and plants containing DMT, 5-methoxy-DMT, and mescaline, i.e. predominantly exotic plants and cacti, were deleted from the list.

In response to a massive increase in the supply of new synthetic drugs recorded in late 2010, Act No. 167/1998 Coll., on addictive substances, was amended in the spring of 2011; 33 new substances were added to its schedules.

A law on the criminal liability of legal entities and on proceedings against them was adopted in 2011. In addition to individuals (natural persons), corporate entities may now also be prosecuted for drug offences involving the manufacturing and selling of drugs according to this legal norm.

In November 2011 the Parliament of the Czech Republic passed a package of new regulations prepared as part of the healthcare reform. This new health legislation framework, a major part of which became effective in April 2012, introduces new definitions of forms and types of health care.

The year 2011 experienced the culmination of public and professional discussions on the issue of making cannabis available for medical use and the necessary legislative changes were drafted to provide for the new developments in this area.

The National Drug Policy Strategy for the Period 2010–2018 and its first action plan for the period 2010–2012 are in effect. The interim evaluation of the action plan concluded that 52 out of the 84 activities under evaluation (62%) have been completed, 26 (31%) have been completed in part, and six activities (7%) remained unaccomplished. The implementation of the action plan was affected by the lack of financial resources. Both the Government and its Council for Drug Policy Coordination dealt with the issue of the funding of the drug policy repeatedly in 2011.

Public expenditure on drug policy amounted to a total of CZK 563.8 million (€ 22,933 thousand) in 2011. This sum included CZK 341.9 million (€ 13,908 thousand) (60.6%) provided from the state budget and CZK 221.9 million (€ 9,025 thousand) made available from local budgets – regions contributed CZK 157.0 million (€ 6,387 thousand) (27.9%) and municipalities CZK 64.9 million (€ 2,638 thousand) (11.5%). In comparison to the previous year, the total expenditures dropped by 10.1%; the drop is even more pronounced when one controls for inflation. The most dramatic cuts were observed in the funding of sobering-up stations (by 22.9%) and law enforcement (by 10.6%). Subsidies to support primary prevention, harm reduction programmes and treatment were reduced by 11.8, 8.1% and 6.2% respectively. Medical treatment is mainly covered by health insurance: an estimated CZK 1,633 million (€ 58,821 thousand) was spent on treatment associated with the use of psychoactive substances in 2010 (the latest year for which relevant data are available), including CZK 1,173 million (€ 42,252 thousand) and CZK 459 million (€ 16,533 thousand) incurred by health insurers in relation to the treatment of users of alcohol and those of drugs other than alcohol, respectively. The cost of inpatient treatment for alcohol and illicit drug use is eight times and six times, respectively, higher than that incurred in relation to the provision of outpatient treatment. Mental health specialisations account for 50–60% of total costs; this proportion was 90% and 50% in inpatient and outpatient care respectively.

#### 1.1 Legal Framework

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

###### 1.1.1.1 Criminal Law Regulations

Legal definitions of drug-related criminal offences remained unchanged in 2011 (Sections 283–287 of Act No. 40/2009 Coll., the Penal Code, as amended). The implementing regulations pertaining to the Penal Code were amended with relevance to drug-related offences. Government Regulation No. 467/2009 Coll., specifying for the purposes of the Penal Code what constitutes a poison and defining the quantities greater than small for narcotic substances, psychotropic substances, any preparations containing such substances, and poisons, was amended in

November 2011[1] with effect from 5 January 2012. Certain items were specified and quantities greater than small were defined for additional substances which had not previously had such levels determined, which was mainly due to the extension of the schedule of substances controlled under Act No. 167/1998 Coll., on addictive substances (see further below). Government Regulation No. 455/2009 Coll., setting out for the purposes of the Penal Code which plants and mushrooms should be considered plants and mushrooms containing a narcotic or psychotropic substance and what quantities of them should be considered greater than small in accordance with the Code, was amended[2] at the same time. As a result of the amendment, the content of the active principle (THC) in the cannabis plant is to be considered in relation to the flowering or fructiferous top of the plant (with the exception of its seeds), including leaves, only, rather than in relation to its total mass. As an innovation, the list of plants and mushrooms attached to the Regulation does not include plants containing DMT, 5-methoxy-DMT, and mescaline (i.e. mainly exotic plants and cacti), which, however, does not mean these substances are excluded from the addictive substances envisaged in the criminal statutes. According to the report accompanying the submission of the bill, the main rationale for the deletion of plants containing such substances from the list was to align the Regulation with Act No. 167/1998 Coll., on addictive substances, which bans the cultivation of cannabis with an excessive THC content and coca bush only.

A long-awaited law on the criminal liability of legal entities and on proceedings against them was adopted on 27 October 2011 and published as Act No. 418/2011 Coll. Section 7 of this legal regulation specifying the offences and felonies which may involve the criminal liability of legal entities also lists three drug-related crimes, namely the unauthorised production and other handling of narcotic and psychotropic substances and poisons (Section 283 of the Penal Code), the possession of a narcotic or psychotropic substance or poison (Section 284 of the Penal Code), and the unauthorised cultivation of plants containing a narcotic or psychotropic substance (Section 285 of the Penal Code). As regards the two remaining drug-related crimes, i.e. the manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison (Section 286 of the Penal Code) and the promotion of drug use (Section 287 of the Penal Code), only the criminal liability of perpetrators – natural persons – as provided for in the Penal Code may be claimed.

An amendment[3] to Act. No. 141/1961 Coll., the Code of Criminal Procedure, effective from 1 September 2012, means significant changes in the area of criminal procedure by introducing the instrument of agreement about guilt and punishment.[4] The possibility of the execution of an agreement about guilt and punishment will also apply to the vast majority of drug-related crimes, with the exception of those coming under the category of particularly serious crimes (i.e. criminal offences carrying a sentence of a minimum of 10 years' imprisonment). The latter drug offences include the unauthorised production and other handling of narcotic and psychotropic substances according to Section 283 (3) and (4) of the Penal Code and the manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison according to Section 286 (2) of the Penal Code.

#### 1.1.1.2 Changes Concerning Misdemeanour (Administrative) Proceedings

As regards the process of dealing with misdemeanours against protection from alcoholism and abuse of other substances, it is explicitly stipulated, with effect from 22 June 2011, that the Police of the Czech Republic are under an obligation to destroy any narcotic or psychotropic substance seized as part of misdemeanour proceedings, or make it available for the purposes of education, training, and/or tests and forensic, expert, and research activities, as applicable; see the 2010 Annual Report for more details.

#### 1.1.1.3 Changes in the Act on Addictive Substances

Act No. 167/1998 Coll., on addictive substances, has undergone major changes as a result of an amendment[5] thereto causing its schedules of narcotic and psychotropic substances to include additional 33 substances. The amendment came into force on 22 April 2011. The main reason for this action was the emergence of new synthetic drugs on the retail market at the turn of 2010 and 2011; for more details see the chapter Drug Markets (p. 139) and the 2010 Annual Report.

At the time of writing, another four amendments to the Act on Addictive Substances had been adopted and all but the last one mentioned below had also become effective. They concern changes in public administration and the implementation of the health reform. The amendment process reflects the organisational, terminological, and

[1] By virtue of Government Regulation No. 4/2012 Coll.
[2] By virtue of Government Regulation No. 3/2012 Coll.
[3] By virtue of Act No. 193/2012 Coll.
[4] It provides for the possibility of negotiating in preliminary proceedings an agreement between the public prosecutor and the accused to the effect that the latter pleads guilty and accepts a punishment. The agreement will subsequently be approved by the court in a public hearing without the need for evidence to be heard at a trial. The benefits of this measure include the victims of crime not having to repeatedly testify before the court and suffer secondary harm as a result of the details of the crime being discussed in public. It should also accelerate criminal proceedings and shorten court hearings.
[5] By virtue of Act No. 106/2011 Coll.

institutional innovations that also needed to be projected into the law on addictive substances. None of the amendments, however, extends the inventory of addictive substances or alters the mode of handling them.[6]

#### 1.1.1.4 Physical and Mental Eligibility for Driving

Users of alcohol and illicit drugs who are the holders of driver's licences were affected by another legislative change made in 2011, specifically the amendment to the Road Traffic Act, executed by virtue of Act No. 297/2011 Coll., amending Act No. 361/2000 Coll., on road traffic and amendments to certain laws (the Road Traffic Act), and Act No. 247/2000 Coll., on obtaining and improving professional competence for the driving of motor vehicles and amendments to certain laws, as amended. A new provision, Section 89a, effective from 14 October 2011, that was inserted into the Road Traffic Act is another instance of infringement on physicians' obligation of confidentiality.

The above provision stipulates that *"a physician who ascertains that the applicant for a driver's licence or the holder of a driver's licence is physically or mentally fit to drive motor vehicles under certain conditions or is not physically or mentally fit to drive shall promptly report such information to the authority of the municipality with extended competencies where the applicant for a driver's licence or the holder of a driver's licence has their usual domicile or studies."* In particular, the amendment met with a negative response from psychiatrists who provide treatment for drug dependency. If the health professionals are to comply with their statutory obligation, their patients who are the holders of drivers' licences are in fact subjected to "punishment" for seeking professional help with their use of alcohol or illegal drugs by having their driver's licences suspended. According to the professional community, this state of affairs may have a negative impact on the motivation for voluntary entry into treatment. On the other hand, a physician who fails to comply with this new statutory obligation may be held liable for any damage to health and property in civil proceedings, or even face criminal charges, in the event that their patient causes a road accident related to their failure to observe their duty to report. In theory, administrative sanctions could also be imposed, should the failure to report became known without any adverse consequences such as a traffic accident. A number of professional associations have issued statements[7] on the new provision. However, no detailed information on the practical application of this newly defined duty to report is available at the time of writing.

#### 1.1.1.5 New Health Legislation

In November 2011 the Parliament of the Czech Republic passed a package of new health-related regulations prepared as part of the healthcare reform. They included Act No. 372/2011 Coll., on health services and the terms and conditions of the provision thereof (the Act on Health Services),[8] and Act No. 373/2011 Coll., on specific health services. Both laws became effective on 1 April 2012.

The health reform will have a significant influence on the operation of the entire system of health care, including substance users, providers of drug services, psychiatrists providing drug treatment, and other individuals engaged with health services. It may be too early to evaluate the impact of the reform at this stage. However, two points may be brought up. The Act on Health Services provides for a new instrument of a "wish made in advance", which makes it possible for patients to express their prior agreement or disagreement with the provision of health services and the way in which they are provided in case they are later in a condition that would not allow them to make such a decision (Section 36 of the Act on Health Services). Both professionals and the public responded negatively to a new requirement of the law to the effect that both parents of minor patients must grant their consent to the provision of health services that may have major negative consequences for the health status of the patient and/or their quality of life. Such care may also involve addressing substance use. Any disagreement between the parents and/or the parents and the child or cases when it is impossible to obtain the consent from the parents are to be dealt with by a court. Both the Government and the Parliament, in cooperation with professional associations and the Medical Chamber, have drawn up an amendment bill which should make the requirement for both parents' consent void.

According to the Act on Specific Health Services, such services include compulsory treatment. As an innovation, the imposition of compulsory treatment is now covered by both criminal and health regulations. The stipulations governing compulsory treatment provide mainly for regimen-related measures of relevance for the patient; special emphasis is placed on the specification of the patient's rights and obligations. In addition, the law stipulates the provider's obligations in relation to both the patient and the criminal court. In particular, this legal regulation has a crucial impact on the provision of compulsory treatment in prison. The stipulation of Section 83 (1) explicitly states that "*court-ordered compulsory treatment may also be completed during the term of imprisonment in the health*

[6] They are Act No. 341/2011 Coll., on the General Inspection of Security Forces and amendments to related laws, Act No. 375/2011 Coll., amending certain laws in connection with the adoption of the Act on Health Services, the Act on Specific Health Services, and the Act on Emergency Medical Services, Act No. 167/2012 Coll., amending Act No. 499/2004 Coll., on record-keeping and documentary services, and amendments to certain laws, as amended, Act No. 227/2000 Coll., on electronic signatures and amendments to certain other laws (the Electronic Signature Act), as amended, and other related laws and, finally, Act No. 18/2012 Coll., amending certain laws in connection with the adoption of the Act on the Customs Administration of the Czech Republic.

[7] See, for example, www.diab.cz/dokumenty/dps66d.pdf, http://www.infekce.cz/zprava12-19.htm, http://www.saof.cz/hlaseni-nezpusobilosti-k-rizeni-motorovych-vozidel-obecnimu-uradu/ (2012-09-01).

[8] The new health legislation uses the term "provider of health services" instead of "healthcare facility" that has been widely used hitherto. Thus, where the term "healthcare facility" is used throughout the text of this report, it is meant to be synonymous with "provider of health services".

*facilities of the Prison Service. It may take the form of institutional compulsory treatment provided on the basis of one-day care and compulsory treatment provided on an outpatient basis. The conditions under which compulsory treatment is provided must not interfere with the conditions of the prison sentence."* The existing specialised wings where compulsory institutional treatment was previously provided do not have the status of a healthcare facility. As a result, prisons are not legally qualified to deliver compulsory treatment in the institutional form.

For more information on the new health legislation see also the chapter Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55).

#### 1.1.1.6 Changes Concerning Compulsory Treatment

In addition to the legal grounding of the provision of compulsory treatment in healthcare facilities set out in Act No. 373/2011 Coll., on specific health services, changes concerning court-ordered compulsory treatment were also brought about by amendments to criminal law regulations; see also the 2010 Annual Report. With effect from 14 November 2011, as a result of an amendment to Act No. 40/2009 Coll., the Penal Code, the terms and conditions governing the change of compulsory treatment to security detention were moderated to the detriment of offenders. As an innovation, according to the stipulations of Section 99 (5) of the Penal Code, a court may *"change compulsory institutional treatment to security detention if compulsory treatment imposed on and undergone by a person does not fulfil its purpose or does not provide sufficient protection for the public, particularly in cases where an offender escapes from a healthcare facility, uses violence against the staff of a healthcare facility or other individuals undergoing compulsory treatment, and/or repeatedly refuses to accept examination or treatment interventions or otherwise expresses a negative attitude to compulsory treatment.*" This legal regulation as amended may have a massive impact on offenders who are users of alcohol and/or illicit drugs.

The amendment[9] to Act No. 218/2003 Coll., on the liability of young people for unlawful acts and on juvenile justice and amendments to certain laws (the Juvenile Justice Act), eliminated interpretative disputes about whether compulsory treatment may be imposed on a juvenile delinquent, as such a possibility was explicitly stipulated in the law, with effect from 1 November 2012.

#### 1.1.1.7 Changes Concerning the Profession of an Addictologist

The Health Ministry's Decree No. 55/2011 Coll., concerning the activities of health professionals and other practitioners, issued in 2011, described specific activities which an addictologist[10] is allowed to perform: (1) without the expert supervision and indication of a physician – specialist in substance dependency and other forms of addiction; (2) on the basis of an indication of a physician with a specialist qualification in the field of psychiatry or child and adolescent psychiatry or a physician with special expertise in addiction medicine, and, finally, (3) under the professional supervision of a physician with a specialist qualification in the field of psychiatry or child and adolescent psychiatry or a physician with special expertise in addiction medicine. Since 2012 the role of the profession of an addictologist in the treatment of substance users in healthcare facilities and the establishment of outpatient addiction treatment services have also been envisaged in the implementing decrees pertaining to Act No. 372/2011 Coll., on health services and the terms and conditions of the provision thereof (the Act on Health Services), namely the Health Ministry's Decree No. 92/2012 Coll., concerning the minimum requirements for the technological and material equipment of healthcare facilities and home care contact centres, and the Health Ministry's Decree No. 99/2012 Coll., concerning the minimum requirements for the staffing of health services. Other changes are being prepared. The efforts of the Czech Association of Addictologists to define health interventions provided by adictologist, which is one of the steps towards the partial coverage of addiction treatment services by the general health insurance system, are noteworthy in this respect; for more information see the chapter Legal Framework, Strategies, and Policies Concerning Treatment (p. 55).

#### 1.1.1.8 New Civil Code

The long process of the recodification of the material civil law was completed on 3 February 2012 with the adoption of Act No. 89/2012 Coll., the Civil Code, which will become effective from 1 January 2014. In addition to the legal relationships provided for by Act No. 40/1964 Coll., the Civil Code, this comprehensive legal code is an innovation in that it also covers legal areas, such as family law, commercial law, labour law, and insurance law, which were previously governed by separate statutory regulations. A positive aspect of this new legislation in relation to substance users and the mentally ill in general is the elimination of the instrument of the removal of legal capacity; the new Civil Code only allows for its limitation (it introduces the concept of limited legal capacity). Another new element is the stipulation of other supporting measures, such as assistance in decision making in the event of an adult individual's impaired legal capacity.

The new Civil Code also introduces major changes in relation to non-governmental organisations that provide drug services, as most of them will undergo changes in their legal status. The existing associations as specified in Act No. 83/1990 Coll., on associations of citizens, as amended, will be considered societies in accordance with Section 214 of the new Civil Code. Associations will be entitled to convert their legal status into an institute or social

[9] By virtue of Act No. 301/2011 Coll.
[10] Addictologist is a non-medical health profession in the field of drug use and addiction.

cooperative in accordance with Act No. 90/2012 Coll., on companies and cooperatives (the Business Corporations Act), which will come into force on 1 January 2014. An interest association of legal entities will have the right to convert its legal status into that of a society. From the date on which the new Civil Code becomes effective, it will not be permissible to establish any new public service companies. The new Civil Code continues to allow for the legal status of both foundations and endowment funds.

### 1.1.2 Implementation of Laws

The 2010 recodification of the material criminal law also had a bearing on the consideration of primary drug crimes, and crucial changes were introduced by the adoption of regulations specifying the implementation of Act No. 40/2009 Coll., the Penal Code, which define and quantify addictive substances for the purposes of selected drug-related criminal offences. In order to follow up on these changes, by virtue of its Resolution No. 150, dated 14 December 2009, the Government commissioned the Ministry of Justice to evaluate the effects of the relevant implementing regulations[11] by 31 March 2011. Subsequently, by virtue of its Resolution No. 281, dated 20 April 2011, the Government acknowledged the evaluation of the application of selected bylaws[12] specifying the execution of Act No. 40/2009 Coll., the Penal Code, carried out on the basis of its previous assignment. In particular, the report indicated that a standard evaluation of the effectiveness of legal norms requires a longer interval from the date on which new regulations become effective. The evaluation concluded that the available data did not suggest any major difficulties in the application of the regulations by the bodies involved in criminal proceedings. Nevertheless, the evaluation recommended certain changes in the regulations that were inspired by their application in practice. They included the incorporation of the effective International Convention against Doping in Sport, including the updated lists of prohibited substances and methods, into Government Regulation No. 454/2009 Coll. and the review of the list of plants that are considered plants containing narcotic and/or psychotropic drugs (excluding those containing mescaline) in the sense of Government Regulation No. 455/2009 Coll. Furthermore, a recommendation was made to update Government Regulation No. 467/2009 Coll. so that it reflects the extension of the list of addictive substances specified in Act No. 167/1998 Coll., on addictive substances. The recommendations were accepted by the Government and converted into practice in the meantime (see above).

The judicial practice continued to produce new case law decisions with relevance to areas where interpretative difficulties may be encountered, especially as regards the terms “on a significant scale”, “on a substantial scale”, and “on a large scale”, which are used to formally describe the constituting elements of drug crimes, as not even the decision-making practice of the Supreme Court of the Czech Republic was consistent with respect to these issues in the past. An accurate interpretation may be found in a decision of the Supreme Court dated 12 May 2010,[13] for example: *“Each of the individual types of scale of a narcotic or psychotropic substance should be determined in consideration of a quantification level of the scale of offending (significant, substantial, and large), and these may be differentiated according to their relative proportionality and social harmfulness expressed by the possibility of imposing prison sentences in those cases involving particularly aggravating circumstances. However, the specific quantity and quality of a narcotic or psychotropic substance may not be enough to make it possible to draw a conclusion about a certain type of scale (significant, substantial, and large). Other circumstances, such as the amount of money which the offender earned, wanted to, or could earn for the substance he or she manufactured or distributed, the length of time for which the offender engaged in the unauthorised handling of the substances under consideration, or the group of people at which his or her activities were aimed, should also be taken into account. In addition, decision making must be supported by the assessment of other secondary circumstances under which the offence was committed, particularly the ways in which the offender handled the substances at issue, the level of harm posed or really inflicted on the victims, and any other facts (compare with Decision No. 1/2006, Digest of Criminal Decisions).”* This interpretation is also consistent with the case law decision relevant to the previous legal regulation governing drug crimes, contained in Act No. 140/1961 Coll., the Penal Code, in the wording effective until 31 December 2009.

The Supreme Court of the Czech Republic also looked into the interpretation of the element of “personal use”, for example in its resolution of 30 June 2011,[14] where it concluded that another person’s participation in the manufacturing of a psychotropic substance evidently precludes such an activity from being judged as the possession of such a substance or the cultivation of a plant containing such a substance for individual use. The resolution concerned criminal activity involving the hydroponic cultivation of cannabis by the offender together with another person.

[11] They include Government Regulation No. 454/2009 Coll., which determines for the purposes of the Penal Code which substances should be deemed those with anabolic and other hormonal effects and what quantities of them should be considered “significant” and which methods should be considered those involving enhanced oxygen transfer in the human body and those producing other doping effects, Government Regulation No. 455/2009 Coll., setting out for the purposes of the Penal Code which plants and mushrooms should be considered plants and mushrooms containing a narcotic or psychotropic substance and what quantities of them should be considered greater than small in accordance with the Code, and Government Regulation No. 467/2009 Coll., which specifies for the purposes of the Penal Code what constitutes a poison and defines the quantities greater than small for narcotic substances, psychotropic substances, any preparations containing such substances, and poisons.

[12] For more information see http://racek.vlada.cz/usneseni/usneseni_webtest.nsf/web/cs?Open&2011&04-20 (2012-09-03).

[13] File Ref. 8 Tdo 463/2010.

[14] File Ref. 6 Tdo 228/2011.

As regards traffic violations and the testing of drivers for illegal drugs, the taking of blood samples following a positive screening test for illegal drugs has become a routine procedure. In comparison to the previous practice, which involved only urine tests in many cases, it is now possible to determine the levels of active metabolites, in THC users, for example, although the results of laboratory tests often fail to include such specifications and are thus difficult to interpret.

The practical impact of the health reform and the changes concerning the instruments of compulsory treatment and security detention cannot be examined with a reasonable level of significance, given the short time that has lapsed since both relevant laws became effective.

### 1.2 National Action Plan, Strategy, Evaluation, and Coordination

The year 2011 was the second year of the operation of the National Drug Policy Strategy for the Period 2010–2018 (the 2010–2018 National Strategy) and the Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2010–2012 (the 2010–2012 Action Plan).

The 2010–2018 National Strategy was adopted by Government Resolution No. 340, dated 10 May 2010. The strategy defines four general objectives and features seven key drug policy-related areas of intervention comprising four cornerstones (Prevention, Treatment and Social Reintegration, Harm Reduction, and Drug Supply Reduction) and three supporting domains (Coordination and Funding, Monitoring, Research, and Evaluation, and International Cooperation); for more details see the 2009 and 2010 annual reports.

The 2010–2012 Action Plan was adopted by Government Resolution No. 47, dated 19 January 2011. The Action Plan further develops the National Strategy and lays down specific procedures and activities to be pursued as part of the drug policy in the shorter term. For the first time, the action plan sought to specify the financial resources needed for its implementation (approximately CZK 54 million for three years – € 2,196 thousand). The Government, however, conditioned the allocation of financial resources for the implementation of the action plan on the situation of the state budget ("depending on the possibilities of the state budget"); for more details see the 2010 Annual Report.

For the period of its operation, the Action Plan defines the following four priorities that should be pursued while maintaining the best practices from the previous years: (1) to adopt measures aimed at reducing the high level of (heavy) use of cannabis; (2) to provide new interventions for the target group of methamphetamine (pervitin) and opiate/opioid users; (3) to strengthen the drug policy in relation to legal drugs (alcohol and tobacco), and (4) to improve the coordination of drug policy funding; for more information see the 2010 Annual Report.

#### 1.2.1 Implementation and Evaluation of the National Action Plan and/or Strategy

In order to assess the degree of implementation of the action plan, each activity encompasses milestones, deadlines for completion, indicators of completion, and the specification of the party responsible for the fulfilment of the tasks, including the cooperating government departments and institutions. "Requirements" are also defined for each activity. They refer to conditions which must be met for a given activity to be carried out. In particular, the requirements involve the specification of the financial amounts necessary for the implementation of the activity and the adoption of the relevant legislation.

The first interim evaluation of the implementation of the 2010–2012 Action Plan was carried out in August 2011. It was an internal evaluation coordinated by the Secretariat of the Government Council for Drug Policy Coordination (GCDPC). Information about the course of the performance of activities was provided by all the government portfolios that act as parties responsible for the implementation of the individual tasks set out in the action plan. The implementation report was considered by the GCDPC in October 2011.

The evaluation focused on the tasks to be completed by 30 June 2011 (including the 2010 tasks), as well as those that are being worked on continuously. They comprised 84 activities (out of 200 in total): 52 (62%) were completed or are in progress, 26 (31%) were partly completed, and 6 activities (7%) were not completed.

The evaluation report points out that the tasks that were found to be completed are mostly those that are pursued on a continuous basis and are thus likely to comprise a common agenda covered by sufficient human and financial resources. On the contrary, the tasks that the evaluation identified as unaccomplished or only accomplished to a certain degree involved new or one-off activities that required additional resources in terms of staffing and funds. Another reason for a relatively large number of the partially completed tasks was the late approval of the action plan.

Six activities were not completed, with a shortage of funds being the reason in three cases. The lack of financial resources was also noted as a threat to the implementation of the activities of the action plan in the future. This concern was particularly pointed out by the Ministry of Health, which, together with the Secretariat of the Government Council for Drug Policy Coordination, assumes the key responsibility for most of the tasks laid down in the action plan (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2011a).

The evaluation of the drug policy strategy for the previous period was conducted in 2010, when the implementation of the 2005–2009 National Drug Policy Strategy and the 2007–2009 Action Plan was examined. The reports are

available on the GCDPC website.[15] Summaries of the results of both evaluation studies were published in the 2009 Annual Report and the *Adiktologie* journal (Kiššová and Mravčík, 2011).

In 2012 the Open Society Foundation's Global Drug Policy Program published a report entitled *A Balancing Act – Policymaking on Illicit Drugs in the Czech Republic*[16] (at the time of writing being prepared by the Czech National Monitoring Centre for Drugs and Drug Addiction for publication in Czech as *Hledání rovnováhy – Koncepce protidrogové politiky v České republice*) analysing the development of the Czech drug policy in the period of the post-1989 transformation (Csete, 2012). The report identified four key aspects that contributed to the Czech drug policy serving as a *"precedent for transforming drug policy from repression-based to evidence-based approaches":* (1) the profile of national drug coordinators and other key players; (2) the influence of scientific evidence on policymaking; (3) the role of civil society and the non-governmental sector, and (4) the effect of the then prospective EU membership.

### 1.2.2 Other Drug Policy Developments

A process involving the amendment of Act No. 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances, which also falls within the competence of the Ministry of Health, was initiated in 2011. The draft amendment to this law was originally to be submitted by December 2011. In view of the scope of the substantive changes proposed, their interagency nature, and the wide-ranging professional discussion accompanying the preparation of the bill, the original deadline for its submission to the Government was postponed.

One of the principles of the current drug policy of the Czech Republic declared in the 2010–2018 National Strategy is a comprehensive approach to addictive substances, irrespective of their legal status, and networking and coordination of measures aimed at addressing the challenges related to the use of both legal and illegal drugs. The corresponding 2010–2012 Action Plan postulates the strengthening of the drug policy in relation to legal drugs as one of its four priorities, with an independent Alcohol and Tobacco domain being created in the action plan for this purpose. Nevertheless, in its Resolution No. 468 on the Government's non-legislative tasks, dated 26 June 2012, the Government approved the intention of the Ministry of Health to submit the Action Plan for the Prevention of Alcohol Use in the Czech Republic to the Government in 2013.

Commissioned by the Czech Prime Minister, a working group for the Project of the Protection of Children and Young People from the Misuse of Alcohol and Other Addictive Substances was established in February 2011. It drew up proposals for legislative changes (pertaining especially to Act No. 379/2005 Coll.) aimed at increasing the liability of people who operate outlets serving alcohol. It has been proposed that the system of sanctions should be changed in such a way as to further motivate the operators of businesses to observe the ban on serving alcohol to minors by, for example, increasing the fines and making it possible to close down a business outlet if a material violation of the law has been ascertained. In addition, the proposal should simplify the process of evidence taking, or reduce the risk of the failure of evidence, which the authorities are experiencing as a result of the existing legal regulation. At the time of writing (June 2012), the above-mentioned proposal for legislative changes had not been formally passed on to the Ministry of Health for its incorporation into the ongoing amendment process concerning Act No. 379/2005 Coll.

Becoming the last EU member state to do so, the Czech Republic ratified the World Health Organisation Framework Convention of Tobacco Control (FCTC) in May 2012. The European Union has also been a party to the Convention since 2005. The FCTC is a binding international treaty that creates a global legal environment for addressing the issue of smoking. It provides for comprehensive protection from the health, social, environmental, and economic consequences of tobacco consumption and exposure to tobacco smoke. On 30 August 2012 the Czech Republic became the 176th contracting party to this convention. This act concluded an eight-year-long process which commenced in December 2004, when the Government of the Czech Republic approved a motion for such ratification. The Ministry of Health is planning to incorporate some of the measures promoted by the Convention into the ongoing amendment process concerning Act No. 379/2005 Coll., particularly with a view to enhancing the protection of non-smokers from passive smoking (Ministerstvo zdravotnictví ČR, 2012). For more information on environmental strategies relevant to the drug issue see the chapter Prevention (p. 36).

In April 2012 the Government endorsed the new Rules for Granting Financial Resources from the State Budget on Drug Policy.[17] Their main purpose is to secure the basic and vital functions of the drug policy in times of diminishing financial resources and lay down principles for the co-funding of the drug policy from the national and local governments' budgets. The Rules introduce new mechanisms which are particularly intended to ensure the operation of the basic network of drug services in the face of the negative impact of fluctuations in the public funding of drug policy.

[15] http://rvkpp.vlada.cz/ (2012-09-07)
[16] http://www.soros.org/reports/balancing-act-policymaking-illicit-drugs-czech-republic (2012-08-24)
[17] Approved by the Government for the first time in 1999, these rules were revised significantly in 2005 and 2007.

#### 1.2.2.1 Initiatives and Activities Related to the Legalisation of Cannabis

The year 2011 experienced the culmination of the previous discussions among the public, the professional community, and policymakers about making cannabis available for medical use (see also the 2010 Annual Report).

The "Medical Cannabis" petition launched in August 2011 had been signed by over 43 thousand people as of the end of July 2012.[18] In reaction to the media response provoked by the publication of the petition, an interagency and interdisciplinary working group was established in September 2011 under the aegis of the Czech Prime Minister and the Chair of the Chamber of Deputies of the Parliament of the Czech Republic and with support from the National Drug Coordinator. Headed by the Dean of the First Faculty of Medicine of Charles University in Prague, the group was commissioned to propose legislative changes that would allow the medical use of cannabis in the Czech Republic. The group's work resulted in the identification of relevant medical indications accompanied by statements of professional societies belonging to the J. E. Purkyně Czech Medical Association and proposals for specific legislative changes. The stipulations as proposed should allow the import of cannabis and cannabis-based products into the Czech Republic, the state-controlled cultivation of cannabis for medical purposes (under the conditions prescribed by international conventions), and the supply of medical cannabis to patients under a special regime of strict controls over the prescription and dispensation of the preparations by pharmacies. The proposal does not allow for patients to grow medical cannabis on their own.

The resulting draft amendment was submitted to the Government for consideration as a parliamentary initiative. On 29 February 2012 the Government took a neutral standpoint on the parliamentary bill and formulated ten substantive comments in relation to it. Subsequently, the members of parliament who had presented the bill initiated the establishment of another working group to work on the comments made by the Government and modify the parliamentary proposal. The bill on the medical use of cannabis in the Czech Republic passed its first reading in the Chamber of Deputies of the Parliament of the Czech Republic. However, the bill under consideration has been criticised by some civil society initiatives and activists who demand that patients, or any individuals, should be allowed to cultivate medical cannabis on their own. One of their arguments is that the terms and conditions laid down in the draft amendment will cause the price of cannabis available from pharmacies to rise above its illicit market level.[19]

The discussion on the accessibility of medical cannabis is, nonetheless, confused very often and in many situations with the discussion concerning the legalisation of cannabis-derived drugs in general or the legalisation of the growing of cannabis for personal use, which makes the issue even more complicated.

In May 2011 the *Legalizace.cz* civic association organised an annual demonstration, the Million Marijuana March. In response to the legislative changes concerning the accessibility of medical cannabis that are being considered, *Legalizace.cz*, too, has declared its disapproval of the fact that the bill does not make it possible for patients to grow their own cannabis for personal use[20] (see above).

In addition, in 2011 *Legalizace.cz* organised what was the fourth year of the campaign entitled Seeds to Seniors. The purpose of the campaign is to support adult citizens who want to grow cannabis for their own personal use. As part of Cannafest 2011, an international cannabis fair held in Prague in November, the association provided each adult individual who showed interest with cannabis seeds and information about how to grow, process, and further use it as medicine. The association gives out the seeds on the basis of an affidavit in which a recipient declares that he or she will use the produce for self-treatment only.[21]

The documentary *Rok konopí – Year of Mari©huana* began to be shown in cinemas in June 2012. Using the stories of people who take cannabis for their illnesses and interviews with scientists, politicians, and officials, the film presents the issue of medical cannabis in the Czech Republic within the wider context of personal freedom and the functioning of an individual in society.[22]

### 1.2.3 Coordination Arrangements

#### 1.2.3.1 Coordination at the National Level

The Government Council for Drug Policy Coordination (GCDPC), the main coordinating body of the Government for matters related to the drug policy, met four times in 2011; by June it had convened on two occasions in 2012.[23]

The statute of the GCDPC was updated in September 2011. By virtue of its resolution approving the Statute of the Government Council for Drug Policy Coordination, the Government upheld the professional associations and

[18] http://www.lecebnekonopi.cz (2012-07-25)
[19] For example, Stanislav Penc (e.g. http://blog.aktualne.centrum.cz/blogy/stanislav-penc.php?itemid=16628), Dušan Dvořák (e.g. http://www.konopijelek.cz/?stranka=vladni-podvod), Libuše (Bushka) Bryndová (e.g. http://www.bushka.cz/archiv/registrovana_samolecba.html).
[20] http://mmm.legalizace.cz/article/tiskovka2012 (2012-08-08)
[21] http://www.magazin-legalizace.cz/cs/articles/detail/38-seminka-seniorum?author=Robert+Veverka, http://www.legalizace.cz/projekty/seminka-seniorum/ (2012-08-08)
[22] http://www.aerofilms.cz/filmy/190-Rok-konopi/ofilmu/, http://www.rokkonopi.cz/ (2012-07-25)
[23] http://www.vlada.cz/scripts/detail.php?pgid=370, http://www.vlada.cz/scripts/detail.php?pgid=366 (2012-08-08)

regional representatives as members of the GCDPC and agreed to the Council including an additional expert appointed by its Chair (i.e. the Czech Prime Minister). As a result, the number of the GCDPC's members increased to 14; see Table 1-1. As an innovation, the amended statute also introduces and defines the office and position of the National Drug Coordinator, who acts in parallel as the executive vice-chair of the GCDPC.

*Table 1-1: Composition of the Government Council for Drug Policy Coordination according to the GCDPC's Statute approved in 2011*

| **Position in the Council** | **Position in the institution represented** |
|---|---|
| Chair | Prime Minister |
| Executive Vice-chair | National Drug Coordinator and Director of the GCDPC Secretariat |
| Members | Minister of Health |
| | Minister of the Interior |
| | Minister of Education, Youth, and Sports |
| | Minister of Labour and Social Affairs |
| | Minister of Justice |
| | Minister of Defence |
| | Minister of Finance |
| | Minister or Government Commissioner for Human Rights * |
| | Representative of the Association of Regions of the Czech Republic ** |
| | Representative of the Society for Addictive Diseases, J. E. Purkyně Czech Medical Association |
| | Representative of the Association of NGOs |
| | Expert appointed by the Chair of the Council |

*Note: * The latter applied in 2011; no minister for human rights was appointed. ** The Governor of the Olomouc region assumed this position in 2011.*

In providing horizontal coordination at the national level, the GCDPC is supported by its permanent advisory bodies. The mission of the Working Group for Non-Substance Addiction, the operation of which was secured by the office of the Commissioner for Human Rights in organisational terms, was terminated in 2011. The working group was established in 2008 in order to collaborate on the development of new legislation intended to mitigate the negative effects of lotteries, betting, and other similar games, but by 2011 was basically inactive (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2012c).

Nevertheless, the issues of betting games, the legal framework for their operation, and the monitoring of the situation with respect to betting games and their effects were addressed by the Government and a number of legislative, political, and civil society initiatives. For example, within the past year this topic was explored by the office of the Public Defender of Rights,[24] the *Brnění* civic association,[25] and the *Esentia* endowment fund.[26] The Government has dealt with the issue of gambling on several occasions recently. On 14 March 2012, for example, at the instigation of the Ombudsman, they discussed the procedures and decision making applied by the Ministry of Finance in authorising betting games operated by means of "other gambling devices" (VLTs, gaming machines similar to traditional slot machines). In addition, the topic of gambling was considered by the Government in mid-May, when they also commissioned the Minister of Finance to have a study produced on the impact of gambling by the end of August 2012. For this purpose, the Ministry of Finance established a working group which examined whether relevant information was available in the Czech Republic. At its session on 15 August 2012, the Government passed a bill concerning the operation of betting games, which is to replace the existing Act No. 202/1990 Coll., on lotteries and other similar games. As an innovation, the bill places the authorisation proceedings within the structure of the General Financial Directorate. It regulates the share of foreign investment in the operation of betting games in the Czech Republic, defines two-step authorisation proceedings (basic authorisation and the authorisation for the installation of a gaming application), and introduces responsible gaming principles involving prevention and measures adopted by the operator, including self-restricting measures on the part of the individuals engaging in betting games.[27]

At its meetings in 2011 and 2012, the GCDPC dealt regularly with the issue of drug policy funding, especially the funding of the network of drug services. To a great extent, drug services are funded using the subsidies from the state budget, the total sum of which was affected by governmental measures aimed at cutting down on the national public expenditure. In view of this, the GCDPC reviewed the priorities for subsidy proceedings (see the 2010 Annual Report). In response to the cuts in the financial resources available to the GCDPC for subsidies in 2012, the advisory bodies to the GCDPC discussed the issue of limiting support for selected types of services (it was suggested, for

[24] http://www.ochrance.cz/ (2012-09-07)
[25] http://www.osbrneni.cz/ (2012-09-07)
[26] http://www.nfesentia.cz/ (2012-09-07)
[27] See, for example, resolutions No. 156, dated 14 March 2012, No. 347, dated 16 May 2012, and No. 597, dated 15 August 2012.

example, that the GCDPC would not support any of the primary prevention programmes or the prison-based programmes for drug users), which finally did not happen. However, the GCDPC was advised of the problems with the funding of drug services in prisons by the regions. Some regions refused to support these services from their budgets and made it explicit, with reference to the assurance of the availability of drug services at the local and regional levels as their priority, that they would not recommend the provision of support for prison drug programmes within the subsidy proceedings administered by the Ministry of Labour and Social Affairs either (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2012a).

#### 1.2.3.2 Coordination at the Local Level

The coordination instruments used by the regions are similar to those that exist at the national level. The regions and the municipalities with extended competencies, respectively, have established the offices of a regional drug coordinator and a local drug coordinator. In addition, regional drug commissions and working groups are established, regional drug policy strategies and/or action plans are developed, and reports on the implementation of regional drug policies are also produced every year.

No major changes in the coordination of the drug policy at the regional level have occurred. The office of a regional drug coordinator has been established in all the regions, with the exception of the Moravia-Silesia region.[28] The regional drug coordinators mostly work as junior officials in divisions for social services, prevention, and humanitarian or health affairs. While the law stipulates that a regional drug coordinator should be a full-time position, their jobs often incorporate other agendas, such as crime prevention.

Regional drug policy-specific commissions exist in eight out of 14 regions; in three regions, the drug policy is dealt with by advisory commissions with a broader range of focus (including other areas such as crime prevention and social issues). In two regions (Moravia-Silesia and South Moravia) where such commissions are absent, there are at least working groups concerned with the coordination of the drug policy. Detailed information about the arrangement of coordination mechanisms in regions was provided in the 2010 Annual Report.

Several regions adopted their new drug policy strategies in 2011. The regions usually develop drug policy-specific strategic documents. Only in two regions (Pilsen and Ústí nad Labem) is the drug policy a part of a broader strategy that covers the fields of social policy and crime prevention in general.

At the municipal level, the coordination of the drug policy is provided through local drug coordinators. They have been appointed in all the Prague city districts and in the majority of the municipalities with extended competencies. Some of the municipalities develop their own drug policy plans and/or write final reports on the implementation of their drug policies. In most cases, however, local drug coordinators can dedicate only a minimum part of their working time to drug policy, as their workload involves other agendas too. The regional reports indicate that the rapid turnover of people in the positions of local drug coordinators is an issue. For a more thorough coverage of urban drug policies see the selected issue chapter Drug Policies of Large Cities (p. 164).

### 1.3 Economic Analysis

#### 1.3.1 Public Expenditures

The drug policy is funded from the state and local (regional and municipal) budgets. Financial resources earmarked in these budgets for drug policy programmes and activities are referred to as special-purpose labelled expenditures.[29]

Public expenditure on drug policy amounted to a total of CZK 563.8 million (€ 22,933 thousand)[30] in 2011. This sum included CZK 341.9 million (€ 13,908 thousand) (60.6%) provided from the state budget and CZK 221.9 million (€ 9,025 thousand) made available from local budgets – regions contributed CZK 157.0 million (€ 6,387 thousand) (27.9%) and municipalities CZK 64.9 million (€ 2,638 thousand) (11.5%). In comparison to the previous year, the total expenditures dropped by 10.1%. 2011 public expenditures are specified in Table 1-5 and Table 1-6. A historical summary of expenditures from the state budget in the period 2002–2011 according to ministries and institutions is provided in Table 1-2.

[28] In the Moravia-Silesia region, the job of a drug coordinator is performed by an official responsible for social services.
[29] The data were obtained from the national final accounts of the ministries whose budgets include a drug policy programme. Additional information was obtained directly from the representatives or contact persons of individual ministries and governmental institutions, as well as from regional drug coordinators.
[30] 2011 average exchange rate was used (1€ = CZK 24.586).

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

| Institution | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|
| GCDPC | 2,886 | 3,261 | 3,153 | 3,547 | 3,838 | 3,762 | 4,008 | 3,686 | 3,381 | 3,695 |
| Ministry of Education | 299 | 293 | 316 | 315 | 381 | 452 | 499 | 426 | 592 | 528 |
| Ministry of Defence | 125 | 147 | 109 | 133 | 172 | 129 | 212 | 162 | 173 | 122 |
| Ministry of Labour and Social Affairs | 1,104 | 1,391 | 1,323 | 1,546 | 1,753 | 2,054 | 3,186 | 3,282 | 3,628 | 3,129 |
| Ministry of Health | 808 | 692 | 829 | 1,124 | 635 | 801 | 757 | 569 | 849 | 861 |
| Ministry of Justice | 302 | 442 | 427 | 1,233 | 1,455 | 454 | 296 | 409 | 280 | 165 |
| General Customs Headquarters | 863 | 708 | 292 | 487 | 829 | 963 | 427 | 120 | 83 | 79 |
| National Drug Squad | n.a. | 3,022 | 2,711 | 3,189 | 3,757 | 4,601 | 5,527 | 5,542 | 5,709 | 5,328 |
| **Total** | **6,387** | **9,957** | **9,161** | **11,574** | **12,821** | **13,217** | **14,912** | **14,196** | **14,694** | **13,908** |

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

In 2011 the GCDPC provided a total sum of almost CZK 85.5 million (€ 3,478 thousand) to support 133 projects implemented by 45 entities in the fields of prevention, harm reduction, treatment, and aftercare. The expenditure designated for the activities developed by the GCDPC's Secretariat, including the National Monitoring Centre for Drugs and Drug Addiction (National Focal Point), amounted to CZK 5.3 million (€ 217 thousand).

According to the final national accounts, the Ministry of Education, Youth, and Sports (the Ministry of Education) spent a total of CZK 13.0 million (€ 528 thousand) on the drug policy in 2011. The Ministry of Education provided subsidies for 129 local primary prevention projects to the total tune of CZK 8.5 million (€ 345 thousand); the balance accounts for the expenditures used to support national projects.

In 2011 the Ministry of Defence used its drug policy-labelled funds to purchase detection devices, professional literature, and sports equipment and to lease sports and recreational facilities; a total of CZK 3.0 million (€ 122 thousand) was spent.

While the budget of the Ministry of Labour and Social Affairs did not include expenses earmarked for the drug policy programme, it provided subsidies for projects aimed at the target group consisting of individuals at risk of the use of addictive substances and dependency on them. In 2011 the Ministry of Labour and Social Affairs funded 140 projects involving drop-in centres, outreach programmes, social counselling, therapeutic communities, and aftercare services for drug users[31] to the total tune of CZK 76.9 million (€ 3,129 thousand), of which CZK 60.6 million (€ 2,464.8 thousand) was used for local projects and CZK 16.3 million (€ 663 thousand) for those implemented at the national level.

In 2011 the Ministry of Health provided a total sum of CZK 21.2 million (€ 861 thousand) for the drug policy, including CZK 9.9 million (€ 402 thousand) which the ministry provided to co-fund projects involving the treatment of drug addicts (alcohol/drug treatment clinics, substitution treatment, detoxification, and institutional treatment) and the purchase of medical supplies for drop-in centres and outreach programmes. Another CZK 161 thousand (€ 6.5 thousand) was provided by the ministry to support three projects concerned with the prevention of tobacco and alcohol use as part of the "National Health Programme – Health Promotion Projects" subsidy programme. CZK 10.3 million (€419 thousand) was made available for substance use-related research and development.

In 2011 the Ministry of Justice had CZK 4.1 million (€ 165 thousand) earmarked for the drug policy, of which the Judicial Academy used CZK 190 thousand (€ 7.7 thousand), the Institute for Criminology and Social Prevention spent CZK 48 thousand (€ 1.9 thousand), the providers of probation programmes for drug users were provided with CZK 158 thousand (€ 6.4 thousand), and CZK 961 thousand (€ 39 thousand) went to NGOs providing services in prisons. The largest amount of resources, CZK 2.7 million (€ 110 thousand), was consumed by the Prison Service of the Czech Republic (the Prison Service); first and foremost, this money was used for the treatment of drug users in prisons (CZK 1.7 million – € 69 thousand) and to detect narcotic and psychotropic substances among prisoners (CZK 607 thousand – € 24.6 thousand).

[31] The expenditures on the part of the Ministry of Labour and Social Affairs do not include subsidies for special-regime homes providing services for older clients dependent on alcohol.

The budget of the General Customs Headquarters, incorporating the Customs Drug Unit, did not account for any independent drug policy programme in 2011. However, it provided investment expenditure of CZK 1.9 million (€ 79 thousand) associated with the investigation of drug trafficking.

Neither does the budget of the Ministry of the Interior include a special chapter dedicated to the drug policy programme. However, this ministry is responsible for the National Drug Squad of the Criminal Police and Investigation Service of the Police of the Czech Republic (the National Drug Squad), whose total expenditures in 2011 amounted to CZK 131.1 million (€ 5,328 thousand), excluding investment (capital) expenditure.

The GCDPC has analysed all the overlaps between projects subsidised by governmental agencies. This analysis showed that in 2011 the government provided a total of CZK 185.2 million (€ 7,532 thousand) to support 333 projects implemented by 157 entities. 64.3% of these projects, accounting for 28.9% of all the government's subsidy projects, are supported by a single donor. The largest number of independent projects is associated with the Ministry of Education. It provides its subsidies to finance mainly school-based prevention programmes, which receive financial support from no other public donor. Similarly, the Ministry of Health makes 65.3% of its drug-specific financial resources available for supporting health projects which receive no such support from any other government portfolios. Other types of services are usually supported by multiple state donors. The largest number of joint projects is run together by the GCDPC and the Ministry of Labour and Social Affairs (52 projects worth a total of CZK 64.6 million – € 2,627.5 thousand). Up to 16.2% of the projects were supported by three different donors to the tune of 33.1% of the total expenditure.

In addition to the state budget, the drug policy is also funded by local budgets, i.e. those of the regions and municipalities.[32] In 2011 the regions and municipalities provided CZK 157.0 million (€ 6,386 thousand) and CZK 64.9 million (€ 2,640 thousand), respectively, for this field. A detailed overview of local budgets in 2011 by service categories is provided in Table 1-3 and the developments in expenditures from local budgets since 2004[33] are shown in Table 1-4. The highest drug policy expentitures from local budgets can be seen in Prague in total as well as in all types of services except primary prevention, which was supported the most in Central Bohemia primarily due to the support of the "Drug Prevention Train" project (CZK 8 million – € 325 thousand).

The data on funding at the local level are divided according to the location where the projects were implemented. The 2011 drug policy expenditures from the state and local budgets designated for use on regional levels are depicted by regions in Map 1-1.

An additional CZK 87.8 million (€ 3,571 thousand) provided from the European Social Fund (ESF)[34] was used to co-fund drug policy projects at the local level. These financial resources were drawn via the Ministry of Labour and Social Affairs. These undertakings involved several calls announced by the ministry and a range of individual regional projects focusing on employment support programmes for people with drug problems. ESF projects developed as part of the Education for Competitiveness Operational Programme were also associated with the drug problem in certain regions; the 2011 regional annual reports referred to a total of CZK 7.5 million (€ 305 thousand) provided by the ESF for drug prevention. It may thus be assumed that a total of almost CZK 100 million (€ 4,067 thousand) was channelled into prevention and drug services from this source in 2011, which is a considerable amount, given the aggregate sum of resources specifically earmarked for the drug policy. The termination of this European source of funding may cause an outage of financial support for services in the future; see also the selected issue chapter Recent Trends in Drug-related Public Expenditures and Drug Services (p. 157).

A detailed analysis of the developments in drug policy expenditures was carried out using a consistent time series between 2004 and 2010. This analysis looks thoroughly into the developments in the funding of the Czech drug policy in the period under study on the basis of both current and constant prices,[35] with current price expenditures for the individual years being adjusted to control for inflation. The developments in drug policy expenditures were subsequently compared with those in GDP (Vopravil and Běláčková, 2012). For the first time in history, the year 2011 recorded a decline in the drug policy-labelled expenditures even when considered in current prices; see the selected issue chapter Recent Trends in Drug-related Public Expenditures and Drug Services (p. 157).

[32] The data on regional and municipal expenditure are based on the annual reports on drug policy implementation in regions and/or the specifying information requested from regional drug coordinators.
[33] Comparable data about local drug policy expenditures that make it possible to construct a time series are available for every year since (and including) 2004.
[34] These financial resources have been monitored since 2010. They have not been included in the total expenditures in order to maintain the consistency of the time series.
[35] Current price = expenditures in current-year prices, constant prices = individual year prices converted into base-year prices.

*Table 1-3: Drug policy expenditures from local budgets by service categories, 2011 (€ thousand)*

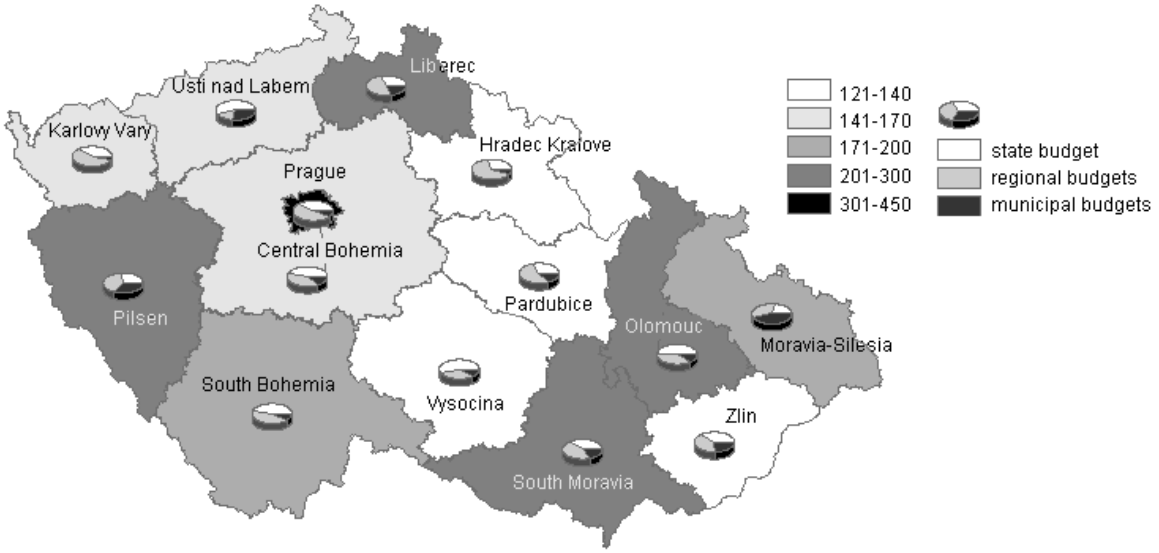
| Region | | Primary prevention | Harm reduction | Treatment | Aftercare | Sobering-up stations | Coordination, research, evaluation | Others | Total |
|---|---|---|---|---|---|---|---|---|---|
| Regional budgets | Prague | 271 | 401 | 555 | 121 | 593 | 16 | 0 | 1,957 |
| | Central Bohemia | 378 | 8 | 32 | 0 | 122 | 0 | 0 | 540 |
| | South Bohemia | 37 | 151 | 62 | 23 | 81 | 4 | 0 | 359 |
| | Pilsen | 64 | 54 | 61 | 32 | 99 | 0 | 9 | 319 |
| | Karlovy Vary | 18 | 20 | 11 | 0 | 136 | 0 | 0 | 186 |
| | Ústí nad Labem | 8 | 97 | 33 | 9 | 0 | 0 | 0 | 147 |
| | Liberec | 2 | 41 | 79 | 11 | 203 | 1 | 0 | 337 |
| | Hradec Králové | 28 | 37 | 12 | 0 | 234 | 0 | 0 | 311 |
| | Pardubice | 1 | 29 | 10 | 0 | 220 | 0 | 0 | 260 |
| | Vysočina | 0 | 70 | 88 | 0 | 0 | 0 | 0 | 158 |
| | South Moravia | 55 | 149 | 141 | 75 | 287 | 11 | 23 | 741 |
| | Olomouc | 6 | 78 | 18 | 13 | 248 | 0 | 0 | 363 |
| | Zlín | 0 | 69 | 0 | 0 | 114 | 0 | 0 | 183 |
| | Moravia-Silesia | 0 | 81 | 10 | 10 | 394 | 0 | 30 | 526 |
| | **Total** | **870** | **1,284** | **1,113** | **294** | **2,731** | **32** | **62** | **6,387** |
| Municipal budgets | Prague | 138 | 53 | 68 | 5 | 0 | 9 | 0 | 274 |
| | Central Bohemia | 59 | 46 | 1 | 0 | 76 | 0 | 0 | 182 |
| | South Bohemia | 10 | 45 | 14 | 6 | 0 | 0 | 0 | 75 |
| | Pilsen | 36 | 135 | 78 | 38 | 0 | 0 | 12 | 300 |
| | Karlovy Vary | 0 | 16 | 1 | 0 | 0 | 0 | 0 | 17 |
| | Ústí nad Labem | 0 | 209 | 14 | 66 | 0 | 0 | 0 | 289 |
| | Liberec | 5 | 73 | 28 | 13 | 0 | 0 | 2 | 121 |
| | Hradec Králové | 0 | 16 | 12 | 0 | 0 | 0 | 0 | 28 |
| | Pardubice | 7 | 51 | 13 | 0 | 0 | 0 | 0 | 71 |
| | Vysočina | 19 | 31 | 0 | 0 | 0 | 0 | 0 | 50 |
| | South Moravia | 14 | 136 | 93 | 43 | 0 | 0 | 4 | 291 |
| | Olomouc | 25 | 58 | 9 | 11 | 0 | 0 | 0 | 101 |
| | Zlín | 64 | 56 | 0 | 0 | 0 | 0 | 0 | 120 |
| | Moravia-Silesia | 263 | 275 | 128 | 36 | 0 | 0 | 19 | 720 |
| | **Total** | **641** | **1,200** | **459** | **218** | **76** | **9** | **37** | **2,638** |
| Local budgets in total | Prague | 409 | 454 | 623 | 126 | 593 | 26 | 0 | 2,230 |
| | Central Bohemia | 438 | 54 | 33 | 0 | 198 | 0 | 0 | 722 |
| | South Bohemia | 48 | 196 | 76 | 30 | 81 | 4 | 0 | 434 |
| | Pilsen | 100 | 189 | 140 | 70 | 99 | 0 | 21 | 619 |
| | Karlovy Vary | 18 | 36 | 13 | 0 | 136 | 0 | 0 | 203 |
| | Ústí nad Labem | 8 | 306 | 47 | 75 | 0 | 0 | 0 | 436 |
| | Liberec | 7 | 114 | 107 | 24 | 203 | 1 | 2 | 458 |
| | Hradec Králové | 28 | 53 | 24 | 0 | 234 | 0 | 0 | 339 |
| | Pardubice | 9 | 80 | 23 | 0 | 220 | 0 | 0 | 331 |
| | Vysočina | 19 | 101 | 88 | 0 | 0 | 0 | 0 | 208 |
| | South Moravia | 70 | 285 | 234 | 118 | 287 | 11 | 27 | 1,031 |
| | Olomouc | 31 | 135 | 27 | 24 | 248 | 0 | 0 | 464 |
| | Zlín | 64 | 125 | 0 | 0 | 114 | 0 | 0 | 303 |
| | Moravia-Silesia | 263 | 356 | 138 | 46 | 394 | 0 | 49 | 1,246 |
| | **Total** | **1,511** | **2,484** | **1,571** | **512** | **2,807** | **42** | **99** | **9,025** |

*Table 1-4: Drug policy expenditures from local budgets by region, 2004–2011 (€ thousand)*

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

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

*Map 1-1: Drug policy expenditures from state and local budgets in regions of the Czech Republic, 2011 (€ thousand per 100,000 inhabitants aged 15–64)*




It should be taken into account that the extent of the expenditure that is included may vary on a year-on-year basis and that more sources of drug policy expenditures are being identified and specified[36]. A decline was observed in expenditures earmarked for all categories of services – primary prevention, harm reduction programmes and treatment were reduced by 11.8, 8.1% and 6.2% respectively. The most dramatic drop (by 22.9%) in financial resources was recorded in relation to sobering-up stations. Law enforcement expenditures declined by 10.6% on a year-on-year basis. A detailed summary of expenditures by service categories is provided in Table 1-6; their developments since 2007 are shown in Table 1-7.

[36] For example in 2011, reported expenditures from regional budget versus European Social Fund were subject of specification (for example in Hradec Králové region), primary prevention expenditures were cleared from costs to low-threshold facilities for children and young people (for example in Zlín region).

*Table 1-5: Drug policy expenditures from state and local budgets by region of implementation, 2011 (€ thousand)*

| Region | GCDPC | Ministry of Education | Ministry of Defence | Ministry of Labour and Social Affairs | Ministry of Health | Ministry of Justice | General Customs Head-quarters | National Drug Squad | Total state budget | Regions | Munici-palities | Total local budgets | Total | Total (%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prague | 961 | 14 | – | 370 | 175 | – | – | – | **1,519** | 1,957 | 274 | **2,230** | **3,750** | **16.4** |
| Central Bohemia | 78 | 59 | – | 468 | 28 | – | – | – | **633** | 540 | 182 | **722** | **1,355** | **5.9** |
| South Bohemia | 182 | 62 | – | 117 | 38 | – | – | – | **399** | 359 | 75 | **434** | **834** | **3.6** |
| Pilsen | 137 | 24 | – | 46 | 22 | – | – | – | **229** | 319 | 300 | **619** | **848** | **3.7** |
| Karlovy Vary | 61 | 3 | – | 51 | 16 | – | – | – | **132** | 186 | 17 | **203** | **335** | **1.5** |
| Ústí nad Labem | 222 | 18 | – | 262 | 32 | – | – | – | **534** | 147 | 289 | **436** | **970** | **4.2** |
| Liberec | 90 | 0 | – | 111 | 0 | – | – | – | **201** | 337 | 121 | **458** | **659** | **2.9** |
| Hradec Králové | 82 | 6 | – | 27 | 29 | – | – | – | **145** | 311 | 28 | **339** | **484** | **2.1** |
| Pardubice | 42 | 29 | – | 81 | 0 | – | – | – | **152** | 260 | 71 | **331** | **483** | **2.1** |
| Vysočina | 57 | 28 | – | 152 | 4 | – | – | – | **241** | 158 | 50 | **208** | **449** | **2.0** |
| South Moravia | 290 | 38 | – | 306 | 27 | – | – | – | **662** | 741 | 291 | **1,031** | **1,693** | **7.4** |
| Olomouc | 209 | 24 | – | 222 | 7 | – | – | – | **463** | 363 | 101 | **464** | **927** | **4.0** |
| Zlín | 86 | 11 | – | 104 | 2 | – | – | – | **202** | 183 | 120 | **303** | **505** | **2.2** |
| Moravia-Silesia | 187 | 15 | – | 146 | 1 | – | – | – | **349** | 526 | 720 | **1,246** | **1,594** | **7.0** |
| Expenditure with regional designation | 2,684 | 331 | – | 2,464 | 382 | – | – | – | **5,862** | 6,387 | 2,638 | **9,025** | **14,887** | **64.9** |
| Expenditure with central designation | 1,011 | 197 | 122 | 665 | 479 | 165 | 79 | 5,328 | **8,046** | 0 | 0 | **0** | **8,046** | **35.1** |
| **Total** | **3,695** | **528** | **122** | **3,129** | **861** | **165** | **79** | **5,328** | **13,908** | **6,387** | **2,638** | **9,025** | **22,933** | **100.0** |
| – including investment expenditure | 0 | 0 | 0 | 0 | 0 | 0 | 79 | 0 | **79** | 0 | 0 | **0** | **79** | **0.3** |
| **Total (%)** | **16.1** | **2.3** | **0.5** | **13.6** | **3.8** | **0.7** | **0.3** | **23.2** | **60.6** | **27.9** | **11.5** | **39.4** | **100.0** | – |

*Table 1-6: Drug policy expenditures in the Czech Republic by service categories, 2011 (€ thousand)*

| Service category | | GCDPC | Ministry of Education | Ministry of Defence | Ministry of Labour and Social Affairs | Ministry of Health | Ministry of Justice | General Customs Head-quarters | National Drug Squad | Total state budget | Regions | Munici-palities | Total local budgets | Total | Total (%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Primary prevention | | 77 | 487 | 122 | 0 | 37 | 0 | 0 | 0 | **723** | 870 | 641 | **1,511** | **2,234** | **9.7** |
| Harm Reduction | Drop-in centres | 1,062 | 0 | 0 | 1,161 | 58 | 0 | 0 | 0 | **2,281** | 763 | 704 | **1,467** | **3,748** | **16.3** |
| | Outreach programmes | 653 | 0 | 0 | 536 | 21 | 0 | 0 | 0 | **1,210** | 451 | 463 | **914** | **2,124** | **9.3** |
| | Unspecified* | 235 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **235** | 70 | 33 | **103** | **338** | **1.5** |
| | Total | 1,950 | 0 | 0 | 1,697 | 79 | 0 | 0 | 0 | **3,725** | 1,284 | 1,200 | **2,484** | **6,209** | **27.1** |
| Léčba | Health care ** | 92 | 0 | 0 | 0 | 323 | 35 | 0 | 0 | **450** | 269 | 76 | **345** | **795** | **3.5** |
| | Non-health outpatient care *** | 263 | 0 | 0 | 320 | 0 | 80 | 0 | 0 | **663** | 301 | 204 | **505** | **1,168** | **5.1** |
| | Therapeutic communities | 770 | 0 | 0 | 701 | 0 | 0 | 0 | 0 | **1,471** | 542 | 179 | **721** | **2,192** | **9.6** |
| | Total | 1,125 | 0 | 0 | 1,020 | 323 | 116 | 0 | 0 | **2,584** | 1,113 | 459 | **1,571** | **4,155** | **18.1** |
| Sobering-up stations | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 2,731 | 76 | **2,807** | **2,807** | **12.2** |
| Aftercare | | 276 | 0 | 0 | 412 | 0 | 0 | 0 | 0 | **688** | 294 | 218 | **512** | **1,200** | **5.2** |
| Law enforcement | | 0 | 0 | 0 | 0 | 0 | 25 | 79 | 5,328 | **5,431** | 0 | 0 | **0** | **5,431** | **23.7** |
| Coordination, research, evaluation | | 268 | 0 | 0 | 0 | 422 | 25 | 0 | 0 | **715** | 32 | 9 | **42** | **756** | **3.3** |
| Others, unspecified | | 0 | 41 | 0 | 0 | 0 | 0 | 0 | 0 | **41** | 62 | 37 | **99** | **140** | **0.6** |
| **Total** | | **3,695** | **528** | **122** | **3,129** | **861** | **165** | **79** | **5,328** | **13,908** | **6,387** | **2,638** | **9,025** | **22,933** | **100.0** |

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

*Table 1-7: Comparison of expenditures provided from public budgets by service categories, 2007–2011 (€ thousand)*

| Service category | 2007 | | 2008 | | 2009 | | 2010 | | 2011 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Spent | % | Spent | % | Spent | % | Spent | % | Spent | % |
| Prevention | 1,753 | **8.7** | 2,340 | **9.8** | 2,078 | **9.0** | 2,463 | **9.9** | **2,234** | **9.7** |
| Harm reduction | 5,078 | **25.3** | 6,389 | **26.7** | 6,616 | **28.8** | 6,572 | **26.5** | **6,209** | **27.1** |
| Treatment | 3,817 | **19.0** | 4,890 | **20.4** | 4,278 | **18.6** | 4,304 | **17.4** | **4,155** | **18.1** |
| Sobering-up stations | 1,680 | **8.4** | 2,509 | **10.5** | 2,421 | **10.5** | 3,449 | **13.9** | **2,807** | **12.2** |
| Aftercare | 739 | **3.7** | 999 | **4.2** | 1,201 | **5.2** | 1,238 | **5.0** | **1,200** | **5.2** |
| Coordination, research, evaluation | 605 | **3.0** | 504 | **2.1** | 421 | **1.8** | 749 | **3.0** | **756** | **3.3** |
| Law enforcement | 5,792 | **28.8** | 6,100 | **25.5** | 5,851 | **25.5** | 5,906 | **23.8** | **5,431** | **23.7** |
| Others, unspecified | 620 | **3.1** | 217 | **0.9** | 106 | **0.5** | 125 | **0.5** | **140** | **0.6** |
| **Total** | **20,084** | **100.0** | **23,947** | **100.0** | **22,973** | **100.0** | **24,807** | **100.0** | **22,933** | **100.0** |

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

### 1.3.2 Drug Treatment Costs Incurred by Health Insurers

In the Czech Republic, health care is funded from three sources, including health insurers (public health insurance), public budgets (the state budget, local budgets), and households. Covering approximately three quarters of all the health-related costs, health insurers provide the largest segment of funding.

The costs incurred by health insurance companies are provided on the basis of the information from health account statistics compiled in line with the System of Health Accounts (SHA).

According to the SHA, the total volume of expenditures[37] incurred by health insurers was CZK 184 billion (€ 6,630 million) in 2007, CZK 197 billion (€ 7,098 million) in 2008, CZK 218 billion (€ 7,852 million) in 2009, and CZK 214 billion (€ 7,708 million) in 2010. CZK 6.4 billion (€ 231 million), CZK 6.6 billion (€ 238 million), CZK 7.7 billion (€ 277 million), and a CZK 7.8 billion (€ 281 million) were spent on the treatment of mental and behavioural disorders (Chapter V, ICD-10) in 2007, 2008, 2009, and 2010 respectively (Český statistický úřad, 2012c). On the basis of data reported by health insurers, the annual costs of treatment related to conditions caused by psychoactive substance use (diagnoses F10–F19) were estimated to have amounted to CZK 1,363 million (€ 49,109 thousand) CZK 1,446 million (€ 52,103 thousand), CZK 1,658 million (€ 59,718 thousand), and CZK 1,633 million (€ 58,821 thousand) in the years 2007, 2008, 2009, and 2010 respectively (Nechanská, 2012d); see Table 1-8.

In this section, the costs incurred by health insurers in relation to the F10–F19 diagnoses are presented according to the type of health care provided and are divided into directly identifiable costs, i.e. those reported as incurred in relation to the treatment of the F10–F19 primary diagnoses, and unidentifiable costs, i.e. those with no link to a diagnosis, the proportion of which spent in relation to the F10–F19 diagnoses was estimated. Separate analyses for the F10 diagnosis (mental and behavioural disorders caused by alcohol use) and the F11–F19 diagnoses (mental and behavioural disorders caused by the use of other psychoactive substances, including tobacco) were made. The directly identifiable costs incurred by health insurers accounted for approximately two thirds of the total annual costs incurred by health insurers in the period under scrutiny.

The unidentifiable costs with no link to a diagnosis had to be adjusted before being processed.[38] The share of the costs of the F10–F19 diagnoses in the identifiable costs (i.e. costs reported as incurred in relation to specific diagnoses) was used to estimate the share of the costs of this diagnostic group in the total amount of unidentifiable costs. Unidentifiable costs attributed to the different types of care were estimated using the structure of the overall unidentifiable costs.

The largest proportion of the total costs (both identifiable and unidentifiable) incurred by health insurers in relation to the treatment of alcohol users (diagnosis F10) from 2007 to 2010 was spent on treatment services (almost 72%), which are divided into inpatient and outpatient care modalities, which account for a little less than 64% and 8%, respectively, of these expenditures; almost one fifth of the costs were used to pay for medication. The share of other types of care (including rehabilitation, long-term care, and supporting services) was small. Specialisations associated

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

[38] These unspecified costs had to be set apart from health insurance companies’ operating costs, per capita payments to general practitioners for adults, per capita payments to general practitioners for children and adolescents, and some other costs of care which cannot be determined on the basis of contractual specialisations, or are recorded separately for the sake of greater statistical accuracy, but are defined using other suitable methods, such as a group of health interventions and codes from the classifiers of health resources. The following costs incurred by health insurers were further excluded from these additional costs of care: convalescent care, spa care in spa sanatoria for children, acute and emergency care provided abroad, refunds to patients, inoculation provided by general practitioners for children and adolescents, preventive check-ups by general practitioners, and occupational medicine related to the specialisation of an occupational physician for adults. On average, in the years 2007–2010 these costs accounted for a quarter of the costs other than those linked to a specific diagnosis. Following such adjustments, the other costs were used as the basis for the estimation of the total amount of unidentifiable costs attributable to the F10–F19 diagnoses.

with psychiatric and alcohol/drug treatment accounted for over 88% and over 50% respectively of the provision of inpatient and outpatient treatment services for alcohol users.

*Table 1-8: Total costs incurred by health insurers in relation to the F10–F19 diagnoses according to the type of care, 2007–2010 (€ thousand) (Nechanská, 2012d)*

| Type of care | Cost of diagnosis F10 | | | | Cost of diagnoses F11–F19 | | | |
|---|---|---|---|---|---|---|---|---|
| | 2007 | 2008 | 2009 | 2010 | 2007 | 2008 | 2009 | 2010 |
| **Treatment services** | **26,736** | **27,472** | **31,187** | **30,211** | **7,826** | **9,127** | **10,766** | **11,283** |
| **Inpatient care** | **23,825** | **24,487** | **27,712** | **26,669** | **6,620** | **7,857** | **9,244** | **9,699** |
| Inpatient intensive care | 1,034 | 871 | 1,264 | 1,489 | 323 | 339 | 467 | 532 |
| incl. psychiatric care | 47 | 27 | 44 | 52 | 122 | 111 | 129 | 117 |
| others | 987 | 844 | 1,219 | 1,436 | 201 | 227 | 338 | 415 |
| Inpatient standard care | 2,961 | 3,090 | 3,673 | 2,793 | 1,289 | 1,552 | 1,583 | 1,659 |
| incl. psychiatry | 1,479 | 1,478 | 1,501 | 971 | 870 | 1,031 | 901 | 915 |
| child psychiatry | 0 | 2 | 1 | 1 | 1 | 1 | 9 | 1 |
| others | 1,482 | 1,610 | 2,171 | 1,821 | 417 | 520 | 673 | 743 |
| Inpatient long-term care | 19,809 | 20,495 | 22,746 | 22,343 | 5,002 | 5,955 | 7,182 | 7,492 |
| incl. drug/alcohol treatment (AT clinics) | 4,681 | 4,026 | 5,287 | 5,331 | 1,686 | 1,591 | 2,198 | 2,242 |
| psychiatry | 15,054 | 16,395 | 17,338 | 16,890 | 3,264 | 4,276 | 4,879 | 5,127 |
| child psychiatry | 0 | 0 | 0 | 1 | 51 | 88 | 98 | 120 |
| others | 73 | 74 | 120 | 121 | 2 | 1 | 8 | 3 |
| **One-day care** | **22** | **30** | **30** | **44** | **7** | **11** | **11** | **17** |
| **Outpatient care** | **2,842** | **2,859** | **3,406** | **3,461** | **1,184** | **1,223** | **1,496** | **1,553** |
| Primary care | 51 | 38 | 58 | 61 | 24 | 15 | 25 | 28 |
| Dental care | 11 | 10 | 42 | 13 | 4 | 4 | 15 | 5 |
| Specialised outpatient care | 2,178 | 2,248 | 2,689 | 2,737 | 931 | 994 | 1,193 | 1,282 |
| incl. drug/alcohol treatment (AT clinics) | 313 | 261 | 281 | 277 | 150 | 128 | 163 | 144 |
| psychiatry | 1,363 | 1,347 | 1,303 | 1,279 | 552 | 582 | 603 | 639 |
| child psychiatry | 5 | 4 | 4 | 3 | 15 | 11 | 16 | 13 |
| others | 810 | 897 | 1,382 | 1,455 | 364 | 400 | 574 | 630 |
| Other specialised outpatient services | 337 | 398 | 376 | 410 | 90 | 117 | 114 | 108 |
| incl. clinical psychology | 289 | 303 | 336 | 371 | 75 | 82 | 98 | 92 |
| psychotherapy | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| others | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| **Home care** | **47** | **96** | **40** | **37** | **15** | **35** | **14** | **14** |
| **Rehabilitation services** | **22** | **23** | **262** | **337** | **10** | **8** | **100** | **136** |
| Inpatient rehabilitation | 7 | 8 | 86 | 77 | 2 | 3 | 33 | 31 |
| Independent ergotherapy clinics | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 3 |
| Outpatient rehabilitation | 15 | 15 | 177 | 256 | 7 | 5 | 66 | 102 |
| **Long-term care** | **405** | **678** | **679** | **781** | **37** | **138** | **99** | **144** |
| Inpatient long-term care | 355 | 618 | 552 | 650 | 22 | 123 | 56 | 99 |
| At-home long-term care | 51 | 59 | 126 | 131 | 15 | 16 | 43 | 46 |
| **Supporting services** | **1,801** | **1,842** | **2,216** | **2,347** | **1,419** | **1,369** | **1,558** | **1,637** |
| Laboratories | 658 | 696 | 910 | 999 | 1,169 | 1,100 | 1,247 | 1,306 |
| incl. toxicology | 157 | 148 | 183 | 175 | 295 | 303 | 388 | 320 |
| others | 501 | 548 | 727 | 825 | 874 | 796 | 860 | 987 |
| Imaging techniques | 280 | 275 | 361 | 374 | 84 | 85 | 122 | 134 |
| Transport and emergency medical services | 863 | 871 | 944 | 973 | 166 | 184 | 189 | 198 |
| **Medication and medical supplies** | **7,974** | **7,380** | **9,050** | **8,254** | **2,561** | **2,753** | **3,306** | **3,233** |
| incl. medication | 7,461 | 6,916 | 8,391 | 7,689 | 2,395 | 2,579 | 3,066 | 3,011 |
| medical equipment | 513 | 464 | 658 | 565 | 166 | 174 | 241 | 222 |
| **Prevention** | **230** | **514** | **350** | **292** | **76** | **738** | **154** | **114** |
| **Unknown** | **30** | **75** | **23** | **92** | **10** | **28** | **9** | **19** |
| **Total** | **37,178** | **37,953** | **43,737** | **42,270** | **11,931** | **14,150** | **15,981** | **16,551** |

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

As regards users of drugs other than alcohol, treatment services also consumed the largest proportion of expenditures (two thirds), with the inpatient and outpatient care modalities accounting for 57% and almost 10% of the total costs being incurred in relation to the treatment of the F11–F19 diagnoses; almost one fifth of the health insurers' costs, too, was used to cover medication. A relatively high percentage (10%) was made up by the costs of supporting services that encompass the use of laboratories, imaging techniques, transport, and emergency medical

services. The share of psychiatric specialisations was greater than that in alcohol use treatment, with almost 90% and 55% in inpatient and outpatient services respectively.

### 1.3.3 Social Costs Related to Alcohol Use

Between 2009 and 2011 the Department of Addictology of the First Faculty of Medicine of Charles University in Prague and of the General University Hospital in Prague[39] carried out a study of the social costs in 2007 of the use of alcohol, tobacco, and illicit drugs in the Czech Republic. The study sought to quantify the economic burden imposed on society in relation to the most commonly used psychoactive substances. The social costs (Cost of Illness, COI) in 2007 related to the use of three major groups of addictive substances, i.e. tobacco, alcohol, and illegal drugs, amounted to CZK 56.2 billion (€ 2,023 million) in the Czech Republic (Zábranský et al. 2011), with CZK 33.1 billion (€ 1,193 million) (59.0%), CZK 16.4 billion (€ 589 million) (29.1%), and CZK 6.7 billion (€ 241 million) (11.9%) attributed to tobacco, alcohol, and illegal drugs respectively; see Table 1-9.

The study was conducted using the internationally standardised methodology as laid down in a handbook published by the World Health Organisation (WHO). The costs are divided into direct (resources that society expends directly in order to address the problems ensuing from the given group of psychotropic substances) and indirect ones (resources that society fails to gain as a result of psychotropic substance use).

Direct costs are categorised into health-related costs (those incurred in relation to services for substance users, addiction treatment, and the treatment of other attributable illnesses), law enforcement costs (those related to the operation of the criminal justice system – the police, public prosecutors, courts, and prisons – in responding to primary and secondary crime), and other areas (such as those involving the costs of research and excise tax administration).

Indirect costs are associated with lost productivity. In health care, they include the costs of morbidity (incurred during treatment and as a result of incapacity to work and absence from work) and mortality (years of life lost), while in terms of law enforcement, they are divided into costs related to criminal careers and those incurred by the victims of crime in relation to their morbidity and mortality.

The total direct costs amounted to CZK 24.1 billion (€ 900 million) (42.8%), while the indirect costs totalled CZK 32.1 billion (€ 1,100 million) (57.2%). As for tobacco, the indirect costs were two-and-a-half times higher that the direct ones, particularly because of the high mortality-related costs. As far as alcohol is concerned, the direct costs were slightly higher than the indirect ones; the most significant items included both primary and secondary crime and mortality. As regards illicit drugs, the direct costs surpassed the indirect ones enormously, which was caused by the significant level of secondary crime involving offences against property.

The total costs associated with all three groups of substances represent approximately 1.6% of GDP, which is about half as much as in other developed countries. In comparison to other countries, tobacco and alcohol use accounts for relatively more expenditure than the use of illegal drugs.

[39] With support from the Internal Grant Agency of the Czech Ministry of Health, Grant No. NS/10034-4.

*Table 1-9: The total social costs of the use of alcohol, tobacco, and illicit drugs in the Czech Republic, 2007 (€ million) (Zábranský et al. 2011)*

| Type of costs | Alcohol | Tobacco | Illicit drugs | Total |
|---|---|---|---|---|
| **Direct health care costs** | **95.1** | **310.0** | **27.5** | **432.6** |
| Addiction treatment | 24.3 | 0.2 | 5.2 | **29.6** |
| Treatment of other attributable illnesses | 69.4 | 309.9 | 8.6 | **387.8** |
| Demand reduction | – | – | 13.1 | **13.1** |
| Crime victims' physical injuries | 1.4 | – | 0.7 | **2.1** |
| **Direct law enforcement costs** | **196.5** | **0.0** | **183.9** | **380.4** |
| Supply reduction | – | – | 5.8 | **5.8** |
| Primary crime | 64.5 | – | 35.8 | **100.2** |
| Secondary crime | 107.3 | – | 140.5 | **247.8** |
| Transport and traffic accidents | 24.7 | – | 1.9 | **26.6** |
| **Other direct costs** | **24.7** | **26.4** | **2.2** | **53.3** |
| Research | 0.2 | 0.3 | 0.5 | **1.1** |
| Excise tax collection costs | 20.8 | 6.3 | – | **27.1** |
| Fire service costs | – | 10.0 | – | **10.0** |
| Drug policy coordination costs | – | – | 1.2 | **1.2** |
| Insurers' administrative costs | 3.7 | 9.8 | 0.4 | **13.9** |
| **Direct costs in total** | **316.3** | **336.4** | **213.7** | **866.3** |
| **Indirect health-related costs** | **252.9** | **856.7** | **10.6** | **1,120.2** |
| Morbidity (hospitalisations) | 11.2 | 3.7 | 1.3 | **16.3** |
| Morbidity (sickness benefits, without hospitalisations) | 19.5 | 42.5 | 0.0 | **62.0** |
| Mortality | 222.2 | 810.5 | 9.3 | **1,041.9** |
| **Indirect law enforcement costs** | **19.9** | **0.0** | **16.4** | **36.3** |
| Imprisonment for primary crime | 0.4 | – | 4.0 | **4.4** |
| Imprisonment for secondary crime | 2.2 | – | 10.0 | **12.2** |
| Crime victims' morbidity (sickness benefits) | 2.4 | – | 1.2 | **3.6** |
| Crime victims' mortality | 1.7 | – | 1.1 | **2.8** |
| Traffic accident damages | 13.2 | – | 0.1 | **13.3** |
| **Indirect costs in total** | **272.8** | **856.7** | **27.0** | **1,156.6** |
| **Direct and indirect costs in total** | **589.1** | **1,193.1** | **240.7** | **2,022.9** |

*Note: Average exchange rate in 2007 was used for re-calculation of expenses from CZK to €.*

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

The level of drug use among the general population has remained stable in the long run. The results of a 2011 survey carried out on a quasi-representative sample of the Czech population are consistent with those generated by surveys conducted in the past three years. The most frequently used illegal drug is cannabis (23–34%, depending on the study), followed by ecstasy (4–10%), hallucinogenic mushrooms (4–9%), and LSD (2–6%). Higher prevalence levels of the use of illicit drugs were observed in the 2008 general population survey, which focused specifically on drug use.

A comparison with a survey carried out among the population of internet users also produced analogous results concerning the level of illicit drug use within the time frame of the last 12 months; internet users reported experiences with cannabis and hallucinogenic mushrooms more frequently.

While the level of acceptability of tobacco smoking has recorded a slight decline in Czech society, the acceptability of alcohol use has retained the same level and cannabis use is becoming more acceptable. There is a growing percentage of people who oppose the criminalisation of cannabis users in general, users of medical cannabis, and people who cultivate cannabis for their personal use.

The results of the ESPAD survey confirmed the long-term declining trends in the prevalence of the use of pervitin, heroin, ecstasy, and hallucinogenic mushrooms among the population of 16-year-olds; a drop in relation to cannabis was recorded for the first time in 2011. The perceived availability of cigarettes and alcohol has maintained a high level in the Czech Republic; the availability of illegal drugs, including cannabis, appears to be decreasing over time.

A study looking into the degree of experience with addictive substances among children in institutional care showed a significantly higher level of experience with the individual illicit drugs, a significantly earlier age of drug initiation, and a higher frequency of drug use among this group in comparison to the general population of a similar age.

### 2.1 Drug Use in the General Population

#### 2.1.1 The Survey on the Prevalence of Drug Use among the Population of the Czech Republic

In December 2011 the National Focal Point, in association with the *Factum Invenio* agency, conducted a research study entitled "The Prevalence of Drug Use among the Population of the Czech Republic". Using a single question, this omnibus survey on the general population sought to identify the level of experience with selected legal and illegal substances among respondents above 15 years of age. A total of 1028 respondents over 15 were selected[40] using quota sampling so as to match the population of the Czech Republic in terms of the respondents' gender, age, education, region, and the size of the place of their rezidence. Data were collected using Computer-Assisted Personal Interviewing (CAPI) (Factum Invenio, 2011). In comparison to similar omnibus studies carried out in the previous years, this survey included a new question about the use of the so-called new synthetic drugs (NSDs).[41]

Lifetime alcohol and tobacco use was reported by the majority of the respondents (91% and 66% respectively). The use of alcohol and tobacco in the last month also recorded high levels: smoking tobacco and drinking in the last 30 days were reported by almost 39% and 69% of the respondents respectively. Men are more likely to use legal drugs. While smoking cigarettes was reported more frequently by individuals aged 15–24, older age categories showed higher levels of alcohol use.

Traditionally, the most common illicit substance is cannabis (marijuana and hashish), which 24.9% of the respondents (30.8% of the males and 18.8% of the females) reported having used at least once in their lifetime, followed by ecstasy (5.8%) and hallucinogenic mushrooms (4.1%) (Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio, 2011). The use of the "new synthetic drugs" was reported by a total of 1.4% of the respondents, which exceeds the respective rates of experiences with cocaine, heroin, and inhalants reported by the respondents; see Table 2-1.

8.9% of the respondents (12.7% of the males and 4.9% of the females) reported cannabis use in the last 12 months), with 16.1% and 22.5% of the respondents falling into the 15–34 and 15–24 age categories respectively.

[40] The results of the survey presented further below are indicated for standard EMCDDA age groups, i.e. 15–24 (very young adults), 15–34 (young adults), and 15–64 (adults in total).

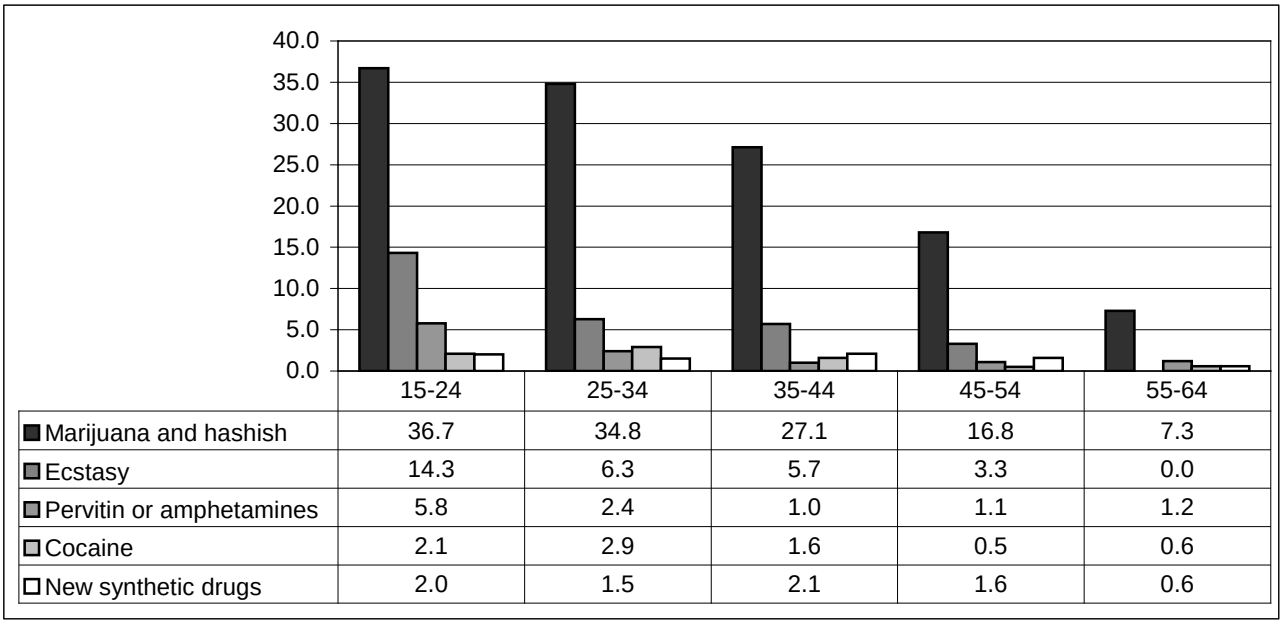
[41] For the purposes of the survey, new synthetic drugs were defined as "synthetic substances with effects similar to traditional drugs such as pervitin, marijuana, ecstasy, cocaine, and hallucinogens, which are not subject to the drug control system, as they are not included in the list of prohibited narcotic and psychotropic substances. First and foremost, they include mephedrone and other cathinones and synthetic cannabinoids. These substances are often sold via the internet or the co-called "Amsterdam shops" (Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio, 2011).

*Table 2-1: Lifetime prevalence rates of drug use in the general population, 2011 (%) (Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio, 2011)*

| Prevalence | Drug | Gender | | Selected age groups | | Total |
|---|---|---|---|---|---|---|
| | | Males (n=456) | Females (n=445) | 15–24 years (n=157) | 15–34 years (n=361) | 15–64 years (n=901) |
| Lifetime prevalence | Tobacco | 74.6 | 57.3 | 70.7 | 68.7 | 66.0 |
| | Alcohol | 91.9 | 90.4 | 87.1 | 89.7 | 91.1 |
| | Marijuana, hashish | 30.8 | 18.8 | 36.7 | 35.6 | 24.9 |
| | Ecstasy | 8.1 | 3.4 | 14.3 | 9.8 | 5.8 |
| | Pervitin, amphetamines | 3.1 | 1.1 | 5.8 | 3.8 | 2.1 |
| | Cocaine | 1.8 | 1.1 | 2.1 | 2.5 | 1.4 |
| | Heroin | 1.3 | 0.4 | – | 0.7 | 0.9 |
| | LSD | 2.6 | 1.6 | 5.4 | 3.0 | 2.1 |
| | Hallucinogenic mushrooms | 5.5 | 2.7 | 8.7 | 6.7 | 4.1 |
| | Inhalants | 2.0 | 0.7 | 4.1 | 1.8 | 1.3 |
| | New synthetic drugs | 1.8 | 1.1 | 2.0 | 1.6 | 1.4 |
| Prevalence in the last 12 months | Tobacco | 53.1 | 37.3 | 56.8 | 50.4 | 45.3 |
| | Alcohol | 90.1 | 86.5 | 83.2 | 87.2 | 88.4 |
| | Marijuana, hashish | 12.7 | 4.9 | 22.5 | 16.1 | 8.9 |
| | Ecstasy | 2.2 | 0.9 | 5.7 | 2.5 | 1.6 |
| | Pervitin, amphetamines | 0.9 | 0.7 | 3.2 | 1.4 | 0.8 |
| | Cocaine | 0.4 | 0.7 | 1.3 | 1.2 | 0.6 |
| | Heroin | 0.7 | – | – | – | 0.3 |
| | LSD | 1.1 | 1.1 | 4.2 | 1.8 | 1.1 |
| | Hallucinogenic mushrooms | 1.1 | 0.9 | 2.0 | 0.9 | 1.0 |
| | Inhalants | 0.7 | 0.2 | 1.8 | 0.8 | 0.4 |
| | New synthetic drugs | 1.1 | – | 1.5 | 0.6 | 0.6 |
| Prevalence in the last 30 days | Tobacco | 46.5 | 31.2 | 42.2 | 40.5 | 38.9 |
| | Alcohol | 76.3 | 61.7 | 60.0 | 68.2 | 69.1 |
| | Marijuana, hashish | 4.4 | 1.8 | 9.8 | 6.1 | 3.1 |
| | Ecstasy | 0.2 | – | 0.5 | 0.2 | 0.1 |
| | Pervitin, amphetamines | – | – | – | – | – |
| | Cocaine | 0.2 | – | – | 0.3 | 0.1 |
| | Heroin | 0.2 | – | – | – | 0.2 |
| | LSD | – | – | – | – | – |
| | Hallucinogenic mushrooms | – | – | – | – | – |
| | Inhalants | 0.2 | – | 0.6 | 0.3 | 0.1 |
| | New synthetic drugs | – | – | – | – | – |

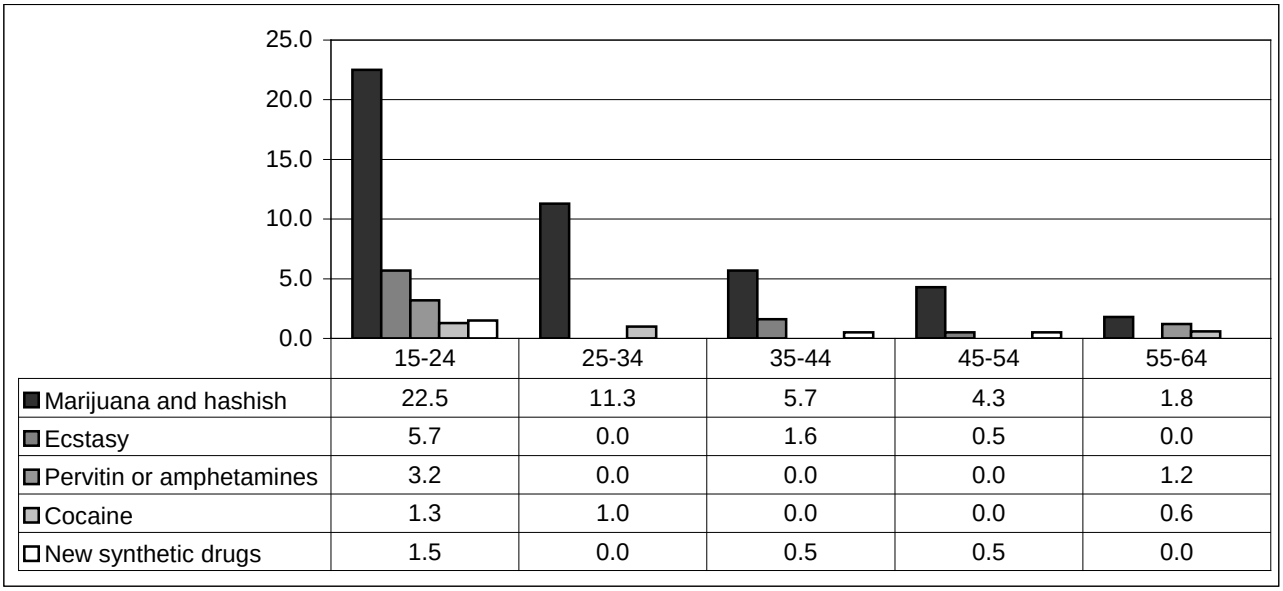
The lifetime use of illegal drugs was most likely to be reported by respondents from younger age categories; the use of cannabis and ecstasy was most frequently reported in the 15–24 age category, and the use of cocaine also in the 25–34 age group. The relatively high prevalence of the use of new synthetic drugs was found among individuals belonging to the 35–44 age category; see Graph 2-1 and Graph 2-2.

*Graph 2-1: Lifetime prevalence of the use of selected illicit drugs among the general population (15–64 years) by age groups (%) (Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio, 2011)*




| | 15-24 | 25-34 | 35-44 | 45-54 | 55-64 |
|---|---|---|---|---|---|
| Marijuana and hashish | 36.7 | 34.8 | 27.1 | 16.8 | 7.3 |
| Ecstasy | 14.3 | 6.3 | 5.7 | 3.3 | 0.0 |
| Pervitin or amphetamines | 5.8 | 2.4 | 1.0 | 1.1 | 1.2 |
| Cocaine | 2.1 | 2.9 | 1.6 | 0.5 | 0.6 |
| New synthetic drugs | 2.0 | 1.5 | 2.1 | 1.6 | 0.6 |

*Graph 2-2: Prevalence of the use of selected illicit drugs among the general population (15–64 years) in the last 12 months by age groups (%) (Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio, 2011)*



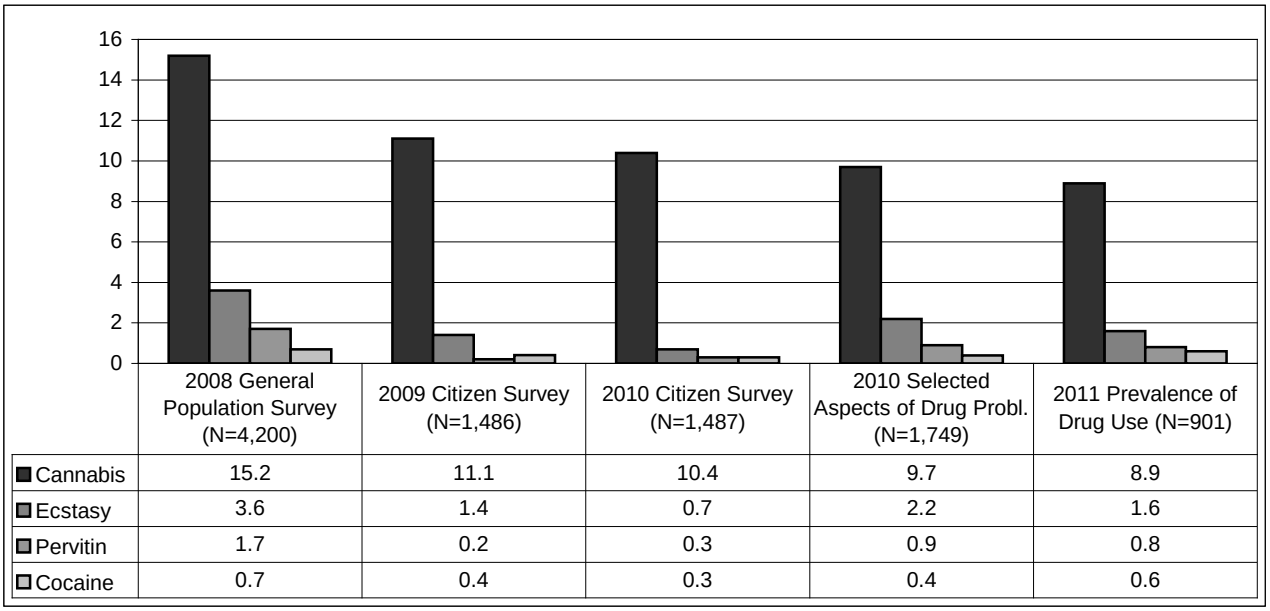

| | 15-24 | 25-34 | 35-44 | 45-54 | 55-64 |
|---|---|---|---|---|---|
| Marijuana and hashish | 22.5 | 11.3 | 5.7 | 4.3 | 1.8 |
| Ecstasy | 5.7 | 0.0 | 1.6 | 0.5 | 0.0 |
| Pervitin or amphetamines | 3.2 | 0.0 | 0.0 | 0.0 | 1.2 |
| Cocaine | 1.3 | 1.0 | 0.0 | 0.0 | 0.6 |
| New synthetic drugs | 1.5 | 0.0 | 0.5 | 0.5 | 0.0 |

### 2.1.2 Drug Use Trends as Shown by Surveys Carried Out from 2008 to 2011

All the surveys undertaken in recent years drew the same conclusions about the patterns of substance use among the general population (15–64 years). The most frequently used illegal drugs included cannabis (23–34%, depending on the study), followed by ecstasy (4–10%), hallucinogenic mushrooms (4–9%), and LSD (2–6%). The highest prevalence rates of the use of illegal drugs were recorded by the 2008 General Population Survey on the Use of Psychotropic Substances in the Czech Republic, a monothematic research project focusing specifically on drug use. Similar results have long been produced by other surveys, generally designed as omnibus studies, that did not focus specifically on the use of addictive substances, which indicates a stable drug use situation in the Czech Republic.

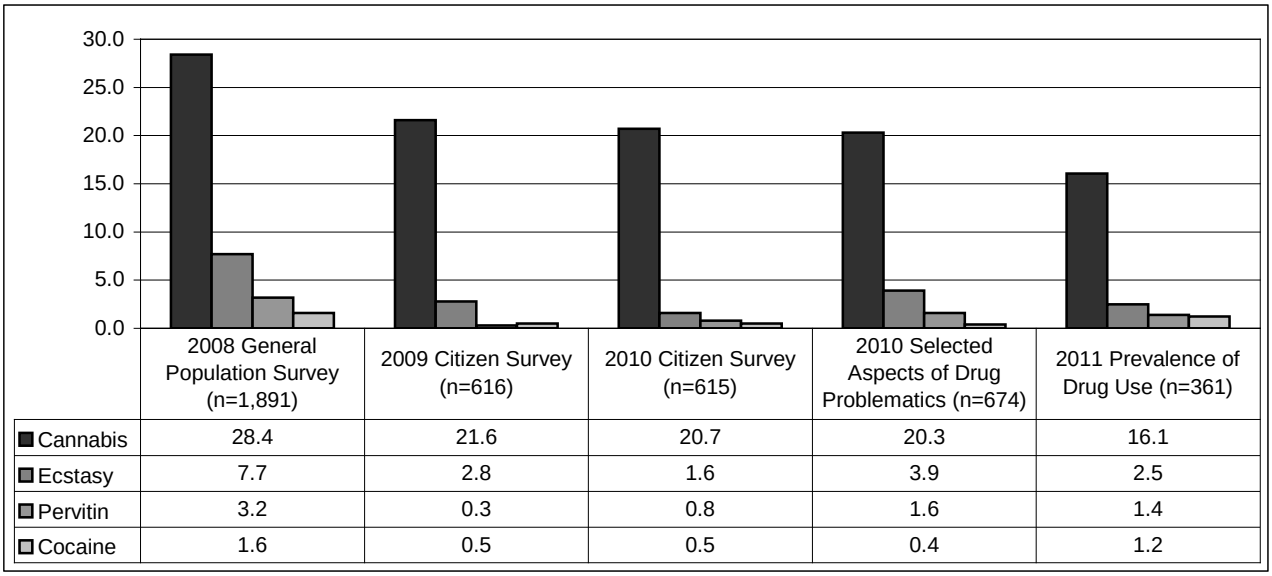
Within the last 12 months, cannabis had been used by 8–10% of the respondents aged 15–64, with 16–22% of them falling within the 15–34 age category. The situation concerning ecstasy and pervitin use has been stable in the long term, but the year 2011 recorded a slight increase in the reported use of cocaine within the time frame of the last 12 months (among both the general population and young adults). While cocaine use in the last year was previously reported by less than 0.5% of respondents, the 2011 last-year prevalence of cocaine use among young adults came up to the same level as that of pervitin use by reaching 1.2%; see Graph 2-3 and Graph 2-4.

*Graph 2-3: Prevalence of the use of illicit drugs among the general population (15–64 years) in the last 12 months, 2008–2011 (%) (Běláčková et al. 2012; Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2009; Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010; Zeman et al. 2011; Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio, 2011)*




| | 2008 General Population Survey (N=4,200) | 2009 Citizen Survey (N=1,486) | 2010 Citizen Survey (N=1,487) | 2010 Selected Aspects of Drug Probl. (N=1,749) | 2011 Prevalence of Drug Use (N=901) |
|---|---|---|---|---|---|
| Cannabis | 15.2 | 11.1 | 10.4 | 9.7 | 8.9 |
| Ecstasy | 3.6 | 1.4 | 0.7 | 2.2 | 1.6 |
| Pervitin | 1.7 | 0.2 | 0.3 | 0.9 | 0.8 |
| Cocaine | 0.7 | 0.4 | 0.3 | 0.4 | 0.6 |

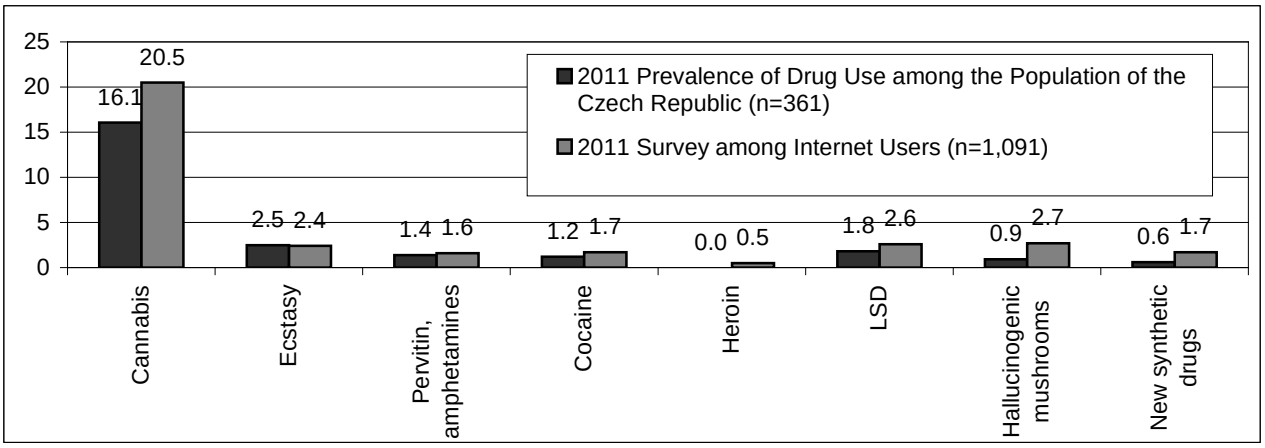
*Graph 2-4: Prevalence of the use of illicit drugs among young adults (15–34 years) in the last 12 months, 2008–2011 (%) (Běláčková et al. 2012; Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2009; Národní monitorovací středisko pro drogy a drogové závislosti and Agentura INRES-SONES, 2010; Zeman et al. 2011; Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio, 2011)*




| | 2008 General Population Survey (n=1,891) | 2009 Citizen Survey (n=616) | 2010 Citizen Survey (n=615) | 2010 Selected Aspects of Drug Problematics (n=674) | 2011 Prevalence of Drug Use (n=361) |
|---|---|---|---|---|---|
| Cannabis | 28.4 | 21.6 | 20.7 | 20.3 | 16.1 |
| Ecstasy | 7.7 | 2.8 | 1.6 | 3.9 | 2.5 |
| Pervitin | 3.2 | 0.3 | 0.8 | 1.6 | 1.4 |
| Cocaine | 1.6 | 0.5 | 0.5 | 0.4 | 1.2 |

In the spring of 2011, a questionnaire survey looking into the use of new synthetic drugs, so-called "legal highs", and the market practices associated with them was carried out by the National Focal Point in association with the *Median s.r.o.* agency. A sample of 1091 individuals aged 15–34 representing the internet population (internet users) was studied using the CAWI (Computer-Assisted Web-based Interviewing) method (Národní monitorovací středisko pro drogy a drogové závislosti and Median, 2011); for more details see the 2010 Annual Report. This survey was compared to the study of a quasi-representative sample of the general population (compiled by quota sampling), specifically a subsample comprising individuals of the same age category (15–34), which employed the CAPI (Computer-Assisted Personal Interviewing) method. It was found that both research studies produced identical results as regards the patterns and the level of illicit drug use within the time frame of the last 12 months. The internet user population was more likely to report the use of cannabis, hallucinogenic mushrooms, and new synthetic drugs; see Graph 2-5.

*Graph 2-5: Prevalence of the use of illicit drugs among young adults (15–34 years) in the last 12 months, 2011 – comparison of surveys (%) (Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio, 2011; Národní monitorovací středisko pro drogy a drogové závislosti and Median, 2011)*




### 2.1.3 2012 National Survey on Substance Use

The data collection part of a general population survey entitled the 2012 National Survey on Substance Use is planned for the autumn of 2012. Focusing specifically on substance use, this study of a representative sample of the population of the Czech Republic aged 15–64 follows up on the 2008 General Population Survey on the Use of Psychotropic Substances in the Czech Republic as far as its questionnaire, sample size, and extent are concerned. Prepared by the National Focal Point in collaboration with its Working Group for Drug Use among the General Population, the study should cover the domains of legal drugs (cigarettes, alcohol, prescription and over-the-counter drugs, and inhalants), illegal drugs (cannabis, ecstasy, pervitin or amphetamines, heroin, cocaine, LSD, hallucinogenic mushrooms, and new synthetic and herbal drugs), and attitudes to drug use. The questionnaire will include a short screening scale used to test for heavy and risky cannabis use (CAST). Users of selected drugs will also be assessed for the context of their use (including the frequency and route of administration). Based on the European Model Questionnaire (EMQ), this questionnaire is further complemented with selected questions about drug availability and cannabis users' market behaviour and also contains a set of items concerning experience with gambling, including a pathological gambling screening tool.

## 2.2 Attitudes to Substance Use

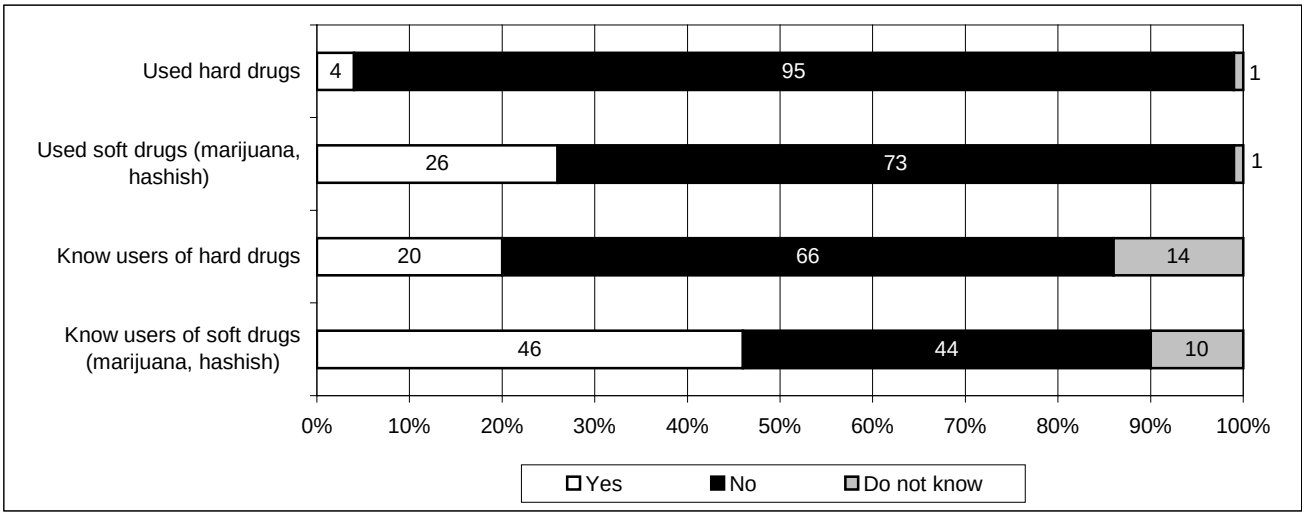
### 2.2.1 Citizens' Opinions on Drugs

In May 2012 the Public Opinion Poll Centre carried out a survey entitled Citizens' Opinions on Drugs, which focused on people's perception of the drug issue and their attitudes to the criminalisation of the use, manufacturing, and selling of drugs (Centrum pro výzkum veřejného mínění, 2012b). The sample of respondents comprised 1,402 individuals above 15 years of age who were selected using quota sampling on the basis of their gender, age, education, and the region and the size of the place of their domicile.

The survey looked into the direct and indirect experience of illicit drug use. As in 2011, a total of 26% of the respondents reported lifetime cannabis use and 4% reported having used other drugs; see Graph 2-6.

Respondents belonging to the 20–29 and 15–19 age categories were the most likely to report cannabis use (53% and 49% respectively). In the 30–44, 45–59, and over–60 age groups, there were respectively 29%, 19%, and only 3% of the respondents who have used cannabis.

*Graph 2-6: Direct and indirect experience of drug use among the population aged over 15 years (Centrum pro výzkum veřejného mínění, 2012b)*




A total of 46% of the respondents know personally someone who uses cannabis-based substances and 20% of the respondents know users of other illicit drugs, which is more than in the previous year (42% and 17% respectively).

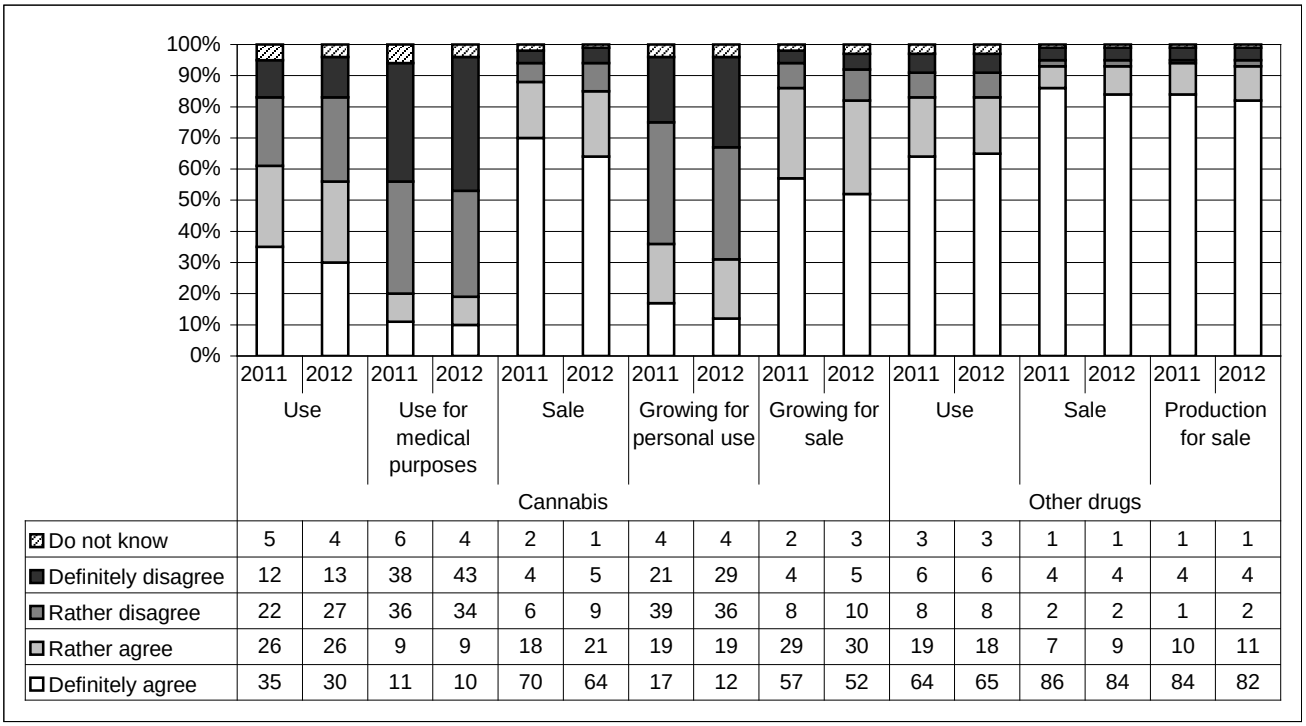
The vast majority of the respondents (86%) perceive the current drug use situation as a problem of the Czech Republic at the national level; about half of the respondents (54%) believe that drugs are an issue of concern in their own community. On the contrary, 11% of the respondents do not find drug use an issue in the Czech Republic (Centrum pro výzkum veřejného mínění, 2012b). Approximately half of the respondents assume that the competent institutions pay reasonable attention to the drug problem, 35% consider such attention insufficient, and 6% see it as excessive.

In comparison to 2011, the level of acceptability of tobacco use decreased (from 82% in 2011 to 76% in 2012). While the acceptability of alcohol use maintained the same level (77% in 2011 and 76% in 2012), the degree of acceptability of cannabis use recorded an increase (from 26% to 32% in 2012). The use of painkillers, sleeping pills, and tranquillisers was also found highly acceptable (86%).

In comparison to 2011, there was a slight increase in the proportion of the respondents who oppose the criminalisation of cannabis users and sanctions against people who use cannabis for medical purposes and those who cultivate cannabis for their own personal use; see Graph 2-7. While more than three quarters of the respondents still support sanctions against the sale of cannabis-based substances and the cultivation of cannabis for sale, a slightly lower percentage of people who approve of criminal prosecution for such activities has been observed in this area too. More than 80% of the respondents support criminal prosecution for the use of any other illegal drugs and over 90% are in favour of criminal prosecution for the production and sale of such drugs (Centrum pro výzkum veřejného mínění, 2012b).

The survey also inquired about the population groups which the respondents find to be most engaged with drug use (more than one answer was possible). Almost 70% of the respondents identified young people (teenagers, including basic and secondary school students and apprentices). Over 40% of the respondents associated the issue of drug use with poverty, social exclusion, and homelessness; 22% reported Roma and foreigners of other ethnic backgrounds. However, 20% indicated rich people, including their children, or celebrities (Centrum pro výzkum veřejného mínění, 2012b).

*Graph 2-7: Agreement with criminal prosecution of the use, production, and sale of drugs (Centrum pro výzkum veřejného mínění, 2012b)*




| | Cannabis | | | | | | | | | | Other drugs | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Do not know | 5 | 4 | 6 | 4 | 2 | 1 | 4 | 4 | 2 | 3 | 3 | 3 | 1 | 1 | 1 | 1 |
| Definitely disagree | 12 | 13 | 38 | 43 | 4 | 5 | 21 | 29 | 4 | 5 | 6 | 6 | 4 | 4 | 4 | 4 |
| Rather disagree | 22 | 27 | 36 | 34 | 6 | 9 | 39 | 36 | 8 | 10 | 8 | 8 | 2 | 2 | 1 | 2 |
| Rather agree | 26 | 26 | 9 | 9 | 18 | 21 | 19 | 19 | 29 | 30 | 19 | 18 | 7 | 9 | 10 | 11 |
| Definitely agree | 35 | 30 | 11 | 10 | 70 | 64 | 17 | 12 | 57 | 52 | 64 | 65 | 86 | 84 | 84 | 82 |

### 2.2.2 Moral Acceptability of Behaviour and Tolerance towards Selected Groups of People

Similarly, the Public Opinion Poll Centre's survey carried out in March 2012 among 1053 respondents over 15 years of age showed a significant rise in the level of acceptability of cannabis during the period from 2005 to 2012. Drinking to drown one's sorrows, drinking out of joy, and playing cards for money were also found more acceptable among people, while driving under the influence of alcohol was still regarded as the least acceptable behaviour (it was condemned by 72% of the respondents). There seem to be generational differences: the younger generation (aged 15–29 years) tends to be much more tolerant towards these selected types of behaviour than the older one (over 60). The population of the Czech Republic showed the least tolerance towards people who are dependent on drugs (86% would not like to have them as their neighbours), people who are dependent on alcohol (78%), and people with a criminal history (74%) (Centrum pro výzkum veřejného mínění, 2012a; Centrum pro výzkum veřejného mínění, 2012c).

### 2.2.3 The Czech Republic's Ranking in the Global Vice Index

In March 2012 the American news agency Bloomberg published its Global Vice Index comparing world countries' average consumption of alcohol, tobacco, and illicit drugs among the adult population (15–64 years) and the money spent on gambling, using the latest data from the World Health Organisation (WHO), the United Nations Office on Drugs and Crime (UNODC), and other institutions.

Using a 0–100-point scale, the countries were ranked according to per capita alcohol consumption in litres, the number of cigarettes per person, prevalence rates of the use of illicit drugs (cannabis, amphetamines, ecstasy, cocaine, and opioids, including prescription opioids for substitution treatment) in the last year, and gambling losses (indicated as a percentage of the country's GDP) (Bloomberg, 2012). The overall rankings resulted from the scores summing up the points for each category. In addition to leading the "alcohol" and "cannabis" categories, the Czech Republic topped the overall chart (out of 57 rated countries for which the indicators under scrutiny were available); see Table 2-2.

*Table 2-2: The Global Vice Index rankings of selected countries according to the final score (Bloomberg, 2012)*

| Rank | Country | Final Score |
|---|---|---|
| 1. | Czech Republic | 68.94 |
| 2. | Slovenia | 62.50 |
| 3. | Australia | 57.84 |
| 4. | Armenia | 57.53 |
| 5. | Spain | 56.51 |
| 6. | Bulgaria | 53.25 |
| 7. | Italy | 52.58 |
| 8. | Greece | 51.24 |
| 9. | Croatia | 51.14 |
| 10. | Bosnia and Herzegovina | 50.72 |
| 15. | United Kingdom | 48.13 |
| 18. | Slovakia | 47.15 |
| 19. | Hungary | 46.86 |
| 31. | Poland | 39.81 |
| 32. | France | 37.61 |
| 34. | Germany | 36.63 |
| 40. | Sweden | 28.68 |
| 46. | Norway | 22.69 |
| 51. | Turkey | 18.78 |
| 57. | Zambia | 7.17 |

## 2.3 Drug Use in the School Population and among Young People

### 2.3.1 ESPAD Study

The year 2011 experienced what was already the fifth round of the collection of data for the European School Survey on Alcohol and Other Drugs (ESPAD) among 16-year-old students (basic and secondary school students born in 1995). The 2011 sample comprised a total of 3913 respondents.

Daily smoking was reported by 25.7% of 16-year-olds (27.2% and 24.2% of the boys and girls respectively), with a total of 8.2% of the students falling within the heavy smoking category (11 cigarettes per day or more). Approximately 60% of those who were interviewed (66% and 50% of the boys and girls respectively) can be considered regular drinkers (having drunk alcohol on 20 or more occasions in their lifetime). Frequent heavy episodic drinking (i.e. the consumption of five drinks or more on three or more occasions during the last thirty days) was reported by 21.3% of the students.

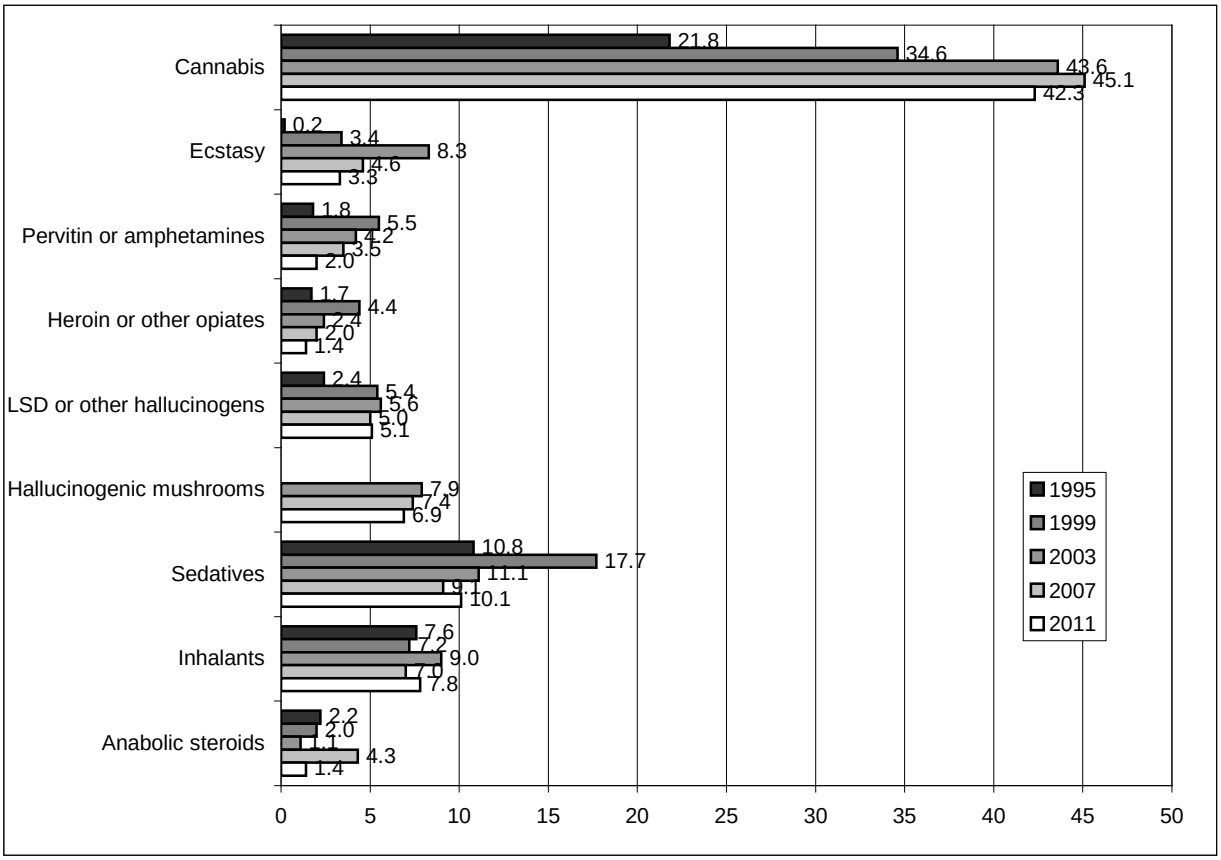
The lifetime use of any illicit drug was reported by 43.4% of the students who were interviewed, with cannabis being stated with the highest rate (42.3%). 11.0% of the respondents reported having used other illicit drugs than cannabis; the most frequently mentioned ones included hallucinogenic mushrooms, LSD, and ecstasy; see Graph 2-8.

After comparing the changes observed in recent years, it may be concluded that the lifetime prevalence of the use of the majority of drugs under study has fallen. Since 1999 there has been a decline in the prevalence of the use of pervitin and amphetamines, as well as heroin or other opiates, the prevalence of the use of ecstasy and hallucinogenic mushrooms has been declining since 2003, and in 2011, for the first time, cannabis use recorded a decrease.

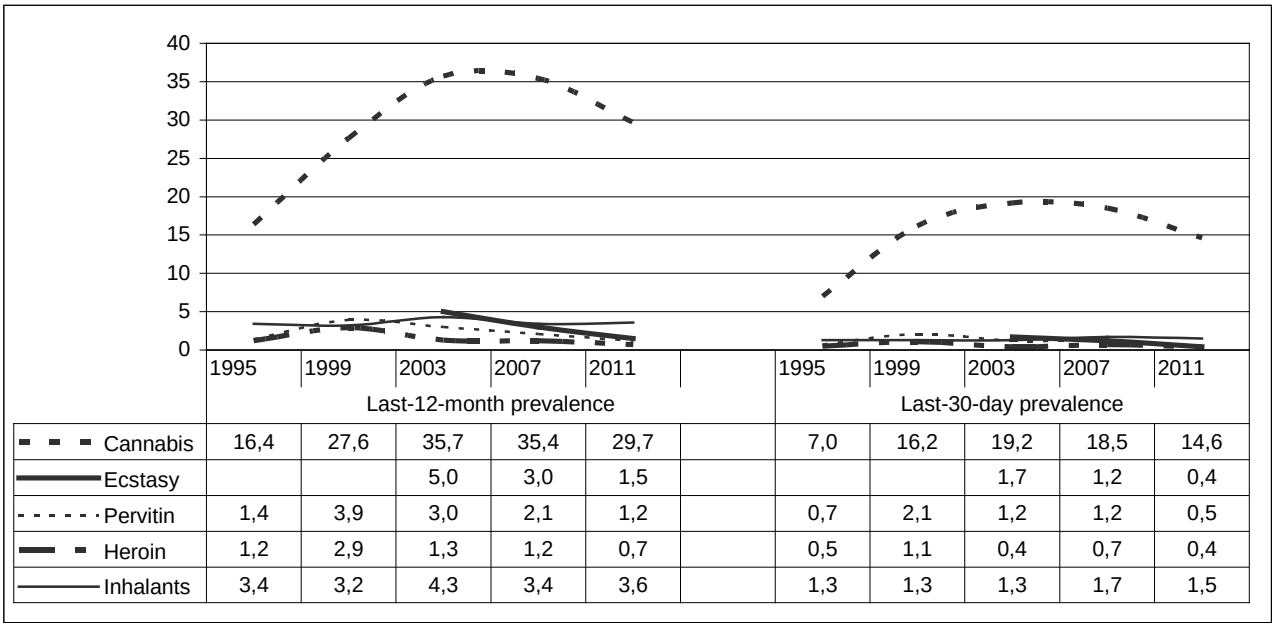
The development of the prevalence of the use of selected drugs in the last 12 months and last 30 days indicates that since 2003 there has been a decline in the level of use of all the drugs under scrutiny, including cannabis; the last-30-day prevalence of the use of illegal drugs, with the exception of cannabis, reaches just a minimum level; see Graph 2-9.

The availability of cigarettes and alcohol as perceived by 16-year-olds maintains high levels in the Czech Republic, in spite of the fact that the law prohibits these substances from being readily available to this age group. Cannabis, ecstasy, and pervitin were found fairly or very easy to obtain by 59%, 20%, and almost 9% of the respondents respectively. Perceived availability has declined over time: pervitin and ecstasy have been found less available since 1999 and 2003, respectively, and the year 2011 recorded a drop in the level of the perceived availability of cannabis, too (Csémy and Chomynová, 2012).

*Graph 2-8: Lifetime prevalence of the use of illicit drugs, 1995–2011 (%) (Csémy and Chomynová, 2012)*




*Graph 2-9: Prevalence of the use of selected drugs during the last 12 months and last 30 days (%) (Csémy and Chomynová, 2012)*




| | Last-12-month prevalence | | | | | | Last-30-day prevalence | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1995 | 1999 | 2003 | 2007 | 2011 | | 1995 | 1999 | 2003 | 2007 | 2011 |
| Cannabis | 16,4 | 27,6 | 35,7 | 35,4 | 29,7 | | 7,0 | 16,2 | 19,2 | 18,5 | 14,6 |
| Ecstasy | | | 5,0 | 3,0 | 1,5 | | | | 1,7 | 1,2 | 0,4 |
| Pervitin | 1,4 | 3,9 | 3,0 | 2,1 | 1,2 | | 0,7 | 2,1 | 1,2 | 1,2 | 0,5 |
| Heroin | 1,2 | 2,9 | 1,3 | 1,2 | 0,7 | | 0,5 | 1,1 | 0,4 | 0,7 | 0,4 |
| Inhalants | 3,4 | 3,2 | 4,3 | 3,4 | 3,6 | | 1,3 | 1,3 | 1,3 | 1,7 | 1,5 |

### 2.3.2 Regional School Surveys

In 2011 the public service company *A Clubs Czech Republic* conducted a survey entitled Youth and Drugs in the Region of South Moravia. A questionnaire was administered to a total of 4918 respondents from 24 basic schools (1967 respondents, 39.9% of the sample), 8 grammar schools, 13 secondary schools and vocational training centres (2904 respondents, 59.0% of the sample), and one higher vocational school (47 respondents, 0.9% of the sample). The ages of the respondents ranged from 11 to 25 years (47% were aged 11–15, 52% were in the 16–20 age category).

32.3% of the sample of students who participated in the survey reported lifetime cannabis use, while 6.5% had used hallucinogenic mushrooms, 3.2% inhalants, and 3.0% ecstasy; see Table 2-3. The questionnaire also inquired about their experience of gambling; this was reported by 21.6% of the students.

Current regular substance use (i.e. use of any of the substances specified, including tobacco, alcohol, and gambling with a frequency of at least once per week for a period of two months) was admitted by a total of 31.6% of the respondents, with another 13.8% reporting a history of regular use as defined (A Kluby ČR o.p.s., 2011). Current regular use was reported by 20.4% of individuals aged 11 to 15 years old, 41.1% aged 16–20, and 48.5% of the respondents in the 21–25 age category.

*Table 2-3: Lifetime prevalence of substance use among students aged 11–25 in the South Moravia region (%) (A Kluby ČR o.p.s., 2011)*

| Drug | Lifetime prevalence |
|---|---|
| Tobacco | 62.3 |
| Alcohol | 74.1 |
| Cannabis | 32.3 |
| Ecstasy | 3.0 |
| Pervitin | 2.5 |
| LSD | 2.2 |
| Cocaine | 1.4 |
| Heroin | 1.1 |
| Hallucinogenic mushrooms | 6.5 |
| Inhalants | 3.2 |
| Gambling | 21.6 |

A total of 12.1% admitted to regular gaming, including playing computer games. Smoking tobacco on a daily basis was reported by 18.5% of the respondents, 9.9% drink beer at least twice a week, 4.2% drink spirits with a similar frequency, and cannabis is used at least once per week by 10% of the respondents.

The most common places where young people encounter drugs include discos, clubs, and pubs (64.4%), followed by the street (22.1%); the 11–15 age category also often comes across drugs at private parties (11.2%) and at school (6.1%).

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

### 2.4.1 Drug Use among Children in Institutional Care Establishments

For the purposes of a student's bachelor's thesis, data on the degree of experience with addictive substances among children placed in institutional care establishments were collected between October 2011 and March 2012. Data collection questionnaires were administered in six special education facilities, including children's homes, institutions for juvenile delinquents and children with behavioural disorders ("diagnostic institutions"), and correctional institutions, located in the South Bohemia region. A total of 150 questionnaires were collected. The target group comprised children aged 14–15. The respondents were included in the study following consultation with the staff of the individual facilities about the prospective participants' files. 130 valid questionnaires were analysed. The sample consisted of 63 boys and 67 girls. Qualitative interviews with therapists working in the respective establishments were conducted in parallel.

The survey showed that 66.6% of the respondents smoked on a daily basis; they were initiated into smoking cigarettes at an average age of 9.6 years old and were regular smokers by the time they were 10.9 years old on average. Lifetime alcohol use was reported by 92.6% of the respondents; the average age at which they had first consumed alcohol was 11.1 years, and friends (72%) were the most common source of initiation to alcohol. A total of 85% of the respondents reported having been drunk at least once (Chrtová, 2012).

The lifetime use of illicit drugs was reported by 75% of the respondents; they were most likely to report experience with cannabis (74% and 25.9% indicated the use of marijuana and hashish respectively), while the use of pervitin was reported by 29.6%, LSD 16.7%, cocaine 9.3%, and ecstasy 5.6%. The lifetime use of inhalants and pills was reported by 13.9% and 14.8% respectively. Hallucinogenic mushrooms constituted a significant group of drugs which were reported as having been used (24%). The average age on the occasion of the first use of marijuana, pervitin, and ecstasy was 12.2, 13.9, and 14 years respectively. In comparison to the general population of a similar age, significantly higher prevalence rates of the lifetime use of illicit drugs, a significantly earlier onset of drug use, and a higher frequency of drug use were shown among children in institutional care. The most common reasons for the first use of illicit drugs included curiosity (35.5%) and life crises and distress (8.1%); 48% of the children had used a drug without prior knowledge of its effects and 47% of the children could not name any health risks ensuing from drug use (Chrtová, 2012).

The qualitative part of the research study pointed out the fact that children from disadvantaged settings use drugs to compensate for problematic relationships with their parents, fit in with their peer group, and escape from reality involving problematic life situations (such as being placed in institutional care). In addition, it may provide them with a sense of happiness and overcoming depression and anxiety (Chrtová, 2012). The children themselves often stated that their relationship with their family is disturbed or problematic (16.7%), or even negative (2%).

### 2.4.2 Drug Use among the Prison Population

A survey of the use of addictive substances among offenders serving their prison sentences took place in 2010 (Mravčík et al. 2011b); see also the 2010 Annual Report. It is planned to be repeated in 2012.

### 2.4.3 Drug Use in the Nightlife Setting

The latest round of the Dance and Drugs survey took place in 2010; see also the 2010 Annual Report. No other studies concerned with the nightlife setting were undertaken.

## 3 Prevention

In the Czech Republic, the coordination of the primary prevention of risk behaviour among children and young people, including the primary prevention of substance use, is within the competence of the Czech Ministry of Education, Youth, and Sports (the Ministry of Education). The key documents concerning primary prevention were revised in 2011: the Standards of Professional Competency of Providers of School-based Primary Prevention and the Certification Rules were updated, a recommended structure and scope of the Minimum Prevention Programme were prepared, the good practices in prevention programmes were collected, and an explanatory dictionary of the key terms in the area of the prevention of risk behaviour was drawn up. The main idea behind the changes is a comprehensive approach on the part of the Ministry of Education to prevention, which should cover all forms of risk behaviour in the future.

The Minimum Prevention Programme is the fundamental strategy for the prevention of risk behaviour in schools; there are also an increasing number of long-term, proven programmes aimed at vulnerable groups and individuals in the area of selective and indicated prevention.

There are currently approximately 90 specialised providers of various types of specific drug prevention in the Czech Republic.

With few exceptions, prevention campaigns in the media focus on the issue of non-smoking and driving under the influence of alcohol and illicit drugs (e.g. the "Pay Attention – Or Pay the Price!" and "Designated Driver" campaigns). Prevention activities are also targeted at participants in summer music festivals so as to reach the group of young people most at risk.

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

In the Czech Republic, the coordination of the prevention of risk behaviour among children and young people, including the primary prevention of substance use, is within the competence of the Czech Ministry of Education, Youth, and Sports (the Ministry of Education). The main documents in this area are the Strategy for the Prevention of Risk Behaviour among Children and Young People in the Jurisdiction of the Ministry of Education in the Period 2009–2012, the methodological recommendations on the primary prevention of risk behaviour among children and young people, and the State Policy Concerning Children and Young People for the Period 2007–2013 (the "State Policy"). The preparation of the new Strategy for the Primary Prevention of Risk Behaviour for 2013–2018 was launched in 2011. Starting in May 2011, the State Policy and its Action Plan for 2010–2011 were also evaluated and work commenced on the new Action Plan for 2012–2013.

Further legislation prepared in 2011 included the draft of the amendment to the Act on education professionals and the amendment to the government decree aiming to reduce the amount of direct teaching by 10 hours per week so as to create appropriate conditions for the activities of the school prevention workers in schools (resulting in the reduction of the amount of direct teaching to the level applicable to educational/careers counsellors) and for the activities of prevention workers in pedagogical and psychological counselling centres; for the system of prevention coordinators and prevention workers in the Czech Republic see the 2010 Annual Report.

In addition, Decree No. 116/2011 Coll. amending Decree No. 72/2005 Coll. on the provision of counselling services in schools and school counselling facilities was amended. The objective of the amendment to the decree was to modify the terminology used in the existing legislation; the terminological shift from "social pathology" to "risk behaviour" represented a significant change.

The standards of primary prevention and the process for certifying primary prevention programmes are major quality management tools in the field of prevention. The process for the certification of the professional competency of the programmes for the primary prevention of substance use was suspended in early 2011. One of the reasons behind this was the restructuring of the organisations managed directly by the Ministry of Education, which also concerned the Czech Institute for Pedagogical and Psychological Counselling, which had carried out the certification in practice. The fact that the Ministry of Education considered the existing certification system to be too narrow and to cover only a very small part of the primary prevention programmes (substance use prevention), while the Ministry aimed to introduce a comprehensive approach to the prevention of all the forms of risk behaviour, was another reason. At the same time, the Ministry of Education worked on a new quality evaluation system (professional competency certification) for prevention programmes. The system should also cover other forms of risk behaviour (Ministerstvo školství, mládeže a tělovýchovy ČR, 2012a). For the time being, the validity of the professional competency certificates has been extended and an exemption concerning mandatory certification was granted to parties who applied for subsidies from the Ministry of Education in 2012 but were not holders of a certificate. A new system for the certification of programmes for the primary prevention of risk behaviour is expected to be launched in 2013.

The Methodics of the Ministry of Education, Youth, and Sports for the Provision of Subsidies from the State Budget for the Implementation of Activities in the Area of the Primary Prevention of Risk Behaviour in the Period 2013–2018

was prepared.[42] The period for which it will be possible to apply for a subsidy will be extended from one or two years to up to five years.

The Methodological Recommendations on the Primary Prevention of Risk Behaviour among Children and Young People, Ref. No. MŠMT-21291/2010-28, were published, withdrawn, and, with consideration being given to the comments from both the general and the professional public, reissued during 2011.[43] The document also includes a "What to do if..." manual for schools which includes highly detailed yet practical recommendations for headteachers and school prevention workers for handling certain risk behaviours in schools; see also the 2010 Annual Report.

The revision of the key documents concerning primary prevention continued in 2011 as part of the "Development of a System of Modular Training in the Prevention of Risk Behaviour for Educational and Counselling Professionals in Schools and Educational Institutions at the National Level" project[44] (hereinafter refered to as VYNSPI project), implemented by the Department of Addictology of the First Faculty of Medicine of Charles University in Prague and of the General University Hospital in Prague ("Department of Addictology")[45] and financed from the European Social Fund and the state budget. The VYNSPI project ran from 2009 to September 2012; see also the 2010 Annual Report.

The most important output of the project includes the Standards of Professional Competency of the Providers of Programmes of School-based Primary Prevention, Certification Rules and On-site Inspection Guidelines, and Certifier's Manual (Pavlas Martanová et al., 2012b; Pavlas Martanová, 2012a; Pavlas Martanová et al., 2012a; Pavlas Martanová, 2012b). These documents specify the conditions for the certification of primary prevention programmes in schools and provide the practical tools to be followed by the certifying agency while conducting on-site inspections in the facilities to be certified. In 2011–2012 the Standards underwent further revision and were modified so as to enable all primary prevention programmes associated with schools to be certified, regardless of the type of risk behaviour they relate to. The revision meets the needs for quality and unified terminology, while taking into consideration the funding policy of the Ministry of Education. The efforts resulted in four general Standards (governing the programme itself, the client's rights, the staffing practices in the facility, and the organisational aspects) and three special standards (which cover the programmes according to the type of prevention – universal, selective, and indicated). The most significant change is the addition to the Standards of a practical explanation which provides a more specific explanatory framework for the application of the Standards and for quality certification, including document templates.

Another policy-making document created under the VYNSPI project is the "Recommended Structure and Scope of the Minimum Prevention Programme for the School-based Prevention of Risk Behaviour" (Miovský et al. 2012c). It is a proposal for a comprehensive 90-hour prevention programme for basic schools, which includes a fixed number of hours dedicated to various types of risk behaviour and, additionally, a set of rules concerning the ways of ensuring a safe environment in schools.

In general, the Minimum Prevention Programme is to comprise three components: a set of rules applicable to the school setting and school events, programmes intended to promote the development of life skills, and programmes aimed specifically at addressing the individual forms of risk behaviour. Good rules for internal and external communication are the cornerstone of successful prevention; they are usually laid down by the school regulations but are also featured in certain safety or emergency plans of the school which deal with a certain risk phenomenon and its prevention in greater detail (Miovský et al. 2012c).

In 2011, work continued on the preparation of the four-level model of qualifications for the practitioners of the primary prevention of risk behaviour in the school system, which proposes the classification of qualification levels according to the verifiable knowledge, skills and competences acquired through study or practical experience (Charvát et al. 2012).

The project also resulted in the publishing of "Interdisciplinary School-based Primary Prevention: the Explanatory Dictionary of Basic Terms" (Miovský et al., 2012a), which goes beyond the school-based primary prevention of risk behaviour and represents the first publication in the Czech Republic to focus on the prevention terminology from an interdisciplinary and interdepartmental perspective.

In addition, "School-based Prevention of Risk Behaviour: Examples of Good Practice" (Širůčková et al. 2012), was also compiled in 2011, containing tested and proven primary prevention programmes at three different implementation levels in terms of the target group, i.e. universal, selective, and indicated prevention. They follow up

[42] Ref. No.: MSMT-18917/2012-27/2, http://www.msmt.cz/socialni-programy/dotacni-programy-a-certifikace (2012-09-03)
[43] http://www.msmt.cz/socialni-programy/metodicke-pokyny (2012-09-01)
[44] Full name of the project: "The Development of a System of Modular Training in the Prevention of Risk Behaviour for Educational and Counselling Professionals in Schools and Educational Institutions at the National Level, CZ.1.07/1.3.00/08.0205 ESF ECOP", http://www.adiktologie.cz/cz/articles/detail/220/1592/Tvorba-systemu-modularniho-vzdelavani-v-oblasti-prevence-socialne-patologickych-jevu-pro-pedagogicke-a-poradenske-pracovniky-skol-a-skolskych-zarizeni-na-celostatni-urovni (2012-08-22)
[45] The Department of Addictology was created through the merger of the "*U Apolináře*" Addiction Treatment Unit and of the Centre for Addictology of the Department of Psychiatry of the General University Hospital and the First Faculty of Medicine of Charles University in Prague in January 2012.

on the components of the VYNSPI project specified above, highlighting specific programmes implemented in specific schools and by specific organisations and people. The so-called "code list" of the school-based prevention programmes, i.e. a system for the classification and categorisation of the prevention programmes, was a by-product of the project. All the documents mentioned above build upon the ideas of the previous publication "Primary Prevention of Risk Behaviour in the School System", published in 2010 (Miovský et al. 2010).

Also launched within the framework of the VYNSPI project in 2011 was an analysis of the situation regarding the testing of pupils and students for substances in schools with a view to assisting schools in resolving situations involving suspected substance use by their students.

Education professionals in facilities providing institutional and court-ordered compulsory ("protective") education were also trained under the VYNSPI project in 2011. Modular in nature, the courses focused on enhancing the professional and personal competences of the practitioners, mainly in areas such as high-risk sexual behaviour, subcultures, mental trauma, group work, work with children with psychiatric problems and addictive behaviour, motivational interviewing, and the meeting of the educational and therapeutic objectives for the clients of the relevant facilities. Eleven accredited courses were held for a total of 139 education professionals between January and December 2011.

In addition, an Evaluation Centre was established at the Department of Addictology under the VYNSPI project,[46] which mediates information about the evaluation methodology, offers a list of evaluation tools for practical application, etc. A summary paper dedicated to the evaluation of preventive interventions in the Czech Republic in the past 20 years from the perspective of five specific studies ("Smoking and Me", "Drugs-Reason-Impact", the community-based programme of the *Prevcentrum* civic association, "Skills for Adolescence", and "Unplugged") was published in 2011,[47] forming the presumed foundation of good practices in the research on the effectiveness of the preventive interventions in the Czech Republic (Miovský et al. 2011).

### 3.2 Environmental Prevention

Whether physical, chemical, biological or social, cultural or economic in nature, environmental factors are significant determinants of health, including substance use and the occurrence of the associated problems or consequences. Favourable environmental factors thus have a preventive effect, and environmental prevention or environmental strategies are often referred to as the fourth pillar,[48] complementing universal, selective, and indicated prevention (Burkhart, 2011).

In terms of addictive substances, this mainly involves policies and interventions regarding tobacco and alcohol control, which can also include issues such as the pricing policy for tobacco and alcohol and measures regarding the advertising and marketing of such products and their availability, but also the effect and rules of the local communities.

Measures aimed at increasing the prices of alcohol and tobacco are considered to be an effective way of reducing the harmful use of alcohol and tobacco. Taxes represent an important tool in terms of the price policy.

Since 1993, alcoholic beverages (spirits, beer, wine, and intermediate products) and tobacco products (cigarettes, cigars and cigarillos,[49,] and smoking tobacco) have been subject to excise duty in the Czech Republic.[50] The rate of the excise duty has increased with time. Since the accession of the Czech Republic to the EU in 2004, the rate of the excise duty has increased seven times in connection with the harmonisation of the legislation. The most recent increase in the excise duty on tobacco products occurred in 2010. The excise duty on spirits and beer was most recently increased in the same year. The rates of the excise duty on spirits, beer, wine, and intermediate products and on tobacco remained unchanged in 2011.

[46] http://www.adiktologie.cz/cz/articles/detail/374/3197/Evaluacni-centrum (2012-08-22)
[47] http://www.muni.cz/research/publications/345648/, http://www.muni.cz/research/publications/708312/, http://www.prevcentrum.cz/Primarni-prevence, http://www.adiktologie.cz/cz/articles/detail/160/322/Evaluace-pilotni-faze-skolniho-preventivniho-programu-Pripraveni-pro-zivot-, http://www.adiktologie.cz/cz/articles/detail/70/2591/Unplugged-Program-primarni-prevence-pro-zaky-6-trid-zakladnich-skol (2012-09-01)
[48] The terms "primordial" or "pre-primary" prevention are also used, referring to a set of measures forming a preliminary step or foundation of primary, secondary, and tertiary prevention – see e.g. http://lekarske.slovniky.cz/pojem/prevence-primordialni (2012-08-08).
[49] I.e. short and slim cigars.
[50] The excise duty on the individual commodities is calculated by multiplying the quantity of the product (in hectolitres, units, kilograms, etc.) by the relevant rate of excise duty. For spirits, the calculation is based on the content of ethanol, in hectolitres, at the temperature of 20 °C. For beer, the arithmetical product mentioned above is additionally multiplied by the applicable percentage of concentration of the beer. A certain exception applies to cigarettes. The so-called two-part excise duty is applied in the calculation. It consists of a fixed and a variable component. The fixed (specific) component is set as a defined amount per quantity unit. The variable (ad valorem) component is based on the price for the end consumer. The final excise duty equals the sum of the two components. In other words, unlike in the case of the other selected products, the amount of the excise duty on cigarettes is derived not only from quantity but also from the specific price for which the product is sold to the end consumer.

As for alcohol, wine[51] is subject to a zero rate of excise duty; excise duty is imposed on spirits, beer, sparkling wine, and intermediate products containing ethanol. In 2011, the rate of the excise duty on spirits was CZK 28,500 (€ 1.159 thousand) per hectolitre; the basic rate of the excise duty on beer was CZK 32 (€ 1.3) per hectolitre, and the rate of the excise duty on sparkling wine and intermediate products was CZK 2,340 (€ 95) per hectolitre.

The excise duty on cigarettes was 28% of the end consumer price for the variable component and CZK 1.12 (€ 0.04) per cigarette for the fixed component in 2011. The minimum rate of excise duty was CZK 2.10 (€ 0.08) per cigarette. Cigars and cigarillos were subject to excise duty of CZK 1.25 (€ 0.05) on each individual unit, and the rate applied to tobacco was CZK 1,400 (€ 56.9) per kilo.

In addition to excise duty, value added tax applies to alcoholic beverages and tobacco products; the 2011 rate was 20%. The amount of excise duty is included in the base for the calculation of value added tax.

The Czech Republic is one of the countries with lower taxation of alcoholic beverages and tobacco in comparison with the average taxation in other EU Member States (which is, however, influenced by the extremely high tax rates in certain countries). Compared to the other countries which joined the EU in or after 2004, the Czech Republic is a country with a higher rate of taxation; the price of cigarettes is also higher in the Czech Republic than in most West European countries in relation to incomes.

The results of research conducted by a team from the University of Bath, which focused on the impact of tobacco producers on the policy in the area of tobacco control in the Czech Republic by analysing the internal documents of tobacco companies published in litigation that took place in the USA (511 documents dated between 1989 and May 2004 were analysed in detail), eight interviews with key informants conducted in the Czech Republic in November 2010, and other sources, were published in July 2012. Among other findings, the researchers concluded that "there is clear evidence of past and ongoing transnational tobacco companies' influence over tobacco advertising and excise policy" in the Czech Republic and the tobacco control policy in the Czech Republic was referred to as "particularly poor" (Shirane et al. 2012). Another study, which monitors the ranking of countries in the area of tobacco control using the so-called Tobacco Control Scale[52] (Joossens and Raw, 2006; Joossens and Raw, 2011), ranked the Czech Republic in an unflattering fourth-to-last spot in 2010, indicating a drop of the country in the rankings since 2004.

The sale of tobacco products and alcoholic beverages in the Czech Republic is subject to minimal controls and does not require a licence. The places where the sale of such products is permitted and banned are mainly defined by Act No. 379/2005 Coll. concerning the measures for protection from harm caused by tobacco products, alcohol and other addictive substances; in addition, Act No. 353/2003 Coll. on excise duty also partially regulates tobacco products and spirits. The places where the sale of alcohol is banned include, for example, health care facilities, all types of schools and educational facilities, sports events (except beer containing less than 10 per cent by weight of wort, i.e. ten-degree beer), and events intended for persons under the age of eighteen.

The possibility of imposing controls on sales in response to the current local situation only exists for alcohol. According to Section 13 of Act No. 379/2005 Coll., a municipality may independently and within its competence use a generally binding decree to restrict or prohibit the sale, serving, and consumption of alcoholic beverages at cultural, social, or sports events accessible to the public which involve a justified risk of an increase in the occurrence of problems and negative social phenomena caused by individuals under the influence of alcohol.

Tobacco products, smoking paraphernalia, electronic cigarettes, and all types of alcoholic beverages must not be sold to persons under the age of eighteen. The enforcement of this ban, which may be exercised by municipalities as a delegated competence, the Police of the Czech Republic, and municipal police forces, is not monitored statistically. However, the findings of school surveys (such as ESPAD and HBSC), which show a relatively high prevalence of cigarette and alcohol use among young Czech people, indicate a low level of observance of the ban.

The age limit of 18 also applies to persons selling alcoholic beverages, tobacco products, electronic cigarettes, and smoking paraphernalia unless the person sells the products as part of their professional training in the spheres of hotels and tourism, catering, and sales. As for the use of tobacco or alcohol itself, there is no legal limit.

Training or awareness-building events for the staff of hotels and restaurants concerning the legal obligations and specifics regarding the sale of alcoholic beverages are neither obligatory nor common in the Czech Republic.

The issue of restricting the availability of alcohol to young people under the age of 18 was also addressed in 2011 by the Project of the Protection of Children and Young People from the Misuse of Alcohol and Other Addictive Substances; for more details see the chapter Other Drug Policy Developments (p. 11).

[51] "Still wine", which is a legislative term generally referring to fermented wine which is not semi-sparkling or sparkling wine without the addition of spirit.

[52] The scale consists of items concerning the relative cost of cigarettes, the extent of the smoking ban in the workplace and in public spaces, the public expenditure on the prevention of smoking, the regulation of advertising, the size of the warning signs on tobacco products, and the size of the network of treatment and counselling programmes and the payment for preparations supporting abstinence from nicotine.

The control of tobacco and alcohol advertising and promotion is another instrument of environmental prevention. The control of advertising and sponsorship is harmonised[53] with the applicable EU regulations; for tobacco products the regulation is stricter than that applicable to alcohol advertising. The advertising of tobacco products is permitted by the legislation only in certain cases – e.g. at the points of their sale or in print media intended for tobacco trade professionals; the advertising ban applies to television and radio broadcasting, including on-demand audiovisual media services. Tobacco advertising must also be accompanied by a health risk warning, and meet certain additional conditions – it must not be aimed at persons under 18, in particular by depicting such persons or using elements, means, or events such persons usually find appealing, it must not involve enticement to smoking verbally or, for example, by showing scenes involving open cigarette packets, people smoking or holding cigarettes, cigarette packets or other tobacco products, or smoking paraphernalia. However, the restrictions do not extend to the advertising of electronic cigarettes, which is quite widespread. Nevertheless, even the advertising of this type of product is governed by the general advertising restrictions, which prohibit advertising that promotes behaviours harmful to human health.

On the other hand, the control of alcohol advertising more or less consists of only some restrictions in terms of the content (for example, the message must not promote intemperate alcohol consumption or judge abstinence or temperance negatively or sarcastically; it must not focus on underage persons and, in particular, depict these persons or persons who look younger than 18 years of age drinking alcoholic beverages; it must not use elements, means, or events which appeal to persons under the age of 18; it must not associate drinking alcohol with increased performance; it must not be used in connection with driving; etc.). Alcohol advertisements can be seen in the media, on vehicles, billboards etc.; what is also common is the sponsorship of sports and cultural events by alcohol producers (e.g. the top Czech football league is named after a beer brand, and Pilsner Urquell is a "proud partner" of the Czech Olympians[54], see Figure 3-1). As in other Member States of the EU, self-regulation activities by the industry are present in the Czech Republic – through the activities of the Council for Advertising. No changes in the legislation governing tobacco or alcohol advertising occurred in 2011.

*Figure 3-1: "The right values persist" – a Pilsner Urquell campaign during the 2012 London Summer Olympics*


Promoting a non-smoking environment and protection against exposure to tobacco smoke can be considered to be another preventive measure of an environmental nature. According to Section 8 of Act No. 379/2005 Coll., smoking is prohibited in the following places:

- in public places, which include enclosed spaces freely accessible to the public; the interiors of state and local authorities, facilities established by the state or local government units, financial institutions freely accessible to the public; public transport vehicles on roads or railways and urban public transport vehicles; freely accessible interiors of buildings related to public transport; covered platforms, shelters, and waiting halls in public transport on roads or railways and in urban public transport, (except structurally separated dedicated smoking areas, with the ventilation leading outside the building while persons are present in such areas);
- inside and outside all types of schools and educational facilities;

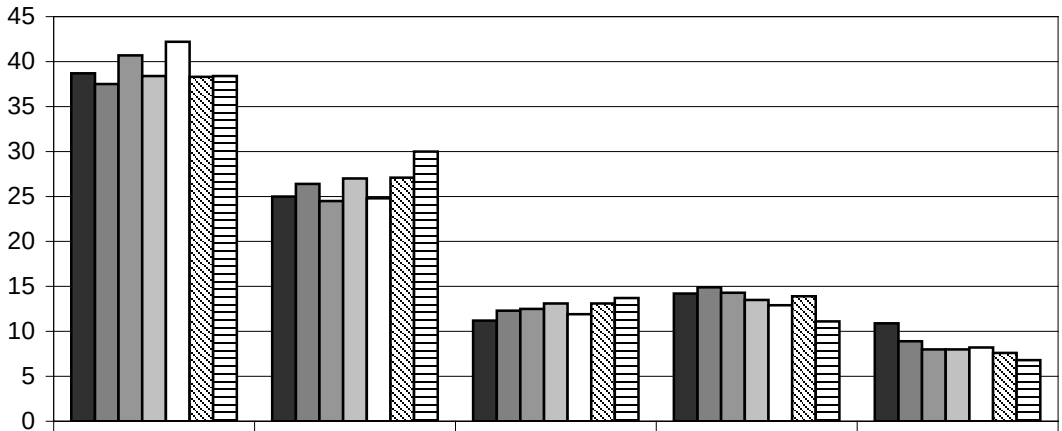
[53] As far as alcoholic beverages are concerned, European harmonisation only applies to audiovisual commercial messages, television advertising, and teleshopping.
[54] E.g. http://www.gambrinus.cz/, http://www.gambrinusliga.cz/, http://www.spravnehodnoty.cz/, http://www.atletika.cz/kratce/za-olympijsky-uspech-pivni-odmena/ (2012-08-08).

- in enclosed spaces intended for entertainment, such as cinemas, theatres, exhibition and concert halls, sports arenas, and in premises where business meetings are held, except special, structurally separated dedicated smoking areas, with sufficient ventilation as per the requirements of special laws and regulations;
- inside all types of health care facilities, except in enclosed psychiatric departments or in other addiction treatment facilities where smoking is only permitted in structurally separated dedicated smoking areas, with the ventilation leading outside the building while persons are present in such areas.

Since 1 July 2010, the operators of public establishments run under a catering licence (restaurants, cafés, bars, etc.) have had to decide whether smoking is permitted or prohibited in the entire establishment or whether to introduce structurally separated smoking and non-smoking areas, and they must inform the guests about the operating regime prior to the latter's entry into the establishment, using the relevant pictogram near the entrance; see, for example, Figure 3-2. Even though Act No. 379/2005 Coll. so far does not impose an absolute ban on smoking in restaurants, there is the possibility of running a completely smoke-free establishment and this type of place is becoming more and more common. However, statistical data about the actual number of the individual types of establishments are not available, nor is the information regarding the observance of the legal requirements and the inspection activities. Research conducted by the National Institute of Public Health showed that over 68% of Czech citizens agreed with the imposition of a general smoking ban in restaurants in 2011. In comparison with 2010, the percentage of advocates of a smoking ban has increased slightly, including among smokers (Sovinová et al. 2012); see Graph 3-1.

*Figure 3-2: A template of the sign designating an establishment with structurally separated smoking and non-smoking areas*


*Graph 3-1: Public opinion on a complete ban on smoking in restaurants, 2005–2011 (%), (Sovinová et al. 2012)*




| | Definitely agree | Rather agree | Do not know | Rather disagree | Definitely disagree |
|---|---|---|---|---|---|
| 2005 (N=1,612) | 38.7 | 25.0 | 11.2 | 14.2 | 10.9 |
| 2006 (N=1,788) | 37.5 | 26.4 | 12.3 | 14.9 | 8.9 |
| 2007 (N=1,606) | 40.7 | 24.5 | 12.5 | 14.3 | 8.0 |
| 2008 (N=1,790) | 38.4 | 27.0 | 13.1 | 13.5 | 8.0 |
| 2009 (N=1,795) | 42.2 | 24.8 | 11.9 | 12.9 | 8.2 |
| 2010 (N=1,788) | 38.3 | 27.1 | 13.1 | 13.9 | 7.6 |
| 2011 (N=1,797) | 38.4 | 30.0 | 13.7 | 11.1 | 6.8 |

Smoking in certain places may also be regulated at the local level: as part of its competence, a municipality may use a generally binding decree to temporarily or permanently prohibit smoking in publicly accessible children's playgrounds or publicly accessible sports facilities, inside buildings intended for holding sports, cultural, and social events, or at sports, cultural and social events provided that such places or events are intended for or reserved for persons under the age of eighteen.

Smoking in the workplace is a separate issue. The legal regulations do not prohibit smoking in the workplace. Act No. 379/2005 Coll. only specifies certain types of workplaces, such as schools, health care facilities, etc., and premises where business meetings are held, with the exception of structurally separated dedicated smoking areas with sufficient ventilation. In general, Act No. 262/2006 Coll. (the Labour Code) must be considered as it bans employees from smoking in workplaces and in other areas where non-smokers are exposed to the effects of smoking – see Section 106 (4) (e).

As for the use of other addictive substances in the workplace, employees are prohibited by Section 106 (4) (e) of the Labour Code from drinking alcoholic beverages and abusing other addictive substances in the employer's workplaces and, during their working hours, also outside such workplaces, and from entering the employer's workplaces under the influence of such substances.[55] Section 16 of Act No. 379/2005 Coll. also bans the use of alcohol and other addictive substances before or during the performance of activities which may result in death or injury or in damage to property. The employer may conduct screening tests for alcohol or other substances.

Reports occurred in June 2012 that drug tests are becoming more and more common in companies in the Czech Republic;[56] the report explicitly mentions three large employers, who were approached by the National Focal Point with a request for more detailed information. A reply was received from two of them. One of them generally commented that tests for alcohol and other addictive substances which are not permitted in the workplace were performed and that, if such substances are detected, the employee is dismissed; however, no drug tests are performed in the recruitment phase. The second employer generally tests the employees for alcohol and even though the tests performed in certain plants can detect drugs, the cases of positive tests only concerned alcohol.

The environmental prevention measures also include those that aim to prevent driving under the influence of alcohol and reduce the number of accidents caused under the influence of alcohol, in particular in road traffic. There is a zero limit for blood ethanol content while driving in the Czech Republic; for additional information on alcohol and other drugs in terms of traffic see also the chapters Drugs and Road Accidents (p. 97) and Media Campaigns, Conferences, and Other Activities with Media Response (p. 45).

As far as the specific impact of the school environment is concerned, the school's internal standards, in particular the school regulations and internal rules, are a factor complementing the school-based primary prevention activities because they should also include the procedures to address any current challenges related to the occurrence of risk behaviour in the school – including drug use.

For example, the Methodological Guidelines of the Ministry of Education, Youth, and Sports of the Czech Republic on the Prevention of Social Pathologies among Children and Young People, Ref. No. 14514/2000-51, currently no longer in force, stated that the headteacher or director of the school or education facility had to ensure that the internal regulations of the school or facility prohibited the bringing, possession, distribution, and use of addictive substances within the premises of the school or facility, including the sanctions arising from the violation of the ban.

The currently effective Methodological Recommendations on the Primary Prevention of Risk Behaviour among Children and Young People, Ref. No.: 21291/2010-28 (see above), include the obligation of the headteacher to provide in the school regulations and internal rules for the issue of risk behaviour (which, according to these methodological recommendations, encompasses the use of all addictive substances, dependence on virtual drugs, and gambling), including the controls and sanctions. The specific instructions for the incorporation of the issue of addictive substances in the school regulations are listed in Annex 1: Addictive Substance – Drugs. It states that the school must use the school regulations to explicitly ban the use, distribution, possession, and other forms of handling addictive substances in the school and entering the school under the influence of such substances, as well as the sanctions for violating the ban; the methodological recommendations call for a distinction to be drawn between the distributor and the user.

In 2011 the Sociology Department of the Philosophical Faculty of Charles University in Prague joined the international project "AAA Prevent – Alcohol Abuse among Adolescents in Europe".[57] The objective of the project is to compare the extent and patterns of the use of alcohol among European adolescents and, at the same time, to

[55] The prohibition of alcoholic beverages does not apply to employees working in adverse microclimatic conditions provided that they drink beer with a reduced alcohol content, or to employees for whom the drinking of such beverages represents a part of their job description or is usually associated with it.
[56] http://m.ihned.cz/c1-56277230-firmy-v-cesku-stale-casteji-testuji-zamestnance-na-drogy-kvuli-thc-hrozi-vyhazov (2012-08-28)
[57] Effective Environmental Strategies for the Prevention of Alcohol Abuse Among Adolescents in Europe, see http://ec.europa.eu/research/health/public-health/health-promotion-and-disease-prevention/projects/aaa-prevent_en.html, http://www.aaaprevent.eu/ (2012-07-20)

compare the effectiveness of the approaches applied by the individual countries to controlling alcohol abuse in terms of both prevention and repression strategies.

Finally, the environmental aspects must also include the activities pursued at the level of local communities, which take a comprehensive approach to creating healthy local living conditions and to promoting health. The long-term projects include the WHO programmes such as "Healthy Cities" or regions as part of the National Network of Healthy Cities, the Health-Promoting School programme, and the Health-Promoting Business programme.[58]

### 3.3 Universal Prevention

The Minimum Prevention Programme is the fundamental strategy for the prevention of risk behaviour in schools and educational institutions, drawn up by the school prevention worker in collaboration with the school management and other education professionals. The Minimum Prevention Programme is subject to checks by the Czech School Inspectorate. The implementation of the Minimum Prevention Programmes is supported by the Ministry of Education through subsidy arrangements on a yearly basis. Funding remains a problem in the practical implementation of the Minimum Prevention Programmes – the schools implement the programmes themselves and usually choose the cheapest option, which may be an ineffective programme.

The development of the "Unplugged" network of certified prevention programme trainers continued. The programme is aimed at preventing the use of addictive substances (alcohol, tobacco, and illicit drugs) by pupils in the 6th grade, i.e. children aged 12–14, and it was implemented in 70 Czech basic schools. The programme was evaluated as effective as far as smoking, frequent inebriation, the frequent use of cannabis, and the use of any drug were concerned (Miovský et al. 2012b; Gabrhelik et al. 2012b; Gabrhelik et al. 2012a). A total of 68 new persons, predominantly education professionals, were trained in 2011, bringing the total number of persons trained in the methodics to over 200. The Unplugged prevention programme is followed up by the Unplugged prevention methodics for parents, which was translated into Czech in 2011.

Implemented by the Department of Addictology, the international project named Family Empowerment: Improving Family Skills[59] continued in 2011 with a view to preventing alcohol use and drug-related problems. The objectives of the project are to identify the potential preventive effects of the family in reducing undesirable forms of addictive behaviour in children and adolescents and the involvement of entire families in prevention. The key component of the study was a questionnaire survey conducted among children aged 13–19 in the school class and their parents, focusing on the risk and protective factors in the family.

In 2011, the National Institute for Children and Youth (NIDM), falling under the Ministry of Education, implemented the "Keys for Life" project aimed at promoting and developing the informal and extra-curricular training of staff working with children in leisure centres, after-school centres, school clubs, and NGOs. The project seeks to promote the lifelong learning of professionals working with children and young people and, in particular, to improve the system supporting the permanent and sustainable development of extra-curricular and informal education. The primary prevention of risk behaviour is one of the topics covered by the Keys for Life project. The website of the National Youth Information Centre (NICM)[60] operated by the National Institute for Children and Youth includes a rather extensive information platform regarding the various aspects of risk behaviour.

*Prevcentrum, s.r.o.* developed an interactive board game named "The Journey Through the City Labyrinth", aimed at the primary prevention of risk behaviour. It is a methodological instrument which can be used by education professionals when working with children and adolescents aged 10–17 (from the 4th grade of basic school to the 2nd year of secondary school) or even with older classes.[61]

In the 2011 subsidy proceedings, the Government Council for Drug Policy Coordination supported a total of 11 projects providing prevention programmes: eight of them concerned universal prevention measures, six operated in the area of selective prevention, and eight in indicated prevention. Seven programmes offered both curricular and extracurricular programmes, while one programme involved only extracurricular activities. Two programmes offered training, and four also included information services and counselling. The universal prevention programmes involved blocks concerning primary prevention, interactive seminars, and feature sessions; the selective prevention programmes concerned primary prevention blocks, consultations, and situational interventions, and the indicated prevention programmes involved both individual and family consultations and situational interventions (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h).

In its subsidy proceedings held in 2011, the Ministry of Education supported a total of 113 projects, 68 of which were implemented by schools and educational institutions (one in a kindergarten, 35 in basic schools, 30 in secondary schools, and 2 projects that were carried out by children's homes with a school). Pedagogical and psychological counselling centres implemented 11 projects, and NGOs accounted for 27 projects. Seven projects focused on

[58] http://www.nszm.cz/, http://www.program-spz.cz/ (2012-09-03)
[59] European Family Empowerment: Improving Family Skills to Prevent Alcohol- and Drug-Related Problems (JLS/DPIP/2008-2/112)
[60] http://www.nicm.cz/oblasti/socialne-patologicke-jevy (2012-08-22)
[61] http://www.cesta-mestem.org/ (2012-09-04)

providing information (via magazines, conferences, or the internet). In total there were 37 local, 60 regional, 9 supraregional, and 7 national projects.

In its grant scheme "National Health Programme – Health Promotion Projects", the Ministry of Health supported three projects aimed specifically at the prevention of tobacco or alcohol use in 2011, as well as additional projects with a more general scope of promoting a healthy lifestyle.

The regions reported a total of 87 prevention programmes in 2011, most of which were reported from Prague (a total of 24, after modifications and code changes).[62] They were mainly specialised prevention centres or programmes provided predominantly by NGOs, which often also offer other types of drug services (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2012b). With a certain degree of simplification and uncertainty, these approximately 90 providers of primary prevention programmes can be considered a network of specialised providers of specific primary drug prevention in the Czech Republic.

### 3.4 Selective Prevention

The interventions falling within the area of selective prevention are aimed at the population groups with a higher danger of risk behaviour and substance use.

In August 2012, there were a total of 238 low-threshold facilities for children and young people; for details see the 2010 Annual Report. At the turn of 2011 and 2012, the second round of data collection for the research concerning low-threshold facilities for children and young people was carried out by the Czech Outreach Work Association[63] as part of a five-year longitudinal research study, which will lead to a comprehensive picture of the sector of low-threshold facilities for children and young people. The main purpose of the research is to map the low-threshold facilities with regard to the best practices in working with the clients, the factors affecting success/failure, and approaches to the client.

The Pedagogical and Psychological Counselling Centre in Brno runs a peer programme focusing on young people aged 12–18. The peer activists cooperate with the school prevention worker in their school, participate in organising talks with a guest speaker for their schoolmates, and influence these schoolmates informally through their attitude to drugs and through their healthy lifestyle. They also often assist their friends, as well as other peers around them (Skácelová & Macková in Širůčková et al., 2012).

Unlike in the previous years, no activity was pursued in 2011 in the area of recreational drug use. For nearly seven years, the "*Promile INFO*" text message and internet service,[64] run by the SANANIM civic association, has been in operation in the Czech Republic; for details see the 2010 Annual Report. This service is now also available as a mobile phone application.[65]

In December 2011, the Centre for Addictology, in cooperation with the Prague Primary Prevention Centre, the Ministry of Education, and the Association of School Sports Clubs of the Czech Republic, launched the "ProYouth" online prevention project[66] aimed at the prevention of eating disorders. The project focuses on the students of basic and secondary schools and universities aged 15–25 with a view to identifying and working with persons at risk of eating disorders. A total of seven European countries are participating in the project.

Implemented by the Pedagogical and Psychological Counselling Centre in the Prague 6 District, the "Multi-system model of group psychotherapy for children, a model of indicated and selective primary prevention – group counselling for schoolchildren (aged 6 to 15) showing problem behaviour and their parents" combines selective and indicated prevention. Children with attention and behavioural disorders and those with adaptation and relationship problems are the target group of the psychotherapeutic efforts of the programme (Pavlas Martanová in Širůčková et al., 2012).

The 2010 Annual Report provides several additional examples of projects and organisations operating in the area of selective prevention in the Czech Republic.

### 3.5 Indicated Prevention

The interventions in the area of indicated prevention focus on specific at-risk individuals who show signs of substance use but who do not meet the problem use and addiction criteria, and on their families and friends. Indicated prevention is carried out by institutions managed by the national, regional, or local authorities (including pedagogical and psychological counselling centres, child and family counselling centres, institutions for juvenile delinquents and children with behavioural disorders, rehabilitation institutions, and educational care centres) as well as non-governmental organisations (including low-threshold facilities for children and young people).

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[62] Central Bohemia was the only region not to report a single prevention programme, which, however, does not mean that there are no prevention programmes being implemented in the region of Central Bohemia. The region failed to follow the prescribed structure of the annual report.
[63] http://www.streetwork.cz/index.php?option=com_content&task=view&id=3791 (2012-08-22)
[64] http://promile.info/ (2012-08-22)
[65] https://play.google.com/store/apps/details?id=cz.motion.alcotest (2012-09-01)
[66] http://www.prevence-praha.cz/pro-youth (2012-07-18)

*Preventure* crosses the line between selective and indicated prevention (Conrod et al. 2008; Šucha, 2010b; Šucha, 2010a; Conrod et al. 2006). It is aimed at the prevention of drug use and other risk behaviours, with the target group being students of the 6th to 9th grades of basic schools, aged 11–16. *Preventure* is a comprehensive, systematic programme consisting of six school lessons and a total of four sessions, with the first intervention session being preceded by using the SURPS screening questionnaire, filled in by all the students, subject to the written consent of their legal representatives (Šucha, 2010a; Šucha, 2010b). The SURPS questionnaire measures four basic risk personality traits (negative thinking, impulsivity, sensation seeking, anxiety sensitivity), which, as research shows, are associated with a higher probability of risk behaviour, in particular substance use (Maierová in Širůčková et al., 2012).

Also bordering on selective prevention is the "Brave Hearts" interactive programme of the SCAN civic association. It is intended for children aged 10–15 with a long-term upbringing in children's homes. It is aimed at promoting a negative attitude to drug use (to prevent the phase of actively seeking drugs and reduce alcohol and tobacco consumption), promoting the ability to identify other forms of risk behaviour in oneself as well as in others, and promoting a healthy lifestyle and effective forms of communication with the surrounding world (Smutná, Zaplatilová & Hašan in Širůčková et al., 2012).

The "Care for Children and Adolescents" grant scheme of the Ministry of Health supported a project concerning the upgrading of the Drug Prevention Manual for Paediatricians and regional training courses concerning screening and brief interventions in 2011. The project aims to revise and complement the Manual and prepare the training of paediatricians in this area.

### 3.6 Media Campaigns, Conferences, and Other Activities with Media Response

A regional conference dealing with the role of the school in the primary prevention of risk behaviour, organised by the Centre for Addictology in cooperation with the Psychology Department of the Philosophical Faculty of Palacky University in Olomouc, the Institute for Psychological and Pedagogical Counselling, and the Pedagogical and Psychological Counselling Centre of the Olomouc Region, took place in Olomouc in January 2011. Its objective was to provide current information and introduce proven practical procedures and good practices in the area of the primary prevention of risk behaviour to prevention practitioners (Centrum adiktologie, 2011).

The "2011 Sexuality and Drugs Conference" was organised by the SANANIM civic association in late March and early April 2011.[67] The topics presented at the conference included the sexuality of marijuana users, drug use among sex offenders, promiscuity among substance users, high-risk sexual behaviour on the part of young people in institutional care, homosexuality in relation to drug use, the sex and sexuality of the clients in a therapeutic community, and drug use among sex workers (Preslová and Hanková, 2011).

The 50th anniversary national addictology conference, co-organised by the AT Section of the Psychiatric Association and the Society for Addictive Diseases of the J. E. Purkyně Czech Medical Association, was held in April 2011. It featured the topic of addiction and public health[68]

The eighth annual conference on the primary prevention of risk behaviour, entitled "The Minimum Prevention Programme in the Context of School-based Prevention: Can We Really Create an Interdisciplinary and Interdepartmental Prevention Model in Czech Schools?" took place in November 2011[69] and dealt with interdisciplinary cooperation in the implementation of the Minimum Prevention Programme in schools.

A one-day regional conference, "New Drugs – Prevention, Treatment, and Control", took place in December 2011[70] with the objective of summarising the occurrence of synthetic drugs in the Czech Republic with regard to the relevant legislation, demand reduction, and harm reduction. The awards for exceptional contributions to addictology were announced at the conference, which was organised by the Centre for Addictology.

The first year of the national competition "SAPERE – Know How to Live" took place in 2011,[71] focusing on children's theoretical and practical knowledge regarding healthy lifestyles, including healthy nutrition. Nearly 19 thousand pupils and students of 419 basic and secondary schools entered the competition through learning programmes, shows for schools, residential events, and occasional activities for the public.

The Czech Coalition Against Tobacco[72] organises an annual campaign on 31 May – the World No Tobacco Day. An event entitled "Swap the Pack" was organised on this year's (2012) World No Tobacco Day to support quitting smoking: smokers could exchange packets of cigarettes for non-smoking boxes prepared specially for this event by children from basic schools in Prague.

[67] http://www.sananim.cz/projekty/odborne-konference.html (2012-07-18)
[68] http://www.at-konference.cz/archiv/rocnik-2011/ (2012-07-18)
[69] http://www.pprch.cz (2012-07-18)
[70] http://www.adiktologie.cz/cz/articles/detail/172/3251/Regionalni-konference-Nove-drogy-prevence-lecba-regulace-6-12-2011-1-LF-UK (2012-07-18)
[71] http://www.saperesoutez.cz/o-celoevropskem-projektu-sapere.htm (2012-08-22)
[72] http://www.dokurte.cz/?stranka=aktuality&typ=clanky&vypsat=2118 (2012-08-22)

The Czech Coalition Against Tobacco is also behind the now-completed campaign of the European Commission "Help – For a life without tobacco" (2005–2010), which focused on the prevention of smoking, quitting smoking, and passive smoking. It was mainly targeted at young people aged 15–25. This campaign is now being followed by the "Ex-smokers are unstoppable" project of the European Commission, aimed at motivating smokers to quit. The iCoach,[73] which should help smokers quit, has been launched for this purpose. Available free of charge in the 23 official languages of the EU, the iCoach is a digital health coaching platform. Unlike other digital health care instruments, the iCoach also focuses on those who do not wish to quit and on people with a high risk of relapse.

In 2011, BESIP, the Czech Government Council for Road Safety (an organisation within the Ministry of Transport), launched a roadshow named "It's Up to You",[74] intended to familiarise young drivers with the risks associated with driving under the influence of addictive substances. The project takes the form of BESIP stalls at music festivals, where participants can get information materials, as well as disposable alcohol testers for drivers. The campaign's slogan "Want to see the next fest live?" is meant to alert drivers to the fact that they may not live to the next festival if they drive under the influence of alcohol or drugs. Another ongoing project of the Czech Government Council for Road Safety that continued to be implemented in 2011 was the "Designated Driver" campaign,[75] aimed at preventing road accidents resulting from alcohol and drug use while returning from parties and similar events. As part of the project, what is already the seventh year of the prevention multimedia show "The Action" took place in 2011, focusing on young and novice drivers and alerting them to the tragic consequences of accidents caused by drivers driving under the influence of addictive substances.

The "I'm Driving – I Drink Non-Alcoholic Beer" project[76] was launched in 2011 by the Police of the Czech Republic in cooperation with the Czech Beer and Malt Association (the Responsible Brewery Initiative) to promote alcohol-free beer as a safe option for drivers. A driver who is stopped for a routine roadside check and has not committed any traffic offence receives a can of non-alcoholic beer as a reward. The project also continues in 2012 during the summer months. During this year, the project also includes the provision of information at beer and music festivals, also featuring the "Drunk Glasses" campaign as a novelty. The visitors of the project's festival tents can try on special glasses that induce the feeling of inebriation.

While in the previous years some of the social marketing campaigns (such as "Stay in the Game", aimed at non-alcoholic beer in 2010, and "Pay Attention – Or Pay the Price", aimed at road safety in 2009) received an award in the EFFIE competition for the most effective advertising,[77] which is organised by the Association of Communication Agencies, no campaign aimed at legal or illicit drugs received an award in the competition in 2011. On the contrary, the awards for the most effective advertising in 2011 (in terms of the effect of the campaign in relation to its cost) went only to advertisements promoting alcoholic beverages (Amundsen Vodka and Fernet Z).

The national "Say NO! to Drugs" campaign, aimed at schoolchildren and young people aged 10–19 and their parents and teachers, continued in 2011. The project includes a media campaign which presents videos dealing with smoking, alcohol, drugs, and gambling; for details see the 2010 Annual Report.

Since 2003, the Say No to Drugs – Say Yes to Life civic association[78] has organised the annual "Cycle Run for the Czech Republic Without Drugs". The Cycle Run (an anti-drug campaign associated with sports) is always held in June (a 10th annual event was held in 2012) to warn against drug use and lack of information in the area of prevention; it symbolically ends before the International Day Against Drug Abuse and Illicit Trafficking (26 June). The project was previously criticised by the professional public (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2004); see also, for example, the 2004 and 2007 Annual Reports), to which the organisers responded by publishing their opinion.[79]

A substance use prevention campaign was prepared to be launched within the "3D – A Healthy and Safe Citizen: Improving Drug Literacy among Czech Citizens" project in 2012. The campaign sought to change the tolerant attitude of the general population to the use of alcohol and cannabis. The project was prepared by the Ministry of Education in cooperation with the Government Council for Drug Policy Coordination; the costs, amounting to CZK 150 million (€ 6.1 million), were to be covered by the EU Education for Competitiveness programme. The cost of the campaign was estimated at CZK 60 million (€ 2.4 million), while the amount that was expected to be spent on the education of young people and drug users was CZK 80 million (€ 3.2 nillion). The project should address up to 6 million people (approximately 60% of the population of the Czech Republic), using a massive campaign aimed at reducing the negative impact of the use of alcohol and illicit drugs (Ministerstvo školství, mládeže a tělovýchovy ČR, 2012b). However, the launch of the project, originally scheduled for April 2012, has been suspended.

[73] http://www.stopsmokingcoach.eu/home.ashx?lang=cs#registertab-tab (2012-08-22)
[74] http://www.jetonatobe.cz/hlavni-stranka.html (2012-07-20)
[75] http://www.ibesip.cz/, http://www.domluvme-se.cz (2012-07-20)
[76] http://www.ridimpijunealkopivo.cz/ (2012-07-20)
[77] http://www.effie.cz/cz/results/ (2012-07-20)
[78] http://www.rekninedrogam.cz/o_nas.html (2012-07-20)
[79] http://www.scientologie.cz/tisk/index.php?display=article&ID=95&back=category&search=&searchBy=&cat=6&pg=10&version=CZ&PHPSESSID=3k06u6a4ashd7t30fujecspo50 (2012-09-07)

With few exceptions, the financial costs of the individual preventive campaigns are not published in the Czech Republic.

The “Iron Addictologist” amateur triathlon race, organised by the PREVENT civic association, took place in České Budějovice in August 2012 under the auspices of the Mayor and Deputy Mayor of the city. It was a “national sports and social event held to increase the awareness of addiction services and addictions”.[80]

*Figure 3-3: The Iron Addictologist triathlon race, České Budějovice, 25 August 2012, before the swimming portion (© Občanské sdružení Prevent)*

[80] http://www.os-prevent.cz/, http://www.zelezny-adiktolog.cz/ (2012-08-08)

# 4 Problem Drug Use

The EMCDDA defines problem drug use as injecting drug use and/or the long-term/regular use of opioids and/or amphetamine-type drugs and/or cocaine (European Monitoring Centre for Drugs and Drug Addiction, 2009). In the Czech Republic, cocaine users have not been included in the estimates of problem drug users as their number in the data sources used for estimates (particularly those from helping services) is still at a very low level in the country.

Of the group of amphetamines, pervitin (methamphetamine) is the one that prevails in the Czech Republic almost exclusively. The opioids included in the estimates of problem drug use in the Czech Republic are mainly heroin and diverted buprenorphine. Besides this, to a lesser extent, problem drug use includes the use of raw opium and, increasingly, the abuse of painkillers containing opiates/opioids, such as fentanyl or morphine. For the first time in more than 20 years, the National Drug Squad uncovered illegal laboratories producing "braun", i.e. a home-made solution of codeine and morphine derivatives made from medicines containing codeine.

In 2011, the number of problem drug users estimated from the number of clients of low-threshold programmes increased slightly again – the mean value reached 40,200. The growth mainly involved methamphetamine users (30,900), while the number of opiate users decreased further (to 9,300). The estimated number of injecting drug users also increased (to approximately 38,600). However, these trends must be interpreted with caution, as they have been based on the same multiplier (the proportion of drug users in contact with low-threshold programmes) since 2009; however, the overall picture in the form of an increase in the number of methamphetamine users and a decrease in that of opiate users is probably a reflection of reality. The regions with the greatest numbers of problem drug users, as well as the greatest numbers of opiate users, traditionally include Prague and Ústí nad Labem. Injecting buprenorphine (especially Subutex®) is particularly widespread in Prague and in other regions of Bohemia. The combined use of methamphetamine and opiates is also common.

A prevalence estimate of problem drug use using the capture-recapture method for 2006 and 2007 has been published with the use of treatment data sources. The estimates are statistically comparable with those obtained using the multiplication method from the data provided by low-threshold facilities.

Furthermore, the number of problem drug users in Prague in 2011 was estimated using the capture-recapture method applied to data about the overlaps of clients between the low-threshold programmes, which reached 8,000 to 10,000 people. The data show, inter alia, that the number of clients in contact with low-threshold programmes in Prague is, as a result of overlaps between programmes, approximately 40% lower than the sum of the clients reported by the individual programmes.

## 4.1 Prevalence and Incidence Estimates of Problem Drug Use

As in previous years, the multiplication method was used to estimate the number of problem drug users in 2011 from the data on clients in low-threshold programmes in the Czech Republic. In addition, there is a nationwide estimate using the capture-recapture method and an estimate of problem drug users in Prague in 2011 obtained using the same method.

### 4.1.1 Estimate of Problem Drug Use Using the Multiplication Method

Estimation using the multiplication method arises as the product of the size of the known population of problem drug users (in this case the number of problem drug users in contact with low-threshold programmes in a calendar year) and the value of the multiplier[81]. The value of the multiplier for the Czech Republic and for each region was found using the peer nomination technique in the Multiplier 2010 survey, conducted among the clients of low-threshold facilities; for more details see the 2009 Annual Report.

The trends in the estimated numbers of problem drug users are influenced by both input data entries: there is a positive correlation with regard to the number of low-threshold service clients, while the multiplier value impacts on the estimates in a negative correlation (the higher the number of persons in contact, the lower the overall estimated number of problem drug users). Given that in recent years there has been increasing pressure on the economic efficiency of programmes and the number of clients is one of the indicators monitored in the funding of these services, one can assume a systematic increase in the number of reported clients as a result of more thorough records and more intensive outreach work. At the same time, the same multiplier established in 2010 is used in the estimates for 2009, 2010, and 2011 and may not accurately reflect the actual proportion of problem drug users in contact. Both factors probably cause an overestimation in the estimates.

[81] The sources of data on the number of problem drug users in contact are the annual final reports of projects funded as part of the GCDPC subsidy proceedings and in 2009–2011 also an additional survey of the programmes that were not supported in the grant scheme, and therefore did not submit a final report. The multiplier essentially expresses the proportion of problem users in contact with low-threshold programmes out of all problem drug users. The rest is the hidden population of problem drug users. In 2010, the value of the multiplier established using the peer nomination technique (see the 2009 Annual Report) for the whole country, without Prague, expressed as a percentage, was 67% (95% CI 63–70%) and declined by one percentage point compared to the value for 2008. The value of the multiplier for Prague, however, is four percentage points higher and is 80% (95% CI: 70–91%). The estimate of the number of problem drug users in the Czech Republic is the sum of the estimates for individual regions.

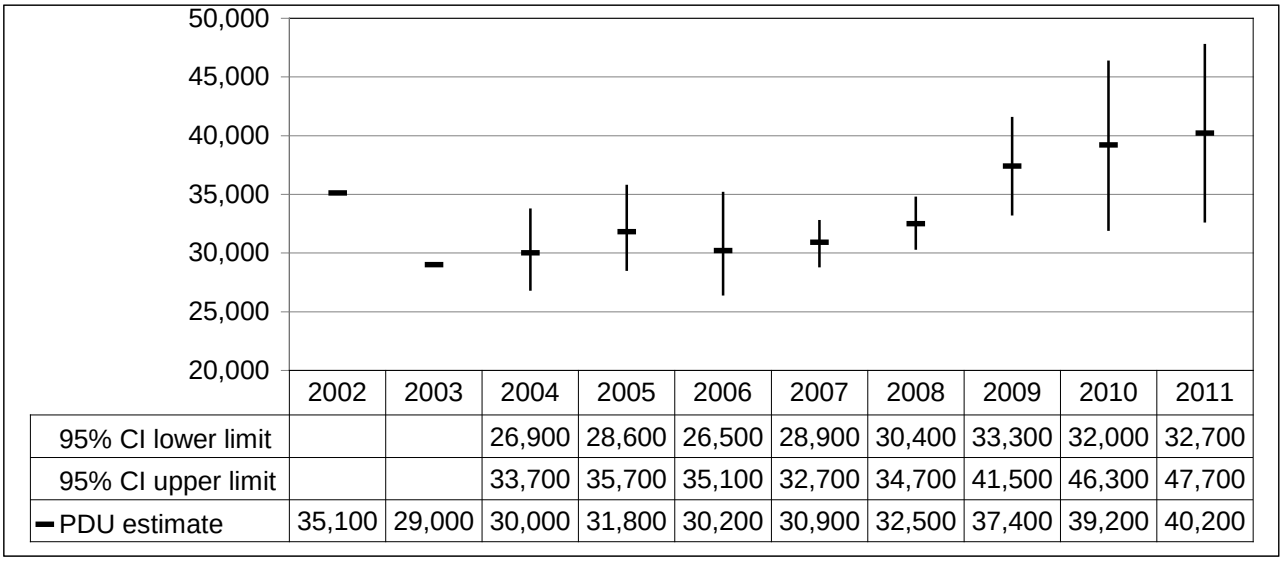
In 2011, the number of problem drug users in the Czech Republic was estimated at approximately 40,200 (95% CI[82]: 32,700–47,700), of whom 30,900 (29,900–31,900) were pervitin users, 4,700 (4,350–6,000) were heroin users, and 4,600 (4,300–4,850) were users of buprenorphine (primarily Subutex®). Therefore, the numbers of opiate users were estimated at 9,300 (8,800–9,750) in total. The number of injecting drug users (IDUs) was estimated at 38,600 (37,300–39,900).

Trends in 2002–2011 are shown in Table 4-1 and Graph 4-1. There was a slight (statistically insignificant) increase in the total number of problem drug users in 2011. Statistically significant changes can be observed, however, in the individual drugs – there was a further substantial annual decline in opiates/opioids and a further increase in pervitin. Over a period of four years, the mean estimated number of methamphetamine users thus increased by about a third and the overall increase in problem drug use in the same period is also statistically significant.

*Table 4-1: Mean values of prevalence estimates of problem drug use obtained using the multiplication method with the use of data from low-threshold programmes, 2002–2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012a)*

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

*Graph 4–1: Mean values and 95% confidence intervals of prevalence estimates of problem drug use obtained using the multiplication method with the use of data from low-threshold programmes, 2002–2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012a)*




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

Prevalence estimates of problem drug use by region are shown in Table 4-2 and Map 4-1, and trends in Table 4-3. The highest relative number of problem drug users was traditionally estimated in Prague and the Ústí nad Labem region, i.e. in the areas that concurrently have high numbers of problem opiate users (which is also evident in the

[82] The 95% confidence interval delimits the interval in which the value occurs with a 95% probability.

South Moravia region). The Olomouc region also shows an extraordinarily high prevalence of problem drug users in the population.

Independently of these estimates for 2011, a regional estimate of problem drug users in South Bohemia is also available, which came into being thanks to a "significant expansion of outreach programmes" in the South Bohemia region, providing "new insights into (injecting) methamphetamine use in smaller, more remote areas of the region" (Jihočeský kraj, 2012). The number of problem drug users in the South Bohemia region is estimated at approximately 1,900 people, including 1,700 injecting drug users, a number that is higher than that estimated by the multiplication method at the national level.

An estimate of problem drug users in Prague was also made for 2011 using the capture-recapture method; for more details see the chapter Estimate of Problem Drug Use in Prague Using the CRM Method (p. 52). The data used show that the number of individual clients in contact with low-threshold programmes in Prague is, because of overlaps between programmes, approximately 40% lower than the simple sum of the clients reported by the individual programmes. An estimate for Prague therefore requires an adjustment; however, as the trends are maintained, the results obtained by means of a comparable procedure are presented.

*Table 4-2: Prevalence estimates of problem drug users in the Czech Republic by region, 2011 – mean values (Národní monitorovací středisko pro drogy a drogové závislosti, 2012a; Národní monitorovací středisko pro drogy a drogové závislosti, 2011a)*

| Region | Number of problem drug users in total | Number of opiate users | | | Number of pervitin users | Number of IDUs |
|---|---|---|---|---|---|---|
| | | Heroin | Subutex® | Total | | |
| Prague | 10,900 | 2,200 | 3,300 | 5,500 | 5,400 | 10,900 |
| Central Bohemia | 2,100 | 200 | 500 | 700 | 1,450 | 2,150 |
| South Bohemia | 1,300 | 50 | 150 | 150 | 1,150 | 1,300 |
| Pilsen | 1,900 | 350 | 50 | 400 | 1,500 | 1,850 |
| Karlovy Vary | 1,200 | 50 | 0 | 50 | 1,150 | 1,200 |
| Ústí nad Labem | 6,200 | 500 | 450 | 1,000 | 5,200 | 6,200 |
| Liberec | 2,800 | < 50 | < 50 | < 50 | 2,750 | 2,700 |
| Hradec Králové | 1,100 | 50 | 50 | 100 | 950 | 1,050 |
| Pardubice | 400 | < 50 | < 50 | 50 | 400 | 400 |
| Vysočina | 600 | 50 | 50 | 50 | 550 | 550 |
| South Moravia | 4,000 | 1,100 | < 50 | 1,100 | 2,900 | 3,700 |
| Olomouc | 3,200 | 50 | 0 | 50 | 3,150 | 2,700 |
| Zlín | 2,500 | < 50 | < 50 | < 50 | 2,500 | 2,150 |
| Moravia-Silesia | 2,000 | 150 | < 50 | 150 | 1,850 | 1,750 |
| **Total** | **40,200** | **4,700** | **4,600** | **9,300** | **30,900** | **38,600** |

*Map 4-1: Number of problem drug users per 1,000 inhabitants aged 15–64 in the Czech Republic by drug and region, 2011 – mean values (Národní monitorovací středisko pro drogy a drogové závislosti, 2012a)*

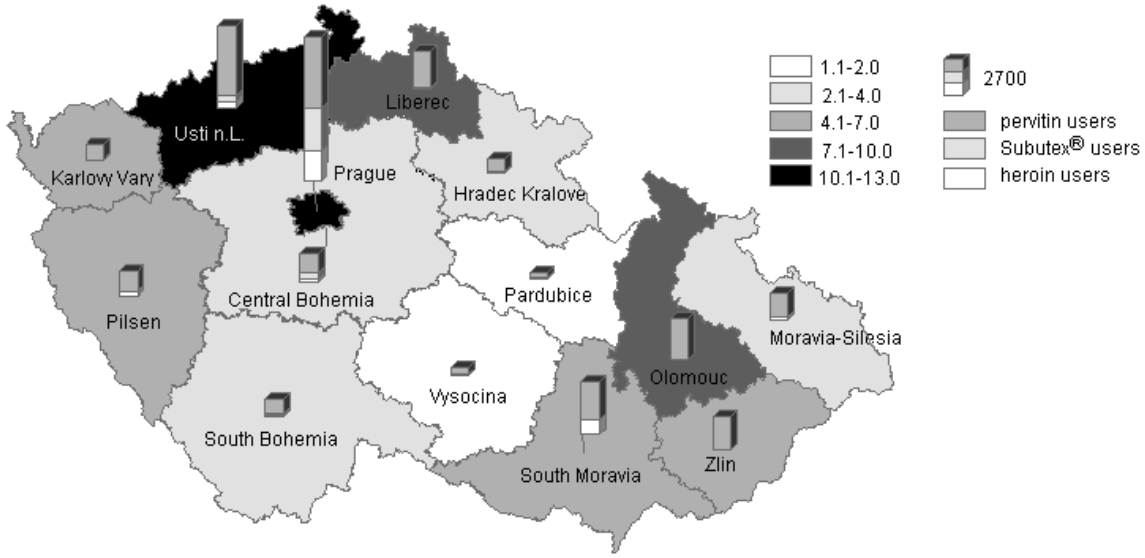


*Table 4-3: Prevalence estimates of problem drug users in the Czech Republic by region, 2005–2011 – mean values (Národní monitorovací středisko pro drogy a drogové závislosti, 2012a; Mravčík et al. 2011d; Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

| Region | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|
| Prague | 9,800 | 8,400 | 10,000 | 11,500 | 10,400 | 11,350 | 10,900 |
| Central Bohemia | 2,500 | 2,450 | 1,700 | 1,750 | 2,400 | 2,150 | 2,100 |
| South Bohemia | 1,700 | 1,750 | 1,500 | 1,550 | 1,500 | 1,400 | 1,300 |
| Pilsen | 1,450 | 1,350 | 1,300 | 1,650 | 2,400 | 2,000 | 1,900 |
| Karlovy Vary | 1,450 | 1,250 | 900 | 1,000 | 1,200 | 900 | 1,200 |
| Ústí nad Labem | 4,450 | 4,450 | 4,100 | 4,150 | 5,300 | 4,900 | 6,200 |
| Liberec | 750 | 500 | 500 | 1,500 | 1,300 | 2,650 | 2,800 |
| Hradec Králové | 1,150 | 1,050 | 1,750 | 1,100 | 1,000 | 950 | 1,100 |
| Pardubice | 600 | 350 | 450 | 450 | 500 | 400 | 400 |
| Vysočina | 600 | 350 | 700 | 500 | 600 | 600 | 600 |
| South Moravia | 2,800 | 3,150 | 3,400 | 3,250 | 3,400 | 3,900 | 4,000 |
| Olomouc | 1,900 | 2,350 | 1,650 | 1,600 | 3,000 | 3,300 | 3,200 |
| Zlín | 1,150 | 1,300 | 1,850 | 1,350 | 2,400 | 2,350 | 2,500 |
| Moravia-Silesia | 1,500 | 1,450 | 1,100 | 1,150 | 2,000 | 2,350 | 2,000 |
| **Total** | **31,800** | **30,200** | **30,900** | **32,500** | **37,400** | **39,200** | **40,200** |

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

The capture-recapture method (CRM) makes it possible to use the information about the extent to which the databases of registered drug users overlap for statistical modelling to derive the size of the hidden population, and hence the size of the entire population of drug users. One condition for the application of CRM is that individual cases need to be identified so that it is possible to verify their presence in each source.

An estimate was made of the number of problem drug users in the Czech Republic (and especially in Prague) for 2006 and 2007, for which the following data sources were used[83]:

- the General Health Insurance Company (VZP) database on reimbursements to outpatient and inpatient psychiatric care facilities for services provided to patients with the F11–F19 primary diagnoses,
- data from the National Register of Hospitalisations (NRHOSP), maintained by the Czech Institute of Health Information and Statistics (IHIS), on the patients with the F11–F19 primary diagnoses discharged from and deceased in inpatient healthcare facilities,
- data from the National Register of Users of Medically Indicated Substitution Substances (NRULISL), also maintained by the Czech Institute of Health Information and Statistics on patients in opioid substitution treatment,
- data from the official register of infectious diseases (EPIDAT), maintained by the National Institute of Public Health, on cases of viral hepatitis reported among injecting drug users.

The VZP, NRHOSP, and EPIDAT registers were used to estimate the total number of problem drug users, whereas the number of problem opioid users was estimated separately using the VZP, NRHOSP, and NRULISL registers. The identification code consisted of the personal identification number, used as a standard by all the data sources employed, which was unidirectionally encrypted at the level of each database administrator[84]. A log-linear analysis was applied for statistical analysis using the Rcapture package of the R statistical software.

What constitutes a methodological problem is the interdependence of the data sources, since all of them collect information about the provision or reimbursements of health care and it is very likely that if a person is captured by one source, he or she will also appear in the other sources. Log-linear analysis makes it possible to take the interaction between sources into account when selecting the most likely model. When the total number of problem drug users was being estimated, the most probable model in which there is a positive interaction between sources was selected as the most likely model (if a problem drug user is found in the EPIDAT register of infectious diseases or the National Register of Hospitalisations, they will probably also be in the database of the General Health Insurance Company). To estimate the number of opiate users a model was selected in which the NRULISL substitution treatment register is independent of the NRHOSP and VZP databases – NRULISL is the most autonomous among all three sources. Both solutions thus approximate real-life assumptions.

An estimate of the total number of problem drug users and problem opiate users in the Czech Republic in 2006 and 2007 is provided in Table 4-4 and Table 4-5.

[83] Persons with the diagnoses F11, F15, and F19 in the VZP and NRHOSP databases were considered to constitute cases meeting the definition of problem drug users. NRULISL, by definition, registers problem opioid users. EPIDAT records information about injecting drug use, not about the drug used.

[84] This was done using the EPICRYPT software developed by the National Focal Point and approved by the Office for Personal Data Protection. Recovery of the identification number from the resulting cipher is virtually impossible.

*Table 4-4: Estimated number of problem drug users in the Czech Republic using the CRM method, 2006 and 2007 (data sources used: VZP, NRHOSP, EPIDAT)*

| Year | Estimated problem drug users | | |
|---|---|---|---|
| | Mean value | 95% confidence interval lower limit | 95% confidence interval upper limit |
| 2006 | 23,885 | 20,662 | 28,533 |
| 2007 | 30,982 | 25,464 | 39,414 |

*Table 4-5: Estimated number of problem opioid users in the Czech Republic using the CRM method, 2006 and 2007 (data sources used: VZP, NRHOSP, NRULISL)*

| Year | Estimated problem opioid users | | |
|---|---|---|---|
| | Mean value | 95% confidence interval lower limit | 95% confidence interval upper limit |
| 2006 | 6,864 | 6,641 | 7,113 |
| 2007 | 7,096 | 6,871 | 7,346 |

The number of problem drug users in 2006 and 2007 estimated using the CRM method gave results comparable with the above-mentioned estimates made using the multiplication method.

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

Six low-threshold programmes in Prague[85] provided the National Monitoring Centre with the anonymous identification codes[86] of their clients in 2011 in order for the number of problem drug users to be estimated using the CRM method. Two models were applied for statistical analysis:

- Truncated Poisson for a closed population, a model which only takes into account the frequencies of occurrence of the same case (code) in one or more sources, regardless of the type of sources, i.e. all data sources are considered mutually independent in the analysis. Results obtained using the Truncated Poisson model should therefore be considered only as a guide.
- A log-linear analysis of the capture-recapture method (CRM) taking into account the extent to which the individual sources overlap with each other. This model makes it possible to take relationships between sources into account and select the most likely option.

In addition, it was necessary to make an adjustment with a view to the fact that there are clients who were not assigned a code (so-called 'no-codes') and who contribute significantly to the number of contacts made in the Prague-based low-threshold programmes. The programmes were asked to share their expert estimate or monitoring results, where available.

All six programmes reported a total of 6,786 clients with a code assigned to them. In total, 3,990 unique codes were identified by comparing the lists provided by each programme, of which 2,722 (68.2%) were reported only by one programme and 1,268 (31.8%) by two or more programmes. 28 persons (or codes) were in contact with all six programmes at the same time; see Table 4-6.

*Table 4-6: Distribution of codes by the number of programmes in which they are registered (Národní monitorovací středisko pro drogy a drogové závislosti, 2012b)*

| Number of programmes | Number of codes |
|---|---|
| 1 | 2,722 |
| 2 | 476 |
| 3 | 290 |
| 4 | 296 |
| 5 | 178 |
| 6 | 28 |
| **Total** | **3,990** |

The total number of problem drug users estimated using these statistical methods is provided in Table 4-7. These are estimates before adjustment for incomplete coding.

[85]These included three drop-in centres and three outreach programmes run by the SANANIM civic association, the Drop-In public service company, and the Progressive civic association, each organisation providing one drop-in centre and one outreach programme.
[86]These are called harm reduction codes, with the following structure: the first three letters of the mother's first name, the first two digits of the client's date of birth, the first three letters of the client's first name, and the first two digits of the client's month of birth. Other data, such as gender, year of birth, and the drug used or route of its administration were not available. However, one can assume that these are mainly injecting drug users.

*Table 4-7: Estimated number of problem drug users in Prague based on overlaps between harm reduction programmes, 2011 – results before the final adjustment for no-codes (Národní monitorovací středisko pro drogy a drogové závislosti, 2012b)*

| Method | Estimated number of problem drug users | | |
|---|---|---|---|
| | Mean value | 95% confidence interval lower limit | 95% confidence interval upper limit |
| Truncated Poisson | 5,157 | 5,053 | 5,268 |
| Log-linear CRM | 6,469 | 6,358 | 6,580 |

The log-linear analysis adopted a model which considers the sources to be mutually independent and assumes that the majority of clients are in contact with only one programme. At the same time, it admits that there is a small although statistically significant group of clients who use all or almost all of the programmes, especially the outreach programmes.

The SANANIM drop-in centre provided an expert estimate of the proportion of clients without a code, which amounted to 25–30% of the programme's clients. The Drop-In outreach programme conducted a survey among its clients in January 2012: of the 2,563 clients in contact (of whom 2,014 were men), 1,135 persons (44.3%) were identified without a code being assigned to them.

If the proportion of clients without a code in Prague-based low-threshold programmes is assumed to be 35%, the resulting estimate of problem drug users in Prague ranges from 8,000 to 10,000 people (Národní monitorovací středisko pro drogy a drogové závislosti, 2012b); see Table 4-8.

*Table 4-8: Estimated number of problem drug users in Prague based on overlaps between harm reduction programmes, 2011 – final results after adjustment for incomplete codes (Národní monitorovací středisko pro drogy a drogové závislosti, 2012b)*

| Method | Estimated number of problem drug users | | |
|---|---|---|---|
| | Mean value | 95% confidence interval lower limit | 95% confidence interval upper limit |
| Truncated Poisson | 7,934 | 7,774 | 8,105 |
| Log-linear CRM | 9,952 | 9,782 | 10,123 |

The analysis shows that the overlaps between the programmes are not large. For example, only 1.8% of clients use the same provider's outreach programme and drop-in centre services concurrently – in effect, the outreach programmes and the drop-in centres of one and the same provider work independently of each other. If there are overlaps, these mainly concern the services of street workers – 11.4% of clients are in contact with all three outreach programmes. Only 14.9% of clients use the services of all three providers, regardless of the type of programme; 29.9% of clients use the services of at least two providers concurrently.

### 4.2 Data on Problem Drug Use from Non-Treatment Sources

Information obtained from the annual reports on the implementation of drug policy in the regions for 2011 is essentially confirmed by other available information and estimates concerning the regional distribution of problem drug users in the Czech Republic (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2012b). Almost all the regional reports emphasised a high prevalence of injecting among problem drug users and a significant or predominant proportion of pervitin. Most regional reports also concur in their description of the declining prevalence of opiates, particularly the decreasing prevalence and quality of heroin. On the other hand, the reports identify the diversion of substitution drugs containing buprenorphine (mainly Subutex® and especially in Prague and other regions in Bohemia), other drugs containing opiates/opioids, such as Vendal® retard or Tramal® (the Pilsen and Liberec regions), and the seasonal use of raw opium and poppy straw from poppy fields (the Přerov area and the Liberec, Pardubice, and South Bohemia regions). Regions with an otherwise low prevalence of heroin reported heroin use in connection with the Roma and other ethnic minorities (the Prostějov, Brno, and Karlovy Vary areas) and the Ústí nad Labem region reported an increase in heroin use in the Teplice area.

Some areas of the Czech Republic report the diversion of the opioid analgesic fentanyl, obtained from transdermal patches. Drug users collect them from the waste containers of social or health services and after extraction with alcohol inject the solution containing residual fentanyl; see the chapter Drug Markets (p. 139).

The drug career of people who were included in a study focused on addiction risk factors between April 1996 and December 1998 and gave their consent to follow-up monitoring was examined[87] (Csémy, 1999). This cohort of injecting drug users, who were in the early stages of problem drug use at the time of their participation in the study, was contacted again after 13 to 14 years to determine the prevalence of abstinence or else development of patterns of use and to describe in the lifelong context the risk and protective factors influencing the onset, progress and, as the case may be, the end of a drug career. Interviews were conducted with 52 persons, of whom 32 (62%) were

[87] A previous detailed analysis (Zábranský et al. 2010) of the mortality of this cohort was also published (Zábranský et al. 2011); see also the chapter Drug-Related Deaths and Mortality of Drug Users (p. 101).

long-term abstainers, five are undergoing treatment in substitution programmes, nine are occasional users of illicit drugs, and six (12%) are still regular heavy users. Among other things, it was found that the length of a drug career correlates with the level of risk of developmental psychological factors and overall life context. Various forms of abstinence-oriented treatment and the number of treatment episodes had a significantly smaller influence than is usually assumed on the cessation or management of drug use (Brenza et al. 2012).

### 4.2.1 The Open Drug Scene in Prague

Detailed information about open drug scenes in Prague was provided in the 2010 Annual Report. These are found mainly in the city districts of Prague 1, 2, and 5, in the very centre of Prague, on Wenceslas Square and Charles Square and in the Vrchlický Gardens near the main railway station, but also in Smíchov. In 2011, the open drug scene did not change much, covering mainly the city centre – especially Wenceslas Square, with an estimate of more than 2,500 people each year and 300–500 daily, and Charles Square. At the end of 2011 the open drug scene shifted significantly towards the Vrchlický Gardens, i.e. a site where (injecting) drug use is tolerated (200–300 drug users daily). Smaller local drug scenes can be observed in the districts of Prague 3, 7, 8, 10, and 13 (Hlavní město Praha, 2012).

The relocation of a physician prescribing buprenorphine from Prague 5 to Prague 4 led to the creation of a new open drug scene there in the spring of 2012. In addition, the provision of substitution treatment there was temporarily discontinued at the end of April 2012, which caused an interim shortage of prescription buprenorphine and the escalation of tensions on the drug scene. The price of ¼ tablet of Subutex® on the black market rose from CZK 100 (€ 4) to CZK 300 (€ 12) and it was estimated that several hundred injecting drug users were temporarily without access to drug substitution. A working group of the Prague City Council responded to the situation by issuing 2,000 copies of warning leaflets for users, entitled Subutex Crisis[88]; see also the chapter Estimation of Clients in Substitution Treatment and Problem Use of Buprenorphine (p. 68).

More information on problem drug users in contact with the various types of services is provided in the chapters Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55), Responses to Health Correlates and Consequences of Drug Use (p. 109) and Social Correlates and Social Reintegration (p. 117).

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

Updated information for 2011 is not available. The latest available data are provided in the 2010 Annual Report.

[88] http://www.drogy.net/aktuality/z-domova/nedostatek-subutexu-na-cernem-trhu-s-sebou-prinasi-vazna-rizika.html (2012-08-30)

## 5 Drug-Related Treatment: Treatment Demand and Treatment Availability

The number of providers of outpatient health services[89] reporting the treatment of drug users in 2011 remained almost unchanged; the number of patients receiving outpatient alcohol/drug (AT) treatment decreased again, by more than 2%, as a result of a drop in the number of patients using alcohol, as well as those using drugs other than alcohol (excluding tobacco). There was a decline in the number of patients in all three of the most numerous groups treated for non-alcohol drugs, i.e. opiates/opioids, stimulants other than cocaine, and polydrug use.

Again, the number of patients entered in the Substitution Treatment Register increased, both in specialised centres and at the offices of other physicians who prescribe products containing buprenorphine; however, treatment with these preparations is still not fully covered by the Register. As a new development, aggregated data on the number of patients in substitution treatment in the offices of psychiatrists and general practitioners for adults are monitored. 2,290 people were reported to the Substitution Treatment Register in 2011, approximately half of the total number reported by psychiatrists and general practitioners.

In 2011, the detoxification units were located in 17 inpatient facilities with 150 dedicated beds and detoxification was provided in an additional 12 inpatient facilities. In total, 7,161 persons underwent detoxification from addictive substances during the year, of whom 3,199 underwent detoxification from illicit drugs.

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

The number of drug users in the Public Health Service's Register of Treatment Demands has been rising since 2008. In 2011, a total of 9,284 drug users sought treatment services, i.e. 279 more people than in 2010. The users of stimulants have long dominated among treatment demands (64.9%) – most of them use pervitin as their primary drug. As in previous years, opiate/opioid users (19.3%) represented the second largest group of all treatment demands, while cannabis users (18.6%) are number two among first treatment demands. It is obvious that the population of users demanding treatment is growing older, as in 2011 the average age of those demanding treatment was 27.4 years. Women consistently make up less than a third of those demanding treatment.

In 2011, a total of 273 facilities were registered in the Register of Treatment Demands, with 205 actively reporting. 255 facilities completed the questionnaire administered as part of the 2012 Drug Services Survey. They included facilities of various types – social, health, and educational, as well as religious facilities providing a range of low-threshold, outpatient, and residential services. The core of the drug services in the Czech Republic can be considered as consisting of approximately 250 facilities (excluding prevention programmes).

### 5.1 Drug Treatment Legislation, System, and Professional Competency

#### 5.1.1 Legal Framework, Strategies, and Policies Concerning Treatment

As part of the Czech health care reform a number of regulations approved in 2011 came into force on 1 April 2012 that change the framework for the provision of health services, particularly Act No. 372/2011 Coll., on health services and the terms and conditions of the provision thereof (the Act on Health Services), Act No. 373/2011 Coll., on specific health services, Act No. 374/2011 Coll., on emergency medical services, and Act No. 369/2011 Coll., amending Act No. 48/1997 Coll., on public health insurance. This body of laws brings a number of important changes to health care in the following areas:

- it strengthens the rights of patients, especially the right to be informed and to determine under what circumstances they want to be treated (or not),
- it changes the rules for reimbursement for medicines and vaccines,
- it establishes rules for special health services and interventions, such as castration, sterilisation, donation of reproductive cells, assisted reproduction, and compulsory treatment, i.e. treatment ordered by a court, which also applies to the so-called "protective" treatment of alcohol and drug use in institutional or outpatient settings,
- it lays down the obligations of employers in company preventive care,
- it enacts the possibility of providing above-standard health care, or providing health services at a basic level or at a more expensive level, and the conditions for the provision thereof.

The Act on Health Services defines new types or forms of health care based on various criteria:

- depending on time urgency, a distinction is made between urgent, acute, necessary (applicable to foreigners who are insured), and planned care,

[89]The new health legislation uses the term "provider of health services" instead of "healthcare facility" that has been widely used hitherto. Thus, where the term "healthcare facility" is used throughout the text of this report, it is meant to be synonymous with "provider of health services".

- depending on the purpose for which the service is provided, a distinction is made between the following types of care: preventive, diagnostic, continuing, medical, assessment, medical rehabilitation (including spa), nursing, palliative, and pharmacy care,
- depending on the form of health care, a distinction is made between outpatient, one-day, and inpatient care, as well as health care provided in the client's own social environment.

The Act on Health Services is followed by further implementing legislation, in which the relevant area of care for drug users is covered by Decree No. 99/2012 Coll., concerning the minimum requirements for the technological and material equipment of healthcare facilities and home care contact centres, Decree No. 102/2012 Coll., on the evaluation of the quality and safety of inpatient health care, and Communication No. ZD27/2012, on the minimum requirements for the establishment of an internal system for the evaluation of the quality and safety of health services.

The Annex to the Health Services Act further specifies 10 national health registers, whose management has been placed in the hands of the Institute of Health Information and Statistics (IHIS).

These registers also include the National Drug Treatment Register (NRLUD), now being newly established, which will arise as a result of the merging of two existing information systems, the National Register of Users of Medically Indicated Substitution Substances (NRULISL), managed by the Institute of Health Information and Statistics, and the Register of Treatment Demands, managed by the Public Health Service. The National Drug Treatment Register will be a register aimed at collecting data on patients on their entry to and exit from addiction treatment, including outreach, counselling, and rehabilitation programmes.[90] The collection of data for the NRLUD register should be launched in 2014.

In May 2012, the concept of a network of addiction-related health services was introduced, aiming to transform the system of addiction care to one that is acceptable to the entities reimbursing the care (health insurance companies and other donors) and to the state administration and local government and is in line with the new legal framework for health services, with the legal framework for the provision of social services, and with the National Drug Policy Strategy. The concept also defines a network of specialised addiction health services (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012). The concept constitutes part of a whole process of profiling the discipline of addictology and the development of fundamental policy documents in the field, including those providing for training, research and development, a code of ethics, and best practices in addiction treatment.

The concept proposes the establishment of three types of specialised outpatient units and five types of one-day care and inpatient addiction care departments; see Table 5-1 and Table 5-2. The concept foresees, among other things, a gradual transformation of (some) drop-in centres into outpatient healthcare clinics. According to the concept, aftercare and follow-up treatment are potentially to become part of the content of the services provided in the above-mentioned outpatient and residential programmes, but may also be provided as part of a specialised aftercare programme (if in an outpatient setting, then often with links to sheltered housing).

*Table 5-1: Basic types of outpatient addiction care as foreseen*

| Type of care | Name of facility | Main types of interventions |
|---|---|---|
| Medical outpatient care | Medical clinic for addictive disorders | Treatment and preventive care, pharmacotherapy, individual and group psychotherapy, education, social work |
| Non-medical outpatient care | Addiction treatment outpatient clinic | Health care – harm reduction, early diagnosis and intervention, education, group work, individual counselling, social work, outsourced psychiatric and psychological care |
| Day care | Addiction treatment day care service | Group therapy, therapeutic community principles, daily routine, social work, psychological diagnosis and care, (outsourced) psychiatric care |

[90] Another national health register newly listed in the Act on Health Services is the National Register of Autopsies and Toxicology Tests Carried Out at the Departments of Forensic Medicine; see the chapter Drug-Related Deaths and Mortality of Drug Users (p. 101).

*Table 5-2: Basic types of one-day care and inpatient addiction care as foreseen*

| Type of care | Name of facility | Main types of interventions |
|---|---|---|
| One-day care | Stabilisation unit/ stabilisation bed | Stabilisation in crisis, relapse, acute intoxication, etc. These facilities could assume the role of sobering-up stations, but only for patients with a medical indication and subject to referal to other addictological services, e.g. on the principle of case management. |
| **Inpatient care** | | |
| Detoxification | Detoxification unit | Prevention and control of withdrawal syndrome primarily by pharmacological and psycho-therapeutic interventions and daily routine measures. |
| Short- and medium-term drug treatment | Psychiatric hospital for addiction treatment<br><br>Addiction treatment unit | A structured comprehensive treatment programme covering medical therapy (including pharmacotherapy), psychotherapy, education, social reintegration, leisure time activities, etc. It involves the motivational cycle of change in order to achieve and maintain abstinence, stabilise the client's mental and physical condition, and rehabilitate the patient to the maximum extent possible. Primarily, it has the nature of acute care. |
| Residential treatment in therapeutic communities | Therapeutic community for addiction treatment | Long-term treatment of addiction featuring mainly aftercare following up on acute care. It focuses on achieving and maintaining abstinence, working with motivation, stabilising the patient's mental and physical condition, and rehabilitating the patient to the maximum extent possible.<br>The treatment programme in a therapeutic community has a comprehensive structure and includes medical therapy, psychotherapy, education, social reintegration, leisure time activities, and other (outsourced) psychiatric care. |
| Palliative treatment | Home with addiction treatment regimen | Palliative residential treatment of terminal addiction conditions aimed at abstinence in a sheltered residential environment and at addiction rehabilitation. It encompasses medical treatment and supportive psychotherapy interventions, including relapse prevention and craving management, as well as daily routine activities, psychosocial rehabilitation, occupational therapy, leisure time activities, and more. |

At the end of 2011 and beginning of 2012, a working group of the Czech Association of Addictologists began to operate, given the task of creating and defining a list of health interventions linked to the paramedical profession of an addictologist that could be covered by health insurance. The first option to develop the list of health interventions in the profession of an addictologist was to propose a number of interventions that could be shared with other specialist health professions (e.g. a general nurse or a psychiatric nurse).[91] This proposal was rejected by the working group assessing the list of health interventions at the Ministry of Health in February 2012, despite the consent of the Czech Association of Nurses, the entity that developed these descriptions. A new proposal has been drafted, defining eight new health services to be primarily provided by the profession of an addictologist. So-called registration lists of health interventions will be submitted to the Ministry of Health in August 2012. After approval by the Ministry of Health, each service (intervention) is entered into the Database of Health Interventions with point values assigned to it, forming the basis for the issue of a relevant decree. These interventions include comprehensive, screening, and targeted examinations, individual, group, and family therapies, education in addictology, and a day of treatment in an addiction treatment day care facility.[92]

### 5.1.2 Drug Services Network and Quality Assurance

Treatment and counselling programmes for drug users and their capacity and utilisation rates in 2011 are summarised in Table 5-3.

[91] E.g.: 06123 (Package – education, reeducation, rehabilitation nursing), 06613 (Nursing intervention – time allocation 10 minutes), 06621 (Package – collection of biological material), 06611 (Introduction or completion of specialist health care, administrative activities conducted by the nurse).

[92] http://www.asociace-adiktologu.cz/zdravotnicke-vykony/ (08/09/2012), personal communication with Ondřej Sklenář (2012-07).

*Table 5-3: Treatment programmes providing services to drug users in the Czech Republic in 2011*

| Type of programme | Total[1] | | | of which | | | |
|---|---|---|---|---|---|---|---|
| | | | | Non-alcohol drugs (excluding tobacco) | | Alcohol | |
| | Number of facilities/ programmes | Capacity (persons, beds) | Occupancy (number of persons) | Number of facilities/ programmes | Occupancy (number of persons) | Number of facilities/ programmes | Occupancy (number of persons) |
| Outpatient psychiatric facilities | 454 | – | 39,033 [2] | 394 | 14,535 | 428 | 23,643 |
| Outpatient (non-health) programmes operated by NGOs | 12 [5] | – | 1,524 [5] | The target group consists primarily of the users of non-alcohol (illicit) drugs. | | | |
| Day care centres | 1 | 10 | 32 | The target group consists primarily of the users of non-alcohol (illicit) drugs. | | | |
| Healthcare facilities providing substitution treatment and reporting clients to the Substitution Treatment Register (NRULISL) | 55 | – | 2,290 | These are data on treatment provided to users of opiates, or opiates in combination with other substances (polydrug users). | | | |
| Substitution treatment provided by psychiatrists and general practitioners for adults | 424 | – | 4,092 | These are data on treatment provided to users of opiates, or opiates in combination with other substances (polydrug users). | | | |
| Sobering-up stations | 17 | 152 | 28,365 [11] | – | 3,760 | – | 23,429 |
| Drop-in centres and outreach programmes (low-threshold programmes) | 99 | – | 35,500 | The target group of these facilities consists primarily of the users of non-alcohol (illicit) drugs or problem (injecting) drug users. | | | |
| Detoxification units in inpatient healthcare facilities | 17 [6] (29 [7]) | 150 | 7,161 [2] | – | 3,199 | – | 3,960 |
| Psychiatric hospitals for adults | 18 | 8,994 [3] (1,305 [4]) | 11,305 [2] | – | 3,976 | – | 7,329 |
| Psychiatric wards in hospitals | 31 | 1,328 [3] | 3,812 [2] | – | 1,466 | – | 2,345 |
| Psychiatric hospitals for children | 3 | 260 [3] | 33 [2] | – | 32 | – | 1 |
| Other inpatient facilities with a psychiatric ward | 2 | 66 [3] | 103 [2] | – | 13 | – | 90 |
| Therapeutic communities | 15–20 (10 [5]) | 158 [5] | 402 [5] | The target group consists primarily of the users of non-alcohol (illicit) drugs. | | | |
| Specialised departments for children at risk of drug addiction in residential special education facilities | 5 | 68 | 155 | The target group consists primarily of the users of non-alcohol (illicit) drugs. | | | |
| Aftercare programmes | 25–30 (15 [5]) | 129 [5] | 1,095 [5] | The target group consists primarily of the users of non-alcohol (illicit) drugs. | | | |
| Detoxification in prisons | 5 | Unknown | 309 | These are the data on the detoxification from non-alcohol (illicit) drugs. | | | |
| Substitution treatment in prisons | 7 | – | 99 | The target group consists of the users of opiates, or opiates in combination with other substances (polydrug users). | | | |
| Departments for voluntary treatment in prisons | 7 | 287 | 535 | These are data on the treatment of the users of non-alcohol (illicit) drugs. | | | |
| Departments for undergoing compulsory substance use treatment in prisons | 3 | 113 | 206 | These are data on the treatment of the users of non-alcohol (illicit) drugs. | | | |
| Drug-free zones in prisons | 33 [8] | 1,905 | 4,279 | The target group consists primarily of the users of non-alcohol (illicit) drugs. | | | |
| NGO programmes in prisons | 25 [9] | – | 578 (3,422) [10] | The target group consists primarily of the users of non-alcohol (illicit) drugs. | | | |

*Note: [1]This is the total capacity and total number of users of all addictive substances; other columns contain data for alcohol and non-alcohol drugs, if available. [2]This is the number of patients with the primary diagnoses F10–F19 treated in the given year. [3]Number of all psychiatric beds. [4]Number of beds in wards for treating AT patients. [5]Number of programmes, capacity and number of clients in programmes supported by subsidies from the Government Council for Drug Policy Coordination. [6]Number of detoxification units with dedicated detoxification beds. [7]Number of facilities providing inpatient detoxification to alcohol/drug patients, including detoxification in various departments without dedicated beds. [8] Drug-free zones are not essentially a therapeutic programme, but rather provide a safe and motivating environment for prisoners who are ready to abstain; however, four of the drug-free zones have a therapeutic programme. [9]Number of prisons in which NGOs operated. [10]Number of visits to prisons (number of clients). [11]This is not the sum of the categories of alcohol and non-alcohol drugs, as the sobering-up station in the Pardubice region did not distinguish the persons treated by drug – there were 1,176 persons in total.*

Information about treatment and counselling services for drug users is also provided in other chapters. This year, the annual report includes a special chapter entitled Residential Treatment for Drug Users (p. 146). Low-threshold and counselling services and outreach programmes are described in the chapter Responses to Health Correlates and Consequences of Drug Use (p. 109) and aftercare programmes in the chapter Social Correlates and Social Reintegration (p. 117). Court-ordered treatment is discussed in the chapter Protective and Educational Measures (p. 130) and treatment interventions in prisons in the chapter Drug Use and Problem Drug Use in Prisons (p. 134).

In 2011, the work continued of the expert working group established to innovate the Standards of Professional Competency of Drug Services (which form an essential part of the GCDPC certification system) within the framework of a project entitled Sharing Experience and Disseminating Good Practice in the Quality Management of Drug Services 2009–2012, implemented by the Centre for Quality and Standards in Social Services of the National Training Fund. (For details about the certification system see the dedicated chapter in the 2009 Annual Report). The purpose of this innovation was to streamline the standards, eliminate duplication between general and special standards, and simplify the rating system used for on-site inspection visits. The innovated standards were officially presented to the GCDPC Secretariat in May 2012. Currently (September 2012), the process of review and approval is under way[93].

By the end of May 2012, a total of 151 programmes had a valid certificate of professional competency within the framework of the GCDPC system; see Table 5-4. Two other programmes of the drop-in and counselling type of service are not certified, but having completed the certification survey, the GCDPC Certification Committee proposed that certification be granted to them; three other outpatient treatment programmes are not certified, but already have dates scheduled for their on-site inspection visits.

Detailed information about the system to assure the professional competency of services for drug users (the Certification System) was provided in a selected issue chapter on the history, methods, and implementation of national standards in the treatment of drug users included in the 2009 Annual Report.

*Table 5-4: The list of certified programmes by type in 2011 (as of 16 May 2011) and 2012 (as of 29 May 2012)*

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

#### 5.1.2.1 Drug Services Census 2012

During June–August 2012 a cross-sectional questionnaire study was carried out among the providers of drug treatment services in the Czech Republic, entitled the Drug Services Census 2012. The data were collected through a web-based form consisting of three parts: (1) the characteristics of the facility[94] and the services provided, (2) the number of clients as of 20 June 2012 and their structure, and (3) further use of the data collected and willingness to cooperate in research and development activities.

A call for participation in the survey was sent specifically to pre-selected facilities of various types providing drug treatment services. A total of 865 programmes were approached; their distribution (Table 5-5) should be understood only as a basic guide with a view to the comprehensive typology of the programmes.

[93] See also http://snncls.cz/2012/06/13/standardy-odborne-zpusobilosti/ (2012-08-20).
[94] In this survey, the term facility was taken to mean an individual programme, office etc. which forms a separate organisational unit and has defined objectives, procedures, and rules for providing services, types of interventions provided, target group, team, manager (person in charge), place of service provision etc.

*Table 5-5: Distribution of respondents by programme type*

| Type of programme | Number of respondents |
|---|---|
| Outreach programmes | 44 |
| Low-threshold drop-in centres | 60 |
| Specialised psychiatric outpatient facilities (AT) | 44 |
| Other psychiatric outpatient facilities | 446 |
| Substitution treatment | 35 |
| Smoking cessation | 17 |
| Day care centre | 3 |
| Other outpatient programmes | 35 |
| Aftercare programmes | 29 |
| Detoxification | 19 |
| Psychiatric hospitals for adults | 18 |
| Hospital-based psychiatric units | 31 |
| Psychiatric hospitals for children | 3 |
| Therapeutic communities | 21 |
| Special education facilities | 6 |
| Services provided by NGOs in prisons | 7 |
| Other programmes* | 47 |
| **Total** | **865** |

*Note: Pedagogical and psychological counselling centres, psychologists, psychotherapists etc.*

A total of 261 questionnaires were filled in, of which 233 were sent completed, 27 partially completed, and one was entered manually from the data sent by e-mail. Of the 27 incomplete questionnaires, 21 were used and the remaining six not, because of their (overall) incompleteness or duplication with another questionnaire. The sample under analysis therefore consists of 255 questionnaires. The initial preliminary results are presented below; details of the drug services census will be provided in a separate publication to be issued by the National Focal Point.

Most facilities were located in Prague (18%) and in the South Moravia and the Moravia-Silesia regions (12% each). They included civic associations (39%), natural persons, and state-funded organisations (13% each). These facilities provided addiction treatment services in all the regions of the Czech Republic, especially in Prague (62 facilities), the Central Bohemia, South Moravia (51 each), and the Moravia-Silesia regions (49); see Table 5-6.

*Table 5-6: Number of facilities by region of registered office and region of provision of addiction services*

| Region | Number of facilities located in the region | Number of facilities providing services in the region* |
|---|---|---|
| Prague | 46 | 62 |
| Central Bohemia | 17 | 51 |
| South Bohemia | 30 | 33 |
| Pilsen | 6 | 27 |
| Karlovy Vary | 13 | 23 |
| Ústí nad Labem | 10 | 36 |
| Liberec | 9 | 25 |
| Hradec Králové | 30 | 27 |
| Pardubice | 19 | 25 |
| Vysočina | 6 | 33 |
| South Moravia | 12 | 51 |
| Olomouc | 23 | 34 |
| Zlín | 19 | 36 |
| Moravia-Silesia | 15 | 49 |
| **Total in the sample** | **255** | **255** |

*Note: * One facility can provide services in multiple regions.*

Nearly half of the facilities (125) had the status of social services, 96 had the status of health services, and 9 reported both. The remaining 25 facilities reported having another status or reported that they did not have the status of either social or health services (e.g. religious organisations, educational facilities, etc.). Furthermore, the primary focus of the facility in question was monitored. More than half (53%) of the facilities identified themselves as a service aimed at users of addictive substances (addictological care), almost a quarter ranked themselves among facilities providing psychiatric care, and more than 13% of the facilities identified themselves as a social service aimed at drug users as one of their target groups.

The questionnaire monitored the provision of nine types of drug services. The facilities were asked to identify all the types of services they provide. The number of facilities by type of addiction services is given in Table 5-7.

*Table 5-7: Number of facilities by type of addiction services*

| Type of service | | Number of facilities |
|---|---|---|
| Low-threshold services and counselling | | 111 |
| Outpatient treatment and counselling | | 145 |
| Day care | | 6 |
| Inpatient detoxification | | 26 |
| Inpatient (residential) care | short-term (up to 1 month) | 18 |
| | medium-term (up to 3 months) | 18 |
| | long-term (over 3 months) | 18 |
| Therapeutic community-type residential treatment | | 16 |
| Aftercare | | 94 |

The total capacity of residential services specifically dedicated to the treatment of disorders caused by substance use as of 20 June 2012 was 1,368 beds, the total daily capacity of outpatient programmes (i.e. how many clients the facility is able to provide with services within one working day) was 4,002 clients, and the total capacity of facilities providing sheltered housing or accommodation for clients on that day was 332 beds.

Most facilities receive financial support or subsidies for their programmes aimed at drug users from public administration bodies, especially from the GCDPC, Ministry of Labour and Social Affairs or other ministries, and from regional authorities (Table 5-8).

*Table 5-8: Sources of financial contributions or subsidies received to support programmes for drug users, 2011*

| Source of financial contributions or subsidies | Number of facilities |
|---|---|
| Public administration bodies | 163 |
| Regions | 132 |
| Municipalities | 127 |
| Other sources | 90 |

The method of payment for care by the patient or reimbursement by health insurance is given in Table 5-9. Most facilities provide their services to clients free of charge, while 15% of them collect fees for their services from their clients.

*Table 5-9: Method of payment for care by the client*

| Client participation | Number of facilities |
|---|---|
| No payment required | 138 |
| Full payment by the client | 14 |
| Partial payment by the client | 24 |
| Fully covered by health insurance | 79 |

The largest group of clients to whom addictological facilities provide services are users of illicit drugs (227 out of 255 facilities), psychoactive pills (192), and alcohol (168). Clients having problems with gambling were targeted by 144 facilities. Clients' significant others (such as family members and friends) were provided with services by 181 facilities (Table 5-10).

*Table 5-10: Target group of clients of the facility providing drug services*

| Target group | Number of facilities |
|---|---|
| Tobacco users | 55 |
| Alcohol users | 168 |
| Users of psychoactive pills | 192 |
| Illicit drug users | 227 |
| People with gambling problems | 144 |
| People with eating disorders | 65 |
| Users of other substances or with other mental or behavioural disorders | 125 |
| Significant others (such as family members and friends of the above individuals) | 181 |
| Other target groups | 52 |

As of 20 June 2012, the 255 facilities in the sample reported contact with a total of 6,256 addicted patients/clients. Their structure is shown in Table 5-11.

*Table 5-11: Number of clients by type of addiction treatment service, sex, and age group, as of 20 June 2012*

| Type of service | Men | | | Women | | | Total |
|---|---|---|---|---|---|---|---|
| | 0–14 years | 15–44 years | 45 years and over | 0–14 years | 15–44 years | 45 years and over | |
| Low-threshold services and counselling | 3 | 1,559 | 130 | 10 | 608 | 67 | **2,377** |
| Outpatient non-pharmacological treatment and counselling | 9 | 353 | 64 | 14 | 356 | 52 | **848** |
| Substitution treatment | 0 | 231 | 17 | 0 | 114 | 1 | **363** |
| Other pharmacologically assisted outpatient treatment | 0 | 105 | 50 | 2 | 59 | 46 | **262** |
| Day care treatment | 0 | 34 | 10 | 0 | 12 | 6 | **62** |
| Inpatient detoxification | 0 | 83 | 29 | 1 | 21 | 17 | **151** |
| Short- and medium-term residential drug rehabilitation | 0 | 455 | 218 | 0 | 179 | 123 | **975** |
| Long-term residential treatment | 6 | 168 | 90 | 4 | 100 | 25 | **393** |
| Aftercare | 5 | 167 | 62 | 0 | 122 | 30 | **386** |
| Another type of of service | 0 | 262 | 50 | 0 | 103 | 24 | **439** |
| **Total** | **23** | **3,417** | **720** | **31** | **1,674** | **391** | **6,256** |

A client survey confirmed that the facilities in the sample are primarily focused on the users of non-alcohol illicit drugs; see Table 5-12.

*Table 5-12: Structure of clients by addictive substance or behaviour, as of 20 June 2012*

| Substance/behaviour | Proportion of clients (%) |
|---|---|
| Pervitin only | 30.3 |
| Opiates only | 12.9 |
| Pervitin and opiates concurrently | 11.3 |
| Other non-alcohol drugs | 5.2 |
| Alcohol and concurrently non-alcohol drugs | 11.4 |
| Alcohol only | 24.8 |
| Gambling and other behavioural addiction | 4.1 |
| **Total** | **100.0** |

## 5.2 Availability of Drug Services and Drug Users in Treatment

### 5.2.1 The System of Collecting Data on Drug Users in Treatment

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

The National Health Information System (NHIS) administered by the Institute of Health Information and Statistics (IHIS) is the largest source of data on persons using addictive substances. It includes data from inpatient and outpatient (psychiatric) facilities that are required to report them and data from the Substitution Treatment Register (NRULISL). A higher number of facilities contribute to the National Health Information System than to the Public Health Service's Register of Treatment Demands (see below); nonetheless, these are solely healthcare facilities. Summary data on patients with substance use problems treated in both outpatient and inpatient facilities have been known since the 1960s, and the historical development of drug treatment derived from the health statistics data has recently been described in detail (Nechanská et al. 2011; Mravčík et al. 2011c; Mravčík et al. 2011a; Nechanská and Mravčík, 2012).

Another source of data is the Treatment Demand Register, which has been managed by the Public Health Service of the Czech Republic since the beginning of 1995. This register collects data on the drug users who, in a given year, sought treatment and counselling services in both healthcare and non-healthcare (e.g. therapeutic communities or low-threshold centres) facilities for drug users. Users who did so for the first time in their life (first treatment demands) are registered separately. The data set collected, the structure of the data, and the definitions used comply with the EMCDDA standard for the collection of treatment demand data. However, the register does not give sufficient coverage of treatment provided by outpatient psychiatrists and general practitioners, substitution treatment, and treatment in prisons.

Data on clients and services provided by NGOs supported in the GCDPC subsidy proceedings are available from final project reports. This information is processed annually by the National Focal Point. This is the case of low-threshold programmes in particular, but also other types of programmes.[95]

The above-mentioned data collection systems overlap. As a result, for example, an outpatient healthcare facility operated by an NGO providing substitution treatment reports data to the Treatment Demand Register, completes a report on the activities of a healthcare facility for the National Health Information System, reports data to the the Substitution Treatment Register, and submits a report as part of the subsidy proceedings. The information coming from various sources should therefore be approached with a view to the fact that these data sources overlap. This should be partially improved with the new National Drug Treatment Register; for more details see the chapter Legal Framework, Strategies, and Policies Concerning Treatment (p. 55).

## 5.3 Outpatient Treatment

### 5.3.1 Outpatient Psychiatric Treatment

Outpatient health care for users of alcohol and drugs is currently provided primarily in outpatient psychiatric clinics and so-called AT (alcohol and drug) clinics specialising in addiction treatment. Since 1993, the network of AT clinics has not been centrally managed and their number has only been monitored in the Healthcare Facilities Register, administered by the Institute of Health Information and Statistics. This Register contains all healthcare facilities that have been registered by the region (or municipality) to provide health services. At the end of 2011, a total of 55 AT outpatient clinics/centres were registered.

Patients using addictive substances (AT patients), i.e. patients with the primary diagnoses F10–F19, were registered in 2011 by a total of 454 outpatient psychiatric clinics. These are not solely specialised AT units, but all outpatient psychiatric clinics that treated at least one AT patient. Following an increase in 2010 (see the 2010 Annual Report), the number of these outpatient psychiatric clinics remained almost unchanged in 2011 (Table 5-13). Of the total number of facilities reporting care for alcohol/drug patients, outpatient psychiatric clinics accounted for 83% (377), followed by 52 AT clinics, 23 outpatient psychiatric clinics for children, and two outpatient sexology clinics (Table 5-14).

*Table 5-13: The number of clinics and number of drug users in treatment, 2000–2011 (Nechanská et al. 2011; Nechanská, 2012b)*

| Year | Drugs other than alcohol (excluding tobacco) | | Alcohol | | Addictive substances, total* | |
|---|---|---|---|---|---|---|
| | Number of clinics | Number of clients | Number of clinics | Number of clients | Number of clinics | Number of clients |
| 2000 | 272 | 11,423 | 298 | 27,021 | 320 | 39,721 |
| 2001 | 285 | 13,050 | 309 | 28,582 | 330 | 42,955 |
| 2002 | 288 | 14,203 | 317 | 25,400 | 342 | 41,136 |
| 2003 | 312 | 15,786 | 340 | 25,017 | 368 | 42,881 |
| 2004 | 320 | 14,040 | 358 | 25,235 | 382 | 40,625 |
| 2005 | 337 | 16,394 | 379 | 27,440 | 401 | 44,971 |
| 2006 | 340 | 16,392 | 367 | 26,966 | 394 | 44,887 |
| 2007 | 311 | 15,684 | 348 | 25,342 | 367 | 42,196 |
| 2008 | 298 | 15,711 | 328 | 25,293 | 349 | 42,612 |
| 2009 | 298 | 16,343 | 331 | 24,206 | 346 | 41,419 |
| 2010 | 370 | 15,187 | 428 | 24,182 | 453 | 40,198 |
| 2011 | 394 | 14,535 | 428 | 23,643 | 454 | 39,033 |

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

The degree of specialisation in care for AT patients can be judged by the proportion of patients using addictive substances out of the total number of patients of these clinics (Table 5-14), but also by the absolute number of AT patients treated in these clinics (Table 5-15).

In the majority (89%) of the 454 outpatient facilities, the proportion of AT patients out of the total number of patients was less than a half in 2011. AT patients constituted a majority of the total number of patients only in 52 outpatient facilities (11%), of which 39 were AT clinics, 12 outpatient psychiatric clinics, and one an outpatient psychiatric clinic for children; see Table 5-14 (Nechanská, 2012b).

[95]Since 2003 the National Focal Point has managed a software application for a unified system of data collection in low-threshold facilities called FreeBase and since 2008 also the UniData application, designed for all types of services. In the area of primary prevention, a similar application, named PrevData, has been in place since 2008 and is currently integrated into UniData. UniData is primarily designed to record data about the clients and the services provided to them. For example, it makes it possible to compile outputs compatible with the requirements of the Register of Treatment Demands and with the requirements for the interim and final reports in the GCDPC subsidy proceedings. Applications are free to download at http://www.drogovesluzby.cz; after registration you can use the free e-mail user support.

*Table 5-14: Number of psychiatric outpatient facilities by type of department/unit, addictive substance, and share of the users of addictive substances in treatment, 2011 (Nechanská et al. 2011; Nechanská, 2012b)*

| **Department/unit** | | | **Proportion of AT patients of the total number of patients** | | | | | | **Total** |
|---|---|---|---|---|---|---|---|---|---|
| | | | 0–10% | 11–25% | 26–50% | 51–75% | 76–90% | 91–100% | |
| Psychiatry | Number of outpatient units | | 281 | 66 | 18 | 8 | 0 | 4 | **377** |
| | Number of patients | | 12,292 | 6,839 | 4,909 | 1,402 | 0 | 971 | **26,413** |
| AT clinics | Number of outpatient units | | 2 | 4 | 7 | 8 | 7 | 24 | **52** |
| | Number of patients | | 12 | 858 | 1,470 | 2,401 | 2,518 | 4,731 | **11,990** |
| Child psychiatry | Number of outpatient units | | 21 | 1 | 0 | 1 | 0 | 0 | **23** |
| | Number of patients | | 189 | 63 | 0 | 367 | 0 | 0 | **619** |
| Sexology | Number of outpatient units | | 2 | 0 | 0 | 0 | 0 | 0 | **2** |
| | Number of patients | | 11 | 0 | 0 | 0 | 0 | 0 | **11** |
| **Total** | **Number of outpatient units** | | **306** | **71** | **25** | **17** | **7** | **28** | **454** |
| | **Number of patients** | | **12,504** | **7,760** | **6,379** | **4,170** | **2,518** | **5,702** | **39,033** |
| | Of whom | Alcohol | 9,207 | 5,275 | 2,766 | 2,038 | 1,191 | 3,166 | **23,643** |
| | | Non-alcohol drugs excluding tobacco | 3,242 | 2,440 | 3,309 | 1,914 | 1,298 | 2,332 | **14,535** |
| | | Tobacco | 55 | 45 | 304 | 218 | 29 | 204 | **855** |

Looking at the outpatient facilities by the absolute number of drug users treated, one can see that three-quarters (341) of the clinics provided care to a maximum of 100 AT patients, while 68 outpatient facilities treated more than 150 patients using addictive substances. Patients using alcohol were provided with care by a total of 428 outpatient facilities, of which only 31 outpatient facilities treated more than 150 patients using alcohol. A total of 394 outpatient facilities cared for patients using drugs other than alcohol (excluding tobacco), of which only 22 facilities cared for more than 150 patients using illicit drugs; see Table 5-15 (Nechanská, 2012b).

*Table 5-15: Number of psychiatric outpatient facilities by the number of treated users of addictive substances, 2011 (Nechanská et al. 2011; Nechanská, 2012b)*

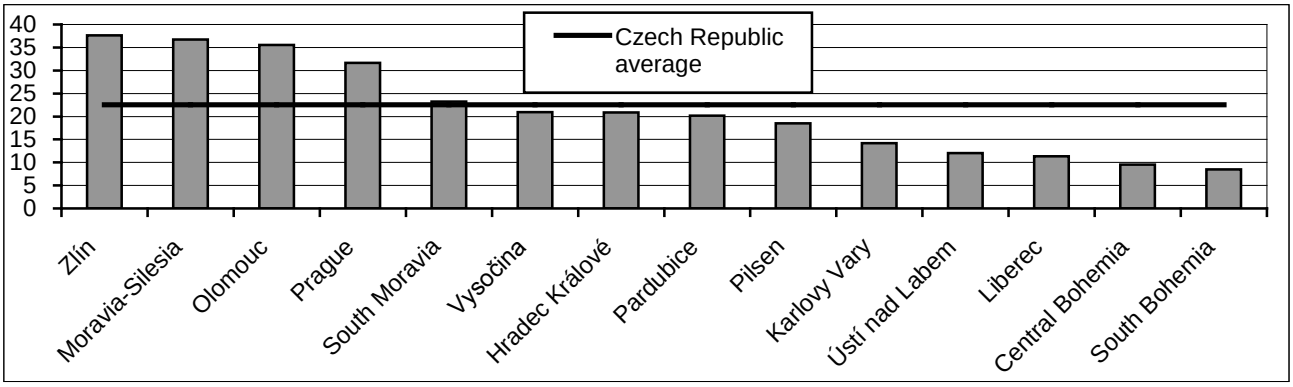
| **Department /unit** | **Number of outpatient facilities** | | | | | | | | | **Total number of patients** |
|---|---|---|---|---|---|---|---|---|---|---|
| | By number of AT patients | | | | | | | | Total | |
| | 1–10 | 11–50 | 51–100 | 101–150 | 151–200 | 201–300 | 301–400 | 401 and more | | |
| | **Addictive substances, total** | | | | | | | | | |
| Psychiatry | 66 | 148 | 84 | 37 | 13 | 18 | 7 | 4 | 377 | **26,413** |
| AT clinics | 1 | 10 | 8 | 8 | 7 | 7 | 3 | 8 | 52 | **11,990** |
| Child psychiatry | 17 | 4 | 1 | 0 | 0 | 0 | 1 | 0 | 23 | **619** |
| Sexology | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | **11** |
| **Total** | **86** | **162** | **93** | **45** | **20** | **25** | **11** | **12** | **454** | **39,033** |
| | **Alcohol** | | | | | | | | | |
| Psychiatry | 98 | 165 | 57 | 26 | 6 | 7 | 2 | 1 | 362 | **16,322** |
| AT clinics | 1 | 12 | 13 | 7 | 6 | 4 | 1 | 4 | 48 | **7,184** |
| Child psychiatry | 14 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 16 | **130** |
| Sexology | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | **7** |
| **Total** | **115** | **178** | **71** | **33** | **12** | **11** | **3** | **5** | **428** | **23,643** |
| | **Non-alcohol drugs excluding tobacco** | | | | | | | | | |
| Psychiatry | 165 | 119 | 22 | 5 | 5 | 5 | 1 | 2 | 324 | **9,313** |
| AT clinics | 8 | 21 | 6 | 4 | 1 | 3 | 0 | 4 | 47 | **4,730** |
| Child psychiatry | 16 | 5 | 0 | 0 | 0 | 0 | 1 | 0 | 22 | **488** |
| Sexology | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **4** |
| **Total** | **190** | **145** | **28** | **9** | **6** | **8** | **2** | **6** | **394** | **14,535** |

The largest proportion of clinics providing treatment services to drug users in 2011 was in Prague (almost 16%, i.e. 71 outpatient facilities out of 454), and in the South Moravia and Moravia-Silesia regions (13% each, i.e. 59 and 58 facilities, respectively). Outpatient facilities in which AT (drug and alcohol) patients made up more than three-quarters of the patients were located mainly in the Olomouc region (7 facilities), Prague (6), and in the Moravia-Silesia region (4). In the Liberec and the Zlín regions there was no clinic in which AT patients constituted the majority of patients, and the Karlovy Vary and Pardubice regions only had one such outpatient facility each (Nechanská, 2012b).

The number of AT patients who actively attended treatment and visited a psychiatric clinic at least once in 2011 reached 39,033 people, i.e. almost 3% (about 1,165 patients) less than in 2010. Both patients using alcohol and those using other drugs than alcohol (excluding tobacco) contributed to this decrease.

In terms of the type of substance, most patients (23,643 or 61%) were treated for disorders caused by alcohol abuse, of whom 15,563 were men and 8,080 women. More than a half (54%) of those patients were aged 40–64 and 35% of the patients were aged 20–39. The number of adolescents aged 15–19 years accounted for 2% (507 patients) of the total number of outpatients treated for alcohol abuse and 14 children under 15 years of age were reported. The largest numbers of patients with problems caused by alcohol per 10,000 inhabitants were treated in the healthcare facilities of the Zlín, Moravia-Silesia, and Olomouc regions and Prague; see Graph 5-1.

*Graph 5‑1: Number of patients using alcohol by region of the facility's regional location, per 10,000 inhabitants, 2011 (Nechanská et al. 2011; Nechanská, 2012b)*




In 2011, a total of 15,390 patients with disorders caused by the use of drugs other than alcohol (diagnoses F11–F19) were recorded, of whom 9,966 were men and 5,424 women. Compared to 2010, the number of these patients decreased by 626, mainly because the activities of one of the AT clinics in Prague with a high number of patients (with 325 patients treated for non-alcohol drug use in 2010) were limited and the activities of the psychiatric clinic at the SANANIM drop-in centre (with 189 patients in treatment in 2010) were terminated. The largest share (69%) of patients with the diagnoses F11–F19 was in the group aged 20–39. There were 1,642 (11%) adolescents aged 15–19 and 51 children under the age of 15 years. For all the non-alcohol drugs under monitoring there was a higher proportion of men than women, except for sedatives and hypnotics, where the proportion of women was 60%.

Among outpatients treated for the use of non-alcohol drugs the most numerous group were those abusing opiates and opioids (28%),[96] followed by stimulants other than cocaine (21%), which, in the context of the Czech Republic, primarily include pervitin (19%), and polydrug use (19%).[97] The proportion of patients treated for the use of cannabinoids reached 9% and for those using sedatives and hypnotics the figure was 15%. The number and proportion of users of other drugs was very low; see Table 5-16 .

The number of problem drug users[98] in outpatient psychiatric treatment in 2011 reached 10,543 patients (271 less than in 2010), which represents 68% of the patients with non-alcohol drug problems.

[96]In 2011, the monitoring of patients abusing opiates and opioids was modified in order also to monitor, in addition to heroin users, patients abusing buprenorphine and methadone without medical indication (i.e. coming mainly from the black market) and patients in substitution treatment for opioid dependence. As a result of these changes, the proportion of opiates/opioids users who were treated with heroin reported as the drug of choice decreased (from 70% in 2010 to 31% in 2011). This can most probably be explained by the fact that in previous years patients in substitution treatment whose primary drug was heroin were also reported as heroin users. Patients in substitution treatment made up a third of the number of opiate/opioid patients in treatment, the proportion of patients abusing buprenorphine was more than 7%, and the proportion of those abusing methadone was less than 1%.

[97]In 2011, the monitoring of polydrug use was also expanded. As a new development, the monitoring includes patients treated for the combined use of opiates and methamphetamine (pervitin) alone or in combination with other drugs, who made up more than 29% of the total number of patients in this category. The combination of methamphetamine and drugs other than opiates, with a share of 26%, and a combination of opiates and drugs other than methamphetamine, with a share of 13%, were also monitored. As with opiates/opioids, substitution treatment is also monitored in polydrug use (see also the chapter Opiate Substitution Treatment on p. 67).

[98]Problem drug use – intravenous (injecting) drug use and/or the long-term use of opioids and/or cocaine and/or amphetamine-type drugs. As a result of the frequent presence of opiates or pervitin in combinations of drugs in the Czech Republic, diagnosis F19 – polydrug use – was also included in problem drug use.

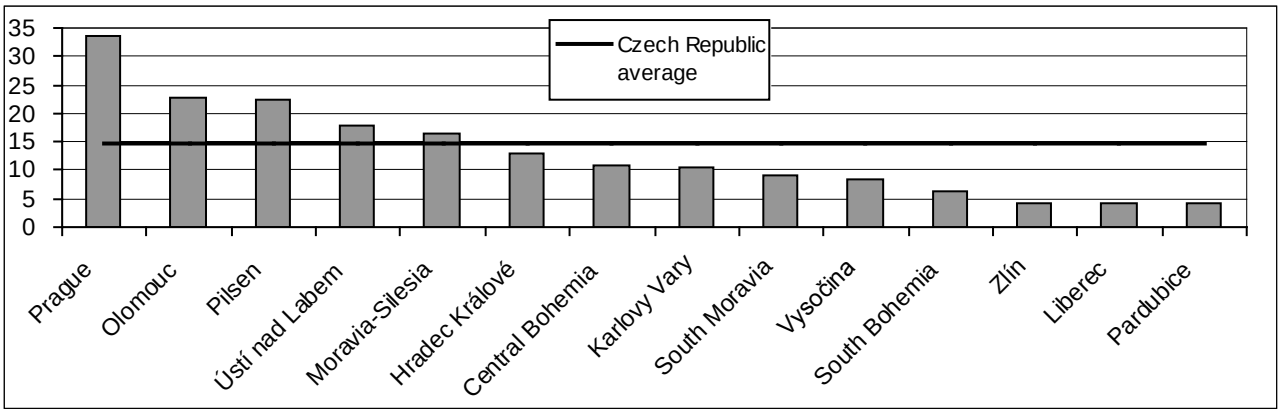
*Table 5-16: Development of the number of users of addictive substances treated in outpatient healthcare facilities by (groups of) addictive substances, 1993–2011 (Nechanská et al. 2011; Nechanská, 2012b; Mravčík et al. 2011c)*

| Year | **Alcohol** | Opiates and opioids | of which heroin | Buprenorphine, non-prescription | Methadone, non-prescription | Cannabinoids | Sedatives and hypnotics | of which benzodiazepines | Cocaine | Other stimulants | of which methamphetamine | Hallucinogens | Tobacco | Inhalants | Polydrug use | of which opiates and methamphetamine | opiates and other drugs without methamphetamine | methamphetamine and other drugs without opiates | Other | **Non-alcohol drugs, total** | Non-alcohol drugs excluding tobacco |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1993 | **49,102** | 816 | – | – | – | 211 | 2,589 | – | 8 | 595 | – | 62 | – | 561 | 260 | – | – | – | 132 | **5,234** | 5,234 |
| 1994 | **44,660** | 653 | – | – | – | 291 | 2,561 | – | 8 | 706 | – | 87 | – | 380 | 558 | – | – | – | 367 | **5,611** | 5,611 |
| 1995 | **32,956** | 461 | – | – | – | 383 | 712 | – | 14 | 699 | – | 69 | – | 281 | 473 | – | – | – | 246 | **3,338** | 3,338 |
| 1996 | **30,259** | 1,619 | – | – | – | 474 | 761 | – | 20 | 1,471 | – | 84 | – | 347 | 685 | – | – | – | 480 | **5,941** | 5,941 |
| 1997 | **31,691** | 2,183 | 1,813 | – | – | 659 | 810 | 347 | 33 | 2,125 | 979 | 120 | – | 347 | 710 | – | – | – | 527 | **7,514** | 7,514 |
| 1998 | **31,955** | 2,255 | 1,823 | – | – | 1,039 | 1,011 | 456 | 95 | 2,896 | 2,436 | 127 | – | 370 | 1,148 | – | – | – | 491 | **9,432** | 9,432 |
| 1999 | **28,022** | 3,368 | 2,552 | – | – | 1,293 | 1,613 | 1,080 | 42 | 3,655 | 3,211 | 160 | 1,965 | 368 | 1,750 | – | – | – | 247 | **14,461** | 12,496 |
| 2000 | **27,021** | 3,815 | 3,176 | – | – | 1,152 | 1,122 | 491 | 52 | 3,169 | 2,695 | 244 | 1,277 | 280 | 1,430 | – | – | – | 159 | **12,700** | 11,423 |
| 2001 | **28,582** | 4,336 | 3,464 | – | – | 1,248 | 1,787 | 644 | 57 | 3,415 | 2,718 | 182 | 1,323 | 310 | 1,559 | – | – | – | 156 | **14,373** | 13,050 |
| 2002 | **25,400** | 4,029 | 3,171 | – | – | 1,505 | 2,292 | 774 | 63 | 3,185 | 2,719 | 232 | 1,533 | 261 | 2,480 | – | – | – | 156 | **15,736** | 14,203 |
| 2003 | **25,017** | 4,768 | 4,035 | – | – | 1,718 | 2,090 | 799 | 129 | 3,714 | 3,162 | 200 | 2,078 | 189 | 2,912 | – | – | – | 66 | **17,864** | 15,786 |
| 2004 | **25,235** | 4,592 | 3,644 | – | – | 1,354 | 2,257 | 1,014 | 79 | 3,025 | 2,579 | 170 | 1,350 | 180 | 2,279 | – | – | – | 104 | **15,390** | 14,040 |
| 2005 | **27,440** | 5,558 | 3,635 | – | – | 1,634 | 2,312 | 1,101 | 47 | 4,076 | 2,662 | 196 | 1,137 | 174 | 2,275 | – | – | – | 122 | **17,531** | 16,394 |
| 2006 | **26,966** | 4,640 | 3,357 | – | – | 1,681 | 2,190 | 1,153 | 45 | 3,746 | 3,055 | 137 | 1,529 | 187 | 3,631 | – | – | – | 135 | **17,921** | 16,392 |
| 2007 | **25,342** | 4,259 | 2,614 | – | – | 1,544 | 1,799 | 1,057 | 33 | 3,979 | 3,272 | 198 | 1,170 | 140 | 3,616 | – | – | – | 116 | **16,854** | 15,684 |
| 2008 | **25,293** | 4,585 | 3,055 | – | – | 1,620 | 2,229 | 1,408 | 73 | 4,103 | 3,330 | 177 | 1,608 | 79 | 2,489 | – | – | – | 356 | **17,319** | 15,711 |
| 2009 | **24,206** | 4,797 | 3,120 | – | – | 1,667 | 2,377 | 1,492 | 36 | 3,907 | 3,383 | 74 | 870 | 90 | 3,071 | – | – | – | 324 | **17,213** | 16,343 |
| 2010 | **24,182** | 4,458 | 3,118 | – | – | 1,477 | 2,379 | 1,461 | 59 | 3,361 | 3,003 | 63 | 829 | 114 | 2,936 | – | – | – | 340 | **16,016** | 15,187 |
| 2011 | **23,643** | 4,359 | 1,365 | 323 | 26 | 1,446 | 2,268 | 1,701 | 28 | 3,282 | 2,970 | 56 | 855 | 79 | 2,874 | 841 | 360 | 742 | 143 | **15,390** | 14,535 |

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

In terms of regional comparison, the highest relative number of users of non-alcohol drugs was recorded, as in the previous year, in health facilities in Prague, while the smallest numbers were recorded in the Pardubice, Liberec, and Zlín regions; see Graph 5-2 (Nechanská, 2012b). The number of patients most probably correlates with the regional availability of specialised addiction treatment – see above.

*Graph 5-2: Number of patients using non-alcohol drugs by region of the facility's regional location, per 10,000 inhabitants, 2011 (Nechanská et al. 2011; Nechanská, 2012b)*




### 5.3.2 Opiate Substitution Treatment

#### 5.3.2.1 Import and Distribution of Substitution Drugs

In 2011, there were five medications available for the substitution treatment of opiate addiction:

- methadone, prepared from an imported generic substance, available in specialised substitution centres since 1997,
- Subutex®, with buprenorphine as the active substance, available since 2000,
- Suboxone®, a composite medication containing buprenorphine and naloxone as the active substances, available since February 2008,
- Buprenorphine Alkaloid®, containing buprenorphine, available since January 2011, and
- Ravata®, containing buprenorphine, since June 2011.

Substitution drugs are administered only orally in treatment in the Czech Republic and may be prescribed by any physician, regardless of their specialisation.

In 2009–2012, other proprietary medicinal products containing methadone, as well as buprenorphine, intended for substitution treatment were registered in the Czech Republic, but they were not placed on the market.[99] Suboxone® 8 mg is the only substitution medication that can be partially reimbursed from public health insurance, from 2010 on (see the 2010 Annual Report for details), but because of the conditions for reimbursement, this is not happening in practice.

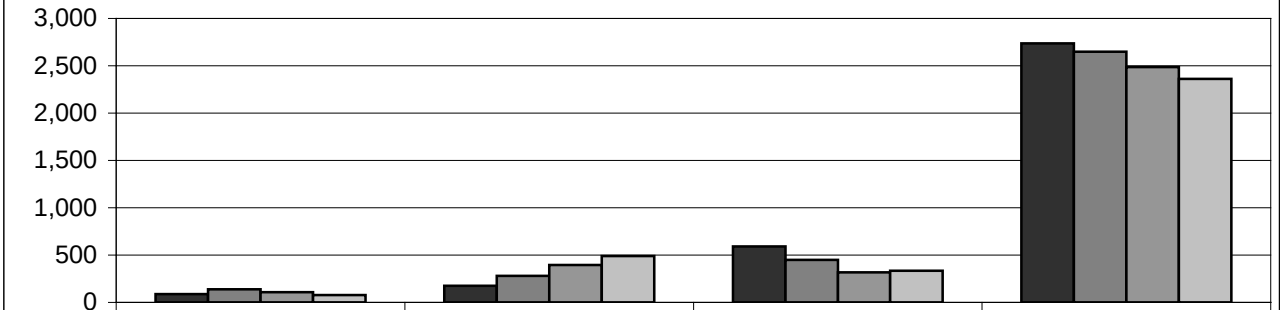
A total of 24.3 kg of pure methadone substance was imported to the Czech Republic and 3,446.8 grams of buprenorphine in the four above-mentioned medications were distributed in 2011 (Ministerstvo zdravotnictví ČR, IOPL, 2012); see Table 5-17. Since 2008, there has been a decline in the share of Subutex® and an increase in the proportion of Suboxone® of the total amount of buprenorphine distributed (consumed) for substitution treatment; however, Subutex® still has a dominant share; see Graph 5-3. The proportion of Buprenorphine Alkaloid® and Ravata® of the total consumption of buprenorphine for substitution treatment was 5.3%, with Ravata® 8 mg taking the lead (137.2 grams, i.e. 4.0% of the total consumption of buprenorphine in substitution treatment).

[99] The product in question is Methadone-Zentiva® (see the 2010 Annual Report). In addition, on 19 May 2010 the State Institute for Drug Control issued a marketing authorisation for the medication Buprenorphine SMB® with a strength of 0.4 mg, on 16 November 2011 for Bupainx® with strengths of 0.4 mg, 2 mg, and 8 mg, and on 18 April 2012 for Buprenorphine Actavis® with strengths of 0.4 mg, 2 mg, and 8 mg, all in the form of sublingual tablets. None of these three products has yet been placed on the Czech market, though. The marketing authorisation for Addnok®, a substitution medication registered in the Czech Republic in 2010, has been suspended.

*Table 5-17: Quantities of substitution drugs imported (methadone) and distributed (buprenorphine), 1999–2011(Ministerstvo zdravotnictví ČR, IOPL, 2012)*

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

*Graph 5-3: Quantities of buprenorphine (g) distributed in the various medicinal products, 2008–2011 (Ministerstvo zdravotnictví ČR, IOPL, 2012)*




| | Suboxone® 2 mg | Suboxone® 8 mg | Subutex® 2 mg | Subutex® 8 mg |
|---|---|---|---|---|
| 2008 | 88.0 | 176.7 | 592.7 | 2,737.1 |
| 2009 | 138.7 | 279.6 | 450.8 | 2,647.8 |
| 2010 | 108.3 | 395.3 | 317.6 | 2,486.7 |
| 2011 | 76.1 | 490.6 | 335.7 | 2,361.0 |

### 5.3.2.2 Estimation of Clients in Substitution Treatment and Problem Use of Buprenorphine

On the basis of a survey among physicians in the Czech Republic, it was estimated that 240 general practitioners prescribed Subutex® to 1,360 patients and 150 psychiatrists prescribed Subutex® to 3,000 patients in 2007; see the 2007 Annual Report. In 2010, data from another round of the survey indicated an estimated 230 general practitioners for adults who provided substitution to an estimated 800 to 1,300 patients; see the 2010 Annual Report.

Furthermore, it was estimated that only 71% of the physicians providing substitution were registered and that only a third of the physicians providing substitution always reported their patients to the register; see the 2010 Annual Report. Lack of control over prescribing and dispensing is the main factor in the diversion of buprenorphine to the black market, which primarily takes the form of the trading of small amounts of tablets between users. Medical prescriptions are also traded, being exchanged directly for tablets; see also the 2010 Annual Report.

There were an estimated 4,600 problem (injecting) buprenorphine users in the Czech Republic in 2011; for more details see the chapter Problem Drug Use (p. 48). The proportion of problem drug users and problem users of opiates/opioids who participate in substitution treatment was estimated in 2010 at 8% (95% CI: 7–10%) and 23% (95% CI: 20–27 %), respectively, which means 2,000 to 3,000 people in 2011.

In April and May 2012, the services of one Prague-based outpatient psychiatrist with a large number of patients on substitution medications containing buprenorphine were temporarily discontinued. The amount of buprenorphine tablets available on the black market in Prague decreased in this period, affecting a number of problem opiate users estimated in the hundreds, who lost access to the drug. The price of ¼ tablet containing 8 mg of buprenorphine rose

from CZK 100 (€ 4) to CZK 300 (€ 12). A working group of the Prague City Council responded to the situation by issuing 2,000 copies of warning leaflets for drug users, entitled "Subutex Crisis".[100]

#### 5.3.2.3 Substitution treatment in health care facilities

From 2011 on, there are two sources of data about the number of patients in substitution treatment for dependence on opiates/opioids. The first source is the National Register of Users of Medically Indicated Substitution Substances (NRULISL), in existence since 2000. Data are newly available from annual reports on the activities of psychiatric outpatient facilities and general practitioners for adults, processed by the Institute of Health Information and Statistics. The reports in the field of psychiatry monitor patients by age group and gender, those on general practitioners by gender.

#### 5.3.2.4 National Register of Users of Medically Indicated Substitution Substances

All physicians administering a substitution preparation are obliged by law to report the patient data to the National Register of Users of Medically Indicated Substitution Substances (NRULISL), which has been operated in the country since May 2000, developed and administered by the Institute of Health Information and Statistics of the Czech Republic. A web-based application named NRULISL has been operating since November 2007.[101] A total of 55 health facilities reported having patients on substitution in 2011. The Pardubice region remains the only region that does not have an actively reporting facility. Information on the development of actively reporting facilities by region is shown in Table 5-18 (Nechanská et al. 2011; Nechanská, 2012g).

*Table 5-18: Number of healthcare facilities actively reporting clients to the Substitution Treatment Register, by regional location, 2000–2011 (Nechanská et al. 2011; Nechanská, 2012g)*

| Regional location | 2000* | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prague | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 4 | 6 | 10 | 16 |
| Central Bohemia | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 3 | 3 | 5 |
| South Bohemia | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 2 | 1 | 2 | 3 |
| Pilsen | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 2 |
| Karlovy Vary | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 2 | 1 | 2 | 2 |
| Ústí nad Labem | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 |
| Liberec | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Hradec Králové | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 3 | 4 | 4 | 4 |
| Pardubice | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Vysočina | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 |
| South Moravia | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 4 | 5 |
| Olomouc | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Zlín | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 2 |
| Moravia-Silesia | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 3 | 3 |
| Nationwide operation (military hospitals, prisons) | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 4 | 9 | 8 | 8 |
| **Total** | **7** | **8** | **8** | **8** | **8** | **9** | **12** | **13** | **24** | **34** | **45** | **55** |

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

In 2011, only 13 facilities registered with the Substitution Treatment Register, the lowest number since the launch of the electronic application. At the end of 2011 a total of 109 facilities were registered in the Substitution Treatment Register (of these, 23 were alcohol/drug treatment outpatient clinics, 31 psychiatric outpatient clinics, 34 general practitioners for adults, 9 with other specialisations, and 11 prisons); see Table 5-19 and Map 5-1 (Nechanská et al. 2011; Nechanská, 2012g).

[100] http://www.drogy.net/aktuality/z-domova/nedostatek-subutexu-na-cernem-trhu-s-sebou-prinasi-vazna-rizika.html (2012-08-08)

[101] Available at https://snzr.uzis.cz/nrulisl/. Until 2007, the register was kept in a simple database form, only collecting data from specialised substitution centres accredited by the Ministry of Health, while communication took place in the form of paper reports and by telephone.

*Table 5-19: Number of healthcare facilities registered in the NRULISL electronic application, 2007–2011 (Nechanská et al. 2011; Nechanská, 2012g; Nechanská, 2011c)*

| Type of facility | Year of registration | | | | | Total |
|---|---|---|---|---|---|---|
| | 2007 | 2008 | 2009 | 2010 | 2011 | |
| AT clinic | 0 | 11 | 3 | 8 | 1 | 23 |
| Psychiatry | 1 | 11 | 8 | 5 | 6 | 31 |
| General practitioner for adults | 0 | 4 | 19 | 6 | 5 | 34 |
| Other departments | 0 | 1 | 3 | 4 | 1 | 9 |
| Prison | 0 | 10 | 0 | 1 | 0 | 11 |
| Military hospital | 0 | 0 | 1 | 0 | 0 | 1 |
| **Total** | **1** | **37** | **34** | **24** | **13** | **109** |

*Map 5-1: Network of healthcare facilities registered in the NRULISL electronic application in 2007–2011 (Nechanská, 2012g)*


During 2011, 2,290 patients (1,621 men and 669 women) were registered in the Substitution Treatment Register. More than 58% of them were aged 30–39 and 32% were aged 20–29. The average age of the persons treated during the year was 32.0 years. The men were on average 2.4 years older than the women (men 32.7 years, women 30.3 years). In terms of regional comparison, the largest share (42%) of the persons treated had their domicile in Prague and in the Ústí nad Labem (17%), Central Bohemia (16%), and South Bohemia (6%) regions. The number of people increased in almost all the regions except the Pilsen, South Moravia, and Olomouc regions; see Graph 5-4. The largest number of patients treated in 2011 were registered with the Prague-based Remedis facility (411 persons, 18% of the total number of patients treated), the Masaryk Hospital in Ústí nad Labem (389, 17%), Drop-In in Prague (228, 10%), one AT clinic in Prague (228, 10%), and the Podané ruce association in Brno (125, 6%); see Table 5-20.

In 2011, 1,623 of the 2,290 (71%) persons reported to the Register were treated with buprenorphine, with almost three-quarters of them being treated with Subutex® (1,212 persons) and a quarter of them with Suboxone® (396 persons). Other buprenorphine-based preparations put on the market in the course of 2011 were prescribed to 15 people in total. The remaining 667 subjects were treated with methadone; see Table 5-20.

A total of 1,080 initiated treatments involving 929 persons were reported to the Register in 2011, with men accounting for about three-quarters of the total number of cases. Of the reported number of persons, 472 (51%) started substitution treatment for the first time in their life.[102] Treatment was discontinued during the year 2011 with a total of 723 persons in 833 cases (Nechanská et al. 2011; Nechanská, 2012g); see Table 5-20.

[102]It is not uncommon for patients addicted to opiates/opioids to start substitution treatment repeatedly. Of the 929 people who entered a treatment programme in 2011, two reported commencements of treatment in the year under monitoring were on record among 110 people (12%), 14 people had reported entering treatment three times, three people entered treatment four times, one client entered five times, and the remaining 801 persons (86%) had only one commencement of treatment on record. There was an average of 1.2 attempts at treatment per person in 2011 (the same as in the previous year).

*Graph 5-4: Development of the number of clients in substitution treatment by region of domicile, 2009–2011 (Nechanská, 2012g)*

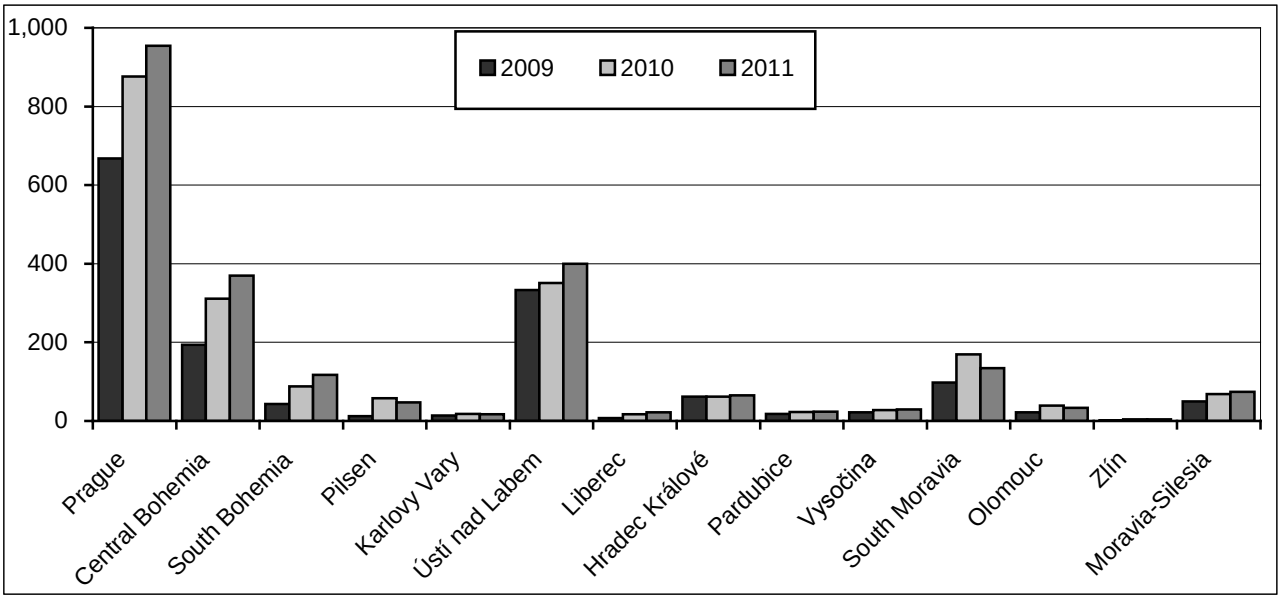



*Table 5-20: Development of the number of persons treated, number of reported treatment episoded, and number of completed treatment episodes in the NRULISL from 2000 to 2011, by gender (Nechanská et al. 2011; Nechanská, 2012g)*

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

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

Substitution treatment in 2011 was reported by a total of 67 psychiatric outpatient facilities and was provided to 2,786 patients (1,900 men and 886 women). Almost 91% of these patients were aged 20–39, 8% were aged 40–46, and less than 1% was aged 15–19. Substitution treatment was provided by 23 Prague-based facilities, which reported almost 61% of the total number of patients in the Czech Republic. Less than 14% of those on substitution treatment were recorded in three facilities in the Ústí nad Labem region and 5% in the Central Bohemia (7 facilities) and South Bohemia regions (4 facilities). Substitution treatment by psychiatrists was not provided in the Pardubice and Liberec regions. Low numbers of patients on substitution were reported by psychiatric clinics in the Zlín (2 patients), Vysočina (12), and Karlovy Vary regions (30).

Substitution treatment was also provided by 357 general practitioners for adults, who treated a total of 1,306 persons (776 men and 530 women). Most general practitioners provided care for less than 10 patients, only 17 practitioners treated 10–20 patients, and 8 treated more than 20 patients. The largest proportion of patients treated by general practitioners was recorded in the Ústí nad Labem region (15%), Prague (13%), and the South Moravia region (11%).

Thus, a total of 4,092 patients received substitution treatment from outpatient psychiatrists and general practitioners in 2011 (Table 5-21). This confirms the estimates made by the National Focal Point on the basis of information obtained in the regular omnibus survey conducted among physicians in the Czech Republic – see above.

*Table 5-21: Substitution treatment for addiction to opiates/opioids provided by psychiatrists and general practitioners for adults in 2011 (Nechanská, 2012g)*

| Region | Psychiatric clinics | | | | General practitioners for adults | | | |
|---|---|---|---|---|---|---|---|---|
| | Number of patients | | | Number of facilities | Number of patients | | | Number of facilities |
| | Men | Women | Total | | Men | Women | Total | |
| Prague | 1,139 | 560 | 1,699 | 23 | 120 | 49 | 169 | 55 |
| Central Bohemia | 95 | 32 | 127 | 7 | 63 | 38 | 101 | 37 |
| South Bohemia | 95 | 35 | 130 | 4 | 38 | 20 | 58 | 24 |
| Pilsen | 43 | 18 | 61 | 4 | 24 | 17 | 41 | 13 |
| Karlovy Vary | 22 | 8 | 30 | 1 | 25 | 17 | 42 | 8 |
| Ústí nad Labem | 265 | 123 | 388 | 3 | 121 | 78 | 199 | 36 |
| Liberec | 0 | 0 | 0 | 0 | 65 | 51 | 116 | 21 |
| Hradec Králové | 61 | 23 | 84 | 3 | 26 | 21 | 47 | 18 |
| Pardubice | 0 | 0 | 0 | 0 | 50 | 47 | 97 | 18 |
| Vysočina | 10 | 2 | 12 | 3 | 33 | 37 | 70 | 15 |
| South Moravia | 57 | 22 | 79 | 7 | 90 | 54 | 144 | 46 |
| Olomouc | 55 | 16 | 71 | 3 | 21 | 30 | 51 | 20 |
| Zlín | 1 | 1 | 2 | 2 | 71 | 33 | 104 | 26 |
| Moravia-Silesia | 57 | 46 | 103 | 7 | 29 | 38 | 67 | 20 |
| **Total** | **1,900** | **886** | **2,786** | **67** | **776** | **530** | **1,306** | **357** |

### 5.3.3 Sobering-up Stations

In 2011, the number of stations increased by one to a total of 17 facilities with 152 beds (five beds less than in 2010).[103] Sobering-up stations were found in all regions except the Ústí nad Labem and Liberec regions in 2011 (Nechanská et al. 2011; Mravčík et al. 2011c; Nechanská, 2012e; Mravčík et al. 2011c; Nechanská, 2011b). One of the stations operates at a psychiatric hospital in Brno.

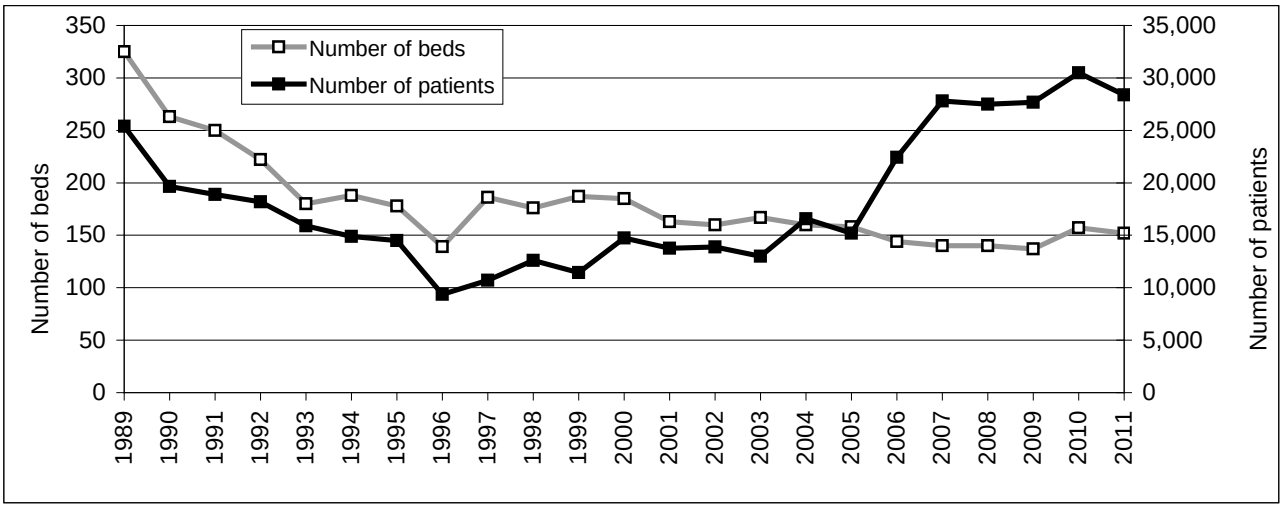
*Map 5-2: Network of sobering-up stations in 2011 (Nechanská, 2012e)*


Until 2005, the trend in the number of clients of sobering-up stations reflected their number and capacity; from 2005 on, one can observe a decrease in their capacity, but an increase in the number of clients, especially men. For historical data and development see the 2009 and 2010 Annual Reports. In 2011, there was a year-on-year decrease in the number of patients by 7% to 28,365 persons (Graph 5-5) because of a drop in the number of places and a lower rate of those brought to the facility in Prague, mainly caused by the fact that cooperation between the

[103]In 2011, the data monitored were divided between sobering-up stations in Karviná and Opava, which are operated by the Regional Rescue Service Centre of the Moravia-Silesia region; these two stations previously reported data jointly.

sobering-up station and the police worsened.[104] From 2006 to 2011, 84% of those treated were men. The structure of those treated by gender and age is given in Table 5-22.

*Graph 5-5: Development of the capacity of sobering-up stations and the number of patients treated, 1989–2011 (Nechanská et al. 2011; Nechanská, 2012e)*




In 2011, the persons brought to sobering-up stations were, for the first time ever, divided according to whether they were intoxicated with alcohol or some other addictive substance.[105] Of the total number of those brought to sobering-up stations, 86% were intoxicated with alcohol and 14% with other drugs. The proportion of cases related to drugs other than alcohol was higher in males (15%) than females (8%). The highest proportion of those brought to sobering-up stations for non-alcohol drugs was in the 0–19 age group (20%), as opposed to 14% in the group aged 20–64 and almost 8% in the group aged over 65 years, the percentages referring to the proportion of those brought to sobering-up stations out of the total number of those treated there in each age group. Most patients intoxicated with non-alcohol drugs, specifically 3,657 patients (i.e. more than 97% of these intoxications), were recorded by the sobering-up station in Prague, the only one that reported persons over 65 years being brought to the station for addictive substances other than alcohol; see Table 5-22 and Table 5-23 (Nechanská, 2012g).

*Table 5-22: Number of persons treated for alcohol intoxication by region of the facility's regional location and the patient's gender and age group, 2011 (Nechanská, 2012g)*

| **Regional location** | **Number of stations** | **Number of beds** | **Total number of patients** | **Gender** | | **Age** | | |
|---|---|---|---|---|---|---|---|---|
| | | | | Men | Women | 0–19 years | 20–64 years | 65 years and over |
| Prague | 1 | 17 | 5,681 | 4,129 | 1,552 | 896 | 4,302 | 483 |
| Central Bohemia | 3 | 14 | 833 | 735 | 98 | 22 | 787 | 24 |
| South Bohemia | 1 | 9 | 946 | 814 | 132 | 47 | 874 | 25 |
| Pilsen | 1 | 10 | 1,610 | 1,352 | 258 | 113 | 1,409 | 88 |
| Karlovy Vary | 1 | 5 | 667 | 581 | 86 | 23 | 628 | 16 |
| Hradec Králové | 1 | 8 | 992 | 880 | 112 | 51 | 845 | 96 |
| Pardubice* | 1 | 11 | – | – | – | – | – | – |
| Vysočina | 1 | 8 | 1,095 | 981 | 114 | 19 | 1,040 | 36 |
| South Moravia | 1 | 13 | 3,731 | 3,008 | 723 | 101 | 3,405 | 225 |
| Olomouc | 1 | 15 | 1,489 | 1,266 | 223 | 208 | 1,206 | 75 |
| Zlín | 1 | 5 | 733 | 645 | 88 | 7 | 698 | 28 |
| Moravia-Silesia | 4 | 37 | 5,652 | 4,990 | 662 | 144 | 5,238 | 270 |
| **Total** | **17** | **152** | **23,429** | **19,381** | **4,048** | **1,631** | **20,432** | **1,366** |

*Note: * The sobering-up station in the Pardubice region did not divide the people treated according to the addictive substance.*

[104]Source: comments by a physician working at a Prague-based sobering-up station in the annual data sheet.
[105]The sobering-up station in the Pardubice region did not divide the people treated according to the substance – a total was 1,176 individuals.

*Table 5-23: Number of persons treated for intoxication with substances other than alcohol, by region of the facility's regional location and the patient's gender and age group, 2011 (Nechanská, 2012g)*

| Regional location | Number of stations | Number of beds | Total number of patients | Gender | | Age | | |
|---|---|---|---|---|---|---|---|---|
| | | | | Men | Women | 0–19 years | 20–64 years | 65 years and over |
| Prague | 1 | 17 | 3,657 | 3,319 | 338 | 381 | 3,163 | 113 |
| Central Bohemia | 3 | 14 | 0 | 0 | 0 | 0 | 0 | 0 |
| South Bohemia | 1 | 9 | 41 | 36 | 5 | 4 | 37 | 0 |
| Pilsen | 1 | 10 | 0 | 0 | 0 | 0 | 0 | 0 |
| Karlovy Vary | 1 | 5 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hradec Králové | 1 | 8 | 6 | 6 | 0 | 0 | 6 | 0 |
| Pardubice* | 1 | 11 | – | – | – | – | – | – |
| Vysočina | 1 | 8 | 0 | 0 | 0 | 0 | 0 | 0 |
| South Moravia | 1 | 13 | 0 | 0 | 0 | 0 | 0 | 0 |
| Olomouc | 1 | 15 | 5 | 3 | 2 | 5 | 0 | 0 |
| Zlín | 1 | 5 | 51 | 48 | 3 | 6 | 45 | 0 |
| Moravia-Silesia | 4 | 37 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **17** | **152** | **3,760** | **3,412** | **348** | **396** | **3,251** | **113** |

*Note: * The sobering-up station in the Pardubice region did not divide the people treated according to the addictive substance.*

In the period from May 2011 to January 2012 there was a survey intended to describe the current operational practice of sobering-up stations and the problems faced by them (Burešová and Popov, 2012). All 17 sobering-up stations participated in it. The client is most frequently brought to the sobering-up station by the Police of the Czech Republic or the city/municipal police, but the decision concerning admission to the facility is solely in the hands of the physician on duty there. One half of the sobering-up stations do not report the admission of the client to his/her general practitioner, although they are obliged to do so under Act No. 379/2005 Coll. The reasons for non-reporting include a lack of financial and human resources. Only four sobering-up stations collaborate with the AT (alcohol/drug treatment) outpatient clinic in their catchment area. Juveniles brought to sobering-up stations are reported to their legal representatives and to the authority responsible for the social and legal protection of children (this is also required by law) by only a third of the stations. The study also looked into the services provided by the sobering-up stations. In addition to safe detoxification, all the stations reported that their standard services include clinical examination by a physician and an emergency service in the event of sudden changes in the client's state of health. Most facilities perform blood, urine, and breath tests on request. Saliva tests for drugs are only performed by one station, and working with family members or collaboration with another organisation is not common. Almost half of the stations are staffed by a physician, a nurse, and a nursing aide/orderly. The frequent practice is that the physician is only present to admit/release the client, otherwise remaining on call and called in if necessary, while the operation of the station is only in the hands of the middle or lower medical staff. Sobering-up stations in major cities consider their capacity insufficient, while stations in small towns take the opposite view. In recent years, an increase in the number of persons intoxicated with non-alcohol drugs has been observed. The problems that sobering-up stations are often faced with in their operation and which have been highlighted by Burešová and Popov (2012) include the following.

- Financial problems: treatment at the sobering-up station is not covered by health insurance, but it is subject to a fee; the operation is co-financed by the regions, which are responsible for the treatment of intoxicated people by law (Act No. 379/2005 Coll.). The fee is not uniform. It is determined by the managing authority and ranges from CZK 600 (€ 24) to CZK 9,000 (€ 366); usually it is CZK 2,000 (€ 81) to CZK 3,000 (€ 122) (Burešová et al. 2011). Payments from the persons treated at the sobering-up stations are difficult to collect. For example, the Prague-based station issued four thousand invoices amounting to more than CZK 8 million (€ 325 thousand) in 2006 to cover the cost of their services, but almost 3,000 invoices remained unpaid (Chromčák et al. 2007). This is further complicated by the fact that most debtors are impossible to track down after their release. Most of the costs associated with the operation are therefore borne by the managing authority, which can be a problem for some regions (Hlásenský, 2003).
- The sobering-up stations receive persons whose state of health is an indication for admission to hospital-based intensive care units. Unfortunately, as a drunk patient is regularly dirty, troublesome, and often aggressive, they are usually not provided with all the necessary care at the facility or are provided with no care at all (Podlaha, 2005). By contrast, there are cases in which people are referred to other hospital departments, although they are indicated for treatment at the sobering-up station; they are brought there by the police, who often respond to the intoxicated people first.
- The physical and technical resources of the sobering-up stations are also an issue, because they do not match the requirements for dealing with life-threatening conditions (Wildová, 2011). Therefore, patients with more serious conditions need to be transferred to the intensive care unit.

### 5.3.4 Outpatient Treatment Provided by NGOs

Outpatient treatment in the Czech Republic is also provided by NGOs. Their common feature is that they are co-financed from the public budget through subsidy proceedings, although some of these programmes have the status of an accredited healthcare facility and are involved in the system of public health insurance. In 2011, the Government Council for Drug Policy Coordination supported via its subsidy proceedings 12 outpatient programmes that provided services to a total of 1,524 drug users. Of this number, 640 (41.9%) were males and the average age of the clients using drugs was 25.6 years. A total of 754 (49.5%) clients injected drugs, 744 (48.8%) used pervitin, 170 (11.2%) heroin, 136 (8.9%) cannabis, and 73 (4.8%) Subutex® acquired illegally. Comparisons across 2004–2011 are given in Table 5-24.

Intensive outpatient treatment in the form of a day care centre has only been on offer in the long term from one facility in Prague, operated since 1996 by the SANANIM civic association. The programme's capacity is 10 persons. In 2011, there were 32 clients in the programme (9 men) and the average age was 29 years. A total of 17 clients had injected drugs prior to treatment, 16 clients had used pervitin, and a total of 12 people used heroin. Treatment was successfully completed by 19 clients (59.4%). The average duration of treatment was 87 days (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h).

*Table 5-24: Outpatient treatment programmes operated by NGOs and selected characteristics of their clients, 2004–2011 (Mravčík et al. 2011d; Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

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

## 5.4 Residential Treatment

### 5.4.1 Detoxification Units

Detailed information about detoxification units has been collected by the Institute of Health Information and Statistics since 2010; for details see the 2009 and 2010 annual reports. In 2011, there were 17 inpatient facilities that reported having dedicated beds for detoxification from addictive substances, with three in university hospitals, five in acute care hospitals, and nine in psychiatric hospitals. The largest number of detoxification units was in Prague (4), while the Vysočina and South Moravia regions reported two units each. There were no detoxification units in the Karlovy Vary and Pardubice regions in 2011. An additional 12 inpatient detoxification facilities performed withdrawal management, although they did not have specifically dedicated beds for this type of treatment. The Karlovy Vary region was the only one not to provide detoxification to patients dependent on alcohol or other substances; Table 5-25 and Map 5-3.

A total of 17 facilities had 150 beds dedicated to the detoxification of alcohol/drug dependent patients (13 beds less than in 2010). Most beds were in (male/female) detoxification units in the Bohnice psychiatric hospital in Prague (16 beds in total), while the Military Hospital in Olomouc had 15 dedicated beds. The psychiatric hospital in Havlíčkův Brod, the University Hospital in Brno, and the Child and Adolescent Detoxification Centre at the Hospital of the Sisters of Mercy of St. Charles Borromeo in Prague had 14 beds. The detoxification unit at the Central Military Hospital in Prague reported the smallest number of beds (2) (Nechanská, 2012f).

A total of 7,161 patients were hospitalised for detoxification from addictive substances in 2011, i.e. 511 (7%) more than in 2010. This increase is probably due to a higher number of facilities reporting detoxified patients in 2011. More than a third (35%) of the patients were detoxified in Prague-based facilities, and more than a tenth in the South Bohemia and South Moravia regions. The largest proportion of patients were admitted for detoxification from alcohol (55%), a combination of multiple substances (18%), stimulants other than cocaine (14%), which also include pervitin, and opiates/opioids (6%). In Prague, the highest rates of detoxification recorded in 2011 were from alcohol (33%) and other drugs (38%); see Table 5-26.

*Table 5-25: Network of inpatient facilities providing detoxification to AT patients and the numbers of dedicated beds in detoxification units, 2011 (Nechanská, 2012f)*

| Region | Dedicated beds | | | | | | | | Number of facilities with non-dedicated beds | | | | Dedicated beds |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | University hospitals | | Hospitals (acute care) | | Psychiatric hospitals | | Total | | University hospitals | Hospitals (acute care) | Psychiatric hospitals | Total | |
| | Number of facilities | Number of beds | Number of facilities | Number of beds | Number of facilities | Number of beds | Number of facilities | Number of beds | | | | | |
| Prague | 1 | 9 | 2 | 16 | 1 | 16 | 4 | 41 | 0 | 0 | 0 | 0 | **4** |
| Central Bohemia | 0 | 0 | 0 | 0 | 1 | 9 | 1 | 9 | 0 | 2 | 0 | 2 | **3** |
| South Bohemia | 0 | 0 | 0 | 0 | 1 | 13 | 1 | 13 | 0 | 0 | 1 | 1 | **2** |
| Pilsen | 1 | 6 | 0 | 0 | 0 | 0 | 1 | 6 | 0 | 1 | 0 | 1 | **2** |
| Karlovy Vary | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Ústí nad Labem | 0 | 0 | 1 | 3 | 0 | 0 | 1 | 3 | 0 | 0 | 1 | 1 | **2** |
| Liberec | 0 | 0 | 1 | 5 | 0 | 0 | 1 | 5 | 0 | 0 | 0 | 0 | **1** |
| Hradec Králové | 0 | 0 | 0 | 0 | 1 | 6 | 1 | 6 | 0 | 1 | 0 | 1 | **2** |
| Pardubice | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | **1** |
| Vysočina | 0 | 0 | 0 | 0 | 2 | 19 | 2 | 19 | 0 | 0 | 0 | 0 | **2** |
| South Moravia | 1 | 14 | 0 | 0 | 1 | 10 | 2 | 24 | 0 | 2 | 0 | 2 | **4** |
| Olomouc | 0 | 0 | 1 | 15 | 0 | 0 | 1 | 15 | 1 | 0 | 0 | 1 | **2** |
| Zlín | 0 | 0 | 0 | 0 | 1 | 4 | 1 | 4 | 0 | 0 | 0 | 0 | **1** |
| Moravia-Silesia | 0 | 0 | 0 | 0 | 1 | 5 | 1 | 5 | 1 | 1 | 0 | 2 | **3** |
| **Total** | **3** | **29** | **5** | **39** | **9** | **82** | **17** | **150** | **2** | **8** | **2** | **12** | **29** |

*Map 5-3: Network of detoxification units and facilities providing detoxification in non-dedicated beds, 2011 (Nechanská, 2012f)*


*Table 5-26: Number of persons hospitalised for detoxification from addictive substances, 2011 (Nechanská, 2012f)*

| Regional location | Number of facilities | F10 (alcohol) | F11 (opiates/opioids) | F12 (cannabis) | F13 (sedatives/hypnotics) | F14 (cocaine) | F15 (other stimulants) | F16 (hallucinogens) | F17 (tobacco) | F18 (inhalants) | F19 (other psychoactive substances) | F19 (combination of two or more substances) | Non-alcohol drugs, total | Total number of persons |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prague | 4 | **1,321** | 96 | 59 | 72 | 1 | 348 | 1 | 2 | 1 | 0 | 628 | **1,208** | **2,529** |
| Central Bohemia | 3 | **184** | 20 | 2 | 4 | 0 | 10 | 0 | 0 | 0 | 0 | 53 | **89** | **273** |
| South Bohemia | 2 | **294** | 135 | 24 | 18 | 0 | 262 | 0 | 0 | 1 | 0 | 133 | **573** | **867** |
| Pilsen | 2 | **129** | 13 | 8 | 15 | 0 | 24 | 0 | 0 | 0 | 1 | 42 | **103** | **232** |
| Karlovy Vary | 0 | **–** | – | – | – | – | – | – | – | – | – | – | **–** | **–** |
| Ústí nad Labem | 2 | **121** | 51 | 7 | 16 | 2 | 93 | 1 | 0 | 2 | 0 | 72 | **244** | **365** |
| Liberec | 1 | **32** | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 2 | 3 | **8** | **40** |
| Hradec Králové | 2 | **158** | 2 | 1 | 9 | 0 | 26 | 0 | 0 | 0 | 0 | 36 | **74** | **232** |
| Pardubice | 1 | **125** | 0 | 1 | 4 | 0 | 1 | 0 | 0 | 0 | 0 | 15 | **21** | **146** |
| Vysočina | 2 | **248** | 24 | 7 | 13 | 10 | 16 | 1 | 0 | 0 | 0 | 77 | **148** | **396** |
| South Moravia | 3 | **666** | 41 | 24 | 17 | 0 | 63 | 0 | 0 | 0 | 7 | 128 | **280** | **946** |
| Olomouc | 3 | **250** | 19 | 10 | 24 | 0 | 41 | 0 | 0 | 0 | 0 | 25 | **119** | **369** |
| Zlín | 1 | **83** | 0 | 0 | 2 | 0 | 21 | 1 | 0 | 0 | 0 | 32 | **56** | **139** |
| Moravia-Silesia | 3 | **349** | 40 | 53 | 26 | 0 | 127 | 0 | 0 | 0 | 0 | 32 | **278** | **627** |
| **Total** | **29** | **3,960** | **442** | **196** | **220** | **13** | **1,034** | **4** | **2** | **4** | **10** | **1,276** | **3,201** | **7,161** |

More than two thirds (67%) of the total number of detoxified patients were males, the proportion being higher (69%) for alcohol than for non-alcohol drugs (65%). Detoxification was provided to 592 children (8%) and adolescents aged 0–19 years in 2011, the proportion of boys being 55%; 250 of them (42%) underwent detoxification from other stimulants, 116 (nearly one fifth) from alcohol, 96 (16%) from a combination of several substances, and 84 (14%) from cannabinoids (Nechanská, 2012f).

Detoxification was also provided in five prisons in 2011; see the chapter Drug Use and Problem Drug Use in Prisons (p. 134).

### 5.4.2 Psychiatric Inpatient Facilities

Details of the specialised inpatient care for users of addictive substances are also provided this year in the selected issue chapter Residential Treatment for Drug Users (p. 146).

Residential medical treatment of patients addicted to drugs is predominantly provided by psychiatric hospitals and hospital-based psychiatric wards. In psychiatric hospitals, in particular, this type of care is provided in specialised addiction treatment units. In 2011, the classification of the PATEB inpatient facility changed from the original category of "other inpatient facility" to "psychiatric hospital" (the total number of reporting facilities was not altered by this change). While there was a further decline in the number of beds in psychiatric hospitals (by 64) in 2011, the percentage of beds dedicated to alcohol/drug treatment remained almost unchanged. The number of hospital-based psychiatric wards remained the same in 2011, 31. Out of these, only one, with a capacity of 61 beds, specialised in alcohol/drug treatment services and two other had dedicated AT units, with a combined capacity of 29 beds. Data on the number of facilities (wards) and number of beds and patients are given in Table 5-27 (Nechanská et al. 2011; Nechanská, 2012c).

*Table 5-27: Number of inpatient psychiatric facilities, their total capacity, and number of patients – users of non-alcohol drugs (excluding tobacco), 2002–2011 (Nechanská, 2012c)*

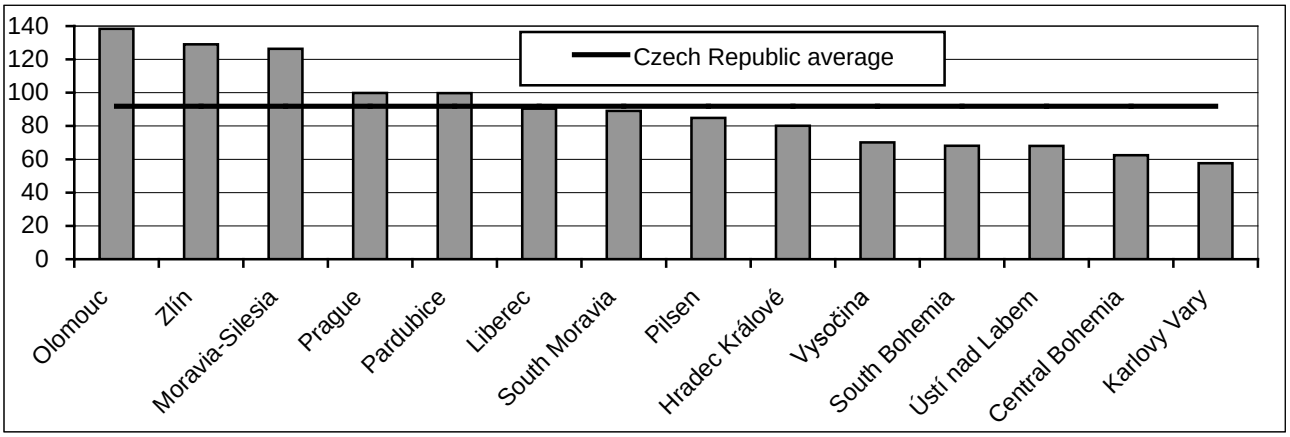
| Year | Psychiatric hospitals for children | | | Psychiatric hospitals for adults | | | | Hospital-based psychiatric wards | | | Other inpatient facilities* | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Number of beds | Number of patients | Number | Number of beds | of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

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

In 2011, there was a slight annual decline in the number of hospitalisations for disorders caused by substance use (i.e. a primary diagnosis F10–F19) by 111 hospitalisations (1%), to 15,253. This decrease is attributable mainly to hospitalisations related to alcohol use, in which there has been a significant decline since 2005. In 2011, the number of admissions for disorders caused by alcohol use decreased by 238 (2%) to 9,765. The number of hospitalisations for disorders caused by the use of drugs other than alcohol (excluding tobacco) increased by 131 (2%) to 5,487 in 2011; see Table 5-28.

Patients with the F10 (alcohol) primary diagnosis accounted for almost two thirds of all hospital admissions for disorders resulting from psychoactive substances (diagnoses F10–F19); men represented more than 68% of those admitted; see Table 5-29. The average length of hospitalisation for alcohol in all inpatient psychiatric facilities was 52.9 days. More than 55% of the patients were aged 40–59 and 80% of the patients were aged 30–59. Seven child patients aged 0–14 and 93 juvenile patients aged 15–19 were hospitalised. In terms of regional distribution, most patients admitted to hospitals in relation to alcohol were those with a permanent place of residence in the Olomouc (138 hospitalisations per 100,000 regional inhabitants), Zlín (129 hospitalisations), and Moravia-Silesia regions (126 hospitalisations); see Graph 5-6 (Nechanská, 2011a).

*Graph 5-6: : Number of hospitalisations of patients using alcohol by region of domicile per 100,000 inhabitants, 2011 (Nechanská, 2012c)*




The trends in hospitalisations for each group of non-alcohol drugs vary. Between 2001 and 2002, there was a significant decrease in the number of hospitalisations for disorders caused by opiates/opioids (diagnosis F11), which continued, with minor fluctuations, in the following years. The number of hospitalisations for disorders caused by a combination of substances (F19) increased in the long term, as did the number of hospitalisations for disorders caused by the use of stimulants other than cocaine (F15). The number of hospitalisations for disorders caused by other drugs was much lower in 2011; the number of hospitalisations for the use of cannabinoids, hallucinogens, and inhalants decreased, while the number of hospital admissions related to sedatives/hypnotics and cocaine rose slightly; see Table 5-28 (Nechanská et al. 2011; Mravčík et al. 2011a; Nechanská, 2012c).

*Table 5-28: Development of the number of hospitalisations for disorders caused by alcohol and other psychoactive substances in inpatient psychiatric facilities, 1997–2011 (Nechanská et al. 2011; Nechanská, 2012c)*

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

Polydrug use (dg. F19) was again the most common cause of the hospitalisations (50%) of users of non-alcohol drugs (excluding tobacco) in inpatient psychiatric facilities in 2011. Other causes of hospitalisation included the use of stimulants (31%) and opiates/opioids (8%); see Table 5-29. The average duration of treatment in hospitalisations for non-alcohol drug use was 34.7 days; 42.8 days in psychiatric hospitals for adults and children and 12.3 days in the psychiatric wards of hospitals. More than 44% of the hospitalised users of illicit drugs were in the group aged 20–29 and 27% in the group aged 30–39, while juveniles aged 15–19 made up 13% of the overall number of these hospitalisations. Thirty children under 15 years old were hospitalised in connection with illicit drugs, the reasons being primarily the use of other stimulants (13 hospitalisations), polydrug use, cannabis (6 each), and inhalants (4). For most drugs other than alcohol, male users made up approximately two thirds of hospitalisations. An exception to this is the diagnosis F13 (sedatives and hypnotics), where half of the patients were aged 40–59 years old and 70% of the admissions with this primary diagnosis were females (Nechanská, 2012c).

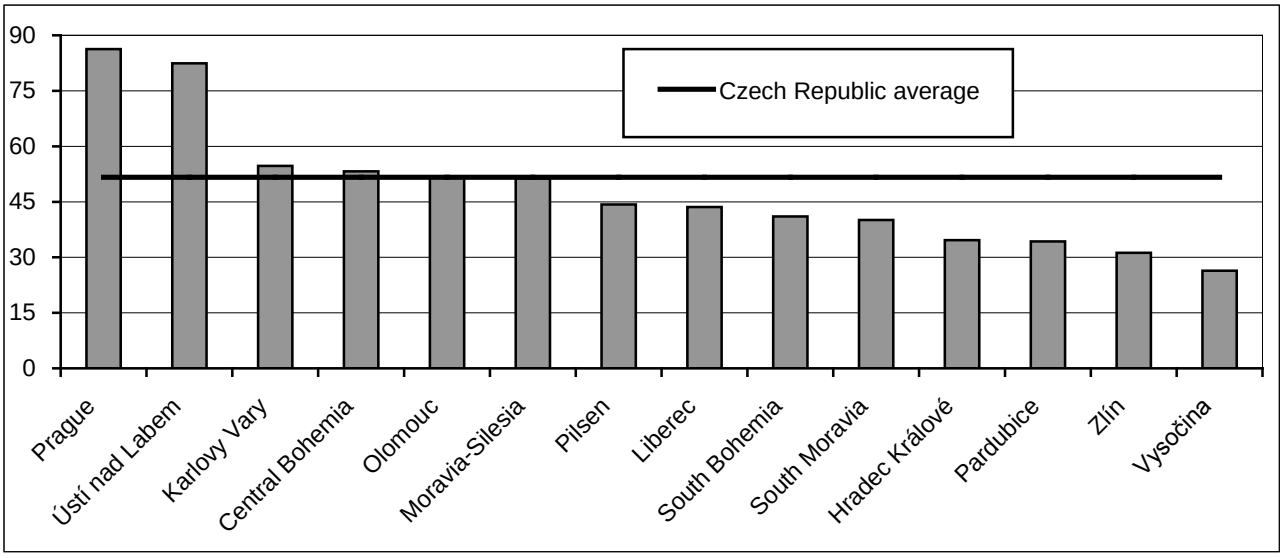
*Table 5-29: Number of hospitalisations for disorders caused by alcohol and other psychoactive substances in inpatient psychiatric facilities, by type of healthcare facility, gender, and diagnosis, 2011 (Nechanská, 2012c)*

| Addictive substance | Psychiatric hospitals for children | | Psychiatric hospitals for adults | | Hospital-based psychiatric wards | | Other inpatient facilities | | Psychiatric inpatient facilities, total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Men | Women | Men | Women | Men | Women | Men | Women | **Men** | **Women** | **Total** |
| Opiates/opioids | 1 | 0 | 173 | 98 | 114 | 62 | 0 | 0 | 288 | 160 | 448 |
| Cannabinoids | 9 | 1 | 82 | 10 | 70 | 12 | 1 | 0 | 162 | 23 | 185 |
| Sedatives/ hypnotics | 0 | 1 | 54 | 137 | 51 | 108 | 0 | 1 | 105 | 247 | 352 |
| Cocaine | 0 | 0 | 3 | 1 | 1 | 0 | 0 | 0 | 4 | 1 | 5 |
| Other stimulants | 1 | 2 | 803 | 426 | 282 | 206 | 2 | 1 | 1,088 | 635 | 1,723 |
| Hallucinogens | 0 | 0 | 1 | 0 | 3 | 1 | 0 | 0 | 4 | 1 | 5 |
| Inhalants | 4 | 1 | 14 | 0 | 2 | 1 | 0 | 0 | 20 | 2 | 22 |
| Polydrug use | 9 | 3 | 1,581 | 592 | 360 | 191 | 7 | 1 | 1,957 | 787 | 2,744 |
| **Illegal drugs, total** | **24** | **8** | **2,711** | **1,264** | **883** | **581** | **10** | **3** | **3,628** | **1,856** | **5,487*** |
| Alcohol | 0 | 1 | 5,101 | 2,228 | 1,448 | 897 | 67 | 23 | 6,616 | 3,149 | 9,765 |
| Tobacco | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 1 |
| **Addictive substances, total** | **24** | **9** | **7,812** | **3,492** | **2,332** | **1,478** | **77** | **26** | **10,245** | **5,005** | **15,253*** |

*Note: *The age and gender of patients was not reported in two cases of hospitalisation with the primary diagnosis F13 (sedatives/hypnotics) and in one case with the primary diagnosis F19 (polydrug use).*

In terms of regional distribution, most patients admitted to hospitals in connection with illicit drug use had a place of residence in Prague (86 hospitalisations per 100,000 inhabitants of the region) and the Ústí nad Labem region (82 hospitalisations); the Karlovy Vary and Central Bohemia regions were above the national average (52 admissions); see Graph 5-7.

*Graph 5-7: Number of hospitalisations of patients using non-alcohol drugs (excluding tobacco) by region of domicile per 100 inhabitants, 2011 (Nechanská, 2012c)*




### 5.4.3 Therapeutic Communities for Drug Users

Details of the therapeutic communities for users of addictive substances are also provided this year in the special chapter Residential Treatment for Drug Users (p. 146).

There are 11 therapeutic communities associated in the specialist section of the Association of Non-Governmental Organisations (A.N.O.).[106] According to the Register of Social Services Providers maintained by the Ministry of

[106] http://www.asociace.org/sekce-terapeutickych-komunit-clenske-organizace.html (2012-08-14). The internet portal www.terapeutickekomunity.org was not functional as of 14 August 2012.

Labour and Social Affairs, there were 14 programmes in the Czech Republic as of August 2012 registered as therapeutic communities whose primary target group is people at risk of dependency on addictive substances or dependent on them.[107] Nine therapeutic communities were supported in the GCDPC subsidy proceedings in 2011. Final reports on project implementation, and therefore, the details of the clients and the interventions provided, are available from these communities and from the *Vršíček* therapeutic community (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h); see Table 5-30. The capacity of these 10 therapeutic communities was 158 beds and 402 drug users with an average age of 27.2 years underwent treatment in them. Of the total number of clients in therapeutic communities, 351 (87.3%) had injected drugs prior to treatment; 313 (77.9%) had used pervitin and 46 (11.4%) heroin. Compared to 2010, the share of pervitin users increased and, conversely, the number of heroin users decreased in the therapeutic communities under scrutiny. The treatment programme was successfully completed by 106 clients (26.4%) and the average duration of successful (completed) treatment was 321 days. 163 clients (40.5%) dropped out of the treatment, 35 of them terminating treatment within two weeks of its commencement, and the other 58 clients left treatment within three months of starting. The average duration of the treatment for all clients was 193 days.

*Table 5-30: Therapeutic communities supported by GCDPC subsidies and their clients, 2003–2011*

| Indicator | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011* |
|---|---|---|---|---|---|---|---|---|---|
| Number of communities | 17 | 14 | 12 | 12 | 11 | 10 | 10 | 10 | 10 |
| Capacity | 238 | 218 | 183 | 185 | 169 | 138 | 160 | 160 | 158 |
| Number of clients | 510 | 546 | 491 | 451 | 472 | 427 | 349 | 408 | 402 |
| – injecting drug users | 428 | 429 | 400 | 375 | 347 | 326 | 343 | 350 | 351 |
| – pervitin users | 270 | 306 | 287 | 281 | 291 | 283 | 276 | 292 | 313 |
| – heroin users | 187 | 151 | 132 | 93 | 66 | 67 | 69 | 68 | 46 |
| Average age of clients | 23.4 | 24.2 | 24.9 | 25.1 | 24.2 | 23.8 | 26.6 | 26.7 | 27.2 |

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

Between 2007 and 2010, a research study entitled "Treatment Outcome Evaluation of Therapeutic Communities for Drug Users" (EVLTK) was conducted by the SANANIM civic association; see also the 2008 Annual Report. It was a prospective study of drug users entering treatment in 2007 and 2008. Participants were monitored from the start of treatment until one year after leaving the therapeutic community. The study tracked changes in several areas: the use of addictive substances, including alcohol, risky behaviour, crime, social functioning, state of health, and quality of life. Five therapeutic communities originally participated in the study; complete data are available from four of them (Šefránek, 2012).

The sample included 176 clients, 61% of whom were males. The average age of the clients on entering the study was 25.9 years (16–45 years). Before treatment, 78% had used pervitin, 45% opiates/opioids, and 34% benzodiazepines and 64% of the clients had used two or more addictive substances. Half of the respondents consumed alcohol excessively, 21% moderately, and 29% were abstainers. 76% of the clients had injected drugs before entering treatment, and the lifetime prevalence of injecting drug use was 92%. 73% of the clients had committed a crime in the last 30 days prior to treatment, the total number of crimes committed being 12,728. Only 9% of the respondents had had a job throughout the period of 30 days prior to treatment (Šefránek, 2012).

One year after the end of treatment in a therapeutic community, 78% of the clients were successfully contacted. There was a significant reduction in drug use, risk behaviour, and crime, and an improvement in health and quality of life. 86% of clients were abstinent from non-alcohol drugs (methamphetamine, opiates, benzodiazepines)[108] after one year of treatment. It was confirmed that relapse is a relatively common occurrence after treatment (reported by 47% of clients within a year after the end of treatment). Injecting drug use decreased from 76% to 11%. The proportion of offenders in the sample dropped to 10% and the total number of crimes committed dropped from 12,728 to 478. There was only a slight improvement in the harmful use of alcohol, sexual risk behaviour, and the prevalence of mental health problems. It was confirmed that clients who stayed in treatment longer and completed treatment achieved significantly better results in a number of areas. Following treatment in a therapeutic community, virtually all the clients used other professional addiction services, such as outpatient aftercare programmes and aftercare programmes with sheltered housing (66%) or further residential treatment (25%), which is very likely to have affected the results obtained. The preliminary results of the EVLTK study, consistently with similar studies from Europe and the US, show that long-term drug users with a profile of highly serious problems in various areas are able to achieve very significant positive changes following treatment in a therapeutic community (Šefránek, 2012).

### 5.4.4 Specialised Departments in Residential Special Education Facilities

The Ministry of Education manages a system of alternative educational care for children at risk. The system comprises educational establishments for young people in institutional care, protective custody, or preventive care. They include institutions for juvenile delinquents and children with behavioural disorders ("diagnostic institutions"),

[107] http://iregistr.mpsv.cz/, retrieved on 13 August 2012.
[108] Abstinence was defined as the non-use of controlled substances in the last 30 days at follow-up one year after leaving the therapeutic community.

children's homes with schools, rehabilitation institutions, children's homes, and educational care centres; for more information see the 2010 Annual Report. These comprise a total of 244 facilities, five of which also have departments that specialise in the treatment of children at risk of drug addiction – the total capacity of these special departments was 68 places and 155 children stayed in them in 2011[109]; see Table 5-31 and Table 5-32.

*Table 5-31: Educational establishments for children in institutional care or protective custody and for preventive care in the Czech Republic, 2009–2011*

| Type of facility | Number of facilities | | |
|---|---|---|---|
| | 2009 | 2010 | 2011 |
| Children's home | 155 | 150 | 149 |
| Children's home with school | 29 | 31 | 31 |
| Correctional institution | 34 | 33 | 33 |
| Diagnostic institution for children | 8 | 9 | 8 |
| Diagnostic institutions for adolescents | 4 | 4 | 4 |
| Diagnostic institution for children and adolescents | 1 | 0 | 1 |
| Diagnostic institution for the children of foreigners | 1 | 1 | 1 |
| Educational care centres* | 17 | 17 | 17 |
| **Total** | **249** | **245** | **244** |

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

*Table 5-32: Capacity and number of children with drug use problems in specialised departments of educational facilities providing institutional, protective, and preventive care in the Czech Republic in 2009–2010*

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

### 5.5 Treatment Demand Register

In 2011, the Register of Treatment Demands received data from 205 centres (65 low-threshold centres, 70 healthcare outpatient facilities, 23 non-healthcare outpatient facilities, and 47 residential facilities) out of the total of 273 registered facilities. The most sought-after type of facility has traditionally been the low-threshold centre; as in the previous years, the clients of these facilities accounted for more than half of treatment demands – more than 58% of first treatment demands and 53% of all treatment demands). While outpatient facilities (providing both health and non-health services) were the most widely represented type among the centres, they comprised just one fifth of the total volume of treated drug users reported. Most facilities were located in Prague (28 centres), followed by the Moravia-Silesia region, with 25 centres (Studničková and Petrášová, 2012).

In 2011, a total of 9,284 drug users were reported, i.e. 279 more people than in 2010. Of these, 4,512 individuals sought treatment for the first time, 150 more than the number of first treatment demands in 2010. The number of first treatment demands, as well as of all treatment demands, has been rising since 2008.

The newly registered drug users included 3,089 men (68.5%) and 1,412 women (31.2%); there was no indication of gender in 11 patients. Among all the treatment clients there were 6,348 men (68.4%) and 2,908 women (31.3%); there was no indication of gender in 28 patients.

The order of drugs used which are the cause of first treatment demands has remained the same in 2011 as in previous years. Users of stimulants predominate among first treatment demands (69.3% of all newly registered clients), in particular those using pervitin (69.1%). The next most frequent drugs were cannabis (18.6%) and opiates (9.8%), mainly heroin (6.0%). Trends in the numbers of first treatment demands according to the drug used are given in Graph 5-8 (Studničková and Petrášová, 2012).

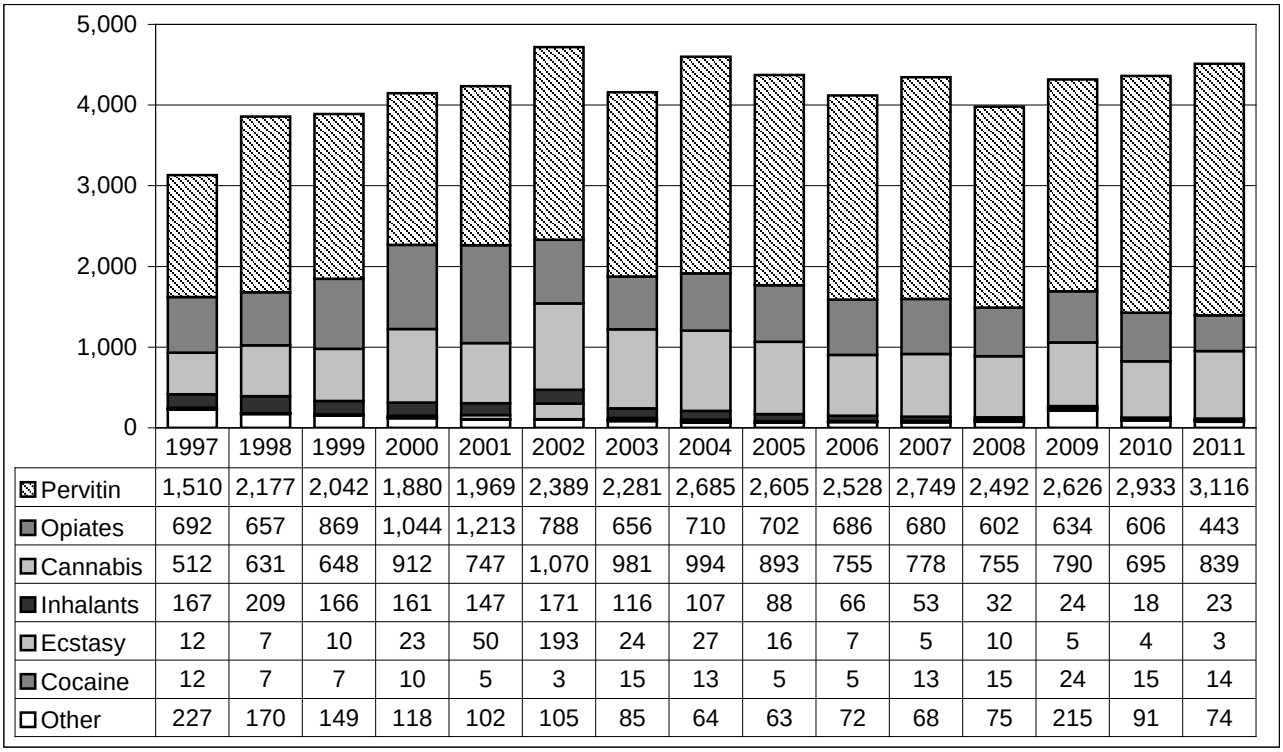
Among all the clients receiving treatment during 2011, the most commonly used drug was also stimulants (64.9%), particularly pervitin (64.6%). The second most frequently used drug was opiates (19.3%), mainly heroin (12.1%). Trends in the numbers of all treatment demands according to the drug used are given in Graph 5-9.

The highest number of treatment demands per 100,000 inhabitants was recorded in the Olomouc region (177.5 per 100,000 inhabitants), and in the Ústí nad Labem region (151.4), Vysočina (139.0), and Prague (121.1). The highest proportion of users of stimulants was reported in the South Bohemia region (85%), followed by the Liberec (80%) and Karlovy Vary regions (79%), while the lowest proportion of treated stimulant users is reported in Prague (51%).

[109] Information submitted by the Ministry of Education, Youth, and Sports, Department 22, on 20 August 2012.

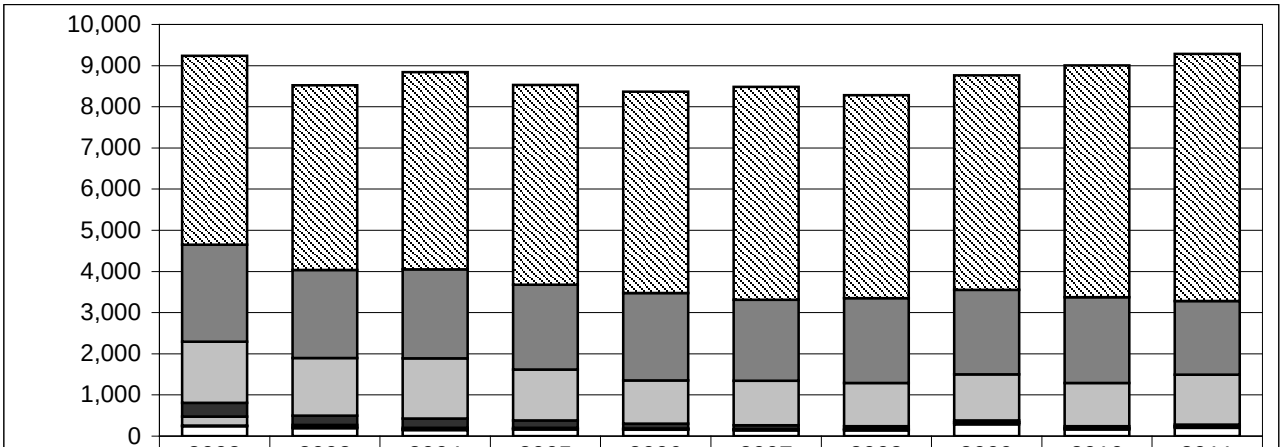
Opiate users were most represented among treatment demands in Prague (34%) and the Central Bohemia region (31%). The highest proportions of cannabis users were reported from the Pilsen (37%), Vysočina (26%), Moravia-Silesia (23%), and Zlín (21%) regions (Studničková and Petrášová, 2012); see Map 5-4.

*Graph 5-8: Number of first treatment demands by primary drug, 1997–2011 (Studničková and Petrášová, 2012)*



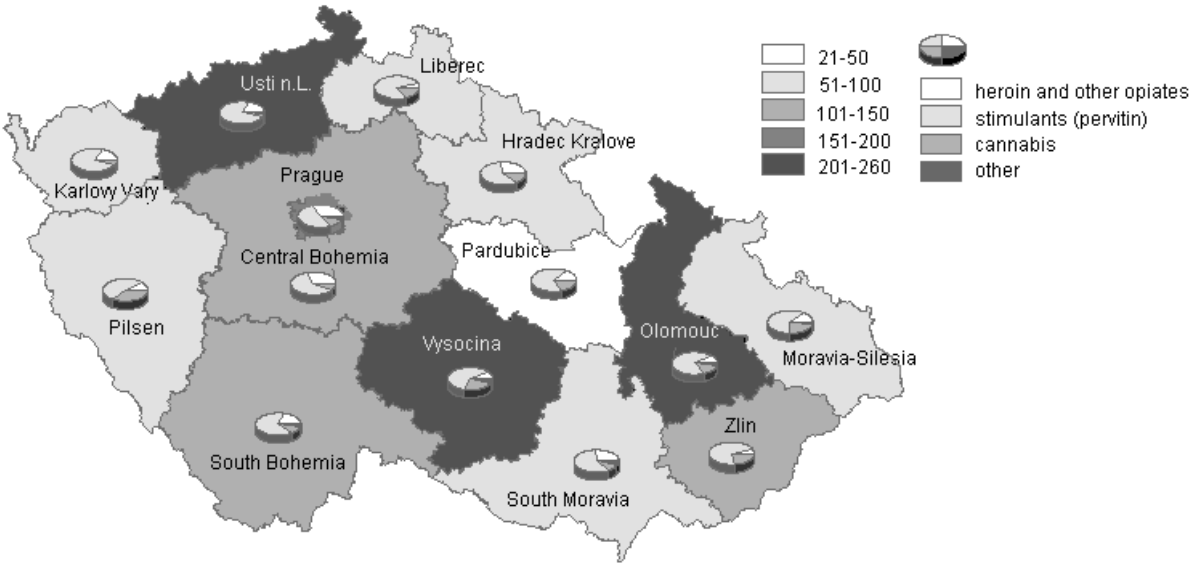

| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pervitin | 1,510 | 2,177 | 2,042 | 1,880 | 1,969 | 2,389 | 2,281 | 2,685 | 2,605 | 2,528 | 2,749 | 2,492 | 2,626 | 2,933 | 3,116 |
| Opiates | 692 | 657 | 869 | 1,044 | 1,213 | 788 | 656 | 710 | 702 | 686 | 680 | 602 | 634 | 606 | 443 |
| Cannabis | 512 | 631 | 648 | 912 | 747 | 1,070 | 981 | 994 | 893 | 755 | 778 | 755 | 790 | 695 | 839 |
| Inhalants | 167 | 209 | 166 | 161 | 147 | 171 | 116 | 107 | 88 | 66 | 53 | 32 | 24 | 18 | 23 |
| Ecstasy | 12 | 7 | 10 | 23 | 50 | 193 | 24 | 27 | 16 | 7 | 5 | 10 | 5 | 4 | 3 |
| Cocaine | 12 | 7 | 7 | 10 | 5 | 3 | 15 | 13 | 5 | 5 | 13 | 15 | 24 | 15 | 14 |
| Other | 227 | 170 | 149 | 118 | 102 | 105 | 85 | 64 | 63 | 72 | 68 | 75 | 215 | 91 | 74 |

*Graph 5-9: Number of all treatment demands by primary drug, 2002–2011 (Studničková and Petrášová, 2012)*




| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|
| Pervitin | 4,589 | 4,490 | 4,790 | 4,855 | 4,889 | 5,177 | 4,925 | 5,209 | 5,632 | 5,999 |
| Opiates | 2,353 | 2,133 | 2,169 | 2,058 | 2,126 | 1,961 | 2,063 | 2,053 | 2,084 | 1,791 |
| Cannabis | 1,489 | 1,403 | 1,462 | 1,238 | 1,044 | 1,083 | 1,053 | 1,121 | 1,050 | 1,214 |
| Inhalants | 332 | 226 | 221 | 183 | 124 | 94 | 62 | 47 | 46 | 40 |
| Ecstasy | 218 | 50 | 37 | 23 | 12 | 11 | 14 | 8 | 7 | 6 |
| Cocaine | 13 | 22 | 18 | 15 | 12 | 22 | 24 | 38 | 23 | 30 |
| Other | 243 | 198 | 148 | 162 | 159 | 139 | 138 | 287 | 163 | 204 |

*Map 5-4***:** *Number of all treatment demands according to drug type, by region per 100,000 inhabitants aged 15–64 years, 2011 (Studničková and Petrášová, 2012)*

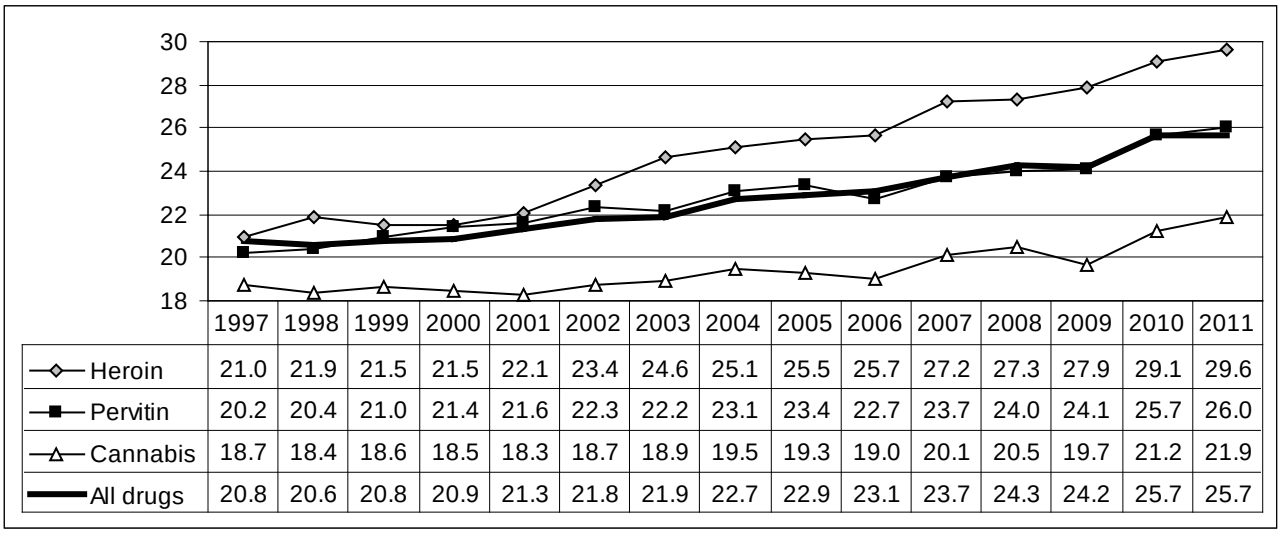



The representation of males and females among those making treatment demands has remained stable in the long term and corresponds to a 2:1 male-to-female ratio. The highest proportion of males is among all treated users of cannabis (76%) and inhalants (73%). The highest proportion of females is in the group of users of sedatives and hypnotics (39%).

In the medium term, the average age shows a noticeable growing trend; see Graph 5-10 and Graph 5-11. The average age was 25.7 years for first treatment demands and 27.4 years for all treatment demands, an increase of 3.9 and 4.0 years, respectively, since 2002. In 2011, the group aged 25–39 made up the highest share of all treatment demands, accounting for almost a quarter of them; the group aged 20–24 was the most numerous one among first treatment demands, making up over a quarter of them. Similarly to the gradual increase in the average age of those making treatment demands, one can also observe a decrease in the age of the youngest users in treatment, those under 19 years of age (see Table 5-33). Of all treatment demands, 48 were children under 15 years of age.

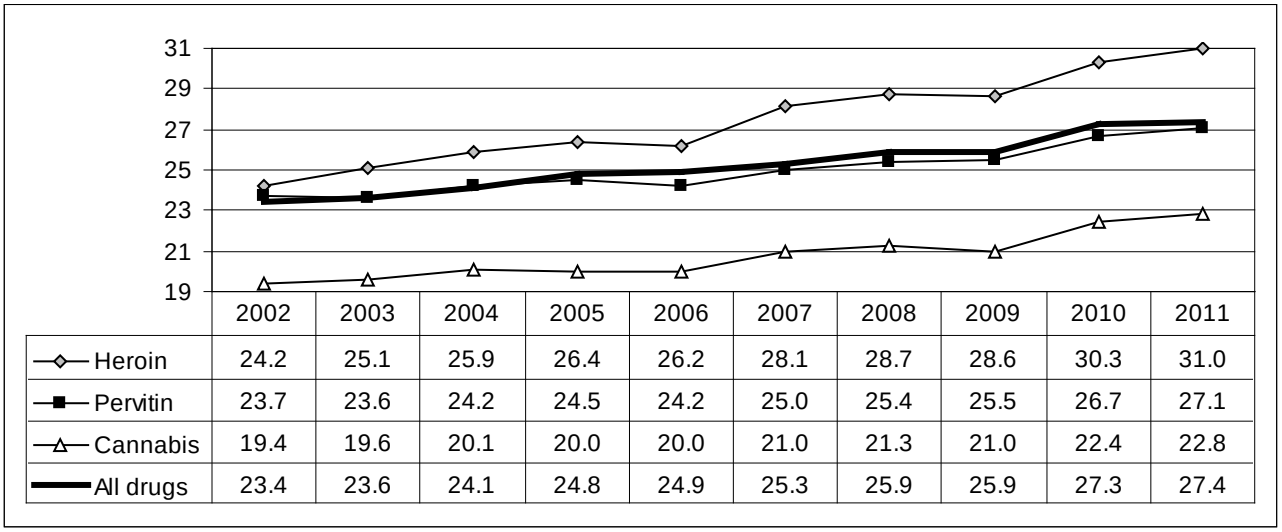
In 2002–2011, the group with the fastest-growing average age was that of heroin users (by about 6.8 years), who are the oldest and currently the fastest-aging group of applicants in terms of their average age. Contrarily, cannabis users are the youngest (Studničková and Petrášová, 2012).

*Graph 5-10: Average age of first treatment demands according to selected drugs, 1997–2011 (Studničková and Petrášová, 2012)*




| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Heroin | 21.0 | 21.9 | 21.5 | 21.5 | 22.1 | 23.4 | 24.6 | 25.1 | 25.5 | 25.7 | 27.2 | 27.3 | 27.9 | 29.1 | 29.6 |
| Pervitin | 20.2 | 20.4 | 21.0 | 21.4 | 21.6 | 22.3 | 22.2 | 23.1 | 23.4 | 22.7 | 23.7 | 24.0 | 24.1 | 25.7 | 26.0 |
| Cannabis | 18.7 | 18.4 | 18.6 | 18.5 | 18.3 | 18.7 | 18.9 | 19.5 | 19.3 | 19.0 | 20.1 | 20.5 | 19.7 | 21.2 | 21.9 |
| All drugs | 20.8 | 20.6 | 20.8 | 20.9 | 21.3 | 21.8 | 21.9 | 22.7 | 22.9 | 23.1 | 23.7 | 24.3 | 24.2 | 25.7 | 25.7 |

*Graph 5-11: Average age of all drug treatment demands according to selected drugs, 2002–2011 (Studničková and Petrášová, 2012)*




| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|
| Heroin | 24.2 | 25.1 | 25.9 | 26.4 | 26.2 | 28.1 | 28.7 | 28.6 | 30.3 | 31.0 |
| Pervitin | 23.7 | 23.6 | 24.2 | 24.5 | 24.2 | 25.0 | 25.4 | 25.5 | 26.7 | 27.1 |
| Cannabis | 19.4 | 19.6 | 20.1 | 20.0 | 20.0 | 21.0 | 21.3 | 21.0 | 22.4 | 22.8 |
| All drugs | 23.4 | 23.6 | 24.1 | 24.8 | 24.9 | 25.3 | 25.9 | 25.9 | 27.3 | 27.4 |

In 2011, the number of problem drug users was 8,368 (90.1%) among all treatment demands and 3,884 (86.1%) among first treatment demands.[110] There is still a high proportion of injecting drug users demanding treatment; injecting drug use was reported by 6,155 (66.3%) of all treatment demands and 2,578 (57.1%) of first treatment demands, a slight decline in comparison with 2010.

Daily drug use was reported by 2,591 (27.9%) people demanding treatment for the first time, while another 2,205 (23.8%) used drugs 2–6 times per week. Daily use was reported by 37.0% of heroin users, 21.0% of pervitin users, and 65.6% of buprenorphine users.

The socio-economic characteristics of those demanding treatment have hardly changed in recent years. Of the total number of 9,284 of all treatment demands in 2011, 13.4% were homeless and another 12.7% resided in institutions (prisons, institutions, hostels, or shelters); a permanent place of residence was reported by 35.2% of those demanding treatment.

Approximately a third of all registered drug users in treatment, including new ones, live with their parents, 22.0% of all treatment clients report living alone, and 7.3% of the users treated live with their children. People with a temporary place of residence, placed in an institution, or even homeless are significantly more frequent among drug users treated repeatedly and long-term drug users than among first treatment demands.

55.7% of treatment demands were made by unemployed or temporarily employed people; regular employment was reported by 16.2% of those making treatment demands. In total, 49.5% of the clients in 2011 had a basic or incomplete basic education, while secondary education without a final examination was reported by 26.2% of those demanding treatment (Studničková and Petrášová, 2012).

The trends of selected characteristics among treatment demands are given in Table 5-33. More information about injecting drug use among treatment demands is provided in the chapter Risk Behaviour of Drug Users (p. 95).

[110]The EMCDDA defines problem drug use as injecting drug use and/or the long-term/regular use of opioids and/or amphetamine-type drugs and/or cocaine (European Monitoring Centre for Drugs and Drug Addiction, 2009).

*Table 5-33: Selected characteristics of first treatment demands, 1997–2011, and all treatment demands, 2002–2011 (Studničková and Petrášová, 2012)*

| Year | Total number of clients | of which (%) | | | |
|---|---|---|---|---|---|
| | | Problem drug users | Injecting drug users | Persons aged under 19 years | Women |
| **First treatment demands** | | | | | |
| 1997 | 3,132 | 71.9 | 55.0 | 54.1 | 36.8 |
| 1998 | 3,858 | 74.4 | 61.8 | 52.4 | 33.9 |
| 1999 | 3,891 | 75.6 | 64.0 | 49.2 | 34.4 |
| 2000 | 4,148 | 71.5 | 62.3 | 47.5 | 34.5 |
| 2001 | 4,233 | 75.3 | 64.8 | 43.9 | 38.7 |
| 2002 | 4,719 | 73.6 | 58.5 | 42.4 | 32.7 |
| 2003 | 4,158 | 76.9 | 60.5 | 43.5 | 32.7 |
| 2004 | 4,600 | 80.5 | 64.9 | 36.0 | 32.7 |
| 2005 | 4,372 | 82.3 | 64.0 | 34.4 | 31.6 |
| 2006 | 4,119 | 84.4 | 62.5 | 32.2 | 33.6 |
| 2007 | 4,346 | 78.9 | 63.3 | 30.7 | 33.3 |
| 2008 | 3,981 | 86.1 | 62.0 | 29.8 | 33.8 |
| 2009 | 4,318 | 83.5 | 55.6 | 27.0 | 32.6 |
| 2010 | 4,363 | 87.7 | 61.8 | 22.3 | 31.2 |
| 2011 | 4,512 | 86.1 | 57.1 | 23.4 | 31.3 |
| **All treatment demands** | | | | | |
| 2002 | 9,237 | 80.6 | 67.4 | 30.0 | 31.3 |
| 2003 | 8,522 | 82.9 | 70.0 | 29.8 | 31.0 |
| 2004 | 8,845 | 84.5 | 72.0 | 26.3 | 30.6 |
| 2005 | 8,534 | 86.4 | 71.8 | 24.2 | 30.5 |
| 2006 | 8,366 | 89.1 | 72.4 | 21.6 | 31.7 |
| 2007 | 8,487 | 84.1 | 72.0 | 21.1 | 32.6 |
| 2008 | 8,279 | 90.5 | 72.3 | 19.6 | 32.2 |
| 2009 | 8,763 | 89.1 | 66.6 | 18.3 | 32.3 |
| 2010 | 9,005 | 91.4 | 69.8 | 15.2 | 31.8 |
| 2011 | 9,284 | 90.1 | 66.3 | 15.8 | 31.3 |

# 6 Health Correlates and Consequences of Drug Use

The relatively favourable situation concerning the occurrence of infections among injecting drug users continued in 2011; HIV seroprevalence remains below 1%, although not all the sources of data are consistent in reporting such low levels. Seven new cases of HIV-positive people who contracted the infection through injecting drug use were identified. The number of newly reported cases of HCV among injecting drug users has risen in recent years, while the number of HBV infections remained the same as in 2010. The number of reported cases of syphilis and gonorrhoea among injecting drug users is lower. The number of reported cases of tuberculosis among injecting drug users has not changed much.

Depending on the characteristics and selection criteria of the sample studied, the prevalence of HCV among drug users ranges from approximately 20% in low-threshold programmes to 40% in prisons and 70% in substitution treatment. These results, however, need to be interpreted with caution, bearing in mind the possibility of a sampling error – this may be due to diagnostic screening in low-threshold programmes identifying cases that had already been diagnosed as positive and the treatment programmes in prisons possibly showing cases examined on suspicion of infection, which may, on the contrary, artificially inflate the prevalence rates.

The Treatment Demand Register has seen a long-term decline in the proportion of injecting pervitin users (77% in 2011), whereas the injecting use of heroin has been increasing (90%) and is common among problem users of buprenorphine. Among the clients of outpatient psychiatrists, the proportion of injectors among heroin users is 63% and among pervitin users 41%.

The information from the register of autopsies carried out by forensic medicine departments shows that the number of fatal overdoses on illicit drugs and inhalants declined significantly in 2011 to a total of 28 cases identified. A significant year-on-year drop in the number of fatal overdoses on opiates/opioids, from 19 to 6 cases, and on inhalants, from 16 to 4 cases, was recorded, while the number of cases of fatal overdoses on pervitin remained at virtually the same level (two German nationals died of pervitin overdoses). Fatal overdoses on other illegal drugs are still very rare. 162 fatal overdoses on psychotropic medication were detected in 2011, of which 64 and 32 cases involved benzodiazepines and medicines containing opiates/opioids respectively. According to the data extracted from the General Mortality Register, fatal overdoses on alcohol (ethanol) occur at a rate of approximately 330 cases per year. Pervitin and cannabis were the most likely illegal drugs to be detected in connection with indirect drug-related deaths (i.e. deaths from causes other than overdoses, mainly as a result of accidents and suicides, with the presence of drugs) examined by forensic medicine departments.

The traffic police records indicate that the number of drunk driving accidents increased in 2011, while the rate of accidents under the influence of other drugs remained at the same level. The number of fatalities in accidents caused under the influence of psychoactive substances decreased in 2011.

## 6.1 Drug-Related Infections

### 6.1.1 Newly diagnosed (reported) cases

#### 6.1.1.1 HIV/AIDS

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

The number of newly diagnosed cases of HIV among injecting drug users (IDUs), i.e. persons who experienced HIV transmission through injecting drug use, decreased to 4 cases in 2009 and remained the same in 2010, but increased to 7 cases in 2011. In 2011, another 7 newly diagnosed HIV-positive persons had a history of injecting drug use.

Altogether, 1,675 HIV-positive persons with a permanent place of residence in the Czech Republic were registered in 1985–2011; 76 (4.5%) of them were injecting drug users; men made up more than three-quarters (77.6%). Another 79 HIV-positive individuals (4.7%) had a history of injecting drug use. Injecting drug use remains a significantly minor route of HIV infection in the Czech Republic (Státní zdravotní ústav Praha, 2012b; Státní zdravotní ústav Praha, 2011); see Table 6-1.

*Table 6-1: The number of newly diagnosed HIV cases in the Czech Republic, 2011, by route of transmission (Státní zdravotní ústav Praha, 2012b)*

| Route of transmission | | 1985–2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| IDU | | 33 | 4 | 4 | 12 | 8 | 4 | 4 | 7 | **76** |
| of whom | men | 27 | 3 | 3 | 5 | 7 | 4 | 3 | **59** | **59** |
| | women | 6 | 1 | 1 | 7 | 1 | 0 | 1 | **17** | **17** |
| Homo-/bisexual intercourse and IDU | | 11 | 1 | 1 | 5 | 4 | 3 | 3 | 5 | **33** |
| Other with a history of IDU | | 27 | 2 | 1 | 4 | 2 | 3 | 5 | 2 | **46** |
| Other without a history of IDU | | 665 | 83 | 85 | 100 | 134 | 146 | 168 | 139 | **1,520** |
| **Total** | | **736** | **90** | **91** | **121** | **148** | **156** | **180** | **153** | **1,675** |

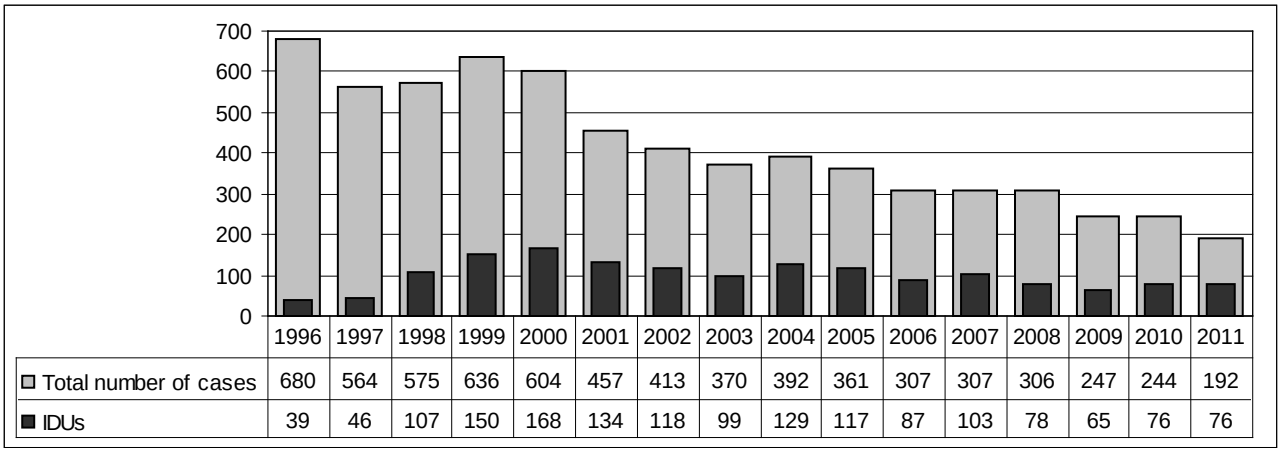
*Note: The number of cases is being corrected for previous years – corrections stem from duplications that were found and from the subsequent clarification of information regarding the route of transmission.*

#### 6.1.1.2 Viral hepatitis

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

The total number of newly reported cases of acute viral hepatitis B (HBV, diagnosis B16) has been declining in recent years. The number of cases of HBV infection among injecting drug users did not change year-on-year, but their proportion of the total number of HBV cases increased from 26% in 2008 to 40% in 2011 (Státní zdravotní ústav Praha, 2012a); see Graph 6-1.

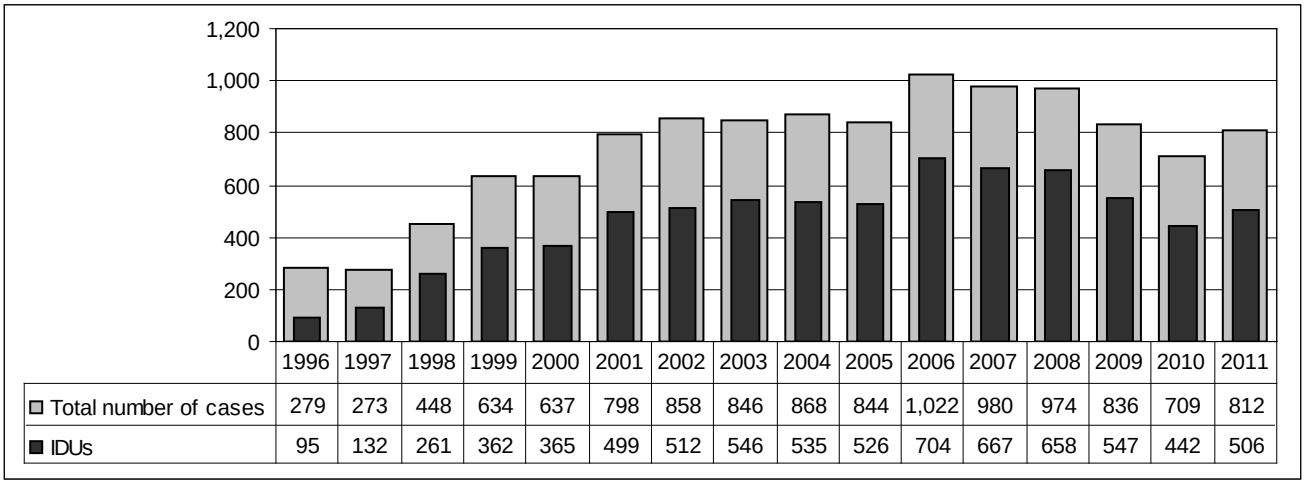
*Graph 6-1: Reported incidence of acute HBV among all patients and injecting drug users in the Czech Republic, 1996–2011 (Státní zdravotní ústav Praha, 2012a)*




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

After a period of a decline in the total number of newly reported cases of acute and chronic viral hepatitis C (HCV diagnosis, B17.1 and B18.2), the number of cases increased by nearly 15% in 2011 and the same trend was also observed among injecting drug users (Státní zdravotní ústav Praha, 2012a); see Graph 6-2.

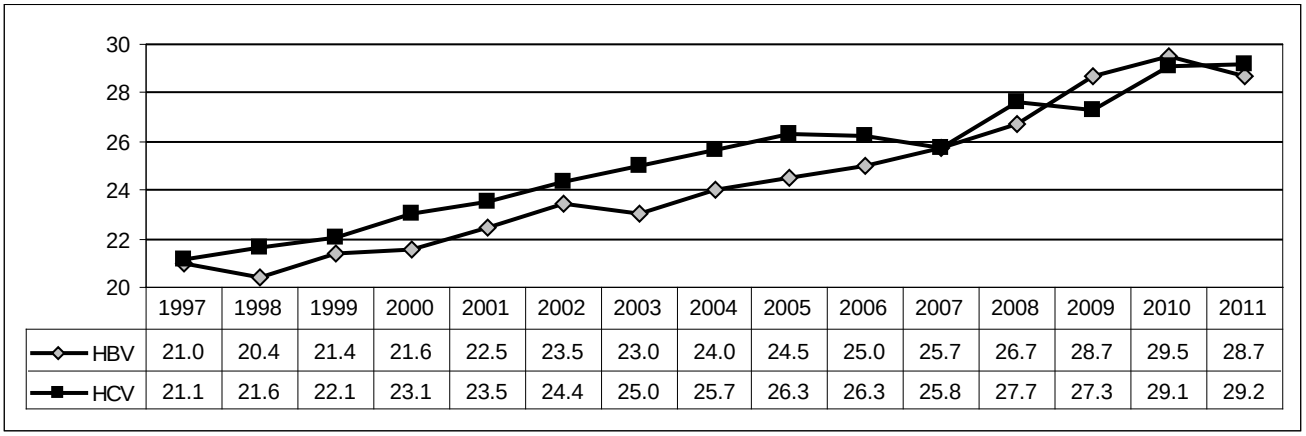
*Graph 6-2: Reported incidence of acute and chronic HCV among all patients and injecting drug users in the Czech Republic, 1996–2011 (Státní zdravotní ústav Praha, 2012a)*




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

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

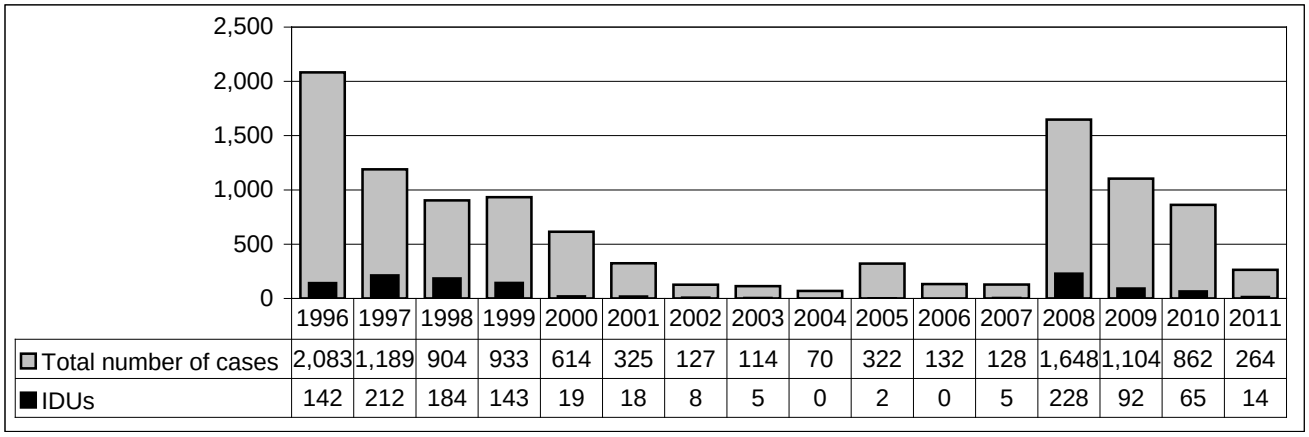
*Graph 6-3: Average age of injecting drug users with reported HBV and HCV in 1997–2011 (Státní zdravotní ústav Praha, 2012a)*




| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HBV | 21.0 | 20.4 | 21.4 | 21.6 | 22.5 | 23.5 | 23.0 | 24.0 | 24.5 | 25.0 | 25.7 | 26.7 | 28.7 | 29.5 | 28.7 |
| HCV | 21.1 | 21.6 | 22.1 | 23.1 | 23.5 | 24.4 | 25.0 | 25.7 | 26.3 | 26.3 | 25.8 | 27.7 | 27.3 | 29.1 | 29.2 |

Following the epidemic of viral hepatitis A (HAV, diagnosis B15) which broke out at the end of May 2008, mainly in Prague, and later spread to Central Bohemia (see the 2008 Annual Report), the number of cases in 2011 returned to its low pre-epidemic values (Státní zdravotní ústav Praha, 2012a); see Graph 6-4.

*Graph 6-4: Reported incidence of HAV among all patients and injecting drug users in the Czech Republic, 1996–2011 (Státní zdravotní ústav Praha, 2012a)*




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

In terms of regional distribution, almost a quarter of the reported cases of HAV, acute HBV, and HCV among injecting drug users in 2011 was reported from the Ústí nad Labem region, one fifth from Prague, and 15% from the Central Bohemia region (Státní zdravotní ústav Praha, 2012a); see Table 6-2. When interpreting these results, however, it is necessary to take into account possible differences in the implementation of epidemiological investigation and reporting.

*Table 6-2: The reported incidence of hepatitis HAV, acute HBV, and HCV among injecting drug users by region of residence, 2011 (Státní zdravotní ústav Praha, 2012a)*

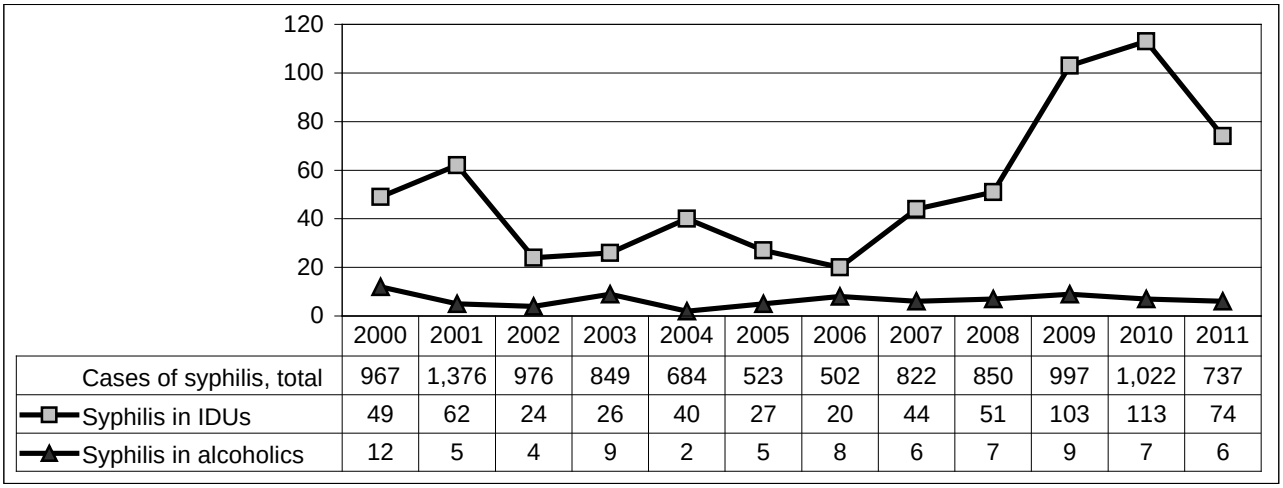
| **Region** | **HAV** | **HBV** | **HCV** | **Total** |
|---|---|---|---|---|
| Prague | 0 | 10 | 106 | **116** |
| Central Bohemia | 0 | 12 | 74 | **86** |
| South Bohemia | 0 | 1 | 43 | **44** |
| Pilsen | 0 | 1 | 11 | **12** |
| Karlovy Vary | 0 | 2 | 8 | **10** |
| Ústí nad Labem | 12 | 10 | 116 | **138** |
| Liberec | 2 | 5 | 18 | **25** |
| Hradec Králové | 0 | 1 | 16 | **17** |
| Pardubice | 0 | 3 | 7 | **10** |
| Vysočina | 0 | 3 | 15 | **18** |
| South Moravia | 0 | 4 | 38 | **42** |
| Olomouc | 0 | 0 | 5 | **5** |
| Zlín | 0 | 0 | 10 | **10** |
| Moravia-Silesia | 0 | 3 | 39 | **42** |
| **Total** | **14** | **55** | **506** | **575** |

#### 6.1.1.3 Sexually Transmitted Diseases

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

Developments in the number of reported cases overall and among injecting drug users (IDUs) for syphilis are shown in Graph 6-5. Following an increase in the number of cases of syphilis in 2006–2010, both among IDUs and overall, the number of reported cases decreased in 2011. Injecting drug users accounted for a tenth of the total number of cases of syphilis in 2011. Reported cases of syphilis are characterised by significantly higher rates in men than in women (the difference being 37%). However, the number of IDUs with syphilis was higher in women than in men (the difference being 10%). IDUs represented 7.6% of the women and 5.1% of the men in the period reported. However, the number of reported cases of syphilis among alcohol-dependent persons[111] was much lower, and the proportion of men is twice that of women in the long term (Nechanská, 2012a).

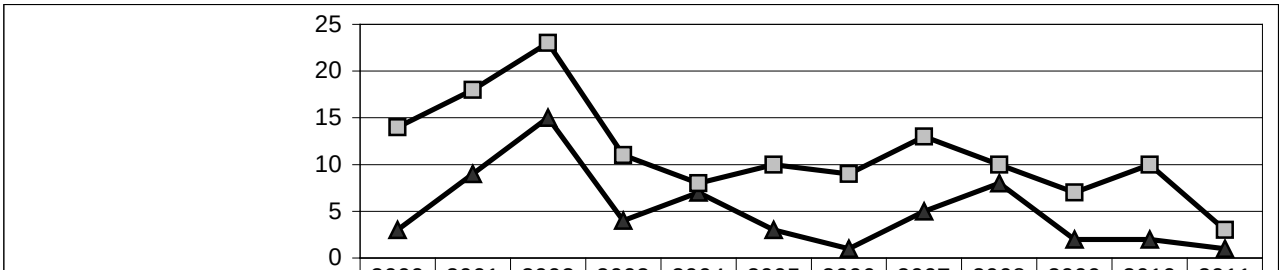
*Graph 6-5: Reported incidence of syphilis among all patients and among injecting drug users and alcoholics in the Czech Republic, 2000–2011 (Nechanská, 2012a)*




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

The total number of reported cases of gonorrhoea decreased over the period; the number of cases among IDUs and alcohol users has remained low in the long term; see Graph 6-6 (Nechanská, 2012a).

*Graph 6-6: Reported incidence of gonorrhoea among all patients and among injecting drug users and alcoholics in the Czech Republic, 2000–2011 (Nechanská, 2012a)*




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

Data on the prevalence of high-risk behaviour pertaining to the reported cases of sexually transmitted diseases indicate that concurrent commercial sex and injecting drug use is relatively common. In 2000–2011, injecting drug use was found in a total of 20.4% of syphilis cases in commercial sex workers and the provision of commercial sex was concurrently found in 16.9% of injecting drug users (mainly females) (Nechanská, 2012a); see Table 6-3.

[111]The National Register of Sexually Transmitted Diseases uses categories with the headings of „alcoholic“ and „intravenous drug user“ in its reports.

*Table 6-3: Number of commercial sex workers (CSW) and injecting drug users (IDU) in the reported cases of syphilis and gonorrhoea, 2000–2011 (Nechanská, 2012a)*

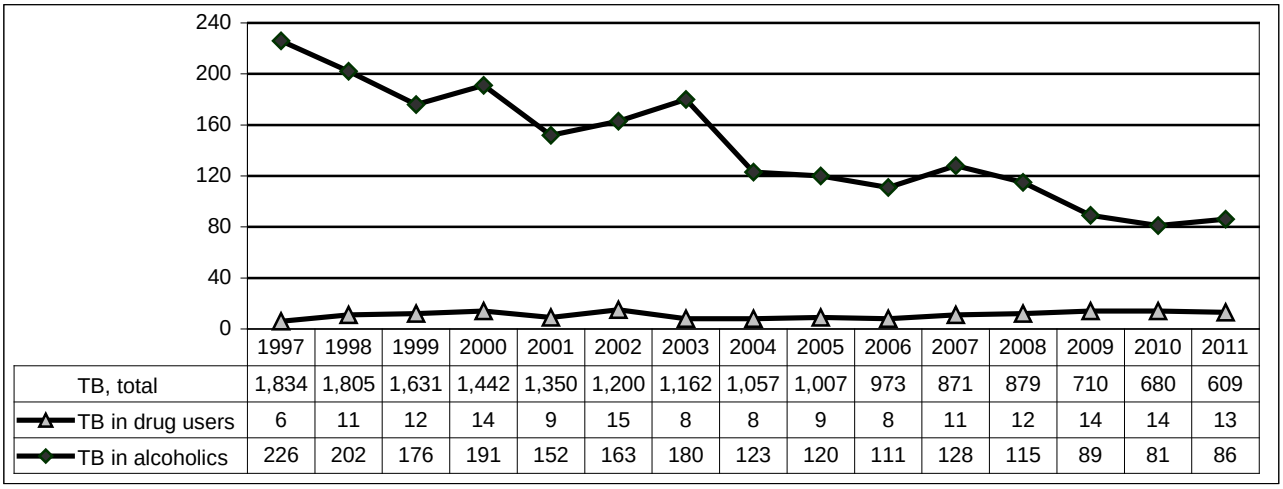
| Infection | Number of cases reported | | | | Proportion (%) | |
|---|---|---|---|---|---|---|
| | **Total** | CSW | IDU | CSW and IDU | IDU per CSW | CSW per IDU |
| Syphilis | **10,305** | 524 | 633 | 107 | 20.4 | 16.9 |
| Gonorrhoea | **10,751** | 231 | 136 | 14 | 6.1 | 10.3 |

#### 6.1.1.4 Tuberculosis

Data on the prevalence of tuberculosis (TB, diagnosis A31) are obtained from the Tuberculosis Register, which monitors people who have been diagnosed with active tuberculosis or other mycobacteriosis in the Czech Republic[112] and those followed up. In addition to the information related to the disease itself, the mandatory report also contains records of associated circumstances, including whether the patient is a user of alcohol or non-alcohol drugs.[113]

In 1997–2011, the number of registered TB cases reported decreased by three times. Men accounted for more than 62% of the total number of cases. The number of reported cases among alcohol users is much higher than that among non-alcohol drug users; a downward trend is observed among alcohol users; see Graph 6-7 (Nechanská, 2012a).

*Graph 6-7: Reported incidence of tuberculosis among all patients and among users of alcohol and other drugs in the Czech Republic, 1997–2011 (Nechanská, 2012a)*




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

### 6.1.2 Prevalence of Infections among Drug Users

#### 6.1.2.1 Monitoring of HIV Tests in Laboratories (Laboratory Surveillance)

In 2011, the National Reference Laboratory for AIDS recorded 893 examinations[114] of IDUs, with two positive results (0.2%). These were men aged 18 and 27, respectively, one of them being examined as part of acute intoxication treatment. The number of registered tests conducted annually among IDUs decreased again (Státní zdravotní ústav Praha, 2012b); see Table 6-4.

[112] I.e. infections caused by bacteria of the Mycobacterium genus, which include, in addition to M. tuberculosis, M. avium complex, M. Kansasii, and M. abscessus.
[113] The Tuberculosis Register uses categories with the headings of „alcoholic“ and „drug addict“ in its reports.
[114] These are cases in which information about drug use is known prior to the test or is reported as the reason for testing. Injecting drug users can also be tested for many other reasons, and in these cases it only becomes apparent afterwards that the subject was an injecting drug user. Testing in low-threshold facilities for drug users (see below) is not monitored by the National Reference Laboratory for AIDS in its entirety.

*Table 6-4: Testing of injecting drug users for HIV antibodies, 1994–2011 (Státní zdravotní ústav Praha, 2012b)*

| Year | Blood tests | | Saliva tests | | Total | |
|---|---|---|---|---|---|---|
| | Number of tests | Number of positive results | Number of tests | Number of positive results | Number of tests | Number of positive results |
| 1994–1997 | 1,206 | 1 | 895 | 0 | 2,101 | 1 |
| 1998 | 1,034 | 0 | 1,124 | 0 | 2,158 | 0 |
| 1999 | 1,101 | 0 | 1,219 | 0 | 2,320 | 0 |
| 2000 | 1,090 | 0 | 1,001 | 0 | 2,091 | 0 |
| 2001 | 1,208 | 1 | 961 | 0 | 2,169 | 1 |
| 2002 | 801 | 0 | 735 | 1 | 1,536 | 1 |
| 2003 | 985 | 1 | 652 | 0 | 1,637 | 1 |
| 2004 | 1,382 | 0 | 227 | 0 | 1,609 | 0 |
| 2005 | 925 | 1 | 449 | 1 | 1,374 | 1* |
| 2006 | 994 | 1 | 412 | 0 | 1,406 | 1 |
| 2007 | 845 | 1 | 531 | 1 | 1,376 | 2 |
| 2008 | 886 | 1 | 477 | 0 | 1,363 | 1 |
| 2009 | 806 | 1 | 0 | 0 | 806 | 1 |
| 2010 | 1,050 | 0 | 0 | 0 | 1,050 | 0 |
| 2011 | 893 | 2 | 0 | 0 | 893 | 2 |
| **Total** | **15,206** | **10** | **8,683** | **3** | **22,483** | **12** |

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

#### 6.1.2.2 Testing for Infections among IDUs in Low-Threshold Programmes

Monitoring of the testing and prevention of infections among injecting drug users in low-threshold programmes has been carried out since 2004. The 2011 results were collected using an online questionnaire in August 2012 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012g). A total of 52 low-threshold programmes responded, of which 20 were drop-in centres, 16 outreach programmes, and 16 were services operating both drop-in centres and outreach programmes. The results are shown in Table 6-5. These results suggest relatively low levels of HIV, HBV, and HCV among drug users, but assessment should take into account that it is a diagnostic form of screening, which is probably used to a greater extent by hitherto HIV/HBV/HCV-negative clients. These results therefore underestimate the true prevalence of infection among injecting drug users or clients of low-threshold facilities.

*Table 6-5: Results of testing for infections among injecting drug users in low-threshold facilities, 2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012g)*

| Infection | Indicator tested | Number of programmes by type of test | | | Number of tests | | Number of persons | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Rapid | Laboratory | Total | Total | Positive | Total | Positive | Positive (%) |
| HIV | anti-HIV | 33 | 7 | 40 | 2,089 | 5 | 1,871 | 5 | 0.26 |
| HCV | anti-HCV | 39 | 7 | 45* | 2,368 | 375 | 2,040 | 371 | 18.18 |
| HBV | HBsAg* | 21 | 3 | 24 | 965 | 2 | 804 | 1 | 0.12 |
| | anti-HBc IgG ** | 3 | 3 | 6 | 273 | 0 | 232 | 0 | 0.0 |
| Syphilis | anti-treponema pallidum | 22 | 4 | 26 | 1,235 | 27 | 1,158 | 27 | 2.33 |

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

The results of testing for HCV by region are shown in Table 6-6. When assessing the results and the differences between the regions, it is necessary to take into account that this is not a representative sample of drug users or facilities. The testing takes the form of diagnostic screening and the indication criteria for selection of clients for testing may differ between the individual facilities. However, it is clear that the regional distribution of HCV infection among IDUs shows considerable variation in the Czech Republic.

The total number of low-threshold facilities in the Czech Republic which offered testing for the infections monitored, and the number of tests performed and their trends are given in Table 7-7 (p. 115) in the chapter Prevention and Treatment of Drug-Related Infectious Diseases.

*Table 6-6: Results of HCV testing among drug users in low-threshold facilities by programme site, 2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012g)*

| Region | Number of facilities | | Number of persons tested | | |
|---|---|---|---|---|---|
| | Responded to questionnaire | Testing HCV | Total | Positive | Positive (%) |
| Prague | 5 | 3 | 452 | 216 | 47.8 |
| Central Bohemia | 6 | 5 | 121 | 13 | 10.7 |
| South Bohemia | 3 | 3 | 81 | 10 | 12.3 |
| Pilsen | 2 | 2 | 86 | 19 | 22.1 |
| Karlovy Vary | 2 | 2 | 84 | 9 | 10.7 |
| Ústí nad Labem | 6 | 6 | 195 | 41 | 21.0 |
| Liberec | 2 | 2 | 53 | 3 | 5.7 |
| Hradec Králové | 2 | 2 | 91 | 3 | 3.3 |
| Pardubice | 1 | 1 | 28 | 1 | 3.6 |
| Vysočina | 3 | 2 | 92 | 5 | 5.4 |
| South Moravia | 7 | 7 | 272 | 28 | 10.3 |
| Olomouc | 2 | 2 | 113 | 7 | 6.2 |
| Zlín | 4 | 4 | 301 | 11 | 3.7 |
| Moravia-Silesia | 6 | 3 | 71 | 5 | 7.0 |
| **Total*** | **51** | **44** | **2,040** | **371** | **18.2** |

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

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

The data about testing for infections and the results of the tests are also captured by the Register of Treatment Demands (Studničková and Petrášová, 2012). This information is provided by the clients themselves or is obtained from their records; only tests on IDUs with known results are included; see Table 6-7. Although they provide limited evidence only, the trends of the seroprevalence of viral hepatitis indicate stable and, in recent years, falling levels of infections among drug users (in line with the medium-term trends in new cases of viral hepatitis in the Czech Republic reported in the EPIDAT official register of infectious diseases; see above). Levels of HIV show a consistently rising trend, although the prevalence is still very low.

*Table 6-7: Results of testing for HIV, HAV, HBV, and HCV (self-reported) among IDUs demanding treatment in 2003–2011 (Studničková and Petrášová, 2012)*

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

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

Of the total of 2290 persons registered in 2011 in the Substitution Treatment Register, 212 persons were tested for HIV, two of them testing positive. 218 persons treated were tested for HBsAg, the surface antigen of viral hepatitis B (HBV), with 18 of them (8.3%) testing positive, an indication of an ongoing acute or chronic HBV infection. 198 individuals were tested for antibodies against HBV, anti-HBc, with 77 (38.9%) testing positive, which means that they have been infected with HBV at some point. Anti-HBs antibodies have a similar information value to anti-HBc, but the test results may also be positive for them after vaccination against HBV (a sign of so-called post-vaccination immunity). As for viral hepatitis C (HCV), a total of 222 individuals were tested for antibodies against HCV, anti-HCV, with 139 (62.6%) testing positive, which means that they have been infected with HCV at some point. Of these 222 subjects, 180 were tested for direct identification of the HCV virus (HCV PCR-RNA), and 92 tests (51.1%) were positive, indicating an active ongoing HCV infection (Nechanská, 2012g); see Table 6-8. The rates of seroprevalence found among clients in their first episode of substitution treatment (so-called first contacts) were slightly higher, which is also evidence of targeting in examination and, as a result, selection bias – therefore, the results should be interpreted with caution.

*Table 6-8: Results of the testing of patients receiving opioid substitution treatment for HIV, HBV, and HCV, 2011 (Nechanská, 2012g)*

| Infection | Indicator tested | All clients | | | New clients | | |
|---|---|---|---|---|---|---|---|
| | | Total tested | Number of positive results | Positive tests (%) | Total tested | Number of positive results | Positive tests (%) |
| HIV | anti-HIV | 212 | 2 | 0.9 | 112 | 2 | 1.8 |
| HBV | HBsAg* | 218 | 18 | 8.3 | 122 | 5 | 4.1 |
| | anti-HBc IgG ** | 198 | 77 | 38.9 | 112 | 44 | 39.3 |
| | anti-HBs** | 205 | 92 | 44.9 | 113 | 56 | 49.6 |
| HCV | anti-HCV | 222 | 139 | 62.6 | 125 | 87 | 69.6 |

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

#### 6.1.2.5 Testing among Drug Users in Prisons

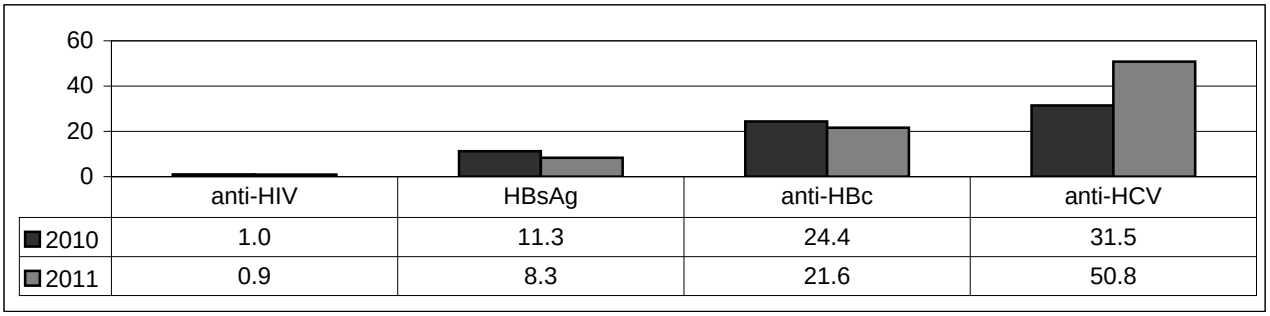
The results for 2011 of the testing of imprisoned injecting drug users are available (Generální ředitelství Vězeňské služby ČR, 2012c). The sample of prisoners is not representative and repeated tests on the same (positive) person in the various stages of serving a custodial sentence cannot be ruled out – therefore, caution must be exercised in the interpretation and generalisation of the results and trends. Nevertheless, the results indicate a higher rate of infection among prisoners in comparison with the available results of studies and monitoring systems aimed at drug users in the community-based facilities – in particular, the prevalence of HIV (even though the number of persons examined is low) is relatively high; see Table 6-9. A year-on-year comparison is provided in Graph 6-8. What is particularly noticeable is an increase in the rates of HCV; however, this increase may be influenced by a higher intensity of testing as a result of a study investigating the prevalence of HIV and HCV among prisoners. It is also quite likely in this context that there has been a significant year-on-year increase in the number of imprisoned IDUs whose HCV treatment was initiated; for more details see the chapter HIV/AIDS and Viral Hepatitis C Treatment (p. 115).

*Table 6-9: Results of testing for HIV, HBV, and HCV among injecting drug users in prisons, 2011 (Generální ředitelství Vězeňské služby ČR, 2012c)*

| Infection | Indicator tested | | Start of serving prison sentence | Start of remand | In the course of prison sentence | Total |
|---|---|---|---|---|---|---|
| HIV | anti-HIV | Total tested | 136 | 316 | 613 | 1,065 |
| | | Positive | 4 | 4 | 2 | 10 |
| | | Positive (%) | 2.9 | 1.3 | 0.3 | 0.9 |
| HBV | HBsAg* | Total tested | 1,334 | 1,076 | 1,103 | 3,513 |
| | | Positive | 110 | 75 | 108 | 293 |
| | | Positive (%) | 8.2 | 7.0 | 9.8 | 8.3 |
| | anti-HBc IgG** | Total tested | 1,178 | 647 | 709 | 2,534 |
| | | Positive | 243 | 119 | 186 | 548 |
| | | Positive (%) | 20.6 | 18.4 | 26.2 | 21.6 |
| HCV | anti-HCV | Total tested | 1,344 | 1,094 | 1,355 | 3,793 |
| | | Positive | 794 | 522 | 611 | 1,927 |
| | | Positive (%) | 59.1 | 47.7 | 45.1 | 50.8 |

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

*Graph 6-8: Comparison of seroprevalence for HIV, HBV, and HCV among injecting drug users in prisons, 2010 and 2011, (%) (Generální ředitelství Vězeňské služby ČR, 2011; Generální ředitelství Vězeňské služby ČR, 2012c)*

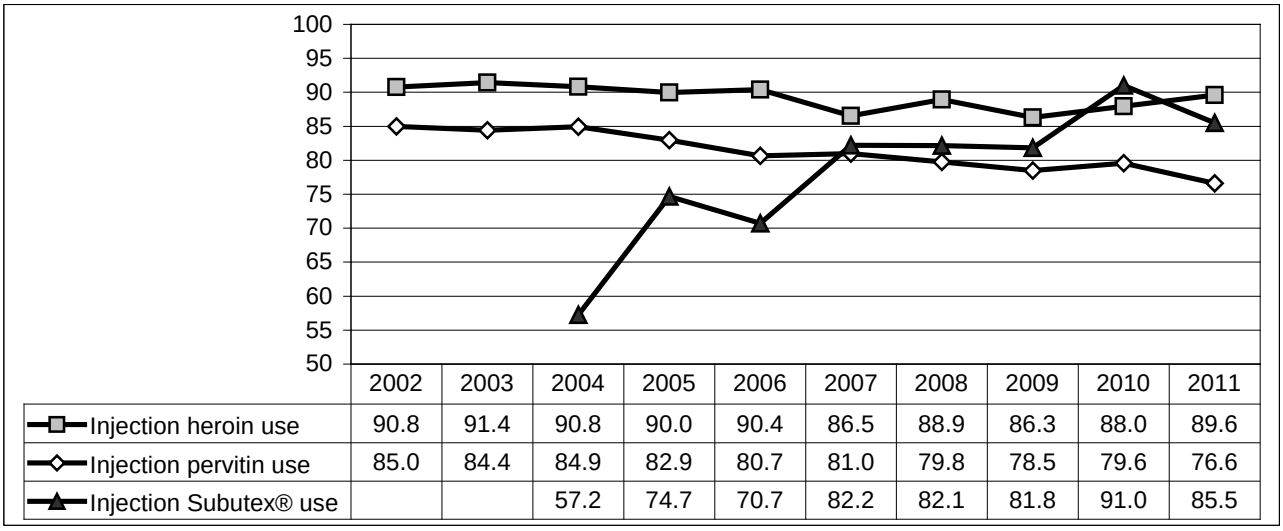


### 6.1.3 Risk Behaviour of Drug Users

#### 6.1.3.1 Proportion of Injection Use

There has been a slight decline in the proportion of injecting among users of methamphetamine in the Register of Treatment Demands in the long term, while injecting has increased among heroin users in the last two years (Studničková and Petrášová, 2012); see Graph 6-9.

*Graph 6-9: Proportion of injecting drug use among all treatment demands related to heroin, Subutex®, and pervitin in 2002–2011, in % (Studničková and Petrášová, 2012)*

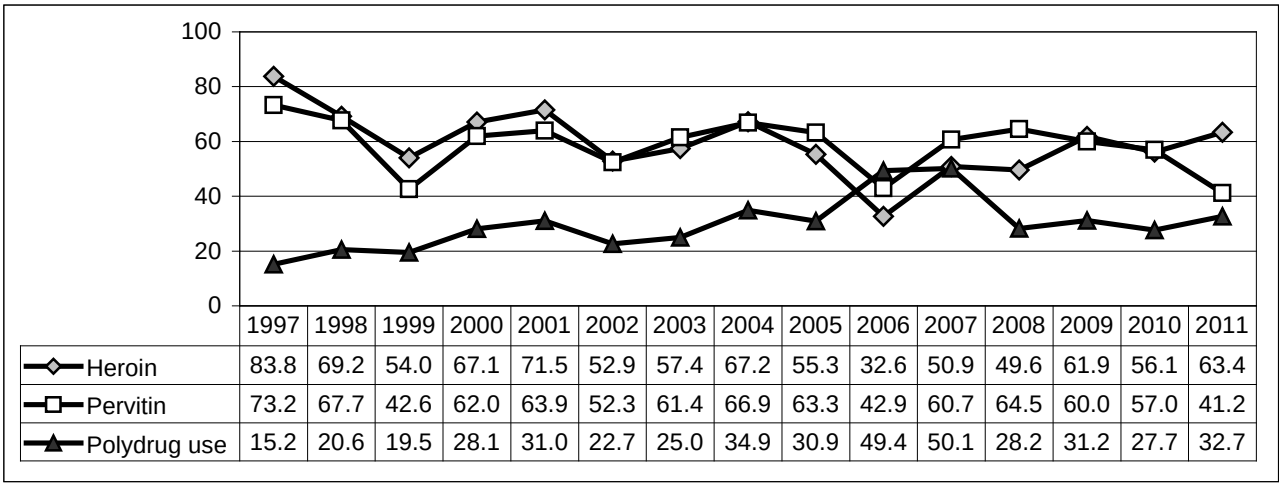



| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|
| Injection heroin use | 90.8 | 91.4 | 90.8 | 90.0 | 90.4 | 86.5 | 88.9 | 86.3 | 88.0 | 89.6 |
| Injection pervitin use | 85.0 | 84.4 | 84.9 | 82.9 | 80.7 | 81.0 | 79.8 | 78.5 | 79.6 | 76.6 |
| Injection Subutex® use | | | 57.2 | 74.7 | 70.7 | 82.2 | 82.1 | 81.8 | 91.0 | 85.5 |

The development of the proportion of injecting among the patients treated by outpatient psychiatric facilities is shown in Graph 6-10. The proportion of injecting among heroin users has been rising, with minor fluctuations, since 2006; it has been decreasing in patients abusing pervitin since 2008 and the proportion of injecting among polydrug users has been nearly the same during this period; see Graph 6-10.

Starting from 2011, the reports from outpatient psychiatric clinics include users of buprenorphine without a medical indication. The proportion of injecting drug users in this group of patients was nearly 81%. Polydrug use monitoring was also expanded. A newly registered group is that of patients treated for the combination of opiates and methamphetamine (pervitin), almost half of them being IDUs. A new development in monitoring is the inclusion of the combination of methamphetamine and drugs other than opiates, and a combination of opiates and drugs other than methamphetamine, with an identical proportion of IDUs of 34% in both groups (Nechanská, 2012b).

*Graph 6-10: Trends in the proportion of injecting heroin, pervitin, and polydrug users treated at outpatient psychiatric facilities, 1997–2011 (%) (Nechanská et al. 2011; Nechanská, 2012b)*




| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Heroin | 83.8 | 69.2 | 54.0 | 67.1 | 71.5 | 52.9 | 57.4 | 67.2 | 55.3 | 32.6 | 50.9 | 49.6 | 61.9 | 56.1 | 63.4 |
| Pervitin | 73.2 | 67.7 | 42.6 | 62.0 | 63.9 | 52.3 | 61.4 | 66.9 | 63.3 | 42.9 | 60.7 | 64.5 | 60.0 | 57.0 | 41.2 |
| Polydrug use | 15.2 | 20.6 | 19.5 | 28.1 | 31.0 | 22.7 | 25.0 | 34.9 | 30.9 | 49.4 | 50.1 | 28.2 | 31.2 | 27.7 | 32.7 |

#### 6.1.3.2 Sharing of Needles and Syringes

The proportion of injecting drug users seeking treatment who report sharing needles and syringes increased in 2011; see Table 6-10.

*Table 6-10: Sharing of needles and syringes at any time in the past reported by IDUs demanding treatment, 2002–2011 (Studničková and Petrášová, 2012)*

| Year | Number of IDUs | Number of those sharing | Sharing (%) |
|---|---|---|---|
| 2002 | 6,437 | 2,590 | 40.2 |
| 2003 | 5,901 | 2,356 | 39.9 |
| 2004 | 6,314 | 2,725 | 43.2 |
| 2005 | 5,769 | 2,421 | 42.0 |
| 2006 | 5,860 | 2,313 | 39.5 |
| 2007 | 5,338 | 2,139 | 40.1 |
| 2008 | 5,766 | 2,057 | 35.7 |
| 2009 | 6,012 | 2,263 | 37.6 |
| 2010 | 6,581 | 2,146 | 32.6 |
| 2011 | 6,471 | 2,506 | 38.7 |

In the Multiplier 2010 study (for more information see the chapter Problem Drug Use on p. 48 and the 2009 Annual Report) on a sample of clients of low-threshold facilities in the Czech Republic, 463 (81.7%) of the 567 respondents who reported injecting drugs during the last month reported the use of sterile needles and syringes the last time they administered the drug.

### 6.2 Other Drug-Related Health Correlates and Consequences

#### 6.2.1 Psychiatric comorbidity

A study was published about the treatment of patients with psychiatric drugs at the addiction treatment unit of the Psychiatric Hospital in Brno-Černovice. At the end of June 2008, a survey was conducted of patients at Department No. 19, where patients addicted to alcohol and, to a lesser extent, gamblers are treated on a voluntary basis (Pokora, 2011). The sample consisted of 49 persons, of whom 38 (77.6%) were men; their average age was 42.1 years (19–63 years). The alcohol dependence syndrome was diagnosed in 47 persons, one person was a pathological gambler, and one person was diagnosed with both of these simultaneously. In addition to the substance dependence and gambling syndromes, patients in the sample were diagnosed with other psychiatric disorders; see Table 6-11. Psychopharmaceuticals were prescribed to 23 patients (46.9%), specifically, antidepressants (especially citalopram and mirtazapine) to 16 patients (69.5% of those treated with psychiatric drugs), antipsychotics to seven patients (30.4%), anxiolytics, particularly clonazepam, to five patients (21.7%), nootropics (piracetam) to four patients (17.4%) and mood stabilisers[115] to two patients (8.7%).

*Table 6-11: Psychiatric comorbidity in patients hospitalised as of 30 June 2008 at the addiction treatment unit of the Psychiatric Hospital in Brno-Černovice (Pokora, 2011)*

| Disorder | Number | Proportion (%) N = 49 persons |
|---|---|---|
| Mixed anxiety and depressive disorder | 7 | 14.3 |
| Mild cognitive disorder | 6 | 12.2 |
| Adjustment disorder with anxiety-depressive symptoms in mixed personality disorder | 3 | 6.1 |
| Light to moderate depressive episode (secondary in alcohol dependence) | 3 | 6.1 |
| Mixed personality disorder | 2 | 4.1 |
| Gambling with secondary depressed moods | 1 | 2.0 |
| Prolonged adjustment disorder in an accentuated personality | 1 | 2.0 |
| Recurrent depressive disorder | 1 | 2.0 |
| Schizoaffective disorder | 1 | 2.0 |

#### 6.2.2 Non-Fatal Drug Intoxications

The collection of data about non-fatal intoxications[116] has been performed by the Public Health Service within a special warning (sentinel) system since 1995. However, there are considerable regional differences in the data

[115]Antidepressants – drugs for the treatment of a pathologically low mood; anxiolytics – drugs for suppressing anxiety; nootropics – drugs that increase the activity of neurons and thereby improve cognitive functions; mood stabilisers – also known as thymprophylactics, are drugs that decrease the frequency and intensity of manic, depressive, and mixed episodes.

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

collection systems, which complicate the interpretation of the current state of affairs and trends.[117] 805 cases of non-fatal intoxications with drugs were reported in 2011; see Table 6-12. Pervitin (19%) and benzodiazepines (17%) represent the highest proportion of the intoxications reported.

*Table 6-12: Non-fatal drug intoxications in the Czech Republic registered by the Public Health Service, 2002–2011 (Studničková and Petrášová, 2012)*

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

In addition, the annual report includes, for the first time ever, information on the occurrence of intoxication with addictive substances collected from the National Register of Hospitalisations (NRHOSP), managed by the Institute of Health Information and Statistics (Ústav zdravotnických informací a statistiky, 2012d). Only cases requiring hospitalisation for more than 24 hours are reported to this register. Cases of accidental, intentional, or undetermined poisoning caused by illegal drugs were extracted, i.e. diagnoses of intoxications with non-alcohol drugs, excluding medications (diagnoses T40 and T43.6) and the toxic effect of alcohol (T51.0, T51.9) and the toxic effect of organic solvents (T52.0–T52.9). Despite the obvious flaws in the coding of substances by physicians, one can see a long-term decline in the number of admissions for drug poisoning; see Table 6-13.

*Table 6-13: Number of admissions to acute care hospitals for intoxication caused by drugs as recorded in NRHOSP, Czech Republic, 2002–2011 (Ústav zdravotnických informací a statistiky, 2012d)*

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

[117] In 2011, problems with reporting persisted in Prague (8 cases reported), as well as other regions (the South Bohemia, Hradec Králové, and South Moravia regions did not report a single case in 2011 either).

### 6.2.3 Drugs and Road Accidents

Since 2003, cases have been analysed of ethanol and other drugs detected[118] in victims of traffic accidents autopsied by forensic medicine departments in the Czech Republic; see the chapter Drug-Related Deaths and Mortality of Drug Users (p. 101). So-called "active participants in traffic accidents" (pedestrians, cyclists, and and drivers) are monitored separately[119].

In 2011, the forensic medicine departments, excluding the *Na Bulovce* University Hospital,[120] performed autopsies on 781 individuals who died in road accidents or as a result of injuries sustained in them, of whom 397 (51%) were subjected to toxicological examination,[121] which is less than in previous years. The largest share of positive tests was found for ethanol. As far as the three most common non-alcohol drugs are concerned, there was a year-on-year decrease in the total proportion of positive tests for pervitin, cannabis, and benzodiazepines among all the active participants. The number of positive tests for ethanol increased and that of positive tests for illicit drugs decreased in drivers who died in road accidents, while the number of positive tests for ethanol increased and that of positive tests for illicit drugs increased significantly in pedestrians; see Table 6-14. Opiates were only detected in the case of one pedestrian, barbiturates in two cases, one pedestrian and one driver, and inhalants or cocaine were not detected in 2011 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2012). Among the active participants who died in traffic accidents in 2011 and were autopsied by forensic medicine departments in the Czech Republic (except for the *Na Bulovce* University Hospital), 111 active road users were identified as being positive for ethanol (including 38 drivers) and 21 were positive for any of the narcotic and psychotropic substances that were monitored (8 of them drivers).

[118] A test is considered to be positive for ethanol if the level of ethanol is higher than 0.2 g/kg (Společnost soudního lékařství a soudní toxikologie, 1999); positive for cannabis if THC or its active metabolite is proven (i.e. not THC-COOH, for instance); and positive for inhalants if post mortem detects substances which do not develop post mortem or are not indicated in some physiological or pathological conditions (e.g. acetone, acetaldehyde, n-propanol, n-butanol).

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

[120] Data were not available at the closing date of this report.

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

*Table 6-14: Detection of ethanol and other drugs in the bodies of active road users who died in traffic accidents in 2007–2011 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2012)*

| Drug | Year | Category of active road users who died in traffic accidents | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Pedestrians | | Cyclists | | Drivers | | **Total** | |
| | | Examined | Positive (%) | Examined | Positive (%) | Examined | Positive (%) | **Examined** | **Positive (%)** |
| Ethanol | 2007 | 130 | 50.8 | 44 | 40.9 | 215 | 20.9 | 389 | 33.2 |
| | 2008 | 139 | 51.8 | 40 | 37.5 | 202 | 29.2 | 381 | 38.3 |
| | 2009 | 114 | 50.9 | 30 | 16.7 | 184 | 25.0 | 328 | 33.2 |
| | 2010 | 144 | 50.0 | 30 | 43.3 | 198 | 19.7 | 372 | 33.3 |
| | 2011 | 115 | 56.5 | 19 | 42.1 | 139 | 27.3 | 273 | 40.7 |
| Stimulants (incl. pervitin and ecstasy) | 2007 | 107 | 0.9 | 27 | 0.0 | 223 | 5.8 | 357 | 3.9 |
| | 2008 | 121 | 3.3 | 21 | 0.0 | 195 | 9.2 | 337 | 6.5 |
| | 2009 | 84 | 3.6 | 18 | 0.0 | 175 | 5.1 | 277 | 4.3 |
| | 2010 | 97 | 1.0 | 16 | 0.0 | 172 | 4.7 | 285 | 3.2 |
| | 2011 | 67 | 6.0 | 7 | 0.0 | 120 | 2.5 | 194 | 3.6 |
| Cannabis (active metabolites of THC) | 2007 | 61 | 3.3 | 11 | 0.0 | 154 | 4.5 | 226 | 4.0 |
| | 2008 | 60 | 6.7 | 13 | 0.0 | 130 | 6.2 | 203 | 5.9 |
| | 2009 | 49 | 4.1 | 9 | 0.0 | 125 | 1.6 | 183 | 2.2 |
| | 2010 | 51 | 5.9 | 8 | 0.0 | 119 | 5.9 | 178 | 5.6 |
| | 2011 | 39 | 10.3 | 4 | 0.0 | 82 | 1.2 | 125 | 4.0 |
| Benzodiazepines | 2007 | 114 | 7.0 | 30 | 3.3 | 223 | 5.8 | 367 | 6.0 |
| | 2008 | 135 | 5.2 | 24 | 12.5 | 204 | 2.0 | 363 | 3.9 |
| | 2009 | 99 | 6.1 | 22 | 13.6 | 189 | 4.2 | 310 | 5.5 |
| | 2010 | 114 | 4.4 | 18 | 0.0 | 197 | 6.1 | 329 | 5.2 |
| | 2011 | 83 | 3.6 | 14 | 21.4 | 131 | 3.1 | 228 | 4.4 |
| Any drug other than ethanol | 2007 | 122 | 9.0 | 30 | 6.7 | 233 | 13.7 | 385 | 11.7 |
| | 2008 | 142 | 10.6 | 29 | 10.3 | 213 | 12.7 | 384 | 11.7 |
| | 2009 | 100 | 8.0 | 22 | 13.6 | 191 | 11.5 | 313 | 10.5 |
| | 2010 | 124 | 7.3 | 21 | 0.0 | 205 | 14.6 | 350 | 11.1 |
| | 2011 | 93 | 10.8 | 14 | 21.4 | 135 | 5.9 | 242 | 8.7 |

Information about the influence of alcohol and other drugs on the rate of road traffic accidents registered by the traffic police is given in Table 6-15 (Ředitelství služby dopravní policie Policejního prezidia ČR, 2012). In comparison with 2010, accidents under the influence of alcohol increased in number, while accidents under the influence of other drugs remained at the same level. The number of fatalities in accidents caused under the influence of psychoactive substances decreased in 2011. The influence of non-alcohol drugs on traffic accidents as reported by the traffic police is still much lower than suggested by the results of autopsies and toxicological examinations of road fatalities conducted by forensic medicine departments (see above).

*Table 6-15: Road accidents in the Czech Republic, 2003–2011 – the influence of alcohol and other drugs (Ředitelství služby dopravní policie Policejního prezidia ČR, 2012; Ředitelství služby dopravní policie Policejního prezidia ČR, 2011)*

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

*Note: * Effective from 1 January 2009, the estimated damage limit for the mandatory reporting of accidents to the police was increased from CZK 50,000 (€ 2,033) to CZK 100,000 (€ 4,067); as a result, the number of accidents reported dropped.*

The traffic police test drivers for alcohol and, since 2007, they have also tested drivers for narcotic and psychotropic substances using orientation saliva tests.[122] If the rapid test for non-alcohol drugs is positive, it is necessary to carry out a specialist medical and subsequent toxicological examination. The number of positive tests for narcotic and psychotropic substances and alcohol among drivers in 2007–2012 is shown in Table 6-16.

*Table 6-16: Positive tests for narcotic and psychotropic substances and alcohol (ethanol) among drivers, 2007–2012 (Ředitelství služby dopravní policie Policejního prezidia ČR, 2012)*

| Year | Narcotic and psychotropic substances | Ethanol |
|---|---|---|
| 2007 | 347 | 7,395 |
| 2008 | 794 | 7,600 |
| 2009 | 1,149 | 13,298 |
| 2010 | 1,450 | 13,268 |
| 2011 | 1,717 | 12,777 |
| 2012 (1st half) | 1,151 | 5,920 |

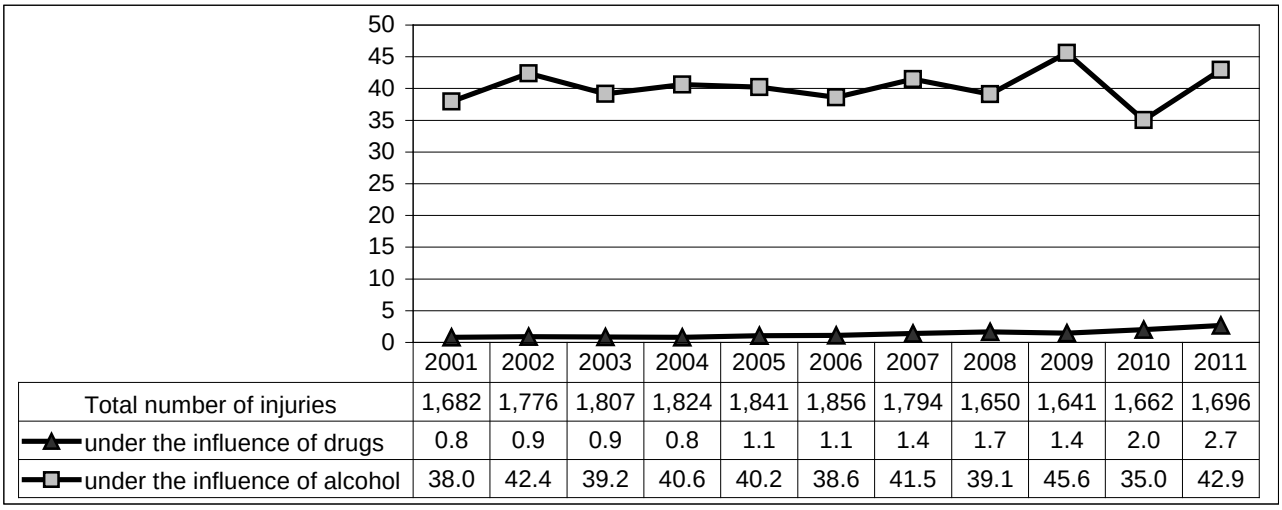
### 6.2.4 Injuries under the Influence of Drugs and Alcohol

The annual report includes, for the first time ever, information on the number of injuries collected from the annual data sheets of the surgical departments,[123] collected by the Institute of Health Information and Statistics as part of the statistics it provides to the Ministry of Health.

The number of accidents under the influence of non-alcohol drugs in the period 2001–2011 increased 3.3 times (from 816 accidents in 2001 to 2,696 accidents in 2011) and their share of the total number of injuries that were treated also increased, from 0.05% in 2001 to 0.15% in 2011. Men accounted for more than 65% of accidents under the influence of drugs between 2010 and 2011 (when the monitoring of accidents by gender and more detailed age groups was introduced). The number of accidents under the influence of non-alcohol drugs in children (aged 0–14 years) did not change much in the long run, reaching around 30 accidents per year; the number of accidents under the influence of drugs among young people (aged 15–19 years) has been monitored since 2009 and around 400 accidents are recorded annually.

The number and proportion of accidents under the influence of alcohol in 2001–2011 did not change significantly and averaged about 40,000 injuries a year, i.e. about 2.3% of the total number of injuries that were treated. As regards accidents under the influence of alcohol, there was a higher proportion of men than in non-alcohol drugs (73% in 2010 and 87% in 2011). The number of accidents under the influence of alcohol in children fluctuated around 250 a year; as regards juveniles, an average of 3,800 accidents under the influence of alcohol per year were treated in 2010 and 2011 (Ústav zdravotnických informací a statistiky, 2012f).

*Graph 6-11: Number of injuries treated in surgical wards in total and under the influence of alcohol and drugs in 2001–2011, in thousands (Ústav zdravotnických informací a statistiky, 2012f)*




| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of injuries | 1,682 | 1,776 | 1,807 | 1,824 | 1,841 | 1,856 | 1,794 | 1,650 | 1,641 | 1,662 | 1,696 |
| under the influence of drugs | 0.8 | 0.9 | 0.9 | 0.8 | 1.1 | 1.1 | 1.4 | 1.7 | 1.4 | 2.0 | 2.7 |
| under the influence of alcohol | 38.0 | 42.4 | 39.2 | 40.6 | 40.2 | 38.6 | 41.5 | 39.1 | 45.6 | 35.0 | 42.9 |

[122] DrugWipe tests are used (http://www.drugwipe.us).

[123] The data sheet is completed annually by each outpatient department or unit for surgery, neurosurgery, plastic surgery, cardiac surgery, traumatology, orthopedics, the treatment of burns, vascular surgery, thoracic surgery, pediatric surgery, and corrective dermatology. The data sheet tracks the total number of injuries treated in surgical departments and particularly the number of accidents that occurred under the influence of alcohol or under the influence of drugs.

### 6.2.5 Use of Alcohol, Tobacco, and Illegal Drugs among Pregnant Women

In 2011, an analysis of drug use among women hospitalised in connection with childbirth and the post-natal period was conducted in order to describe the occurrence of drug use and its association with maternal complications during pregnancy, childbirth, or the post-natal period and the health of the foetus and the newborn.

The data from the National Register of Mothers at Childbirth and the National Register of Newborn Babies, managed by the Institute of Health Information and Statistics, were analysed and published[124] (Nechanská et al. 2012).

In the period 2000–2009, 1,008,821 mothers giving birth were reported, of whom 60,502 (6%) were recorded to be tobacco users, 1,528 (0.2%) alcohol users and 1,836 (0.2%) users of other (illegal) drugs. In total, 1,027,200 newborn babies were reported. The average age of the mothers recorded as using addictive substances was about 0.5–3 years lower than that of non-users, users of illegal drugs constituting the youngest group among them. Users of drugs were more often unmarried and had lower educational attainment than non-users – almost two-thirds of substance users were not married or did not live in permanent cohabitation, and more than 82% of these women had lower educational attainment (primary or secondary school without a final examination). The influence of substance use on the rate of abortions and miscarriages was manifested only in mothers giving birth recorded as smoking tobacco. In severe complications during pregnancy, the influence of addictive substances was demonstrated for all substances. Smokers were 40% more likely to develop these complications, drug users 13% more likely, and alcohol users 5% more likely to experience complications during pregnancy. Substance use had almost no influence on the emergence of problems during childbirth. The use of alcohol and the use of illicit drugs had the effect of an increased rate of complications in the post-natal period. Tobacco use in particular had a negative impact on the health of the foetus/newborn; this was shown, by a statistical test, to be significant in almost all of the observed characteristics, including lower birth weight, shorter gestational age, impaired clinical status of the foetus during childbirth, and a higher rate of stillbirth. Alcohol use by mothers during pregnancy had an impact primarily on the overall health of the foetus immediately after childbirth, on the incidence of birth defects, on the probability of a child being stillborn, or on the newborn's need for treatment in the delivery room. Newborn babies of drug-using mothers also had a higher probability of continued hospitalisation after discharge from the neonatal department and a higher probability of being transferred to the infants' home, and the newborn's stay in the neonatal ward ended in its death more often. The influence of illicit drug use has thus been shown to be much weaker than the influence of alcohol or smoking. However, it is necessary to take into account the methodological limitations and data quality (especially the fact that the use of all kinds of illegal drugs is reported in a mixed category) and, as the case may be, adjust the criteria for reporting illicit drug use among mothers giving birth (Nechanská et al. 2012).

## 6.3 Drug-Related Deaths and Mortality of Drug Users

### 6.3.1 Drug-Related Deaths in the Special Mortality Register

In the Czech Republic, a forensic medical examiner carries out a mandatory autopsy in all cases of sudden death in which the examining practitioner could not determine the cause of death and in all cases of violent deaths (all injuries and poisonings). Since 1998 drug-related deaths (fatal overdoses), and since 2003 also indirect fatalities (with the presence of drugs), have been monitored on a routine basis by means of a special register kept by all thirteen departments of forensic medicine, with close collaboration between the National Focal Point and the Society for Forensic Medicine and Toxicology of the J. E. Purkyně Czech Medical Association. For 2011, data were obtained electronically from all 13 departments, which performed 13,559 autopsies in total (in 2010 the number was 13,241). Since 2007, aggregated reports have also been provided by three departments of pathology where irregular autopsies are carried out by forensic surgeons as prescribed by the provisions of Section 115 of the Criminal Code (forensic autopsies); two of them wound up their activities in December 2010 and the third did not report any drug-related deaths for 2011.

On 1 April 2012, the new Act No. 372/2011 Coll., on health services and the terms and conditions of the provision thereof (the Act on Health Services), came into force, providing for all the national health registers; for more details see the chapters Legal Framework (p. 5) and Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55).

Also among these registers is the National Register of Autopsies and Toxicology Tests Carried Out at the Department of Forensic Medicine, the purpose of which will be to register the data obtained from autopsies and toxicology tests performed by forensic medicine departments. The register is intended to be a source of information both about the details and circumstances of sudden and violent deaths and their causes. The register will also be a source of information about drug-related deaths, i.e. deaths resulting from overdoses on addictive substances and deaths from other causes with the presence of drugs, thereby replacing the existing information system of the special drug mortality register. Data collection for the new health registers should be launched in 2014.

[124]Reporting to the registers is carried out in the Mother Report and the Infant Report. Both registers provide a summary of the basic socio-demographic information on the mother, information about previous pregnancies and abortions/miscarriages, her current pregnancy, the course of the childbirth, childbirth and postpartum therapy and the health of the newborn when the female is hospitalised in connection with childbirth or the post-natal period. Substance use has been monitored in the National Register of Mothers at Childbirth since 2000. Addictive substances are divided into the categories of tobacco, alcohol, and drugs.

#### 6.3.1.1 Fatal Drug Overdoses

In 2011, 190 fatal overdoses on illicit drugs, inhalants, and psychotropic medication were identified (194 in 2010). Of this number, 28 cases fell under the standard EMCDDA selection D for drug-related deaths, i.e. cases of fatal overdoses on illegal drugs and inhalants (55 in 2010), which is a dramatic decrease. Psychotropic medications were the cause of the overdoses in 162 cases (139 in 2010). The substances which caused the fatal overdoses were successfully identified in all cases in 2011.

A total of only six cases of fatal overdoses on (illegal) opiates were identified (there were 19 cases in 2010), which is the lowest figure since drug-related deaths started to be thoroughly monitored using the special registers maintained by the forensic medicine departments. Heroin was identified in only one case (in combination with pervitin and ethanol), and codeine was also detected once (in combination with pervitin and benzodiazepines). Methadone was found in two cases (always in combination with pills), including one where buprenorphine was also present; it was the first time ever in the Czech Republic that buprenorphine had been found to be involved in a fatal overdose. The administration of opium led to death in one case.

Pervitin was the cause of a fatal overdose in 16 cases (there were 18 cases in 2010), with two cases also involving pills. There were two cases of German nationals dying of pervitin overdoses. Four cases were fatal overdoses on inhalants (16 cases in 2010), including toluene on two occasions. In addition, one fatal overdose on ketamine and one on cocaine (in combination with THC and ethanol) were identified. No fatal overdoses on hallucinogens were reported in 2011 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2012); see Table Table 6-17.

Fatal overdoses on psychotropic pills represent a very heterogeneous category which it would be difficult to evaluate accurately. This is because this category comprises suicidal overdoses, accidental overdoses, and overdoses of undetermined intent, both on pills that were prescribed *lege artis* and on abused medication. A total of 162 cases of overdoses on psychotropic pills were identified in 2011[125] (139 cases in 2010), out of which 64 cases involved benzodiazepines (49 in 2010) and 32 medication containing opiates (36 in 2010).

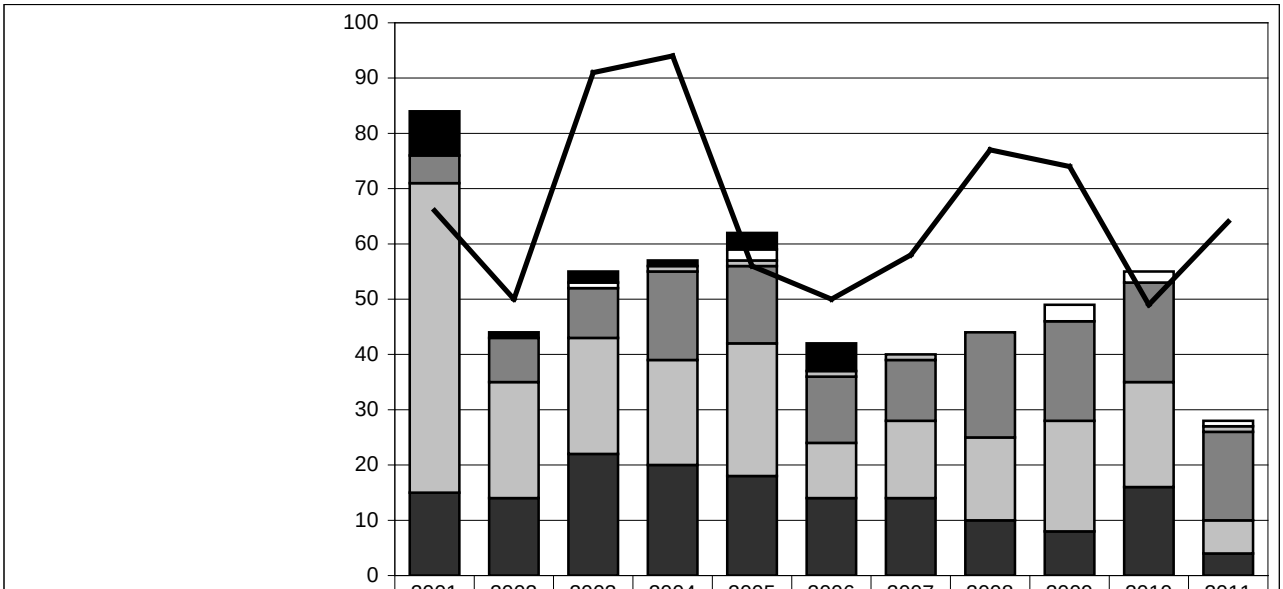
The year 2011 recorded a marked year-on-year decline in the number of fatal overdoses on illicit drugs, especially as a result of the drop in the number of fatal overdoses on opiates/opioids, from 19 to 6 cases, and on inhalants, from 16 to 4 cases; the number of cases of fatal pervitin overdoses remained essentially the same. Overdoses on other illicit drugs are still rather rare. The long-term trend is shown in Graph 6-12.

[125] The vast majority of pill overdoses are suicidal in nature, most often involving a combination of (several) pharmaceuticals with alcohol.

*Table 6-17: Fatal drug overdoses in the Czech Republic by groups of drugs, age groups, and gender, in 2011 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2012)*

| Drug/age group | <15 | 15–19 | 20–24 | 25–29 | 30–34 | 35–39 | 40–44 | 45–49 | 50–54 | 55–59 | 60–64 | >64 | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | Males | Females | **Total** |
| Only opiates/opioids (excluding methadone) | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | **2** |
| Only methadone | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** |
| More substances incl. opiates/opioids | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | **3** |
| – methadone | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **1** |
| **Total opiates/opioids** | **0** | **0** | **0** | **1** | **3** | **1** | **1** | **0** | **0** | **0** | **0** | **0** | **5** | **1** | **6** |
| **One or more substances, excluding opiates/opioids** | **0** | **1** | **4** | **1** | **4** | **6** | **3** | **0** | **2** | **1** | **0** | **0** | **18** | **4** | **22** |
| – inhalants | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 4 | 0 | **4** |
| – pervitin | 0 | 1 | 3 | 0 | 3 | 5 | 2 | 0 | 1 | 1 | 0 | 0 | 13 | 3 | **16** |
| – cocaine | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **1** |
| – synthetic (dance) drugs (such as ecstasy, ketamine etc.) | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** |
| – hallucinogens | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Unspecified / unknown** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Total illegal drugs and inhalants (EMCDDA selection D)** | **0** | **1** | **4** | **2** | **7** | **7** | **4** | **0** | **2** | **1** | **0** | **0** | **23** | **5** | **28** |
| **Psychoactive pills** | **1** | **1** | **9** | **9** | **15** | **16** | **16** | **11** | **22** | **20** | **16** | **26** | **84** | **78** | **162** |
| – benzodiazepines | 0 | 1 | 5 | 4 | 5 | 7 | 5 | 6 | 13 | 7 | 4 | 7 | 37 | 27 | **64** |
| **Total** | **1** | **2** | **13** | **11** | **22** | **23** | **20** | **11** | **24** | **21** | **16** | **26** | **107** | **83** | **190** |

*Graph 6-12: Fatal overdoses on benzodiazepines, illegal drugs, and inhalants, 2001–2011 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2012)*




| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Not specified | 8 | 1 | 2 | 1 | 3 | 5 | 0 | 0 | 0 | 0 | 0 |
| Synhetic (dance) drugs | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 3 | 2 | 1 |
| Cocaine | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 1 |
| Amphetamines (pervitin) | 5 | 8 | 9 | 16 | 14 | 12 | 11 | 19 | 18 | 18 | 16 |
| Opiates/opioids | 56 | 21 | 21 | 19 | 24 | 10 | 14 | 15 | 20 | 19 | 6 |
| Inhalants | 15 | 14 | 22 | 20 | 18 | 14 | 14 | 10 | 8 | 16 | 4 |
| Illicit drugs and inhalants in total (Selection D) | 76 | 43 | 53 | 56 | 59 | 37 | 40 | 44 | 49 | 55 | 28 |
| Benzodiazepines | 66 | 50 | 91 | 94 | 56 | 50 | 58 | 77 | 74 | 49 | 64 |

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

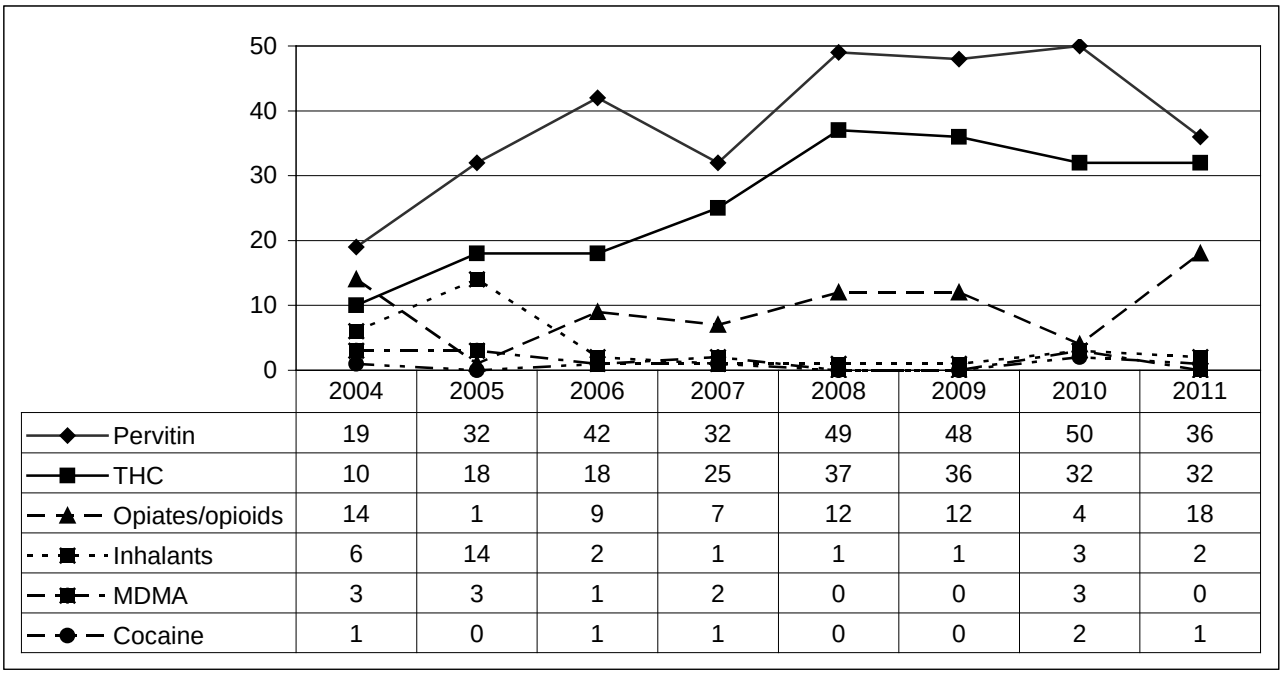
### 6.3.1.2 Deaths with the Presence of Drugs

Altogether, 113 deaths with the presence of drugs were identified in 2011 (there were 117 in 2010). Six of these cases were due to illness (11 in 2010), 48 cases resulted from accidents (58 in 2010), 52 cases involved suicides (46 in 2010), there were six cases of homicide or murder (2 in 2010), and in one case the cause of death was not established. An overview of the numbers and proportions of selected groups of drugs in the individual groups of deaths in which drugs were present is given in Table 6-18 and the trends since 2004 in Graph 6-13 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2012). In the long term, a growing number of cases of indirect deaths where pervitin and THC were found are particularly evident, although there has been a slight decline in the case of THC in the past two years. Opioids used in substitution treatment were not found in any cases of deaths with the presence of drugs in 2011.

*Table 6-18: Deaths with the presence of drugs detected by forensic medicine departments in the Czech Republic, by selected groups of drugs and causes of death, 2011(Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2012)*

| Drug | Illness (n=6) | Accident (n=48) | Suicide (n=52) | Homicide / murder (n=6) | Other (n=1) | Total (n=113) | Proportion (%) |
|---|---|---|---|---|---|---|---|
| Pervitin | 1 | 17 | 15 | 2 | 1 | 36 | 31.9 |
| Benzodiazepines | 0 | 13 | 22 | 1 | 0 | 36 | 31.9 |
| THC | 1 | 21 | 8 | 2 | 0 | 32 | 28.3 |
| Other substances | 3 | 6 | 13 | 0 | 0 | 22 | 19.5 |
| Opiates/opioids | 2 | 6 | 9 | 1 | 0 | 18 | 15.9 |
| Inhalants | 0 | 1 | 1 | 0 | 0 | 2 | 1.8 |
| Cocaine | 0 | 0 | 1 | 0 | 0 | 1 | 0.9 |
| MDMA and other synthetic (dance) drugs | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 |

*Graph 6-13: Deaths with the presence of selected drugs detected by forensic medicine departments in the Czech Republic, 2004–2011 (Národní monitorovací středisko pro drogy a drogové závislosti and SSLST ČLS JEP, 2012)*




| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|
| Pervitin | 19 | 32 | 42 | 32 | 49 | 48 | 50 | 36 |
| THC | 10 | 18 | 18 | 25 | 37 | 36 | 32 | 32 |
| Opiates/opioids | 14 | 1 | 9 | 7 | 12 | 12 | 4 | 18 |
| Inhalants | 6 | 14 | 2 | 1 | 1 | 1 | 3 | 2 |
| MDMA | 3 | 3 | 1 | 2 | 0 | 0 | 3 | 0 |
| Cocaine | 1 | 0 | 1 | 1 | 0 | 0 | 2 | 1 |

For information on the detection of drugs in the bodies of road accident fatalities see the chapter Drugs and Road Accidents (p. 98).

### 6.3.2 Drug-Related Deaths in the General Mortality Register

The General Mortality Register is managed by the Czech Statistical Office[126] and provided for further processing and publication to the Institute of Health Information and Statistics.[127] When data on drug-related deaths are being

[126]The Act on Health Services, adopted in 2011 and coming into force on 1 January 2013, fundamentally changes the process for sending the Certificate of Examination of the Deceased between/to various institutions (healthcare facilities, the registers of births and deaths, and the Institute of Health Information and Statistics), the method of collecting and reporting of diagnoses associated with the death, and the time limits for reporting, and also adds to the report a number of other pieces of data, including the influence of narcotic and psychotropic substances on the death.

[127]In all cases of death in the Czech Republic, the physician diagnosing the death must, according to the current procedure, complete a Certificate of Examination of the Death, which, if an autopsy is performed, is augmented by an autopsy diagnosis and sent to the

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

Since 2002, the number of direct drug-related deaths under selection B had increased almost continuously (from 13 cases in 2002 to 33 cases in 2009), while in the last two years it has gradually decreased, to 22 such deaths in 2011. Along with inhalants (5 cases) in 2011, the number of these cases totalled 27. Approximately 40% of the deaths in 1994–2011 were caused by inhalants, less than a third by opiates/opioids, and about 7% by other drugs; one fifth of the substances remained unspecified. Less than a half of the drug-related deaths in the reporting period occurred in people aged 20–29 years, and three-quarters of the total number were men.

The structure of fatal drug overdoses in 2011, according to the standard and the extended EMCDDA selection B by age, gender, and type of drug, is shown in Table 6-19 and the development of drug-related deaths in 1994–2011 in Table 6-20 (Ústav zdravotnických informací a statistiky, 2012c).

*Table 6-19: Fatal drug overdoses in the Czech Republic according to selection B and expanded selection B in the general mortality register by groups of drugs, age groups, and gender (Ústav zdravotnických informací a statistiky, 2012c)*

| **Drug** | **Age group** | | | | | | | | | | | | **Total** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | <15 | 15–19 | 20–24 | 25–29 | 30–34 | 35–39 | 40–44 | 45–49 | 50–54 | 55–59 | 60–64 | >64 | Men | Women | **Total** |
| Opiates/opioids | 1 | 0 | 1 | 0 | 3 | 3 | 1 | 0 | 1 | 1 | 1 | 0 | 8 | 4 | **12** |
| Cannabis | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Cocaine | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **1** |
| Other stimulants | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | **3** |
| Hallucinogens | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **1** |
| Unspecified drugs | 0 | 0 | 0 | 0 | 3 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 1 | **5** |
| **Selection B (standard)** | **1** | **0** | **2** | **1** | **6** | **7** | **2** | **0** | **1** | **1** | **1** | **0** | **16** | **6** | **22** |
| Inhalants | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 0 | 1 | 0 | 0 | 5 | 0 | **5** |
| **Selection B (expanded)** | **1** | **0** | **2** | **1** | **7** | **7** | **3** | **2** | **1** | **2** | **1** | **0** | **21** | **6** | **27** |

register of births and deaths. At the register of births and deaths, data from the Certificate of Examination of the Deceased are copied into a Czech Statistical Office form (Report of Death). The WHO recommendations for coding the causes of death are applied. In the event that the physician or forensic medical examination department ascertains new facts regarding the cause of death, a change to the Certificate of Examination of the Deceased is reported to the regional office of the Institute of Health Information and Statistics in Prague, Hradec Králové, Brno, or Ostrava, which passes this on to the Czech Statistical Office.

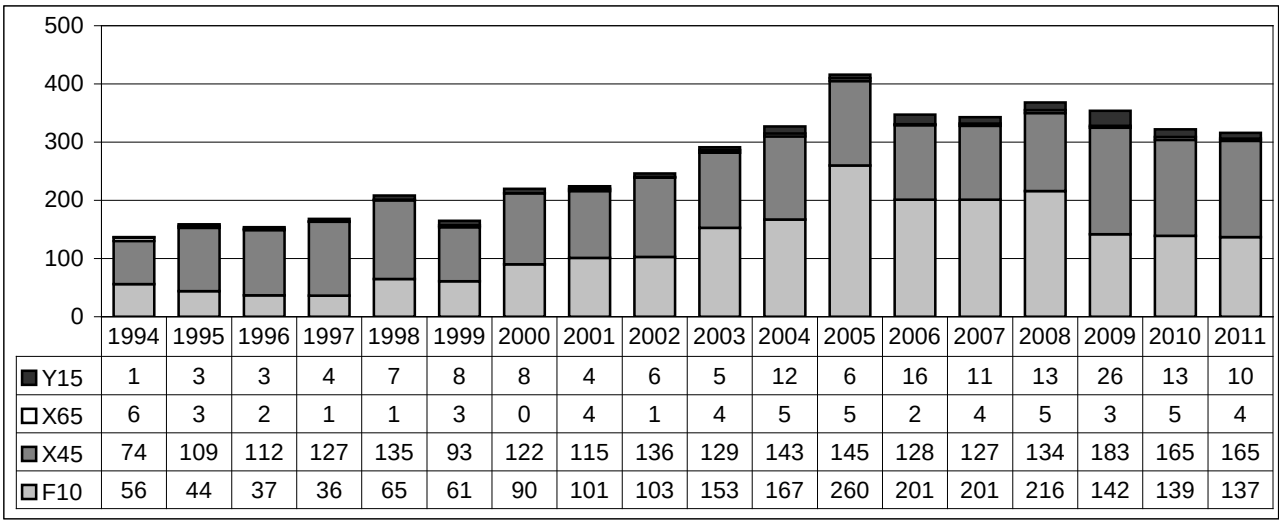
*Table 6-20: Fatal drug overdoses in the Czech Republic according to selection B and expanded selection B in the general mortality register by groups of drugs, 1994–2011 (Ústav zdravotnických informací a statistiky, 2012c)*

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

Direct drug-related deaths associated with alcohol (alcohol overdoses) were extracted from the General Mortality Register according to similar criteria to those for non-alcohol drugs, i.e. deaths with the primary cause of mental and behavioural disorders caused by alcohol (diagnosis F10) or death from accidental, intentional, or undetermined alcohol poisoning, i.e. a combination of diagnoses for alcohol poisoning (diagnoses X45, X65, and Y15) with diagnoses for the toxic effect of alcohol or ethanol (diagnoses T51.0 and T51.9).

In 1994–2005, the number of cases grew until 2005 (from 137 cases in 1994 to 416 in 2005), when it peaked; in the following years the number was around 350 cases per year and there were 316 cases identified in 2011 (Ústav zdravotnických informací a statistiky, 2012c); see Graph 6-14.

*Graph 6-14: Structure of fatal alcohol overdoses in the Czech Republic in the general mortality register, 1994–2011 (Ústav zdravotnických informací a statistiky, 2012c)*




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

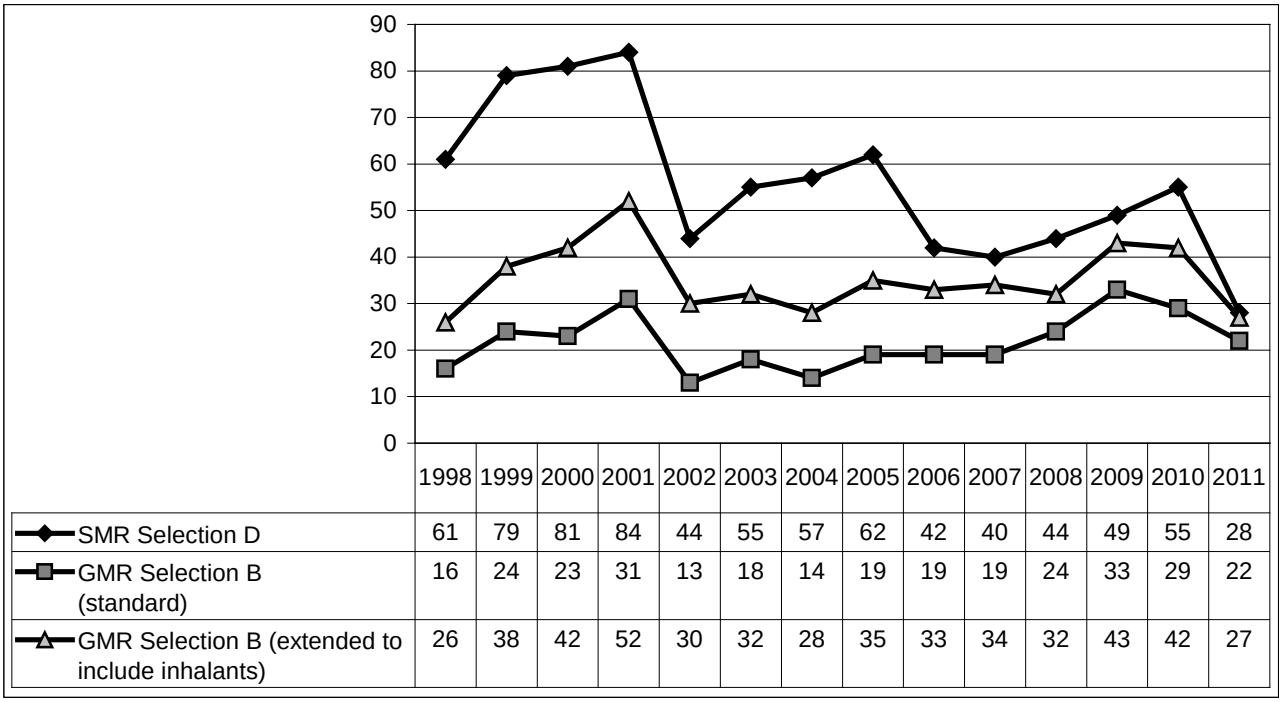
*Note: Mental and behavioural disorders resulting from the use of alcohol, X45 – Accidental poisoning by and exposure to alcohol, X65 – Intentional self-poisoning by and exposure to alcohol, Y15 – Poisoning by and exposure to alcohol, undetermined intent.*

### 6.3.3 Comparison of Direct Drug-Related Deaths across Data Sources and Selection Criteria

Developments in the number of drug-related deaths according to the standard and expanded EMCDDA selection B and alternative selection in comparison with data regarding fatal illegal drug and inhalant overdoses from the special register of drug-related deaths (selection D) are shown in Graph 6-15. It is evident that since 2006 all the lines have

shown the same trend and, moreover, in the past three years they have also converged as far as the absolute values are concerned.

*Graph 6-15: Comparison of trends in fatal drug overdoses extracted from the general mortality register (GMR) and special mortality register (SMR) in 1998–2011 (Ústav zdravotnických informací a statistiky, 2011)*



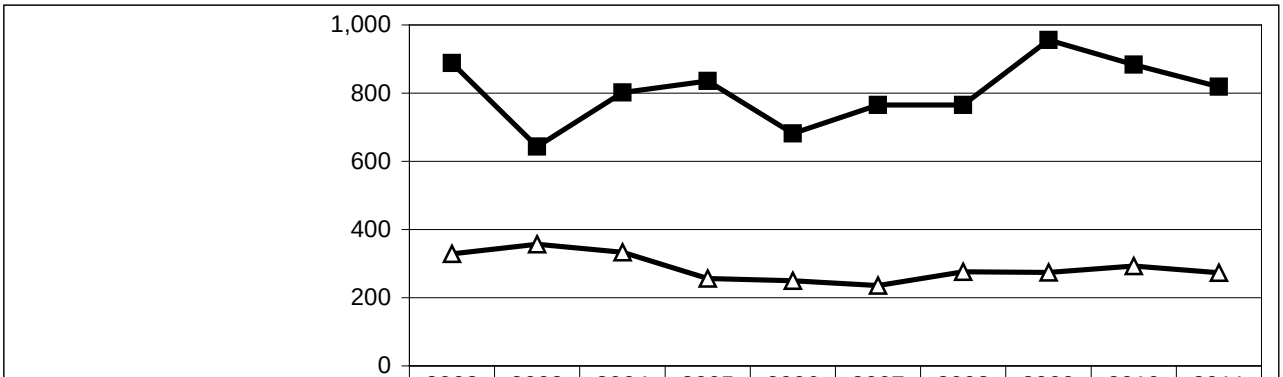

| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SMR Selection D | 61 | 79 | 81 | 84 | 44 | 55 | 57 | 62 | 42 | 40 | 44 | 49 | 55 | 28 |
| GMR Selection B (standard) | 16 | 24 | 23 | 31 | 13 | 18 | 14 | 19 | 19 | 19 | 24 | 33 | 29 | 22 |
| GMR Selection B (extended to include inhalants) | 26 | 38 | 42 | 52 | 30 | 32 | 28 | 35 | 33 | 34 | 32 | 43 | 42 | 27 |

### 6.3.4 Autopsies Performed by Forensic Medicine Departments

Another source of information on the occurrence of drug-related deaths is the annual forensic medicine data sheets,[128] collected by the Institute of Health Information and Statistics as part of the statistics it provides to the Ministry of Health. Developments in the total number of autopsies and autopsies following an overdose in connection with the use of alcohol and/or narcotic and psychotropic substances are shown in Graph 6-16 (Ústav zdravotnických informací a statistiky, 2012e). The number of deaths related to the consumption of addictive substances (i.e. indirect deaths) according to the annual data sheets is approximately three times higher than the number of fatal overdoses.

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

*Graph 6-16: Number of autopsies performed by forensic medicine departments in 2002–2011 (Ústav zdravotnických informací a statistiky, 2012e)*




| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total number of autopsies | 10,520 | 11,730 | 12,725 | 12,842 | 12,790 | 13,517 | 13,573 | 13,402 | 13,721 | 14,046 |
| of which deaths caused by overdose on alcohol/drugs | 329 | 357 | 333 | 256 | 250 | 236 | 276 | 274 | 293 | 273 |
| of which deaths related to the use of alcohol/drugs | 888 | 643 | 802 | 836 | 682 | 765 | 765 | 956 | 884 | 819 |

### 6.3.5 Mortality of Drug Users

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

An analysis was published of the drug careers of people who were included in a study focused on addiction risk factors between April 1996 and December 1998 and gave their consent to being monitored in the future; see the chapter Problem Drug Use (p. 48). A mortality analysis was published last year (Zábranský et al. 2011); see also the 2010 Annual Report.

The Substitution Treatment Register also includes the deaths of clients among the reasons for terminating treatment. In 2011, a total of 2,290 persons were registered as being in treatment. Deaths were reported for four of these patients (Nechanská, 2012g), representing an annual gross mortality rate of approximately 1.7‰. Despite the very low numbers, the data since 2000 show a declining mortality trend among registered patients; see Table 6-21. However, the mortality rate in the Register is underestimated because physicians do not report all of their patients' deaths to it. Studies of the mortality rate for drug users in treatment, comparing data on patients who were treated in the registers of the Institute of Health Information and Statistics with data in the General Mortality Register, found that the gross annual mortality rates for patients in substitution treatment were 7.2‰ (Lejčková and Mravčík, 2005; Lejčková and Mravčík, 2007) and 3,5‰ (Zábranský et al. 2009).

*Table 6-21: Mortality rate for patients in the Substitution Treatment Register, 2000–2011 (Nechanská, 2012g)*

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

## 7 Responses to Health Correlates and Consequences of Drug Use

Harm reduction has been one of the main areas of the Czech drug policy in the long term. Low-threshold drop-in centres and outreach programmes across the Czech Republic form the basis of the network of services in this area.

The number of low-threshold programmes for drug users varies between 90 and 100 programmes from year to year; in recent years, however, there has been a marked increase in the number of clients in contact. In the long term, there has also been a steady increase in the number of contacts and the quantity of needles, syringes, and other injecting paraphernalia exchanged; over 5 million needles and syringes were distributed in 2011.

In the last three years, there has been a noticeable increase in the number of tests for infectious diseases among drug users who are in contact with the low-threshold services, the largest year-on-year increase having been recorded in testing for syphilis. In the Czech Republic, there is still no statutory regulation or guidance for the testing and prevention of infections among drug users that would consider using rapid screening tests in low-threshold services for drug users.

There has been an increase in the number of programmes that distribute gelatine capsules as an oral alternative to the injecting application of pervitin. According to the available information, there were at least 42 programmes distributing these capsules in the Czech Republic, in which nearly 70 thousand capsules were distributed in 2011.

Specific harm reduction programmes in recreational settings were conducted by a total of six organisations in 2011 and the number of contacts with clients decreased year-on-year.

The treatment of HIV-infected persons and AIDS patients, including IDUs, and care for them is provided by seven AIDS centres in the Czech Republic. The treatment and follow-up of viral hepatitis in the Czech Republic is provided in about 75 centres for the treatment of viral hepatitis, with about half of them treating injecting drug users.

### 7.1 Legal Framework, Strategies, and Policies for Harm Reduction

In 2010, the government approved the National Drug Policy Strategy for 2010–2018, as well as the 2010–2012 Action Plan. Harm reduction is one of the four cornerstones of the strategy. For details see the 2010 Annual Report and the chapter National Action Plan, Strategy, Evaluation, and Coordination (p. 10).

At the end of 2010, an HIV screening test kit began to be distributed in the Czech Republic and its launch on the market was accompanied by a campaign in which the distributor emphasised that the test would be routinely available in pharmacies, even for the general public[129]. The Ministry of Health, the National Institute of Public Health – National Reference Laboratories for AIDS, and the Medical Society for Infections of the J. E. Purkyně Czech Medical Association responded by issuing a joint statement on testing for HIV antibodies,[130] in which they dismissed the media campaign as misleading and strongly highlighted some statutory provisions and methodological guidelines applicable in the Czech Republic, stating, besides other things, that the examination of HIV antibodies in the Czech Republic may be carried out only after prior authorisation by the Chief Health Officer, HIV tests may only be performed by authorised healthcare facilities, and medical staff must undergo mandatory training at the National Reference Laboratory for AIDS. Although the statement was primarily aimed at selling HIV tests in pharmacies and general self-examination, it drew attention again to the unresolved policy framework of testing for infections in programmes for drug users and, in some cases, it may have complicated the implementation of testing in facilities for drug users[131].

This case once again pointed out the absence of a methodical procedure for the testing and prevention of infections among injecting drug users that takes into account the interdisciplinary, community nature of (especially low-threshold) services for drug users, the development of rapid tests intended to be used in lieu of contact with the target group (so-called point-of-care tests) and, last but not least, the recommendations of international organisations in this field. The latest document of this kind is the joint guidance published by the European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) entitled “Prevention and control of infectious diseases among people who inject drugs” (ECDC and EMCDDA, 2011). The guidance defines a total of seven major interventions aimed at the prevention and control of infectious diseases among (injecting) drug users, supported by conclusive scientific evidence and practical experience and in line with the existing EU-wide policies on drugs and infectious diseases. The principles of service provision according to the ECDC and EMCDDA require, besides other things, the availability of testing for infectious diseases in low-threshold programmes: “The second core principle ensures that services can easily be reached by people who inject drugs and that a low threshold of access is achieved. This means that services must be located where the users are, or where they can easily get to.” The guidance emphasises collaboration between the various component parts at the national and local levels based on the principle of public health protection (ECDC and EMCDDA, 2011). A summary of

[129] See http://www.aidstest.cz (2012-08-28)
[130] See http://www.mzcr.cz/dokumenty/spolecne-stanovisko-ministerstva-zdravotnictvi-crstatniho-zdravotniho-ustavu-narodni-referencni-laboratore-pro-aids-a-spolecnosti-infekcniho-lekarstvi-cls-jep-k-testovani-hiv-protilatek_5146_1524_1.html (2012-08-28)
[131] Annual Report on the Drug Policy Implementation in the South Bohemia Region in 2011.

this guidance was published in Czech in the *Zaostřeno na drogy* ("Focused on Drugs") bulletin, No. 2/2012[132], and a translation of the whole document will be issued in the publication series of the National Focal Point by the end of 2012.

In August 2012, a draft of the National Programme for HIV/AIDS in the Czech Republic for 2013–2017, containing a number of activities that are also targeted at injecting drug users, was submitted to the Ministry of Health for an inter-agency review process.

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

In the Czech Republic, the prevention of overdoses is conducted through the counselling and education of drug users as part of the services provided by low-threshold and treatment facilities. For low-threshold programmes see below; treatment is discussed in the chapter Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55). The main educational topics include first aid in the event of an overdose, the risks of polydrug use, and the principles of safer drug use. Most low-threshold facilities also provide counselling in this area via email and by telephone. There is a whole range of information documents drafted by the facilities themselves, some of them also in foreign languages (e.g. Romani, Russian, and Polish).

The regularly updated web portal *eDekontaminace.cz* focuses on sharing information on harm reduction, including safe use and overdose prevention information[133].

In the Early Warning System for new psychoactive substances (EWS), all low-threshold facilities are notified if new drugs or dangerous drugs involving higher health and overdose risks are detected in the Czech Republic (or anywhere across Europe). For example, in 2011 the facilities were repeatedly notified about the risks of fentanyl[134] on the drug market in the Czech Republic and the occurrence of anthrax among heroin users in Germany and the UK[135] and provided with information regarding the emergence of new synthetic drugs.

No other specific activities leading to the prevention of overdosing, such as the preventive distribution of opiate antagonists (naloxone) among users, have been implemented in the Czech Republic. Information about counselling and other services provided to drug users upon their release from prison is given in the chapter Drug Use and Problem Drug Use in Prisons (p. 134).

In 2011 the National Focal Point conducted a targeted survey on specific interventions aimed at drug overdoses as part of the monitoring of testing for and prevention of infections in low-threshold programmes (see below). Most low-threshold programmes participating in the survey reported that they did not provide specific overdose prevention interventions except for the standard approach of providing information about safer use, distributing leaflets etc. Some programmes indicated that they specifically focused on seasonal (injecting) users of raw opium (see below), including the risk of overdoses.

### 7.3 Prevention and Treatment of Drug-Related Infectious Diseases

#### 7.3.1 Low-Threshold Harm Reduction Programmes

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

The network of low-threshold facilities in the Czech Republic comprises drop-in centres and outreach programmes. Their number has remained relatively stable in recent years;[136] there were 99 of them in operation in 2011.

The total number of drug users maintaining contact increased in 2011 to 35,500 individuals and so did the number of injecting drug users and pervitin users (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h); see Table 7-1. The number of cocaine users in contact is still very low; 17 people were reported for the whole Czech Republic.

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[132] http://www.drogy-info.cz/index.php/publikace/zaostreno_na_drogy/2012_zaostreno_na_drogy/ (2012-09-06)
[133] http://www.edekontaminace.cz (2012-08-30)
[134] Fentanyl is a highly potent opioid. It was first detected in the Slovak Republic in 2009, an event that immediately triggered a warning being issued to drug services.
[135] See http://www.drogy-info.cz/index.php/o_nas/varovani_nove_drogy/vyskyt_antraxu_u_uzivatelu_heroinu_ve_skotsku_anglii_a_nemecku_v_r_2009_2011 (2012-08-30)
[136] The number of programmes is influenced by the projects submitted by low-threshold facilities to subsidy proceedings and by the formal differentiation of the individual activities. A drop-in centre and an outreach programme may both be operated by one and the same entity within a single project, while in other cases or in other years, they may form two or more separate projects. Information about the services provided in the low-threshold facilities is mainly available from the final reports drawn up by the facilities for the purposes of the subsidy proceedings of the Government Council for Drug Policy Coordination.

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

In the first half of 2012, an institutional analysis of low-threshold services for drug users was carried out (Burešová, 2012). The author conducted a survey with the participation of 60 facilities in total (39 drop-in centres and 21 outreach programmes). The analysis shows that the harm reduction programmes are essentially provided outside the healthcare system. These services are, for the most part, provided by social service facilities, although most of them also provide purely medical interventions (such as medical attendance and testing for infectious diseases). Approximately half of the respondents are considering extending their status to that of a healthcare facility, while, at the same time, 70% admit that they have insufficient information about how this process works. More stable funding for their services is emphasised as the main motivating factor for this change. The facilities approached have little interest in expanding their target groups; about half of the facilities would also be willing to provide services to clients whose primary drug is alcohol (Burešová, 2012).

In terms of regional distribution, the low-threshold programmes in Prague, followed by those in the Ústí nad Labem and Moravia-Silesia regions, reported the highest numbers of contacts in 2011. The highest number of interventions in exchange programmes (number of exchanges) was reported by the services in Prague, followed by the Ústí nad Labem, Moravia-Silesia, South Moravia, and Central Bohemia regions (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h). A detailed account of the services reported by the low-threshold programmes in 2011 by region is provided in Table 7-3.

*Table 7-1: Clients of Czech low-threshold programmes, 2003–2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

| Indicator | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|
| Number of low-threshold programmes | 93 | 92 | 92 | 90 | 109 | 100 | 95 | 96 | 99 |
| Number of drug users | 25,200 | 24,200 | 27,800 | 25,900 | 27,200 | 28,300 | 30,000 | 32,400 | 35,500 |
| – injecting drug users | 16,700 | 16,200 | 17,900 | 18,300 | 20,900 | 22,300 | 23,700 | 24,500 | 25,300 |
| – pervitin users | 11,300 | 12,200 | 12,300 | 12,100 | 14,600 | 14,900 | 16,000 | 17,500 | 19,400 |
| – opiate/opioid users | 6,100 | 6,000 | 6,800 | 6,900 | 7,300 | 8,300 | 8,900 | 8,100 | 6,800 |
| – heroin users | – | – | – | 4,000 | 4,100 | 4,600 | 4,950 | 4,200 | 3,300 |
| – Subutex® users | – | – | – | 2,900 | 3,200 | 3,700 | 3,950 | 3,900 | 3,500 |
| – cannabis users | 5,500 | 4,100 | 3,600 | 2,700 | 2,000 | 1,700 | 2,200 | 1,900 | 3,200 |
| – inhalant users | 705 | 560 | 470 | 450 | 390 | 300 | 250 | 300 | 250 |
| Average age of drug users (years) | 23.2 | 23.4 | 25.0 | 25.3 | 26.1 | 26.4 | 27.4 | 27.0 | 28.1 |

*Table 7-2: Selected services of low-threshold facilities, 2005–2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

| Indicator | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|
| Needle/syringe exchange | 249,000 | 191,000 | 215,800 | 217,200 | 237,800 | 234,900 | 256,500 |
| Food service | 99,500 | 97,600 | 94,100 | 87,800 | 108,800 | 107,700 | 100,700 |
| Hygiene service | 40,900 | 41,100 | 40,000 | 34,800 | 44,300 | 56,300 | 53,000 |
| Individual counselling | 25,800 | 21,900 | 24,100 | 21,000 | 27,800 | 37,600 | 30,800 |
| Medical attendance | 12,500 | 10,500 | 9,400 | 7,700 | 10,200 | 9,700 | 9,500 |
| Crisis intervention | 2,500 | 1,800 | 1,600 | 1,100 | 1,600 | 2,400 | 2,400 |
| Group counselling | 1,500 | 1,500 | 1,000 | 1,100 | 1,300 | 1,300 | 700 |
| Total number of contacts | 403,900 | 322,900 | 338,100 | 329,500 | 365,600 | 396,800 | 415,400 |

*Table 7-3: Selected services of low-threshold centres by region, 2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

| Region | Contact | First contact | Needle/syringe exchange | Food service | Hygiene service | Individual counselling | Referral* | Medical attendance | Crisis intervention | Group counselling |
|---|---|---|---|---|---|---|---|---|---|---|
| Prague | 141,038 | 777 | 118,119 | 21,002 | 8,152 | 5,068 | 3,293 | 3,970 | 222 | 190 |
| Central Bohemia | 17,870 | 470 | 10,072 | 4,447 | 3,010 | 1,958 | 1,447 | 111 | 38 | 9 |
| South Bohemia | 18,472 | 690 | 9,281 | 8,412 | 2,444 | 1,999 | 1,910 | 341 | 70 | 0 |
| Pilsen | 20,066 | 679 | 6,410 | 6,120 | 2,820 | 1,878 | 2,298 | 675 | 273 | 127 |
| Karlovy Vary | 26,980 | 474 | 9,910 | 8,886 | 7,580 | 2,048 | 529 | 507 | 129 | 32 |
| Ústí nad Labem | 69,216 | 1,840 | 46,137 | 12,884 | 8,947 | 1,812 | 1,994 | 930 | 67 | 33 |
| Liberec | 11,734 | 374 | 6,409 | 4,151 | 2,387 | 337 | 733 | 75 | 38 | 0 |
| Hradec Králové | 8,405 | 336 | 4,302 | 3,724 | 2,715 | 637 | 124 | 72 | 39 | 4 |
| Pardubice | 3,215 | 134 | 1,517 | 386 | 601 | 151 | 152 | 25 | 9 | 0 |
| Vysočina | 6,907 | 335 | 1,929 | 3,891 | 1243 | 1,299 | 528 | 98 | 28 | 0 |
| South Moravia | 26,952 | 746 | 15,642 | 7,771 | 4,733 | 3,474 | 528 | 628 | 57 | 101 |
| Olomouc | 21,678 | 1,829 | 6,599 | 4,503 | 2,490 | 4,105 | 2,834 | 821 | 142 | 41 |
| Zlín | 10,425 | 298 | 4,453 | 1,007 | 658 | 1,332 | 1,164 | 308 | 47 | 22 |
| Moravia-Silesia | 32,401 | 702 | 15,760 | 13,499 | 5,206 | 4,727 | 640 | 964 | 1,247 | 173 |
| **Total** | **415,359** | **9,684** | **256,540** | **100,683** | **52,986** | **30,825** | **18,174** | **9,525** | **2,406** | **732** |

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

More details on the clients of low-threshold facilities are also provided in the chapter Data on Problem Drug Use from Non-Treatment Sources (p. 53).

#### 7.3.1.1 Needle and Syringe Exchange Programmes

A needle and syringe exchange programme was provided by all 99 low-threshold programmes in 2011. The amount of material distributed is growing steadily; the number of syringes and needles distributed in 2011 exceeded 5 million units for the first time (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h). Comparisons of the number of programmes and the number of syringes distributed in 1998–2011 are provided in Table 7-4, and the numbers of syringes issued in each region are shown in Table 7-5.

According to information available from the final reports, each injecting drug user who visited a low-threshold facility made over 9 exchanges in 2011 on average and received approximately 190 sterile needles and syringes on average. The regional distribution of the needles and syringes provided in each region corresponds with the relative numbers of injecting (problem) drug users; Map 7-1 (see below) and Map 4-1 (p. 50).

*Table 7-4: Exchange programmes in the Czech Republic, 1998–2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

| Year | Number of exchange programmes | Number of needles and syringes exchanged |
|---|---|---|
| 1998 | 42 | 486,600 |
| 1999 | 64 | 850,285 |
| 2000 | 80 | 1,152,334 |
| 2001 | 77 | 1,567,059 |
| 2002 | 88 | 1,469,224 |
| 2003 | 87 | 1,777,957 |
| 2004 | 86 | 2,355,536 |
| 2005 | 88 | 3,271,624 |
| 2006 | 93 | 3,868,880 |
| 2007 | 107 | 4,457,008 |
| 2008 | 98 | 4,644,314 |
| 2009 | 95 | 4,859,100 |
| 2010 | 96 | 4,942,816 |
| 2011 | 99 | 5,292,614 |

*Table 7-5: Number of needles and syringes distributed in the exchange programmes in 2003–2011, by region (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

| Region | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|
| Prague | 979,560 | 1,210,704 | 1,697,554 | 1,850,330 | 2,071,788 | 2,060,588 | 2,130,729 | 2,130,433 | 2,198,651 |
| Central Bohemia | 31,682 | 66,600 | 110,325 | 168,220 | 215,640 | 309,590 | 345,214 | 350,052 | 332,827 |
| South Bohemia | 69,004 | 102,621 | 124,454 | 141,825 | 212,791 | 228,872 | 239,690 | 183,278 | 202,545 |
| Pilsen | 44,670 | 88,450 | 116,611 | 157,317 | 189,894 | 207,938 | 188,416 | 190,648 | 181,408 |
| Karlovy Vary | 29,299 | 35,756 | 58,680 | 66,382 | 83,462 | 79,834 | 102,467 | 141,437 | 177,835 |
| Ústí nad Labem | 262,418 | 351,561 | 479,383 | 612,259 | 655,882 | 637,887 | 678,007 | 604,191 | 735,929 |
| Liberec | 21,108 | 33,467 | 32,800 | 47,756 | 63,967 | 129,903 | 87,272 | 129,995 | 150,793 |
| Hradec Králové | 45,089 | 41,021 | 86,221 | 98,269 | 139,075 | 173,417 | 183,186 | 200,616 | 253,306 |
| Pardubice | 23,330 | 36,081 | 38,725 | 48,144 | 29,908 | 52,690 | 62,541 | 84,950 | 88,867 |
| Vysočina | 29,363 | 39,348 | 61,425 | 68,682 | 99,447 | 65,343 | 81,127 | 89,846 | 86,053 |
| South Moravia | 122,137 | 165,846 | 173,090 | 227,833 | 269,236 | 264,872 | 252,145 | 286,251 | 331,113 |
| Olomouc | 33,832 | 85,872 | 96,416 | 150,024 | 134,433 | 137,321 | 164,699 | 197,767 | 199,930 |
| Zlín | 11,362 | 41,977 | 52,169 | 69,005 | 115,744 | 89,913 | 111,099 | 96,330 | 91,471 |
| Moravia-Silesia | 75,103 | 56,232 | 143,771 | 162,834 | 175,741 | 206,146 | 232,508 | 257,022 | 261,886 |
| **Total** | **1,777,957** | **2,355,536** | **3,271,624** | **3,868,880** | **4,457,008** | **4,644,314** | **4,859,100** | **4,942,816** | **5,292,614** |

*Map 7-1: Number of needles and syringes distributed in Czech regions in 2011, per 1,000 inhabitants aged 15–64 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*


Needle and syringe exchange programmes are complemented in the low-threshold centres by the distribution of aluminium foil for smoking heroin and the distribution of gelatine capsules intended for the oral application of the drug as an alternative to injecting, in particular in the case of pervitin.

Programmes for distributing gelatine capsules to pervitin users have been described in detail previously (Guryčová, 2010; Mravčík et al. 2011e); see also the 2009 and 2010 Annual Reports. In the monitoring of the tests for infections and their prevention among drug users in low-threshold programmes in 2011, a total of 52 low-threshold programmes provided their responses (see also the chapter Drug-Related Infections on p. 87). Forty-two (81%) of these services conducted a capsule distribution programme and issued more than 72,000 capsules. There is a clear upward trend in the number of capsules supplied. At the same time, however, validated information on the methods of use of these capsules and their potential benefits in terms of harm reduction principles is unavailable (Národní monitorovací středisko pro drogy a drogové závislosti, 2012g).

*Table 7-6: Information about the gelatine capsule distribution programmes in low-threshold facilities in the Czech Republic, 2008–2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012g; Národní monitorovací středisko pro drogy a drogové závislosti, 2010; Národní monitorovací středisko pro drogy a drogové závislosti, 2011b)*

| Year | Number of programmes which responded to the questionnaire | Capsule distribution programmes | | Number of capsules distributed |
|---|---|---|---|---|
| | | Number | Share (%) | |
| 2008 | 50 | 16 | 32.0 | 23,865 |
| 2009 | 20 | 14 | 70.0 | 28,638 |
| 2010 | 43 | 30 | 69.8 | 56,868 |
| 2011 | 52 | 42 | 80.8 | 72,609 |

In the 2011 monitoring of testing for and prevention of infections, low-threshold programmes reported that the amount of material and injection paraphernalia, condoms, and gelatin capsules distributed is increasing. Positive changes in clients' behaviour towards the principles of safer use were also reported. On the other hand, they repeatedly came across clients who use raw opium (poppy) on a seasonal basis. Typically, client groups move directly into the field (even for a number of weeks), where they collect and prepare raw opium. It is not uncommon for users of stimulants (pervitin) to shift seasonally to the use of opiates, or both substances combined. The prevailing injecting use of raw opium and lack of basic hygiene in the field conditions have a deleterious effect on the users' health, mainly because of the injecting and subsequent infections and abscesses at the injecting site (Národní monitorovací středisko pro drogy a drogové závislosti, 2012g).

In the Hradec Králové region, pharmacies were repeatedly monitored in 2011 for selling and collecting syringes, selling drugs used as precursors for drug production, and for the number and characteristics of the persons who buy syringes. 124 pharmacies across the region participated (113 in 2010); injecting material was available in 65% of the pharmacies (70% in 2010). The network of pharmacies selling syringes in the region is stable and at least one pharmacy in each town or community sells injecting material. Only nine pharmacies would be willing to accept used syringes and only two actually do so. Substitution preparations containing buprenorphine are offered by 14% of pharmacies (most of the sales of these drugs are not associated with the concurrent purchase of syringes).

Pharmacies in the Hradec Králové region sell an estimated 45,000 syringes per year, i.e. 17% of the current consumption of syringes by injecting drug users in the region (Královéhradecký kraj, 2012).

#### 7.3.1.2 Testing for Infectious Diseases

The National Focal Point is informed about the extent of testing for infections in low-threshold facilities by the final reports concerning projects supported as part of the subsidy proceedings of the Government Council for Drug Policy Coordination. The test results are available from the monitoring of the tests in low-threshold programmes; for detailed information see the chapter Drug-Related Infections (p. 87). In 2011, 78 low-threshold facilities offered HIV testing, 80 HCV testing, 69 HBV testing, and 66 low-threshold facilities offered syphilis testing; see Table 7-7. There has been a significant increase in the number of tests conducted, as well as the number of programmes providing testing for all the infections under monitoring[137] (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h).

*Table 7-7: Number of tests for infectious diseases and the number of low-threshold programmes providing tests, 2002–2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

| Year | HIV | | HBV | | HCV | | Syphilis | |
|---|---|---|---|---|---|---|---|---|
| | Programmes | Tests | Programmes | Tests | Programmes | Tests | Programmes | Tests |
| 2002 | 35 | 1,158 | 26 | 515 | 33 | 1,202 | 2 | 176 |
| 2003 | 64 | 2,629 | 21 | 739 | 60 | 2,499 | 4 | 209 |
| 2004 | 58 | 2,178 | 25 | 932 | 53 | 2,582 | 1 | 84 |
| 2005 | 54 | 2,425 | 28 | 1,370 | 55 | 2,664 | 2 | 54 |
| 2006 | 46 | 1,253 | 56 | 693 | 62 | 1,133 | 3 | 209 |
| 2007 | 53 | 609 | 19 | 370 | 24 | 401 | 4 | 62 |
| 2008 | 50 | 1,120 | 18 | 399 | 40 | 862 | 3 | 124 |
| 2009 | 47 | 1,592 | 23 | 560 | 43 | 1,501 | 4 | 143 |
| 2010 | 58 | 1,821 | 40 | 1,200 | 59 | 2,134 | 20 | 771 |
| 2011 | 78 | 2,833 | 69 | 1,598 | 80 | 3,158 | 66 | 1,516 |

The clients' history of HIV, HBV, and HCV testing is also monitored in the Register of Treatment Demands. The information contained in these items is mostly self-reported but may also come from the client's documentation or from reports on the examination of infection as part of the relevant treatment episode. The percentage of injecting drug users demanding treatment in 2002–2011 and reporting prior tests for the individual infections at any time in their life is shown in Table 7-8.

*Table 7-8: History of HBV, HCV, and HIV testing of all clients – injecting drug users demanding treatment in 2002–2011, (%)* (Studničková and Petrášová, 2012)*

| Year | HBV | HCV | HIV |
|---|---|---|---|
| 2002 (N=6,225) | 39.8 | 45.6 | 47.7 |
| 2003 (N=5,959) | 41.3 | 47.8 | 48.2 |
| 2004 (N=6,364) | 38.7 | 44.8 | 52.8 |
| 2005 (N=6,125) | 39.8 | 44.1 | 54.8 |
| 2006 (N=6,022) | 38.4 | 42.2 | 55.7 |
| 2007 (N=6,109) | 37.4 | 40.3 | 53.4 |
| 2008 (N=5,986) | 42.1 | 45.0 | 55.1 |
| 2009 (N=6,157) | 42.9 | 48.2 | 57.8 |
| 2010 (N=6,581) | 43.1 | 48.5 | 57.7 |
| 2011 (N=6,471) | 45.0 | 50.6 | 57.1 |

*Note:* The proportion of injecting drug users tested (regardless of the knowledge of test outcome) out of all injecting drug users demanding treatment in that year.*

### 7.3.2 HIV/AIDS and Viral Hepatitis C Treatment

The treatment of HIV and AIDS patients and care for them in the Czech Republic is provided according to the Recommended Procedure for Comprehensive Care for Adult HIV Patients (Rozsypal et al. 2010) and is organised within the network of seven AIDS centres. In April 2012, the Society for Infectious Diseases of the J. E. Purkyně Czech Medical Association published a draft update of this recommended procedure, which takes into account the results of new studies and modern medical practices. For example, special attention is newly paid to patients with renal insufficiency, as well as the procedure for post-exposure prophylaxis of HIV infection[138].

In addition to following the standard recommended procedures of the Czech Society for Hepatology and of the Society for Infectious Diseases of the J. E. Purkyně Czech Medical Association, the prevention and treatment of viral

[137] The increase in the number of tests (particularly for HIV) can partly be attributed to the ongoing international study entitled Imp.Ac.T. (Improving Access to HIV/TB Testing for Marginalised Groups), in which three programmes run by the SANANIM civic association participated in 2010–2012.

[138] http://www.infekce.cz/DoporART12xx.htm (2012-09-10)

hepatitis in drug users follows the Standard for the Treatment of Viral Hepatitis in Drug Users (Galský et al. 2008) and is concentrated in the centres for the treatment of viral hepatitis (there are approximately 75 of them officially registered in the Czech Republic); for details see the 2008 Annual Report.

At the beginning of 2011, the National Focal Point conducted a study among the centres for the treatment of HCV to survey (estimate) the scope of the provision of HCV treatment to drug users in the Czech Republic, to map the rules and practices for the admission of injecting drug users to HCV treatment, and to describe the factors that influence the patient's admission to treatment and the course of treatment. The results have already been presented in the 2010 Annual Report and in a detailed communication (Mravčík, 2012).

It can be estimated that in 2010, a total of 61 centres provided the standard HCV treatment with the combination of pegylated interferon alpha with ribavirin, of which 39 treated injecting drug users. An estimated 781 persons were treated for HCV in the Czech Republic in 2010, of whom approximately 370 were (mostly former or abstinent) injecting drug users. The percentage of injecting drug users (IDUs) who were referred to the centre for HCV treatment and whose treatment eventually started was 60% on average. The percentage of IDUs who completed treatment after being admitted was 80% on average. Most physicians saw no difference in the percentage of patients admitted for treatment or in the level of adherence between drug users and non-users and between pervitin and opiate users. However, physicians in the Czech Republic tend to be conservative in the treatment of HCV among injecting drug users; active IDUs are rarely treated, for fear of low adherence. The absence of a consistent application of a multidisciplinary approach to the treatment of HCV, the low level of integration between the treatment of HCV and treatment of addiction, and financial limits on healthcare can be considered to be the main obstacles to increasing the admission levels of IDUs for the treatment of HCV (Mravčík, 2012).

The data provided by the Prison Service of the Czech Republic show that in 2011, 239 persons commenced HCV treatment while serving custodial sentences; compared to the 69 persons entering prison-based HCV treatment in 2010, this means a significant increase (Generální ředitelství Vězeňské služby ČR, 2012c).

### 7.3.3 Programmes Aimed at Drug Use in Recreational Settings

Specific harm reduction programmes in recreational settings were conducted in 2011 by a total of six programmes[139] (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h). These programmes established a total of 1,580 contacts (54.4% of them men) and the most commonly reported illicit drug used was cannabinoids (34.5%), followed by pervitin (4.3%) and ecstasy (4.2%). In 2010, a total of four organisations in five programmes reported 2,021 contacts with clients in recreational settings. This fluctuation in the availability of services in recreational settings, i.e. the number of programmes providing this type of intervention, reflects both the amount of funding provided for the implementation of these programmes and the negative political and departmental standpoints regarding screening tests for the quality of ecstasy at dance parties, which used to form part of the interventions in recreational settings in the past; for details see the 2007–2010 Annual Reports. The Safer Party Tour project (for more details see the 2009 and 2010 Annual Reports) was not active in 2011.

## 7.4 Responses to Other Health Correlates and Consequences of Drug Use

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

[139] Compared to the previous year, interventions in recreational settings were additionally reported in 2011 by the Open House civic association from Bruntál and the *Kotec* civic association from Mariánské Lázně.

# 8 Social Correlates and Social Reintegration

A number of social problems such as low education, unemployment, relationship and family problems, low-quality and unsteady housing, or even homelessness can be associated with drug use. These problems may often occur simultaneously and may even lead to social exclusion. They are present to a higher degree in certain population groups, such as ethnic and national minorities (mainly Roma in the Czech Republic), the homeless, migrants, and immigrants.

New partial data area available for 2011 regarding drug use among Roma and among young homeless individuals and the available information about other groups which are difficult to reach were analysed.

The Social Service Register contains 34 programmes dealing with aftercare for drug users. However, the 2012 Drug Services Census shows that aftercare services are provided by many more programmes of various types. Social work and support services promoting the social reintegration of drug users are provided by tens to hundreds of facilities, in particular as far as assistance concerning housing, employment, and debt are concerned. It is common for contact with other health care or social services to be arranged and for attention to be paid to the development of the client's social skills and competences.

## 8.1 Social Exclusion and Drug Use

### 8.1.1 Social Exclusion among Drug Users

Social exclusion is a phenomenon that often occurs among various population groups whose lifestyle or other characteristics distinguish them from the general population. The lack of (financial) resources is a common cause of social exclusion. Other important factors include a low level of education, unemployment, disturbed family relations, loss of housing, and, consequently, general changes in lifestyle associated with living on the streets and with drug use. The social exclusion of drug users is deepened if they are unemployed or homeless or members of ethnic minorities or make their living in unusual or illegal ways (e.g. prostitution and crime). The factors mentioned above are also often barriers to the successful reintegration of socially excluded persons into (general) society (European Monitoring Centre for Drugs and Drug Addiction, 2003).

A detailed analysis of drug use among migrants, ethnic minorities, and other groups which are difficult to reach in the Czech Republic was prepared in 2011–2012 (Nepustil et al. 2012a).

### 8.1.2 Drug Use among Socially Excluded Groups

#### 8.1.2.1 Roma Communities

It was estimated in 2005–2006 that there were up to 350 excluded Roma communities with a total population of 60 to 80 thousand (Ministerstvo práce a sociálních věcí ČR, 2006). The analyses focused in detail on the topics of the housing, education, and health of persons living in excluded localities. In addition, it dealt with the issue of risk behaviour (crime, addiction, prostitution) and insufficient social competences. The analysis showed that the level of social exclusion of Roma in the Czech Republic was increasing.

In the long term, the Czech Government Council For Roma Minority Affairs has been involved in addressing the situation of Roma communities in the Czech Republic. The Agency for Social Inclusion in Roma Localities has worked within this Council since 2007. It first operated in 13 pilot communities;[140] by the end of 2011 it had worked in 26 excluded communities (Agentura pro sociální začleňování v romských lokalitách, 2011b).

In September 2011 the Government adopted the Strategy for Combating Social Exclusion for 2011–2015,[141] which had been prepared by the Agency for Social Inclusion in Roma Localities. The strategy includes a number of specific tasks for the agency and, in particular, for the Ministry of Education, the Ministry of Labour and Social Affairs, the Ministry of the Interior, and the Ministry for Regional Development in the area of promoting employment, education, the prevention of broken homes, the prevention of children being placed into institutional care, and the issue of safety in socially excluded communities (Agentura pro sociální začleňování v romských lokalitách, 2011a).

The 2011 Report on the Situation of the Roma Minority in the Czech Republic summarises the available information about housing, education, employment, health, and crime and other risk behaviour, including drug use. It shows that members of the Roma minority generally have a lower level of education and a very low level of employment, and their housing and health conditions are on a much lower level than those of other population groups. These circumstances and the subjectively perceived hopelessness of the situation increase crime in the excluded communities, which further widens the social gap and exclusion. Unemployment, elimination from employment office registers as a penalty for prior conduct, substance addiction, the withdrawal of social contributions, and unexpected life emergencies requiring extra resources have been reported as the most common triggers of crime (Rada vlády pro záležitosti romské menšiny, 2012).

[140] http://www.socialni-zaclenovani.cz/agentura-pro-socialni-zaclenovani-zverejnila-vysledky-evaluace-cinnosti-v-pilotnich-lokalitach
[141] http://www.socialni-zaclenovani.cz/vlada-prijala-strategii-boje-proti-socialnimu-vylouceni-v-letech-2011-2015 (2012-09-07)

Among other phenomena, substance use and gambling are two negative effects accompanying life in social exclusion. Children's street gangs also exist in the excluded communities, forming an environment characterised by substance use, vandalism, and property crime. According to the regional coordinators for Roma affairs, the most widespread substances include pervitin, marijuana, Subutex®, and inhalants (especially toluene). Problems related to addictive substances affect multiple generations in Roma families and communities. The substances are often distributed by Roma dealers. The age of the first exposure of Roma children and young people to addictive substances is very low; injecting drug use also occurs among Roma. However, there is often a low level of willingness on the part of Roma to address the problem of substance use. Besides substance use, gambling is also widespread in excluded Roma communities, including among Roma women (Rada vlády pro záležitosti romské menšiny, 2012).

The 2011 figures from the Field Social Workers Support Programme[142] regarding the types of problems addressed by the Roma field social workers in Roma communities are not available and thus cannot be provided to the same extent as they were in the 2010 and previous annual reports.

The results of two studies conducted in 2011 in selected excluded communities are available. The *Podané ruce* civic association and the Roma organisations *Drom* and *IQ Roma Servis* carry out a programme aimed at the protection of public health and at outreach work involving people endangered by addiction in excluded Roma communities in Brno. The programme follows up on a previous project of the *Podané ruce* civic association, aimed at infectious diseases and risk behaviour among injecting drug users in an excluded Roma community in Brno. The 2011 data show a high prevalence of HCV among IDUs of Roma descent (70%), a high number of problem drug users, especially those of heroin (450–1,000 individuals), and a high prevalence of heroin use among Roma prostitutes. The average daily dose of heroin was 1 gram, and the distribution was provided by the Wallachian (Olah) Roma. The researchers proposed the establishment of a specialised prevention, counselling, and treatment centre directly in the excluded community (Jihomoravský kraj, 2012).

A questionnaire study associated with the testing for HCV of the Roma population in Ostrava was conducted between July 2011 and February 2012 (Schůdky, 2012). The sample consisted of 506 individuals, mostly women (69%), aged 15–88, with the 20–40 age group being the largest. Injecting drug use was reported by 22 individuals (4%), 18 (4%) of whom were men and 4 (1%) were women. The primary drug was most commonly pervitin (17 individuals), followed by heroin (3 individuals), and marijuana (3 individuals). Only one positive case of HCV antibodies was identified in the entire sample, which involved a male injecting drug user. Among the Roma injecting drug users, the seroprevalence of HCV was less than 5% (Schůdky, 2012).

#### 8.1.2.2 Other Ethnic Minorities and Migrants

Other ethnic minorities or migrants face similar obstacles in the Czech Republic, such as difficulty of access to the labour market, housing market, education, and health care. Foreigners must often pay the full price of treatment at psychiatric departments (where addiction is also treated), which is often a problem for them. For example, approximately 30% of the foreigners treated by the psychiatric hospital in Bohnice, Prague, never pay for the care received (Hnilicová and Dobiášová, 2009). Medical staff and the health care system are not ready for contact and working with foreigners; there are not enough specific health promotion programmes which are aimed at migrants and foreigners (Janatová et al. 2010). Because of language and cultural barriers, these groups also have difficulty in accessing drug services. The 2012 Drug Services Census (for details see the chapter Drug Services Network and Quality Assurance on p. 57) shows that 47 of the 255 facilities included in the sample are able to deliver services in English, 19 in Russian, and 10 in German, and only 2 facilities reported the ability to provide services in Romani. For additional information about migrants who are drug users see also the 2010 Annual Report.

The only research study to attempt to describe the phenomenon of drugs among the Vietnamese in the Czech Republic was conducted in Brno (Nepustil, 2007). The answers of three Vietnamese drug users and three other key informants familiar with the situation in the Vietnamese community, which is otherwise very closed, were obtained. The patterns of drug use that were described are very different from those observed in the general society. The typical characteristics include the smoking of heroin using aluminium foil, which occurs in enclosed spaces in the Vietnamese community, and the drug users are not typically excluded from the community – they go to work and remain in close contact with their families. The origins of drug use are either related to business failure in the Czech Republic or involve people who have a prior history of drug use in Vietnam. However, the situation may be different among the second-generation Vietnamese. The authors of the study also describe a possible transition towards injecting application, which is related to a poor financial situation and attempts to intensify the effects of the drug. As for drug services, the Vietnamese only use outreach programmes and the methadone programme (albeit only marginally). Rehabilitation and treatment occur with the support of the family; imprisonment is considered an opportunity for abstinence.

The above-mentioned study conducted in Brno also dealt with migrants from the Balkans. According to the authors, these migrants avoid injecting use and, if such use occurs, they seek to follow the principles of safer use. Two

[142] One of the subsidised programmes within the competence of the Government Council for Roma Minority Affairs.

groups can be distinguished in terms of their patterns of use: Albanians, who predominantly smoke heroin, and the nationals of former Yugoslavia, who use heroin, pervitin, and cocaine in different ways. Only the methadone programme is used, and that sporadically, as far as drug services are concerned. The importance of the drug as a symbol of prestige can be one of the causes of the general lack of interest in drug services as this attitude is not compatible with accepting the help that is offered. When attempting recovery, the users mostly engage with their own social network, especially their family and relatives, to be with whom they often travel to their country of origin or to the country where such family members currently live (Nepustil, 2007).

The same study also highlights the different patterns of drug use among Russian-speaking drug users. Ukrainian workers in the Czech Republic reportedly use pervitin to increase their performance. Russian-speaking members of the criminal underworld use marijuana in a controlled fashion or pervitin. Drug users from nearly all the states of the former USSR generally prefer opiates (Nepustil, 2007). Heavy alcohol use is a typical problem of this group: alcohol addiction and the associated disorders were the most common reason for their hospitalisation in psychiatric facilities in the Czech Republic (Hnilicová and Dobiášová, 2009).

#### 8.1.2.3 Female Sex Workers

The provision of paid sexual services and drug use are often related. Women may make money for drug use by providing sexual services; these cases often involve street prostitution, and street prostitutes face an increased risk of various types of abuse, violence, etc. In addition, these women start using drugs in connection with their work in the sex business. The second group of women most commonly work in clubs, use stimulants more frequently, and report a lower level of injecting application. It is also important how the provision of sexual services is defined. Female drug users do not always necessarily provide sexual services in exchange for money; they can do so, for example, in exchange for drugs or accommodation. The customers do not include only anonymous men; they can also be very good friends or potential partners (Frišaufová, 2006).

#### 8.1.2.4 The Homeless

There is a close link between addiction or another mental disorder on the one hand and homelessness on the other hand. However, the cause and effect are not always easily distinguishable. Combined with socio-economic difficulties, a mental disorder may trigger homelessness. On the other hand, homelessness may result in mental problems, depression, and substance abuse (Šupková, 2008).

International comparative research was carried out in 2008–2011 regarding the young homeless population in four countries[143] (Netherlands, the United Kingdom, Portugal, and the Czech Republic). The objective of the research was to describe the context of the homelessness of young people in the individual countries and analyse the role of various (social) factors.

A total of 54 respondents (39 men and 15 women), nationals of the Czech Republic (87%) and Slovakia (13%) aged 16–25 and living in Prague, participated in the research. The study shows that the group most endangered by homelessness in the Czech Republic is that of young people leaving institutional care. Even though exact records are not available, adolescents and young people are estimated to account for 15% of the homeless. They are most frequently young men with no or low education and no family background who have a history of drug use and low social skills. According to the research report, the risk factors for homelessness among young people in the Czech Republic include, among the factors mentioned above, a dysfunctional family, criminal history, debt, and unsteady housing.

### 8.2 Social Reintegration

It is especially aftercare services that are concerned with the social rehabilitation of and support for drug users, i.e. their return into society, after treatment. They include outpatient aftercare programmes, which may be extended to encompass other support services, in particular sheltered housing and protected employment (sheltered workshops, protected and supported employment) or, most recently, services aimed at intermediating or facilitating the access of drug users to the labour market. In July 2012, a total of 34 aftercare programmes for the target group of persons at risk of addiction or persons with a substance addiction were included in the Register of Social Service Providers, administered by the Ministry of Labour and Social Affairs.

The final reports on projects subsidised by the Government Council for Drug Policy Coordination provide information about 15 aftercare programmes. Thirteen programmes offered their clients sheltered housing and three programmes provided protected employment. Altogether, 1,095 clients (517 of them male) used the aftercare services; 635 (57.9%) of them used to inject drugs before they entered treatment; 577 (52.7%) used to use pervitin and 148 (13.5%) heroin. The capacity of the sheltered housing facilities was 129 in 2011; a total of 20 clients worked in sheltered workshops (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h); see Table 8-1.

[143] http://www.fhs.cuni.cz/kos (2012-09-13)

*Table 8-1: Facilities providing aftercare according to the final reports on projects subsidised by the Government Council for Drug Policy Coordination, 2005–2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

| Indicator | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|
| Number of facilities | 20 | 18 | 18 | 18 | 15 | 16 | 15 |
| Number of aftercare clients | 865 | 904 | 883 | 1,041 | 986 | 987 | 1,095 |
| Sheltered housing capacity | 118 | 126 | 126 | 283 | 134 | 127 | 129 |
| Number of clients in sheltered housing | 244 | 235 | 261 | – | – | – | – |
| Number of clients in sheltered workshops | 59 | 40 | 44 | 25 | 29 | 25 | 20 |

Unstructured aftercare was provided by 13 facilities and used by 624 clients, 243 of whom were men. The average age of the clients was 29.2 years, an increase against 2010. A total of 274 clients (43.9%) used to inject drugs before they entered treatment; 272 (43.6%) had used pervitin and 57 (9.1%) heroin (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h); see Table 8-2.

*Table 8-2: Facilities providing unstructured aftercare according to the final reports on projects subsidised by the Government Council for Drug Policy Coordination, 2005–2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

| Indicator | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|
| Number of facilities | 13 | 10 | 12 | 12 | 11 | 13 | 13 |
| Number of clients | 336 | 380 | 389 | 487 | 443 | 494 | 624 |
| – injecting drug users | 218 | 230 | 236 | 306 | 235 | 335 | 274 |
| – pervitin users | 182 | 216 | 209 | 259 | 246 | 286 | 272 |
| – heroin users | 58 | 78 | 69 | 71 | 64 | 82 | 57 |
| – cannabis users | – | – | – | – | 10 | 12 | 26 |
| Average age of clients | 27.4 | 26.4 | 29.3 | 30.3 | 30.4 | 28.3 | 29.2 |

Fourteen facilities provided intensive aftercare within a long-term structured programme (typically involving sheltered housing or protected employment); their total capacity of 228 beds was used by 471 clients (274 of whom were men) and the average age of the clients of the structured programmes was 29.5, an increase against the previous period. A total of 361 clients (76.6%) used to inject drugs before they entered treatment; 305 (84.5%) of them had used pervitin and 91 (25.2%) heroin (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h); see Table 8-3.

*Table 8-3: Facilities providing structured aftercare according to the final reports on projects subsidised by the Government Council for Drug Policy Coordination, 2005–2011 (Národní monitorovací středisko pro drogy a drogové závislosti, 2012h)*

| Indicator | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|
| Number of facilities | 15 | 16 | 15 | 15 | 12 | 13 | 14 |
| Capacity | 385 | 365 | 325 | 283 | 316 | 269 | 228 |
| Number of clients | 526 | 524 | 494 | 554 | 543 | 493 | 471 |
| – injecting drug users | 399 | 364 | 360 | 422 | 392 | 385 | 361 |
| – pervitin users | 276 | 304 | 284 | 317 | 329 | 297 | 305 |
| – heroin users | 143 | 105 | 104 | 105 | 99 | 73 | 91 |
| – cannabis users | – | – | – | – | 5 | 5 | 11 |
| Average age of clients | 26.4 | 27.1 | 26.6 | 28.7 | 29.2 | 28.8 | 29.5 |

Aftercare is not provided only by dedicated aftercare programmes but may also be associated with other types of services. The 2012 Drug Services Census, in which 255 facilities provided their responses (for details see the chapter Drug Services Census 2012 on p. 59), reported that 94 (36.9%) of these facilities provided aftercare services. They were predominantly facilities that provided outpatient treatment and counselling along with aftercare services. Nevertheless, combinations with other types of services were also quite frequent (Národní monitorovací středisko pro drogy a drogové závislosti, 2012e); see Table 8-4.

*Table 8-4: Additional services provided within aftercare programmes according to the 2012 Drug Services Census (Národní monitorovací středisko pro drogy a drogové závislosti, 2012e)*

| Type of additional services provided | | Number of facilities |
|---|---|---|
| Low-threshold services and counselling | | 21 |
| Outpatient treatment and counselling | | 70 |
| Day care | | 2 |
| Inpatient detoxification | | 9 |
| Inpatient (residential) care | short-term (up to 1 month) | 8 |
| | medium-term (up to 3 months) | 8 |
| | long-term (over 3 months) | 9 |
| Therapeutic community-type residential care | | 6 |
| **Total** | | **94** |

The 16 programmes that declared that they provided aftercare reported a total capacity of 413 beds; the outpatient capacity was 982 clients per day in a total of 74 programmes. Sheltered housing, with a total capacity of 168 beds, was reported by 15 aftercare programmes, and another 3 programmes which did not provide aftercare reported that they offered sheltered housing.

The Drug Services Census also asked the facilities whether they provided additional support services and what forms of social work they used; see Table 8-5.

*Table 8-5: Support services provided by the facilities according to the 2012 Drug Services Census (Národní monitorovací středisko pro drogy a drogové závislosti, 2012e)*

| Intervention type | Number | Percentage |
|---|---|---|
| Assistance in accessing additional health and social services | 182 | 71.4 |
| Development of social skills | 151 | 59.2 |
| Job search counselling and assistance | 142 | 55.7 |
| Housing search assistance | 136 | 53.3 |
| Debt counselling | 120 | 47.1 |
| Case management services | 109 | 42.7 |
| Legal counselling | 84 | 32.9 |
| Supporting services in the area of mental health | 79 | 31.0 |
| Assistance with transport to treatment facilities | 54 | 21.2 |
| Services concerning family, partner, or domestic violence (physical, sexual, and mental abuse) | 51 | 20.0 |
| Self-help groups (such as Alcoholics Anonymous and Narcotics Anonymous) | 37 | 14.5 |
| Coping programmes | 31 | 12.2 |
| Provision of sheltered housing, halfway houses, etc. | 21 | 8.2 |
| Peer support | 20 | 7.8 |
| Care for clients' children | 19 | 7.5 |
| Provision of protected employment | 9 | 3.5 |
| Possibility of accommodating the children in the facility along with the hospitalised client | 8 | 3.1 |
| **Total** | **255** | **100.0** |

The table above indicates that, besides housing and employment, debt is a very frequent area of intervention in programmes aimed at drug users. In its 2011 annual report, the SANANIM civic association raises concerns about the increasing problem of clients' debt; the debt and the penalties often accumulate, the amount of the distraint order is a multiple of the actual amount owed, and loans from loansharks and companies not concerned with whether or not the person can actually repay the debt abound. Most clients cannot achieve the status of personal bankruptcy, which is often the solution to debt (SANANIM, o.s. 2012).

In cooperation with the Association of Citizens Advice Bureaus, the National Focal Point conducted a survey in the citizen advice bureaus participating in the Debt Counselling project in 2012. The survey was aimed at the reasons for their clients' debt in 2011. The loss or reduction of income (e.g. because of an illness or job loss) was the most commonly reported reason for the debt (reported in 287 out of 1,791 cases, involving an average debt of CZK 370 thousand (€ 15,049). Only one person (male), whose debt had reached CZK 350 thousand (€ 14,236), reported substance use as the reason. No client reported gambling as the reason for their debt. Drug users and gamblers thus either are not clients of the citizens advice bureaus or they do not admit to drug use being the reason for their debt (Národní monitorovací středisko pro drogy a drogové závislosti, 2012c).

A study dealing with the historical development of self-help groups in the Czech Republic was published in 2011, noting that the influence of the principles of self-help was still rather low in the Czech Republic and that the current treatment programmes are largely dominated by the expert model (Gabrhelík and Miovský, 2011). The findings of

the 2012 Drug Services Census contradicts this conclusion, because 37 facilities reported the existence of self-help groups. According to the Association for the Services of Alcoholics Anonymous, a total of 49 AA groups were operating in 37 Czech cities in July 2012.[144] According to the available information, there are two Narcotics Anonymous groups: one in Prague and one in Brno.[145]

The 2012 Drug Services Census also inquired about the provision of services to specific target groups, i.e. whether the facility accepts clients from these target groups and whether it offers a special programme for them. A total of 255 facilities participated in the census. The findings highlighted the fact that the offer of special services was very limited as far as services for ethnic minorities, migrants, or foreigners were concerned (Národní monitorovací středisko pro drogy a drogové závislosti, 2012e); see Table 8-6.

*Table 8-6: Number of facilities offering services to specific target groups according to the 2012 Drug Services Census (Národní monitorovací středisko pro drogy a drogové závislosti, 2012e)*

| Target group | Number of facilities working with the target group | Number of facilities offering a special programme |
|---|---|---|
| Injecting drug users | 218 | 69 |
| Lesbian, gay, bisexual, and transgender individuals | 110 | 41 |
| Clients in conflict with the law | 57 | 29 |
| Pregnant women, women after giving birth, mothers with children | 187 | 27 |
| Children and adolescents | 168 | 19 |
| Commercial sex workers | 155 | 19 |
| Pathological gamblers | 194 | 18 |
| Adult women | 167 | 18 |
| Senior or elderly persons | 138 | 15 |
| Drug users in recreational and nightlife settings | 180 | 6 |
| Ethnic or national minorities | 114 | 6 |
| Migrants and foreigners | 153 | 2 |
| Clients with a history of a mental disorder | 122 | 2 |

A study aimed at describing the good practices of programmes intended for the ethnic minorities in the Czech Republic was conducted in 2011 and 2012 (Nepustil et al. 2012b). In the course of its conduct, the study was narrowed down to include only Roma, and five programmes described by the authors as examples of good practices were identified. The authors considered the following aspects to be the attributes of good practices:

- defining the target Roma subgroup in the locality by working together with the Roma community;
- identification and assessment of the needs before the programme is launched;
- offer of additional health services;
- staff training in the area of the cultural and social specifics of Roma;
- establishing close cooperation with organisations working with Roma;
- communication with the entire Roma community;
- open, humane, natural, and partnership-based approach;
- understandable and clear rules of the programme;
- outreach efforts directly in the clients' milieu;
- supporting peer workers who come from the community;
- a broader range of services provided;
- establishing contact and working with the entire family and community;
- confidentiality when working in public.

[144] http://www.anonymnialkoholici.cz/setkani/adresar-skupin.html (2012-07-18)
[145] http://anonymni-narkomani.webnode.cz/ (2012-07-18)

## 9 Drug-related Crime, Prevention of Drug-related Crime, and Prison

The total number of drug-related criminal offences and their share of the reported crimes have been rising since 2007. Nearly 2,782 persons were prosecuted for drug-related crime in 2011 (representing 1.2% of all offences), most commonly for the illicit production, trafficking, and sale of pervitin and cannabis. 2,549 persons were charged. Final court sentences were imposed on 1,870 people, 41% of whom had no previous convictions. The most common sanction imposed was a term of suspended imprisonment. As in the previous year, women accounted for approximately 15% of those prosecuted, charged, and sentenced in connection with drug-related offences. The highest per capita numbers of drug-related offences were reported from Prague and the Vysočina and Karlovy Vary regions.

Compulsory treatment was imposed upon 286 persons: drug treatment upon 117 persons and alcohol treatment upon 169 persons. Compulsory institutional or outpatient alcohol treatment was most frequently imposed upon persons sentenced for the offence of causing bodily harm; drug treatment was imposed upon the offenders sentenced for unauthorised drug production and the possession of drugs and poisons. The number of compulsory treatment sentences decreased every year between 2008 and 2010. However, a slight year-to-year increase can be observed in 2011.

Proceedings regarding a total of 1,169 misdemeanours involving the unauthorised handling of narcotic and psychotropic substances were held in 2011, representing 0.4% of all the misdemeanours dealt with. Similarly to the previous year, misdemeanours involving the unauthorised possession of narcotic and psychotropic substances accounted for 93% of the cases.

In 2011, a total of 122.2 thousand offences were cleared up, 16% of which had been committed under the influence of addictive substances. Offences committed under the influence of alcohol accounted for nearly 89% of these cases, i.e. 17.1 thousand offences. They were most commonly the offences of endangerment under the influence of an addictive substance and inebriation.

The level of secondary drug-related crime (mainly property crime) was again estimated for selected offences for 2011. Drug users are estimated to have committed 33.4% of the selected offences reported and 28.5% of the selected offences cleared up. Theft was the most common offence.

A total of 13,497 drug screening tests on persons serving sentences of imprisonment or awaiting trial in custody were performed in 2011. 521 positive results (4%) were identified, with methamphetamine, THC, and benzodiazepines being the substances detected most frequently. Despite the increasing number of clients, the capacity of the various types of treatment and counselling programmes for drug users in prisons has been decreasing.

### 9.1 Drug Law Offences

The term “primary drug-related crime” refers to criminal offences including the unauthorised handling of narcotic and psychotropic substances, poisons and articles intended for their manufacture, and inciting or enticing others to use addictive substances other than alcohol (Štefunková, 2011). These so-called drug-related offences are defined by Act No. 40/2009 Coll., the Penal Code (“the new Penal Code”), which came into force on 1 January 2010, and replaced the previous Act No. 140/1961 Coll., the Penal Code (“the old Penal Code”). The two norms were applied in parallel in 2011. In practice, this meant that cases which had not been closed prior to the coming into force of the new Penal Code were judged according to that norm which stipulated milder penalties for the conduct in question. The individual types of primary drug-related offences and the relevant sections according to the old Penal Code and the new Penal Code are provided in Table 9-1. The text and tables further below provide data for the same offence according to the provisions of the old and new Penal Codes, and the name of the relevant category is in the “Section of the old Penal Code/Section of the New Penal Code” format.

*Table 9-1: Primary drug-related offences and their description (according to the old Penal Code and the New Penal Code)*

| Act No. 40/2009 Coll. (new Penal Code) | Act No. 140/1961 Coll. (old Penal Code) | Offence type |
|---|---|---|
| Section 283 | Section 187 | Unauthorised production and other handling of narcotic or psychotropic substances and poisons |
| Section 284 | Section 187a | Possession of narcotic or psychotropic substances and poisons (for personal use) |
| Section 285 | – | Unauthorised cultivation of plants and mushrooms containing narcotic or psychotropic substances for personal use |
| Section 286 | Section 188 | Manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance and poison |
| Section 287 | Section 188a | Inciting, promoting or enticing substance use |

Data on drug-related crime are collected and evaluated by a number of agencies, depending on their tasks during criminal proceedings. Comprehensive information about the offences reported and individuals prosecuted is kept by the Headquarters of the Police of the Czech Republic within the Crime Statistics Record System. A dedicated police unit – the National Drug Squad of the Criminal Investigation Service of the Police of the Czech Republic – deals exclusively with drug-related crime, keeping its own information system concerning drug-related offences. The statistics from the public prosecutors' offices and courts are prepared by the Ministry of Justice of the Czech Republic, and information about persons awaiting trial in custody and those sentenced is collected by the Prison Service and the Probation and Mediation Service.

Persons arrested or prosecuted for drug-related offences are recorded in the systems of the National Drug Squad, the Police Headquarters, and the Ministry of Justice. The data from these sources vary slightly, because of the different reporting practices and methodological differences among the individual reporting systems.[146]

### 9.1.1 Drug Law Offences by Type and Drugs

According to data from the Criminal Statistics Record System, a total of 2,782 persons were prosecuted for drug-related offences, 5% of whom were juvenile offenders (Policejní prezidium Policie ČR, 2012). 2,549 persons were charged. Final judgement was issued against 1,870 persons, 41% of whom had no prior criminal history (Ministerstvo spravedlnosti ČR, 2012). As in the previous year, women accounted for 15% of the persons prosecuted, charged, and sentenced in connection with drug-related offences.

In comparison with the previous period, there was an increase in the number of persons prosecuted, charged, and sentenced for drug-related offences in 2011. The biggest increase was observed in the number of persons prosecuted (Ministry of Justice) and charged (Ministry of Justice). In the long term, it is the number of persons arrested and prosecuted (National Drug Squad and the Police Headquarters) that has been increasing in particular. However, there has also been an increase in the number of persons sentenced for drug-related offences; see Table 9-2.

*Table 9-2: Number of persons arrested (National Drug Squad) and prosecuted (Police Headquarters, Ministry of Justice), charged (Ministry of Justice), and sentenced for drug-related offences, 2002–2011 (Národní protidrogová centrála SKPV Policie ČR, 2012e; Policejní prezidium Policie ČR, 2012; Ministerstvo spravedlnosti ČR, 2012)*

| Year | Arrested (National Drug Squad) | Prosecuted (Police Headquarters) | Prosecuted (Ministry of Justice) | Charged (Ministry of Justice) | Sentenced (Ministry of Justice) |
|---|---|---|---|---|---|
| 2002 | 2,000 | 2,204 | 2,504 | 2,247 | 1,216 |
| 2003 | 2,357 | 2,295 | 3,088 | 2,737 | 1,304 |
| 2004 | 2,157 | 2,149 | 2,944 | 2,589 | 1,376 |
| 2005 | 2,168 | 2,209 | 2,429 | 2,157 | 1,326 |
| 2006 | 2,198 | 2,344 | 2,630 | 2,314 | 1,444 |
| 2007 | 2,031 | 2,023 | 2,282 | 2,042 | 1,382 |
| 2008 | 2,322 | 2,296 | 2,304 | 2,100 | 1,360 |
| 2009 | 2,340 | 2,415 | 2,553 | 2,332 | 1,535 |
| 2010 | 2,525 | 2,437 | 2,377 | 2,152 | 1,652 |
| 2011 | 2,759 | 2,782 | 2,798 | 2,549 | 1,870 |

[146] For example, the police statistics (the National Drug Squad database and the Criminal Statistics Record System) register a case as early as when prosecution starts, while the individual cases appear in the statistics of the Ministry of Justice with a certain delay – after the preliminary stage of the criminal proceedings is concluded. Additional reasons for the variation include the different definitions of the cases reported, and different statistical units (individuals or offences), and double entries of persons in the recorded data (e.g. if a single person has committed multiple drug-related offences and/or in connection with multiple drug types). The non-existence of a uniform record-keeping system for all the institutions involved in criminal proceedings is a major disadvantage in this context.

The composition of the drug-related offences by the type of offence did not change significantly in any of the phases of the criminal proceedings in 2011. Criminal proceedings were most typically initiated on the grounds of the illicit production, smuggling, and sale of drugs, which accounted for approximately 80% of the cases in all the phases of the criminal proceedings. On the contrary, persons prosecuted, charged or sentenced for the offence of promoting drug use accounted for the lowest proportion, representing less than 1% across all the phases of the criminal proceedings; see Table 9-3.

*Table 9-3: Number of persons arrested, prosecuted, charged, and sentenced for drug-related offences in 2011, by type of offence (Národní protidrogová centrála SKPV Policie ČR, 2012e; Policejní prezidium Policie ČR, 2012; Ministerstvo spravedlnosti ČR, 2012)*

| Offenders, by phase of criminal proceedings | Section 187 of old Penal Code / Section 283 of new Penal Code | | Section 187a of old Penal Code / Section 284 of new Penal Code | | Section 285 of new Penal Code | | Section 188 of old Penal Code / Section 286 of new Penal Code | | Section 188a of old Penal Code /Section 287 of new Penal Code | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % |
| Arrested (National Drug Squad) | 2,224 | 80.8 | 271 | 9.8 | 151 | 5.5 | 94 | 3.4 | 12 | 0.4 | 2,752 | 100.0 |
| Prosecuted (Police Headquarters) | 2,223 | 79.9 | 273 | 9.8 | 157 | 5.6 | 110 | 4.0 | 19 | 0.7 | 2,782 | 100.0 |
| Prosecuted (Ministry of Justice) | 2,266 | 81.0 | 269 | 9.6 | 110 | 3.9 | 140 | 5.0 | 13 | 0.5 | 2,798 | 100.0 |
| Charged (Ministry of Justice) | 2,098 | 82.3 | 232 | 9.1 | 73 | 2.9 | 133 | 5.2 | 13 | 0.5 | 2,549 | 100.0 |
| Sentenced (Ministry of Justice) | 1,504 | 80.4 | 186 | 9.9 | 82 | 4.4 | 92 | 4.9 | 6 | 0.3 | 1,870 | 100.0 |

According to the National Drug Squad data, drug offenders were most commonly arrested for the illicit production, smuggling, and sale of pervitin or cannabis in 2011. In 2011, the share of those arrested for drug-related offences in connection with pervitin remained practically unchanged in year-on-year terms (54%), while a slight increase (by 3 percentage points) was observed as far as cannabis was concerned. The share of persons arrested for drug-related offences involving other drugs did not exceed 3%; see Table 9-4.

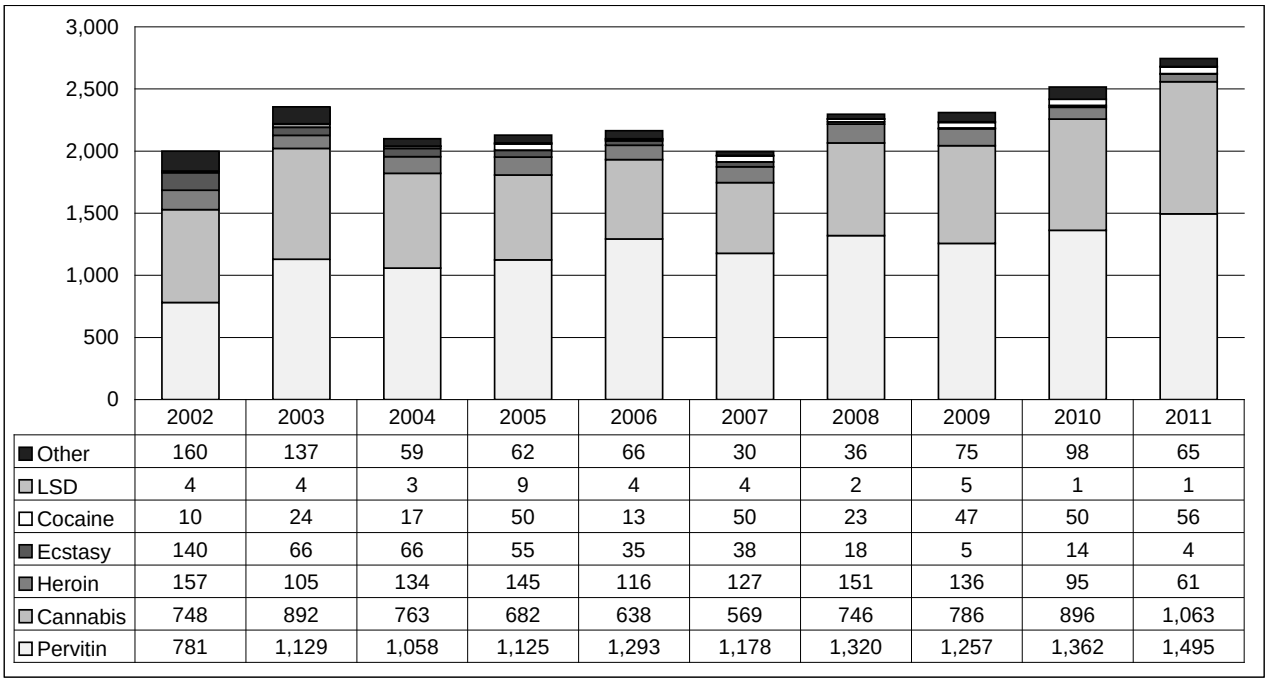
*Table 9-4: Number of persons arrested in 2011, by main drug type and drug offence type (Národní protidrogová centrála SKPV Policie ČR, 2012e)*

| Drug | Production, trafficking, and sale | | Possession for personal use | | Promoting drug use | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % |
| Cannabis | 885 | 36.0 | 178 | 62.7 | 8 | 57.1 | 1,071 | 38.8 |
| Pervitin | 1,414 | 57.5 | 81 | 28.5 | 4 | 28.6 | 1,499 | 54.3 |
| Cocaine | 52 | 2.1 | 4 | 1.4 | 0 | – | 56 | 2.0 |
| Heroin | 50 | 2.0 | 11 | 3.9 | 0 | – | 61 | 2.2 |
| Ecstasy | 4 | 0.2 | 0 | – | 0 | – | 4 | 0.1 |
| LSD | 0 | – | 1 | 0.4 | 0 | – | 1 | 0.0 |
| Other drugs | 56 | 2.3 | 9 | 3.2 | 2 | 14.3 | 67 | 2.4 |
| **Total number of persons** | **2,461** | **100.0** | **284** | **100.0** | **14** | **100.0** | **2,759** | **100.0** |

*Note: Production, trafficking, and sale includes Section 187 of the old Penal Code/Section 283 of the new Penal Code, Section 188 of the old Penal Code/Section 286 of the new Penal Code and Section 285 of the new Penal Code; possession for personal use includes Section 187a/Section 284 of the new Penal Code; promoting drug use includes Section 188a of the old Penal Code/Section 287 of the new Penal Code.*

The number of persons arrested in connection with pervitin has been rising in the past three years, and their share of all the cases reaches a steady 54%. As far as cannabis is concerned, the share of the persons arrested has been growing since 2007. While only 29% of the persons were arrested in connection with cannabis in 2007, the share was 39% in 2011. The number and share of persons arrested in connection with heroin has been decreasing since 2008 – from approximately 7% in 2008 to approximately 2% in 2011. The number of persons arrested in connection with cocaine has been growing in the past 4 years; in 2008 their share was under 2%; see Graph 9-1.

*Graph 9-1: Number of persons arrested for drug-related offences in the period 2002–2011, by drug type (Národní protidrogová centrála SKPV Policie ČR, 2012e)*




| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|
| Other | 160 | 137 | 59 | 62 | 66 | 30 | 36 | 75 | 98 | 65 |
| LSD | 4 | 4 | 3 | 9 | 4 | 4 | 2 | 5 | 1 | 1 |
| Cocaine | 10 | 24 | 17 | 50 | 13 | 50 | 23 | 47 | 50 | 56 |
| Ecstasy | 140 | 66 | 66 | 55 | 35 | 38 | 18 | 5 | 14 | 4 |
| Heroin | 157 | 105 | 134 | 145 | 116 | 127 | 151 | 136 | 95 | 61 |
| Cannabis | 748 | 892 | 763 | 682 | 638 | 569 | 746 | 786 | 896 | 1,063 |
| Pervitin | 781 | 1,129 | 1,058 | 1,125 | 1,293 | 1,178 | 1,320 | 1,257 | 1,362 | 1,495 |

According to the data from the Ministry of Justice, the number of persons prosecuted for all drug-related offences increased in 2011. Most people were prosecuted for the unauthorised production, smuggling, and sale of pervitin or cannabis. 792 persons were charged in connection with cannabis, and 1,400 in connection with pervitin. In terms of the breakdown of the drug-related offences by drug type, there was a slight decrease in the share of persons prosecuted in connection with pervitin (Ministerstvo spravedlnosti ČR, 2012). Nevertheless, those prosecuted in connection with this drug continue to represent the largest group of individuals prosecuted for drug-related offences; see Table 9-5.

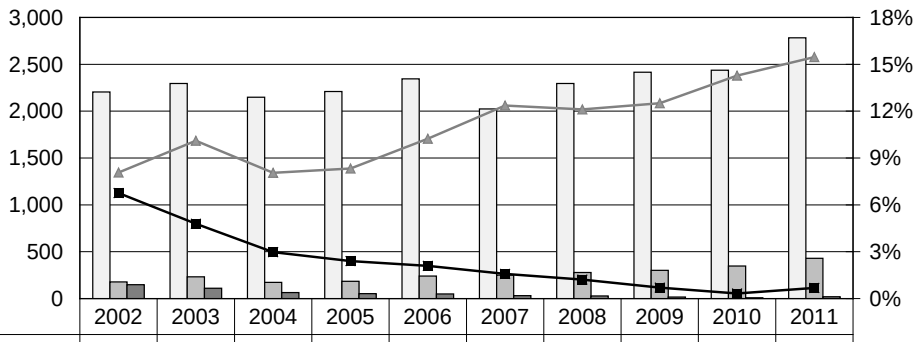
*Table 9-5: Number of persons prosecuted in 2011, by main drug type and drug-related offence type (Ministerstvo spravedlnosti ČR, 2012)*

| **Drugs** | **Section 187 of old Penal Code / Section 283 of new Penal Code** | | **Section 187a of old Penal Code / Section 284 of new Penal Code** | | **Section 285 of new Penal Code** | | **Section 188 of old Penal Code / Section 286 of new Penal Code** | | **Section 188a of old Penal Code /Section 287 of new Penal Code** | | **Total** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % |
| Cannabis | 792 | 32.3 | 141 | 47.2 | 99 | 84.6 | 20 | 12.7 | 5 | 35.7 | 1,057 | 34.7 |
| Pervitin | 1,400 | 57.0 | 109 | 36.5 | 11 | 9.4 | 118 | 75.2 | 8 | 57.1 | 1,646 | 54.1 |
| Cocaine | 45 | 1.8 | 6 | 2.0 | 0 | – | 0 | – | 0 | – | 51 | 1.7 |
| Heroin | 85 | 3.5 | 8 | 2.7 | 0 | – | 1 | 0.6 | 0 | – | 94 | 3.1 |
| Ecstasy | 10 | 0.4 | 4 | 1.3 | 0 | – | 2 | 1.3 | 0 | – | 16 | 0.5 |
| Other drugs | 123 | 5.0 | 31 | 10.4 | 7 | 6.0 | 16 | 10.2 | 1 | 7.1 | 178 | 5.9 |
| **Total** | **2,455** | **100.0** | **299** | **100.0** | **117** | **100.0** | **157** | **100.0** | **14** | **100.0** | **3,042** | **100.0** |

*Note: The data provided in the "Total" row are not the aggregate number and percentage of drug-related offences by drug type because certain persons were prosecuted for the violation of multiple drug-related sections of the Penal Code or in connection with multiple drug types; a single person can therefore appear in the statistics several times.*

In the long term, the number of individuals prosecuted for drug-related offences has been increasing. According to data from the Police of the Czech Republic, the number and share of persons prosecuted for the possession or cultivation of drugs for their personal use continue to grow. In 2011 the total figure was 430 individuals, accounting for 15.5% of the drug-related offences. 19 persons were prosecuted for promoting drug use in 2011, i.e. 11 persons more than in 2010. Even though relatively small, this is the very first increase in the number of persons prosecuted for this offence since 2000; see Graph 9-2.

*Graph 9-2: Number of persons prosecuted for drug possession/cultivation for personal use and for promoting drug use and their share of drug-related crime in 2002–2011 (Policejní prezidium Policie ČR, 2012)*




| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total no. of drug offences prosecuted | 2,204 | 2,295 | 2,149 | 2,209 | 2,344 | 2,023 | 2,296 | 2,415 | 2,437 | 2,782 |
| Sec. 187a old, Sec. 284 and Sec. 285 new | 178 | 232 | 173 | 184 | 240 | 250 | 278 | 302 | 348 | 430 |
| Sec. 188a old, Sec. 287 new | 149 | 110 | 64 | 53 | 49 | 32 | 28 | 17 | 8 | 19 |
| Share of cultivation/possession for personal use | 8.1% | 10.1% | 8.1% | 8.3% | 10.2% | 12.4% | 12.1% | 12.5% | 14.3% | 15.5% |
| Share of promoting drug use | 6.8% | 4.8% | 3.0% | 2.4% | 2.1% | 1.6% | 1.2% | 0.7% | 0.3% | 0.7% |

An increase in the number of the persons charged was reported for all the drug-related offences in 2011. Most people were charged for the unauthorised production, smuggling, and sale of pervitin or cannabis; see Table 9-6. In terms of division by drug type, there was an increase in the number of persons charged in connection with all drugs except heroin.

*Table 9-6: Number of persons charged in 2011, by main drug type and drug-related offence type (Ministerstvo spravedlnosti ČR, 2012)*

| **Drugs** | **Section 187 of old Penal Code / Section 283 of new Penal Code** | | **Section 187a of old Penal Code / Section 284 of new Penal Code** | | **Section 285 of new Penal Code** | | **Section 188 of old Penal Code / Section 286 of new Penal Code** | | **Section 188a of old Penal Code /Section 287 of new Penal Code** | | **Total** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % |
| Cannabis | 683 | 29.9 | 111 | 42.7 | 67 | 83.8 | 19 | 12.8 | 5 | 35.7 | 885 | 31.7 |
| Pervitin | 1,352 | 59.2 | 105 | 40.4 | 9 | 11.3 | 113 | 75.8 | 8 | 57.1 | 1,587 | 56.9 |
| Cocaine | 45 | 2.0 | 6 | 2.3 | 0 | – | 0 | – | 0 | – | 51 | 1.8 |
| Heroin | 84 | 3.7 | 8 | 3.1 | 0 | – | 1 | 0.7 | 0 | – | 93 | 3.3 |
| Ecstasy | 9 | 0.4 | 4 | 1.5 | 0 | – | 1 | 0.7 | 0 | – | 14 | 0.5 |
| Other drugs | 112 | 4.9 | 26 | 10.0 | 4 | 5.0 | 15 | 10.1 | 1 | 7.1 | 158 | 5.7 |
| **Total** | **2,285** | **100.0** | **260** | **100.0** | **80** | **100.0** | **149** | **100.0** | **14** | **100.0** | **2,788** | **100.0** |

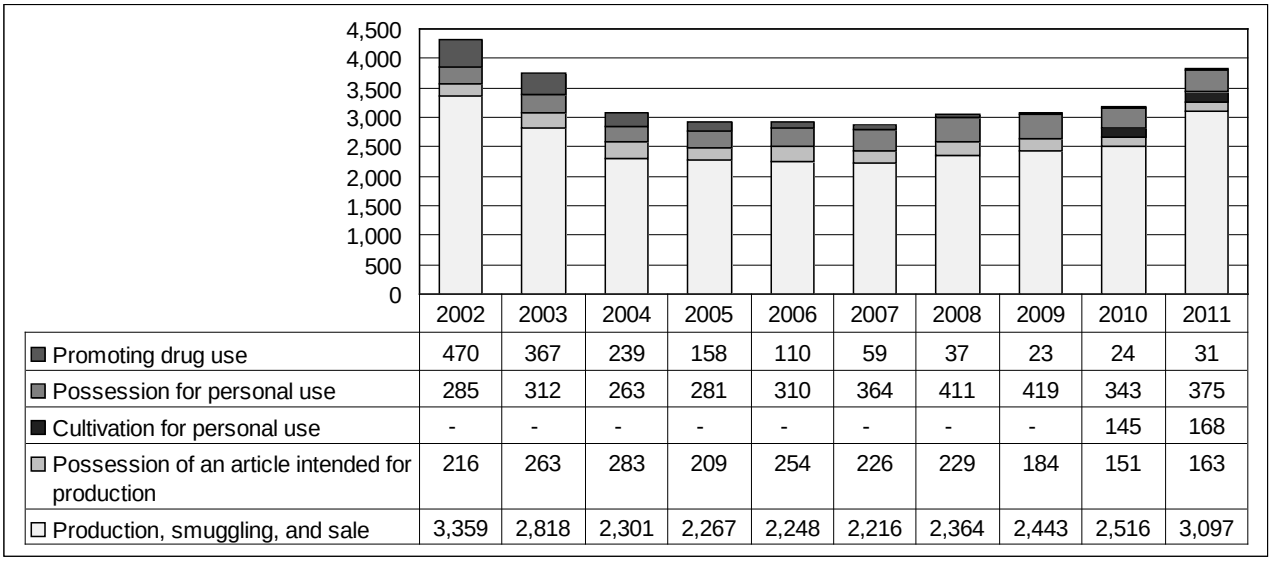
*Note: The data provided in the "Total" row are not the aggregate number and percentage of drug-related offences by drug type because certain persons were prosecuted for the violation of multiple drug-related sections of the Penal Code or in connection with multiple drug types; a single person can therefore appear in the statistics several times.*

The total number of drug-related offences and their share in the reported crimes have been rising since 2008; see Table 9-7. A major part in this trend is played by the growing number of offences involving the production, smuggling, and dealing (Section 283 of the new Penal Code/Section 187 of the old Penal Code, Section 286 of the new Penal Code/Section 188 of the old Penal Code). An increase in the number of these offences by nearly 22% was observed in 2011, representing the highest year-on-year increase since 2007. Even though the number of offences of drug possession for personal use (Section 187a/284) increased between 2004 and 2009, the year-on-year increase was not as significant as it was in the previous group of offences; see Graph 9-3.

*Table 9-7: Development of the number of drug-related offences (thousands) and their share of the offences reported in 2002–2011 (Policejní prezidium Policie ČR, 2012)*

| Year | Total offences reported | Number of drug-related offences | Share of drug-related offences (%) |
|---|---|---|---|
| 2002 | 372.34 | 4.33 | 1.16 |
| 2003 | 357.74 | 3.76 | 1.05 |
| 2004 | 351.63 | 3.09 | 0.88 |
| 2005 | 344.06 | 2.92 | 0.85 |
| 2006 | 336.45 | 2.92 | 0.87 |
| 2007 | 357.39 | 2.87 | 0.80 |
| 2008 | 343.80 | 3.04 | 0.88 |
| 2009 | 332.83 | 3.07 | 0.92 |
| 2010 | 313.39 | 3.18 | 1.01 |
| 2011 | 317.18 | 3.83 | 1.21 |

*Graph 9-3: Number of drug-related offences in 2002–2011, by drug offence type (Policejní prezidium Policie ČR, 2012)*




| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|
| Promoting drug use | 470 | 367 | 239 | 158 | 110 | 59 | 37 | 23 | 24 | 31 |
| Possession for personal use | 285 | 312 | 263 | 281 | 310 | 364 | 411 | 419 | 343 | 375 |
| Cultivation for personal use | - | - | - | - | - | - | - | - | 145 | 168 |
| Possession of an article intended for production | 216 | 263 | 283 | 209 | 254 | 226 | 229 | 184 | 151 | 163 |
| Production, smuggling, and sale | 3,359 | 2,818 | 2,301 | 2,267 | 2,248 | 2,216 | 2,364 | 2,443 | 2,516 | 3,097 |

The highest number of drug-related offences and of persons prosecuted in connection with drug-related offences was reported in Prague and in Central Bohemia. The regions with a high absolute number of drug-related offences and of persons prosecuted in connection with drug-related offences also included the Vysočina, Moravia-Silesia, and Ústí nad Labem regions. The highest increase in drug-related crime was observed in Prague (by 187 drug-related offences) and in the Vysočina region (by 143 drug-related offences). The number of drug-related offences dropped in only two regions: those of South Moravia (by 30 offences) and Ústí nad Labem (by 3 offences). Prague, and then Vysočina and Karlovy Vary, were the regions with the highest number of drug-related offences in relative terms per 100 thousand inhabitants aged 15–64 in 2011; see Table 9-8 and Map 9-1.

*Table 9-8: Drug-related offences and persons prosecuted for drug-related offences in 2011, by region (Policejní prezidium Policie ČR, 2012)*

| Region | Drug-related offences | | | Persons prosecuted for drug-related offences | | |
|---|---|---|---|---|---|---|
| | Number | % | Per 100 thousand inhabitants aged 15–64 | Number | % | Per 100 thousand inhabitants aged 15–64 |
| Prague | 918 | 23.9 | 106.0 | 376 | 13.5 | 43.4 |
| Central Bohemia | 483 | 12.6 | 54.8 | 452 | 16.2 | 51.3 |
| South Bohemia | 233 | 6.1 | 52.8 | 186 | 6.7 | 42.1 |
| Pilsen | 185 | 4.8 | 46.7 | 135 | 4.9 | 34.1 |
| Karlovy Vary | 175 | 4.6 | 81.9 | 119 | 4.3 | 55.7 |
| Ústí nad Labem | 278 | 7.3 | 47.9 | 255 | 9.2 | 43.9 |
| Liberec | 157 | 4.1 | 54.4 | 142 | 5.1 | 46.5 |
| Hradec Králové | 153 | 4.0 | 40.3 | 121 | 4.3 | 31.9 |
| Pardubice | 117 | 3.1 | 32.8 | 99 | 3.6 | 27.8 |
| Vysočina | 316 | 8.2 | 89.4 | 198 | 7.1 | 56.0 |
| South Moravia | 206 | 5.4 | 25.5 | 176 | 6.3 | 21.8 |
| Olomouc | 148 | 3.9 | 33.4 | 131 | 4.7 | 29.6 |
| Zlín | 159 | 4.1 | 38.9 | 139 | 5.0 | 34.0 |
| Moravia-Silesia | 306 | 8.0 | 35.5 | 253 | 9.1 | 29.4 |
| **Total** | **3,834** | **100.0** | **52.6** | **2,782** | **100.0** | **38.1** |

*Map 9-1: Drug-related offences, 2011, in relative terms per 100 thousand inhabitants aged 15–64, by region (Policejní prezidium Policie ČR, 2012)*


### 9.1.2 Sentences for Drug-related Offences

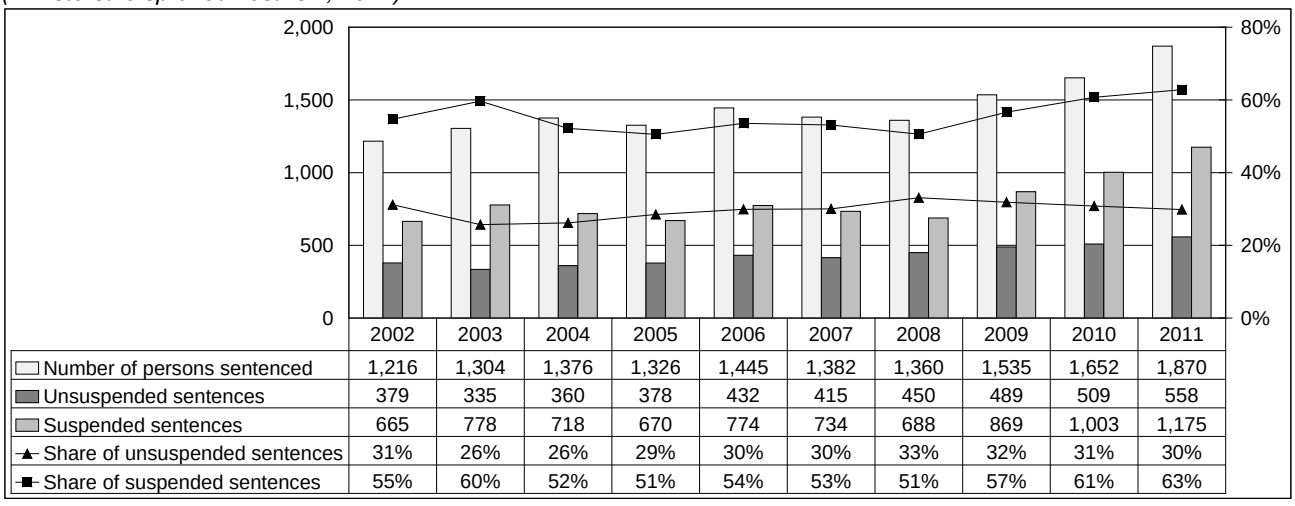
Final sentences for drug-related offences were issued against 1,870 persons in 2011. Women accounted for nearly 15% and juveniles for over 3% of this number. The share of women remained essentially identical in comparison with 2010; the share of juveniles decreased by 1.8 percentage points against 2010. People with no previous convictions accounted for 41% of the individuals upon whom a final sentence was imposed in 2011. In terms of age, the 30–39 age group was the largest. As Table 9-9 shows, suspended imprisonment (64%), unsuspended imprisonment (31%), and community service (4%) were the most commonly imposed sentences in 2011. Supervision by a probation officer was ordered in 21% of the cases of suspended prison sentences (compared to 20% in 2010). Most of the unsuspended sentences of imprisonment were for a period of one to five years. In comparison with the previous year, there was an increase by four percentage points in this type of sentence. At the same time, the share of prison sentences for a maximum of one year decreased by nearly five percentage points. The court most commonly ordered unsuspended prison sentences to be served in high-security prisons – 318 sentences (57% of the unsuspended sentences of imprisonment), an increase by 6 percentage points against 2010 (51% in that year). The share of sentences to be served in medium-security prisons increased (47% in 2010 and 51% in 2011).

*Table 9-9: Sentences imposed for drug-related offences in 2011, by type of offence (Ministerstvo spravedlnosti ČR, 2012)*

| Sentence | Section 187 of old Penal Code / Section 283 of new Penal Code | | Section 187a of old Penal Code / Section 284 of new Penal Code | | Section 285 of new Penal Code | | Section 188 of old Penal Code / Section 286 of new Penal Code | | Section 188a of old Penal Code /Section 287 of new Penal Code | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % |
| Unsuspended imprisonment | 491 | 33.4 | 31 | 16.7 | 5 | 6.1 | 31 | 34.8 | 0 | – | 558 | 30.5 |
| Suspended imprisonment | 907 | 61.8 | 141 | 75.8 | 71 | 86.6 | 52 | 58.4 | 4 | 66.7 | 1,175 | 64.2 |
| House arrest | 4 | 0.3 | 0 | – | 0 | – | 0 | 0.0 | 0 | 0.0 | 4 | 0.2 |
| Community service | 52 | 3.5 | 8 | 4.3 | 3 | 3.7 | 4 | 4.5 | 1 | 16.7 | 68 | 3.7 |
| Forfeiture of property | 0 | – | 0 | – | 0 | – | 0 | – | 0 | – | 0 | – |
| Fine | 11 | 0.7 | 2 | 1.1 | 1 | 1.2 | 1 | 1.1 | 0 | – | 15 | 0.8 |
| Forfeiture of articles | 0 | 0.0 | 3 | 1.6 | 2 | 2.4 | 1 | 1.1 | 0 | – | 6 | 0.3 |
| Expulsion | 3 | 0.2 | 1 | 0.5 | 0 | – | 0 | – | 1 | 16.7 | 5 | 0.3 |
| Prohibition of entry and residency | 0 | – | 0 | – | 0 | – | 0 | – | 0 | – | 0 | – |
| **Total** | **1,468** | **100.0** | **186** | **100.0** | **82** | **100.0** | **89** | **100.0** | **6** | **100.0** | **1,831** | **100.0** |

The number of persons sentenced for drug-related offences has been increasing in the past three years, which applies to both unsuspended and suspended sentences of imprisonment; see Graph 9-4.

*Graph 9-4: Development in the number and structure of sentences imposed for drug-related offences, 2002–2011 (Ministerstvo spravedlnosti ČR, 2012)*




| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of persons sentenced | 1,216 | 1,304 | 1,376 | 1,326 | 1,445 | 1,382 | 1,360 | 1,535 | 1,652 | 1,870 |
| Unsuspended sentences | 379 | 335 | 360 | 378 | 432 | 415 | 450 | 489 | 509 | 558 |
| Suspended sentences | 665 | 778 | 718 | 670 | 774 | 734 | 688 | 869 | 1,003 | 1,175 |
| Share of unsuspended sentences | 31% | 26% | 26% | 29% | 30% | 30% | 33% | 32% | 31% | 30% |
| Share of suspended sentences | 55% | 60% | 52% | 51% | 54% | 53% | 51% | 57% | 61% | 63% |

### 9.1.3 Protective and Educational Measures

Compulsory treatment, which is the most commonly ordered protective measure, is served either in the residential or outpatient form on the basis of a final judgement of the court. The court may impose this sanction on offenders who abuse addictive substances and have committed an offence under the influence of, or in connection with, the abuse of such a substance. The compulsory treatment sentence is served in health care facilities. However, its outpatient form may also be undergone in prisons if compulsory treatment has been imposed along with a prison sentence.[147] There were specialised wings available for this purpose in four prisons: Rýnovice, Opava, Heřmanice, and Znojmo (Generální ředitelství Vězeňské služby ČR, 2012b). Compulsory treatment was imposed upon 286 persons in 2011: drug treatment upon 117 persons and alcohol treatment upon 169 persons. Compulsory institutional or outpatient alcohol treatment was most frequently imposed upon persons sentenced for the offences of bodily harm (33 persons), disorderly conduct (30), assault (23), and abuse of a person living in a shared home (23). Compulsory institutional or outpatient drug treatment was most frequently imposed upon offenders who had committed the

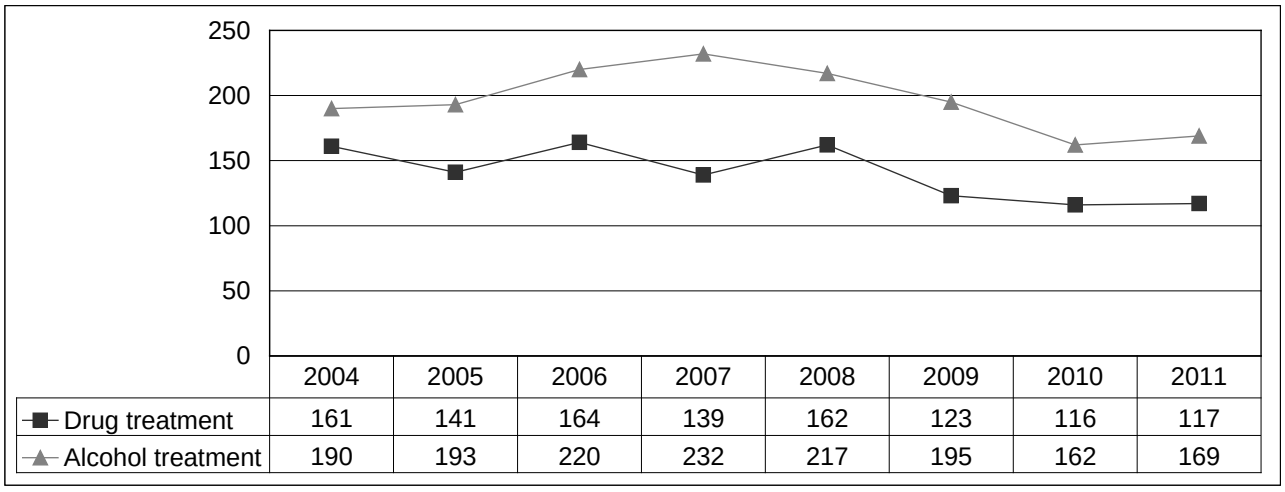
[147] Section 99 of Act No. 40/2009, the Penal Code.

offences of the unauthorised production and possession of narcotic and psychotropic substances and poisons (33 persons), theft (32), arbitrary interference with the home (15), and endangerment under the influence of an addictive substance (14). The number of compulsory treatment sentences decreased after 2008. With a year-on-year increase by 8 cases, the year 2011 represented a change in this trend; see Graph 9-5 (Ministerstvo spravedlnosti ČR, 2012).

If it is obvious from the personality of the offender that sufficient protection of the public cannot be achieved by compulsory treatment, the court may impose a measure in the form of security detention. Security detention may be imposed either separately, when a sentence is waived, or alongside a sentence.[148] It is served in dedicated institutions under high security and in connection with therapeutic, psychological, educational, teaching, rehabilitation, and activity programmes. There were two institutions (located in Brno and Opava, respectively) where security detention could be served in 2011 (Generální ředitelství Vězeňské služby ČR, 2012b). Security detention was imposed upon one person in connection with drug-related crime in 2011 (Ministerstvo spravedlnosti ČR, 2012).

The court may also impose appropriate measures or obligations within the framework of diversion from criminal proceedings or as part of alternative sentencing. The obligation to undergo substance addiction treatment was imposed upon 126 individuals, and a restriction in the form of compulsory abstinence from using alcohol or other addictive substances was imposed upon 282 persons in 2011. The court may also impose an educational measure upon juveniles or upon persons whose age is close to that of juveniles. In 2011 educational measures were imposed in connection with drug-related offences in the form of supervision by a probation officer (upon four persons), educational obligations[149] (five persons), and educational restrictions[150] (six persons) (Ministerstvo spravedlnosti ČR, 2012).

*Graph 9-5: Development in the number of compulsory treatment orders imposed in 2004–2011 (Ministerstvo spravedlnosti ČR, 2012)*




| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|
| Drug treatment | 161 | 141 | 164 | 139 | 162 | 123 | 116 | 117 |
| Alcohol treatment | 190 | 193 | 220 | 232 | 217 | 195 | 162 | 169 |

The Probation and Mediation Service (PMS) kept records on a total of 27,150 persons in 2011. They were people who had received a sentence other than imprisonment, persons upon whom an obligation or restriction had been imposed, or those released from prison on parole. A total of 740 (2.7%) of them had been sentenced for the offence of unauthorised production or other handling of narcotic and psychotropic substances or possession of articles intended for manufacture (Section 187 of old / 283 of new Penal Code, Section 188 of old / 286 of new Penal Code, and Section 285 of new Penal Code), 45 persons had committed the offence of drug possession for personal use (Section 187a of old / 284 of new Penal Code), and five persons the offence of promoting drug use (Section 188a of old / 287 of new Penal Code). Compulsory drug addiction treatment had been imposed upon 81 persons, 54 of whom had been ordered to undergo compulsory alcohol treatment and 27 compulsory drug treatment. An obligation to undergo the appropriate type of drug addiction treatment, which does not represent compulsory treatment according to the new Penal Code, was imposed upon 131 persons.

As a part of its probationary supervision, e.g. when checking adherence to the obligation to abstain from alcohol or other substances,[151] the Probation and Mediation Service introduced screening tests as a standard monitoring instrument in 2010. In 2011, a total of 581 tests were conducted, 101 of which returned a positive result. Methamphetamine and THC were the substances detected most often.

As part of diversion from criminal proceedings or suspended diversion from criminal proceedings, educational measures may be imposed upon a juvenile, which includes supervision by a probation officer, a probation

[148] Section 100 of Act No. 40/2009, the Penal Code.
[149] Such as the obligation to live with their parents, the obligation to pay compensation for damage, and the obligation to undergo substance addiction treatment.
[150] Such as a prohibition on attending certain events and maintaining contact with certain individuals.
[151] Imposed under Section 48 (4) (h) of Act No. 40/2009 Coll.

programme, educational obligations, educational restrictions, and warnings. Three probation programmes accredited by the Ministry of Justice that focused on drug use were implemented in 2011. They were the "*Proboš* Probation Programme" (implemented by the *Renarkon* public service company), the "*Auritus* Probation Programme" (*Tábor* Parish Charity), and "Bridge" (*Most*) probation programme" (Třebíč branch of the Brno Diocesan Charity). A total of 25 persons participated in the programmes during the preparatory proceedings or while serving their sentence. 16 persons successfully completed the programme, seven persons failed to complete the programme, and two individuals continued to participate in the programme in 2012 (Probační a mediační služba ČR, 2012).

### 9.1.4 Misdemeanours Involving the Unauthorised Handling of Narcotic and Psychotropic Substances

Misdemeanours involving unauthorised conduct in connection with alcohol or other narcotic and psychotropic substances are defined by Section 30 of Act No. 200/1990 Coll. on misdemeanours – misdemeanours against protection from alcoholism and abuse of other substances. The unauthorised handling of narcotic and psychotropic substances includes the unauthorised possession of a small quantity of narcotic and psychotropic substances for personal use, Subsection 1 (j), and the unauthorised cultivation of a small quantity of plants or mushrooms containing narcotic and psychotropic substances for personal use, Subsection 1 (k). A fine of up to CZK 15 thousand (€ 610) may be imposed for these misdemeanours.

Proceedings regarding a total of 1,169 misdemeanours involving the unauthorised handling of narcotic and psychotropic substances were held in 2011, representing 0.4% of all the misdemeanours dealt with. Similarly to the previous year, misdemeanours involving the unauthorised possession of narcotic and psychotropic substances accounted for 93% of the cases. These drug-related misdemeanours most frequently involved persons over the age of 18. On the other hand, the share of juvenile offenders decreased by 2.2 percentage points against 2010. The regions with the highest absolute number of misdemeanours reported in 2011 included Prague, Pilsen, Central Bohemia, and Moravia-Silesia; see Table 9-10. In comparison with the previous year, the most significant increase was observed in Prague (122 persons in 2010, against 191 persons in 2011). Conversely, the most significant decrease was observed in Central Bohemia (with 216 persons in 2010 and 116 persons in 2011).

Because of a change in the reporting system (see the 2010 Annual Report), data regarding the breakdown of the misdemeanours by drug type are not available from 2010 onwards. However, we can presume on the basis of the previous years that the misdemeanours were most commonly associated with cannabis and pervitin.

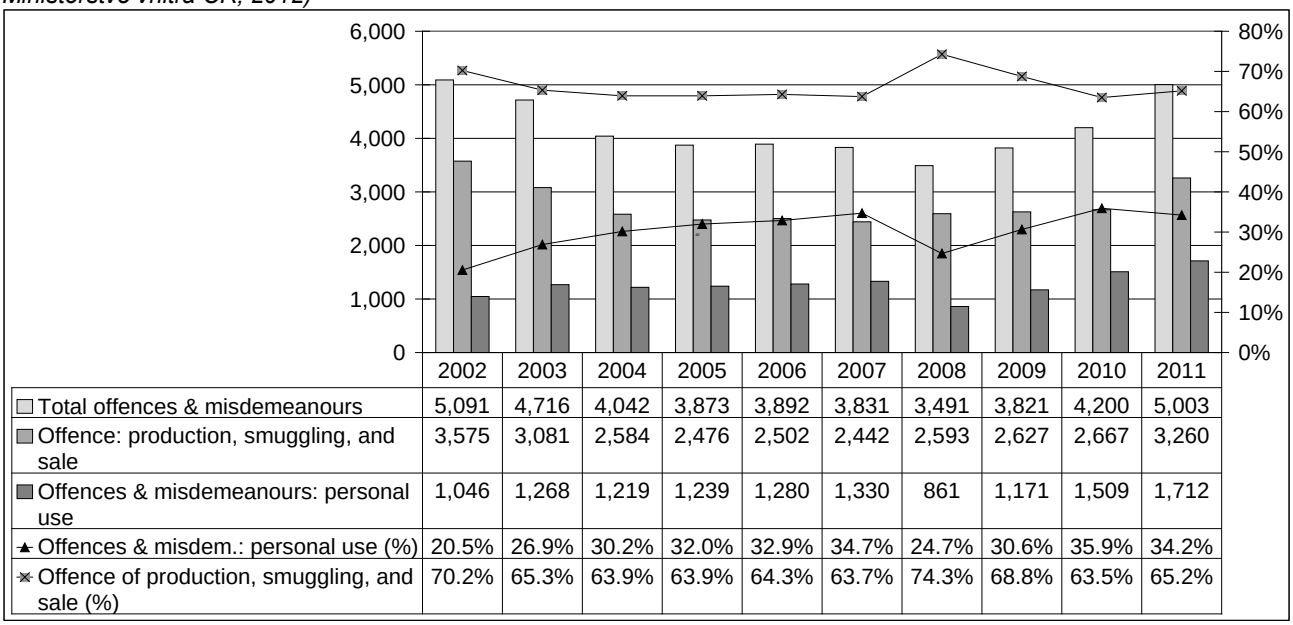
*Table 9-10: Drug-related misdemeanours in 2011, by misdemeanour type, offender age, and region (Ministerstvo vnitra ČR, 2012)*

| **Region** | **Possession for personal use** Section 30 (1) (j) | | **Cultivation of plants or mushrooms** Section 30 (1) (k) | | **Total** |
|---|---|---|---|---|---|
| | Aged under 18 | Aged over 18 | Aged under 18 | Aged over 18 | |
| Prague | 10 | 177 | 0 | 4 | 191 |
| Central Bohemia | 22 | 89 | 0 | 5 | 116 |
| South Bohemia | 18 | 38 | 0 | 7 | 63 |
| Pilsen | 14 | 116 | 0 | 6 | 136 |
| Karlovy Vary | 5 | 67 | 0 | 1 | 73 |
| Ústí nad Labem | 14 | 84 | 0 | 0 | 98 |
| Liberec | 3 | 38 | 0 | 2 | 43 |
| Hradec Králové | 7 | 31 | 0 | 5 | 43 |
| Pardubice | 6 | 17 | 0 | 3 | 26 |
| Vysočina | 4 | 20 | 0 | 2 | 26 |
| South Moravia | 23 | 60 | 0 | 5 | 88 |
| Olomouc | 10 | 57 | 1 | 26 | 94 |
| Zlín | 9 | 55 | 0 | 7 | 71 |
| Moravia-Silesia | 8 | 87 | 0 | 6 | 101 |
| **Total – Czech Rep.** | **153** | **936** | **1** | **79** | **1,169** |

### 9.1.5 Summary of Drug-related Offences and Misdemeanours

A total of 5,091 cases of drug-related violations of the law were reported in 2011. A total of 3,834 of them were drug-related criminal offences and 1,169 were drug-related misdemeanours. The drug-related offences and misdemeanours involving the cultivation and possession of drugs for personal use accounted for 34%; the drug-related offences involving the production, smuggling, and sale of drugs accounted for 65% of the violations of the law in connection with drugs. The development in the period 2002–2011 is shown in Graph 9-1.

*Graph 9-6: The development of the number of drug-related offences and misdemeanours involving personal use and drug-related offences involving production, smuggling, and sale, 2002–2011 (Policejní prezidium Policie ČR, 2012; Ministerstvo vnitra ČR, 2012)*



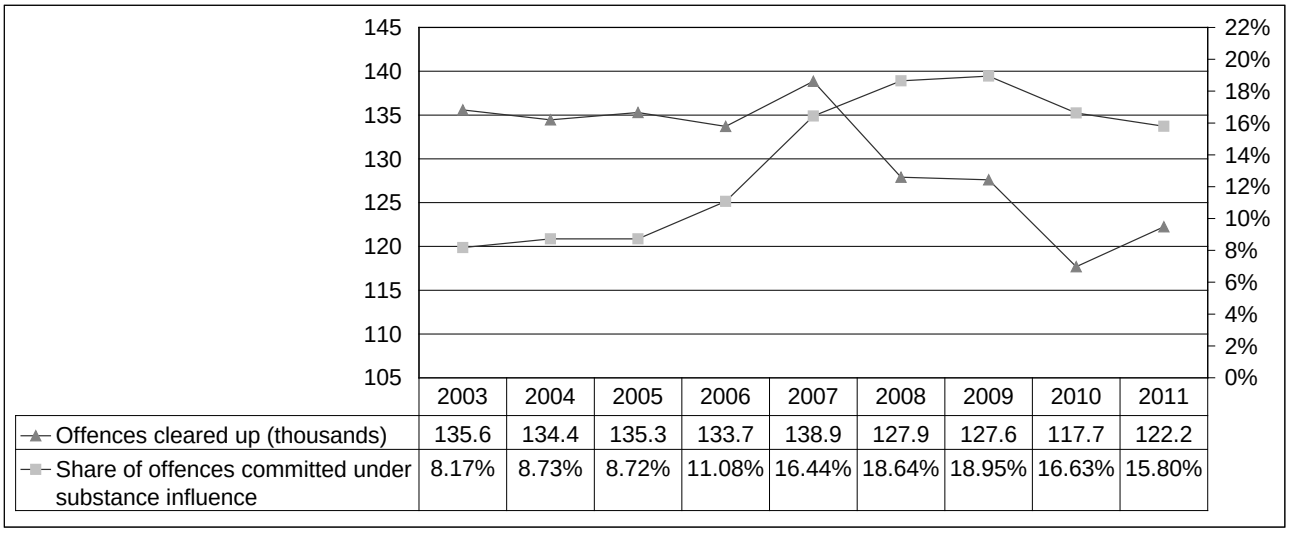

| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total offences & misdemeanours | 5,091 | 4,716 | 4,042 | 3,873 | 3,892 | 3,831 | 3,491 | 3,821 | 4,200 | 5,003 |
| Offence: production, smuggling, and sale | 3,575 | 3,081 | 2,584 | 2,476 | 2,502 | 2,442 | 2,593 | 2,627 | 2,667 | 3,260 |
| Offences & misdemeanours: personal use | 1,046 | 1,268 | 1,219 | 1,239 | 1,280 | 1,330 | 861 | 1,171 | 1,509 | 1,712 |
| Offences & misdem.: personal use (%) | 20.5% | 26.9% | 30.2% | 32.0% | 32.9% | 34.7% | 24.7% | 30.6% | 35.9% | 34.2% |
| Offence of production, smuggling, and sale (%) | 70.2% | 65.3% | 63.9% | 63.9% | 64.3% | 63.7% | 74.3% | 68.8% | 63.5% | 65.2% |

*Note: The offences involving drug production, smuggling, and sale include Section 187 of the old Penal Code/Section 283 of the new Penal Code and Section 188 of the old Penal Code/Section 286 of the new Penal Code; the offences involving personal use include Section 187a/Section 284 of the new Penal Code and Section 285 of the new Penal Code.*

## 9.2 Other Drug-related Crime

A total of 122.2 thousand offences were cleared up in 2011, according to the data of the Police of the Czech Republic reported from the Criminal Statistics Records System. Offences committed under the influence of addictive substances accounted for 15.8% of the offences cleared up, i.e. 19.3 thousand offences in the reporting year. The share of offences committed under the influence of addictive substances increased steadily between 2005 and 2009. However, the trend has changed and reversed in the past two years; see Graph 9-7.

*Graph 9-7: Development in the number of offences cleared up and the share of offences committed under the influence of addictive substances, 2003–2011 (Policejní prezidium Policie ČR, 2012)*




| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|
| Offences cleared up (thousands) | 135.6 | 134.4 | 135.3 | 133.7 | 138.9 | 127.9 | 127.6 | 117.7 | 122.2 |
| Share of offences committed under substance influence | 8.17% | 8.73% | 8.72% | 11.08% | 16.44% | 18.64% | 18.95% | 16.63% | 15.80% |

A total of 17.2 thousand offences committed under the influence of alcohol, i.e. 88.9% of all the offences committed under the influence of addictive substances, were reported by the police for 2011; see Table 9-11. They were most commonly the offences of endangerment under the influence of an addictive substance and inebriation (8.5 thousand offences), road traffic accidents caused by negligence (2.7 thousand), voluntary bodily harm (1.1 thousand), and disorderly conduct (1.0 thousand). In the long term, there is an apparent high percentage of offences committed under the influence of alcohol, even though the number has been decreasing and the percentage of offences committed under the influence of drugs has been increasing in the past three years. 2.1 thousand offences, i.e. 11.1% of the offences committed under the influence of addictive substances, were committed under the influence of drugs other than alcohol in 2011. The offenders most typically committed the offences of endangerment under the influence of addictive substances (1.3 thousand offences), obstructing justice (218 offences), and theft (187 offences).

*Table 9-11: Number of offences committed under the influence of alcohol and other drugs, 2003–2011 (Policejní prezidium Policie ČR, 2012)*

| Year | Offences committed under the influence of alcohol | Offences committed under the influence of other drugs | Total number of offences committed under the influence of addictive substances |
|---|---|---|---|
| 2003 | 10,143 | 939 | 11,082 |
| 2004 | 10,916 | 816 | 11,732 |
| 2005 | 11,020 | 781 | 11,801 |
| 2006 | 14,075 | 735 | 14,810 |
| 2007 | 22,030 | 793 | 22,823 |
| 2008 | 22,826 | 1,019 | 23,845 |
| 2009 | 22,277 | 1,900 | 24,177 |
| 2010 | 17,290 | 2,277 | 19,567 |
| 2011 | 17,168 | 2,142 | 19,310 |

An estimate was again performed in 2011 regarding secondary drug-related crime. The study was conducted in the form of an expert retrospective estimate by the regional headquarters and territorial departments of the Police of the Czech Republic. For each territorial department and for each of the 17 selected offences, the proportion of the offences committed by drug users for acquiring the wherewithal to purchase drugs for personal use was estimated. In the course of the data processing, the estimated percentages were weighed using the actual number of criminal offences cleared up in the individual districts. A total of 230.4 thousand selected offences were reported in 2011. Drug users are estimated to have committed approximately 33.4% of them (76.8 thousand offences). The highest share of the offences reported was committed by drug users as far as the unauthorised production and other handling of narcotic and psychotropic substances and theft were concerned. A total of 74.1 thousand selected offences were cleared up. Drug users are estimated to have committed approximately 28.5% of them (19.1 thousand offences). The results are summarised in Table 9-12.

*Table 9-12: Estimated percentage and number of selected offences committed by drug users in 2011 (Národní protidrogová centrála a Národní monitorovací středisko pro drogy a drogové závislosti, 2012)*

| Offence type | Offences reported | | | Offences cleared up | | |
|---|---|---|---|---|---|---|
| | Total | Committed by drug users | % | Total | Committed by drug users | % |
| Theft | 112,724 | 46,232 | 41.0 | 24,020 | 7,827 | 32.6 |
| Theft and arbitrary interference with the home | 50,767 | 13,234 | 26.1 | 11,346 | 3,096 | 27.3 |
| Theft and unauthorised use of property | 19,786 | 6,728 | 34.0 | 3,630 | 1,169 | 32.2 |
| Unauthorised possession of means of payment | 8,230 | 2,924 | 35.5 | 1,870 | 685 | 36.6 |
| Unauthorised production and other handling of narcotic or psychotropic substances | 3,093 | 2,734 | 88.4 | 2,923 | 2,575 | 88.1 |
| Robbery | 3,758 | 1,386 | 36.9 | 1,984 | 716 | 36.1 |
| Neglect of compulsory maintenance | 15,301 | 1,106 | 7.2 | 15,314 | 1,116 | 7.3 |
| Fraud | 4,150 | 924 | 22.3 | 3,199 | 715 | 22.4 |
| Arbitrary interference with the home | 2,927 | 586 | 20.0 | 1,757 | 365 | 20.8 |
| Embezzlement | 2,556 | 424 | 16.6 | 2,253 | 383 | 17.0 |
| Intentional bodily harm injury | 5,262 | 403 | 7.7 | 4,268 | 325 | 7.6 |
| Extortion | 1,521 | 150 | 9.9 | 1,285 | 132 | 10.2 |
| Illegal restraint | 277 | 9 | 3.2 | 206 | 8 | 3.7 |
| Murder | 11 | 0 | – | 13 | 0 | 1.5 |
| **Total** | **230,363** | **76,841** | **33.4** | **74,068** | **19,112** | **25.8** |

## 9.3 Drug Use and Problem Drug Use in Prisons

The Prison Service administered 36 prisons in 2011. The prison population increased against the previous year: as of 31 December 2011, it comprised 23,170 persons, 20,541 of whom had been sentenced and 2,613 were awaiting trial. 16 persons were committed to detention institutions. Women and juveniles accounted for 6.4% and 0.9% of the prison population, respectively. The number of foreign nationals remained below 6% of the prison population. Most individuals were serving their prison sentence in high-security prisons (48%) and medium-security prisons (42%). The most common prison term was 1–2 years. The most frequent offences committed by the prisoners included theft, obstructing justice, robbery, and arbitrary interference with the home. The number of persons imprisoned for drug-related offences increased by 2,236, i.e. by nearly 11%, against 2010. The offences that account for this increase are exclusively those of the production, smuggling, and sale of narcotic and psychotropic substances (Section 187 of old / Section 283 of new Penal Code) and the possession of an article intended for the production of

narcotic and psychotropic substances (Section 188 of old / Section 286 of new Penal Code). In turn, the share of other drug-related offences decreased. There was a 15% increase in the number of offences directly associated with intoxication with an addictive substance (Section 201 of old / Section 274 of new Penal Code and Section 201a of old / Section 360 of new Penal Code) in 2011; see Table 9-13.

*Table 9-13: Number of individuals imprisoned for drug-related offences and offences related to drug use as of 31 December 2011 (Generální ředitelství Vězeňské služby ČR, 2012a)*

| Section | Offence type | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|
| 187 of old Penal Code / 283 of new Penal Code | Unauthorised production and other handling of narcotic or psychotropic substances | 1,314 | 1,257 | 3,073 | 1,696 | 1,929 |
| 187a of old Penal Code / 284 of new Penal Code | Possession of narcotic or psychotropic substances for personal use | 101 | 127 | 323 | 143 | 126 |
| 188 of old Penal Code / 286 of new Penal Code | Manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance | 144 | 185 | 365 | 145 | 155 |
| 188a of old Penal Code / 287 new Penal Code | Promoting drug use | 69 | 93 | 138 | 32 | 26 |
| 201 of old Penal Code / 274 new Penal Code | Endangerment under the influence of an addictive substance | 299 | 554 | 1,595 | 936 | 1,077 |
| 201a of old Penal Code / 360 of new Penal Code | Inebriation | 95 | 158 | 106 | 27 | 27 |
| **Total** | | **2,022** | **2,374** | **5,600** | **2,979** | **3,340** |

No study aimed at drug use among the prison population was conducted in 2011. The most recent study using a representative sample of the prison population was conducted in 2010, when problem drug users were estimated to account for 25.9% of the prison population (Mravčík et al. 2011b); for details see also the 2010 Annual Report.

Information about the number of drug users in prison, obtained from examinations/treatment interventions by general practitioners, from drug screening tests, and drug seizures in prisons, is again available for 2011 (Generální ředitelství Vězeňské služby ČR, 2012b). As far as the provision of health care is concerned, a total of 424,521 examinations or treatment interventions involving prisoners were performed in 2011. On the basis of the findings of the examinations or treatment interventions, the medical service reported 11,534 persons with a history of drug use (10,763 persons in 2010).

A total of 24,704 drug screening tests of prisoners were performed (compared to 24,826 in 2010); 22,827 of the tests were for drugs other than alcohol (19,703 in 2010). Over 45% of the tests were performed on prisoners entering prisons to await trial or serve their sentence (11,207 tests); only tests for non-alcohol drugs were performed among this group. 4,785 positive results were identified (43% of the persons entering prison to await trial or serve a prison sentence); 1,806 persons tested positive for THC, 1,280 for methamphetamine, 469 for benzodiazepines, and 334 for opiates. Polydrug use was identified in 896 persons (8%). Unlike among those persons who are already awaiting trial in custody or serving a prison sentence, confirmation tests are not usually performed on those entering prison, and the results are therefore for reference only. As for the persons awaiting trial in custody or serving a prison sentence (13,497 tests), 521 positive results were confirmed (4% of the inmates tested), seven of which were positive alcohol tests. Methamphetamine (233), THC (187), and benzodiazepines (46) were the substances detected most frequently. Polydrug use was confirmed in 35 cases (0.3%).

The prison service reported a total of 66 seizures of drugs (totalling 120 grams) and 10 seizures of medicines (341 tablets) containing narcotic or psychotropic substances in 2011. Another 42 seizures involved a suspicious substance but the results of the analysis were not available at the date of the writing of this Annual Report. Methamphetaime (34 seizures totalling 44.5 grams) and cannabis (26 seizures totalling 66.2 grams) were the drugs seized most frequently. The drugs, including medicines, were mainly seized during checks on correspondence (36 cases) and when prisoners were searched (24 cases). In addition to drugs, 54 syringes and 91 litres of a fermented substance containing ethanol were found. Trained drug-sniffing dogs are used during the searches; see Figure 9-1. A total of 703,334 searches using drug-sniffing dogs were performed in 2011. In 49 cases, the dog indicated a place where a suspicious substance was later found; in another 93 cases the drug-sniffing dog indicated a place where a drug had probably been placed but the substance was not found. The drug-sniffing dogs of the Prison Service of the Czech Republic achieve excellent results even by international standards.[152]

[152] http://www.vscr.cz/veznice-jirice-76/informacni-servis-1584/aktuality-210/sluzebni-pes-veznice-jirice-opetovnym-vicemistrem-vezenske-sluzby-slovenske-republiky, http://www.vscr.cz/veznice-valdice-95/informacni-servis-1633/aktuality-669/uspech-valdicke-kynologie (2012-08-17)

*Figure 9-1: Cell search using a drug-sniffing dog, Heřmanice Prison, 19 October 2011*[153]

## 9.4 Responses to Drug-related Health Issues in Prisons

Prevention, addiction treatment, and harm reduction were carried out in prisons through drug prevention counselling centres, drug-free zones, specialised wings, and programmes provided by NGOs (Generální ředitelství Vězeňské služby ČR, 2012b). The key documents in this area included the Drug Policy Action Plan of the Prison Service of the Czech Republic for the Period 2011–2012 and the Guidance for the Provision of Drug Services in Prison by Non-Governmental Organisations. In 2011, the Prison Service issued the "Recommended procedures for the systematic referral of drug users released from prison for aftercare in the community". An overview of the number, capacity, and utilisation of the drug-free zones and specialised wings is provided in Table 9-14.

Drug prevention counselling centres operated in all the prisons. In 2011, a total of 6,223 persons used the services of one of these centres, 225 more than in the previous year. The main task of the counselling centres was to examine the number and characteristics of the drug users and provide information services and, if applicable, counselling. More comprehensive programmes were offered by special prison departments – the so-called drug-free zones with a standard or therapeutic regime. The main purpose of a standard drug-free zone is to motivate the prisoners to abstain and follow a drug-free routine. This type of department was available in 30 prisons in 2011. Their capacity was 1,761 places. The largest number of places were available in medium-security prisons. In 2011, a total of 3,999 individuals used the opportunity to be placed in these wings, 2,138 of whom were newcomers. Altogether, 107 persons were expelled for violating the rules. In comparison with 2010, the number of newcomers dropped (against 2,952 in 2010), while the number of persons expelled for violating the rules increased (85 in 2010). Therapeutic drug-free zones[154] focus exclusively on drug users, aiming to motivate them to undergo treatment either while in prison or after their release. These departments mostly also accept prisoners who have undergone the treatment programme in one of the specialised wings. This type of wing was available in four prisons (Kuřim, Příbram, Vinařice, and Znojmo) in 2011. Their capacity was 119 beds. In 2011, the opportunity to be placed in these zones was taken by 280 persons, 178 were newly assigned to these zones. 14 inmates were expelled for violating the rules. By the end of 2011 there had been 139 prisoners serving their sentence in these wings. The results of the drug tests conducted in the drug-free zones showed a negligible increase in the share of positive cases in comparison with the previous year (32 positive tests out of 1,996 tests in 2011, a total of 16 out of 1562 tests in 2010).

Addiction treatment while serving a prison sentence could be provided by 11 specialised wings in 2011. In seven prisons (Bělušice, Nové Sedlo, Ostrov, Plzeň, Příbram, Valdice, and Všehrdy), these specialised wings were intended for voluntary treatment, while in the remaining four prisons (Heřmanice, Opava, Rýnovice, and Znojmo) they were used for serving court-ordered compulsory treatment. The capacity of the specialised wings for voluntary treatment was 287 places in total in 2011, a decrease by 13 places in comparison with the previous year. They were to be found in medium-security, high-security, and maximum-security prisons; there were no specialised wings for voluntary treatment available for prisoners serving their sentence in minimum-security prisons (approximately 3% of the prison population) or for women (approximately 7% of the prison population). The opportunity to undergo voluntary treatment in any of the specialised wings was taken by 535 persons (with 277 new entries) in 2011. Altogether, 138 persons successfully completed the programme, and 31 were expelled for violating the rules. A total of 313 drug screening tests were conducted in the specialised wings for voluntary treatment in 2011, returning four positive results.

[153] Source: http://www.vscr.cz/veznice-hermanice-73/aktuality-189/prohlidka-veznice-zamerena-na-vyhledani-opl (2012-09-13)
[154] The programme includes at least 10 hours of structured, managed activities per week.

Compulsory alcohol, drug, and gambling treatment could be ordered as a part of a prison sentence in 2011.[155] There were five such wings in four prisons, one of which was intended for women (Opava). The capacity of the specialised wings for compulsory addiction treatment was 157 places in 2011. In 2011, the Prison Service registered a total of 252 persons assigned to one of these wings, with 95 persons successfully completing the programme and three being expelled for violating the rules. A total of 146 tests were performed in the compulsory treatment wings in 2011, all of them negative.

*Table 9-14: Number, capacity, and use of drug-free zones and specialised wings, 2006–2011 (Generální ředitelství Vězeňské služby ČR, 2012b)*

| Year | Drug-free zones | | | Voluntary treatment departments | | | Compulsory treatment departments | | |
|---|---|---|---|---|---|---|---|---|---|
| | Number of prisons | Capacity | Number of people | Number of prisons | Capacity | Number of people | Number of prisons | Capacity | Number of people |
| 2006 | 31 | 1,665 | 3,201 | 6 | 286 | 625 | 3 | 105 | 162 |
| 2007 | 35 | 1,877 | 3,524 | 6 | 258 | 419 | 3 | 114 | 200 |
| 2008 | 33 | 1,998 | 3,646 | 6 | 262 | 422 | 3 | 120 | 206 |
| 2009 | 33 | 2,057 | 4,224 | 7 | 294 | 507 | 3 | 120 | 117 |
| 2010 | 33 | 2,075 | 3,443 | 7 | 300 | 437 | 3 | 109 | 128 |
| 2011 | 33 | 1,960 | 4,279 | 7 | 287 | 535 | 3 | 113 | 206 |

Ten prisons were intended for providing substitution therapy, seven of which reported treating patients in 2011. The substitution treatment programmes in prisons reported 99 clients, i.e. 32 more than in the previous year. In comparison with 2010, the average treatment period was reduced to approximately 5 months; see Table 9-15. Methadone was the main substitution substance. In order to be included in a substitution therapy programme in prison, the clients had to have been included in a substitution therapy programme before they entered the prison to await trial in custody or to serve their prison sentence.

*Table 9-15: Number of persons and average treatment period (in months) in the individual prisons, 2010–2011 (Generální ředitelství Vězeňské služby ČR, 2012b)*

| Prison | 2010 | | 2011 | |
|---|---|---|---|---|
| | Number of persons | Average treatment period | Number of persons | Average treatment period |
| Brno | 11 | 11 | 22 | 3 |
| Břeclav | 0 | – | 0 | – |
| Kuřim | 7 | 19.5 | 12 | 2 |
| Litoměřice | 10 | 4.8 | 11 | 1 |
| Opava | 5 | 6 | 13 | 1.5 |
| Ostrava | 0 | – | 0 | – |
| Praha-Pankrác | 15 | 8.3 | 24 | 5.2 |
| Praha-Ruzyně | 1 | 1 | 0 | – |
| Příbram | 16 | 6.5 | 14 | 11 |
| Rýnovice | 2 | 4 | 3 | 12 |
| **Total** | **67** | **7.6** | **99** | **5.1** |

Detoxification was provided by five prisons in 2011. Acute withdrawal treatment was received by 309 persons, 230 of whom were men and 79 women. Opiate users accounted for 86% and pervitin users for 12% of the persons detoxified. There was a significant decrease in the number of persons undergoing withdrawal management in comparison with the previous year (686 persons in 2010). An increase by over 23 percentage points was also observed in the share of opiate users (63% in 2010). Cells in the crisis departments were used to pacify the acutely intoxicated.[156] In 2011 this concerned 60 cases, i.e. 40 cases more than in the previous year.

A total of 25 prisons cooperated with an NGO on implementing the activities aimed at prevention, addiction treatment, and harm reduction, 11 of which reported intensive cooperation (10 or more visits per year). A total of 3,422 individuals awaiting trial in custody or serving a prison sentence were in contact with an NGO in 2011. In addition to working with imprisoned clients, the NGOs also focused on post-penitentiary care. The programmes involving drug services in prison provided by the *Podané ruce*, *Laxus*, CPPT, and SANANIM associations, i.e. the

[155] In 2011, the General Directorate of the Prison Service stated in its opinion that the health care provided by the existing specialised wings for compulsory treatment cannot be considered institutional health care. "Protective" treatment is therefore delivered in prisons in the outpatient form. The percentage of outpatient treatment cases in prison thus started to increase in 2011. The opinion of the Prison Service is codified by the new Act No. 373/2011 Coll. on specific health services, which came into force on 1 April 2012. According to Section 83 (2) of this Act, compulsory treatment can be provided in the health facilities of the Prison Service while an offender is serving a prison sentence. This concerns compulsory institutional treatment provided in the form of one-day care, and compulsory treatment provided on an outpatient basis; see also the chapter Leg (p. 5).

[156] The crisis department of the prison is intended for prisoners suffering from acute mental distress.

programmes which were most active in the area, reported a total of 149 clients in post-release outpatient care in 2011; see Table 9-16.

*Table 9-16: NGOs providing drug services in prisons, number of visits, and number of prisoners contacted (Generální ředitelství Vězeňské služby ČR, 2012b)*

| **Name of NGO** | **Prison** | **Number of visits** | **Number of persons** |
|---|---|---|---|
| Podané ruce (Brno, Olomouc) | Brno, Kuřim, Rapotice, Znojmo, Mírov, Olomouc | 315 | 1,879 |
| Laxus (Nymburk) | Horní Slavkov, Hradec Králové, Jiřice, Odolov, Pardubice, Rýnovice, Stráž pod Ralskem, Světlá n. Sáz. | 121 | 582 |
| CPPT (Pilsen) | Pilsen | 66 | 263 |
| SANANIM (Prague) | Pilsen, Prague-Ruzyně, Světlá n. Sáz., Vinařice | 56 | 286 |
| Point 14 (Pilsen) | Drahonice | 6 | 51 |
| White Light I. (Ústí n. Labem) | Litoměřice, Nové Sedlo, Všehrdy | 6 | 221 |
| Other | Bělušice, Karviná, Ostrava | 8 | 140 |
| **Total** | | **578** | **3,422** |

## 10 Drug Markets

An estimated 18.2 tonnes of cannabis, 4.6 tonnes of pervitin, 1.2 tonnes of heroin, 870 kilograms of cocaine, 4.6 million tablets of ecstasy, and 1 million doses of LSD were consumed in the Czech Republic in 2011.

The consumption of cannabis in the Czech Republic is mostly covered by the domestic production, which accounted for approximately 16 tonnes of cannabis, mostly grown indoors, in 2011. Another 3 tonnes of cannabis were imported. The THC content in indoor cannabis was between 12% and 20%. The Police of the Czech Republic dismantled 165 cannabis cultivation sites in 2011. The share of people of Vietnamese descent involved in the cultivation of cannabis and distribution of marijuana increased significantly. The number of marijuana seizures and the quantities seized have been increasing since 2009. In 2011, the Police of the Czech Republic and the Customs Administration of the Czech Republic reported 508 seizures of a total of 441 kg of marijuana, 62.8 thousand cannabis plants, and 2.4 kg of hashish.

An estimated 4.7 tonnes of pervitin were produced in the Czech Republic in 2011, approximately 1.7 tonnes of which were intended for the personal use of the manufacturer, while 2.9 tonnes were to be marketed domestically, and 140 kg of pervitin were to be exported. Produced only domestically, pervitin is mainly made in low-volume domestic laboratories. The police detected 338 cooking labs. Medicines containing pseudoephedrine, imported mainly from Poland but also from Germany and Slovakia, were used as the precursors in the manufacture of pervitin. The drug market in pervitin is gaining in importance in northwest Bohemia, where it is stimulated by the demand from German nationals. Altogether, 304 seizures of a total of 20.05 kg of pervitin were reported in the Czech Republic in 2011.

An estimated 650 kg of cocaine with an average purity of 60% are estimated to have been imported into the Czech Republic in 2011. The drug was further cut domestically. Cocaine mostly entered the Czech Republic via Italy, Romania, Spain, the Netherlands, and Austria, either by Czech couriers or in postal consignments. 44 seizures of cocaine were made, involving a total of 16.1 kg.

As far as heroin is concerned, the Czech market is supplied using small shipments. An estimated 375 kg of heroin with an average purity of 25% are estimated to have been imported into the Czech Republic in 2011. The purity of the heroin distributed to the end users after further diluting was around 8%. The number of seizures and the quantity of heroin seized decreased significantly, from 61 seizures of 30.5 kg in 2010 to 34 seizures of 4.7 kg in 2011.

The police discovered three cooking labs for “braun”. According to the National Drug Squad, the most recent seizure of braun was reported in 1991 and involved 250 grams of the drug. Before 1989, braun used to be the main home-made opiate drug and was manufactured from medicines containing codeine.

A total of 35 new psychoactive substances were seized in 2011, with 21 of the substances being detected in the Czech Republic for the first time. In terms of quantities, mephedrone (58 kg), JWH-122 (2 kg), and methylone (1.8 kg) accounted for the largest seizures. The new psychoactive substances were sold via e-shops, as well as regular retail outlets. After April 2011, the retail sales were significantly reduced, and most of the sales took place via the internet (e-shops).

### 10.1 Drug Consumption

#### 10.1.1 Estimated Drug Consumption Based on Data from Users

The level of the consumption of selected drugs in 2011 was estimated on the basis of the level of prevalence of illicit drug use identified in the 2008 General Population Survey (Běláčková et al. 2012), the prevalence-related estimates of problem drug use, and data on the average consumption of drugs according to user habits. An estimated 18.2 tonnes of cannabis, 4.6 tonnes of pervitin, 1.2 tonnes of heroin, 869.5 kilograms of cocaine, 4.6 million tablets of ecstasy, and 1 million doses of LSD were consumed in the Czech Republic in 2011 (Vopravil, 2012). In comparison with 2008, there was a decrease in the consumption of all the drugs except pervitin, for which there was an increase by 166 kg (Vopravil, 2010).

#### 10.1.2 Estimated Drug Consumption Based on the Analysis of Surface and Waste Waters

These estimates are based on the (quantitative) analysis of drugs and their metabolites present in waste water or in surface waters where waste water is released from waste water treatment plants, with a view to back-calculating the consumption of drugs among the population concerned (EMCDDA, 2008; van Nuijs et al. 2011).

The Fisheries and Hydrobiology Institute of the Faculty of Fisheries and Protection of Waters of the University of South Bohemia in České Budějovice was involved in a multi-centre study aimed at analysing samples collected from waste water treatment plants in 19 European cities during a single week in March 2011 (Thomas et al. 2012). In the Czech Republic, the study was carried out in České Budějovice. Along with Helsinki and Turku, Finland, and Oslo, Norway, České Budějovice belonged among the cities with an above-average consumption of methamphetamine (pervitin). The quantity of cannabis (THC-COOH) detected was rather low in České Budějovice in comparison with other European cities, and the quantities of ecstasy, cocaine, and amphetamine were very low. When the published correction factors were used to convert the quantities of the metabolites and drugs excreted to the quantity of drugs

consumed[157] (EMCDDA, 2008; Postigo et al. 2010), the quantity of the pervitin consumed can be estimated as 670 mg and the quantity of THC as 7600 mg per 1,000 inhabitants per day. Converted to the entire population of České Budějovice (112 thousand), it means 27 kg of pervitin and 3,110 kg of marijuana per year; considering other estimates of the consumption in the Czech Republic, the estimate for marijuana is highly likely to be exaggerated by an order of one.

A detailed study, which was performed in the Czech Republic by the T. G. Masaryk Water Research Institute, was conducted using waste water samples collected over 7 days in April 2011 in one of the largest cities in the Czech Republic (Baker et al. 2012). For the first time, the calculation of the estimated consumption also included the quantity of drugs bound to the suspended solids in waste water (which are quite significant for some substances, such as methadone or MDMA). The results were also adjusted to consider the stability of the substances that were monitored. The inclusion in the consumption estimate calculation of the stability factor and of the quantity bound to solids results in higher accuracy of the estimate. A total of 60 substances were monitored, of which 19 analytes were detected every day of the campaign and 38 analytes were not detected at all (e.g. heroin, LSD, and buprenorphine).

The calculation was performed for cocaine, amphetamine, methamphetamine, MDMA, and methadone for each day of the collection campaign, in milligrams per day per 1,000 inhabitants. The estimate of the consumption of the other substances that were monitored was not calculated. The daily values and annual consumption estimates for selected drugs are provided in Table 10-1.

*Table 10-1: Estimated consumption of selected drugs according to waste water analysis (Baker et al. 2012)*

| **Drug** | **Estimated consumption per 1,000 inhabitants per day (mg)** | | | **Estimated consumption per million inhabitants per year* (kilograms of active substance)** |
|---|---|---|---|---|
| | Range | Weekly average | Weekend average | |
| Cocaine | 116–329 | 186 | 317 | 68 |
| Methamphetamine | 293–627 | 412 | 514 | 150 |
| MDMA | 21–173 | 36 | 162 | 13 |
| Amphetamine | 27–94 | 44 | 65 | 16 |
| Methadone | 26–48 | 36 | 43 | 13 |

*Note: *Extrapolated on the basis of the published daily consumption data (Baker et al. 2012).*

After conversion to consider the purity of the drugs (active substance concentration),[158] the consumption can be estimated as 230 kg of cocaine and 250 kg of pervitin per 1 million inhabitants per year. These estimates correspond rather well to the drug consumption in the Czech Republic estimated on the basis of drug use prevalence data (see above). For example, the methadone consumption estimate also corresponds to the methadone imports into the Czech Republic; see Table 5-17 on p. 68.

Higher quantities of cocaine, methamphetamine, and MDMA during weekends indicate the use of these drugs in recreational and nightlife settings. Increased detection rates of cocaethylene on weekends (an increase by 313%) suggest the concurrent use of cocaine and alcohol during weekends. As far as the other substances under monitoring are concerned, the increase at weekends was not significant and the values remained relatively consistent throughout the week (Baker et al. 2012).

## 10.2 Availability and Supply

### 10.2.1 Domestic Production, Imports, and Exports

Information provided by the National Drug Squad of the Police of the Czech Republic and by the Customs Drug Unit represents the basic sources of data (Národní protidrogová centrála SKPV Policie ČR, 2012a; Ministerstvo financí, 2012b). The information mainly concerns the number of seizures of the individual drugs, and the quantities detected, broken down according to the site of the seizure.

The domestic production of cannabis is estimated to have reached nearly 16 tonnes in 2011. An estimated 10.7 tonnes of this quantity were intended for the personal use of the growers, 4.6 tonnes were intended for the domestic market, and 0.5 tonnes were to be exported. Indoor cultivation prevailed, accounting for 56% of the overall domestic production. A total of 2.9 tonnes of cannabis were imported into the Czech Republic (Vopravil, 2012). The THC content in the indoor cannabis seized was between 12% and 20%. The police detected 165 cultivation sites in 2011 (Národní protidrogová centrála SKPV Policie ČR, 2012a). Both the Police of the Czech Republic and the Supreme Public Prosecutor's Office have noted the increasing share of people of Vietnamese descent who are involved in the large-scale cultivation of cannabis and in the distribution of marijuana. In addition, several trading companies owned by people of Vietnamese descent have been reported to be engaged in the importing of cannabis cultivation technologies, specifically from the Netherlands and from the United Kingdom. The marijuana produced by the high-

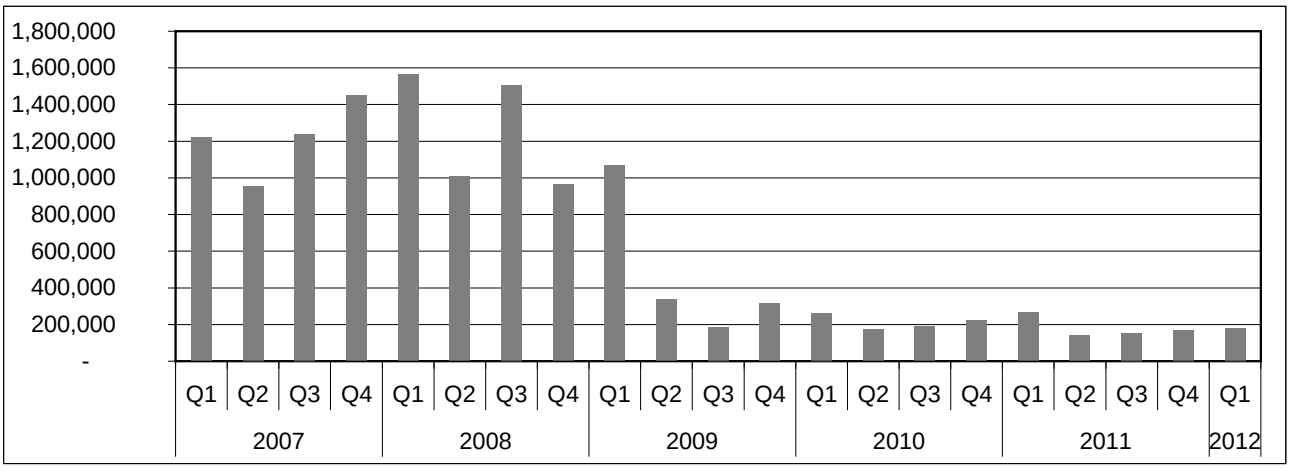
[157] A correction factor of 2.3 was used for methamphetamine; a factor of 152 was used to convert THC-COOH to THC. The conversion also includes the purity of pervitin and the concentration of THC in marijuana, which were determined at 60% for pervitin and 10% for cannabis for reference.
[158] 30% for cocaine and 60% for methamphetamine for reference.

volume plantations was predominantly intended for the German market, where it was mainly distributed in marketplaces near the border. However, the share of marijuana flowing into the domestic market increased, according to the National Drug Squad. A new trend occurred in the form of cannabis cultivation in industrial and farm buildings rented for a short period. The cultivation sites only operated long enough to harvest their production several times, after which the buildings were cleared. The communication with the landlords and with the Czech authorities was often provided by Czech nationals. The actual running of the cultivation site was done by persons of Vietnamese descent. They were often persons who found themselves in a disadvantaged position because of debt, unemployment, violation of the immigration laws, etc. (Národní protidrogová centrála SKPV Policie ČR, 2012c; Nevyšší státní zastupitelství, 2012). The Customs Drug Unit also issued an alert regarding an increase in the level of illegal exports to the UK or USA via air mail (Ministerstvo financí, 2012b).

An estimated 4.7 tonnes of pervitin were produced in the Czech Republic in 2011, approximately 1.7 tonnes of which were intended for the personal use of the manufacturer, while 2.9 tonnes were to be marketed domestically, and 140 kg of pervitin were to be exported (Vopravil, 2012). Pervitin is predominantly made in small home-based laboratories, which are often designed for ease of relocation in order for the manufacturer to avoid detection. The number of cooking labs detected increased from 308 in 2010 to 388 in 2011. Medicines containing pseudoephedrine were mostly used as the precursors in the manufacture of pervitin (Národní protidrogová centrála SKPV Policie ČR, 2012a). The restriction of the dispensation of these medicines in Czech pharmacies in May 2009 resulted in a significant decrease in their sales; see Graph 10-1. However, the reduced availability of medicines containing pseudoephedrine resulted in their illegal imports, especially from Poland, but also from Germany and Slovakia.

The drug market in pervitin is gaining in importance in the border areas in northwest Bohemia, where it is mainly stimulated by the demand from German nationals. According to the data of the National Drug Squad, a total of 389 cases of pervitin smuggling to Germany were detected in 2011, with German nationals accounting for 336 of these cases. The figure was more than double that for 2010 (when 169 cases were reported). A total of 9.6 kilograms of pervitin were seized near the Czech-German border, i.e. approximately 7.5 kg more than in the previous year. In 87 cases, marijuana was seized together with the pervitin. Persons of Vietnamese descent participated in the manufacture of pervitin for the German market to a significant extent, according to the National Drug Squad. The activities of these groups were characterised by a rather high degree of organisation. Some of their members familiarised themselves with the manufacturing procedure; Czech "cooks" were less predominant. The price of pervitin from these sources was approximately EUR 40 per gram at the purity of 75% (Národní protidrogová centrála SKPV Policie ČR, 2012b). The higher purity, in comparison with pervitin produced by Czech manufacturers, was probably related to the reduced cost of raw materials in high-volume production, as well as to the demand from German customers. The drug was mostly sold in marketplaces and through a network of Vietnamese dealers (Národní protidrogová centrála SKPV Policie ČR, 2012b). As far as the situation in northwest Bohemia is concerned, the Supreme Public Prosecutor's Office pointed out the fragmented jurisdiction of all the authorities involved in combating crime (Nevyšší státní zastupitelství, 2012). This issue was also raised by the Working Group on Methamphetamine of the Government Council for Drug Policy Coordination, and the Government Council addressed the topic at its meeting held on 29 May 2012. The situation also solicited a response from German political representatives, as well as media attention.[159] In his press release, the National Drug Coordinator mainly emphasised the international nature of the problem in question.

*Graph 10-1: Development of the sales of medicines containing pseudoephedrine in the Czech Republic from 2007 to Q1/2012 (Státní ústav pro kontrolu léčiv, 2012)*




[159] http://www.novinky.cz/zahranicni/evropa/276139-paseraky-drog-budou-na-cesko-nemecke-hranici-potirat-spolecne-ozbrojene-hlidky.html; http://www.ceskatelevize.cz/ct24/svet/192164-bavorsko-je-v-boji-s-drogami-bezradne-pry-kvuli-ceske-liknavosti/; http://www.ceskatelevize.cz/ct24/domaci/192947-protidrogovy-koordinator-odmitl-kritiku-bavorska-kvuli-pervitinu/ (2012-09-01)

An estimated 650 kg of cocaine with an average purity of 60% are estimated to have been imported into the Czech Republic in 2011 (Vopravil, 2012). Cocaine mostly entered the Czech Republic via Italy, Romania, Spain, the Netherlands, and Austria, either by Czech couriers or in postal consignments containing various articles. It was mainly people from socially disadvantaged groups who were hired as couriers. Cocaine was often smuggled in body cavities. The weight of the smuggled drug was between 10 grams and 1 kilo (Ministerstvo financí, 2012b). West African nationals, mostly those of Nigeria, participated significantly in the smuggling and distribution of the drug, followed by Albanian, Romanian, and Bulgarian nationals (Národní protidrogová centrála SKPV Policie ČR, 2012c; Nevyšší státní zastupitelství, 2012).

The demand for heroin in the Czech Republic was satisfied by using smaller shipments containing only several kilograms each. 375 kg of heroin with an average purity of 25% are estimated to have been imported into the Czech Republic in 2011. For street sale, the heroin was most frequently diluted with paracetamol and caffeine. The purity of the heroin distributed to the end users was around 8%. Tablets of the substitution preparations containing buprenorphine, in particular those of Subutex®, continued to appear on the illicit market in addition to heroin (Národní protidrogová centrála SKPV Policie ČR, 2012b; Vopravil, 2012).

### 10.2.2 New Psychoactive Substances on the Czech Drug Scene

An increase has been observed in the occurrence of new psychoactive substances in the Czech Republic since 2010. They are synthetic and herbal substances with a stimulating, hallucinogenic, or sedative effect, sold under a number of trade names or, in the case of synthetic substances, directly under their chemical name. Their effects are often compared to the effect of established drugs. Herbal substances are sold in the form of extracts, pulp, powders, or mixtures. Synthetic substances are purposely manufactured and distributed to avoid the international control system, as well as the national control system of the target country. They are predominantly imported from Asian countries (mainly from China and India). When imported, they are declared as bath salts or fumigants or under a different chemical name (Ministerstvo financí, 2012b). They include synthetic cannabinoids, phenetylamines, cathinones, tryptamines, piperazines, and other substances. 35 new psychoactive substances were intercepted, 21 of which were detected in the Czech Republic for the first time in 2011. In terms of quantities, mephedrone (58 kg), JWH-122 (2 kg), and methylone (1.8 kg) accounted for the largest seizures (Národní monitorovací středisko pro drogy a drogové závislosti, 2012d).

The new psychoactive substances were sold via e-shops, as well as regular brick-and-mortar shops. Retail outlets offering the new drugs became widespread between the end of 2010 and April 2011 (see the 2010 Annual Report). In order to avoid prosecution, the retailers offered the new drugs as collector's or gift items or souvenirs, bath salts, etc. The composition and the concentration of the active substance were not specified in most cases. After the amendment to Act 167/1998 Coll. on addictive substances, which came into force on 22 April 2011, the imports of the new substances into the Czech Republic virtually stopped, according to the Customs Drug Unit (Ministerstvo financí, 2012b). In addition, the retail sales were significantly reduced, and most of the sales took place via the internet (in e-shops). As of the end of August 2012, the Police of the Czech Republic had knowledge of approximately 10 retail shops offering the new drugs. Their number had thus been reduced to a half or even a quarter in comparison with the situation at the end of March. In February 2012, a total of 19 e-shops with a Czech website were identified, 11 of which were selling only synthetic drugs. The most frequent articles offered by the shops included kratom, 6-APB, and 4-FA. Eight e-shops declared that the products were not intended to be taken internally and that the retailer waived any responsibility for damage incurred if the products are used in contradiction with their purpose. The websites of five e-shops provided information about the legality of the products on offer in the Czech Republic (Národní monitorovací středisko pro drogy a drogové závislosti, 2012f).

The occurrence of fentanyl, nicknamed "vlacho" or "chemical heroin", was reported from the Ostrava region in 2011. Fentanyl was imported from and made in Slovakia; see also the 2010 Annual Report. The police reported one seizure of this substance, amounting to 254 grams, in 2011 (Národní protidrogová centrála SKPV Policie ČR, 2012a). According to information provided by harm reduction services, the use of fentanyl occurred in the Moravia-Silesia, Pilsen, Karlovy Vary, and Prague regions. Fentanyl was mainly available in the form of patches. Healthcare facilities, such as pain management centres, were reported as the source of fentanyl, which was either stolen from these centres or obtained from used patches removed from unprotected medical waste.

## 10.3 Seizures

Information provided by the National Drug Squad of the Police of the Czech Republic and by the Customs Drug Unit represents the basic sources of data concerning drug seizures (Národní protidrogová centrála SKPV Policie ČR, 2012a; Národní protidrogová centrála SKPV Policie ČR, 2012d; Ministerstvo financí, 2012b). The number of seizures and the quantities of the individual drugs seized in 2008–2011 are provided in Table 10-3. As in the previous years, marijuana was the drug that was seized most frequently. The number of marijuana seizures in 2007–2011 was about 500 per year. In 2011, the Police of the Czech Republic and the Customs Administration of the Czech Republic reported 508 seizures of a total of 441 kg of marijuana; 62% of the seizures involved quantities of less than 100 grams, and 13% involved quantities of over one kilogram. The quantity seized in 2011 was 163 kilograms more than in the previous year (278 kg in 2010); the number of seizures of quantities of under 100 grams

decreased by three percentage points (65% in 2010, compared to 62% in 2011). The largest quantity of marijuana that was seized involved 45.9 kg. The number of marijuana seizures and the quantities seized have been increasing since 2009. 240 seizures of a total of 62.8 thousand cannabis plants were reported. Even though the number of seizures of cannabis plants is the highest since 2007, the total number of plants that were seized was lower than that in the previous year. Quantities of less than 50 plants accounted for most (56%) of the seizures. Seizures of quantities of over one thousand plants represented 9%. A significant change against 2010 (by 7 percentage points, from 13% in 2010 to 20% in 2011) was observed in the category of seizures of 50–300 cannabis plants. Conversely, the number of seizures of less than 50 plants dropped by five percentage points (from 61% in 2010 to 56% in 2011). The Police of the Czech Republic dismantled 165 cannabis cultivation sites in 2011, an increase by 20 sites against 2010. The number of hashish seizures and the quantities seized have been decreasing since 2009, reaching 2.4 kg in 2011 (compared to 9.4 kg in 2010). Most of the seizures concerned quantities of less than 50 grams. Seizures of quantities exceeding 500 grams were rather rare.

Pervitin was the second most commonly seized drug. Altogether, 304 seizures of a total of 20.1 kg of pervitin were reported in 2011. Seizures involving quantities of less than 10 grams accounted for over 70% of all seizures. Even though the overall number of seizures increased in comparison with 2010, the total quantity of pervitin seized decreased by 1.2 kg. In terms of the breakdown of the seizures by quantity, an increase was reported in the number of seizures of less than 10 grams (189 seizures in 2010 and 214 seizures in 2011), while the number of seizures of more than 500 grams decreased (17 seizures in 2010 and 5 seizures in 2011). The largest quantity seized was 8.3 kg of pervitin. The yearly number of pervitin cooking labs dismantled is usually in the range of 300–350. In 2011 the police detected 338 cooking labs, i.e. 31 more than in the previous year. They were often small cooking labs designed for quick relocation. A significant increase in the number of cooking labs seized was reported in the Zlín and Olomouc regions. Medicines containing pseudoephedrine, imported mainly from Poland, but also from Germany and Slovakia, were mainly used as pervitin precursors. Imports of these medicines from Hungary were reported for the first time, as were cases of imports from Vietnam and China. Sudafed® and Zyrtec® were the medicines seized most frequently. The number of illegally imported medicines has been growing since 2009, when their dispensation by Czech pharmacies was restricted (see above). An important part is played by the control of the sale of medicines containing pseudoephedrine in the Czech Republic, the lower price, and, especially, a higher content of pseudoephedrine per unit than that in the medicines available on the Czech market. In 2011, the Customs Drug Unit and the National Drug Squad seized a total of 480,604 tablets of medicines containing pseudoephedrine, an increase against 2010 by 35% (309,176 tablets were seized in 2010). A significant decrease in the quantity of ephedrine, the original pervitin precursor, occurred in 2011 in comparison with both 2010 and 2009: a total of 8,152 grams and 15,000 tablets were seized in 2010, while the quantities decreased to 2,317 grams and 4,070 tablets in 2011. The seizures of the individual medicines in 2011 are summarised in Table 10-2. According to the estimates of the National Drug Squad, up to 95% of the medicines containing pseudoephedrine used for pervitin production originated from Poland. The deliveries were mainly intended for large-volume labs. Only the small-scale "cooks" manufactured the drug from raw materials of Czech origin. Poland has no controls over medicines containing pseudoephedrine. A proposal for legislative changes, aimed at restricting the sale of such medicines over the counter, was submitted in 2011 but the Polish Parliament did not pass the bill.

*Table 10-2: Quantities of medicines containing pseudoephedrine seized in 2007–2011 (Národní protidrogová centrála SKPV Policie ČR, 2012a)*

| **Seizures** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Ephedrine (g) | 1,185 | 1,677 | 6,023 | 8,152 | 2,317 |
| (tablets) | – | – | – | 15,000 | 4,070 |
| Pseudoephedrine (g) | 218 | – | – | 2,179 | 2,880 |
| (tablets) | – | – | – | – | 40 |
| Modafen® (tablets) | 3,480 | 7,876 | 840 | 3,356 | 2,762 |
| Nurofen Stop Grip® (tablets) | 11,948 | 21,785 | 876 | 0 | 14,892 |
| Panadol Plus Grip® (tablets) | 72 | 17,021 | 1,224 | 0 | 0 |
| Paralen® Plus | – | 2,261 | 1,440 | 144 | 0 |
| Acatar® (tablets) | – | – | 3,508 | 26,924 | 240 |
| Cirrus® (tablets) | – | – | 6 | 68 | 17,551 |
| Ibuprofen® (tablets) | – | – | 80 | 0 | 0 |
| Ibuprom® (tablets) | – | – | 22,080 | 551 | 1,474 |
| Sudafed® (tablets) | – | – | 12,231 | 278,133 | 403,105 |
| Reactine® duo (tablets) | – | – | – | – | 10,940 |
| Rhinafen® (tablets) | – | – | – | – | 960 |
| Rhinopront® (tablets) | – | – | – | – | 540 |
| Zyrtec® (tablets) | – | – | – | – | 28,140 |

The trend of a growing number of seizures, as well as the quantity of cocaine seized, continued. A total of 44 seizures of cocaine were made in 2011, involving a total of 16.1 kilograms. Over a half of the seizures concerned

quantities of less than 10 grams (23 seizures); 6 seizures of quantities over 1,000 grams were reported. The largest quantity that was seized involved 3.5 kg. As for the seizures of larger quantities (over 1 kg of the substance), cocaine was the second most commonly seized drug in 2011, following marijuana.

The number of seizures and the quantity of heroin seized decreased significantly, from 61 seizures of 30.5 kg in 2010 to 34 seizures of 4.7 kg in 2011. The Czech market is mainly supplied using small consignments, which is also confirmed by data from the Police and the Customs Administration. Most heroin seizures in 2011 involved quantities of less than 100 grams; two seizures concerned more than 1 kg of the drug each. The largest quantity that was seized was 1.1 kg. Nationals of Balkan countries played an important part in the trafficking of heroin from the country of manufacture and in the distribution of the drug.

Even though the number of ecstasy and LSD seizures did not change significantly against 2010, the quantity of the two drugs that was seized increased. The number of ecstasy tablets that were seized increased from 865 tablets in 2010 to 13,000 tablets in 2011. Most seizures concerned quantities of 50–100 tablets (8 seizures); one seizure involved over 10 thousand tablets (12,419 tablets). As far as the number of LSD doses is concerned, 1,313 doses were seized in 2011, i.e. 95 doses more than in the previous year. Most seizures concerned quantities of 50–100 doses (five seizures). The largest seizure of LSD involved 809 doses.

The police detected three cooking labs for "braun" in 2011. Before 1989, braun used to be the main and, in fact, the only opiate used in the country. After 1993, it was gradually pushed out by imported heroin and other opiates/black market opioids, especially buprenorphine. According to the National Drug Squad, the most recent seizure of braun occurred in 1991 and involved 250 grams of the drug.

*Table 10-3: The number of seizures and the quantities of the individual drugs seized in 2008–2011 (Národní protidrogová centrála SKPV Policie ČR, 2012d)*

| Drug type | 2008 | | 2009 | | 2010 | | 2011 | |
|---|---|---|---|---|---|---|---|---|
| | Seizures | Quantity | Seizures | Quantity | Seizures | Quantity | Seizures | Quantity |
| Marijuana (g) | 602 | 392,527 | 384 | 171,799 | 455 | 277,988 | 508 | 440,780 |
| Pervitin (g) | 405 | 3,799 | 326 | 3,599 | 283 | 21,301 | 304 | 20,054 |
| Heroin (g) | 105 | 46,302 | 73 | 31,257 | 61 | 30,453 | 34 | 4,730 |
| Cannabis plants | 69 | 25,223 | 117 | 33,427 | 189 | 64,904 | 240 | 62,817 |
| Hashish (g) | 30 | 696 | 41 | 12,499 | 27 | 9,354 | 24 | 2,375 |
| Ecstasy (tablets) | 18 | 16,610 | 13 | 198 | 16 | 865 | 15 | 13,000 |
| Cocaine (g) | 24 | 7,631 | 26 | 12,904 | 42 | 14,162 | 44 | 16,071 |
| LSD (doses) | 5 | 246 | 5 | 142 | 8 | 1,218 | 7 | 1,313 |

### 10.4 Drug Prices and Purity

Information about the prices of the individual drugs is based on the specific offences reported by the National Drug Squad, provided that price information is available. Drug purity data are only available for a part of the drugs seized and are mostly obtained from the Departments for Forensic and Technical Analyses of the regional police headquarters and from the Forensic Science Institute in Prague. However, the data only have a very limited informative value. The number of cases or samples in which the price and purity are identified is very low for certain drugs. In addition, samples obtained from the seizures of larger quantities of drugs with a higher concentration of the active substance are not distinguished from samples of street drugs with lower purity.

The price and potency of marijuana did not change significantly in 2011. The purity of heroin decreased in comparison with the previous year. In 2010 the samples that were analysed most commonly contained 13% of the active substance, while in 2011 this share was 8%. As in 2010, the price of heroin was around CZK 1,000 (€ 40) per gram. The most significant change occurred for cocaine. In 2010 the samples that were analysed most commonly contained 14% of the active substance, while in 2011 this share increased to 72%. However, the price was known only for a very low number of the samples that were seized. The average content of the pure drug in the samples of pervitin that were analysed was 69%. As in 2010, the price of the samples of pervitin that were seized was most commonly around CZK 1,000 (€ 40) per gram. The price and purity of ecstasy tablets are difficult to evaluate because of the very low number of samples analysed; see Table 10-4 and Table 10-5.

*Table 10-4: Average drug purity values, 2008–2011 (Národní protidrogová centrála SKPV Policie ČR, 2012e)*

| Drug type | 2008 | | 2009 | | 2010 | | 2011 | |
|---|---|---|---|---|---|---|---|---|
| | No. of samples | Average purity (%) | No. of samples | Average purity (%) | No. of samples | Average purity (%) | No. of samples | Average purity (%) |
| Marijuana* | 404 | 5.5 | 289 | 8.1 | 391 | 7.7 | 497 | 7.2 |
| Hashish | 5 | 5.2 | 3 | 15.9 | 8 | 9.3 | 24 | 11.0 |
| Ecstasy** | 20 | 17.5 | 6 | 3.4 | 9 | 15.3 | 5 | 43.0 |
| Pervitin | 145 | 64.3 | 144 | 68.1 | 160 | 64.4 | 163 | 69.0 |
| Heroin | 47 | 22.6 | 57 | 16.6 | 51 | 24.6 | 31 | 14.0 |
| Cocaine | 35 | 43.5 | 21 | 33.1 | 35 | 27.9 | 52 | 45.0 |

*Note: * The concentration of THC is provided for cannabis. ** The average purity of ecstasy tablets is expressed as the average quantity of MDMA in milligrams in one tablet containing MDMA.*

*Table 10-5: Average and most commonly reported (modus) prices of drugs, 2008–2011 (€) (Národní protidrogová centrála SKPV Policie ČR, 2012e)*

| Drug type | 2008 | | 2009 | | 2010 | | 2011 | |
|---|---|---|---|---|---|---|---|---|
| | Average | Modus | Average | Modus | Average | Modus | Average | Modus |
| Marijuana (g) | 7 | 8 | 8 | 9 | 8 | 10 | 8 | 8 |
| Hashish (g) | 9 | 9 | 10 | 11 | 9 | 10 | 9 | – |
| Ecstasy (tablet) | 8 | 8 | 8 | 9 | 8 | 10 | 6 | 6 |
| Pervitin (g) | 43 | 38 | 49 | 38 | 51 | 40 | 52 | 40 |
| Heroin (g) | 41 | 38 | 48 | 38 | 51 | 40 | 44 | 40 |
| Cocaine (g) | 76 | 76 | 73 | 95 | 79 | 79 | 90 | 81 |
| LSD (dose) | 7 | 4 | 8 | 8 | 8 | 8 | 8 | – |

*Note: Prices rounded to €. 2011 average exchange rate was used (1 € = 24.586).*

## PART B: SELECTED ISSUES

Selected issues are included in the Annual Report every year. The topics are set by the EMCDDA in cooperation with the focal points in the individual Reitox countries with regard to the topics' relevance and the research needs. Since last year all the countries have been required to prepare chapters on at least two selected issues, one of which is mandatory (this year it is the chapter on residential treatment for drug users), and one is selected from two options offered. The Czech National Focal Point has chosen to cover all three selected issues.

# 11 Residential Treatment for Drug Users

For the purposes of this Selected Issue, "residential treatment" is defined as treatment delivery programmes of 12 weeks or more in duration which are provided by inpatient or residential facilities and involve therapeutic and other activities for drug users. A distinctive feature of these programmes is that they address a wide range of their clients' treatment needs, including, but not limited to, the following domains: drug use, health, quality of life, and wider social functioning.

In the Czech Republic, two models of residential treatment match this definition: (1) treatment in specialised units of inpatient healthcare facilities, i.e. psychiatric hospitals and general hospitals, and (2) treatment in therapeutic communities.

In general, these two models overlap in certain aspects of their treatment philosophy, characterised by the terms "abstinence-oriented" or "drug-free" treatment (in comparison to substitution treatment), and provide their patients and clients with a basically similar range of services and professional interventions. An important common feature lies in the concept of a "structured programme", which involves not only a fixed timetable within which the services and interventions are incorporated, but also a set of rules that the treatment follows. Another converging characteristic may be seen in the principles of a therapeutic community, which are also applied to a greater or lesser extent by the specialised units of treatment institutions and hospitals.

The differences between these two models are mainly determined by their respective historical development, which, to a great degree, influenced their position within the current system of drug services, the ways in which they are funded and their quality is assured, and the structure of their patients/clients.

More detailed quantitative data about the network of facilities providing residential treatment and the clients of these services are also presented in the chapter Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55).

## 11.1 Specialised Addiction Treatment Units – the Apolinar Model

### 11.1.1 Historical Background

In the Czech Republic, the first specialised inpatient unit for the treatment of alcoholism, known as Apolinar,[160] was established in 1948 as part of the Department of Psychiatry of what is now the First Faculty of Medicine of Charles University and the General University Hospital in Prague. The unit was founded and headed until 1982 (i.e. for 34 years) by Professor Jaroslav Skála. The addiction treatment model (the Apolinar or Skála model) he conceived and developed combines the principles of collective treatment and education or a therapeutic community[161] with behavioural approaches characterised, in particular, by a strict treatment regimen featuring a system of scoring points. The Apolinar model underlines abstinence and patients' responsibilities, both individual and collective. Other core elements include regular community meetings, group therapy, working with the family, an emphasis on psychoeducation, and the enhancement of physical fitness.

With the benefit of hindsight, we can conclude that Prof. Skála created a largely independent and original approach that further developed and incorporated new ideas for over three decades of his active involvement in the field while retaining its own distinctive nature. Skála's approach inspired the establishment of addiction treatment units in a number of psychiatric hospitals (including Prague-Bohnice, Červený Dvůr, Dobřany, Horní Beřkovice, Havlíčkův Brod, Jihlava, Brno-Černovice, Šternberk, and Opava) during the period from the 1950s to the 1980s.

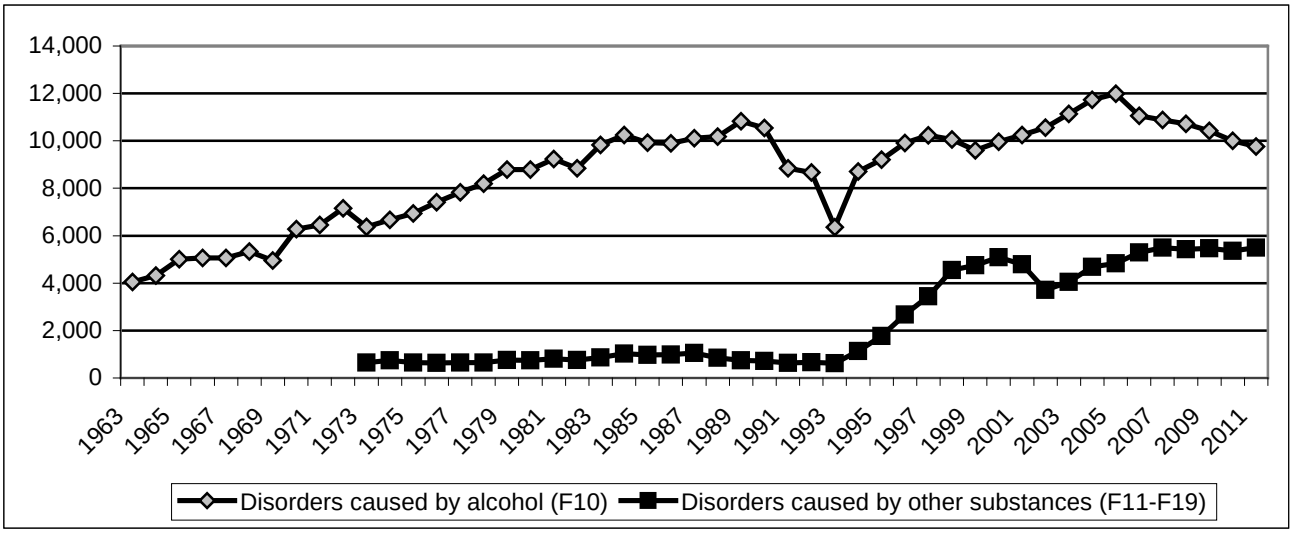
The Apolinar model was originally designed for the treatment of alcohol dependency. Until the 1990s patients falling within this diagnostic category made up a substantial percentage of the clients of inpatient facilities of this type; patients dependent on medication (such as hypnotics, analgesics, and anxiolytics) were also admitted. A growing number of patients addicted to illegal drugs (especially opiates and methamphetamine) emerged in the early 1990s. At the beginning, this new group of clients posed considerable difficulties and provoked discussions as to whether it

[160] The name was derived from the unit being placed in the former monastery affiliated with the Gothic church of Saint Apollinaris ("Apolinář" in Czech) situated on the outskirts of the Prague quarter known as the New Town.

[161] Skála's concept of "collective treatment and education", pursued in the early years of the Apolinar project, referred to the educational communes championed by the Soviet/Ukrainian educator A.S. Makarenko. In the 1960s Skála adopted the therapeutic community model of British provenance associated with Jones and Main. It is not really clear whether he had been acquainted with this model before or, perhaps, from the beginning (Kalina, 2008b).

was appropriate to mix illicit drug users with "traditional" patients in treatment. However, the Apolinar model finally proved to be quite flexible and adaptable. Patients dependent on illicit drugs continue to account for about one third of all the clients of these units in recent years; see Graph 11-1.

*Graph 11-1: Development of the number of hospitalisations for substance use disorders in psychiatric inpatient facilities according to diagnostic categories, 1963–2011 (Mravčík et al. 2011a; Nechanská, 2012c)*




There were 1,305 beds available to the users of both legal and illegal drugs in psychiatric hospitals in 2011; see the chapter Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55). However, this number should not be identified with the real capacity of specialised treatment wards. In addition to units dedicated to institutional detoxification, there are inpatient departments providing treatment programmes that are not fully structured. The people admitted to the latter include chronic users, patients who are not motivated or suited to undergoing the full treatment programme for various reasons, patients who are waiting for enrolment in such a programme, and those who were excluded from it. In the Czech Republic, there are 10 to 12 specialised therapeutic units (with the exception of the Apolinar centre at the General University Hospital in Prague, they are all parts of psychiatric hospitals) that provide treatment based on the philosophy of the Apolinar model, with a total capacity of approximately 800 beds.

While operating in a largely unified manner until 1990, these units currently show certain divergent tendencies. Some of these facilities continue to adhere to the Apolinar model (Petr Popov M.D., Apolinar's present-day head physician, describes it as "regimen-based treatment following the principles of a therapeutic community"[162]) or place more emphasis on the regimen rather than the principles of a therapeutic community, while others seem to be more inclined to pursue the therapeutic community model. Nevertheless, the Apolinar approach may still be considered one of the two principal modalities of residential treatment in the Czech Republic, despite the fact that such a distinction may not always be perfectly accurate.

### 11.1.2 Latest Developments

The Apolinar approach basically follows the *medical, bio-behavioural* model. Institutionally, it stems from health care; almost all the specialised units are parts of psychiatric hospitals directly administered by the Ministry of Health.[163] Treatment is covered by the public health insurance system.

According to the ASAM criteria (American Society for Addiction Medicine, 2006), this type of treatment should be managed by a physician. The physician in charge is usually a psychiatrist with a specialisation in addiction medicine. Given its nature, treatment should be provided by a multidisciplinary team comprised mostly of health professionals. In addition to physicians, mid-level health staff, and clinical psychologists, the therapeutic team may include other mental health practitioners with relevant expertise, social workers, labour therapists, and addictologists (Dvořáček, 2003; Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012).

As regards duration, it is referred to as *medium-term institutional treatment* lasting 3–6 months[164] (Dvořáček, 2003; Kalina, 2003). Some facilities apply the 3-month period to dependency on legal drugs, while a longer period is

[162] Popov, personal communication, 2009. Its founder, however, regarded *Apolinar* as a therapeutic community with no further attributes needed (Skála et al., 1987). In the 1990s *Apolinar* separated from the Psychiatric Department to become an independent addiction treatment unit of the General University Hospital in Prague. Since 2012 it has been a clinical base for the Department of Addictology of the First Faculty of Medicine of Charles University and the General University Hospital.

[163] With the exception of the private mental health hospital PATEB s.r.o., situated in the town of Jemnice.

[164] The current practice is rather 3–4 months. Any treatment lasting less than 3 months is usually referred to as short-term treatment or extended detoxification. This form has not been very common in the Czech Republic so far. Three months are considered a minimum period for effective residential treatment (Dvořáček, 2003; Kalina, 2008a).

allowed for illicit drug addiction; it is not a general rule, though. In practice, the length of treatment is flexible. According to Dvořáček, it results from the assessment of multiple factors, such as the quality of the client's collaboration with treatment, the progress of the treatment process, the presence of any physical or psychological complications and the need for special care, the results of any previous therapeutic attempts, a premorbid personality, the level of seriousness of social and health consequences, the possibility of aftercare in the patient's original environment, and the quality of their social setting. Although some of these factors may be expressed in objective terms, there is no specific matter-of-fact clue as to how to determine the ideal length of the treatment.

The terms "rehabilitation" or "abstinence treatment" are used to refer to the nature and focus of the treatment. The principal goals of the treatment are to achieve and maintain abstinence, stabilise the patients' psychological and physical conditions, and reintegrate them into the community to the greatest degree possible (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012).

The comprehensive structured programme[165] encompasses therapeutic activities involving medical care (including pharmacotherapy), psychotherapy, education, and social reintegration-related and leisure activities. Work with the family, an important legacy of the Apolinar model, is also incorporated.

As mentioned earlier, alcohol users account for two thirds of the patients, while one third comprises users of drugs other than alcohol, among which methamphetamine continues to predominate over opiates/opioids; polydrug use (dg. 19) is also diagnosed very often (whether correctly or not). Patients diagnosed with pathological gambling (dg. F63.0) are admitted too. An increase in the number of psychiatric comorbidities (dual diagnoses) has been observed, although more specific data are not available; see also the chapter Psychiatric comorbidity (p. 96).

### 11.1.3 Treatment Goals

The goals should reflect the length of the programme and the patient's needs. The goal that has been formulated the most frequently (especially with respect to the original Apolinar model) is sustained and consistent abstinence from all addictive substances. Dvořáček (2003) suggests that it takes great therapeutic skills to find an ideal balance between this recommendation, which presents the safest way while best inducing abstinence norms within the treatment community, and an attitude to relapse that does not burden the patient with an unnecessary sense of guilt connected to their failing in their efforts and thus does not worsen their situation by placing excessive demands on them. Abstinence is considered to be not only a goal, but also a means of achieving a higher level of perceived quality of life and resuming the patient's previous social roles to the maximum degree possible; in practice, however, abstinence is highlighted as a goal.

In addition, Dvořáček (2003) presents a set of progressive or partial goals (objectives):

- to stabilise secondary addiction-related problems,
- to develop an insight (to recognise addiction as a problem and to realise its consequences and the steps that need to be taken to compensate for them, including the acceptance of the need to undergo long-term treatment and adhere to certain rules afterwards),
- to adopt progressive measures to address the consequences of the patient's drug career, or to begin to tackle their substance use-related problems,
- to reframe the motivation (from the original external pressure to internal, positively formulated motivation),
- to internalise abstinence norms,
- to internalise the structures of the day and the week (especially the time structures associated with the development of the ability not to respond compulsively to both pleasurable and unpleasurable situations),
- to address in parallel other problems that are not directly related to addiction (such as to initiate treatment of any concurrent mental disorders),
- to identify the risks of relapse and develop strategies for minimising such risks,
- to bring about changes in the original social environment (e.g. avoiding risk-posing jobs, friends, recreational settings, etc.),
- to achieve a reasonable increase in the level of self-esteem and experiencing.

The goals cannot always be accomplished because there is a relatively high percentage of patients with other significant mental health and social issues, as well as those who drop out of the treatment programme. According to Dvořáček, a treatment facility must be able to offer help in seeking to achieve the partial and temporary objectives which are more realistic at a given point. Such objectives may include social stabilisation with referral to other services, stabilisation prior to entering a substitution programme, and education in harm reduction.

[165] A structured programme consists of a minimum of 20 hours of structured activities per week distributed over a minimum of five days (Dvořáček, 2003; Kalina, 2003).

### 11.1.4 Treatment Process and Strategy

As stated above, treatment is based on a structured programme. Dvořáček (2003) explains that a structure applies to:

- the course of treatment: it is divided into several stages with boundaries of varying explicitness,
- the week: the structure of the week assures the well-balanced composition of the programme; all the segments making up the comprehensive programme, encompassing the required minimum of 20 structured hours per week, are applied over a period of one week,
- the day: each activity is performed according to a specific timetable.

The structured programme consists of a balanced body of activities, including psychotherapy (mainly group psychotherapy), work, and recreation. In addition to ensuring the balance and stability of the comprehensive programme, the structure also makes it easier to follow patients' daily activities and the progress of their treatment.

"Treatment structure is closely linked to a set of rules – a regimen," Dvořáček continues (2003, p. 196). "In addition to defining the structure and rules necessary to maintain an ideal therapeutic environment, the regimen also allows for benefits and sanctions, depending on the extent to which the regimen is observed. (…) The majority of the treatment facilities try to objectify and evaluate the way in which the patients cope with the structure and the regimen, mostly using a scoring system. In its elaborated form, the scoring system involves a set of rules against which compliance with structured treatment is evaluated using positive and negative points which entail various advantages or disadvantages for the patient or the group he or she belongs to (as well as the community). In this form, the scoring system serves as one of the tools used for the weekly evaluation of the course of treatment."

### 11.1.5 Referral and Follow-up

Patients are usually referred to medium-term treatment by outpatient physicians; motivated patients with a relevant diagnosis may also be admitted without a medical referral.

Dvořáček (2003) suggests that a specific aftercare plan is a key element of the final stage of the therapy. Some patients join long-term programmes provided by therapeutic communities or various intermediary programmes (such as aftercare centres with sheltered housing and day care facilities) after they have finished medium-term treatment. However, such services for clients in recovery from legal substances are scarce. They thus usually return to their original environment, where aftercare is provided in the outpatient form. Some treatment facilities organise aftercare groups for their former patients, as well as providing "booster stays" as elements of aftercare, usually within the first year of recovery, or later, as appropriate.

## 11.2 Therapeutic Communities – the Sananim Model

### 11.2.1 Historical Background

The first therapeutic community (TC) for drug addicts in the Czech Republic was founded by Dr. Martina Těmínová and her co-workers from the SANANIM civic association in the village of Němčice, South Bohemia, in 1991. At that time it was becoming obvious that the Apolinar model of alcohol dependency treatment was not really suitable for young people with immature personalities who had developed an addiction to illicit drugs. The Němčice therapeutic community was established in order to offer a new service to this emerging and growing group of clients.

The founders of the Němčice TC were young special education professionals with a background of working in youth institutions. They established the community on a non-healthcare basis, as a facility with a focus on social rehabilitation and education, featuring a psychotherapeutic element. In part, they drew inspiration from their knowledge of "hierarchic" therapeutic communities for drug addicts, but they also made good use of the national tradition of "democratic" therapeutic communities, which they espoused.[166] It was this tradition that provided the natural professional basis for the development of communities for drug addicts in the Czech Republic. Professional expertise was emphasised from the very beginning. Therapeutic communities founded by ex-users were rare and were either closed down or professionalised over time.

The Sananim model (Těmínová, 1997) became an example to follow for a number of other communities for people dependent on illegal drugs that came into being in the 1990s. A total of 20 therapeutic communities were established during that period; some of them ceased to exist, others have stayed away from the mainstream providers of professional care. The data on the current numbers of these facilities vary according to different sources[167] – the

[166] Foreign TCs for drug addicts that served as model examples included the North American Daytop Village and Phoenix House projects, and also MONAR in Poland. The domestic tradition was represented especially by the Lobeč and Palata psychotherapeutic communities, Kratochvíl's centre at the Kroměříž Psychiatric Hospital, and, last but not least, the SUR psychotherapeutic training communities (Kalina, 2008b; Kalina, 2011).

[167] Kalina refers to 13–14 therapeutic communities of this type (Kalina, 2006; Kalina, 2007a; Kalina, 2008b). The chapter Drug-Related Treatment: Treatment Demand and Treatment Availability (Table 5-3) indicates 15–20 TCs; 14 programmes identified as therapeutic communities are listed by the Register of Social Service Providers maintained by the Ministry of Labour and Social Affairs, 9–10 programmes receive support from the Government Council for Drug Policy Coordination as part of its subsidy proceedings, the

members of the Therapeutic Communities Section of the Association of NGOs,[168] i.e. 11 therapeutic communities with an overall capacity of 490 beds, may be regarded as the mainstream providers of these services; see Table 11-1.

There are at least five additional establishments in the Czech Republic that refer to themselves as therapeutic communities. They were created on an ex-user or religious basis and maintain contact with neither the professional community nor public authorities. Apart from the often misleading information posted on their websites, nothing is known about them and they are generally regarded as not being credible in professional terms, which does not necessarily mean that they cannot be useful.

The broader circle of therapeutic communities may also be seen as including five residential special education establishments for juvenile substance users with emotional and behavioural problems, with a total capacity of 68 beds; for more details see the chapter Specialised Departments in Residential Special Education Facilities (p. 81). In fact they represent the type of services where the idea of therapeutic communities for drug addicts in the Czech Republic was conceived in the 1990s. Most of these facilities show close links to the Sananim model and apparently developed under its influence. Their staff, or managers at least, are in contact with the professional community. Nevertheless, such services do not meet the criteria for residential treatment models as envisaged in this chapter.[169]

*Table 11-1: Therapeutic communities for drug addicts in the Czech Republic associated in the Therapeutic Communities Section of the Association of NGOs*

| Name | Municipality | Region | Provider |
|---|---|---|---|
| TK Advaita | Nová Ves – Chrastava | Liberec | Advaita, a civic association |
| TK Fénix | Bílá Voda | Olomouc | Bílá Voda Psychiatric Hospital |
| TK Fides | Bílá Voda | Olomouc | Bílá Voda Psychiatric Hospital |
| TK Krok | Kyjov | South Moravia | Krok, a civic association |
| TK Magdaléna | Mníšek pod Brdy | Central Bohemia | Magdaléna, a public service company |
| TK Podcestný mlýn | Kostelní Vydří | South Bohemia | Sdružení Podané ruce, a civic association |
| TK Renarkon | Čeladná | Moravia-Silesia | Renarkon, a public service company |
| TK Karlov | Karlov – Čimelice | South Bohemia | SANANIM, a civic association |
| TK Němčice | Němčice u Volyně | South Bohemia | SANANIM, a civic association |
| TK Sejřek | Sejřek | Vysočina | Kolpingovo dílo, a civic association |
| TK White Light | Mukařov – Úštěk | Ústí nad Labem | White Light I., a civic association |

In the last decade some therapeutic communities have catered to certain types of clients with specific needs, including mothers with small children, very young clients, long-term users with a criminal history, and clients with dual diagnoses.

Therapeutic communities are generally said to have their own peculiar culture and distinctive identity (see Kennard, 1998). This also largely applies to the Czech TCs for drug addicts, which came into being in new times, as autonomous projects, with no guidelines recommended or required on a top-down basis. Despite the above-mentioned diversity of character, the therapeutic communities' operation shows rather converging tendencies that are facilitated by meeting together as part of the activities of the Therapeutic Communities Section of the Association of NGOs, joint events, and impressive publication activities in the past decade. It does make sense, therefore, to talk about a model, despite certain inconsistencies.

### 11.2.2 Latest Developments

The Sananim model is based on an *interdisciplinary, bio-psycho-social* approach.[170] Institutionally, it falls within the sector of social services for administrative reasons. With several exceptions, therapeutic communities are registered as social services, operated by NGOs (civic associations and public service companies), and receive financial resources from national and regional public subsidies. However, the formal affiliation of therapeutic communities with social services reflects neither their distinctive identity, nor the real nature of the activities they are develop.[171] The policy document covering addiction health services stipulates that in the light of the comprehensive approach to patients embraced by addictological services it is insufficient to define the nature of therapeutic communities from the social perspective only (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012).

In terms of the ASAM criteria (ASAM, 2006), this type of treatment should be carried out *under medical supervision*; a physician-psychiatrist or a specialist in addiction medicine is not generally the head of the facility, but a member of

Therapeutic Communities Section of the Association of NGOs has 11 members, and the 2012 Drug Services Census recorded 16 facilities that claim to operate a therapeutic community programme.

[168] http://www.terapeutickekomunity.org (2012-07-07)

[169] They involve the application of therapeutic community approaches in residential educational facilities ("TC approach" according to Kennard, 1998), which cannot be regarded as "treatment".

[170] In Czech addictology, the three-dimensional bio-psycho-social notion of a human being, illness, and treatment according to the WHO is expanded to include a fourth dimension – the spiritual or existential one.

[171] Indeed, some therapeutic communities for drug-dependent individuals exist within the healthcare modalities of psychiatric hospitals.

the team or a contracted consultant. The therapeutic team is typically multidisciplinary, comprising both health and non-health professions (Adameček et al. 2003; Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012). The new paramedical (health, non-medical) profession of an addictologist has been gaining significance within the therapeutic communities' teams recently, as the involvement of these practitioners draws therapeutic communities nearer to the bio-psycho-social model of services grounded in health care, which is where they belong much more than to the less comprehensive social model.

As regards duration, it is referred to as *medium-term to long-term residential treatment* lasting 6–12, or up to 15 months (Adameček et al. 2003; Kalina, 2003). The planning of the length of treatment is sometimes made with the needs of specific client groups being taken into consideration, e.g. six months for juveniles and young adults, eight months for dependent mothers with small children, and 12 months or more for older long-term users. A 12-month programme, nevertheless, is generally regarded as a mainstream standard. In a specific community, the length of the programme is not flexible. It is set in advance and is a subject of the contract with the client.[172]

A therapeutic community-based treatment programme of any duration is always divided into "stages" (see further below).

As for the nature and focus of the treatment, therapeutic communities are drug-free and are intended to promote and motivate their clients to a drug-free life; the term "abstinence-oriented treatment" is also used in relation to this approach. Although, similarly to the Apolinar model, their immediate goals are to achieve and maintain abstinence, stabilise the patients' psychological and physical conditions, and reintegrate them into the community to the greatest degree possible, (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012), therapeutic communities place a greater emphasis on personality changes (involving growth, maturing, and the influencing of underlying personality problems that contribute to the development and maintenance of addiction) and lifestyle-related changes; abstinence is not the aim, but a vehicle to achieve those changes, a precondition that needs to be met, although not sufficient in itself (Adameček et al. 2003; Kalina, 2008b); (Kalina, 2008a) Skála defined the notion of abstinence in similar terms (1987).

The comprehensive structured programme[173] encompasses therapeutic activities involving psychotherapy (mainly group therapy), education, and social reintegration-related and leisure activities. In comparison to the Apolinar model, much more stress is placed on self-help and self-management, which mostly involves the clients' participation in, and responsibility for, the everyday life of the community. Medical interventions, including pharmacotherapy for mental problems, are common and necessary given the structure of the clients (see further below). Various forms of work with clients' family members and significant others are also common.

Therapeutic communities in the Czech Republic are primarily intended for users of illicit drugs. Similarly to illicit drug users in psychiatric hospitals, in therapeutic communities, too, users of methamphetamine outnumber those of opiates/opioids (the ratio ranging from 2:1 to 3:1, depending on the region). The rate of cannabis and cocaine users is very low. While clients who are dependent solely on alcohol or pills are rare in facilities funded by public subsidies, the number of polydrug users, both legal and illegal drugs, sometimes also in combination with gambling, seems to be rising. The rate of dual diagnoses in terms of psychiatric comorbidities is reported to be from 30 to 50% according to different sources (Miovská et al. 2008; Kalina et al. 2012).

### 11.2.3 Treatment Goals

To a great extent, the immediate goals of the treatment provided by therapeutic communities coincide with what Dvořáček (see above) stated in relation to medium-term treatment of the Apolinar model. According to Adameček et al. (2003), abstinence is not the aim of treatment in a therapeutic community, it is only a way, a means and an integral part of recovery. It is the precondition for the client's future reintegration into normal life. Treatment in therapeutic communities aims towards a change in lifestyle which may be achieved through personality growth and a change in self-concept, experiencing, behaviour, and relationships.

The above-cited authors point out the following partial goals, or objectives, of treatment in therapeutic communities:

- to empower clients, enhance their resilience and coping skills, and prepare them to "fight craving" on a daily basis,
- to change clients' patterns of self-destructive thinking and behaviour,
- to promote the development of clients' sense of personal responsibility for themselves, their decisions, and other people,
- to develop a sense and feeling of human community among clients,
- to help clients learn basic social skills, communication skills, and conflict management skills,
- to help clients adopt work and hygiene routines,

[172] The client makes an informed entry into a treatment programme of a specific duration. At the final stage of treatment, nevertheless, earlier completion without the completion ritual and progress to aftercare are often negotiated on an individual basis.

[173] As in the Apolinar model, this term refers to a programme consisting of a minimum of 20 hours of structured activities per week distributed over a minimum of five days (Adameček et al. 2003; Kalina, 2003).

- to promote changes in clients' negative self-concept and encourage their self-acceptance and the adoption of realistic self-perception,
- to provide an environment in which a human being can grow, assume responsibility, and engage in personal development,
- to promote clients' awareness of the importance of their health and the improvement and maintenance of their physical condition.

Highlighting the existential dimension of treatment and recovery, Richterová Těmínová postulates the aims of therapeutic community-based treatment as follows (Richterová Těmínová, 2007):

- to promote clients' finding and accepting the meanings of their own lives,
- to promote clients' finding their own freedoms and responsibilities,
- to promote clients' knowing and accepting themselves and their potential and limits,
- to promote clients' personal growth, development, and confidence,
- to promote clients' finding their place within a community of people,
- to promote clients' developing positive and creative life attitudes,
- to contribute to clients' contentment and happy lives,
- to promote clients' developing and improving the knowledge, abilities, and skills needed to achieve their personal goals.

### 11.2.4 Treatment Process and Strategy

The client's stay in a therapeutic community is divided into four stages (an extra zero stage is common in the Czech Republic) which correspond to the progress of their treatment. Each stage is also associated with expectations as to what the clients are capable of and their responsibilities ensuing from their functioning and the roles they have in the community (Adameček, 2007; Kalina, 2008b).

The therapeutic drug treatment community model and method are thoroughly described in the professional literature (De Leon, 2000; De Leon, 2001; De Leon, 2005). Despite their different tradition, Czech therapeutic communities generally fit within this universal framework. They are, however, less "hierarchic", less confrontational, and managed on a more professional basis. This may be demonstrated by the fact that Czech therapeutic communities do not use the confrontational Synanom Encounter technique,[174] but their psychotherapeutic work stems from group psychotherapy based on psychodynamic and interpersonal approaches, complemented by the flexible utilisation of cognitive-behavioural methods.

While the scoring system in the form peculiar to the Apolinar model is not used, therapeutic communities apply a few fundamental "cardinal" house rules: no drug use or any handling of them, no violent behaviour, submission to the community's decisions, and no sexual relationships. The violation of any of the cardinal rules results in a client's being expelled from the programme. In addition to the above, there are other rules, the violations of which result in less severe sanctions; each case is openly discussed, and it is the group feedback rather than sanctions that has an impact on the client's inappropriate or dysfunctional behaviour (Adameček, 2007; Kalina, 2008b).

### 11.2.5 Referral and Follow-up

Admission to a therapeutic community does not require medical referral. Common referral sources include low-threshold drop-in centres, which also perform pre-treatment counselling and motivational interviewing and, in general, serve as screening facilities. The precondition for referral is the client's undergoing of institutional detoxification immediately prior to their entering a therapeutic community. Other referrals include clients who decide to undergo treatment in a TC during or after their medium-term treatment in a psychiatric hospital.[175] Under all circumstances, however, any applicant for admission to a therapeutic community must show a personal interest and send a cover letter and CV. There are waiting lists for practically all the therapeutic communities.

After completing their treatment in TCs, clients are usually referred to aftercare centres, where they can also use the offer of sheltered housing. The repeated treatment episode common in the Apolinar model (see above) is rather exceptional in therapeutic communities.

## 11.3 Comparing the Apolinar and Sananim Models

In terms of the quality and effectiveness of treatment, both models display mutual differences which are largely associated with the requirements placed on service providers on the part of the government authorities, including care funders. The characteristics of both models are summarised in Table 11-2.

[174] An encounter group technique applied in the first therapeutic communities for drug addicts in the USA.
[175] Neither short-term nor medium-term institutional treatment is, however, a precondition for entering treatment in a therapeutic community (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012).

*Table 11-2: Two models of residential treatment in the Czech Republic*

| Indicator | Specialised units in hospitals and treatment institutions | Therapeutic communities |
|---|---|---|
| Sector – providers | Hospitals and psychiatric institutions managed by the central or local governments and other legal entities | Mostly not-for-profit non-governmental organisations |
| Registration | Health services | Mostly social services |
| Funding | Public health insurance | National and regional subsidies |
| General description of the model | Medical, bio-behavioural | Interdisciplinary, bio-psycho-social |
| Type of treatment according to ASAM | Medically managed treatment | Medically supervised treatment |
| Patients/clients | Users of both legal and illegal drugs | Users of illegal drugs |
| Length of treatment | Medium-term: 3–4 (up to 6) months | Medium- to long-term: 6–15 months (mostly 12) |
| Quality assurance system | Public hospital accreditation | Certification of professional competency<br>Inspection of social services |
| Special standards | Non-existent in the accreditation system | The certification system includes a special standard for therapeutic communities |
| Independent supervision | Rare | Common, required |
| Process and outcome monitoring | Rare | Regular |
| Relationship with the general therapeutic community model | Use of certain approaches and principles | Full use of the TC model and method |

### 11.3.1 Quality Assurance

As providers of health services, since April 2012 specialised addiction treatment units in hospitals and psychiatric institutions have been governed by the stipulations of a new legal regulation, Act No. 372/2011 Coll., which introduces both obligatory internal evaluation of quality, to be performed by an organisation that is a provider of health services itself, and voluntary external evaluation of quality, which may be performed only by a competent individual who posses an authorisation issued by the Ministry of Health.

The internal evaluation of quality is covered by a methodological guideline entitled the Minimum Requirements for Establishing an Internal System of the Evaluation of the Quality and Safety of Health Services. The external evaluation of quality in inpatient healthcare facilities is generally regulated by Decree No.102/2012 Coll., on the evaluation of the quality and safety of inpatient health care. No decree in relation to outpatient services has been issued yet.

Until recently the external evaluation of quality in Czech healthcare facilities was carried out under the departmental health care quality and safety programme which had formulated quality standards for hospitals and treatment institutions audited by the Joint Accreditation Commission (SAK), a public service company, as part of its accreditation process. The Joint Accreditation Commission is always concerned with a hospital or treatment institution as a whole and mainly looks into areas such as the necessary human and technical resources, records management and security, sanitation and the prevention of hospital infections, and the observation of patients' rights. The accreditation system of the Joint Accreditation Commission (and the system of public health care in general) does not encompass any regulation or standard that lays down how drug rehabilitation should be performed so as to be effective. Thus, there is no benchmark for assessing whether a unit meets the criteria for good practice in addiction treatment. Neither have the public health insurers which reimburse the treatment established and applied such criteria.

Therapeutic communities that apply for public funding must have their professional competency certified according to the relevant standards of professional competency for drug services (the so-called GCDPC Certification Standards); see also the chapter Drug-Related Treatment: Treatment Demand and Treatment Availability (p. 55) and the respective Selected Issue chapter in the 2009 Annual Report. The General Part of the Standards concerns basically the same parameters as the accreditation requirements of the Joint Accreditation Commission. The Special Part, however, includes a standard for residential treatment in therapeutic communities, executed as a set of specific good practice criteria for this type of treatment which a facility must comply with in order to be certified.

The Special Part of the Certification Standards also contains a standard for medium-term institutional treatment, i.e. for the Apolinar model, but this remains basically unused; only two programmes hold valid certificates[176] – see Table 5-4 on page 59. Hospitals and treatment institutions do not generally apply for certification, as they do not demand

[176] It is symptomatic that this applies to the men's and women's units of the Apolinar centre.

subsidies, so it is not known to what extent the specialised units following the Apolinar model are in fact compliant with the applicable standard.[177] On the other hand, certification has been passed by some therapeutic communities which do not rely on subsidies.

Therapeutic communities registered as social facilities are subject to mandatory inspection of social services (see also the relevant Selected Issue in the 2009 Annual Report). However, this process involves no specific criteria for good practice of therapeutic communities and its true relevance for the professional quality of their services is debatable. The sharing of experience and feedback among fellow-practitioners within the professional platform provided by the Therapeutic Communities Section of the Association of NGOs appears to be of much greater significance in this respect. It is noteworthy that the Apolinar model has been dramatically lacking such a facility recently.

### 11.3.2 Independent Supervision

Independent qualified supervision is another means of assuring and enhancing the quality of professional services.

In Czech therapeutic communities (as in other addiction treatment professional services provided by non-governmental organisations), supervision has enjoyed a long tradition and advanced culture (Broža, 2009). First and foremost, supervision is performed by supervisors who have received training in integrated supervision provided by the Czech Institute for Supervision under the international aegis of the European Association for Supervision (EAS). Since 2005 supervision has been required by the certification standards, but both providers of services and funders had discovered its importance long before that. As in many other cases, it was NGOs that pioneered good practice in this area.

In the Apolinar model, this type of supervision was rare for a long time; with several exemplary exceptions, it was met with mixed feelings or even rejected as incompatible with the traditional structure of hospitals and treatment institutions featuring a hierarchy topped by the head physician vested with exclusive competences of professional supervision in his or her workplace. The situation seems to have undergone certain changes in recent years as head physicians have come to terms with the idea that independent supervision may be useful.

### 11.3.3 Treatment Process and Outcome Monitoring

Therapeutic communities collect detailed statistical data about their clients and the services they provide and report their aggregates to donors. Some of these data are also used to monitor the process and outcomes of treatment and thus provide relevant information indicative of the level of effectiveness of the treatment (including that about retention rate, early termination of treatment during the first period of the stay, and time spent in the programme; see the chapter Therapeutic Communities for Drug Users (p. 80), Table 5-30. While beneficiaries of public funding are required to collect and report such data, therapeutic communities also use them for their own purposes as feedback on their performance. The Therapeutic Communities Section of the Association of NGOs uses and discuss these data too.[178] Some TCs also carry out follow-up surveys which are subsequently published in their annual reports. Formal research studies have also been conducted (Kalina, 2007a; Kalina, 2007b; Šefránek, 2012); see also the chapter Therapeutic Communities for Drug Users (p. 80).

In comparison to the targeted reporting mentioned above, statistical data from the Apolinar-type residential treatment units are available from the general National Register of Hospitalisations, which records only some of the data reflecting the treatment process and outcomes, including the length of hospitalisation, the reason for the termination of hospitalisation, and the need for follow-up care after discharge (Nechanská, 2012c). However, the specialised addiction treatment units perform no monitoring of their own, and neither their managing agency (Ministry of Health) nor public funders (health insurers) require this practice from them. Follow-up surveys or research studies are virtually non-existent, despite the fact that Skála's *Apolinar* was a facility that pioneered research into the effectiveness of addiction treatment prior to 1990. It is therefore very difficult to assess whether, and to what extent, the Apolinar model works.

### 11.3.4 Scoring System

The scoring system represents a specific tradition and almost an identifying symbol of the Apolinar model. It may be seen as an equivalent of the conventional behavioural "token economy", currently known as contingency management (Gossop, 2009). In comparison to these well-established schemes, the Apolinar scoring system features negative points associated with sanctions, which the behavioural approaches to addiction treatment regard

[177] While Dvořáček (2003) considered the preliminary version of the standard for medium-term institutional treatment authoritative, the credit of these standards has somewhat declined since then. Certification is considered an entrance ticket to certain funding programmes rather than a token of quality. Nevertheless, the Society for Addictive Diseases of the J.E. Purkyně Czech Medical Association endorses the Certification Standards (Společnost pro návykové nemoci ČLS JEP and Klinika adiktologie 1. LF UK a VFN v Praze, 2012) and is considering assuming greater responsibility for the process of certification, which has hitherto been in the remit of the Government Council for Drug Policy Coordination.

[178] Recent discussions concern the circumstances under which treatment in a therapeutic community may be considered "successfully completed": whether this applies to treatment completed with a ritual after Stage 3 or whether it also covers the so-called "planned departure" for medical, employment, or family reasons during Stage 3, where the client may pass the completion ritual later after he or she has successfully completed an aftercare programme.

as counterproductive (Rotgers, 1999). Scoring systems tend to be very complex; usually only the staff can make sense of them. Points are scored automatically. In some establishments, a patient may be discharged from treatment after exceeding a certain threshold number of points, irrespective of the severity of the instances of their non-compliance with the regimen. Even its founder would make critical comments about the scoring system (Skála et al., 1987). Dvořáček (2003) suggests that it may end up causing an imbalance between penalties and rewards and, from a certain moment (particularly when sanctions accumulate), the loss of its therapeutic effect. Both criticism and advocacy of this tradition were summarised by Mladá (2012), who also reported that some units had already abandoned the practice of scoring systems (Mladá, 2012).

Therapeutic communities have not been using this scoring system at all, as it is considered incompatible with the principles of a therapeutic community and its effectiveness is not evidence-based.

### 11.3.5 Application of the Therapeutic Community Principles

Both Czech models of the residential treatment of drug addiction have subscribed to the therapeutic community approach, although their specific history, background, and sources make them distinct from international developments and, mutually, each other. The question is to what degree both models apply the TC principles and approaches, what their profile is, and, accordingly, to what extent the requirements for the provision of standard treatment with proper results are met.

This question was explored as part of a survey undertaken by Kalina in 2006 (Kalina, 2006; Kalina, 2007a). The survey was based on a cumulative questionnaire compiled from two inventories – the SEEQ scale (De Leon and Melnick, 1993) used to cover the items relevant for "generic" therapeutic communities for drug addicts in the USA, and the KLAC checklist intended for European TCs focusing on personality and behavioural disorders, particularly on severe mental disorders without the involvement of addiction issues (Kennard and Lees, 2001). The questionnaire was completed by a total of 24 residential treatment facilities, including 13 therapeutic communities for drug addicts and 11 specialised hospital-based units embracing the Apolinar model and, accordingly, the principles of a therapeutic community. Only the major findings are presented below.

The vast majority of therapeutic communities was found to be in compliance with the internationally recognised criteria for therapeutic communities for drug users to a high standard and most of them also attained satisfactory results in terms of the internationally recognised criteria for therapeutic communities addressing personality and behavioural disorders.

Only about a half of the specialised hospital-based units (6 out of 11) reached satisfactory or high levels of compliance with the internationally recognised criteria for therapeutic communities for drug users, and only a minority of them (4 out of 11) met the internationally recognised criteria for therapeutic communities intended for personality and behavioural disorders to a satisfactory degree. Differences from therapeutic communities were found especially in the domains relevant to the appropriate therapeutic approach to dependent individuals and the comprehensive approach to the treatment of clients with multiple mental health problems.

For example, significant differences were found in the items pertaining to the understanding of substance misuse, the nature of addiction and patients'/clients' problems, and treatment goals (Table 11-3) and in the items that concern the understanding of the general community and team processes, such as open communication, the accountability and transparency of decision making, maintaining boundaries and security concerns, the mutual learning process, and intensive teamwork.

The results suggest that the therapeutic communities can provide standard addiction treatment with the expectations of certain results, as well as being able to address the ever more complex problems displayed by their clients (including dealing effectively with the issue of the integrated treatment of dual diagnoses). In comparison to therapeutic communities, specialised drug addiction units of the Apolinar type show fewer characteristics of the effective profile which is a prerequisite for standard treatment with predictable results and fewer characteristics indicating their capacities to cope with the psychological complications of addiction.[179]

Naturally, today's Apolinar model is not a pure therapeutic community, much as the founder of *Apolinar* was a devotee of this concept (see Skála, 1987); it rather corresponds to the "TC approach" modality (Kennard, 1998).[180]

[179] The latter finding, in particular, is striking. One would expect the opposite, given the medical and psychiatric background of the Apolinar model. Nešpor, a leading author concerned with this area, confirms that the integrated treatment of dual diagnoses, i.e. treatment provided by a single team within a single programme, is preferred to other forms, such as concurrent or subsequent treatment (Nešpor, 2003). He adds: "The treatment of a dual diagnosis patient also places specific demands on the team and interdisciplinary liaison. Not only does this apply to the team's theoretical preparation but also to greater flexibility, higher tolerance of frustration, and good communication and collaboration between physicians, psychologists, social workers, and other practitioners." The experience of psychiatrists working with therapeutic communities (as learnt from discharge reports and clients' statements) indicates that the treatment units following the Apolinar model do not pay much attention to the integrated treatment of dual diagnoses (with the exception of the symptomatic administration of psychopharmaceuticals, mostly little justified in diagnostic terms) and often refuse to accept dual diagnosis patients or discontinue their treatment.

[180] The author distinguishes between "TC proper" and "TC approach", i.e. the application of certain approaches in different contexts. This does not necessarily reduce the value of the "TC approach" modality, especially in view of the fact that, in the Czech Republic, no

Dvořáček (2003) notes that the application of TC approaches in medium-term institutional treatment always involves a compromise between the principles of a therapeutic community and the traditional hierarchical system of inpatient healthcare facilities. The author further states: "Given the specific characteristics of medium-term treatment (including the relatively high rate of patient turnover, less screening for eligibility for admission, and the medical nature of the facility), only some features that are typical of therapeutic communities can usually be retained."

*Table 11-3: Items showing the greatest differences between therapeutic communities and hospital-based specialised units (the first 10 items of the SEEQ inventory)*

| **A** | **View of the Addictive Disorder** |
|---|---|
| 1 | Substance abuse reflects a general problem of coping. |
| 2 | Substance abuse is a disorder of the whole person. |
| 3 | Substance abuse is a symptom, not the essence of the disorder. |
| 4 | The treatment problem to be addressed is not the drug, but the person. |
| **B** | **View of the Addict** |
| 1 | Substance abuse stems from other, more general problems, such as psychological and developmental ones. |
| 2 | Immaturity, conduct or character problems, and low self-esteem are typical psychological features of substance abusers. |
| 3 | The pattern of drug use is less important than the psychological and behavioural disorders. |
| **C** | **View of Recovery** |
| 1 | Recovery involves a global change in self-esteem, behaviour, and lifestyle. |
| 2 | Recovery involves the development of a personal identity and global change in lifestyle, including conduct, attitudes, and values. |
| 3 | Abstinence from psychoactive drugs is a prerequisite for sustained recovery. |

### 11.4 Conclusions

Alongside the traditional Apolinar model, another, autonomous residential treatment model has been formed in the past twenty years. Despite their mutual differences, or, perhaps, thanks to them, these two models of residential care for drug addicts in the Czech Republic provide a unique opportunity to choose for patients/clients seeking treatment and for case management.

Both models have experienced rather dynamic developments during the past twenty years. The Apolinar model opened itself up to clients dependent on illegal drugs and learnt to work with them. It embarked on the road leading from the bio-behavioural model towards a more comprehensive one and from its somewhat self-contained nature to greater interdisciplinary and interagency liaison, which is what Skála always visualised and wished for (see Skála, 1987). The Sananim model of autonomous therapeutic communities steered a course from its initial enthusiasm and rebelliousness to professionalism, from a model based on psychotherapy and education to one involving a more comprehensive approach, and has gained acceptance from the professional community and learnt to collaborate both inside and outside the healthcare framework. The bio-psycho-social (and spiritual or existential) model of addiction and the principles of a therapeutic community are the factors that have made these two residential treatment modalities close to each other at present. The overcoming of differences and barriers, collaboration, and closer contacts are a promising trend.

The comparison made in this chapter may imply that, from a certain perspective, therapeutic communities seem to enjoy a higher level of professional culture and to be able to offer more comprehensive and individualised care than the specialised units of the Apolinar type. Such an impression may be strongly misleading. It may only be concluded that some criteria discussed in this chapter suggest that the Apolinar model is less transparent. To maintain a greater balance of views, it should be pointed out that the network of Apolinar-model facilities can deliver professional care to an incomparably higher number of patients/clients than the facilities that operate on the basis of the Sananim model.

In particular, the treatment of a significant number of users of legal drugs rests fully on the shoulders of the Apolinar model. The above-mentioned possibility of choice between the two treatment models practically applies only to a segment of the indicated clients – those dependent on illegal drugs. Given the access to treatment in therapeutic communities, discrimination against individuals addicted to alcohol (or pills, inhalants, and gambling, or with other non-substance-related, process addictions) is evident. It arises, however, from the distorted and limited purposefulness of the allocation of public funds. Making therapeutic communities fully accessible to all indicated clients of all the addiction-related diagnostic groups would require multiples of the amounts of subsidies that have been provided until now, which is currently unrealistic. On the contrary, the reduction of public subsidies and public funding in general poses a risk of the stagnation of the development of both models of residential treatment and of a reduction in their availability; see also the next Selected Issue on Recent Trends in Drug-related Public Expenditures and Drug Services (p. 157).

"TC approach" can be found in the vast majority of psychiatric wards of hospitals and mental health institutions other than those intended for drug treatment.

## 12 Recent Trends in Drug-related Public Expenditures and Drug Services

The objective of this chapter is to describe the impact of the global financial crisis, which started in 2008, on the expenditure on drug policy and on supporting drug services in the Czech Republic.

The financial crisis became apparent in the Czech Republic in 2009, when the key macroeonomic indicators began to drop. The subsequent impacts of the restrictive budgetary measures affected the area of drug policy (through the budgets of the ministries, regions, and, consequently, service providers) in 2010 and 2011.

The expenditure from the state budget on drug policy decreased by 1% in 2010, and by another 8% in 2011. The subsidies from the state budget, which are used for funding most preventive, counselling, and low-threshold drug services, were reduced by 10% in 2011. On the other hand, local government authorities allocated 10% more to drug policy in 2010 in comparison with the previous year. However, the impact of the crisis also appeared on this level in 2011, and the actual expenditures from the budgets of local authorities were reduced by 13%. If the expenditures did not include those concerning sobering-up stations, stagnation in terms of expenditures on drug services in local budgets would already have been apparent in 2010.

Intense discussions were held in 2010 and 2011 about the priorities of the subsidy proceedings at the central level, in particular within the Government Council for Drug Policy Coordination. Seven out of fourteen regions reported that the financial crisis affected the drug services in their regions. The regions proceeded by taking individual measures in response to the recession. No consistent approach to defining priorities can be seen across the governmental ministries and the regions. In the sector of drug services, however, the cuts mainly concern primary prevention services, information and research projects, and new projects. Cutting the allocations to all the services across the board is the most common response of the regions to the reduced resources for subsidising drug services.

The most typical response of the organisations to the cuts has been to attempt to preserve the entire range of services, albeit at a lower cost. Staff or payroll reductions have been the most common measure adopted by the providers of the services. Success has been marked so far in maintaining the network of drug services at the local level. Programmes and services are not being closed, also thanks to the resources from the European Social Fund through the so-called individual projects. However, the end of the individual projects at the level of regions in 2012 and 2013 represents a real threat to the network of social services in general, especially where there is uncertainty regarding their continuation or funding after the termination of this major source of funding.

### 12.1 Impact of the Financial Crisis on the Basic Macroeconomic Indicators in the Czech Republic

The financial crisis,[181] which began in 2007 as a mortgage crisis in the USA and spread into other parts of the world, reduced the real GDP and increased consumer prices. Individual countries started adopting various measures to mitigate the impact of the crisis.[182] The states restricted further debt and even adopted rather radical austerity measures on the side of budgetary spending. However, economists have warned that restrictive and austerity measures can contribute to further constraining of economic performance: the lower demand will not generate certain types of budgetary revenues and increasing unemployment will put additional pressure on the items of expenditure of a social and welfare nature.[183]

The Czech Republic entered the crisis with relatively good starting conditions. Driven mainly by external demand, the growth of the economy (with decreasing unemployment) was faster than that in the euro area, and the basic macroeconomic parameters were successfully converging with the Maastricht criteria[184] (NERV, 2009). As early as in autumn 2008, the government adopted the National Anti-Crisis Plan.[185]

2009 was the year when the crisis hit the Czech Republic. The growth of the Czech economy began to decelerate in 2006 but in 2009, the economy was noticeably affected, with GDP dropping significantly in 2009 (minus 4%). The highest year-on-year GDP decrease occurred and the level of investment activity of businesses dropped, as did the investments of households in housing in 2009 (Junková, 2010). Household consumption was reduced significantly and the very first major slowdown occurred in the previously long-term and stable pro-growth impact of household consumption on GDP (Český statistický úřad, 2012a). The unemployment rate rose from 4.4% in 2008 to 6.7% in 2009 and 7.3% in 2010.

According to the Ministry of Finance, the Czech economy will continue to stagnate until 2013. GDP is expected to fall by 0.5% and consumer prices and the unemployment rate are expected to grow further in 2012 (Ministerstvo financí, 2012a).

[181] The term “financial crisis” is not clearly defined in the literature. Banking, currency, debt, and systemic crises are usually referred to as a financial crisis (Junková, 2010).
[182] http://cs.wikipedia.org/wiki/Ekonomick%C3%A1_krize_2007–2010 (2012-09-15)
[183] http://www.businessinfo.cz/cs/clanky/financni-ramec-dopady-ekonomicke-krize-5171.html (2012-09-09)
[184] The criteria for the Member States of the EU to join the Economic and Monetary Union of the EU and adopt the euro.
[185] http://www.vlada.cz/assets/media-centrum/predstavujeme/narodni-protikrizovy-plan.pdf (2012-09-09)

### 12.1.1 Breakdown of State Budget Expenditures by Function

According to the Organisation for Economic Cooperation and Development (OECD), the Czech Republic spent a larger part of its expenditures on health and economic affairs (mainly on infrastructure, including transport) and a lower part on education, general public services, and social prevention programmes in comparison with other OECD countries in 2009 (OECD, 2011).

According to the Czech Statistical Office, the growth of the expenditures in the sector and subsectors of government institutions in 2010[186] stopped at the level of the expenditures made in 2009. In 2009, the expenditures dropped in three areas according to the COFOG classification:[187] defence, environmental protection, and social infrastructure. In 2010, lower government spending was reported in multiple areas but not in the areas of health, education, and social affairs (Český statistický úřad, 2012b)Table 12-1.

*Table 12-1: Development of expenditures in the sector and subsectors of government institutions according to COFOG, current prices (€ million) (Český statistický úřad, 2012b)*

| Type of expenditure | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| Total expenditures | 54,143 | 63,488 | 63,516 | 65,846 |
| Social protection | 16,461 | 19,230 | 19,491 | 20,509 |
| Health | 9,058 | 10,668 | 10,952 | 11,698 |
| Economic affairs | 8,601 | 10,540 | 10,589 | 9,911 |
| Education | 5,924 | 6,900 | 6,841 | 7,207 |
| General public services | 5,578 | 6,522 | 6,769 | 6,957 |
| Public order and safety | 2,645 | 3,049 | 2,961 | 3,046 |
| Recreation, culture, and religion | 1,596 | 1,846 | 1,992 | 2,048 |
| Environmental protection | 1,300 | 1,447 | 1,003 | 1,536 |
| Defence | 1,523 | 1,661 | 1,509 | 1,534 |
| Housing and community amenities | 1,457 | 1,625 | 1,409 | 1,400 |

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

## 12.2 Effects of the Crisis as Perceived by the Inhabitants of the Czech Republic

Global institutions such as the World Health Organisation or the European Parliament have emphasised that the worsened social situation at the time of a crisis compromises the protective factors and, conversely, increases the effects of risk factors: poverty, low education, social deprivation, indebtedness, unemployment, instability, and job insecurity (Světová zdravotnická organizace, 2011). In their declarations, these organisations have warned against a decline in the mental health of the population, including an increase in the suicide rate,[188] and highlighted the need to maintain and reinforce social networks, which should not be disrupted during a time of austerity measures.[189] Despite this fact, solidarity and promoting the integration of marginalised social groups receive the second lowest level of support of all the measures proposed by the European Commission among both Czechs (9%) and EU citizens (11%) (Eurobarometr, 2012).

No comprehensive study was conducted that would specifically deal with the impact of the crisis on the inhabitants of the Czech Republic or on specific population groups such as drug users or their financial, social, or health circumstances. The findings of certain partial studies or the results of certain indicators for the period in which the effect of the financial crisis was apparent are presented below.

### 12.2.1 Mental Well-being and Health of the Population during the Crisis

The “Lifestyle 2010” study was conducted in 2009 on a sample of 965 respondents. It focused on the respondents’ financial situation, family, and perception of the economic crisis. A total of 87% believed that the crisis had already arrived in the Czech Republic. The effects of the crisis which were reported most commonly included unemployment, bankruptcies of businesses, and low purchasing power among the population. Worsened mental condition and uncertainty ranked last among the existing effects of the crisis. As for the future, the respondents mainly expected unemployment to rise, but the negative impact of the crisis on mental health was also mentioned. Up to 72% of the respondents believed that the crisis would change human relations for the worse (TNS Aisa, 2010).

[186] http://www.czso.cz/csu/redakce.nsf/i/vydaje_vlady_podle_funkci_cofog_tab (2012-05-09)

[187] The international COFOG classification is used in the EU to classify the expenditures of national and local budgets; in the Czech version it is entitled “Classification of the Functions of Government Institutions” (CZ-COFOG). This classification is not fully implemented in the system of public administration in the Czech Republic; expenditures are classified using the classification laid down by Decree of the Ministry of Finance No. 323/2002 Coll. on the structure of the budget, the items of which cannot be directly converted to COFOG items.

[188] http://www.zdrav.cz/modules.php?op=modload&name=News&file=article&sid=8796, http://byznys.ihned.cz/trhy-a-investice/c1-31193190-zdravotni-krize-financni-krize (2012-08-19)

[189] http://www.europarl.europa.eu/news/cs/headlines/content/20120618STO47109/html/Za-krizi-plat%C3%ADme-i-pochrouman%C3%BDm-du%C5%A1evn%C3%ADm-zdrav%C3%ADm (2012-08-20)

2011 recorded the highest year-on-year increase (by 11%) in the number of patients treated by psychiatric outpatient centres[190] in the past 10 years (from 498 thousand persons in 2010 to 554 thousand in 2011). This increase was largely (40%) due to neurotic disorders (Ústav zdravotnických informací a statistiky, 2012a). The trend in the number of suicides also reversed in 2008. Their number is relatively low and showed a long-term decrease until 2007 (when there were 1,375 suicides). The highest year-on-year increase in the number of suicides was reported in 2009 and 2011 (an increase by 6%); a total of 1,589 suicides occurred in 2011 (Ústav zdravotnických informací a statistiky, 2012b).

### 12.2.2 The Crisis and the Financial Situation of the Citizens

A study conducted in connection with the crisis in 2012 showed that the financial situation of nearly half of the people was worse than a year earlier and that one in three people thought the situation would get even worse. One quarter of Czechs are living close to the edge as they can hardly make ends meet every month and have no financial reserves. Another quarter has reserves of no more than the amount of their income for one month. If Czechs do have a reserve, they do not like to take chances by engaging in more complex financial operations that would increase the value of their money, which is also due to lower financial literacy. In terms of their attitude to their situation during the current financial crisis, up to a half of the respondents stated that they were doing worse than before but 75% of them admitted at the same time that their spending was the same or even higher than before (TNS Aisa, 2012).

In addition to the studies mentioned above, statistical data show that household indebtedness, the number of consumer loans, the number of cases of personal bankruptcies,[191] and the number of distraint proceedings[192] have all been rising since 2000, and this trend has remained unchanged during the crisis. Household indebtedness has been rising at an even faster rate since 2008, as has the number of personal bankruptcies (Dvořák, 2011).

## 12.3 Drug Policy Expenditures during the Crisis

This section of the selected issue concerns “labelled” allocations, i.e. expenditures from public budgets which were originally earmarked for drug policy or expenditures which otherwise clearly suggest their drug-related purpose. Such expenditures are included in the budgets of the Government Council for Drug Policy Coordination (the Office of the Government of the Czech Republic), the Ministry of Health, the Ministry of Labour and Social Affairs, the Ministry of Education, Youth, and Sports, the Ministry of Justice, the Ministry of Defence, the General Customs Headquarters, and the expenditures of the National Drug Squad. In addition, the expenditures of local (regional and municipal) budgets on drug policy are also available; for details see the chapter Economic Analysis (p. 14).

### 12.3.1 Drug Policy Expenditures from the State Budget

The rate of the year-on-year increase in drug-related expenditure from the state budget has been decelerating since 2006, and the expenditures only increased by 1% in year-on-year terms between 2007 and 2009. 2009 was the last year in which the drug-related expenditures from the state budget increased. They decreased by 1% in 2010, and by another 8% in 2011; see also the chapter Economic Analysis (p. 14).

In 2010, the year-on-year drop in expenditures first affected the ministries[193] involved in law enforcement (Ministry of Justice: a year-on-year decrease of 35%, General Customs Headquarters: a decrease by 34%, and the National Drug Squad: a decrease by 1%). In 2010, the subsidy scheme of the Government Council for Drug Policy Coordination was the only programme among the governmental providers of funding in the area of treatment and harm reduction services to experience a year-on-year decrease (by 12%) in the total amount of financial resources. In 2011, the cuts concerned all the providers except the Government Council for Drug Policy Coordination. The Council managed to have its budget intended for subsidising services for drug users increased on a one-off basis through political negotiations; it was not therefore a systematic and planned solution. In comparison with 2009, cuts occurred in 2011 in the budgets of the Ministry of Justice (by 62%), the General Customs Headquarters (49%), the Ministry of Health (35%), the Ministry of Defence (30%), and the Ministry of Labour and Social Affairs (12%), as well as in the budgets of the National Drug Squad (11%) and the Government Council for Drug Policy Coordination (7%).

With the exception of the National Drug Squad and the General Customs Headquarters, the drug-related expenditures of the individual government portfolios are mostly intended to support organisations which provide

[190] The problems reported included organic disorders, disorders caused by addictive substances, schizophrenia, affective disorders, neurotic disorders, personality disorders, mental retardation, development disorders, and other psychiatric diagnoses.

[191] The possibility of filing for personal bankruptcy and discharge of debt has existed since 2008. The application may only be filed by an individual whose debt does not originate from business activities. However, such individuals must be able to repay at least 30% of their debt within five years. If their application is approved, the individuals are entered in the Insolvency Register and all distraint and recovery proceedings taking place against the person are suspended.

[192] According to the Chamber of Distraint Officers, the debtors are most commonly people aged 20–35 and retired individuals. They are often people with basic education and a lower social status. On the other hand, nearly one third of the distraint proceedings are related to small debts of several hundred Czech crowns, such as fines payable to transport authorities, municipal police forces, or health insurance companies or waste collection fees owed to municipalities. There is one distraint procedure per 14 citizens, on average (Dvořák, 2011).

[193] Until 2009 the development varied among the individual government portfolios. As the total expenditures had grown until that year and as we are examining the financial crisis, we did not focus on analysing the previous period.

services in the areas of prevention, harm reduction, treatment and aftercare, and social reintegration. The subsidies disbursed in 2009 and 2010 remained approximately equal (CZK 206 million; € 8,146 thousand); in 2011, the amount of subsidies spent on drug services from the state budget dropped by 10%.[194] For the comparison, the financial resources for subsidies to non-governmental organisations were generally reduced significantly in 2009 in connection with the financial crisis and the restrictive measures adopted for the state budget (from CZK 6.3 billion = € 253 million in 2008 to CZK 5.6 billion = € 212 million in 2009, i.e. by 11.2%. In 2010, the expenditures increased slightly, by nearly 3% (Rada vlády pro nestátní neziskové organizace, 2012).

Intensified discussions about the priorities or criteria for funding drug services within the subsidy schemes of the individual ministries can be observed during the time of the crisis. This mainly concerns the Government Council for Drug Policy Coordination and the Ministry of Health. The first major and important discussion about defining the priorities of supporting drug services took place in 2010. Because of the cuts in the resources allocated to the subsidy schemes aimed at drug policy programmes, the Ministry of Health decided to eliminate harm reduction programmes (implemented mainly by NGOs) from the group of areas supported in the first round and to support treatment programmes provided by health service providers as a priority. The Government Council for Drug Policy Coordination opened a debate about the issue, and the Ministry of Health allocated an additional CZK 2 million (€ 79 thousand for supporting harm reduction services in the second round; for details see the 2010 Annual Report.

The Government Council for Drug Policy Coordination reviewed its subsidy priorities in 2011. Only NGOs, and no other legal forms of organisations (such as organisations established and subsidised by regions or municipalities), could enter the subsidy proceedings. In the subsidy proceedings for 2011, the Government Council for Drug Policy Coordination decided to support the services provided by drop-in centres, outreach programmes, and outpatient care as a priority. A significant reduction was made in terms of supporting primary prevention projects, service evaluation projects, and projects aimed at providing information; for details see the 2010 Annual Report. The option of supporting new projects was eliminated completely. The discussion of the advisory bodies to the Government Council for Drug Policy Coordination about defining the priorities continued in 2012; see also the chapter Coordination Arrangements (p. 12). Because of the anticipated year-on-year cut in the budget of nearly 22% for subsidies for 2012, the option of a more radical solution was discussed, that involving the exclusion of a selected type of services from the group of the services supported; primary prevention programmes and programmes aimed at drug services in prisons were in danger of being completely eliminated from the subsidy scheme of the Government Council for Drug Policy Coordination. Fortunately, the foreseen cut did not take place, and the impending elimination did not occur in 2012.

Also worth mentioning is the development of the expenditures of the Ministry of Health on the projects implemented as part of the "National Health Programme – Health Promotion Projects" and within the National HIV/AIDS Programme. While in 1997 the Ministry of Health provided almost CZK 24 million (€ 666 thousand)[195] to the projects within the National Health Programme – Health Promotion Projects, the amount was only CZK 1 million (€ 41 thousand) in 2011. This support was gradually reduced and the most significant drop occurred in 2011 (from CZK 4.2 million (€ 166 thousand) in 2010 to CZK 1 million (€ 41 thousand) in 2011, i.e. by 76.1%). The situation is similar in the case of the National HIV/AIDS Programme. While the amount available to the programme was CZK 55 million (€1,525 thousand) in 1997, it was only CZK 3 million (€ 122 thousand) in 2011. The most significant drop, from approximately CZK 20 million (€ 720 thousand) to CZK 9.5 million (€ 381 thousand) (i.e. by 52.5%), occurred between 2007 and 2008.

### 12.3.2 Drug Policy Expenditures from Regional and Local Budgets

The share of drug policy funding from the regional budgets increased continuously from 18.7% in 2006 to 39.4% in 2011.[196] In the long term, municipal funding accounts for approximately 10% of all the expenditures specifically earmarked for drug policy (Vopravil and Běláčková, 2012).

Regional and local expenditures on drug policy were also used to cover shortages or cuts in the drug policy expenditures from the state budget. In 2010, which was the year in which the expenditures from the state budget dropped for the first time, the regional and local expenditures increased against the previous year (by 10%). However, the effects of the crisis became apparent at this level too in 2011, and the actual expenditures from regional and local budgets were reduced by 13%; for details see the chapter Economic Analysis (p. 14).

### 12.3.3 Total Labelled Drug Policy Expenditures

The financial crisis first impacted on the amount of resources specifically earmarked for drug policy in 2011, reducing the total expenditures by 10,1%. If the calculation disregarded the contributions made by the regions for the operation of sobering-up stations, the effects of the crisis would have been apparent a year earlier.

[194] Source: reports on the supported projects involving drug policy programmes and on other activities falling within the remit of the relevant ministries and the Government Council for Drug Policy Coordination in 2009, 2010, and 2011, according to the supporting documents submitted for the meetings of the Government Council for Drug Policy Coordination in the respective years.
[195] Exchange rate from 1999 was used for re-calculation of expenses from CZK to €.
[196] However, it is necessary to take into consideration the increasing ability to identify the drug-related expenditures of regions and municipalities and the improving reporting discipline.

The most significant decrease between 2009 and 2011 occurred in the area of law enforcement (14%), followed by harm reduction (13%), treatment (10%), and aftercare (7%). The figure increased against 2009 in the area of coordination, research, and evaluation: the increase was 67% and can be attributed to the fact that the Ministry of Health included expenditures on research in this category; see the 2010 Annual Report. The expenditures on prevention remained almost the same between 2009 and 2011; for details see the chapter Economic Analysis (p. 14). The latter two areas are most frequently mentioned in discussions regarding the potential savings arising from the reduced amount of resources for subsidies.

The data on the drug policy expenditures are mostly published in current prices, i.e. as the nominal value in the relevant year. However, the idea about the development may be rather different when it is expressed in real figures, i.e. in the constant prices of a given year to consider the actual development of the expenditures (inflation). The drug policy expenditures, converted to constant prices, were published in 2012. The conversion, utilising the factor of the inflation rate, was also applied to the labelled drug policy expenditures on a timeline from 2004 to 2010 (Vopravil and Běláčková, 2012).

Expressed in constant prices, the increase in the drug policy expenditures is much smaller than that expressed in current prices; from 2007 to 2010 the expenditures expressed in constant prices virtually stagnate, and the 2011 drop is huge in terms of constant prices; see Table 12-2 and Graph 12-1.

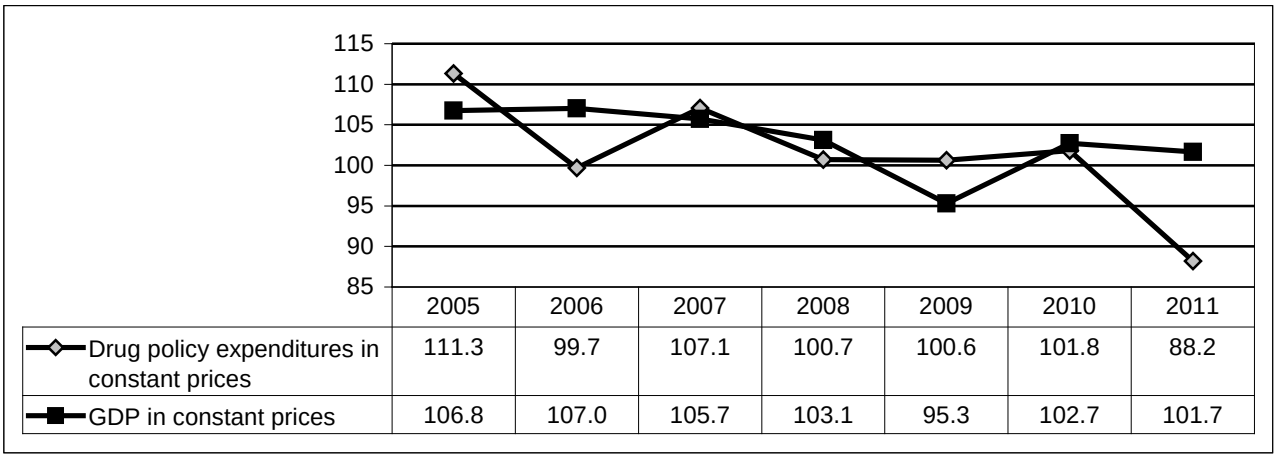
The development of the drug policy-specific expenditures is described in detail in the chapter chapter Economic Analysis (p. 14), including the (estimated) expenditures of health insurance companies on the treatment of drug users in the period 2007–2010.

*Table 12-2: Drug policy expenditures converted to constant prices (Vopravil and Běláčková, 2012; Vopravil, 2012)*

| Indicator | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|
| Inflation rate % (2005 = 100%) | 98.1 | 100 | 102.5 | 105.4 | 112.1 | 113.3 | 114.9 | 117.1 |
| Total drug policy expenditures in current prices (€ million) | 13.7 | 16.7 | 17.9 | 20.1 | 24.0 | 23.0 | 24.8 | 22.9 |
| Total drug policy expenditures in constant prices (€ million) | 14.0 | 16.7 | 17.4 | 19.1 | 21.4 | 20.3 | 21.6 | 19.6 |

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

*Graph 12-1: Index of the year-on-year development of GDP and the drug policy-specific expenditures in constant prices, 2005–2011 (%) (Vopravil and Běláčková, 2012; Vopravil, 2012)*




| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|
| Drug policy expenditures in constant prices | 111.3 | 99.7 | 107.1 | 100.7 | 100.6 | 101.8 | 88.2 |
| GDP in constant prices | 106.8 | 107.0 | 105.7 | 103.1 | 95.3 | 102.7 | 101.7 |

## 12.4 Impact of the Crisis on Drug Services

A questionnaire survey regarding the impact of the financial crisis on the operation and provision of services for drug users took place in 2012. The first part of the survey focused on the regional level and responses were obtained from 13 of the 14 drug coordinators. The second part took place among organisations that provide drug services, and responses were returned by 22 of the 89 organisations invited via e-mail to participate in the survey.

### 12.4.1 Effects of the Crisis at the Regional Level and Its Impact on Decision Making by the Regions in the Area of Supporting Drug Services

According to the responses from the regional coordinators, the impacts of the financial crisis and of the consequent restrictive budgetary measures were most noticeable in 2011 and 2012. The austerity measures related to the financial crisis affected the drug services in seven regions. On the contrary, six regions reported that the financial crisis had not affected their drug services. Prague was the only region to report that the restrictive measures concerning drug policy were more radical than those adopted in other policy areas. Other regions reported that the restrictions concerning drug policy were comparable to those taken in other policy areas of the region. The Olomouc region reported that the restrictions were milder.

As for the restrictive measures concerning drug policy, the regions most commonly reduced the expenditures related to primary prevention programmes. On the contrary, the regional budget remained at the same level for aftercare programmes. As far as other areas (such as harm reduction or outpatient or residential treatment) are concerned, the approaches of the regions vary and no single pattern can be found; while some regions increase the resources for these areas, other regions make budget cuts.

In general, the network of harm reduction services and outpatient and residential treatment programmes has been preserved in most regions and the number of programmes has remained more or less constant in recent years. Four regions even reported an increase in the number of aftercare services. On the contrary, the area of (primary) prevention shows the highest degree of inconsistency across the regions.

As for any future reduction in the funding of the drug policy of the regions, most coordinators stated that it would probably concern all the types of services across the board. Nevertheless, if priorities were defined, harm reduction and outpatient treatment programmes would get top priority, while primary prevention would be given the lowest priority.

Even though the regions do not consider the definition of priorities in their subsidy proceedings to be the ideal solution, certain specific measures can be traced in the regional subsidy schemes. For example, some regions excluded support for research projects from their subsidy schemes (South Bohemia, Moravia-Silesia), limited their support provided to services operating in the entire country or support for coordination activities (South Bohemia), new projects (South Bohemia, Moravia-Silesia, South Moravia), or prevention programmes (South Bohemia, Moravia-Silesia, Prague), or did not support uncertified services (Moravia-Silesia, South Bohemia). Some regions also opposed supporting services for drug users in prisons by external organisations (Vysočina, Hradec Králové, Pardubice, and Central Bohemia) and have announced their intention not to finance them in the future; for details see the chapter Coordination Arrangements (p. 12). In addition, there is also a delay (even though relatively small) in the payment of the subsidies (Prague, Moravia-Silesia). In order to save resources, regions such as Prague also purchase a part of the harm reduction material in bulk for all the organisations that operate drop-in and counselling centres and provide outreach programmes every year. The Liberec region seeks to cover the drop in funding by involving municipal budgets and for this purpose has established a system for the financial participation of municipalities: the municipalities make contributions to the drug services according to a key based on the type and population of the municipality (Liberecký kraj, 2012).

### 12.4.2 Impact of the Crisis on Drug Services and Their Decision Making

Organisations noted the hardest impact of the financial crises in 2010 and 2011. Fourteen out of the 22 organisations that participated in the survey reported that they had been affected by the financial crisis; only three organisations had not observed the impact. As for the range of the services provided in the period 2006–2012, a trend similar to that arising from the survey conducted among the regional coordinators emerges, i.e. primary prevention receiving a lower priority, especially universal primary prevention for schools. Organisations which also provide services other than those intended for drug users reported that the degree to which the services had been limited was not different and that drug services were affected to the same degree as other services.

The most typical response of the organisations to the cuts was to attempt to preserve the entire range of services, albeit at a lower cost. Staff reductions were the most common measure. According to most of the organisations, the current range of services cannot be preserved in the event of further cuts in funding. Three organisations stated that 10% was the maximum level by which the budgets could be cut without the necessity to limit the range of services. The following table shows the responses of the organisations to budget cuts.

*Table 12-3: Responses of organisations in the event of cuts in the available budgets*

| **Response to budget cuts** | **Number** | **%** |
|---|---|---|
| Preserve the full range of services at lower cost | 13 | 59 |
| Staff reductions | 10 | 45 |
| Preserve services by obtaining funding from alternative sources | 6 | 27 |
| Reduce certain types of interventions/services | 5 | 23 |
| Merge services | 2 | 9 |
| Terminate services | 3 | 14 |
| **Total** | **22** | **100** |

In addition, an analysis performed using the final reports on 96 programmes supported by the Government Council for Drug Policy Coordination between 2005 and 2011 confirmed a reduction in the number of staff and full-time equivalents in drug services.

Differences in the development of the number of staff can be observed between different types of services. A sharp drop in 2009, followed by a slight increase in 2010, occurred in the number of full-time employees working in therapeutic communities, outpatient care, and aftercare (31 programmes). In drop-in centres and outreach programmes (50 programmes), this trend occurred a year later. The sharp reduction in the number of full-time

employees in low-threshold services in 2010 was accompanied by a steep increase in the number of external workers. This is most probably related to the attempt to achieve savings on the payroll tax, as one of the respondents to the survey conducted among the organisations confirmed.

Unlike the number of staff, the number of full-time equivalents has decreased since 2009 and this trend has not been reversed for any of the types of services provided. Staff reductions can have a negative impact on the quality of the services provided and can potentially make compliance with the standards of professional competency difficult. For example, the dedicated standard for outreach work specifies that field work in potentially dangerous places and in an unknown environment must always be conducted by two workers, which cannot always be done for financial reasons.

According to the survey, the measures through which drug services respond to insufficient funding include staff reductions, giving an external status to previously internal staff, reducing working hours, limiting the provision of certain interventions (such as hygiene service and testing for infectious diseases), limiting the number of syringes and needles exchanged by a single user as part of an exchange programme, purchasing cheaper material (of a lower quality), or providing some of the harm reduction material for a payment.[197] Large-scale termination or cancellation of services as a result of insufficient funding has not occurred to date.[198] Nevertheless, there were cases in which organisations were merged or programmes transferred to another organisation.

Financing through the so-called individual projects of the regions represented a major factor, which most probably contributed to the preservation or, in some cases, even the development of the network of drug services.[199] These projects, which are administered by regions, are co-financed from the European Social Fund and the state budget. The first wave of the financing of the individual projects started in 2009 and 2010.

However, some individual projects were completed in 2011; most of them are to be completed in 2012 and 2013, which will result in a noticeable gap in the financing of the network of social services, which includes services for drug users. We cannot simply expect this gap to be bridged by an increase in the public budgets, especially the budget of the Ministry of Labour and Social Affairs or regional budgets. For example, a gap of CZK 180 million (€ 7,321 thousand) is expected. The risk of the gap in the funding of social services after July 2012 has also been highlighted by the providers of social services from among church organisations,[200] which expect the drop to mainly concern social prevention services, including those related to sheltered housing, halfway houses, low-threshold facilities providing leisure activities for children in socially excluded communities, social rehabilitation centres, or lodging facilities.[201] Warnings against the termination of social services have also been sounded in other regions: e.g. in Vysočina, the expected gap of CZK 25 million (€ 1,017 thousand) is mainly expected to affect family policy, social prevention, and nursing services.[202]

[197] http://www.streetwork.cz/index.php?option=com_content&task=view&id=3670 (2012-09-10)
[198] Isolated cases involving the termination of services occurred in 2010 and 2011, such as the services of the Nymburk Drop-in Centre of the Semiramis civic association (Central Bohemia region), the Substitution Therapy Centre (Karlovy Vary region), and the Drop-in and Counselling Centre in Uničov (Olomouc region). However, similar isolated cases had also occurred for various reasons in the past.
[199] http://www.esfcr.cz/modules/faq/question.php?id=18 (2012-09-17)
[200] http://www.doo.cz/cs/zpravy/874-charity-varuji-budeme-nuceni-ruit-socialni-sluby-a-propoutt.html (2012-09-14)
[201] Czech charities have analysed the situation in their facilities, warning together that the Ostrava-Opava Diocesan Charity would close 10 facilities and limit another 9 services in 2012, the Silesian Deaconry would close 27 services and limit the services provided by another 20 of its centres, and the Salvation Army would terminate 12 social services in the Moravia-Silesia region during the year.
[202] http://jihlava.nejlepsi-adresa.cz/zpravy/clanky/Poskytovateli-socialnich-sluzeb-zmita-krize-hrozi-zanik-drogove-prevence-i-pecovatelske-sluzby-49 (2012-09-14)

## 13 Drug Policies of Large Cities

This selected issue provides a brief outline of the institutional background and nature of drug policies in the three largest Czech cities: Brno, Ostrava, and Prague.

Traditionally, the regional and local drug policies in the Czech Republic stem from the national drug policy strategy. Those local governments that have their drug policies defined in a special document, such as a drug policy or action plan, can formulate measures aimed at addressing drug use-related problems at the local level in a more focused, comprehensive, and coordinated manner. Out of the cities under consideration, this applies to Brno and Prague. In Ostrava, the drug policy is built into the scheme of community planning. While underlining the social aspect of the issue, such an approach may result in the drug activities being rather fragmentary and difficult to coordinate.

### 13.1 Regional and Local Drug Policies in the Czech Republic

The latest administrative reform in the Czech Republic took place in 2000. Since then the country has been divided into eight areas (NUTS 2) and 14 regions with their respective government authorities (NUTS 3). While the districts as units of public administration were formally cancelled, a number of governmental agencies still have their competencies defined by the former district boundaries. The 2000 administrative reform also introduced municipalities with extended competencies and municipalities with local authorities in which delegated powers are vested. These municipalities have assumed the majority of the competences previously exercised by district authorities.

The Czech drug policy is coordinated on two mutually unsubstitutable levels – the central and regional (local) ones – using the tools of horizontal and vertical coordination. The organisation and implementation of the drug policy at both the central and local levels are laid down in Act No. 379/2005 Coll., on measures for protection from harm caused by tobacco products, alcohol, and other addictive substances. The key means of coordination at the regional and municipal levels include drug coordinators, drug commissions, working groups, and strategy documents.

In some regions (Central Bohemia, Pilsen, Karlovy Vary, Ústí nad Labem, and Moravia-Silesia), the position of a regional drug coordinator also involves other agendas than drugs, although Section 23 (3) of Act No. 379/2005 Coll. explicitly stipulates that "the employment contract with a regional drug coordinator cannot provide for any work responsibilities other than those pertaining to the discharge of the office of a regional drug coordinator". Advisory bodies for the field of drug policy exist in most of the regions; they may take the form of drug commissions of the regional councils (as in Prague, Karlovy Vary, Liberec, and Pardubice) or of advisory bodies to the governors or their deputies (as in Central Bohemia and South Bohemia). Drug policy may also be included in the agenda of other commissions of the regional councils with a broader focus; these are often responsible for a combination of social, health, and public safety issues (as in the Pilsen, Ústí nad Labem, Hradec Králové, Vysočina, Olomouc, and Zlín regions). In the Moravia-Silesia and South Moravia regions, the drug policy issues are dealt with by the Working Group on Drug Prevention as part of the Social Committee of the Regional Assembly and the Working Group on Crime Prevention, respectively. The composition of the advisory bodies varies from region to region. In some regions, the regional drug coordinators are not members of the advisory bodies (Pilsen, Ústí nad Labem, Vysočina, South Moravia, and Olomouc) or act only as their secretaries (Central Bohemia, Karlovy Vary, and Liberec), which may be viewed as a problem in procedural terms.

Coordination at the local level is provided through local drug coordinators. Although they have been appointed in almost all of the municipalities with extended competencies, the vast majority of them deal with multiple agendas and the coordination of the local drug policy-related activities constitutes only a small part of their responsibilities. It may be neither realistic nor meaningful for the coordination of the local drug policy activities to comprise the coordinator's entire workload. However, when their workload involves multiple agendas (more than five in some cases), the coordinators have limited resources to address the drug issues properly and little time for their further education in the field. The municipalities also experience a rapid turnover of the staff members who act as local drug coordinators, which results in the discontinuity of work and limited experience on the part of the people performing this office. This said, the training of the local drug coordinators around the country may be identified as an issue of priority (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2011b). For more up-to-date information on the coordination of the drug policy at the regional and local levels see the chapter Coordination at the Local Level (p. 14).

The following sections describe the content and formal grounding of the local drug policies in the largest Czech cities: Brno, Ostrava, and Prague.

### 13.2 The Drug Policy of the City of Brno

In particular, the drug policy of the city of Brno is formally grounded in the Drug Policy Strategy of the City of Brno for the Period 2011–2014, which was developed by the Working Group for the Assessment of Measures against the Abuse of Alcohol and Other Drugs. An advisory body to the Council of the City of Brno for the issue of substance use, the Working Group (formerly the Drug Commission) is expected to submit specific proposals for measures aimed at addressing drug use-related issues and maintain collaboration with organisations concerned with the drugs

problem in Brno. The four cornerstones of the drug policy of the city of Brno, consisting respectively of the key domains of primary prevention, treatment and social rehabilitation/reintegration, harm reduction, and drug supply reduction, reflect the South Moravia Drug Strategy and the National Drug Policy Strategy of the Czech Republic. The first domain is focused on support for indicated primary prevention programmes targeted at vulnerable groups of children and young people, with an emphasis on the specific needs of the Roma minority. As regards treatment and social rehabilitation, the city of Brno places an emphasis on support for specialised outpatient clinics and family therapy, with a particular focus on children and young people, and for the establishment of a children's detoxification unit, which is currently available in Prague only. As far as drug-related harm reduction is concerned, the Brno strategy also focuses on activities aimed at the target group of children and young adults. The domain of drug supply reduction lies within the competences of the Police of the Czech Republic and the Brno city police and its main goal is to discover pervitin-producing home laboratories and cannabis plantations. In addition, the Drug Policy Strategy of the City of Brno for the Period 2011–2014 articulates the key objectives to be achieved within both the short and long terms. The long-term objectives of particular priority include support for the operation of low-threshold clubs for young people who do not engage in any organised activities, work with children and young people in general, and the maintenance of the existing efficient network of services for drug users. The strategy as a whole appears to be particularly concerned with preventive activities aimed at children and adolescents. The budget of the city of Brno is used to cover an array of services, ranging from primary prevention and harm reduction services to projects focusing on work with drug users serving prison terms (Magistrát města Brna, 2011).

### 13.3 The Drug Policy of the City of Ostrava

In administrative terms, affairs concerning Ostrava's drug policy are within the remit of the Drug and Public Order Commission, which is an advisory body to the Council of the City of Ostrava. The local drug coordinator is not a member of this commission, though. The city of Ostrava has not formulated a drug policy of its own, but this agenda is currently incorporated into the 3rd Ostrava Community Plan for Social Services and Related Activities for the Period 2011–2014, where the drug-related issues are covered by a special chapter. Matters concerning the drug policy are always subject to a three-step approval process: they are first discussed at the level of the Drug and Public Order Commission of the Ostrava City Council and then they are passed on to the City Council and the City Assembly, respectively, for further consideration (Magistrát města Ostravy, 2010). The sections addressing the drug policy cannot be considered as providing a conceptual framework or articulating the key strategic objectives. The part entitled "the Description of Objectives and Measures" consists of an inventory of the existing services that receive support; no strategic objectives of the drug policy for the 2011–2014 period are envisaged in the effective community plan. On the other hand, as early as 1997 the city of Ostrava founded the public service company *Renarkon*, which is now the largest provider of drug services in the region and also provides financial support for various services, ranging from prevention and harm reduction to aftercare. Its outreach work in socially excluded areas of the Ostrava agglomeration may be considered a specific service in this respect. The drug policy of the city of Ostrava is referred to as cross-sectional; the issues in focus concern the clients of social services, as well as the beneficiaries of other activities managed by other working groups of the city of Ostrava. While this scheme has its obvious positive aspects (the drug problem is addressed within a broader social context), the fact that the drug activities are rather fragmentary and thus difficult to coordinate may be viewed as a drawback.

### 13.4 The Drug Policy of Prague, the Capital City

The last section of this chapter deals with the drug policy of the city of Prague and its specific features. In terms of its institutional basis, the situation in Prague does not differ dramatically from those in Brno and Ostrava as described above. There are differences between Prague, Brno, and Ostrava in their respective drug policies which are determined by three factors:

- Prague, the Capital City, also has the status of a region, so its local drug plans function at the same time as regional plans, involving a total of 22 local drug coordinators operating in the respective city districts.[203] The drug coordinators convene at regular meetings held at the Prague City Hall on a monthly basis. The aim of these meetings of drug coordinators is to exchange information about the implementation of the drug policy in the individual city districts and to take coordinated action in response to problems that may have arisen. Last but not least, these sessions facilitate the more effective coordination of services in the domains of prevention, treatment, aftercare, and harm reduction.
- Like other capital cities, Prague, too, has a concentrated drug scene; for more information see the chapter Problem Drug Use (p. 48). Prague also has a special position in that there is a relatively high proportion of problem opiate users there, which results in the need for a specific configuration of services and the drug policy in general; in comparison to the other two cities, Prague's drug policy focuses more on the availability and adjustment of substitution treatment and the provision of appropriate harm reduction programmes, given the high proportion of injecting drug users in Prague. In 2011 four outreach programmes and three drop-in centres focusing primarily on injecting drug users were operating within the limits of Prague, the Capital City. Over two

[203] Drug coordinators have been appointed in the Prague city districts 1 to 22. In addition to drug coordination, their workload mostly includes other agendas, such as crime prevention coordination and social work. The positions of drug coordinators vary in their formal designation, the scope of their workload, and the aggregation of the multiple agendas they are responsible for.

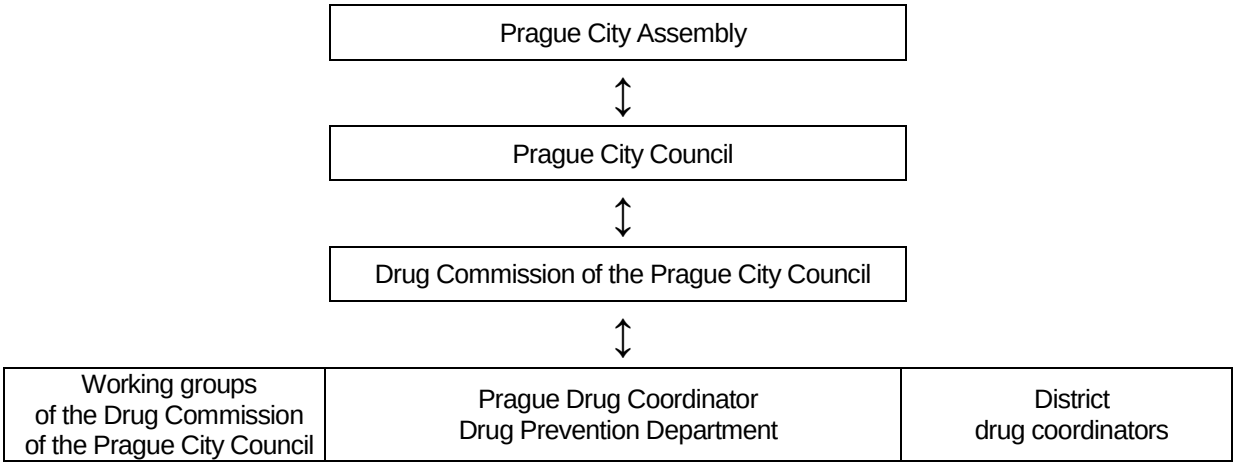
million hypodermic syringes were exchanged as part of these services (40% of the figure for the entire Czech Republic); for more information see the chapter Low-Threshold Harm Reduction Programmes (p. 110).

- Prague is the only Czech city which may be associated with the existence of a major open drug scene. It particularly involves the city centre, specifically Wenceslas Square (300–500 problem drug users per day) and Charles Square. In late 2011 this scene partly moved to the park in the vicinity of the main railway station, where especially intravenous drug use is practised (200–300 problem drug users per day). As indicated by information from outreach programmes, the intensity of open drug scenes and the dynamics of their movement from place to place are largely determined by the location of physicians who prescribe substitution drugs (Subutex®) and pharmacies that dispense such preparations; see also the chapter The Open Drug Scene in Prague (p. 54).

The issue of the open drug scene and the related public nuisance has a bearing on the relationships between the Prague City Hall and the respective city districts. The neighbourhoods faced with the problem of open drug scenes have resorted to steps based on efforts to push problem drug users out of their territories rather than seek systemic solutions. As the local government authorities have only limited opportunities to influence the general orientation of the drug policy pursued in Prague and the general setup of its network of services for problem drug users, the effects of such measures are short-lived and debatable, however immediate and visible they may seem in political terms. In this respect, Prague seems to be lacking coordination mechanisms that would ensure the proportionate deployment of services for problem drug users while remaining realistic and politically accepted.

The institutional and administrative grounding of Prague's drug policy is similar to that used in other cities; see Figure 13-1.

*Figure 13-1: Organisational basis for the implementation of the Prague drug policy (Hlavní město Praha, 2012)*




The central working body is the Drug Commission of the Prague City Council (the Prague Drug Commission), which has the status of an advisory body to the Prague City Council. The staffing of the Prague Drug Commission reflects the recommendations of the Government Council for Drug Policy Coordination. Its members thus include public administration professionals, representatives of service providers, both governmental and non-governmental institutions, and political representatives of Prague. The Prague Drug Commission participate in analysing the situation in Prague, drawing up proposals for both particular and general policy changes, identifying weaknesses in the drug policy system, and in networking the key players in the field of both supply and demand reduction on the territory of the capital city. Four working units were established as part of the Prague Drug Commission. Three of them were established to deal with the respective areas of primary prevention, treatment and aftercare, and harm reduction, and the fourth, the councillor unit, associates the representatives of Prague's districts 1–10. The responsibilities of the Prague Drug Coordinator, who heads the Drug Prevention Department, include the operation and the mutual collaboration of the working groups, the local drug coordinators, and the Prague Drug Commission.

The key documents concerning Prague's drug policy are structured into four-year strategic plans accompanied by two two-year action plans which elaborate on the principles governing the strategy for the period under consideration, as well as providing a detailed breakdown of the tasks to be pursued by the drug policy of the city of Prague. Prague makes use of the action plans to respond to the latest trends and the current situation regarding drug use.

The currently effective 2008–2012 Drug Policy Strategy of the Capital City, Prague[204] follows on from the previous strategy and the then effective 2005–2009 National Strategy; its effective period was also chosen with a view to the EU drugs strategy (2005–2012). As is the case with the national strategy, Prague's strategy is based on four cornerstones, including primary prevention, treatment and social rehabilitation, harm reduction, and drug supply reduction. Its underlying principle is the protection of public health (Magistrát hl. m. Prahy, 2008). Every year a range

[204] The 2008–2012 Strategy was adopted by the Prague City Assembly in its Resolution No. 18/13, dated 19 June 2008.

of services, including primary prevention, treatment and drop-in centres, and aftercare programmes, are supported from the budget of the city of Prague. Specialised services funded by the city of Prague include the Roma Outreach Programme provided by the SANANIM civic association and the programmes for mothers with children. The total expenditures invested in the individual types of services are summarised in Table 13-1.

*Table 13-1: Financial resources made available by the local government budgets for drug services in Prague in 2010 and 2011 (€ thousand) (Hlavní město Praha, 2012)*

| **Service** | **2010** | | **2011** | |
|---|---|---|---|---|
| | City of Prague | City districts | City of Prague | City districts |
| School-based primary prevention programmes | 217 | 222 | 187 | 138 |
| Primary prevention programmes delivered by NGOs | 73 | – | 83 | – |
| **Primary prevention in total** | **291** | **222** | **271** | **138** |
| Outreach programmes | 227 | 48 | 180 | 39 |
| Drop-in centres | 217 | 17 | 221 | 14 |
| **Harm reduction in total** | **445** | **65** | **401** | **53** |
| Outpatient treatment provided by NGOs | 197 | 83 | 181 | 68 |
| Medical treatment of alcohol and drug use | – | – | 12 | – |
| Substitution treatment | 175 | – | 148 | – |
| Therapeutic communities | 225 | – | 209 | – |
| **Prison-based programmes** | – | – | 4 | – |
| **Treatment in total** | **597** | **83** | **555** | **68** |
| **Aftercare** | **133** | **15** | **120** | **5** |
| **Sobering-up stations** | **531** | **–** | **593** | **–** |
| **Information/research/coordination** | **50** | **36** | **16** | **9** |
| **Grand total** | **2,046** | **422** | **1,956** | **274** |

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

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## SELECTED DRUG-RELATED CZECH WEBSITES

The following list provides selected websites of key institutions and services concerned with drug-related issues. An exhaustive list of helping organisations is provided in the Help Map application available at drogy-info.cz.

Adiktologie – odborný časopis pro prevenci, léčbu a výzkum závislostí (*Adiktologie* – a professional journal for the prevention, treatment of, and research into addiction): http://www.adiktologie.cz/Casopis-Adiktologie.html

Agentura pro sociální začleňování (Agency for Social Inclusion): http://www.socialni-zaclenovani.cz/

A.N.O. – Asociace nestátních organizací poskytujících adiktologické a sociální služby pro osoby ohrožené závislostním chováním (Association of NGOs providing addictological and social services for people at risk of addictive behaviour): http://www.asociace.org/

Alcoholics Anonymous: http://www.anonymnialkoholici.cz/

An application used to register drug-related services and their clients: http://www.drogovesluzby.cz

Benzodiazepine counselling service (administered by SANANIM, a civic association): http://www.benzo.cz/

Celní správa ČR (Customs Administration of the Czech Republic): http://www.cs.mfcr.cz/

Centrum pro výzkum veřejného mínění – Sociologický ústav AV ČR (Public Opinion Poll Centre – Institute of Sociology of the Academy of Science of the Czech Republic): http://www.cvvm.cas.cz/

Česká asociace adiktologů (Czech Association of Addictologists): http://www.asociace-adiktologu.cz/

Česká asociace streetwork (Czech Outreach Work Association): http://www.streetwork.cz/

Česká lékařská společnost JEP (J. E. Purkyně Czech Medical Association): http://www.cls.cz/

Česká neuropsychofarmakologická společnost (Czech Neuropsychopharmacological Society): http://www.cnps.cz/

Český statistický úřad (Czech Statistical Office): http://www.czso.cz/

Drug information server (administered by SANANIM, a civic association): http://www.drogy.net/

Drug counselling service (administered by SANANIM, a civic association): http://www.drogovaporadna.cz/

EXTC – web counselling – prevention of synthetic drug abuse: http://www.extc.cz/

Hygienická stanice hl. m. Prahy, referát drogové epidemiologie (Public Health Office in Prague, Drug Epidemiology Unit): http://www.hygpraha.cz

Information for the staff and clients of outreach programmes and drop-in centres (administered by SANANIM, a civic association): http://www.edekontaminace.cz/

Information portal and database of social prevention services for people at risk of social inclusion: https://www.sluzbyprevence.mpsv.cz/

Institut pro kriminologii a sociální prevenci (Institute for Criminology and Social Prevention): http://www.ok.cz/iksp/

Klinika adiktologie 1. LF UK a VFN v Praze (Department of Adictology, First Faculty of Medicine, Charles University in Prague and General University Hospital in Prague: http://www.adiktologie.cz/

Ministerstvo spravedlnosti (Ministry of Justice – portal of Czech judiciary): http://portal.justice.cz/

Ministerstvo práce a sociálních věcí (Ministry of Labour and Social Affairs): http://www.mpsv.cz/

Ministerstvo školství, mládeže a tělovýchovy (Ministry of Education, Youth, and Sports): http://www.msmt.cz/

Ministerstvo vnitra (Ministry of the Interior): http://www.mvcr.cz/

Ministerstvo zdravotnictví (Ministry of Health): http://www.mzcr.cz/

Národní monitorovací středisko pro drogy a drogové závislosti (National Monitoring Centre for Drugs and Drug Addiction – National Focal Point): http://www.drogy-info.cz/

Národní program řešení problematiky HIV/AIDS (National HIV/AIDS Programme): http://www.mzcr.cz/Verejne/Pages/133-narodni-program-reseni-problematiky-hivaids.html, http://www.aids-hiv.cz/

Národní protidrogová centrála služby kriminální policie a vyšetřování, Policie ČR (Police National Drug Squad): http://www.policie.cz/narodni-protidrogova-centrala-skpv.aspx

Národní ústav pro vzdělávání (National Institute for Education – a training and counselling centre for education professionals): http://www.nuv.cz/

Poslanecká sněmovna Parlamentu ČR, Výbor pro zdravotnictví, Zdravotní výbor (Chamber of Deputies of the Parliament of the Czech Republic, Health Committee): http://www.psp.cz/sqw/fsnem.sqw?f1=8&f2=6&id=963

Prevention and treatment of alcohol dependence: http://www.alkohol-alkoholismus.cz/

Prevention of risk behaviour: http://www.prevence-info.cz/

Primary prevention information portal (administered by SANANIM, a civic association): http://www.odrogach.cz/

Probační a mediační služba ČR (Probation and Mediation Service of the Czech Republic): http://www.pmscr.cz

Psychiatrické centrum Praha (Prague Psychiatric Centre): http://www.pcp.lf3.cuni.cz

Rada vlády pro koordinaci protidrogové politiky (Government Council for Drug Policy Coordination): http://rvkpp.vlada.cz

Register of social service providers: http://www.mpsv.cz/cs/3880

"Safer Party" initiative: http://www.saferparty.cz

Sdružení azylových domů v ČR (Czech Association of Shelters): http://www.azylovedomy.cz/

Společnost pro návykové nemoci České lékařské společnosti J. E. Purkyně (Society for Addictive Diseases of J. E. Purkyně Czech Medical Association): http://snncls.cz/

Společnost sociálních pracovníků ČR (Czech Association of Social Workers: http://socialnipracovnici.cz/

Správa uprchlických zařízení (Administration of Facilities for Refugees): http://www.suz.cz/

Státní zdravotní ústav (National Institute of Public Health): http://www.szu.cz/

Státní ústav pro kontrolu léčiv (State Institute for Drug Control): http://www.sukl.cz/

UN Information Centre in Prague: http://www.osn.cz/

Ústav farmakologie 3. LF UK – neuropsychofarmakologie a prevence drogových závislostí (Institute of Pharmacology of the 3rd Medical Faculty of Charles University in Prague – Neuropsychopharmacology and Prevention of Drug Addiction): http://www.lf3.cuni.cz/drogy/

Ústav zdravotnických informací a statistiky ČR (Institute of Health Information and Statistics of the Czech Republic): http://www.uzis.cz/

Vězeňská služba ČR (Prison Service of the Czech Republic): http://www.vscr.cz/

Výzkumný ústav práce a sociálních věcí (Research Institute of Labour and Social Affairs): http://www.vupsv.cz/

## ABBREVIATIONS

2007–2009 Action Plan – Action Plan for the Implementation of the National Drug Policy Strategy for the Period 2007 to 2009

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

2010–2018 National Strategy – National Drug Policy Strategy for the Period 2010–2018

AA – Alcoholics Anonymous

Annual Report – Annual (National) Report: The Czech Republic – Drug Situation

AT – Alcohol – Toxicomania (AT clinic – a name for an outpatient medical facility dealing with addiction treatment)

Centre for Addictology – Centre for Addictology, Department of Psychiatry, First Faculty of Medicine of Charles University in Prague and General University Hospital in Prague (part of the Department of Addictology since 2012)

CRM – capture-recapture method

Department of Addictology – Department of Addictology, First Faculty of Medicine of Charles University in Prague and General University Hospital in Prague

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

EPIDAT – register of infectious diseases

ESF – European Social Fund

ESPAD– European School Survey on Alcohol and Other Drugs

EU – European Union

GCDPC – Government Council for Drug Policy Coordination

GDP – Gross domestic product

HAV – hepatitis A virus, viral hepatitis A

HBSC – Health Behaviour in School-aged Children survey

HBV – hepatitis B virus, viral hepatitis B

HCV – hepatitis C virus, viral hepatitis C

ICD–10 – International Classification of Diseases, 10th Revision

IDU(s) – injecting drug user(s)

NFP – National Focal Point (Czech National Monitoring Centre for Drugs and Drug Addiction)

NGO(s) – non-governmental organisation(s)

NRHOSP - National Register of Hospitalisations

NRLUD - National Drug Treatment Register

NRULISL – Substitution Treatment Register

PMS – Probation and Mediation Service of the Czech Republic

TB – tuberculosis

TC – therapeutic community

VZP – General Health Insurance Company

WHO – World Health Organisation

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