



E.M.C.D.D.A.

European Monitoring Centre
for Drugs and Drug Addiction



Report
on the drug situation
in the candidate
CEECs

2002



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Preface

The EMCDDA presents, for the first time, a report exclusively devoted to the drug phenomenon in the candidate central and eastern European countries (CEECs). This is a result of the cooperation that has been established with its new partner countries and future members, with the financial support of the Phare Programme.

The report shows a different picture than what was known just five to seven years ago. At that time, these countries were generally perceived as 'transit' countries only, with all the associated stereotypes in terms of 'danger' posed to EU citizens. Today they have become a clear target for the consumption of drugs.

The available data suggest that drug use is on the increase, both for heroin, which is progressively replacing the locally produced opiates, and for cannabis, which is the most widely used drug in these countries, especially for experimental and recreational use. An increase in the use of synthetic drugs is also visible, a proportion of which are exported from the EU to CEEC markets. There is also evidence that high-risk behaviours related to drug consumption are prevalent, and that there is the potential for drug-related infectious diseases among injecting drug users to spread.

The phenomenon is occurring in a more general context of exacerbated consumerist behaviour among young people, which is also reflected in the use of licit substances such as alcohol and tobacco.

Within this context, candidate countries are facing a double challenge of developing relevant legislative

measures, administrative and coordination structures, and improving the coverage and range of the services provided in line with the *acquis communautaire* and taking into account the best practice developed in the respective areas.

While the preparation for accession to the EU enables them to benefit from the active support of the Commission and the Member States in developing some of these responses, they are facing huge difficulties in implementing and financing over a few years what took 20 years in the EU and is still ongoing.

It should be noted that in the framework of the technical cooperation established with the EMCDDA, it has been observed by candidate countries that the *acquis communautaire* on drugs was not always 'strong' enough to assist them in overcoming administrative and legislative obstacles.

The challenge for an enlarged Union will be to help new Member States to build together a more comprehensive and more sustainable response to this complex phenomenon and will probably require new political initiatives

This report reflects the willingness of the EMCDDA and the new national focal points to contribute to the debate by providing the European Commission, the Member States and the candidate countries with a picture of the phenomenon based on the scientific evidence available. Improving the quality and coverage of data is our common challenge for the years to come.

Georges Estievenart
Executive Director

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An online, interactive version of the 2002 Report on the drug situation in the CEECs is also available (<http://candidates.emcdda.eu.int>).

This version provides links to the data sources, reports and background documents used in assembling this report.

Introduction

The European Union Drugs Strategy (2000–2004), which was adopted at the Helsinki European Council in December 1999, emphasises the need for the progressive integration of the candidate countries. In order to transpose the strategy into concrete actions, in June 2000 the Feira European Council adopted the EU Action Plan on Drugs (2000–2004). The Action Plan foresees that the European Commission will continue to support, with technical assistance and finance where necessary, the candidate countries in their fight against drug use and drug trafficking. Particular emphasis is placed on the development of national strategies, national drugs units, focal points for the EMCDDA and effective controls on drugs entering the EU and candidate countries. The Phare Programme is similarly oriented. The EU Action Plan also requires the Commission and the Council to ensure that the candidate countries adopt the *acquis communautaire* and best practice in the field of drugs, and that their implementation is satisfactory.

In March 2002, the Council mandated the Commission to initiate negotiations with the candidate countries for their participation in all the activities of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). This participation will be possible on the basis of a clause in the Centre's constituent regulations allowing it to be opened up to candidate countries to the EU. At present, cooperation between the EMCDDA and the candidate central and eastern European countries (CEECs) is in a transitional period during which technical support is being extended to include inter-institutional cooperation and to establish permanent structural links. In order to integrate the CEECs into the EMCDDA's activities, work programme and institutional life, the Phare–EMCDDA technical cooperation project, implemented directly by the Centre, is supporting the establishment of national drug information focal points.

The EMCDDA has published three chapters on the drug situation in the CEECs in its 1998, 2000 and 2001 Annual reports on the state of the drugs problem in the European Union. In order to provide a more complete picture of the drug phenomenon in the candidate countries to the EU, the Phare project 'Cooperation EMCDDA–CEECs' has initiated the production of this report. The report is written mainly by experts from the candidate countries and primarily covers the central and eastern European countries which are actively involved in technical cooperation with the EMCDDA. It makes use of the information available through the 2001 national reports on the

drug situation produced by the candidate countries' national drug information focal points. In the few instances where data is available, reference is also made to other candidate countries to the EU, such as Malta.

The report primarily addresses the policymaking level, both European and national, and is broadly structured around the targets of the EU Action Plan on Drugs (2000–2004). It focuses more in depth on two key issues — treatment and drug-related infectious diseases — and examines the availability of information and the limitations and quality of available data. Wherever possible, the report makes methodological references to the EMCDDA technical tools and guidelines, such as the key epidemiological indicators, and underlines the need for their introduction and implementation at national level in all candidate countries.

The report confirms the major trends in drugs use, patterns of use and responses as well as in the availability and supply of drugs, as already identified by prior EMCDDA reports, and also attempts to provide insight into the underlying causes and possible explanations of the observed processes.

The report recognises that major drugs seizures along the Balkan route and in central Europe confirm the role of the region in the transportation and storage of heroin. However, as heroin consumption increases, it seems that the CEECs are increasingly becoming targets for distribution as well. Patterns of drug use are changing, with imported heroin progressively taking the place of locally produced opiates and other substances, while, at the same time, use is spreading from major urban centres to all regions. Consequently, heroin (which is predominantly injected) is the prevailing drug for problem drug use, which explains the concurrent increase in the demand for treatment for opiate dependency.

Although injecting drug users in the central and eastern European region seem to be relatively spared by the HIV epidemic, which is considered as low level, treatment data and research show that risk behaviours related to drug consumption are highly prevalent. However, the three Baltic states are more affected, with Latvia and, in particular, Estonia recently witnessing an alarmingly rapid increase in the spread of HIV infection among injecting drug users. In 2002, a major outbreak of HIV infection was recorded in one Lithuanian prison. Even though there are considerable differences between the countries in the

region, many of them have implemented measures to confine the spread of drug-related infectious diseases (HIV infection, hepatitis C and hepatitis B) amongst injecting drug users. Nevertheless, it is imperative to improve the coverage and range of the services provided and to introduce harm reduction measures into all settings where drug use takes place, including, for example, the prison system.

Central and eastern Europe also continues to be a transit region for cannabis destined for the EU Member States. Studies show that cannabis is the most widely used drug in the CEECs, especially in the context of experimental and recreational use. Synthetic drugs are also becoming increasingly popular with young people and so their production has increased significantly. The worldwide prevalence of ecstasy use has led to exportation of the drug from the EU to markets in central and eastern Europe.

Within this context, the candidate central and eastern European countries have taken substantial steps to develop relevant legislative measures and administrative and coordination structures. In addition, as part of the process of EU enlargement, the 10 candidate CEECs have adjusted their drug control activities to adopt and implement the *acquis communautaire* in the multifaceted field of drugs.

All the candidate CEECs have signed and ratified the three UN drug control conventions with Estonia being the most recent country to ratify the 1988 'UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances' in 2000. The process of adopting national legislation varies considerably throughout the region, from the adoption of a number of laws addressing specific drug-related issues such as prevention and treatment of drug use, production and trade of illicit substances, control of precursors, etc. (e.g. Hungary, Slovenia), to the concept of a single, wide-ranging, 'umbrella-type' drug law in Poland and Bulgaria. Based on individual implementation experiences and the need to accede to the EU drugs *acquis communautaire*, some of the newly adopted laws have already been reviewed, fine-tuned or amended. In the Czech Republic and Hungary, attempts have even been made to evaluate the impact of these laws.

In line with this new legislation, the national drug coordination and decision-making structures in most of the candidate CEECs are undergoing dynamic change. After a

period without a functioning inter-ministerial coordinating body, the Council for Counteracting Drug Addiction was constituted in June 2002 in Poland. Also in June 2002, the former National Drug Commission in the Czech Republic was renamed the Governmental Council for Drug Policy Coordination, while retaining and even expanding its functions.

The Hungarian Drugs Coordination Commission was reformed in 1999 with a stronger mandate and improved operational capacity. New laws passed in Slovenia and Bulgaria in 1999 re-established the inter-ministerial coordinating bodies in these countries and enhanced their role through the creation of permanent support structures — the Governmental Drugs Office and the National Drug Council Secretariat — similar to those in the Czech Republic, Slovakia and Latvia. The Romanian Inter-ministerial Committee for the Fight against Drugs was formally established in 1999 and is in the process of being organised. Although already established in 1996, the Estonian Ministers' Committee on Drug Policy has yet to start operating. The status and functions of the Lithuanian Governmental Drug Control Commission are being re-examined. Most of this reorganisation is enabling these countries to set up structures that meet the specific needs of a changing society and the problems it is confronted with.

The leadership of these inter-ministerial coordinating bodies is usually taken up by one of the relevant ministries. In most of the countries, this is a ministry dealing with social matters — the Ministry of Health in Bulgaria, Lithuania and Slovenia, the Ministry of Social Affairs in Estonia, and the Ministry of Youth and Sports in Hungary. In other countries, it is the direct responsibility of the government — chaired by the Prime Minister in the Czech Republic and the Deputy Prime Minister in Slovakia. It is the responsibility of the Ministry of the Interior in Latvia. In Romania, the inter-ministerial body is, by definition, 'under the leadership' of the Prime Minister, but its work is organised by the Ministry of the Interior.

For the purpose of implementing and coordinating national policy at local level, decentralised drug coordination structures are being set up. For example, the local drug commissions in the Czech Republic were established in 1994, the regional and district drug commissions in Slovakia in 1997, and the municipal drugs councils in Bulgaria in 2001.

As with most of the EU Member States, the development of drug policies and strategies in the central and eastern European countries since the mid-1990s has been influenced by two factors: the changing nature of the drug phenomenon, which increasingly affects broader segments of society; and the multidimensional character of the problem, which demands a nationally coordinated response across all sectors. Over this period, the initiatives of various international organisations, most notably the European Commission, have been a catalyst for the development of national responses to the drug phenomenon.

In countries where the inter-ministerial drugs body is well established, multidisciplinary national strategies are elaborated and implemented. The Czech Republic, for example, has adopted its third consecutive national strategy, the first one having been adopted already in 1993. The process of elaborating strategic documents and action plans intensified in 1999, and national drug strategies were adopted in Slovakia (1999), Poland (1999), Hungary (2000) and the Czech Republic (2000). National drug strategies are currently being elaborated, and will be adopted by the end of 2002, in Bulgaria, Estonia, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia. In most cases the elaboration of these strategies is supported by experts from EU Member States in the framework of the EC-funded Phare national (twinning) drug project.

This positive approach to developing national strategies, in general, demonstrates the commitment of the CEECs' governments and shows that the drug problem is acknowledged at political level. Most of the recently adopted strategy documents are concrete action plans, stating the objectives, targets, achievement indicators and financial requirements for implementing the policy. The need for improved information on drugs and evaluation of interventions is increasingly recognised and integrated into the national action plans, resulting also in the establishment of the EMCDDA national drug information focal points (see the list of national focal points annexed to this report). The European Commission, through the twinning projects between EU Member States and candidate countries, and the EMCDDA are currently supporting the elaboration of national action plans for the development of national drug information systems in all candidate CEECs.

The partnership between governmental and non-governmental sectors in policy development and programme implementation appears increasingly to be responding to

the individual and collective needs of the general population, as well as to the drug-using population. All new drugs strategies in the candidate countries are striving to ensure consistency between domestic policies and those endorsed at EU level.

Despite the fact that, in general, the legal and institutional framework for national drugs strategies is in place in the candidate CEECs, the capacity to implement effectively the adopted measures is limited and the resources allocated are in general insufficient. The low operational level of the national coordination mechanisms in some countries obstructs the effectiveness of policy implementation, and regional cooperation is still lacking. It is therefore essential that the countries concerned continue to reinforce their policies, institutions and coordination mechanisms and allocate additional resources to this end. It should also be underlined that the efforts of the candidate countries to align their actions in the drugs field with those of the EU and its Member States are worth not only recognition but continuing support.

Experimental and recreational drug use and responses

Introduction

This chapter presents and comments on the available data and information related to experimental and recreational drug use in the candidate CEECs, and attempts to correlate this information with the prevention activities.

Experimental and recreational drug use

Experimental drug use

Experimental drug use describes the use of an illicit drug, usually only once or very few times, for experimental purposes. This category includes all cases of incidental or non-incidental (but not repeated) use of illegal substances, mostly prompted by curiosity and/or a desire to experiment. In surveys, this behaviour is usually covered by the category 'lifetime prevalence', which means 'any use during a person's life'.

Recreational drug use

Recreational drug use describes more frequent use of substances which have become attributes of modern lifestyles for leisure and relaxation (e.g. cannabis, ecstasy, LSD). Important characteristics of this category are a lack of dependency, an absence of serious excesses and a frequency of use that could be categorised as 'sometimes' or 'periodically'.

In surveys, this use may be expressed as 'use in the last 12 months' or 'use in the last 30 days'. However, to become a 'recreational drug user' means an increased likelihood of becoming a 'problem drug user' in the future. (This group is the subject of chapter 2.)

How to monitor the extent of this phenomenon

The spread of the phenomenon of experimental and recreational drug use is uneven and varies across different countries, regions, types of area, age, social and cultural groups, etc. It is difficult to monitor for a number of reasons.

- Experimental drug use is engaged in by quite different groups in varied situations and has a very heterogeneous social basis.
- Experimental drug use is mainly incidental, and people can tend to 'forget' such an episode when answering questionnaires.
- In principle, recreational use is non-problematic, so it is not detected by the more traditional indicators of problems (e.g. demand for treatment).
- Recreational use is limited to specific age groups and cultural settings and therefore may not be sufficiently reflected in nationwide surveys.
- Recreational use is occasional, usually focused on special events and occasions, such as weekends and festivals. This is why targeted surveys and observations are important for the planning of services and responses.
- Recreational use is socially integrated, rather than being the problem of a socially deprived minority. It is therefore not perceived and not reported as a problem by those who engage in it.

In order to get a picture of the extent of this phenomenon, it is possible to obtain information either by representative school and general population surveys, or by focused studies, generally qualitative research. Most of the information presented in this chapter comes from general population surveys and school surveys.

What is known about experimental and recreational drug use in the CEECs?

As with the EU Member States, recreational use and experimentation is increasingly becoming an integral part of youth culture in most of the candidate countries. Also, the substances used and the patterns of use are very similar.

In most of the CEECs, the use and patterns of use of experimental and recreational drugs are relatively new social phenomena, which is why studies and reliable data are scarce. Another important factor is that national

general population surveys are expensive and their relevance has to be fully appreciated in order for funding to be secured. In fact, national studies indicating drug consumption are only reported by five out of the ten candidate CEECs (the Czech Republic, Estonia, Hungary, Poland and Slovakia).

In this situation, it is difficult to ascertain the extent of the problem in order to identify some common factors and make comparisons. Nevertheless, several sources of data do exist which give basic information on the phenomenon.

There has been an increase in experimental drug use in the general population, which is indicated by the increase in lifetime prevalence. This means that the number of people who have tried illicit drugs (in the general population, as well as young people and students) during their lifetime has increased. The data available show that this is true for all the ten candidate CEECs, particularly Bulgaria, the Czech Republic, Estonia, Romania, Slovakia and Slovenia.

Data related to the use of different substances in the Czech Republic show that, during the period 1996–1999, experimentation with cannabis increased from 14.2 to 16.4 %. The data sources are surveys among the general adult population in the country (15–64 years of age). An interesting trend was reported in experimentation with amphetamines, which decreased from 2.6 to 1 %. However, at the end of the same period, another synthetic drug for recreational use — ecstasy — appeared on the scene (0.9 %). Other substances are characterised by a relatively stable level of use, or at least a lack of any visible trend: opiate use being in the range of 0.5 to 1.2 %, and hallucinogens between 1.7 and 2.2 %.

A first impression of the experimental use of illicit drugs in Estonia is based on a national survey that was carried out at the end of 1998. According to this, 7 % of people aged 18–70 reported having tried drugs at least once in their lifetime. The gender breakdown was 11 % of men and 3 % of women of the same age reporting having used drugs at least once. As in all countries, among younger people, the percentage of those who had tried drugs was considerably higher: 25 % of males and 9 % of females among 18- to 24-year-olds, and 17 % and 5 %, respectively, among 25- to 34-year-olds.

Cannabis is the most frequently experimented drug in Estonia, with 5 % of the population (8 % of men and 2 % of women) using it during their lifetime. This compares to a 1 % lifetime consumption of other substances.

In Poland, 10 % of people took an illicit substance at least once in the past year, with 1.1 % of these using drugs other than cannabis derivatives. Comparison between studies made in 1994 and 1998 shows a considerable increase in drug use. In 1994, only 1.4 % of respondents reported having tried any kind of drug during their lifetime; by 1998, this had increased to almost 7 %.

In the vast majority of cases, experience with drugs in Poland was limited to experimenting with cannabis derivatives. Some respondents to the survey, however, had also experimented with other substances, mainly amphetamine and hallucinogens.

In Slovakia, it is significant that the population survey reflected the fact that, between 1994 and 1996, the already substantial number of people that had used some illegal drugs at least once in their lives had doubled. Another survey suggested that this sharp increase had stopped by 1998, but more recent data does not corroborate this. Increasing growth in drug use among young Slovaks appears to have been constant between 1994 and 2000.

Experimental use is on the increase among young people in general, while recreational use, particularly in urban areas, is spreading.

Comparison of the results from the European school survey project on alcohol and other drugs (ESPAD) 1995 and 1999 indicate that the number of 15- to 16-year-old students experimenting with illegal drugs had doubled in Estonia, Hungary, Poland, Slovakia and Slovenia, and had increased fivefold in Lithuania.

In the Czech Republic, where drug use was already high, prevalence increased one-and-a-half times. In

| | Ecstasy | | Amphetamines | | LSD | |
|---------------------------------------|---------|------|--------------|------|------|------|
| | 1995 | 1999 | 1995 | 1999 | 1995 | 1999 |
| Bulgaria | – | 1 | – | 1 | – | 1 |
| Czech Republic | 0 | 4 | 2 | 5 | 2 | 7 |
| Estonia | 0 | 3 | 0 | 7 | 1 | 3 |
| Former Yugoslav Republic of Macedonia | – | 1 | – | 0 | – | 1 |
| Hungary | 1 | 3 | 0 | 2 | 1 | 4 |
| Latvia | 0 | 6 | 0 | 4 | 0 | 4 |
| Lithuania | 0 | 4 | 0 | 2 | 0 | 2 |
| Poland | 0 | 3 | 2 | 7 | 1 | 5 |
| Romania | – | 0 | – | 0 | – | 0 |
| Slovakia | – | 2 | 0 | 1 | 0 | 4 |
| Slovenia | 1 | 4 | 0 | 1 | 1 | 3 |

Table 1: Lifetime experience of ecstasy, amphetamines and LSD use among schoolchildren (%) – ESPAD 1995–1999

1999, the first year of their participation in ESPAD, the percentages of schoolchildren who admitted having tried an illicit drug at least once was 14 % in Bulgaria, 21 % in Latvia and 12 % in Romania. This allows some countries, such as Lithuania, to define drug use as a new social phenomenon.

The increase in lifetime prevalence of 'high-risk' drug use is less marked than for cannabis-type drugs. Solvent use is decreasing in schools, probably not because the relevant age cohort (16 years) is decreasing its usage of the drug but because an increasing stratification in society means the children of marginalised groups are no longer present in the school population.

Drug use among young people in Lithuania

The largest at-risk social group in Lithuania is urban youth, between the ages of 15 and 25, that equate consumption of drugs with relaxation. They tend to be fashion and music conscious, attend discotheques and use stimulants experimentally. They are from well-to-do families, may be studying or working, are not involved in criminal activities and do not consider drug consumption to be dangerous or risky.

The social perceptions of experimentation with some substances is changing, and suggests the emergence of a clear distinction between cannabis and other substances. For instance, school surveys suggest that an ever-increasing number of sixteen-year-olds believe cannabis to be no more harmful than legal drugs and population surveys of older age cohorts show less repressive attitudes towards cannabis usage. Attitudes to other illicit drug use did not change much during the 1990s.

The lifetime prevalence of legal drug use (tobacco and alcohol) in the candidate countries is extremely high and the age of both onset of alcohol use and first drunkenness is very low when compared with Member States. For instance, while a recent survey in the Czech Republic recorded 34 % of 16-years-olds smoking marijuana at least once in their lives, 90 % of them had drunk alcohol in the preceding month and 20 % of them admitted to having been seriously drunk. According to available analysis, early onset of alcohol and/or tobacco use significantly increases the probability of use of illicit drugs, including high-risk ones. Combined with the information available related to the

evolution of social perceptions, this might indicate there is still a potential for growth in experimentation with drugs in the central and eastern European societies.

Data collected nationally, both in the general and school population, may not adequately capture some groups such as ethnic minorities, school drop-outs, the homeless and the unemployed. In order to facilitate the development of tailored prevention programmes, it is necessary to further develop existing monitoring systems to make them more appropriate for specific groups exposed to the risk of developing drug problems.

Targeted responses to experimental and recreational use

The design and implementation of appropriate responses to experimental and recreational drug use, usually through prevention programmes, faces a huge challenge in light of increasing use of licit and illicit substances, as described previously, especially bearing in mind that the top two answers from schoolchildren concerning the reasons for their first use was 'I was curious', and 'I wanted to feel high'.

It must be remembered that most recreational users are well integrated into society. They manage their usage according to the mood and circumstances of the moment, changing the drugs they use or even mixing drugs, according to availability. Their usage is also affected by how established the pattern of drug use is. Behaviour of this type, reflecting a well developed sense of individualism, makes it particularly difficult for prevention messages to reach this group.

Our knowledge of the influencing factors behind experimental and recreational drug use, and consequently potential prevention strategies, is very limited, making it difficult to tailor prevention programmes aimed at this population.

A study, 'The use of drugs within the techno party scene in European metropolitan cities' (Tossmann et al., 2001), was conducted in 1998 among a total of 3 503 visitors to techno parties in Amsterdam, Berlin, Madrid, Prague, Rome, Vienna and Zurich. The study clearly shows the huge discrepancy between figures obtained in nationwide surveys and those obtained in more focused and targeted settings. It also illustrates the need to link the research and prevention strategies to the

target group in order to design more appropriate solutions.

Among the conclusions of this study concerning the impact of the new data on future prevention programmes, it is worth reiterating the authors' conclusions: 'the lifestyle and milieu of the target group should be taken into account and, as far as possible, target groups should take part in working out these measures. However, target group orientation, in this case, also means that the onset of programmes should be at the location of target groups'.

Some recent developments in prevention in the candidate countries

There is considerable variation between the different countries in addressing drug-related problems among young people. There are also many diverse actors in the field and prevention programmes and activities are at different stages of development. This is reflected in the available information concerning prevention programmes and activities in most of the candidate countries.

- In most countries, the main prevention activities take place in schools. The focus seems to be primarily on the delivery of a standard message about drugs, but there is no information about the relevance of this message to specific local problems. However, in some countries the issue of evaluation is emerging as a matter that demands consideration (see the section 'School programmes').
- There are drug prevention messages being promoted through the mass media, but these are often too general to reach local sub-groups and individuals. Mass media information campaigns would seem to offer potential not only for prevention purposes but also for raising awareness generally and highlighting the need for more appropriate responses from society as a whole (see the section 'Work with the media').
- It is worth stressing that both data collection and the organisation of relevant responses are best carried out at local or regional level, provided all the actors can be mobilised towards a common goal. This is one of the areas where the candidate countries have been very active (see the section 'Activities at community level').

School programmes

In Bulgaria, prevention activities take place in secondary schools and are targeted at the whole student body. They aim to acquaint students (depending on their age) with the main drugs, their effects and the harm they can cause both 'psychically and psychologically'.

Since 1998, the Czech Republic has implemented 'Minimal Preventative Programmes', under the auspices of the Ministry of Education, Youth and Sport, in all primary, secondary and high schools, aiming to incorporate prevention measures into school life and education.

In Estonia, the goal of prevention work is to increase young people's knowledge about drugs and drug addiction. In the fifth grade, the curriculum introduces drug prevention in the context of a general health education programme. The main topics of the programme are alcohol, drugs and their impact on the health of the young, age group influences, self-help studies and how to avoid alcohol and drug use. School staff, students, parents and the public are all involved.

In 2000, about 40 % of schools in Hungary were active in prevention and health promotion, although the content was uneven in its quality and presentation. Various prevention subjects were presented, with different emphases. Less than 4–5 % of schools adopted in-depth health promotion programmes in 2000. While, in principle, prevention activities are mandatory in all schools, in practice they are only randomly present as a permanent attribute of the curriculum.

In Latvia, the theme of dependency prevention is integrated into the basic national curriculum. The programmes offered are addressed to all teachers and they devote one lesson per week to prevention activities (the so-called 'educational lesson'). A Teachers' guide has been prepared for teachers of health studies at primary school level, which focuses on physical, emotional and social changes during puberty. The guide includes methodological material on issues related to substance abuse. In the fifth grade curriculum, the questions of drug prevention are included in general health education (which is a compulsory subject).

In Lithuanian schools, primary prevention of drug abuse is usually included in health promotion programmes. School health programmes are currently implemented in only 50 schools, but a national network of 'healthy' schools is under development. Some special training activities for teachers have been organised, and teaching materials and guidelines on substance abuse prevention in schools were provided. In 1998 and 1999, a primary health care curriculum pilot project was adopted in Klaipeda and, a year later, the curriculum was introduced into a further 28 secondary schools in the country. Special schools programmes are needed, due to the rapid increase in drug abuse in schools.

In Poland, the schools prevention programme targets the promotion of healthy lifestyles and encourages character development. Traditional methods, such as lectures and presentations, are combined with more active forms of group work, such as training, discussion and brainstorming.

In Romania, schools have an optional curriculum choice on themes related to the prevention of drug abuse. Seventeen thousand copies of the World Health Organisation's manual, *Young people and drug use*, were printed and distributed to all urban schools. Training programmes based on this manual have also been offered to teachers.

In Slovakia, a support book, *How do I know myself?*, has been made available to 50 % of pupils at second grade elementary level (5th, 6th and 7th classes). Teachers evaluated this book positively for age and didactic appropriateness. It was also deemed suitable for systematic usage at second grade level. In secondary schools, drug prevention was formally incorporated into the curriculum, as well as into the lesson plans of drug prevention coordinators, educational counsellors and leading head teachers.

In Slovenia, a group of professionals has prepared a new cross-curricular teaching aid called 'Education for health'. It is intended that the new system will be fully operational by 2003/2004. Aims and topics were identified for every age group, including the use and abuse of substances. A booklet was published containing the curriculum proposal plus suggested literature for teachers and pupils.

Evaluation of prevention programmes

In Hungary, a research project was financed by the Drug Coordination Department of the Youth and Sport Ministry for the evaluation of school prevention programmes in the city of Budapest in 2001. The direct aim of this project was to analyse and evaluate school prevention programmes operating in Budapest, targeted directly at students (5th to 12th grade). The research provided a detailed and systematic description of school prevention programmes in Budapest. It shows the process and outcome evaluation of a narrow range of the programmes and summarises the methodology of planning and evaluating prevention interventions. These conclusions will serve as a reference for future studies, as well as for the design of new evaluation projects.

Work with the media

Not enough data exists about drug-oriented mass-media campaigns. Furthermore, it seems that a significant proportion do not emanate from any centralised and consistent policy base.

Most of the countries that are running general prevention activities have had these reported by the media. While this is a very important factor in the fight against drug abuse, it cannot really be considered a mass-media campaign.

Two common trends can be mentioned for 2000 and preceding years.

- In practice, all the well-known mass-media campaigns were dedicated to a day, or period, in the national or international calendar, such as the European Drug Prevention Week, the United Nations International Day Against Drug Abuse and Illicit Trafficking on 26 June or 'Mental Health Week' (annually each September).
- As well as campaigns in almost all the CEECs, the total number of publications and articles on drug-related themes in the media has increased as a whole. The media involved and the themes covered have expanded as well.

Lithuania

In Lithuania, a training programme organised for journalists with the support of the Phare Programme had a great impact on the way the press deals with the subject. The results of the training are described below:

- a network of journalists, at national and local level, writing about drug-related problems was established;
- contacts between journalists and professionals were improved;
- journalists are now informed about global drugs phenomena;
- journalists can assist NGOs;
- journalists are more professional in their analysis of drug-related problems; and
- journalists now seek professional advice when they are preparing a paper on the subject.

Activities at community level

Some countries are currently implementing very interesting projects at regional and local level, some of which, like those in Hungary, are supported by the Phare Programme. Although these programmes are not only oriented towards recreational drug users, they could form

a good basis for developing further specific preventive actions adapted to the specific conditions of recreational drug use in the various countries.

A new network of fourteen regional drug coordinators, part of the regional government administrative system, has been created in the Czech Republic. There have also been reforms of the administrative department, as required by EU regulations. Despite the fact that there had been 82 local coordinators in the old system, the new regime places more demands on the knowledge and expertise of regional coordinators. A special training programme has been prepared for them by the National Drug Commission and the future national focal point in close cooperation with the EMCDDA Reitox and Enlargement Coordination. This will cover the following areas:

- understanding the role of the EMCDDA and the national focal point and their possible use in regional policy-making;
- horizontal and vertical coordination of national drug policy;
- management of drug policy decision-making (networking, for the best use of limited resources);
- understanding five key indicators, their mutual relationships and possible interpretations at regional level; and
- case studies and practical exercises.

Bulgaria

A study on the articles dealing with drug trafficking, drug distribution and prevention in four national daily newspapers in 2000 and 2001 in Bulgaria shows that the total number of such articles was 1 972. The results of the study indicated that the most frequent topics were:

- prevention and consequences of drug abuse;
- reports about places where drug addicts gather, from treatment centres for drug addicts to places where juvenile drug users can talk in confidence about their abuse;
- the sale of alcohol and cigarettes near schools, homes for infants and juveniles and youth discos;
- the 'tragic' relationship between drugs and AIDS;
- meetings and seminars, at home and abroad, dedicated to combating drug addiction; and
- opinions by respected specialists in the field — doctors, psychiatrists and sociologists — on the distribution of drugs among young people and the efforts being made to restrict it.

In Estonia, a total of 107 drug prevention activities were organised in 16 local municipalities. A pilot project aimed at assessing the drug prevention network and the main problems at municipal level was also launched. Two training courses were organised for civil servants, social workers, doctors, policemen and probation officers of local municipalities. On the basis of the foregoing, regular training courses were started.

In Hungary, the engine driving drug policy in local communities is the Drug Consultation Forum (KEF), which coordinates local actions and initiatives and serves as a forum for local institutions in line with national objectives. Local Drug Coordination Fora were set up in 56 cities in seven regions of the country (with the support of the Ministry of Youth and Sports through a tendering process). Local governments showed keen interest in the tender. A very promising project will start in September 2002, within the framework of the Phare twinning assistance scheme. This project will improve the coordination and technical capacities of the KEFs.

In Latvia, programmes for the prevention of drug abuse have been formulated by the local governments of four cities: Riga, Jelgava, Liepāja and Ventspils. An integrated approach to drug abuse prevention was developed and general health care workers, social sector employees and education personnel are actively involved in addressing the abuse problem.

The city of Klaipėda's Primary Prevention on Drug Demand Reduction became a model in Lithuania and was adapted by other local communities in the country. Funds from several different international organisations have supported three other model programmes, in Druskininkai, Vilnius and Kaunas. These programmes are aimed at increasing awareness, enhancing primary prevention and related facilities in the community and disseminating information on drug-related problems. The National Drug Prevention Programme has recommended that prevention programmes be implemented in each community.

Poland, in its national report on the drug problem, identifies a primary goal of prevention activity as the creation of coordinated teams in municipalities, administrative districts and provinces. Their other finding, related to the primary prevention of experimental and recreational use, is more or less common to all countries and concerns improving the skills of individuals responsible for coordinating these activities at community level.

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Problem drug use and treatment responses

Introduction

Even if data quality and availability differ a lot between candidate countries and the resulting picture is rather patchy, we can hypothesise that, in the last decade, candidate countries have experienced accelerated growth in problem drug use and treatment responses similar to that experienced by EU Member States over the last 35 years. Not every candidate country is at the same stage of this process (which is also true for the Member States), since the geographical, economic and historical conditions are quite different between countries, but the increase in problem drug use and in responses is generally concordant.

Since the illicit drug market is clearly part of the 'global' market, a process of 'westernisation' of the previously closed national scenes of all candidate countries is occurring, with local specifics increasingly being eroded. At the same time, some of the traditional local drugs have the potential to be exported to the Member States and elsewhere — Czech pervitin represents the best example of this and various amphetamine-type drugs (ATD) from Poland are another.

The treatment response in most CEECs is also beginning to mirror the EU model, with substantial involvement of recognised non-governmental organisations (NGOs) and other bodies. According to available data, the CEECs that are most advanced in this respect are the Czech Republic, Hungary, Poland and Slovenia.

Last but not least, it is important to stress the need to improve data gathering and monitoring systems in all candidate countries. Compared to the EU Member States, the average level of data quality and availability is substantially lower, though with few exceptions. The political support of each government is a priority, as, without quality data, it is

impossible to evaluate interventions and policies — the priority target of the EU Action Plan on Drugs (2000–2004).

Problem drug use

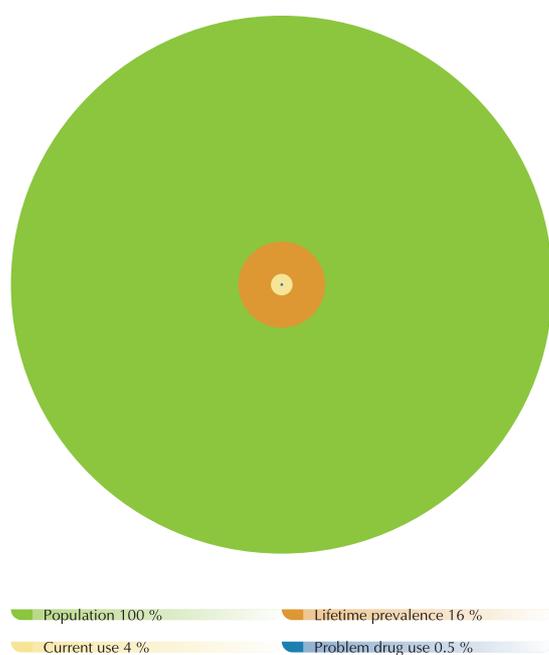
Problem drug users represent a very small minority of the whole population, compared with people who have ever used any illicit drug in their lifetime or with people who currently use illicit drugs (see Figure 1).

Drug-use surveys throughout the world have found the percentage of problem drug use to be much smaller than levels of current use, and these, in turn, are much lower than levels of lifetime prevalence. In striking contrast to this is the fact that problem drug use — as defined by the EMCDDA ⁽¹⁾ — is responsible for the vast majority of (or almost all) harms associated with any drug use (health problems, and social and economic cost to the society and the individual concerned). Indeed, problem drug users suffer extensively from all the potentially negative consequences of their behaviour — from deaths by overdose and other types of mortality, to drug-related infectious diseases (such as HIV/AIDS and different types of viral hepatitis), to socio-economic distress and addiction, which, together with the high price of illegal drugs, leads to various kinds of criminality — especially small-scale drug dealing and property crimes ⁽²⁾ — ultimately resulting in prison sentences in a substantial number of cases.

Problem drug use thus largely corresponds to the (economic) definition of drug abuse: 'Drug abuse exists when drug use involves a net social cost additional to the resource costs of the provision of that drug' (Single et al., 2001). As such, problem drug use and its economic consequences is increasingly attracting the attention of relevant decision-makers. The first target of the European Union Drugs Strategy (2000–2004) is to 'significantly reduce

⁽¹⁾ Problem drug use is defined as intravenous drug use (IDU) or long duration/regular use of opiates, cocaine and/or amphetamine-type drugs. Ecstasy and cannabis are not included in this category (EMCDDA and Institute for Therapy Research, 1998).

⁽²⁾ Apart from the fact that, in all CEECs, simple drug use — or possession for own use — is a crime (or a misdemeanour, in some countries, when committed on a 'small' scale).



Source: 2001 CEEC national reports.

Figure 1: Drug use in the general population aged 15–64 in the Czech Republic

over five years the prevalence of illicit drug use as well as new recruitment to it, particularly among young people under 18 years of age’.

In this respect, EU enlargement could create a new — even if not totally unknown — situation, as drug users differ significantly between Member States and candidate countries. Whereas the general trend in problem drug use in the EU is stable and the population of problem drug users is ageing (especially users of opiates), the majority of candidate countries are still situated in the rising part of the curve and problem drug users are younger, on average.

Heroin, which is generally perceived as the most dangerous and most harmful illicit drug, together with other opiates, is the prevailing drug for problem drug users in almost all candidate CEECs. The only exception is the Czech Republic, where the traditional domestic metamphetamine (amphetamine-type drug) — pervitin — still plays a major role. However, even there, all the relevant indicators since 1997/8 show that pervitin use is on the decrease and heroin use is increasing. This heroin trend is common to all the candidate countries — together with the abovementioned young age of drug users, who are more likely to engage in risky behaviours such as needle sharing, excessive polydrug use, etc., than the experienced ones — and could create substantial risks for the future if not properly responded to. There is also a substantial risk that pervitin, the production of which can no longer

meet demand, will increasingly be exported from the Czech Republic by organised crime.

Apart from the Czech Republic, ATD abuse (injecting and non-injecting) is also present, to a lesser extent (5–10 % of problem drug users seeking treatment), in Slovakia, Hungary, Latvia, Lithuania and Estonia. Intravenous use of amphetamines is marginal in Poland.

The use of cocaine is insignificant in candidate countries, even though there are early signs of an increase in supply, especially in Bulgaria and, to a lesser extent, in central Europe.

Solvent abuse — which is not usually included in the definition of problem drug use, even though it can cause serious health damage — represents a challenge for most of the candidate countries. Quantitative data generally fails to provide a reliable picture of the phenomenon, because the affected population is mostly extremely young, socially marginalised and, consequently, hidden. Also, the treatment facilities and services have not succeeded in reaching the population at risk. Qualitative data, however, suggest that solvent abuse is a significant risk in the candidate countries, especially among marginalised populations such as ethnic minorities.

Treatment responses

The need for appropriate and effective responses is present in all CEECs, but these have to be carefully targeted, especially when the limited resources available in the candidate countries are taken into account.

It is clear that knowledge about the target population, its size and characteristics, and about the harms it is suffering and that it is inflicting on society (see ‘socio-demography’ and ‘drug indicators’ in Figure 2), is essential when planning appropriate interventions and treatment. Without knowing the size and extent of the target group, it is not possible to ascertain the impact of any treatment or repressive measure, or change of any other kind. This underlines the importance of accumulating relevant data on problem drug use in order to influence planning for treatment and other responses.

It is obviously not possible to bring about a decrease in problem drug use simply by applying primary prevention measures (i.e. targeted at the non-using population). Offering treatment, in the broad sense ⁽³⁾, is the only way that this can be achieved.



Source: Palm and Záborský, 2001.

Figure 2: Planning interventions as a process of diagnosis

It is imperative to improve, substantially and without delay, information gathering on treatment in the candidate countries. Even though in some countries — such as Slovenia — treatment modalities for problem drug use have been put in place without proper monitoring and seem to be appropriate in terms of needs matching and goals, it is still necessary to assess the current situation, when planning future responses. However, this is far from being the case in the majority of candidate countries.

Psychiatric hospitals have traditionally offered specialised treatment for substance-abuse disorders, and this situation persists in all the candidate countries. Out-patient treatment is provided by all CEEC public health medical institutions. However, the role of non-governmental organisations — which are better positioned to react quickly to changes in the drug field — differs quite substantially from country to country. The Czech Republic, Hungary, Poland and Slovenia seem to be the most advanced in this regard.

There are also considerable differences between countries as regards the offer of low-threshold services (4) and their

acceptance by the public health system. International sponsors, both public such as the EU Phare Programme and United Nations programmes and private (where the Open Society Institute foundations network has been a major player), have played a crucial role in introducing this type of service. The majority of low-threshold services are provided by NGOs in all candidate countries. However, whereas in the Czech Republic, Slovenia, Poland and Hungary the government and public health authorities recognise the importance of such facilities for public health (5) and have provided resources for them (which also greatly facilitates the introduction of relevant monitoring in this area), in other countries these services still depend almost exclusively on international support. Paradoxically, representative studies (Csémy and Elekes, 2001) have shown that barriers exist to the development of non-governmental facilities in Poland, despite the fact that it was the first candidate country where NGOs were able to develop, at a time when it was impossible in other (ex-)communist countries.

Substitution treatment — usually with methadone or, to a lesser degree, buprenorphine — is provided for opiate users in all candidate countries, although this varies considerably from country to country. Such treatment is least developed in Estonia, where administrative regulations prevented facilities from fulfilling the unrealistic criteria set by government authorities. As a result, treatment was not made available until April 2002. Slovenia, on the other hand, represents an example of good practice, with nationwide availability of treatment. Again, the support of public and private international sponsors has contributed considerably to the introduction and development of this (extremely successful, in terms of treatment goals) model.

Problem drug use estimates

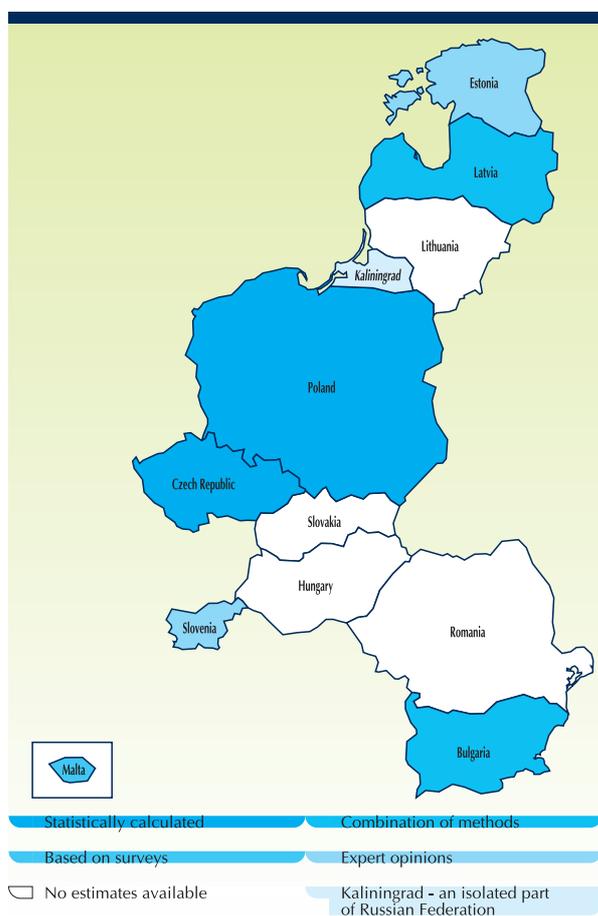
Data quality

The quality of data estimating problem use prevalence is poor in most candidate countries. Only two countries (the Czech Republic and Poland) provide estimates based on statistical procedures. Estimates from Bulgaria and Latvia are based on a combination of rough multiple calculation methods, surveys and snowball sampling. Data from Malta are based on general population surveys, a method which

(3) The term ‘treatment’ is used to define the process that begins when psychoactive substance users come into contact with a health provider or other community service. Treatment may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached (WHO et al., 2000).

(4) Low-threshold services provide treatment whose aim is not solely abstinence and which does not require clients/patients to be drug-free before entering a programme. Low-threshold services target the physical well-being of the user and employ a wide range of measures to achieve this — from nutritional and vitamin help, to needle exchange, to education about safer patterns of drug use.

(5) In some exceptional cases, some relevant services — such as needle exchange — are even provided by public health institutions in these countries.



Source: 2001 CEEC national reports.

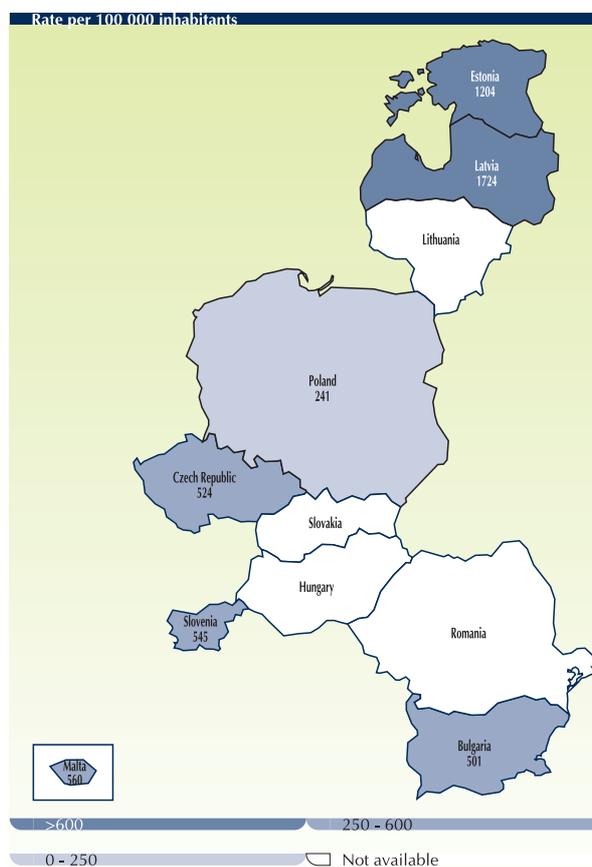
Figure 3: Availability of estimates of problem drug use prevalence in candidate countries

fails to target the relevant groups and thus tends to underestimate (Hartnoll, 2002). Estimates of prevalence in Estonia and Slovenia are based on expert opinions, whereas Slovakia, Romania, Hungary and Lithuania still do not have any estimates available (see Figure 3).

Generally, the capture–recapture and multivariate indicators methods seem to be a good base for reliable estimates of problem drug use at national level, preferably in combination with other methods. Access to relevant law-enforcement (especially police) data is of vital importance for estimating prevalence (6). Without this data, estimates can be too general and, therefore, of little use (7).

Data available

Even though the methodology and data quality on problem drug use are extremely heterogeneous, Figure 4 gives an overview of the estimated prevalence of problem



Source: 2001 CEEC national reports.

Figure 4: Problem drug use (PDU) estimates in seven candidate countries for 100 000 inhabitants aged 15–64

drug use in seven candidate countries (in the age category 15–64).

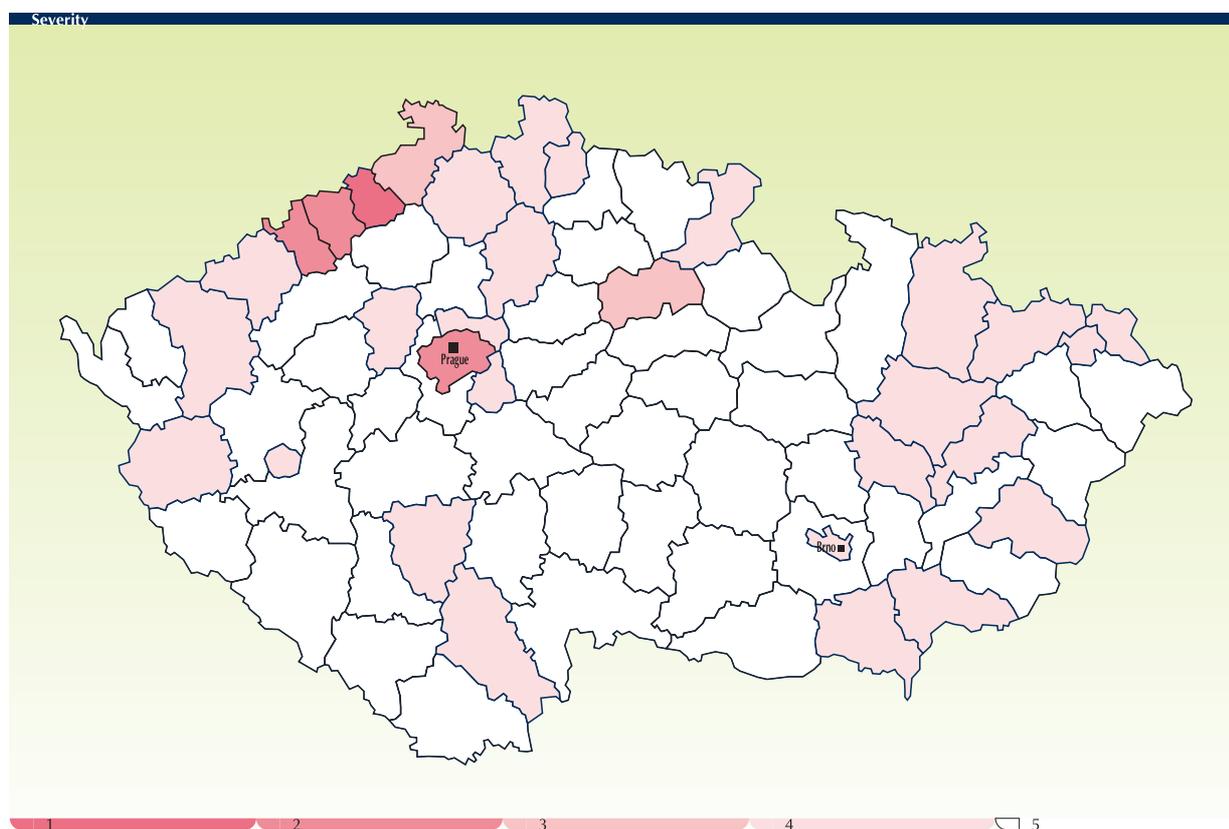
Problem drug use can be estimated as rather high in the Baltic states (above 1 % of inhabitants aged 15–64), whereas, in Bulgaria, the Czech Republic, Malta and Slovenia, prevalence equates with the average EU level of ± 0.5 % (Hartnoll, 2002). Estimates in Poland, based on the results of an isolated study in 1996/7 which is rather old and thus with limited reliability, show relatively low prevalence (around 0.25 %).

Regional differences within countries

Cumulative national estimates fail to show the degree of problem drug use at local level, where communities have to struggle directly with all its negative social consequences. The cluster analysis of local severity of problem drug use,

(6) Since the reliability of an estimate greatly depends on the mutual independence of data sources — and police data are in no way connected to treatment data (e.g. drug-related deaths or infectious diseases, etc.), which is usually used for such estimates.

(7) In the EU, estimates of this type regularly draw on police data, while fulfilling the criteria of relevant personal data protection regulations.



Source: Mravčík, 2002.

Figure 5: Cluster analysis of local severity of problem drug use in the Czech Republic, 1998

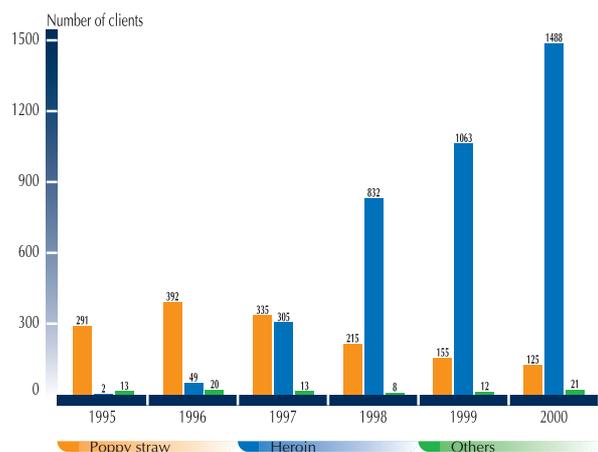
developed within the framework of the EC research project ‘Copernicus’ (Palm and Zábanský, 2001), clearly demonstrates the different local burdens within one country (see Figure 5). The regions with higher levels of problem drug use (where clustering was provided according to nine different indicators describing problem drug use) coincide, to a large extent, with regions with higher levels of known social problems. Such data are particularly relevant for planning specifically targeted interventions.

Also, data gathering at local level is often more developed and more reliable in some CEECs (and Member States), compared to nationwide methods (as demonstrated, below, in the Multi-city study).

Problem drugs

Heroin and other opiates

The major problem drug in all candidate countries is heroin. Although this substance seems to be somewhat out of fashion in EU Member States, it has



NB: Last 30 days before demanding treatment; percentage of clients.

Figure 6: Opiates used by drug addicts demanding treatment in Warsaw (Poland)

found new markets in the candidate countries. It has overtaken the vast majority of existing markets (e.g. for home-made opiates such as ‘braun’⁽⁸⁾ in the Czech Republic; poppy straw extracts known as

⁽⁸⁾ ‘Braun’ is a mixture of different opiates — mostly codeine, hydrocodone and hydrocodynal, where the preferred substance was hydrocodone — prepared from prescribed and/or freely available analgesics containing codeine from the late 1970s until the early 1990s.

'kompot' or 'Polish heroin' in Poland, 'shirka' or 'himka' in Lithuania, another poppy extract in Estonia and Latvia etc. and created a new one, which is actively promoted to newcomers to the drug scene. Even in Lithuania, where the use of home-made poppy straw (often mixed with benzodiazepines and/or antihistamines) has been retained more than in other candidate countries, the late 1990s saw an influx of brown heroin onto the market — a process that occurred in Poland a few years sooner. In Latvia during 1998/9, heroin prices fell to one tenth of its price of previous years and the majority of poppy straw users switched over to it.

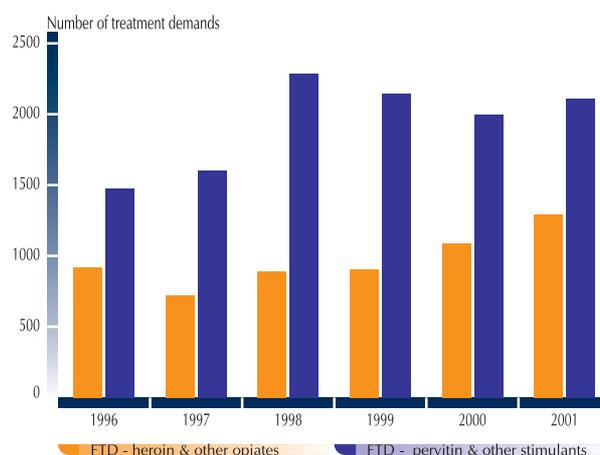
In the Czech Republic, where pervitin (see below) has dominated the scene since the late 1970s, a clear transition is observed from this drug to heroin (Figure 6). Qualitative data from local drug scenes are largely confirmed by the 'first treatment demand' indicator in the Czech Republic, where a stabilisation and slow decline in pervitin-related treatment demands in recent years is recorded (see Figure 7) and a corresponding increase in demand for treatment for opiate dependency. The same applies for drug mortality rates in that country.

Amphetamine-type drugs

Amphetamines-type drugs (ATDs) do not seem to be a problem for southern candidate countries (Bulgaria, Romania and Slovenia) and are only a minor one for the Baltic states (Estonia, Latvia and Lithuania), despite there having been a certain 'Scandinavian' tradition of amphetamine abuse. For example, in Lithuania, an amphetamine-type drug, 'jeff' (which is produced from medication containing ephedrine) and the ephedrine powder, 'Kristal', are injected with high frequency (up to 10 injections a day) by users. Of the central European candidate countries (the Czech Republic, Hungary, Poland and Slovakia), some history of amphetamine use exists in Poland and also in Slovakia and Hungary. The most widespread use of ATDs (pervitin) is found in the Czech Republic.

Pervitin

The metamphetamine, pervitin, represents a traditional Czech drug and the history of its abuse dates back to the late 1970s. Its relatively easy production in primitive home 'kitchen laboratories' predisposed pervitin to be the drug of choice in the Czech Republic. Furthermore, a number of freely available and/or prescribed drugs (containing ephedrine, pseudoephedrine, etc.) can be used for its production. Nevertheless, despite a number of police measures, the leak of ephedrine from its Czech industrial



Source: 2001 CEEC national reports.

Figure 7: Opiate (heroin-related) and stimulant (pervitin-related) first treatment demand in the Czech Republic 1996–2001

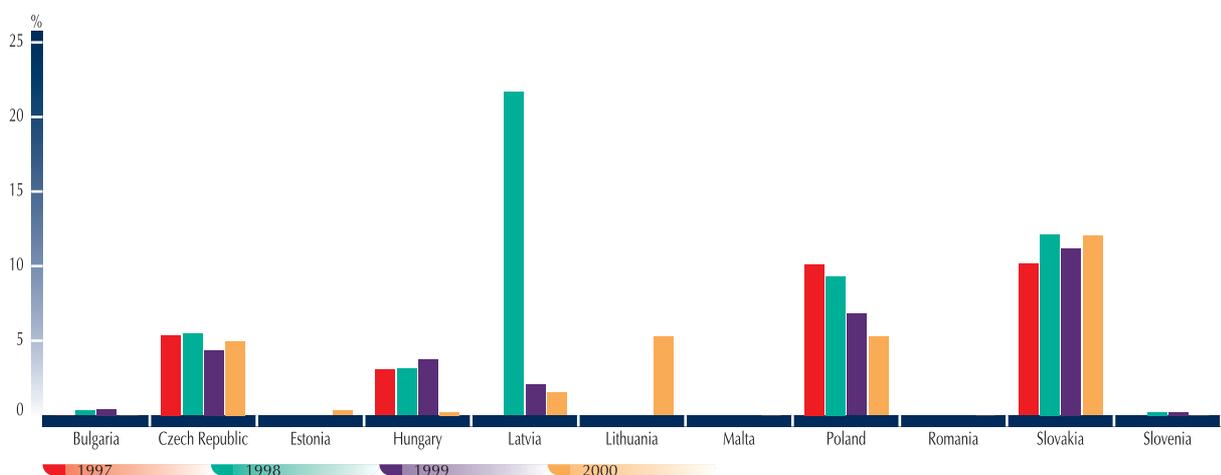
producer⁽⁹⁾ still represents a major source of this substance for domestic pervitin production. This drug is also made (under the name 'ephedrone') in the Baltic states.

Pervitin was the prevailing problem drug on the Czech drug scene until the second half of the 1990s, but it is now increasingly in competition with heroin — a process which has paradoxically been accelerated by the current effectiveness of the police in closing down 'kitchen laboratories' (where pervitin is prepared for small, horizontally organised groups of users, who gather around the 'cooker'). Even short-term gaps in markets have invariably been quickly filled by vertically organised groups of heroin dealers — a chain where the production stage is beyond the reach of the national police (Miovský and Záborský, 2001).

Parallel to this development, the prevailing home-based 'kitchen' production of pervitin started to be increasingly controlled by criminal networks (mainly Russian-speaking) who were striving to take over the market in 1999 and 2000, according to police reports (Národní protidrogová centrála, 2000). Some qualitative data also support this hypothesis.

Theories about the progressive appropriation of closed pervitin markets (as a result of police actions) by organised crime is further supported by reports from the biggest specialised treatment facility in Slovakia of a steady increase in domestic pervitin users, never experienced even at the time of the Czecho-Slovak Federation (Okruhlica, 2002: personal communication), and from outreach workers in Bayern and Upper Austria (Haas, Austrian focal point, 2002: personal communication), where a 'new' drug appeared under the name of 'Fliegersalz' — by all accounts, pervitin again.

⁽⁹⁾ ICN Corporation, based in Roztoky u Prahy.



NB: Romania describes solvent use as ‘insignificant’ and Malta does not mention it at all.

Source: 2001 CEEC national reports.

Figure 8: Solvent-related first treatment demand in candidate countries

This information suggests that, parallel to the gradual change occurring in the Czech drug scene, where heroin is increasingly playing a significant role, the organised crime network which has been gradually taking control of pervitin production has now started to look for new markets for pervitin abroad.

Cocaine

Cocaine abuse is relatively marginal in all candidate countries. Its high price and short-term effect predispose it to be a fairly rare drug, used mostly by ‘high society’. Nevertheless, isolated evidence from Bulgaria, the Czech Republic and Slovakia of a decrease in cocaine prices and its sporadic appearance on the street markets, as well as a slight increase in cocaine-related treatment demand, could indicate a possible slow onset of this drug in central and southern candidate countries, replaying a scenario of the not-too-distant past in Germany, Spain and some other EU Member States.

Solvents

Solvent abuse (inhaling) is not included in the EMCDDA definition of ‘problem drug use’, even though the harmful consequences of its use progress more rapidly and are more devastating and prolonged than with any other illicit drug, including heroin. The neurotoxic effects are extremely debilitating and the somatic consequences are profound: skin and mucosis damage, and lung, liver and kidney disorders, together with a markedly higher probability of various cancers for longer-term solvent users.

According to quantitative treatment data, it could appear as if solvent abuse is only a minor problem and is in decline in the candidate countries (see Figure 8). However, qualitative data suggest that there is a substantial amount of solvent abuse, especially in marginalised groups (Hičárová-Rajniaková, 2002). This is particularly true in Slovakia, as is partially reflected in treatment data (see Figure 9).

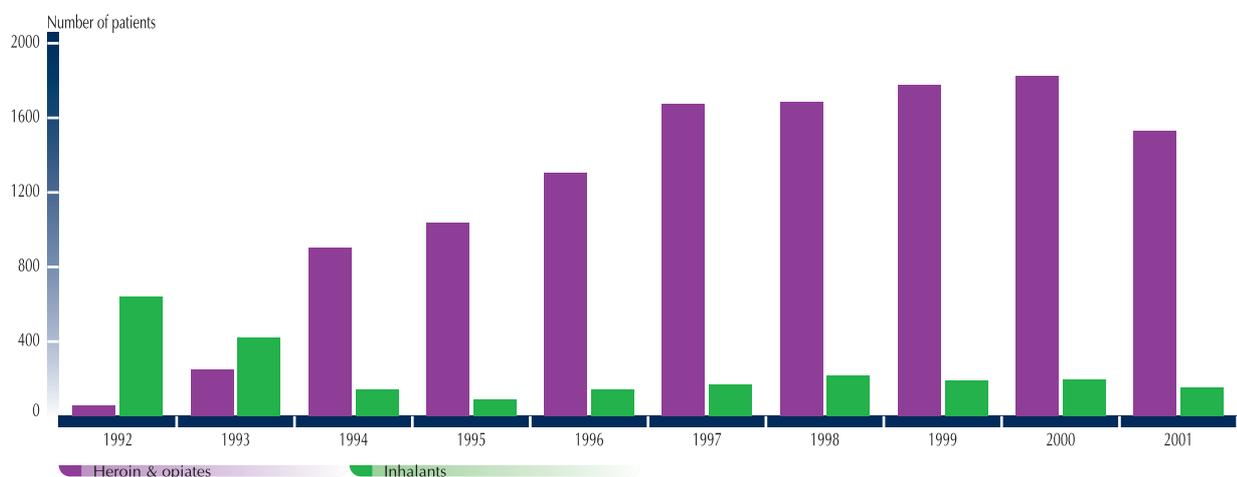
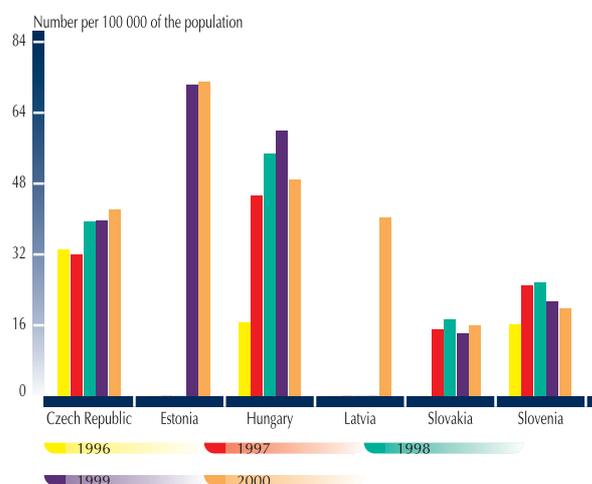


Figure 9: Patients treated for dependence on heroin or inhalants in Slovakia (1992–2001)



Source: 2001 CEEC national reports.

Figure 10: First treatment demand relative to population in some CEECs

Romanian data do not provide evidence of this phenomenon — despite the existence of numerous marginalised, homeless people seeking shelter in the underground of the capital city, Bucharest. This hidden population, which abuses solvents in great amounts, was extensively covered by the world media in the late 1990s (e.g. Šibík and Hrubý, 1999) and the problem attracted the attention of researchers in the first half of the 1990s (Hedrich and Ives, 1994).

Possible reasons for the above-mentioned discrepancy between qualitative and quantitative data could include the fact that solvent abuse usually occurs at a fairly young age. This, together with the often marginalised status of abusers, prevents them from asking for help from services which are not geared to their specific situation and needs. The very low price and licit status of industrial solvents make these psychotropic substances readily available even to a very poor population. Similarly, the legal status of such substances prevents any police action, which would otherwise constitute a valuable source of quantitative information. Clearly, more qualitative research focusing on volatile substances is needed in all candidate countries.

Treatment as a response to problem drug use

The quantitative data collected on treatment demand cover two categories of clients: those who enter into treatment for the first time in their life (recorded as ‘first demand for treatment’, and all those who entered treatment during a given

year, whether for the first time or not (‘all demands’ or ‘treatment demands’).

First treatment demand: quantitative data

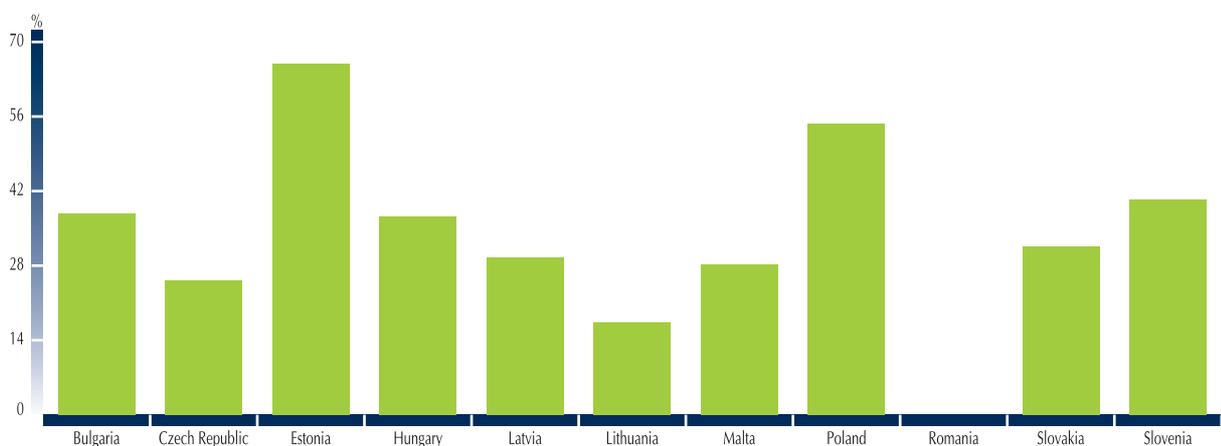
As with problem drug use, information about treatment demand differs substantially — in both quality and coverage — between countries. In the Czech Republic and Hungary, the information gathered covered the whole of the country, both geographically and in terms of different types of facilities/treatment and services. Some difficulties emerged regarding definitions, especially in Hungary, but these were solved in 2001. Data obtained from Slovakia, Malta, Estonia and Lithuania cover public health/state treatment facilities but fail to adequately cover NGOs and/or low-threshold facilities. Slovenia covers out-patient facilities nationwide (no matter what the status or service/treatment) but none of the in-patient clinics and hospitals. Bulgaria covers all types of facilities (although a lack of NGOs and low-threshold facilities should be mentioned) but only in the capital city, Sofia. A similar situation exists in Poland, which covers a few major cities together with the capital, Warsaw, but fails to gather data nationwide. An overview of this situation — i.e. first treatment demand relative to population in the CEECs — is shown in Figure 10. However, all the limitations mentioned above should be kept in mind when interpreting the data.

Due to incompatibility of data, it is impossible to make any comparison between countries. It is only possible to show trends. However, interpretation of these trends is also difficult. Since the first treatment indicator is influenced by (a) the number of drug users in the country and (b) accessibility and matching of needs of users by services/treatment⁽¹⁰⁾ and we have no means of quantifying the impact of these particular influences separately, any verdict of ‘worse’ or ‘better’ is fairly impossible.

Treatment demand: quantitative data

What has been said above about first treatment demand holds true for treatment demand. Whereas data in Hungary covers all types of treatment, in 2000 its classification system was not consistent with the standard EMCDDA definitions. In 1994, Slovakia launched a monitoring system covering the whole country using the former Pompidou Group protocol. The protocol was changed in 2000 to meet EMCDDA requirements. Still there are some gaps in the coverage of the low-threshold facilities run by non-profit NGOs. The all-treatment demand indicator in the Czech Republic was not obtained by standard monitoring, but by calculating an extension of the ratio between treatment demand and first treatment demand obtained from representative samples of different types of facilities (Mravčík and

⁽¹⁰⁾ However, (a) could be seen as a negative phenomenon, whereas (b) is undoubtedly positive.



Source: 2001 CEEC national reports.

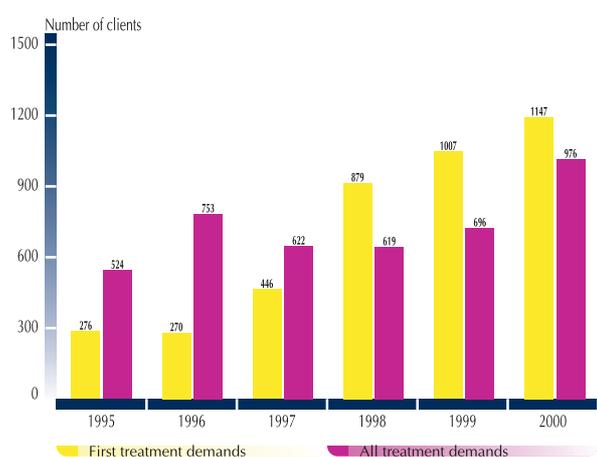
Figure 11: First treatment demand in 2000 relative to all treatment

Zábranský, 2001). Poland’s indicator has a long tradition and has been considerably improved, but overlaps between the two different systems (one for in-patient treatment facilities, another for out-patient) have not yet been fully addressed, even if they are rather insignificant (according to the national report). Romania only reports on hospital cases and Bulgaria’s current system is limited to the capital city, Sofia. It would be possible⁽¹¹⁾ to calculate the first treatment/all treatment ratio (see Figure 11), thus showing the level of ‘stabilisation’ of client influx: the higher the ratio, the bigger the influx of new clients experienced by the facilities and services. However, the ratio could only be interpreted for each country, and, even if the strikingly high level of treatment demand experienced in 2000 in Estonia could be read as an indication that the treatment facilities succeeded in attracting more users than ever before⁽¹²⁾, this theory is hampered by the fact that there is no method for eliminating duplication in the current system, which means that the real number of first treatment (and treatment) may only be a half of that calculated, or even less, because of ‘travelling’ patients migrating from one facility to another.

On the other hand, the extraordinarily high and still increasing influx of new patients in the Polish capital city, Warsaw, which is covered by a stable city monitoring system (see Figure 12), signifies recent major changes in the scene, in particular a sharp increase in the numbers of users — an indicator consistent with qualitative information on heroin onset in the Polish drug scene in the middle 1990s.

Psychiatric hospitals

The candidate CEECs are post-totalitarian countries where the former treatment system was dominated by specialised psychiatrists — ‘alcoholists/narcologists’ — who were responsible for substance-abuse treatment in certain geographical areas (districts). Only Poland, with its long tradition of treatment communities, represents a marked exception to this rule. The overwhelming majority of physicians in psychiatric hospitals were of a strictly bio-medical orientation — an approach fostered by the former political system and its institutions, including the ones that provided treatment, mainly focusing on repression and provision of compulsory treatment to drug users.

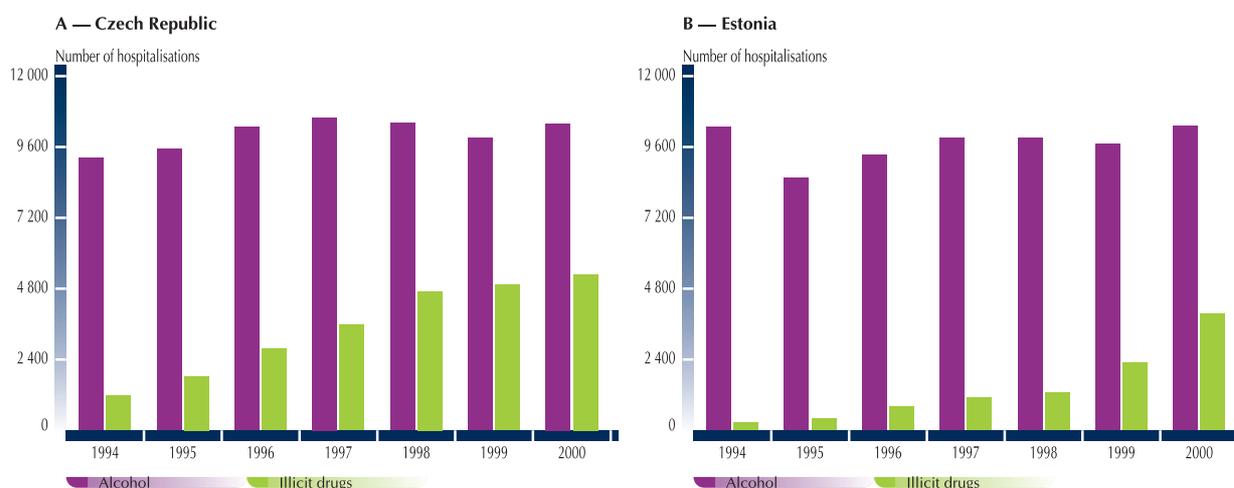


Source: 2001 CEEC national reports.

Figure 12: Number of clients in first and all treatment demands in Warsaw (Poland), 1995–2000

(11) Since both nominator and denominator were obtained by the same or compatible methodology in each particular country where data are available.

(12) It is not clear if double counting is adequately controlled.



NB: One patient could be hospitalised more than once in the relevant year.

Source: 2001 CEEC national reports.

Figure 13: Illicit drug and alcohol hospitalisations in psychiatric institutions in the Czech Republic and Estonia, during 1994–2000

This approach had no capacity to attract users in need of treatment, on the contrary, it was seen as repressive, and the target group generally tried to give such treatment a wide berth. Compulsory treatment as such is no longer applied in the candidate countries.

Treatment as an alternative to prison exists as an option in cases where the judge decides it is more beneficial for society to treat the perpetrator than imprison him/her. However, this is rarely used, with the exception of Hungary, where 814 of such diversions were ordered in 2000, compared for example to 95 in the Czech Republic, a country with a similar population.

Regarding voluntary treatment and services for drug users, large differences exist between candidate countries in treatment responses and the status of providers. The most marked common characteristic⁽¹³⁾ is still the network of inpatient-treatment facilities (mostly in psychiatric hospitals) that was retained or slightly modified from the former system. These clinics, which are oriented towards substance abuse disorders, experienced a rapid change in the characteristics of their clients throughout the candidate countries. Whereas alcohol-related disorders had played by far the major role in the first half of the 1990s, in 2000 the situation was substantially changed everywhere, with a stable number of admissions for alcohol-related disorders and an increasing amount for treatment of illicit substance abuse. Clearly this trend is still on the increase, even though with different dynamics (see Figure 13).

This change in patient characteristics (lower age, different risk behaviour, more involvement in other deviant activities,

different social network, etc.) has been extremely demanding on the staff. An escalating workload for expensive psychiatric institutions also represents an increasing burden for public health resources.

Out-patient facilities

The importance of ambulatory treatment was increasingly recognised in CEECs during the 1990s, and the ratio between in-patient and out-patient treatment has tended towards the latter.

Ambulatory (out-patient) treatment is provided in all candidate countries by the public health system, usually by utilising a (sometimes reduced) network of public health ambulatories. In some countries, newly established private psychiatric ambulatories play an important role. Nevertheless, these non-specialised facilities and services handle only a minority of out-patients, whereas specialised (increasingly non-governmental, non-profit-making) outpatient services are responsible for the majority of patients, in all countries except one, as evidenced by the national focal point in Latvia.

Therapeutic communities

In the central European countries (the Czech Republic, Hungary, Poland and, to a lesser extent, Slovakia), according to available data, therapeutic communities have had satisfactory results in achieving the goal of rehabilitation and prolonged abstinence from illicit drugs. Nevertheless, the demand for this treatment has obviously reached saturation point in the abovementioned countries.

⁽¹³⁾ With the exception of Poland, where a long-term tradition of therapeutic community therapy exists in the treatment of substance-related disorders.

| Country | Methadone maintenance facilities/units | First methadone maintenance treatment (MMT) started | MMT clients in 2000 | MMT clients per 100 000 inhabitants | Buprenorphine (Subutex®) available |
|----------------|--|---|---------------------|-------------------------------------|------------------------------------|
| Bulgaria | 1 | 1995 | 230 | 2.82 | No |
| Czech Republic | 8 | 1993/1997 (1) | 320 | 3.13 | Yes |
| Estonia | 2 | 2001 | 6 (2) | 0.44 | No |
| Hungary | 4 | 1995 | 112 | 1.12 | No |
| Latvia | 1 | 1996 | 107 | 4.50 | No |
| Lithuania | 4 | 1995 | 577 | 15.42 | No |
| Malta | 1 | 1987 | 935 | 257.59 (2) | No (3) |
| Poland | 9 | 1993 | 1 123 | 2.91 | Yes |
| Romania | 1 | 1998 | ? | 0.00 | No |
| Slovakia | 1 | 1998 | 360 | 6.69 | Yes |
| Slovenia | countrywide coverage | 1990/1995 (4) | 1 348 | 67.72 | Yes |

(1) A one-year programme was started in 1993 by an NGO but after its successful run, continuation was not allowed by the public health authorities; in 1997 an 'experimental' programme was started in the faculty hospital in Prague and subsequently — after a Ministry of Health Order — within seven other major cities, in 2000.

(2) Data from 2001.

(3) Treatment with the opiate antagonist Naltrexone is available in Malta.

(4) One 'experimental' programme in 1990; in April 1995, treatment was established by governmental decree.

Table 2: Agonist opiate treatment in candidate countries in 2000

Poland is the country with the longest tradition in this type of treatment. A specific model of treatment services (often church-based) was established there in the middle of the 1980s. The role of these treatment communities in Poland has superseded the otherwise hegemonic position of psychiatric institutions since then.

Substitution treatment

Agonist opiate treatment is available to some degree in all countries. Estonia is the least developed in substitution treatment. In fact, methadone substitution has only been officially permissible since 1998, regulated by the Minister of Social Affairs' *Decree on detoxification and substitution treatment of drug addicts in each health care phase* of 18 March 1998 (No 20). However, the regulation's requirements were extremely high — higher than for other types of treatment — and none of the treatment facilities have been able to meet them. In April 2002, that regulation was abolished and a new one is now in preparation. One NGO and one state hospital decided not to wait for the new regulation and started to provide treatment anyway, but finance and organisational issues are very problematic. Six patients were receiving treatment in Estonia in June 2002.

Slovenia is the only candidate country which offers adequate agonist opiate treatment. A countrywide network of specialised centres — Centres for Prevention of Drugs and the Treatment of Drug Addicts (CPTDAs) — was

approved by the Slovenian government in 1995. These centres provide a broad spectrum of services (counselling, individual, group and family therapy, preparation for hospital treatment, somatic care, etc.). Methadone is dispensed by out-patient clinics or pharmacies; these do not need to be situated within the centres. Methadone may only be prescribed by a doctor chosen by the patient. Such doctors must have received the appropriate licence from a CPTDA and have gained the necessary expertise at a training course organised by the Ministry of Health and the Clinical Department for Mental Health. In this way, both the required expertise and availability of treatment are guaranteed. This system ensures a setting which is predisposed towards successful treatment and rehabilitation of patients, whereas leakage of the substance to the black market is negligible.

The status of agonist opiate treatment in candidate countries is overviewed in Table 2.

Apart from in Slovenia, there is no mechanism in place for methadone provision outside the specialised psychiatric centres in the other candidate countries, a situation which results in unavailability of treatment for a substantial number of the population who live at too great a distance from the facilities⁽¹⁴⁾. Buprenorphine was recently introduced in some candidate countries in 2000 and 2001. In contrast to methadone, there are usually no limitations in these countries for buprenorphine prescribing⁽¹⁵⁾, thus it is only the price that is the limiting factor.

⁽¹⁴⁾ In Latvia, a substantial part of the resources allocated to substitution treatment were spent on transporting patients to the dispensing unit; in the Czech Republic, some of the centres have long waiting lists and others are not used to their full capacity, even if a high number of users live in the surrounding villages and suburbs, due to transportation problems.

⁽¹⁵⁾ This means that any medical doctor can prescribe buprenorphine, regardless of whether s/he is appropriately trained.

With the exception of Slovenia, services offering agonist opiate treatment are totally inadequate ⁽¹⁶⁾. This has significant implications, not only for protecting users' health, but also in terms of protecting public health and society in general. Evaluation of this treatment worldwide has unanimously affirmed its success in preventing the spread of drug-related infectious diseases and substantially decreasing the incidence of crime.

Institutional responses

The role of NGOs

Non-governmental organisations (NGOs) operate in all the candidate countries, but only in central Europe (the Czech Republic, Poland, Hungary and, to a far lesser extent, Slovakia) and Slovenia do they play a major role in public health. In these countries, the role of NGOs is recognised by the government and municipalities, and these provide regular funding (with strict criteria) in order to support the services offered by NGOs. This has been influenced by the experiences of EU Member States and also of the abovementioned countries, where it has been shown that NGOs are more flexible and able to react appropriately to an often rapidly changing situation in the drug field than government/public institutions.

In the four countries mentioned here (the Czech Republic, Poland, Hungary and Slovenia), NGOs, which were previously almost unheard of, have become an important sector with an impact on the whole society. The health care systems in central European

countries underwent huge reforms during the 1990s, with a move away from the traditional institutional system for problem drug users. These changes included privatisation of health care facilities, development of private facilities, the option to choose a physician or service provider, etc. With the return of democracy, there was a rapid development of civil liberties and services (Csémy and Elekes, 2001).

Analysis of the development of institutions in the field of drug demand reduction has shown that the highest number of new organisations in the four countries was established between 1993 and 1996. This was followed by structural changes and an improvement in the quality of services offered. Understandably, the new system of care for drug users has experienced a number of teething problems (Csémy and Elekes, 2001).

Further development, official recognition and consolidation of NGOs is still at an early stage in the other six candidate CEECs (the Baltic states, Bulgaria, Romania and also Slovakia to some extent).

Low-threshold services

Since there has not been a tradition of low-threshold services in the past, they were seen as radical and innovative in the 1990s. The overwhelming majority of low-threshold services operate in the framework of NGOs in the candidate countries. Chapter 3 provides a more detailed overview of low-threshold services in the candidate countries.

| | Eastern Europe | | | | Western Europe | | | |
|----------------------------------|----------------|------|--------------------------|-------|----------------|------|--------------------------|-------|
| | Value | Year | Average number of cities | Trend | Value | Year | Average number of cities | Trend |
| Treatment | | | | | | | | |
| First treatment demand | 100 | | 14 | ▲ | 69 | | 7 | |
| All treatment demand | 339 | | 14 | ▲ | 684 | | 6 | ▲ |
| Mean age (first treatment) * | 22.4 | | 7 | ▼ | 27.9 | | 5 | ▲ |
| % < 25 yrs (first treatment) * | 60.8 % | | 10 | | 41.5 % | | 5 | |
| % females (first treatment) * | 20.7 % | | 12 | | 21.2 % | | 5 | |
| Admissions psychiatric hospitals | 94 | | 9 | ▲ | | | | |
| Admissions general hospitals | 16 | | 4 | | | | | |
| Non-fatal emergencies | 99 | | 11 | ▲ | 36 | | 4 | |

NB: Indicator values are rates per 100 000 of population in the participating cities except those marked with *.

Source: Bless et al., 2000, p. 117.

Figure 14: Comparison between trends in treatment in western and eastern Europe, 1994–1998

⁽¹⁶⁾ This is when compared to the European Union, the United States and other developed countries.

Multi-city study

In 1982, the Ministerial Conference of the Pompidou Group, the Council of Europe established the Epidemiology expert group to develop monitoring systems for evaluating the nature and magnitude of the social and public health problems created by drug abuse. From the start, the expert group adopted a city-based approach and operates as a multi-city network. This was based on the argument that it is more viable to develop and pilot appropriate monitoring systems in cities than to attempt to operate on a national scale. The smaller scale of cities makes it easier to interpret figures and trends. Another argument was that drug problems were mainly concentrated in urban or metropolitan environments at the beginning of the 1980s (Bless et al., 2000).

Even though problem drug use has spread into rural areas during recent years, treatment indicators only represent part of the scope of the Multi-city study and not all candidate countries are covered. On the other hand, the analysis of trends provides a general overview of differences between EU Member States and candidate countries (Figure 14).

Marginalised groups and drugs

There is general agreement that socially and economically marginalised groups are more prone to drug use and its more serious form — problem drug use. The former totalitarian regimes pretended that no social differences existed within ‘their’ countries. Consequently, no real attempt to socially integrate marginalised minorities was ever undertaken. The cultural and economic repercussions of the fall of communism hit the Roma population hardest in all post-communist countries.

The situation of the Russian-speaking population in the Baltic states (with the exception of Latvia) reveals a unique picture of a group that lost its privileged status as a governing majority and found itself in a marginalised position. Since a substantial number of them do not have citizenship of their particular state, they have neither health nor social insurance and the drug services are not available to them — especially rehabilitation and other more expensive services. It is a paradoxical though logical result of this situation that, according to available data, drug use rates (especially for opiates) are substantially higher in the Russian-speaking population than in the majority of the rest of the population.

Last but not least, increased immigration (both legal and illegal) to the CEECs from ex-Soviet republics (such as the Ukraine and Russia) with an extremely high prevalence of opiate injecting and HIV could create another major problem if suitable and accessible services are not in place to respond to this challenge quickly.

The Roma population

It is very difficult to assess the extent of the Roma population in candidate countries. Latent and often visible racial prejudice ensures that the vast majority of ethnic Roma do not identify themselves as such in census data. However, it is safe to say that Roma are the biggest ethnic minority in Europe.

It is also not possible to estimate the number of Roma (or other minority) drug users, as a patient’s ethnic or cultural background is not registered by health care facilities, including drug treatment and syringe-exchange programmes. A comprehensive overview of drug use in the Roma population is absent in all CEECs. An international qualitative study undertaken in 1999 (Grund et al., 2000) is the only scientific source of information available.

Problem alcohol and solvent use has a long history in the Roma population, but, unlike the rest of the population, illicit drug use was unknown before the ‘velvet revolutions’. Hard drugs were introduced into Roma communities in candidate countries in the first half of the 1990s and they first appeared in first treatment demand monitoring around 1995 (Grund et al., 2000). Drug dealing presents an opportunity to make money, a situation that cannot be underestimated in a population with far higher rates of unemployment than national averages everywhere.

Heroin, together with solvents, represents a major threat to the Roma community. All the available evidence suggests that high-risk drug use is much more widespread in the Roma drug-using population than with ‘gadjé’ (non-Roma) junkies⁽¹⁷⁾. This fact, together with other hazardous behaviours (involvement in prostitution, lack of awareness of the health risks associated with unprotected sex, etc.), presents a substantial threat to public health in the CEECs.

In all the candidate countries, very little has been done to set in place appropriate drug and AIDS policies for the Roma communities. The isolation of these communities is a significant barrier to the development of services for Roma injecting drug users (IDUs).

⁽¹⁷⁾ ‘Between Gadjé and Roma drug users [in Budapest] there is a major difference. Gadjé injecting drug users use their own needles, but Roma injecting drug users only have one needle that goes around’ (Roma outreach worker, Budapest; quoted in Grund et al., 2000).

The overall participation of Roma drug users in existing drug treatment programmes is negligible, particularly in high-threshold facilities such as residential therapeutic communities. However, a notable exception is methadone maintenance programmes, which attract many Roma heroin users in some cities (Grund et al., 2000).

The social fabric of Roma communities is beginning to be adversely affected, as drug addiction puts pressure on the traditional social norms of solidarity and mutual assistance. The participation of an unspecified proportion of the Roma population in the drug economy changes the economic balance in these communities and threatens traditional power structures. Furthermore, it seems that Roma leaders have failed to see the problem of drug addiction in their community for what it is — a real problem in its own right. Instead, they have depicted it as just another by-product of unemployment and social segregation (Grund et al., 2000).

All the evidence suggests that drug use among the Roma minority represents a major challenge for both public health and the social structures in all the candidate countries. However, even if rare, some examples of good practice exist, such as the Initiative for Health Foundation in Sofia (Yankova et al., 2002) and outreach work in Slovakia's biggest Roma urban ghetto, Lunik (Hičárová-Rajniaková, 2002). The first official and coordinated (government and non-government) horizontal initiative specifically targeting Roma drug use occurred recently in the Czech Republic. At least three specialised outreach services for Roma drug users also exist there and some initiatives have been taken to employ Roma workers in the treatment facilities. This last practice also operates in Hungary.

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Drug-related infectious diseases

Introduction

Drug-related infectious diseases (DRIDs) – HIV infection, hepatitis B and hepatitis C – are among the most serious health consequences of injecting drug use, and may lead to significant health care costs. Injecting drug users (IDUs) may also act as a ‘core groups’ or pockets of infection that pose a continuous threat of spread of infection to the general population.

Shared needles, syringes and other injecting equipment, as well as shared water for preparation and blood-contaminated drugs, are all vehicles of infection between drug users.

Sexual transmission of HIV and hepatitis B virus occurs less frequently but, due to the relatively high prevalence of these infections among drug users, is still significant. Moreover, HIV and HBV can spread by sexual transmission to the wider population. Sexual transmission of HCV is uncommon.

HIV infection, hepatitis C virus (HCV) and hepatitis B virus (HBV) are viral infections with very serious or even fatal consequences. HCV and HBV often lead to chronic liver disease and, to a lesser extent, liver cancer. With HCV there is a 60–80 % probability of chronic liver disease development and 5–10 % in the case of HBV. HCV, which is a common infection among IDUs, can spread particularly stealthily, because approximately 90 % of cases remain clinically undiagnosed yet still lead to chronic disease. HIV, HCV and HBV have high social costs through hospitalisation, chronic illness and premature death. It is estimated that 0.5 % of the total EU health care budget is allocated to drug-related HIV infection, HCV and HBV, with HIV accounting for 71 %, HCV for 24 % and HBV for 5 % of these costs. The actual proportion and quantity of these costs may vary according to the prevalence of the given infection in the respective country.

Other infections are also closely connected to drug use, including tuberculosis (which re-emerged in recent years due to its close association with HIV infection), sexually transmitted diseases and hepatitis A infection (a typical disease associated with ‘dirty hands’, which can be connected to lack of hygiene in a drug-related lifestyle).

One of the key public health problems arising from drug use is the high burden that DRIDs place on the health care system. One of the six main targets of the EU Drugs Strategy (2000–2004) is a substantial reduction of the incidence of HIV, HCV and HBV infections. Even though the situation regarding DRIDs is more favourable in most of the CEECs than in EU countries, the potential still exists for them to spread.

Preventive measures are needed to control the transmission of infections among drug users in CEECs. Harm-reduction responses such as easy access to clean injecting equipment, condoms, HIV testing and counselling, outreach work and substitution treatment, are very effective in decreasing DRIDs. Improving the quality, accessibility and coverage of these responses must be one of the main targets of CEECs with respect to drugs.

Data quality and availability

Monitoring systems for DRIDs are being developed in the CEECs, but these systems need both financial and institutional support. Due to insufficient budgets, there is often a precarious balance maintained between monitoring needs and the lack of financial resources.

Most CEECs have developed HIV surveillance systems in order to monitor the trends of HIV infection prevalence among IDUs. Less information is available about the prevalence and trends of hepatitis C virus and hepatitis B virus infection. Differences in the available HIV/HCV/HBV prevalence data from individual countries, as well as within these countries, must be inter-

preted with caution. In addition to real differences in prevalence rates, the information may reflect variations in the methodological approach, such as the specific characteristics of subgroups of IDUs included in prevalence surveys or surveillance systems and differences in coverage, sampling and testing approaches.

All CEECs collect relatively valid information on newly diagnosed cases of HIV infection. In many countries, it is probable, even where data is available, that the reported national rates for the incidence of HCV and HBV are substantially underestimated. Despite this proviso, trend monitoring is still useful. Reliable information on the transmission route is often unavailable and the reporting methods may vary greatly between countries. It is therefore very difficult to compare the reported incidence rates of newly diagnosed HCV and HBV infections between the countries.

Data regarding tuberculosis, and other infectious diseases among drug users, is generally lacking in CEECs and further development of the monitoring system in this field is needed.

It is even more difficult to monitor and evaluate prevention measures in the field of infectious diseases among IDUs as many epidemiological, social, economic and legal factors have brought about changes in the situation. Nevertheless, the principal evidence based on harm-reduction approaches is well known. The responses that follow from these approaches have been developed to some extent in the CEECs and, in some countries, it is possible to find examples of good process and outcome evaluation.

The EMCDDA has been supporting candidate countries in order to improve the collection, analysis and dissemination of objective, reliable and comparable information about drug-related infectious diseases and responses. Collated information about HIV infection among IDUs complements the information collected by the EuroHIV.

Overview of situation

Of all the CEECs, the Baltic states are the most affected by HIV infection and viral hepatitis. Poland has serious problems with HIV among IDUs, but the situation has stabilised. In other countries, while HCV is at a high level, the HIV epidemic among IDUs has remained low.

Available data on IDUs infected with HIV show variations from 0 % (Bulgaria, the Czech Republic and

Slovakia) to 40 % (Estonia). In the case of HCV, infection rates vary between 6 % (Hungary) and 80 % (Estonia, Latvia and Lithuania). The situation in most of the CEECs is currently more favourable compared with EU countries, but the potential for adverse change exists, as injecting remains prevalent among heroin and opiates users: 80–90 % of all opiate users are injectors and this trend remains stable, or is even on the increase, in most of the CEECs. On the other hand, as heroin injection has increased in the CEECs, the use of home-made drugs, both opiates and stimulants (which are associated with a higher risk of infection due to needle and paraphernalia sharing), has decreased recently.

The levels of response to DRIDs in CEECs vary according to the activities of the national drug coordinating bodies as well as other governmental and, very importantly, non-governmental organisations. The candidate countries have established harm-reduction and other prevention measures but improvement in the coverage and availability of these is needed throughout the region.

Injecting and sexual risk behaviour

Injected drugs

In the CEECs, heroin is now commonly injected, with heroin users representing more than 90 % of cases treated in Bulgaria and Slovenia. Heroin is practically the only drug which is injected in both these countries, as is also the case for Romania. In other countries, especially the Baltic states and Poland, injecting of home-made opiates still persists. However, the use of such home-made substances has decreased in recent years.

In the Czech Republic and, to a lesser extent, in countries such as Slovakia, Hungary, Lithuania, Estonia and Latvia, stimulants are also injected. Whereas the users of home-made amphetamine-type drug (ATDs) (pervitin) in the Czech Republic represent more than 50 % of all newly treated injecting users and more than 50 % of all estimated injecting users, in the other countries ATD users represent 5–10 % of all treated users.

The main identifiable trend across all CEECs is that, while heroin use has increased in recent years, the use of home-made products, both opiates and ATDs, has decreased.

Characteristics and determinants of injecting

Injecting of opiates, including heroin, is the main pattern of use, but there is not enough data for proper cross-country comparison. Nevertheless, several common features are discernable (see Table 3). The rate of opiate injection, both home-made and heroin, remains high. Across the countries the proportion of injectors among opiate users varies between 80 and 90 %. This trend has remained stable for Bulgaria, Slovakia and Slovenia, but has increased in other countries. In Bulgaria and Slovenia, it is possible to carry out a comparison between ‘all’ clients and ‘new’ clients demanding heroin treatment. While the 10 % difference between ‘all’ and ‘new’ clients injecting heroin indicates a decrease in recent heroin injection in Bulgaria (in line with EU countries), in Slovenia, injectors represent almost 100 % of the total number of existing and new heroin users. In the Czech Republic, pervitin remains the most common injected drug, even though there has been a decline in its use. According to the first treatment demands, the percentage of IDUs among all heroin users, is approximately 90 %, representing an increase in recent years. The percentage of IDUs among pervitin users is approximately 80 %, a figure which has remained stable.

Poland seems to be the only country where there has been a substantial decrease in injecting. It remains open

to question, however, whether the reporting system was artificially influenced. Despite this concern, there is a difference in the number of first and repeated treatment demands, indicating that new users inject less. Smoking of heroin has become more prevalent.

There are some factors that influence the route of administration and lead to more high-risk patterns of drug use. According to qualitative research in the Czech Republic, the shift from low-risk patterns of use (sniffing or smoking) to high-risk ones (intravenous use) is often motivated by the search for more intense experiences and also by developing tolerance. It is clear that financial problems, or less availability of a drug on the market (often due to police activity) and a consequent rise in price, represent factors that could increase the risk level of drug use. However, information provided by the municipal police of Vilnius (Lithuania) indicates that smoking of heroin from aluminium foil was at its most widespread in 1998, a period in which the price of heroin was falling, which would seem to contradict this.

Sharing of needles and other paraphernalia (cookers, filters, etc.) or sharing a prepared drug is the most important risk factor leading to drug-related infectious diseases. Using one container for the drug is especially common when home-made drugs are used.

| Country | Characteristics | 1996 | 1997 | 1998 | 1999 | 2000 |
|------------------|---|------|-------|-------|-------|-------|
| Bulgaria (Sofia) | All treatment — IV (1) route of heroin (%) | 70.2 | 77.6 | 85.4 | 81.6 | 83.3 |
| | First treatment — IV route of heroin (%) | 61.3 | 69.1 | 80.7 | 73.3 | 72.1 |
| Czech Republic | First treatment — IV route of heroin (%) | 67.5 | 74.4 | 78.6 | 87.4 | 89.1 |
| | First treatment — IV route of pervitin (%) | 77.9 | 68.4 | 78.0 | 79.1 | 79.9 |
| Estonia | Recent injecting of any drug (%) | n.a. | n.a. | n.a. | 78.6 | 84.4 |
| Hungary | All treatment — IV route of heroin (%) | 57.4 | 79.9 | 53.3 | 51.2 | 80.5 |
| | Daily injecting heroin users out of all heroin users in treatment (%) | n.a. | n.a. | n.a. | > 70 | > 70 |
| Latvia | Injecting as pattern of first use (in FTD) (2) (%) | n.a. | n.a. | 65.8 | 73.3 | 80.7 |
| | All treatment — IV route of heroin (%) | n.a. | n.a. | 86.1 | 96.7 | 97.7 |
| Lithuania | Recent injecting of any drug (%) | n.a. | 93.4 | 93.2 | 88.8 | 95.0 |
| | All treatment — IV route of opiates (%) | n.a. | n.a. | n.a. | 95 | n.a. |
| Poland (Warsaw) | IV route of all users demanding treatment — repeat contact | 74.7 | 58.9 | 47.6 | 33.8 | 28.0 |
| | IV route of all users demanding treatment — first contact | 24.1 | 20.2 | 11.0 | 12.6 | 9.5 |
| Romania | n.a. | n.a. | n.a. | n.a. | n.a. | |
| Slovakia | All treatment — IV route of heroin (%) | 87.8 | 79.61 | 80.08 | 79.61 | 80.24 |
| | First treatment — IV route of heroin (%) | n.a. | 75.43 | 76.86 | 79.11 | 77.1 |
| Slovenia | All treatment — IV route of heroin (%) | 99.7 | 99.7 | 99.7 | 99.8 | n.a. |
| | First treatment — IV route of heroin (%) | 99.6 | 99.7 | 99.4 | 99.6 | n.a. |

n.a. = not available.

(1) Intravenous use is almost identical to injecting. A very small proportion of long-term IDUs inject subcutaneously or intramuscularly.

(2) FDT – First treatment demand.

Table 3: Intravenous drug use in the CEECs according to different indicators

It is not possible to carry out a cross-country comparison of the data on high-risk behaviour. However, provided time series are available, it is possible to monitor behavioural changes within the particular country.

Estonian data, for example, show an increase in both current and previous needle sharing, even though the existing data is incomplete. In 1999, when heroin replaced the poppy mix in Estonia, the level of needle and drug sharing decreased. This trend did not last long and, by the following year, the level of needle sharing was again on the increase. In 2000, the number of users in treatment who had shared a needle in the previous month had increased from 7.9 to 22.4 %, while lifetime sharing had increased from 24.5 % in 1999 to 34 % in 2000.

Inexperienced users in the Czech Republic tend to use drugs in a risky way, but it seems that age is a significantly more important risk factor than the actual drug use experience. However, it should be noted that even clients currently in harm-reduction programmes (including those who are experienced or older) share needles and paraphernalia to a certain extent, despite awareness of the risks. It appears that there is approximately a 50 % reduction in risky behaviour when a client has spent at least one year in a treatment programme. It is possible to grade the perception of risk in different situations. The actual sharing of a needle is perceived to be the most risky, while clients regard repeated use of one syringe as markedly safer. At least one-third of those interviewed believe that it is sufficient to flush the syringe through with water. In general, drug users seriously underestimate the health risks associated with injecting; they often regard hepatitis as 'normal'. Data from the year 2000 on needle sharing among injecting users varied between 35 and 51 % of current users (in the preceding one to three months) and 49 and 55 % of those who had used longer ago. Data gathered between 1998 and 2000 by the Ikterus project in the Karvina district indicated a rate of lifetime sharing of 91 %.

Between 20 and 27 % of Hungarian IDUs shared their boiling pots in the last month, and 37 % of injectors demanding treatment and 64 % of those outside of treatment did not share their needles in the preceding month.

Polish findings show that sharing is more frequent among users of home-made opiates. Even though IDUs are aware of the risks of infection, they share needles when craving for the drug is at a high. Even users who try to avoid sharing mention one crucial high-risk situation

— the deep stupor following opiate use — when they lose control of their equipment. Users of home-made opiates usually warm the liquid prior to injection in order to avoid infection and they subsequently rinse the equipment in cold water. The risk of infection is frequently ignored and considered a 'professional risk'. Data from Warsaw show a decrease in the level of high-risk drug use. Between 1995 and 1999, the percentage of clients who had shared a needle in the 30 days preceding treatment decreased from 31.3 to 12.8 %. This positive trend was reversed, however, in 2000, when the percentage of sharing IDUs increased to 16.9 %. It is possible that this indicates the presence of a new generation of drug users who have not been reached by the harm-reduction measures.

Sexual risk behaviour

Sexual risk behaviour also represents an important transmission route for infection among drug users. Not alone that, it also allows for the spread of infection into the population at large. However, little data is available in the CEECs on this issue.

Male problem drug users in Hungary, for example, admitted to having sex without a condom 6–8 times in the month prior to treatment, while for females it was 2–4 times (Rácz et al., 2002).

In the Czech Republic, 80 % of problem drug users neither live with a partner nor have a short-term sexual relationship. Only 11 % of users maintain a long-term relationship (Miovský et al., 2001). Approximately half of problem drug users engage in promiscuous sexual behaviour and prostitution is an economic fact of life for 4 % of problem users. However, in some regions, Northern Bohemia for example, as many as one-third of problem users are prostitutes. The data on condom use confirms high degrees of unprotected sex, with only 20 % of problem drug users using condoms regularly and as many as 53 % never using them at all (Bem et al., 1999).

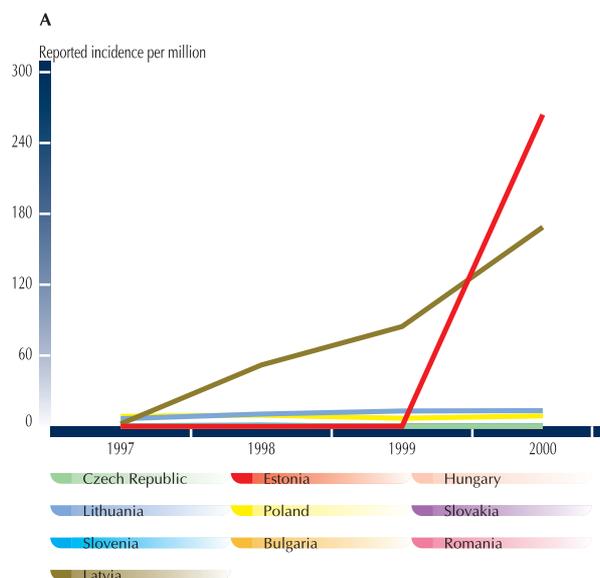
Prevalence and trends

HIV

With regard to HIV infection among IDUs, it is possible to distinguish three different groupings in the candidate CEECs: 1) the three Baltic states, 2) Poland, and 3) the remaining six countries.

The Baltic states

In the Baltic states, there is a high proportion of IDUs among all reported HIV positive cases. A huge increase in



Source: Adapted from European Centre for the Epidemiological Monitoring of AIDS (2001): HIV/AIDS surveillance in Europe, mid-year report 2001, No. 65.

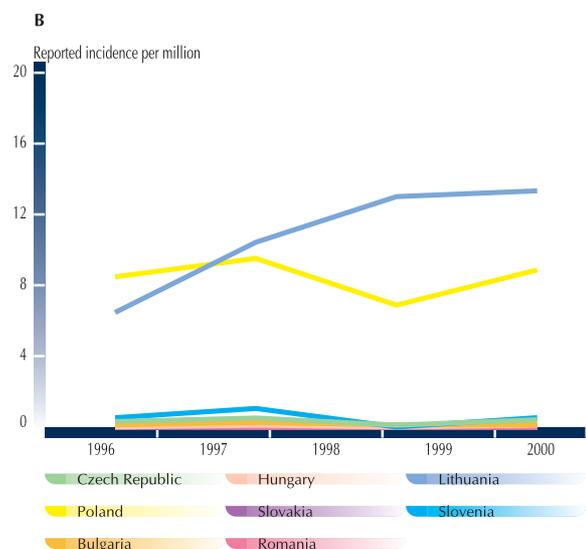
Figure 15 A: Reported newly diagnosed cases of HIV infection among IDUs per million inhabitants in the CEECs

HIV cases were observed, particularly in Latvia, during the 1990s and in Estonia in 2000. Newly reported HIV-positive cases among IDUs in Estonia and Latvia reached 254.1 and 156.3 cases per 1 million inhabitants, respectively. Lithuania had a lower level of newly infected HIV cases among IDUs: 12.7 cases per 1 million inhabitants. In 2000, the percentage of IDUs among all reported HIV positive cases was 90.8 % in Estonia, 81.3 % in Latvia and 72.3 % in Lithuania.

Regarding the prevalence of HIV antibodies, a massive 41 % of IDUs who were tested in Estonia and between 8.8 and 19 % who were tested in Latvia are infected with HIV. The most recent results from Lithuania report 1.6 % of IDUs infected with HIV. The trend of antibody

| Country | Absolute incidence | Relative incidence per 1 million inhabitants | Trend |
|----------------|--------------------|--|-------|
| Bulgaria | 1 | 0.1 | ▶ |
| Czech Republic | 4 | 0.4 | ▶ |
| Estonia | 354 | 254.1 | ▲ |
| Hungary | 1 | 0.1 | ▶ |
| Latvia | 379 | 156.3 | ▲ |
| Lithuania | 47 | 12.7 | ▲ |
| Poland | 330 | 8.5 | ▶ |
| Romania | 0 | 0.0 | ▶ |
| Slovakia | 0 | 0.0 | ▶ |
| Slovenia | 1 | 0.5 | ▶ |

Table 4: Reported newly diagnosed HIV infection cases among IDUs per million inhabitants in 2000



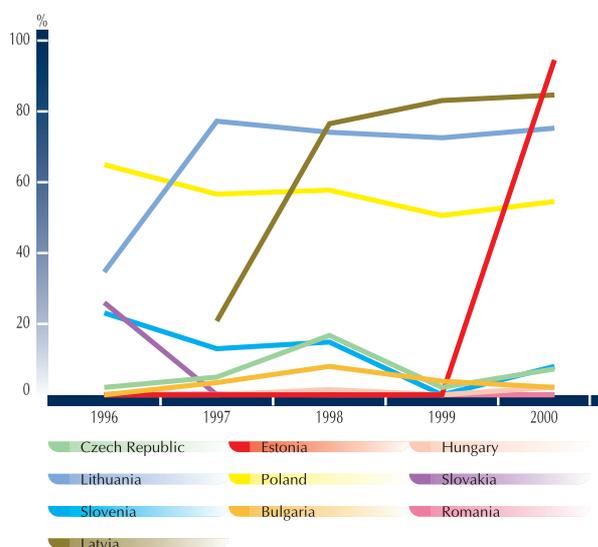
Source: Adapted from European Centre for the Epidemiological Monitoring of AIDS (2001): HIV/AIDS surveillance in Europe, mid-year report 2001, No. 65.

Figure 15 B: Reported newly diagnosed cases of HIV infection among IDUs per million inhabitants in the CEECs (Estonia and Latvia not shown)

prevalence is unknown in Estonia, growing in Latvia and decreasing somewhat in Lithuania, especially in Vilnius (most probably due to the timely implementation of harm-reduction measures).

In 1997 and 1998, the first two cases of HIV infection among IDUs were diagnosed in Estonia. In the year 2000 alone, 390 HIV-positive cases were diagnosed in Estonia, 354 of them among IDUs. The age of those infected was generally between 15 and 24 years, although the youngest person infected was only 13 years old. A considerable proportion of the cases are from Narva, an industrial city in north-eastern Estonia with a mainly Russian-speaking population. The Estonian Ministry of Social Affairs has recommended that the situation be classed as an HIV epidemic. The epidemic spread of HBV and HCV at the end of 1996 and the beginning of 1997 in Tallinn (some 200 cases, 90 % of them connected to IDUs) preceded this HIV outbreak and could be considered as an indication of the risk of HIV infection for IDUs in Estonia.

The first Lithuanian HIV-infected opiate injector was detected in the port city of Klaipeda in 1994. Nearly all instances of HIV in Lithuania originate from the Klaipeda region, which is in close proximity to the Kaliningrad district (a Russian enclave, where IDUs represent the majority of HIV cases). An increased risk is also posed by Belarus, another neighbouring region with significant HIV prevalence.



Source: European Centre for the Epidemiological Monitoring of AIDS (2001): HIV/AIDS surveillance in Europe, end-year report 2000, No. 64.

Figure 16: Percentage of IDUs in all new HIV positive cases in the CEECs

Poland

Newly reported HIV-positive cases among IDUs represented 8.5 cases per 1 million inhabitants in Poland in 2000. Poland was the earliest of all the candidate CEECs to experience an HIV epidemic among IDUs. The outbreak of the epidemic started among IDUs in 1989, when 411 HIV positive IDUs were diagnosed (compared with 12 cases the previous year). By 1991, an annual high of 653 HIV positive cases among IDUs was diagnosed. Since then, the incidence has decreased and stabilised at a level of between 310 and 350 cases of HIV positive IDUs per annum between 1995 and 2000. IDUs represent approximately 50–60 % of all new HIV cases at present and this percentage has remained stable.

The prevalence rate of HIV antibodies among IDUs in 2000 shows that 11–16 % of IDUs were infected with HIV. Local data from Warsaw indicates that this prevalence rate is on the decrease.

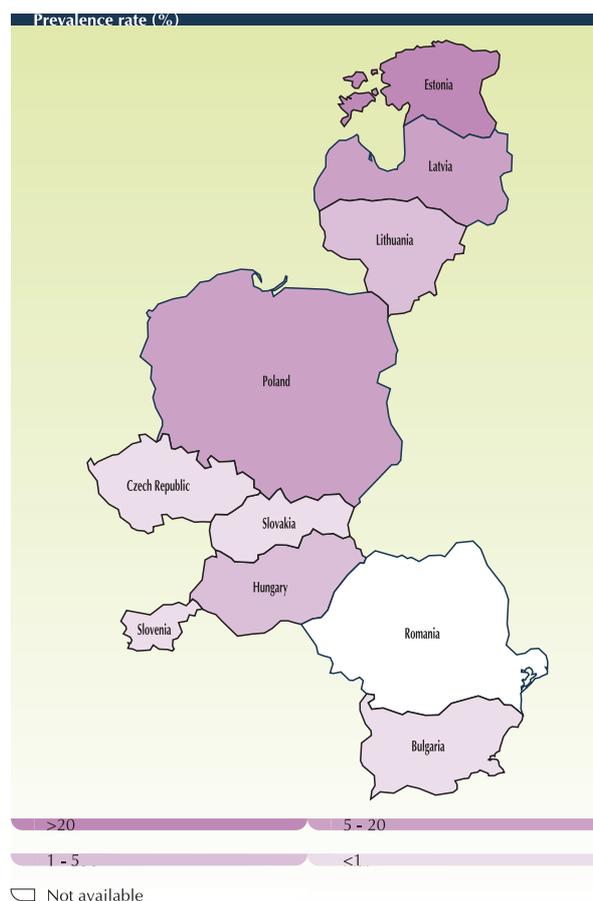
Remaining countries

In Bulgaria, the Czech Republic, Hungary, Romania, Slovakia and Slovenia, the HIV epidemic among IDUs has remained at a low level. Newly reported HIV-positive cases among IDUs vary between 0.0 in Romania and Slovakia and 0.4 and 0.5 cases per 1 million inhabitants in the Czech Republic and Slovenia. In the long term, the percentage of IDUs among all reported HIV cases varies from 0.0 in Romania to 6.5 in Slovenia.

The prevalence rate of HIV antibodies among IDUs has remained low; less than 1 % of IDUs are infected with HIV.

So far, the number of diagnosed AIDS cases among IDUs remains low in all CEECs because of the long latency period of HIV infection, except for Poland, which has a stable trend, and Latvia, where it is on the increase.

It is possible to identify groups of drug users with a higher risk of HIV infection, such as detainees and prisoners. One of the reasons is that these groups are exposed to a higher risk of transmission due to the limited access to harm-reduction measures in the criminal justice systems in the CEECs. In Estonia, for example, approximately 25 % of all reported HIV cases are detainees, but this number has been decreasing recently. In Latvia, approximately 30 % of all reported HIV-positive IDUs are in prison, while in Lithuania the figure is approximately 10 %. In May 2002, 10 % of 1 977 prisoners in one Lithuanian prison were found to be HIV positive, most of the cases



Source: 2001 CEEC national reports.

Figure 17: Prevalence rates of HIV antibodies among IDUs in the CEECs

| Country | Population | Geographical area | Year/period | Sample size | Rate (%) | Trend |
|----------------|--|-----------------------|-------------|-------------|----------|-------|
| Bulgaria | Low-threshold centres, treatment centres, outreach work, syringe exchange schemes | Sofia | 2000 | 711 | 0 | ▶ |
| Czech Republic | n.s. | Czech Republic | 2000 | 2091 | 0 | ▶ |
| | Low-threshold centres | Karvina | 2000 | 123 | 0 | ▶ |
| Estonia | Treatment centres, hospitals, syringe exchange schemes, prisons, overdose cases, emergencies | Tallinn | 2000 | 964 | 41 | n.a. |
| | | | | | | |
| Hungary | Treatment centres, outreach work | Budapest | 1999–2000 | 179 | 1–5 | n.a. |
| Latvia | Treatment centres, hospitals | Latvia | 2000 | 1447 | 9 | ▲ |
| | Outreach work | Riga | 2000 | 113 | 12 | n.a. |
| | Syringe exchange schemes | Riga | 2000 | 307 | 19 | n.a. |
| Lithuania | n.s. | Lithuania | 2000 | 772 | 2 | 6 |
| | Low-threshold centres | Klaipeda | 1999 | 278 | 3 | 6 |
| Poland | Treatment centres, STD clinics, hospitals, testing sites | Poland | 2000 | 3106 | 11 | n.a. |
| | First treatment | Warsaw | 2000 | 275 | 16 | ▼ |
| Romania | n.a. | | | | | |
| Slovakia | Treatment centres | Bratislava and Kosice | 2000 | 801 | 0 | ▶ |
| Slovenia | Treatment centres | Slovenia | 2000 | 484 | 0 | ▶ |
| | Treatment centres | Ljubljana and Koper | 2000 | 147 | 1 | n.a. |

n.a. = not available. n.s. = not specified.

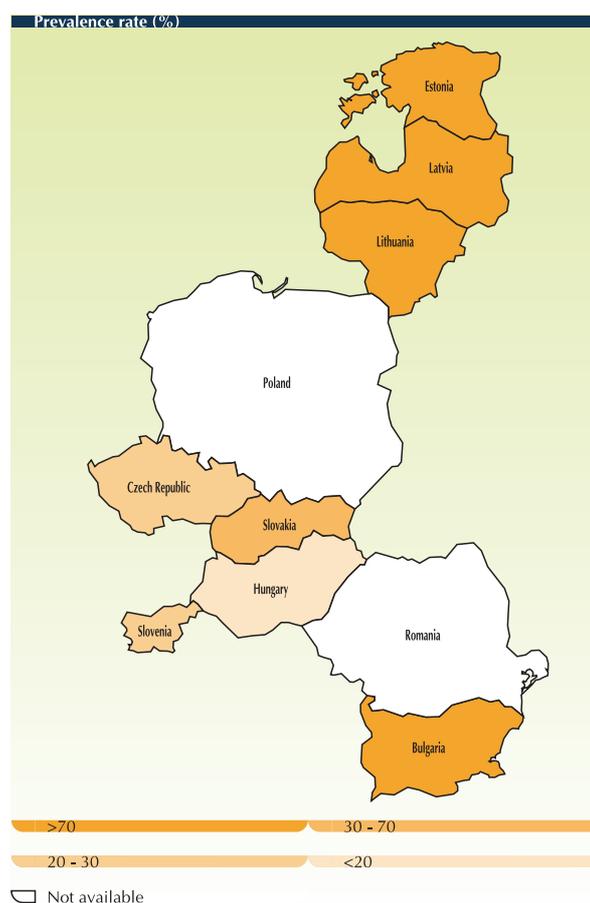
Table 5: Prevalence of HIV antibodies among IDUs in the CEECs

being drug-related. It is estimated that about 80 % of all users in Polish therapy wards are HIV positive. Ethnic minorities, apart from the Russian-speaking inhabitants of the Baltic states (see above), are at a greater risk of infection, due to their social isolation and the low availability of harm-reduction measures. Roma communities are especially endangered, despite several targeted measures that have been implemented in Bulgaria, the Czech Republic, Slovakia and Lithuania.

The situation surrounding HIV infection in some CEECs can be potentially influenced by ongoing epidemics in neighbouring countries. For example, in Russia, including the territories of Kaliningrad, Belarus and the Ukraine, the spread of HIV infection is associated to a large extent with drug injection.

Viral hepatitis

There is not enough data available in order to compare newly reported HCV and HBV infection among IDUs in all the CEECs. Only a few countries are able to provide this data with an acceptable degree of reliability. However, it is known that 45–55 % of all newly reported cases of HCV and 20–50 % of all newly reported cases of HBV are IDUs. One has to bear in mind that most of the new cases, particularly of HCV, remain unreported, due to the low percentage of clinically apparent cases.



NB: A more representative prevalence rate of 20 % for the low-threshold centres was used for the Czech Republic.

Figure 18: Prevalence rates of HCV antibodies among IDUs in the CEECs

| Country | Population | Geographical area | Year/period | Sample size | Rate (%) | Trend |
|----------------|---|-------------------|-------------|-------------|----------|-------|
| Bulgaria | Low-threshold centres, treatment centres, outreach work, syringe exchange schemes | Sofia | 2000 | 673 | 72 | ▲ |
| Czech Republic | Low-threshold centres | Karvina | 2000 | 91 | 20 | ▼ |
| | Methadone treatment | Prague | 1999 | 60 | 68 | n.a. |
| Estonia | n.s. | Tallinn | 1994–1995 | 57 | 83 | n.a. |
| Hungary | Treatment centres, outreach work | Budapest | 1999–2000 | 141 | 6 | n.a. |
| Latvia | Methadone treatment | Riga | 1997 | 161 | 83 | n.a. |
| Lithuania | n.s. | Lithuania | 2000 | 693 | 79 | ▲ |
| Poland | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| Romania | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| Slovakia | First treatment | Bratislava | 2000 | n.a. | 34 | ▶ |
| Slovenia | Treatment centres, hospitals | Slovenia | 2000 | 475 | 21 | ▶ |

n.s. = not specified.

n.a. = not available.

Table 6: Prevalence of HCV antibodies among IDUs in the CEECs (specimen = serum, marker = HCV Ab)

The prevalence rates of HCV and HBV antibodies provide a more reliable picture (and one which bears comparison) within the CEECs (see Tables 6 and 7). However, the figures vary, both between and within countries, in relation to the year of the study, the country, the sample of tested IDUs, the average duration of injecting and the risk level of injecting. A comparison of the HCV prevalence within individual countries is very similar to the comparison of HIV infection. Latvia, with 83 % of IDUs infected with HCV, and Estonia, with 82.5 %, represent the most affected countries. Hungary, with 6 %, has the lowest reported country level.

The incidence rate of HCV antibodies has been calculated in two CEECs in order to estimate the speed of HCV dissemination. In Bratislava (Slovakia), 13 cases per 100 persons per year among retested negative IDUs were infected with HCV. In the Karvina district (Czech Republic), the figure was 18.4 cases per 100 people per year between 1998 and 2000, while the trend during that period showed a decrease.

Except for some countries and some samples of long-term users, the prevalence rate of HBV antibodies is two to three times lower than for HCV.

| Country | Population | Geographical area | Year/period | Sample size | Rate (%) | Trend |
|----------------|---|-------------------|-------------|-------------|----------|-------|
| Bulgaria | Low-threshold centres, treatment centres, outreach work, syringe exchange schemes | Sofia | 2000 | 711 | 75 (1) | ▼ |
| Czech Republic | Low-threshold centres | Karvina | 2000 | 90 | 9 | ▲ |
| | Methadone treatment | Prague | 1999 | 60 | 46 | n.a. |
| Estonia | n.s. | Tallinn | 1994–1995 | 57 | 79 | n.s. |
| Hungary | Treatment centres, outreach work | Budapest | 1999–2000 | 141 | 5 | n.a. |
| Latvia | Methadone treatment | Riga | 1997 | 194 | 38 | n.a. |
| Lithuania | n.s. | Lithuania | 2000 | 698 | 7 | ▶ |
| Poland | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| Romania | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| Slovakia | First treatment | Bratislava | 2000 | n.s. | 7 | ▶ |
| Slovenia | Treatment centres, hospitals | Slovenia | 2000 | 472 | 5 | ▲ |

(1) Bulgaria has reported a 5 % prevalence of HBsAg, which indicates approximately 75 % of IDUs infected with HBV.

n.s. = not specified.

n.a. = not available.

Table 7: Prevalence rates of HBV antibodies among IDUs in the CEECs

Responses

The basic measures employed to reduce negative health consequences and the social costs of high-risk behaviour among drug users include access to clean injecting equipment, substitution treatment (see 'Problem drug use and treatment responses'), reaching out to injecting drug users, counselling and testing, access to condoms and provision of appropriate information. These measures are referred to as 'harm reduction'. Most of them were introduced and further developed as a response to the spread of HIV infection among drug users in the 1980s. Harm-reduction measures are implemented in all the CEECs nowadays, but their range and coverage needs to be improved on.

In recent years, some new harm-reduction approaches, such as medically supervised injecting rooms and controlled heroin distribution, have been applied in some European countries and in the United States. As yet, none of these innovative approaches have been implemented in the CEECs.

Access to clean injecting equipment

In all of the CEECs, needle and syringe exchange programmes (SEPs) have been implemented. The coverage rate per country varies. Needle exchange is available in the capital city or several main cities for Bulgaria, Hungary, Latvia, Lithuania, Slovenia, Slovakia and only in the capital of Romania. Estonia has exchange programmes in nine cities and Poland in 15 municipal areas. Syringe and needle exchange were available in 66 out of 78 districts in the Czech Republic in 2000. Rural regions are rarely covered by the syringe exchange programmes (see Table 8).

In countries which have available data, the number of syringes distributed per year varies from 40 000 in Estonia to over 1 million in the Czech Republic. Even though the syringe exchange programmes are not widely available in most countries, the ratio of exchanged needles and syringes to number of inhabitants of a country is an appropriate comparison technique (see Table 8). Hungary reports the lowest number of needles and syringes distributed in 2000: 57 units per 10 000 inhabitants. The Czech Republic achieved the highest level: 1 120 needles and syringes distributed per 10 000 inhabitants. With the exception of Poland, the prevalence of DRIDs seems to be related to the timeliness of implementation of SEPs, probably indicating early social awareness of the potential threat to public health. Despite Poland being the first of the CEECs to implement SEPs in 1988, the HIV epidemic among IDUs was not avoided. A possible explanation

could be that the availability and coverage of the SEPs in the 1980s and the early 1990s was not sufficient.

There is limited data about the proportion of IDUs involved in the syringe exchange programmes. What is clear is that this needs to be increased in all CEECs. In Estonia, about 10 % of all IDUs are thought to be involved in exchange programmes. In the Czech Republic, approximately 50–60 % of the syringes used by the IDUs per year are distributed within the framework of syringe exchange programmes.

Non-governmental organisations (NGOs) administer most of the syringe exchange programmes in each country. Nowadays, in all countries with available data, needles and syringes are distributed freely without the rigorous application of a 'one for one' exchange. The syringe exchange is often carried out within the framework of outreach work or by use of mobile units. This mobile exchange is usually carried out in places where illicit dealing already takes place. No needle and syringe exchange programmes operate



Source: 2001 CEEC national reports.

Figure 19: Syringes distributed in syringe exchange programmes per 10 000 inhabitants in the CEECs in 2000

| Country | SEP coverage | Number of SEPs | Syringes distributed | Per 10 000 inhabitants | Year of implementation |
|----------------|--------------------------|----------------|----------------------|------------------------|------------------------|
| Bulgaria | 4 cities | 6 | 200 000 | 252 | 1995 |
| Czech Republic | Almost the whole country | 66 | 1 150 000 | 1 120 | 1993 |
| Estonia | 9 cities | 9 | 20 500 | 147 | 1997 |
| Hungary | 4 cities | 4 | 57 000 | 57 | 1995 |
| Latvia | 3 cities | 1 | 52 000 | 215 | 1999 |
| Lithuania | 5 cities | 5 | 33 000 (1) | 89 | 1996 |
| Poland | 15 cities | 15 | 469 000 | 122 | 1988 |
| Romania | The capital | n.a. | n.a. | n.a. | n.a. |
| Slovakia | The capital | 3 | 100 000 | 185 | 1994 |
| Slovenia | 3 cities | 3 | 160 000 | 805 | 1992 |

NB: n.a. = data not available.

(1) Data from the Klaipeda syringe exchange programme in 1997.

Table 8: Needle and syringe exchange programmes (SEPs) in the CEECs in 2000

in prisons or detention units, even in the countries with a high HIV prevalence among prisoners who inject drugs.

Two stumbling-blocks preventing the achievement of a higher volume of distributed syringes were the scarcity of organisations implementing syringe exchange programmes and the lack of financial resources. Other reasons for this failure include the following: special permission for syringe exchange is required from the national authorities (Hungary), police have been reported disturbing clients near exchange points (Estonia) and IDUs can be afraid to exchange needles due to fear of stigmatisation (the Czech Republic).

In all of the CEECs with available data, it is legal for pharmacies to sell syringes and needles. Staff attitudes in the pharmacies vary between countries, with Estonia reporting a rather negative attitude towards IDUs, and Slovenia reporting a fairly positive one. In Slovenia, in the cities of Celje and Zalec, two pharmacies are involved in syringe exchange. The results of a questionnaire carried out in pharmacies in the Czech Republic in 1998 and 2000 show that 38 to 43 % of the staff demonstrated a negative attitude towards the sale of injection materials to drug users.

In most countries, it is impossible to estimate the number of syringes sold by pharmacies. In the Czech Republic, approximately 900 000 syringes have been sold annually in recent years, less than half of all syringes used by IDUs.

The price of an injecting set varies from €0.05 to €0.15 in the CEECs.

Estonia was the only country where an educational programme and staff training for pharmacies was carried out.

Distribution of condoms

Condoms are generally available in stores, shops, pharmacies and petrol stations in all CEECs. Free distribution is provided by syringe exchange programmes, outreach services and low-threshold centres for prostitutes and IDUs, depending on the available financial resources of the given institution. In some countries, condoms are available in prisons. For example, in some Estonian prisons, they are distributed in meeting rooms and are available for relatives of the inmates. In Slovenia, condoms are freely available in prisons. Condom distribution for prisoners is prohibited in Bulgaria.

Availability of HIV testing

Availability of HIV tests varies both between and within countries. In Bulgaria, Estonia and Slovenia, HIV testing is only available in a few centres. In other countries, HIV testing is provided by the institutional network that covers the whole country (county hospitals in Hungary, public health institutions in the Czech Republic and Slovakia). In all countries with available data, testing is anonymous and free. In Lithuania, a Ministry of Health decree obliges HIV testing of known IDUs to be carried out once or twice a year.

HIV/AIDS therapy

In all countries with available data, HIV/AIDS therapy is free and is either covered by insurance or paid for from specific budgets. In many countries there is no difficulty about provision of treatment to IDUs. In Estonia, only drug-free patients are eligible for anti-retroviral treatment.

Vaccination

With regard to HIV, HCV and HBV infections, HBV is the only one for which a vaccine is produced and

used. In most of the countries, HBV vaccination for IDUs is paid for just as it would be if a 'regular' applicant applied for it. In Slovenia, HBV vaccination is covered by insurance and almost all IDUs in treatment are vaccinated free of charge, but the vaccination scheme is encountering some problems. In other countries, only single cases or limited groups of IDUs are vaccinated. In the Czech Republic, an extensive vaccination campaign was conducted among IDUs in 1998 and 1999, when almost 1 000 users were vaccinated against HBV. In the Karvina district of the Czech Republic, vaccination against HBV is provided through a special project supported by the Ministry of Health and there is approximately an 80 % take-up rate for the scheme. In Bratislava (Slovakia), when vaccination against HBV was provided, more than 1 000 clients received all three doses of the basic scheme.

Evaluation of harm-reduction measures

Even though it is very difficult to prove any direct causal relationship between preventive measures focused on IDUs and real changes in their health status or risk profile, mention of a few examples will demonstrate the outcome evaluation of preventive responses.

Evaluation of the Sofia Needle Exchange Project in Bulgaria showed a positive benefit for the project's participants. There was a decrease in the sharing of injecting equipment and in unsafe sexual practices, while the knowledge of risks and the demand for, and use of, condoms increased.

The Ikterus project, controlled by the District Institute of Public Health in Karvina (the Czech Republic), operates through very close cooperation between the institute and four low-threshold centres in the district. The project, which started in 1998, consists of testing, vaccination, syringe exchange and information dissemination. Two HBV infection outbreaks, mostly among IDUs and their sexual partners were controlled by vaccination of contact persons in the locus of the epidemic. In the Karvina district, the incidence rate and seroprevalence of HCV has decreased in recent years, while HIV remains at zero level.

The drop-in centre in Klaipeda (Lithuania) provides needle, syringe and condom distribution plus counselling and information dissemination. Their data indicates a decrease in HIV prevalence among IDUs from 6.8 % in 1997 to 2.9 % in 1999. This positive trend was corroborated by testing undertaken by the Counselling Clinic for Social Diseases, 'Demetra', of the Lithuanian AIDS Centre, which found that approxi-

mately 1.5 % of drug users are infected; this percentage is remaining stable. New cases of HIV have not been diagnosed among young drug users.

The Centre for Treatment of Drug Dependencies in Bratislava (Slovakia) implements a comprehensive programme based on the education of drug users, testing drug users for blood-borne infections, vaccination against hepatitis B, a needle distribution programme and a methadone-maintenance programme. All these programmes were fully functional at the beginning of 1998. All clients with negative HBV markers are vaccinated against HBV. Between 1997 and 2001, 1 817 users, mostly from Bratislava, were involved in this programme. During the same period, HIV prevalence among IDUs has remained almost at zero, the prevalence of HBV has remained low and HCV prevalence has remained below 40 % over the last three years.

Two correlation studies are available indicating the influence that provision of sterile injecting equipment has had on the spread of DRIDs among IDUs. A regional analysis of the data on HIV infection rates in Poland between 1990 and 1995 showed a statistically significant impact of the syringe exchange programmes. Those regions with higher rates of syringe distribution were found to have lower rates of HIV infection. Similarly, the higher volumes of syringes exchanged within Czech districts was related to the lower reported incidence of HCV and to the positive changes in this incidence during the period 1998 to 1999.

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The drug market and drug-related criminality

Changes in domestic markets

Shift from locally produced drugs to 'international' substances

The drug problem is a relatively recent phenomenon in most of the CEECs, as it only started in the 1990s. Even where the problem started earlier, as in Poland, the extent and nature of the problem changed significantly in the 1990s. At present, the drug scene in the CEECs increasingly resembles that of western Europe.

In Poland in the 1970s and 1980s, and in Estonia, Latvia and Lithuania in the late 1980s, home-made opiates were produced by drug users from poppy straw. It is inaccurate to describe this as a 'market' as the 'Polish heroin' was produced by drug users for personal use and only the surplus was sold. In the Czech Republic, the drug scene was dominated by pervitin — the Czech metamphetamine, also produced domestically. The local drug markets were not connected with international ones, so international organised crime was not involved.

The situation has diametrically changed in the 1990s. New drugs such as amphetamines, cannabis, LSD, ecstasy, cocaine and heroin brought organised criminal groups into the drugs arena, and the market was developed with connections to international markets.

The transit and production role of the CEECs has facilitated the creation of domestic markets, thus contributing, to some extent, to the growth of the drug problem in the region. However, the increase in drug consumption in the region is not only determined by supply but also by demand for drugs, and it seems that this second factor plays a more important role. Central eastern European youth consider recreational drug use to be part of a western lifestyle, and this is therefore seen as attractive. As the results of a qualitative study in Poland show, cannabis and synthetic drugs are becoming a common feature of youth culture. It seems that the drug supply only satisfies the demands that result from these cultural influences.

According to drug seizures data, the drug market is expanding. These figures cover seizures by all law-enforcement agencies dealing with drugs, such as the police, customs, border guards, special drug agencies, etc., which vary from country to country. The figures include confiscation of drugs on the street as well as at the wholesale level. The available data, however, do not differentiate between drug seizures on the domestic market and seizures of drugs in transit. It is also difficult to distinguish which come from the wholesalers and producers and which come from the consumers and dealers. Therefore, data on drug seizures can only provide a very general picture of changes in the market.

The increasing trend in both the number of seizures and the quantities of particular drugs varies from country to country. The figures fluctuated over time, but the same trend of increase could be identified in most cases, especially in the number of seizures. The numbers, however, are fairly small, which means they are sensitive to random fluctuation. The figures for the quantity of drugs are even more sensitive, because just one relatively large seizure can have quite a marked effect. The rising trend in drug seizures may simply reflect changes in the actions of law-enforcement agencies rather than changes in the extent of the drug problem. However, sometimes the trend of drug seizures can provide an indication about changes in the drug scene. For example, it seems that heroin appeared on the Baltic states markets later than it did in the other markets in the region (Figure 20).

Over the last three years, there has been a far greater increase in heroin seizures in Estonia and Lithuania (especially Estonia) than in other countries of the region. Heroin seizures in those two countries have also increased more than seizures of other drugs. This could be interpreted as a homogenisation of the drug scene in the region, bringing them more in line with the western drug scene.

| | Quantity of drugs seized in kg | | | | | Number of seizures | | | | |
|-----------------------|--------------------------------|---------|---------|---------|----------|--------------------|------|------|------|------|
| | 1996 | 1997 | 1998 | 1999 | 2000 | 1996 | 1997 | 1998 | 1999 | 2000 |
| Bulgaria (1) | | | | | | | | | | |
| Cannabis | 14195.86 | 13.380 | 752.012 | 0.019 | 687.164 | 4 | 3 | 7 | 3 | 19 |
| Heroin | 195.471 | 311.618 | 158.002 | 261.567 | 1860.987 | 24 | 23 | 20 | 15 | 45 |
| Cocaine | 14.288 | 1.020 | 685.155 | 13.08 | 2.610 | 4 | 2 | 8 | 5 | 6 |
| Amphetamine | 0 | 222.346 | 0 | 0 | 32.530 | 0 | 1 | 0 | 0 | 3 |
| Czech Republic | | | | | | | | | | |
| Cannabis | 12000 | 5.5 | 5.5 | 112.4 | 39.75 | 5 | 14 | 19 | 131 | 517 |
| Heroin | 20 | 3.4 | 147.3 | 108.38 | 114.52 | 12 | 10 | 14 | 19 | 34 |
| Cocaine | 22 | 62.5 | 41.3 | 140.8 | 14.71 | 3 | 2 | 4 | 3 | 28 |
| Amphetamine | 21 | 0 | | 4.1 | 0.72 | 2 | 0 | 1 | 12 | 18 |
| Estonia | | | | | | | | | | |
| Cannabis | 7.754 | 3.962 | 28.106 | 44.632 | 81.75 | 85 | 71 | 147 | 182 | 223 |
| Heroin | - | - | 0.091 | 0.518 | 0.438 | 0 | 0 | 18 | 129 | 249 |
| Cocaine | 0.002 | 0.006 | 2.565 | 0.128 | 0.108 | 4 | 10 | 35 | 26 | 22 |
| Amphetamine | 1.103 | 0.69 | 1.881 | 10.813 | 26.692 | 29 | 37 | 126 | 164 | 207 |
| Hungary | | | | | | | | | | |
| Cannabis | 862 | 2342 | 151.8 | 100.5 | 131 | 345 | 770 | 1340 | 2029 | 2295 |
| Heroin | 319.2 | 206.1 | 937 | 172.7 | 819 | 145 | 177 | 423 | 688 | 688 |
| Cocaine | 8 | 7.6 | 20 | 115 | 10.9 | 59 | 86 | 132 | 152 | 190 |
| Amphetamine | 0.5 | 12.7 | 10.3 | 4.6 | 10.5 | 198 | 490 | 720 | 569 | 408 |
| Lithuania | | | | | | | | | | |
| Cannabis | 0.826 | 8.63 | 30.357 | 25.667 | n.a. | 5 | 13 | 45 | 70 | n.a. |
| Heroin | - | 0.089 | 0.423 | 0.923 | n.a. | 0 | 2 | 6 | 34 | n.a. |
| Cocaine | 1.056 | 2.049 | 10.133 | 0.275 | n.a. | 2 | 2 | 11 | 16 | n.a. |
| Amphetamine | 0.054 | 0.171 | 0.013 | 0.077 | n.a. | 2 | 8 | 12 | 29 | n.a. |
| Slovakia | | | | | | | | | | |
| Cannabis | 24.8 | 874.1 | 15377 | 849.5 | 234.3 | 252 | 161 | 378 | 399 | 619 |
| Heroin | 10.6 | 90.4 | 13.7 | 5.8 | 98.5 | 687 | 1086 | 567 | 401 | 604 |
| Cocaine | n.a. | 9.6 | 1.6 | 2.5 | 0.2 | 19 | 15 | 18 | 29 | 25 |
| Amphetamine | n.a. | n.a. | 9.7 | 0.1 | 1.1 | 20 | 19 | 44 | 51 | 101 |

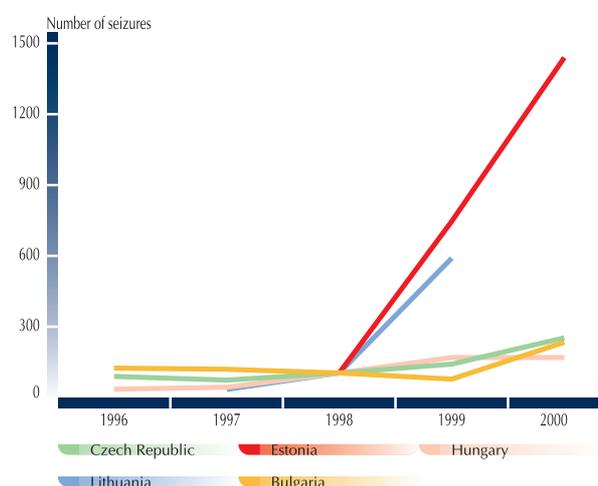
(1) Seizures by customs only.

Table 9: Drug seizures in the CEECs

Cannabis seizures have also increased in recent years, particularly in the Czech Republic, Estonia and Hungary. However, the amount of cannabis seized has decreased. This may be because resources are being targeted by local law-enforcement agencies at street level (making arrests of dealers and users) rather than focusing on traffickers and major dealers.

Shift in patterns of use and the drug culture

In Poland, which has a relatively long history of drug use, using drugs was initially part of the hippie ideology of the 1970s and was later incorporated into other subcultures. In the 1980s, drugs were used — without any ideological justification — for their psychoactive properties alone. In response to law-enforcement measures, groups of drug users began to organise themselves and it is in this context that a subculture of



Source: 2001 CEEC national reports.

Figure 20: Trend in number of seizures of heroin
(Index 1998 = 100)

drug use started to develop and the symbols, norms and customs typical of drug users' groups began to emerge. Drug user circles were quite hermetic at that time. Due to the pharmacological properties of home-made opiates, users rapidly became dependent and social marginalisation soon followed. Although the drug subculture was an attractive alternative for some, fear, repulsion or compassion were more common reactions than the wish to join it. The primitive nature of the drugs used then, together with injecting, HIV infection and rapid social degradation and health impairment, discouraged most people from following that path.

The situation has changed rapidly during the 1990s. New substances have appeared on the drug scene that need not be injected and have the image of being 'clean', sophisticated and harmless — characteristics which have markedly increased the attractiveness of the 'drug use' experience. Over time, understanding of the advantages and risks associated with using particular drugs has improved, and a picture of those using them has emerged. Young people who began experimentation with drugs in the 1990s or after are, in many ways, different from those who began using drugs in earlier decades. Drug use is now relatively common behaviour related to leisure, rather than deviant behaviour associated with socially maladjusted youth. The world of adults has not been able to stop this process, probably partly because of the profound nature of the transformation of societies in the region and its consequences. Rapid social change involving the destruction of social structures and the introduction of entirely new economic and political systems has significantly altered the relationship between generations. The struggle of adapting to the new reality has rendered many parents incapable of giving adequate guidance to their children. Young people, who are often as confused as their parents, are faced with conflicting values, norms and lifestyles. Western cultural patterns are seen as particularly attractive, where commitment or obligations are scorned and self-gratification is actively promoted. Those drugs which are considered sophisticated and safe fit well with such a scenario.

Changes in patterns of drug use are dictated to some extent by fashion. Fashions in drug use are frequently related to other aspects of leisure and entertainment — new trends in music, in particular. For example, this was the case with ecstasy, which was associated with techno music, and heroin, which was associated with hip-hop. Drugs that enter the market in connection with specific trends in youth culture tend to gain a wider base of users over time.

Availability of drugs

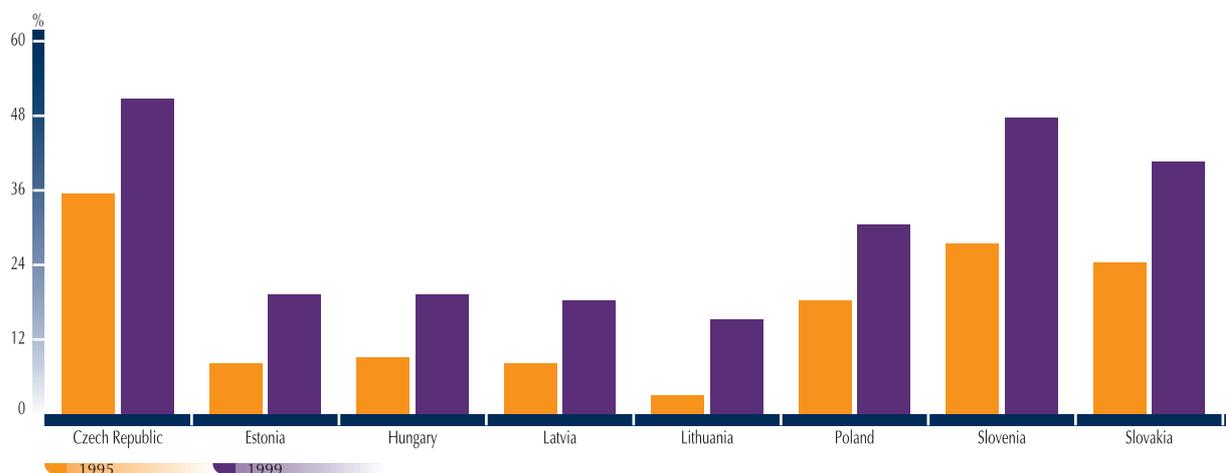
Drug availability is one of the factors influencing drug consumption. It can be considered in terms of individual access to drugs and in terms of supply and price. Individual availability is dependent not only on the amount of drugs on the market but also on the way the market functions. For example, according to a qualitative study in the Polish city, Poznan, it is very difficult to buy drugs there without knowing a dealer or being recommended, while in cities like Warsaw or Krakow, there are open street markets available to all. The availability of new technologies also makes it possible to purchase and sell drugs by mobile phone or the Internet.

The perceived availability of drugs by potential consumers may be an indicator of actual availability. In population or school surveys, for example, respondents are often asked to assess how difficult it would be for them to obtain particular substances or they are asked for their opinion on the general availability of drugs. An indicator constructed in this way could be a useful supplementary tool for assessing changes in availability.

According to the results of the 1995 and 1999 ESPAD school surveys, perceived drug availability varies greatly from country to country in the region. School students were asked to assess how easy it would be for them to buy a particular drug.

In all participating CEECs, significant differences in responses can be observed between 1995 and 1999. The percentage of students perceiving particular drugs to be 'easy' or 'very easy' to obtain increased considerably. Examining the data for cannabis and ecstasy, the graph shows a higher increase in countries where the percentages were lower in 1995, such as the Baltic states and Hungary. In some countries, such as Poland and, in particular, Estonia, the perceived availability of ecstasy increased more than cannabis, while in Lithuania the opposite was the case (see Figures 21 and 22).

Price is an important factor in drug availability. Since countries differed in how they collected drug-price data, the price of a particular drug is not comparable between countries, but price structure could still be compared. Comparison is made even more difficult because price data on some drugs is missing in a number of countries. Figure 23 highlights both similarities and differences between countries in their drug price structures. Cocaine and heroin prices vary widely from country to country. Cocaine is generally the most expensive drug, with heroin usually in second place. However, in Estonia and Latvia, heroin occupies first place. In Poland, cocaine is slightly more expensive than white heroin, but in the Czech



NB: Percentage of students who thought it easy or very easy

Source: ESPAD.

Figure 21: Perceived availability of marijuana or hashish according to ESPAD

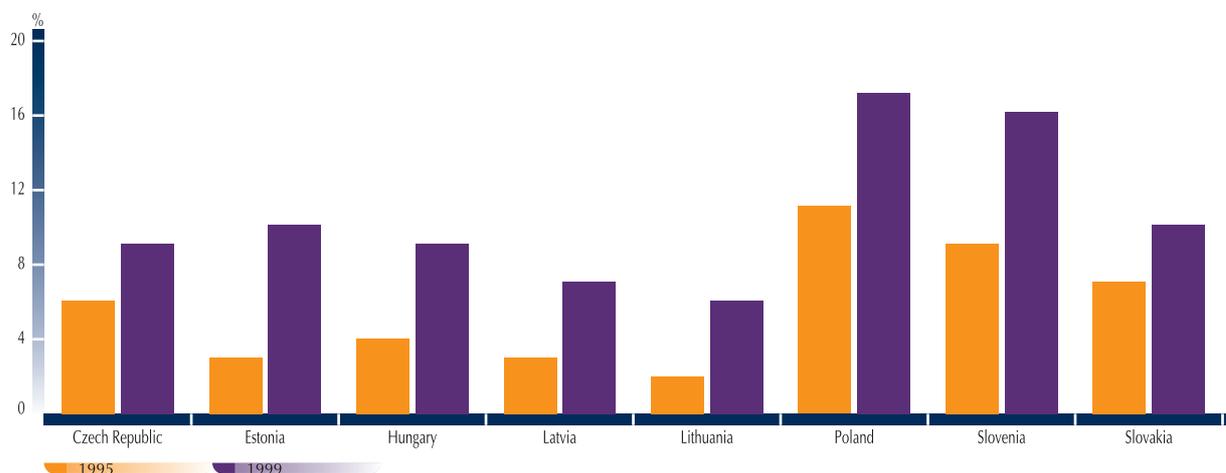
Republic it is more than twice the price. While marijuana is the cheapest drug in all countries, significant price differences still exist from country to country for marijuana and hashish, it being cheapest in Hungary and most expensive in the Czech Republic. The relatively high price of heroin in Latvia and Estonia could be due to its fairly recent appearance on local markets.

Only Hungary and the Czech Republic have collected data on drug prices over a longer period of time, but the methodology of collection may be open to question. Hungarian figures for 1996 to 2000 show an increase in the price of all drugs, and this is particularly evident from 1999 on. Data from the Czech Republic for the corresponding period show drug prices remaining stable. Qualitative information from the other CEECs, gathered over a shorter time period, suggest drug prices have remained stable in recent years.

In summary, the increase in perceived availability, combined with stability in prices, support the contention that there is no decrease in drug availability. At the same time, this could be interpreted as an illustration of certain limitations of supply-reduction strategies in the region.

Traffic and transit of drugs across the region

CEECs are an important drug-transit area, particularly in relation to the European Union. For example, 97 % of drugs seized by Bulgarian customs was destined for the consumer markets in central and western Europe. However, as drug consumption increases, it seems that the CEECs are increasingly becoming targets for distribution as well.

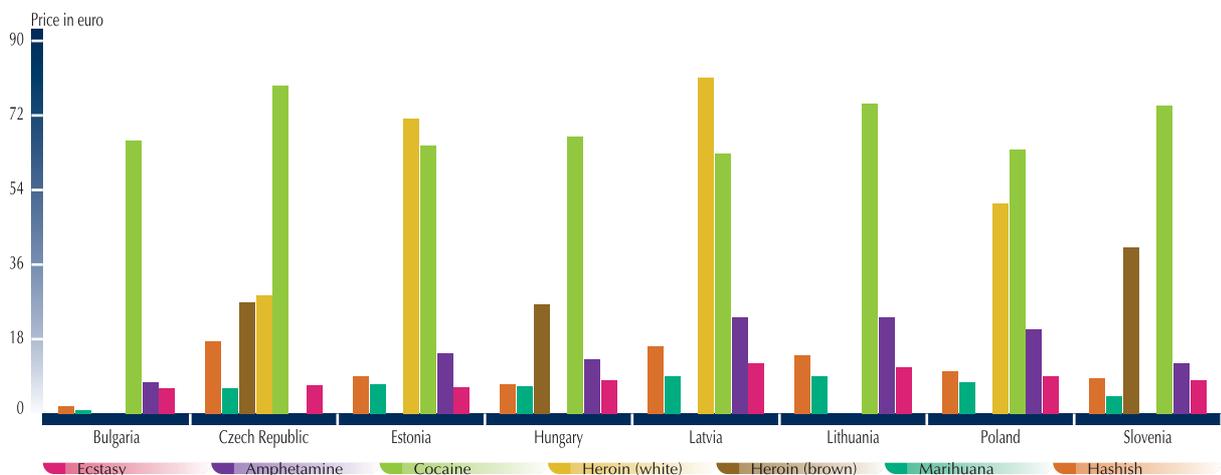


NB: Percentage of students who thought it easy or very easy.

Source: ESPAD.

Figure 22: Perceived availability of ecstasy according to ESPAD

The drug market and drug-related criminality



NB: Prices of ecstasy per tablet, other substances per gram.

Source: 2001 CEEC national reports.

Figure 23: Prices of drugs in Euro in 2000

The region plays a central role as a transit area in heroin trafficking. Heroin is smuggled into the whole of Europe from Afghanistan, Iran, Pakistan and Turkey through Bulgaria, the former Yugoslav republics, Romania and Hungary — the so-called 'Balkan route' — and from the central Asian states through Russia, the Ukraine, Poland and the Baltic states along the so-called 'silk route'. Law-enforcement agencies estimate that at least 80 % of the heroin available in Europe is transported along the Balkan routes. CEECs are used to storing heroin destined for secondary distribution in the European Union. Albania is being used increasingly as a transit country for heroin trafficking, mostly to Italy and Greece.

The Balkan route is used in the opposite direction to smuggle the chemicals used in heroin processing. In 1999, Operation Purple, a voluntary international anti-trafficking programme, was initiated to prevent the distribution of potassium permanganate. Poland, Hungary and Bulgaria have been actively involved in identifying smuggling routes and dismantling trafficking networks. In addition, Operation Topaz, which commenced in March 2001, has been successful in inhibiting the trafficking of acetic anhydride when law-enforcement agencies successfully identified trafficking routes through Romania and Bulgaria (International Narcotics Control Board, 2001).

According to the United Nations Office for Drug Control and Crime Prevention (UNODCCP), 80 % of heroin consumed in western Europe comes from Afghanistan and Pakistan. Half of this drug (about 120 tons of heroin equivalent) comes to Europe via central Asia and eastern and central Europe. During 2000, Germany's role in the 'silk route' was probably

reinforced, since it is not only a consumer country but also a significant gateway en route to the consumer markets of the European Union.

Synthetic drugs, mostly amphetamines, are smuggled from Poland, the Czech Republic, Lithuania, Latvia and Estonia either directly to the Nordic countries or else across the Baltic states. Amphetamines are also transported to Germany. Ecstasy is transported from the west, mostly the Netherlands, to CEECs, although its trafficking also occurs to some extent in the opposite direction (from Poland to Austria or Germany, for example). Baltic states like Estonia are points of transit for synthetic drugs from western and central Europe to the Scandinavian countries. According to the UNDCP, 'amphetamine-type substances (ATS) seizures are also reported from eastern Europe, notably from Bulgaria, Poland, the Russian Federation, the Czech Republic, Estonia and Hungary, which accounted together for 98 % of all ATS seizures in east Europe' (Global illicit drug trends, 2001).

Cannabis, mostly with a high THC (tetrahydrocannabinol) content, crosses the European Union to the CEECs, while herbal cannabis from Albania is destined for the European Union, notably Greece and Italy. Cannabis is also smuggled through the Baltic states, for example from Spain through Estonia to the Nordic countries.

The region is also beginning to play a role in cocaine trafficking. The drug sometimes travels in a roundabout fashion to European Union countries in order to avoid the vigilance of police and customs officers. Cocaine is sometimes shipped from Latin America to ports in the CEEC and then on to the west. Cocaine destined for western Europe has been seized in Poland, Bulgaria,

Estonia, Lithuania and Albania. Sometimes the cocaine is stored in transit countries prior to further distribution in the Europe Union.

In summary, the region serves not only as a point of transit for the west of the continent — this as a result of its geographical location — but it also is beginning to form a common drugs market with the western European countries.

The region as a producer and potential exporter

In some CEECs, the production of traditional drugs is ongoing, though its extent varies. In Poland, production of 'Polish heroin' has diminished due to a decreasing demand for the drug, as well as due to increased difficulty in acquiring the poppy plants. A move to low-opium poppy cultivation has considerably limited supply and virtually no cases of attempted export of the drug to other countries have been recorded. This is in marked contrast to the case of pervitin in the Czech Republic, where production continues both for internal use and export, particularly to Germany, Austria and Slovakia.

The region is now beginning to produce drugs commercially for the first time. At present this appears to be mostly limited to synthetic drug production and cannabis cultivation. Synthetic drugs were initially developed for export to the Nordic states and Germany, but latterly they are being produced for domestic consumption too.

Synthetic drug production has grown, due to weak regional control mechanisms. The initial lack of awareness, experience and proper legal regulation in the CEECs has created an ideal atmosphere for the development of illegal laboratories. Lack of controls on the precursors, especially, has aided illegal production. In the early 1990s, there were even attempts to produce drugs synthetically in official chemical and pharmaceutical factories. Poland was the first of the CEECs to produce amphetamines, but nowadays there are illegal laboratories in Bulgaria, Hungary, the Czech Republic and the Baltic states. In 2000, illegal laboratories producing PMA and PMMA for consumer markets in western Europe were uncovered in Poland. In Poland, Bulgaria and Estonia, laboratories producing ecstasy have also been dismantled.

Cannabis is cultivated primarily for domestic use, but, in the case of Albania, it is also exported.

Drugs and crime

Drug use and criminal activity are interconnected and the nature of this connection is very complicated. Generally speaking, drug-related crime includes any criminal activity that is committed either to fund, or as a consequence of, drug use.

In *Tackling drugs together - a strategy for England 1995–1998*, several types of drug-related offences are distinguished. These include:

- all offences covered by a country's drug legislation (e.g. trafficking, production, using, supplying, etc.);
- criminal acts by persons as a consequence of drug misuse;
- acquisitive crime (such as theft, burglary and fraud) to finance drug misuse;
- laundering of drug-trafficking profits, either to fund further drug trafficking or to allow unrestricted use of assets; and
- violent crime carried out in the course of drug distribution and trafficking (for example, violence between dealers or against innocent parties).

Legislation and changes in legislation

How crimes relating to drug use or supply (such as production, trafficking, distribution and possession, the promotion of drug use and money laundering) are viewed is very dependent on the law of the country in question. Drug control legislation in the CEECs varies from country to country, both in its scope and attitude towards repression. In some countries, drug possession is penalised regardless of the amount involved and whether or not it is for personal use. This is the case, for example, in the Czech Republic, Lithuania, Hungary, Poland, Romania and Slovakia. Other countries do not regard possession of small quantities for personal use as an offence. In Estonia, first-time possession, or purchase of small quantities of drugs for personal use, is considered an administrative offence and is not prosecuted. A second similar misdemeanour committed within 12 months is penalised in accordance with the Criminal Code. In Slovenia, possession of small quantities of illegal drugs for personal use is considered a misdemeanour and merits a fine or prison sentence of up to five days. In Bulgaria, possession for personal use in the case of drug addicts is not punishable.

Drug-related criminality, which appears to be on the increase, determines to a large extent the scale and intensity of repressive measures. In the late 1990s, new harsher laws

were adopted in the Czech Republic, Poland, Lithuania, Romania and Slovakia. These changes in the law make analysis of trends more difficult, as greater repression could increase the number of offences recorded.

Offences against the drug laws

Law-enforcement data on drug-related offences show an increase in almost all CEECs (Figure 24).

A decreasing trend (since 1997) has only been noted in Slovakia, which is related to a Supreme Court ruling on drug law. In the Czech Republic, the trend was going up until the end of 1999, but the following year, 2000, showed a decrease due to changes in the reporting system. Estonia had the largest increase in the number of registered drug-related offences, a 13-fold increase between 1996 and 2000. Slovenia had the least, with two-and-a-half times more.

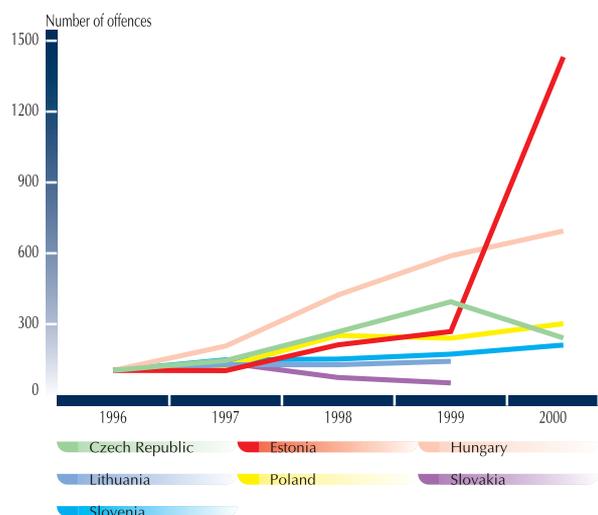
The main offences dealt with by police are possession, use, encouragement to use and retail sale of drugs. In Estonia, for example, offences associated with use or possession of drugs (without intent of trafficking) amount to 80 % of all drug-related offences registered by police. In Slovenia, between 1996 and 2001, the number of drug-related misdemeanours increased 3.7 times (4 352 in total), while the number of drug-related crimes increased 2.3 times (1 537 in total). In Poland, 82 % of all drug-related offences involve possession, sale or use.

Detection and prosecution of wholesale trafficking, large-scale production and laundering of drug money is relatively rare. Law-enforcement agencies, therefore, are not able to influence the drug market significantly in the long-term. At best, a limited impact on local markets for a short time is achieved.

With crime figures on the rise in almost all CEECs, a large influx of drug users can be expected in correctional facilities, causing additional demands on state budgets. In Poland, for example, study results show that drugs are available and used within the prison system. In fact, some people first use drugs when detained in a penal institution.

Offences committed by drug users

It is difficult to assess the extent of criminality among drug users. Statistical data have generally not been collected, nor surveys undertaken, by the CEECs. One exception to this is the Czech survey 'The Impact Analysis Project of New Drug Legislation' (known as the PAD study), which estimated the proportion of drug-related criminal activity (Zabranský et al., 2001). The results show that the most common offences are those against property (theft, burglary and robberies). This study was ordered by the Czech government after an



NB: Index 1996 = 100

Source: 2001 CEEC national reports.

Figure 24: Numbers of drug-related offences registered by the police

amendment to drug laws introduced punishment for drug possession for personal use. The research combined quantitative and qualitative methodology and made extensive use of the EMCDDA harmonised key epidemiological indicators. The study results showed the social and monetary losses arising from this legislation. Following the study findings, the Czech government defined six concrete steps in order to improve the situation.

A qualitative study conducted in Poland among 'street-level drug users' showed that petty offences are common. Offences against property, particularly among drug addicts using Polish heroin, were the commonest. Violence was reported more often among drug addicts using 'new' drugs like amphetamines. In some ways, this mirrors societal transformation, with increasing violence in interpersonal relations becoming commonplace. Young people are surrounded by violence, both from peers and adults, and this is also apparent in the world of drugs.

A Hungarian study carried out in 2001 focused on enforcement by the judicial authority in cases of drug offences in order to determine if the provisions of the Penal code (in effect from 31 March, 1999) would achieve its social goals and impact on drug policies.

Organised crime

The appearance of 'new' drugs in the 1990's (heroin, amphetamines, cannabis, LSD, ecstasy, and ultimately cocaine) in the CEECs paralleled the appearance of organised criminal groups. The market developed through connections to the international market.

Large-scale drug production and trafficking is increasingly becoming the domain of international criminal

groups and local drug distribution is controlled by organised crime gangs that would previously have been involved in theft and smuggling of cars, alcohol and cigarettes. New criminal groupings have also emerged in the drugs business. The fight for control of the developing drugs market has become very vicious, with the use of guns and explosives being seen for the first time.

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A summary report of the PAD study is available at:

http://wtd.vlada.cz/files/rvk/rkpp/dokumenty/pad_en.pdf

<http://www.sananim.cz/dis/engine/texty/help/PAD%20english.zip>

Selected terms used

Capture–recapture method: Sophisticated statistical method using different sources of data in order to identify overlaps and consequently estimate hidden populations.

First treatment demand: Number of people (or percentage of population) seeking drug-related treatment for the first time in a given period.

High-threshold treatment: A ‘drug-free’ treatment aimed at achieving total abstinence from any (illicit) drug as soon as possible. With the exception of detoxification, the patient has to be drug free before entering the programme/treatment.

Lifetime prevalence: Number of people (or percentage of population) who have used any illicit drug at least once in their lifetime.

Low-threshold treatment: Treatment that is not solely focused on the goal of total abstinence and does not insist that clients/patients are drug free before entering the treatment/programme. An important focus of low-threshold services is the general health and safety of the user, and a wide range of measures are used to achieve this, including nutritional and vitamin advice, needle exchange

programmes and education about safer patterns of drug use.

Prevalence of current use: Number of people (or percentage of population) who have used any illicit drug during the last month.

Prevalence of last year use: Number of people (or percentage of population) who have used any illicit drug in the last year.

Problem drug use: Intravenous drug use (IDU) or long duration/regular use of opiates, cocaine and/or amphetamines. Ecstasy and cannabis are not included in this category.

Treatment: This term is used to define the process that begins when problem drug users come into contact with a health provider or other community service. Treatment may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached (WHO et al., 2000).

Treatment demand: Number of people (or percentage of population) receiving drug-related treatment in a given period, whether they have received treatment before or not.

EMCDDA national focal points in the candidate CEECs

Bulgaria

Secretariat of the National Drugs Council
Ministry of Health
39 Stamboliski Blvd.
Sofia 1000 — Bulgaria
Tel: (359-2) 930 13 00
Fax: (359-2) 930 11 88
E-mail: NDC@abv.bg

Legal base

Appointed by the Minister of Health, who is also chairman of the National Drugs Council (NDC).

Czech Republic

Secretariat of the National Drug Commission
Office of the Government of the Czech Republic
Nabr. Edvarda Benese 4
118 01 Praha 1 — Malá Strana — Czech Republic
Tel: (420-2) 96 15 32 22
Fax: (420-2) 96 15 32 64
E-mail: mravcik.viktor@vlada.cz

Legal base

Governmental resolution No. 643 of 19 June 2002 constituted the National Focal Point for Drugs and Addictions in the Secretariat of the Governmental Council for Drug Policy Co-ordination (formerly the National Drug Commission).

Estonia

Estonian Drug Monitoring Centre
Institute of Experimental and Clinical Medicine (IECM)
Hiiu 42
EE 11619 Tallinn — Estonia
Tel: (372) 670 70 99
Fax: (372) 670 68 14
E-mail: ave.talu@ekmi.ee

Legal base

Decree of the Minister of Social Affairs No. 204 of 24 May 2001 established the Estonian Drug Monitoring Centre at the Estonian Institute of Experimental and Clinical Medicine (under the Ministry of Social Affairs) as a national focal point to the EMCDDA.

Hungary

Ministry of Health, Social and Family Affairs
Arany János u. 6–8
H – 1245 Budapest
P.O. Box 487
Tel: (36-1) 332 31 00
Fax: (36-1) 269 40 07
E-mail: liptak.jozsef@eum.hu

Legal base

Pending a governmental resolution, functions of NFP assigned to the Ministry of Health, Social and Family Affairs.

Latvia

State Centre for Drug Abuse Prevention and Treatment
Ministry of Health
Hospitalu iela 55
Riga LV 1013 — Latvia
Tel: (371-7) 37 46 81
Fax: (371-7) 37 23 37
E-mail: iva.berzina@latnet.lv

Legal base

Appointed by the Minister of the Interior, who is also the chairman of the Drug Control and Drug Abuse Combat Coordination Commission.

Lithuania

State Public Health Service
Kalvariju 153
LT-2001 Vilnius — Lithuania
Tel/Fax: (370-2) 66 14 63
E-mail: audrone.astrauskiene@vvspt.lt

Legal base

Order of the Ministry of Health [of 5 April 2002 established the national focal point to the EMCDDA in the State Public Health Service.

Poland

National Bureau for Drugs Prevention
Dereniowa 52/54
02-776 Warsaw — Poland
Tel: +48 22 641 15 01
Fax: +48 22 641 15 65
E-mail: sierosla@ipin.edu.pl

Legal base

Act of Law of 6 September 2001 amending the Act on Counteracting Drug Addiction and other acts of law; Journal of Laws, 2001, No. 125, item 1367, dated 30 October 2001, entrusts the National Bureau for Drug Prevention of the Ministry of Health with monitoring the drug problem (data collection, analysis and reporting).

Romania

Institute of Health Services Management
31 Vaselor, Sector 2
73258 Bucharest — Romania
Tel: (401) 252 78 34
Fax: (401) 252 30 14
E-mail: bmartian@hotmail.com

Legal base

Appointed by the Ministry of Health and the Ministry of the Interior.

Slovakia

Central Node of the Drug Information System
General Secretariat of the Board of Ministers for Drug Dependencies and Drug Control
Námestie slobody 1
81370 Bratislava — Slovakia
Tel: (421-2) 57 29 57 32
Fax: (421-2) 52 49 16 94
E-mail: alojz.nociar@government.gov.sk

Legal base

Governmental resolution No. 534 of 22 May 2002 established the National Monitoring Centre for Drugs (NMCD) as an independent department at the government office serving as a focal point to the EMCDDA; it is also a member of the European Information Network on Drugs, Reitox.

Slovenia

Institute of Public Health
Trubarjeva 2
SI — 1000 Ljubljana — Slovenia
Tel: (386-1) 244 14 90
Fax: (386-1) 244 14 47
E-mail: Mercedes.lovrcec@ivz-rs.si

Legal base

The Prevention of Illicit Drug Abuse and Treatment of Drug Addictions Law (1999) provides for the establishment of an information unit for illegal drugs; Order of the Minister of Health of March 2001 established the Information Unit for Illegal Drugs and its national focal point to the EMCDDA at the Institute of Public Health of the Republic of Slovenia.

European Commission

2002 Report on the drug situation in the candidate CEECs

Luxembourg: Office for Official Publications of the European Communities

2002 — 52 pp. — 21 x 29.7 cm

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About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of 12 decentralised agencies set up by the European Union to carry out specialised technical or scientific work.

Established in 1993 and operational since 1995, the Centre's main goal is to provide 'objective, reliable and comparable information at European level concerning drugs and drug addiction and their consequences'. Through the statistical, documentary and technical information it gathers, analyses and disseminates, the EMCDDA provides its audience – whether policy-makers, practitioners in the drugs field or the general public – with an overall picture of the drug phenomenon in Europe.

The Centre's main tasks are:

- collecting and analysing existing data;
- improving data-comparison methods;
- disseminating information; and
- cooperating with European and international organisations and with non-EU countries.

The EMCDDA online

An online, interactive version of the 2002 Report on the drug situation in the CEECs is also available at <http://candidates.emcdda.eu.int>. This version provides links to the reports and background documents used in assembling this report.



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