European Monitoring Centre for Drugs and Drug Addiction

Krajowe Biuro do Spraw Przeciwdziałania Narkomanii

CENTRUM INFORMACJI O NARKOTYKACH I NARKOMANII

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Summary

Drug Policy

The public discussion in the field of drugs was dominated by the “smart drugs”. In the period of reference two amendments of legal act were introduced putting together 26 substances under legal control. The amendments did not limit the supply of “smart drugs” in Poland. From 2009 different expert teams were working on possible changes of drug low in order to limit or eliminate “smart drugs” from the market. One of the approaches to counteract this problem was described in National Report 2009 Not only government, but also parliament and opposition political parties have prepared their propositions. Due to public pressure and information about possible threat for public health the at the beginning of October 2010 General Sanitary Inspector has decided to close all smart shops for the period of 30 days. Government has rapidly prepared and proceed the amendment of drug low putting ban on all substances acting similar to illicit drugs. The act was widely discussed by experts in different fields, like low and human rights. The amendment was accepted by both chambers of parliament (Sejm and Senat) and is currently waiting for signature of Polish president.

The Council for Counteracting Drug Addiction - a coordination body in the field of drug policy – basing on information on implementation of National Program for Drug Addiction 2006-2010 has identify threat of not reaching the goal of improving access to treatment services the Program in the field of treatment. The task is to provide a substitution treatment to 20% problem opiate users. Up till now this type of treatment is available for around 7% of problem opiate users.

In 2010 most of the activities of the Council, as well as working groups and various institutions and experts in the field of drugs were focused on preparation of Polish presidency in EU and on coordination of work on new program for counteracting Drug Addiction 2011-2016.

General population studies

Under monitoring drug use prevalence in the general population National Bureau for Drug Prevention and Millward Brown SMG/KRC counducted a qualitative study on a representative sample of 1001 Polish population in 2009 (15-75 year old, N = 1001). The study was concerned using psychoactive substances. The study was conducted face to face at respondents’ homes by means of a computer and was based on the Omnibus approach. The results of the study show that the most prevalent drugs in Poland include cannabis (5%) and amphetamine (3%). Among legal psychoactive substances legal highs were the most popular (6%). Last year prevalance were: legal highs – 5%, cannabis – 2% and

amphetamine – 2%. Psychoactive substance use is particularly in residents of cities, especially big ones (over 500 thousand population) and the highest prevalence rates of substances use were recorded in respondents with post-secondary education aged 40 and younger. Similarly to the other general population studies, this study shows that men use psychoactive substances more often than women.

The study “Social diagnosis 2009”, headed by Janusz Czapiński and Tomasz Panek, is intended to provide comprehensive information on the conditions and quality of life of Polish people. In 2009, 12 381 households (37 841 members) were studied. Individual interviews were conducted with 26 178 household members aged 16 and older. The respondents were asked, among other things, about drug consumption in the last 12 months.In 2009 the prevalence of drug use in the last year stood at 1.2%, which is a slight increase compared to 2007 (1.0%). In 2009, 12 381 households (37 841 members) were studied. Individual interviews were conducted with 26 178 household members aged 16 and older. The respondents were asked, among other things, about drug consumption in the last 12 months. Similarly to previous years, the results of the “Social diagnosis 2009” study show that drug users are predominantly male. Among females there are almost three times fewer illegal substance users. Residents of the biggest cities (over 500 thousand population) use drugs nearly two times more often than residents of towns and villages.

Prevention

According to the Regulation of the Minister of National Education of 2002, the school is obliged to develop and implement school (universal) prevention programme in compliance with the curriculum and adequate to developmental needs of students and needs of the community. The obligation also refers to early identification of social maladjustment among school youth and providing psychological and pedagogical assistance for drug-endangered students and their parents.

In 2008, by way of Resolution of the Council of Ministers of 19 August 2008, “Safe and friendly school” governmental programme 2008-2013 was approved. The programme aims at building a school which is both supportive and demanding for students. The programme strengthens the educational role of the school, generates a positive social climate, including the improvement of students-teachers relations.

On 23 November 2009, a Memorandum of Understanding was signed between the Minister of National Education, Minister of Health and Minister of Sport and Tourism on the promotion of health and prevention in children and youth. The Memorandum ensures the synergy of actions in health promotion and problem prevention in children and youth implemented by

the parties thereto in schools, institutions and the local community, including implementing health promotion programmes such as “Schools for Health in Europe”.

In 2009, the National Bureau for Drug Prevention commissioned peer education programmes to 12 NGOs operating across Poland. The tasks commissioned were aimed at preparing young people to implement activities of drug prevention and health promotion in peer environment or the local community.

In 2009, under selective prevention, the National Bureau took part in an international “FreD goes net” project co-financed by the EU under the Public Health Programme. The project aims at promoting a selective prevention model based on short-term intervention for young drug users across European countries.

The National Bureau for Drug Prevention supported programmes for drug-endangered individuals, drug experimenters and their families, implemented by non-governmental organizations. 73 programmes were commissioned. Funding was provided for programmes supporting families of drug-endangered individuals, drug users and addicts, implemented by 24 organizations.

Moreover, selective prevention programmes were implemented directly in the community of occasional drug users or groups at risk of drug addiction (e.g. among sex workers, children of the street) and in setting of higher drug use prevalence (clubs, discotheques, open air events). Such actions included 3 095 occasional drug users.

According to the Act of 29 July 2005 on counteracting drug addiction, local governments (provincial and communal) are obliged to develop and implement Provincial and Communal Programmes for Counteracting Drug Addiction. Under these programmes, local governments support local and regional initiatives, which included school educational programmes, programmes for parents, training courses for programme implementers, programmes for at-risk youth and their families as well as extracurricular classes. In 2009, 16 provincial governments sponsored universal prevention programmes. The programmes included 168 018 participants at schools and approx. 40 995 outside schools.

Local governments also supported selective prevention programmes. A total of five programmes were implemented at schools and 44 outside schools. Selective prevention activities were performed in 16 schools and 33 other institutions. The programmes included the total number of 22 040 participants.

Problem Drug Use

The latest estimation of problem drug users conducted of 2007 shows that there were 100-125 thousand problem drug users in 2005. The Information Centre for Drugs and Drug Addiction conducted a survey of low threshold programme clients in 2008. 773 questionnaire interviews were held under the project. All the survey participants were problem drug users.

The most prevalent drug among the respondents were opioids – three quarters of the survey participants (76%) used opiate (heroin, Polish homemade heroin ('kompot'), methadone or buprenorphine) in the last 30 days prior to survey. Second in terms of prevalence was amphetamine (61%), alcohol ranked third (60%).

Residential treatment data

Based on statistical records of the residential psychiatric treatment we are able to follow trends in drug addiction understood as regular use of drugs causing serious problems including mental or behavioural disorders. The number of patients in specialist drug treatment facilities and hospital wards due to drug dependence was steadily rising in previous years. Then by 2007 a downward trend was recorded in the number of admissions to inpatient treatment. However, the most recent data from 2008 data show stabilization of the trend. In 2008 residential treatment admitted 12 627 patients. Compared to the previous year, the trend of people entering treatment in specialist clinics and hospitals levelled off (in 2007, 12 582 patients were admitted to inpatient clinics). The indicator per 100 000 inhabitants stands at 33.1 (it means that in 2008 33.1 individuals per 100 000 entered residential drug treatment). The proportion of first-time patients decreased from 52.7 in 2006, 50.1 in 2007 to 49.1 in 2008. In 2008 residential treatment centers admitted more men (74%) than women (26%). The most numerous group were opiate users (17.2%), then came users of tranquilizers and sleeping pills (11%), amphetamines (4.4%), cannabis (2.9%). The remaining categories of patients did not exceed 1%. It must be stressed that 63.2% of the patients were classified under the category "mixed and unspecified".

Data from Treatment Demand Indicator (pilot project)

In Poland, the Information Centre for Drugs and Drug Addiction (CINN) works on introducing a new treatment demand data collection system compliant with the TDI protocol ("Treatment Demand Indicator (TDI). Standard Protocol 2.0"). Collecting data under the new drug treatment demand monitoring system started in 2008 and has been performed as a pilot project which aims at identifying frequent problems in completing the questionnaire and verifying the reliability of data collection tools. In 2008, the project included 33 health care units (ZOZ) providing drug treatment and rehabilitation services for problem drug users.

In 2008, drug treatment units, which took part in the Treatment Demand Indicator (TDI) pilot project, admitted 2 082 patients, including 851 first-time patients. There were 1 648 men (79%) and 434 women (21%), including the respective numbers of 668 (78%) and 183 (22%) among first-time patients. The most prevalent primary drug among patients admitted to drug treatment was marijuana (30.6%), then came amphetamine and heroin (respectively 24.6%).

Psychoactive substance treatment system in Poland

Pursuant to Article 26.5 of the Act of 2005 on counteracting drug addiction, services of drug treatment, rehabilitation and reintegration are provided for a drug dependent individual free of charge, regardless of place of residence in Poland. Providing health services for drug dependent individuals is based on a network of outpatient and inpatient clinics with the status of public or non-public health care units. The basic link of the first intervention and psychological assistance is fulfilled by outpatient clinics, mainly by Addiction Prevention and Treatment Counselling Centres.

The system of health care over individuals dependent on narcotic drugs is still dominated by long or medium-term forms of residential treatment. However, a trend to shorten the therapy is emerging. Residential clinics are mainly located outside urban areas and provide drug treatment and rehabilitation programmes based on the therapeutic community model.

In Poland, according to the National Bureau there are 87 residential clinics and 222 ambulatory ones. Moreover, the services for drug dependent individuals are provided at detoxification wards, day care centres for addiction treatment, hospital drug treatment wards, harm reduction programmes, therapeutic wards for drug dependent inmates at penal institutions and social reintegration programmes. Some facilities also provide services for patients with a dual diagnosis. In 2009 substitution treatment included 1 900 patients in 17 programmes run at health care units and 5 programmes in prisons.

Drug-related infectious diseases

The nationwide data on HIV and AIDS cases reported to Sanitary and Epidemiological Stations, including those related to using drugs come from the National Institute of Public Health – National Institute of Hygiene. The number of routinely recorded HIV infections in drug users has been falling in recent years. The 2009 data indicate a stabilization of the trend (49 new cases recorded). While interpreting the above data, one must take into consideration the fact that in a number of HIV infections recorded no route of infection is stated.

The AIDS trend in injecting drug users, which reflects the phenomenon with substantial delay, was falling in 2003-2006. In 2007, 183 AIDS cases in total were recorded (130 cases in 2006), including 102 in injecting drug users (65 in 2006). In the light of the 2008 data showing 161 AIDS cases altogether, including 66 in injecting drug users, the 2007 information points to temporary fluctuation of the trend. The data for 2008 show an upward trend in all cases of AIDS incidence compared to 2006. Simultaneously, incidence rates among IDUs levelled off assuming that the 2007 rise was just a temporary fluctuation of the trend. The 2009 data show a downward trend compared to 2008 (out of 126 new AIDS cases 51 referred to IDUs).

The survey “Estimation of the prevalence of infectious diseases (HCV, HBV and HIV) in injecting drug users in Gdansk and Krakow” was conducted between October 2008 and September 2009 in the cities of Krakow and Gdansk. The recruitment of the survey participants was based on Respondent Driven Sampling and included lifetime injecting drug users. Blood sample-based laboratory tests for HIV, HCV, HBV (HBsAg, anti-HBc) and syphilis (VDRL) were conducted. The survey included 193 participants. Estimated HIV prevalence among ever injectors in both cities was 10.3% (6.1% - 15.3%), estimated prevalence of antibodies against hepatitis C virus (anti-HCV) was 47.6% (34.2% - 56.7%) and estimated prevalence of antibodies against hepatitis B core antigen (anti-HBc) was 30.1% (21.2% - 37.8%).

Drug-related deaths

The most dramatic consequences of drug use are drug-related deaths. The basic source of information concerning this issue in Poland is the database of the Central Statistical Office (GUS). Drug-related deaths were extracted basing on the national definition which covers the following ICD-10 codes: F11-12, F14-16, F19, X42, X44, X62, X64, Y12 and Y14. In recent years we have been watching the drug-related mortality trend level off. In 2006, 241 deaths were recorded. In 2008 the figure stood at 244. Out of the individuals who fatally overdosed drugs 44 (19%) were aged below 25. 56% of all deaths registered in the database of the Central Statistical Office were male.

Responses to health correlates and consequences

Health and social harm reduction activities involve a number of various interventions, adequate to the needs of local community. They might include needle and syringe exchange programmes, substitution treatment programmes, counselling, peer education and outreach. In 2009, the National Bureau co-financed 15 health and social harm reduction programmes for individuals addicted to psychoactive substances. It seems vital that some local governments sponsor harm reduction programmes: 27 communal governments provided financial support for 38 drug-related harm reduction programmes. Harm reduction programmes co-financed by communes included 40 643 participants in 2009.

In Poland there are drug treatment units which offered services for patients with dual diagnosis. According to the data at hand, there are 20 inpatient clinics across Poland which admit patients with dual diagnosis. In most cases drug treatment units are not prepared for patients with dual diagnosis and consequently the real number of treatment units specializing in such disorders is far lower. Such patients are referred to mental health counselling centres and in the event of acute disorders to psychiatric hospitals. In 2009, in Poland there were 2 wards at psychiatric hospitals and 3 rehabilitation centres for psychoactive substance

addicts. They offered 35 beds and provided both psychiatric and drug treatment. 4 of these facilities/wards offered 69 beds. 384 hospitalizations were performed there.

Social correlates and social reintegration

Alarming trends can be observed among provincial governments which finance social reintegration programmes for psychoactive substance dependent clients who completed drug treatment or receive substitution treatment. A total amount of funds earmarked by provincial governments to this end in 2009 was two times lower compared to 2008.

However, it is comforting that communal governments increased the financial resources, number of social reintegration programmes as well as beneficiaries thereof.

Moreover, with every year entities implementing social reintegration programmes increasingly often succeed in obtaining EU funding, which was a rarity only a few years ago.

Drug-related crime, prevention of drug-related crime and prison

The latest data on drug-related crime show a rise in the number of offences under the Act on counteracting drug addiction, which might indicate the intensification of actions of services combating drug-related crime. In 2009, the number of recorded offences almost equalled the level of 2006 i.e. 68 288 offences. The latest rise of 19% in drug-related crime is largely due to the higher number of offences under Articles 58, 59 and 62 (distributing, enticing and possessing), which account for 92% of all crimes recorded in 2009. It must be noted that there was a fall in the number of offences related to drug manufacture (Article 53). A less dramatic rise is observed in the number of suspects (1.2%). Most suspects fell under Article 62 of the Act (illegal possession) – 72% out of 26 294 suspects. In 2009, a single suspect committed 2.5 offences on average. Analysing the juvenile crime we notice a sharp increase in the underage suspects under the Act, from 2 923 (2008) to 3 598 (2009).

Drug market

In the last year there has been a rise in drug seizures of most substances: marijuana, heroin, cocaine, amphetamine and methamphetamine. A fall has been recorded only in two substances: hashish and ecstasy. In 2009, there was almost a twofold increase in marijuana seizures (883 kg), which was a record high in the whole period under study i.e. since 2000. However, there was over a sixfold decrease in hashish seizures (17 kg). More heroin was also revealed (85 kg). There was a sixfold increase in cocaine seizures (117.5 kg). Amphetamine seizures reached the level of 2007 i.e. 421.5 kg (2009) following a decrease in 2008. In the case of two drugs a fall in seizures was recorded: hashish and ecstasy. Small amounts of LSD seizures in recent years should be noted. Numbers of detected LSD pieces were far higher five or six years ago. The highest number of illegal plantations was recorded

in 2009 – 422 on the area of 31 246 m^2. In 2009, the Police seized the highest number of marijuana plants – 97 928, which constitutes an increase of 500% compared to 2008.

In 1995-2009, 179 clandestine laboratories were raided in Poland (8 in 2009). The 2009 Police data show that the average THC concentration stood at 8%. The most recent data indicate a fall in the purity of amphetamine (24% in 2009). Modal prices be noted: marijuana - 7 Euro, hashish – 7 Euro, heroin - 50 Euro, cocaine – 60 Euro, amphetamine – 9 Euro, ecstasy - 3 Euro, LSD - 6 Euro.

Part A: New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

prepared by Michał Kidawa, Anna Strzelecka, Artur Malczewski

Introduction

The basic anti-drug legal act remains the Act of 29 July 2005 on Counteracting Drug Addiction. The Act defines the following: 1) competences of relevant services, central institutions and local governments in counteracting drug addiction, 2) educational activities and information provision, 3) conduct with substance dependent individuals, 4) rules and procedure for handling precursors, narcotic drugs and psychoactive substances, 5) rules and procedure for handling poppy and hemp crops, 6) penal provisions and 7) controlled substances.

The executive act the lays down the priorities serving both as the National Antidrug Strategy as well as the Action Plan is the National Programme for Counteracting Drug Addiction 2006-2010. Since 2006 the National Programme has been a legal act of a regulation status[1]. It promotes sustainable approach to the problem of drugs and drug addiction, balancing the tasks of drug demand reduction and drug supply reduction. The general aim of the programme is "Reducing drug use and drug-related social and health problems".

The general aim is achieved across five areas:

I. Prevention

II. Treatment, rehabilitation, health harm reduction and social reintegration

III. Supply reduction

IV. International cooperation

V. Research and monitoring

The last two areas support the implementation of the first three: prevention, treatment and supply reduction. It must be stressed the NPCDA is fully integrated with the EU Drugs Strategy and Action Plan. Under the National Programme for Counteracting Drug Addiction 60 actions were formulated to be implemented by 10 ministries and 23 central level institutions, Provincial Pharmaceutical Inspectorates, provincial and communal governments. The programme implementation by respective ministers or central agencies often meant the involvement of a number of subordinate institutions, which means that the Programme had a massive coverage. The programme was designed to integrate the vast majority if antidrug actions in Poland. The coordinating role in implementing the National Programme is fulfilled

[1] More information under 1.2. National action plan, strategy, evaluation and coordination

by the Council for Counteracting Drug Addiction. The Council comprises undersecretaries of state of the following ministries: Health, Justice, Social Care, National Defence, Agriculture, Education, Public Finances, Foreign Affairs and Science. In order to better coordinate the programme implementation 3 work teams operate under the auspices of the Council: precursors team, international cooperation team and implementing team for the National Programme[2]. The teams play an advisory role and provide technical support for the Council. The Act defines the competences of the National Bureau for Drug Prevention and the Information Centre for Drugs and Drug Addiction operating within the National Bureau.

1.1. Legal framework

- **Laws, regulations, directives or recommendations in counteracting drug addiction (demand & supply)**

In 2009 and 2010, similarly to previous years (NR 2009), the public discussion on any changes to the antidrug law was largely dominated by the problem of legal highs. Polish government continued actions intended to reduce the phenomenon. In 2009, the amendment of the Act on counteracting drug addiction took effect[3] (see previous report). The amendment extended the list of controlled substances by BZP, JWH-10 and 15 plants[4] of psychoactive qualities, which raised suspicions of being part of legal highs. In 2010, another amendment was passed[5]. The list of controlled substances thereto was extended by mephedrone and 7 synthetic cannabinoids[6]. The amendments did not substantially reduce the phenomenon. According to the estimations of the Ministry of Health in mid-2010 there were more than 1 000 legal highs shops across Poland.

In the second half of 2010 more signals of medical emergencies and hospitalizations most likely related to legal highs were being received from hospitals. In most cases they were the reports of the patients themselves. At the end of September, the media reported at least a few acute poisonings and two deaths caused by legal highs. There was no clear laboratory confirmation whether the deaths were in any way related to legal highs.

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[2] More information under 1.2. National action plan, strategy, evaluation and coordination/coordination arrangements.

[3] Act of 20 March 2009 on amending the Act of counteracting drug addiction (Journal of Laws *"Dz.U."* No. 63, item 520).

[4] argyreia nervosa, banisteriopsis caapi, calea zacatechichi, catha edulis, echinopsis pachanoi, kava kava, leonotis leonurum, mimos tenuiflora, mitragyna speciosa, nymphea caerulea, peganum harmala, rivea corymbosa, salvia divinorum, tabernanthe iboga, trichocereus peruvoanus.

[5] Act of 10 June 2009 on amending the Act of counteracting drug addiction (Journal of Laws "*Dz.U."* No. 143, item 962).

[6] JWH-073, JWH-398, JWH-250, JWH-200, CP 47,497 and homologs C6, C8, C9, HU-210

A rapidly increasing supply of these substances which could be alternative to drugs (over 1 000 legal highs outlets in the last two years) and the information of deaths and poisonings caused a strong social response in the form of local and national protests and campaigns.
On 3 October several hundred sanitary inspectors and approx. 3 000 policemen launched the crackdown operation. Pursuant to the decision of the Chief Sanitary Inspectorate the legal highs shops are to be closed down:
The Chief Sanitary Inspector issued a decision to close down legal highs-related shops, wholesale companies and manufacturing companies by virtue of Articles 27.1, 27.2 and Article 31a of the Act of 14 March 1985 on State Sanitary Inspection[7]. This decision states the following:

1. a collectible product called Tajfun is withdrawn from trade along with any similar products that might directly endanger human life or health
2. the business activity of manufacturing, wholesale and retail companies handling products referred to in point 1 is prohibited
3. the decision is immediately enforceable.

During the weekend 1 100 legal highs wholesale/retail and manufacturing businesses were inspected. Over 900 of them were closed down.

A major strike against legal highs was launched at 3 pm on Saturday. At that time sanitary inspectors and policemen entered almost 1 000 selected retail shops and wholesale companies.

Apart from this action intended to stop legal trade in legal highs in order to eliminate immediate threats for public health the government in an expedient manner prepared a third comprehensive amendment of the Act on counteracting drug addiction and the Chief Sanitary Inspectorate. The Act, without major changes, went through both chambers of Parliament and currently is wating to be signed by the president. The amendment of the Act introduces a few innovative instruments, which have been rarely used in Polish legislation so far. The amendment introduces the following changes in the drug law. Article 4.27 introduces a modified definition of a substitute drug which is substance of natural or synthetic origin in any physical state or a product, plant, mushroom or part thereof, containing such a substance, used instead of a narcotic drug or a psychotropic substance or for the same purposes as a narcotic drug or a psychotropic substance, whose manufacture or introduction to trade is not regulated by separate provisions; provisions on general safety of products do

[7] Act of 14 march 1985 on State Sanitary Inspection (Journal of Laws *"Dz. U."* of 2006 No. 122, item 851, as further amended)

not apply to substitute drugs. The definition has references to psychotropic substances and narcotic drugs, which according to the Act means all scheduled substances thereto.

1. Article 20.3 introduces a ban on advertising suggesting that if used inappropriately the products have psychoactive effects just as psychoactive substances and narcotic drugs. Violating the above regulations is subject to fine, limitation or deprivation of liberty up to 3 years.
2. Article 44b of the Act bans manufacturing or introducing substitute drugs to trade. An institution responsible for the control is the Chief Sanitary Inspectorate. According to Article 52a of the Act, violating the ban on introducing substitute drugs to trade is subject to fine ranging from PLN 20 000 to 1 000 000. The fine is imposed by way of a decision of a competent sanitary inspector. While determining the amount of the fine a sanitary inspector considers a scale of the operation i.e. the quantity of the substitute drugs that is introduced to trade.

Apart from the abovementioned changes in the drug law, the amendment also covered the Act on State Sanitary Inspection[8]. The legislator decided to modify regulations related to the general safety of foods. Article 27b was introduced. It provides that in the event of a reasonable suspicion that a product might be dangerous a competent sanitary inspector may withdraw the product for the period up to 18 months to examine it and verify its harmfulness. This provision does not include products which are regulated by separate provisions. Moreover, a sanitary inspector has the right to order discontinuance of the business operation for the period up to 3 months to remove the threat.

Furthermore, Article 27b introduces an interesting solution related to the costs of proceedings, examination and analyses. These costs are incurred by the subject of the proceedings. If, in the course of examination and expert opinions, the product is considered not to pose any threat to human health and life the costs are refunded.

Despite a general social support and fairly considerable political consensus regarding the amendment, the Act was criticised by some members of the expert community, especially constitutionalists, human rights activists and drug professionals. Some constitutionalists claim the Act is not compliant with the principle of the clarity of the law, which is defined in the Constitution of the Republic of Poland and prevails in the Polish legal system. Human rights activists acknowledged that incompliance with this principle in practice will leave a lot of room for the abuse on the part of state institutions and the public administration and will deprive a certain group of citizens of their right to defend against such abuse. Another claim was the lack of specific procedures and prerequisites to be met by a sanitary inspector in the course of assessing the threat related to a product. As the amendment was being passed,

[8] Act of 14 march 1985 on State Sanitary Inspection (Journal of Laws *"Dz. U."* of 2006 No. 122, item 851, as further amended)

the parliament was considering tow other legislative initiatives related to legal highs. One was submitted as early as 2008/2009 and it was a draft amendment of the Act on counteracting drug addiction proposed by the opposition social-democratic party (SLD). It presented a more liberal approach to the issue of legal highs. A central assumption was treating legal highs in a similar way to alcohol. It assumed the control of the state, setting the age limit and determining which products would be sold. The other draft law was prepared by the Christian democrats (PIS). It equalled legal highs with medical drugs and demanded from entities introducing such substances to trade going through procedures similar to those applied in the registration of medical drugs. Moreover, it imposed high penal sanctions for violating the regulations. However, the parliament decided to proceed only with the government's draft amendment.

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1.2. National action plan, strategy, evaluation and coordination

- **National action plan and/or strategy**

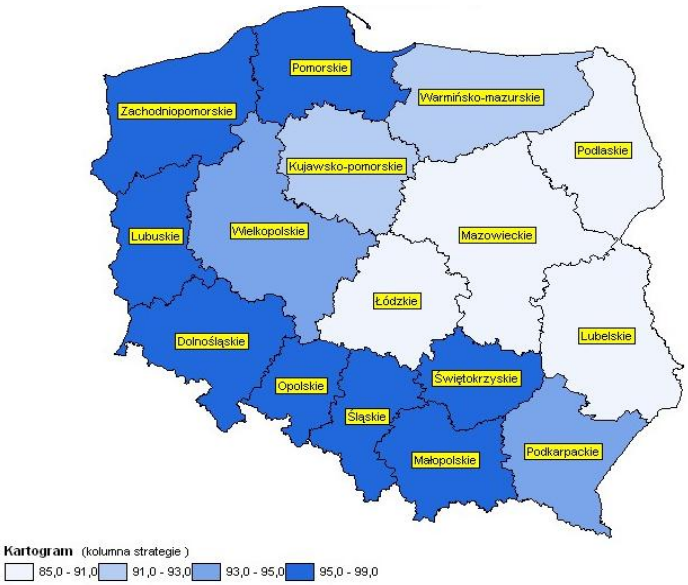
One of the priorities of the National Bureau for drug Prevention is the development of draft National Programme for Counteracting Drug Addiction (KPPN) as well as coordinating and monitoring its implementation. In 2009 KPPN specified 60 activities to be implemented by 10 ministries, 23 central institutions, Provincial Pharmaceutical Inspectorates and provincial and communal governments. In practice, the KPPN implementation by respective ministries or central institutions meant the involvement of a number of subordinate or local branches or departments. That is why the Programme had a wide coverage and was designed to integrate, on a national scale, a vast majority of drug prevention actions. A wide range of institutions, offices and other entities were obliged to implement the National Programme for Counteracting Drug Addiction, pursuant to the Act of 29 July 2005 on counteracting drug addiction. By virtue of the Act, the National Bureau annually drafts a report on the implementation of the National Programme. Information on the Programme implementation was collected by means of specially designed questionnaires, which were sent to the National Programme stakeholders. In the case of provinces and communes, data were collected through drug experts who cooperate with the Information Centre for Drugs and Drug Addiction of the National Bureau for Drug Prevention. The KPPN implementation report questionnaire is prepared by the Information Centre in cooperation with provincial drug experts at annual meetings. In 2002 communal and county data were not collected through questionnaires. Only Marshal Offices completed questionnaires. Such a solution was not effective in capturing the general picture of all actions performed in communes and counties. From 2003 county data (till 2005) and communal data were collected along with provincial drug experts, which helped to obtain a high questionnaire return rate of approx. 80%-90%. Provincial drug expert also monitored

questionnaire collection and completed questionnaires addressed to Marshal Offices. Only pursuant to the new Act of 29 July 2005 on counteracting drug addiction were communes obliged to send information on the implementation of the National Programme for Counteracting Drug Addiction.

In order to receive necessary data for the report special questionnaires were designed to collect quantitative and qualitative data. Each institution involved in the KPPN receives the questionnaire. A total of 50 questionnaires are sent annually to central and provincial institutions and over 2500 communes. In the case of provincial and communal governments standardised questionnaires were developed to collect quantitative data necessary to estimate the involvement of regional and local authorities in the KPPN implementation. Data are collected through provincial drug experts, who cooperate with the Information Centre for Drugs and Drug Addiction of the National Bureau for Drug Prevention (KBPN). Thanks to the drug experts the questionnaire return rate is high. In 2009, 2246 (91%) out of the total of 2 478 communes sent back the questionnaire. In comparison to the previous year 4% more communes sent back the questionnaire. Communal questionnaires are analyzed by means of SPSS 18 statistical software package. Important tasks of the KPPN stakeholders include the development of local KPPN-based programmes.

Under the implementation of the National Programme for Counteracting Drug Addiction, central institutions as well as regional and local governments develop their own ministerial, provincial or communal programmes. Drug demand reduction programmes were developed and implemented by the National Bureau for Drug Prevention, Ministry of National Defence, Ministry of Interior and Administration. All Marshal Offices had in place and implemented provincial strategies. In 2009 91% of communes (2094) implemented communal programmes for counteracting drug addiction or programmes including drug-related issues. Figure 1.1. shows percentages of communes in respective provinces which developed programmes for counteracting drug. It must be stressed that in the case of communes and provinces the programmes might include alcohol issues. In 2009, the highest number of communes had the programmes in dolnoslaskie province - 99% (94% in 2008), malopolskie and opolskie provinces - 97% each (97% each in 2008). The lowest percentages were recorded in podlaskie province - 89% (89% in 2008), mazowieckie province - 89% (86% in 2008) and lodzkie province - 86% (85% in 2008) (Malczewski 2010l, p. 7-8).

Figure 1.1. Percentages of communes having anti-drug strategies in respective provinces in 2009.



Source: Malczewski 2010l, p 8

Basing on data and information gathered from all relevant institution responsible for implementation of National Program for Counteracting Drug Addiction the recommendation and priorities for further actions and were prepared. One of the priority areas was further development of substitution treatment. The implementation of task 2.4 of National Programm to Increase of number of substitution treatment programs and the number of provided services in order to secure the access to substitution treatment programs for at least 20% of problems opiate users was at threat. Council of Counteracting Drug Addiction made a decision to include in the Report on implementation of National Program the recommendation obliging all relevant institution, especially National Health Fund to take actions in order to fulfill a task foreseen in National Program.

In 2009 in Poland there were 22 substitution programs, which provided services for around 1900 patients annually, which is about 7% of opiate addicts. The council stressed that the further development if substitution treatment should be treated as priority in action planning in the scope of treatment for problem opiate users. Therefore number of substitution treatment programs should be increased both in health care facilities and in prisons.

The problem is also with geographical distribution of the substitution treatment. The are 5 Vojevodships in which the substitution treatment programs do not exist. In other two the access to this type of treatment is limited. In penitentiary institutions the most important think is to enable the continuation of substitution treatment for people which were in this type of treatment on freedom.

Another prioritized area is the universal prevention programs for youth from gymnasium. The research shows (Ostaszewski 2009) that this age group seams to be more vulnerable to problem behavior.

Taking into account rapid development of „smart drugs" in Poland, the development in research and monitoring of this phenomenon as well as new substances appearing on the market was given a high priority by the Council.

- **Coordination arrangements**

The main Body responsible for coordination of drug policy in Poland is Council of Counteraction Drug Addiction. In 2009 the Council 1) coordinated the preparation process for Polish presidency in EU in the field of drugs, 2) coordinated and controlled the preparation and proceedings of new legal developments in the field of drugs, 3) monitored the preparation process of new National Program for Counteracting drug Addiction 2011-2016. Additional the Council decided to continue the public information campaign "Do you know what you're carrying?" prepared and implemented by National Bureau for Drug Prevention and Ministry of Internal Affairs and Administration, already mentioned in Polish National Report 2009.

The Council was also involved in actions to improve the coverage of substitution treatment programs in Poland, especially with the main stake holder in that field, the National Health found who is responsible for contracting health services in Poland.

Local monitoring

Under the implementation of the National Programme for Counteracting Drug Addiction 2006-2010 tasks related to the development of cooperation between local and central administration in collecting and analyzing data, the Information Centre for Drugs and Drug Addiction concentrates on developing a local monitoring system at the communal level. It is one of the priority actions in developing monitoring systems for drugs and drug addiction in Poland. The monitoring aims at raising the quality of communal anti-drug strategies and actions at local level through providing support for local strategists and implementers.

In 2009, a number of activities were performed to consolidate and develop provincial networks of local monitoring, including the development of monitoring at communal level. These activities were the continuation of the project Transition Facility 2006 "Support for regional and local communities to prevent drug addiction on the local level – continuation" [Twinning Light with the Spanish Ministry of Health (PL/06/IB/JH/04/TL)]. Under the project, the National Bureau for Drug Prevention conducted trainings on the principles and methodology of local monitoring. Local monitoring is aimed at following trends in psychoactive substance use and abuse as well as studying social and institutional

response. Systematic observation of the situation ensures an up-to-date diagnosis, which facilitates the development of needs-specific programmes and their subsequent evaluation.

The Information Centre for Drugs and Drug Addiction organized "1st National conference for representatives of communes participating in the project of monitoring drugs and drug addiction at local level". The conference was intended to show the experiences of communal governments in performing local monitoring, present the results of respective activities and work out suggestions for monitoring drugs and drug addiction which could be incorporated into the National Programme for Counteracting Drugs and Drug Addiction 2011-2015. The experiences of implementing the local monitoring by communes were summarised and representatives of three communes presented their monitoring achievements. The conference participants familiarized themselves with the methods of estimating populations of problem drug users, the methodology of qualitative studies and principles of evaluating anti-drug strategies.

Due to considerable interest on the part of local governments in the project of monitoring drugs and drug addiction, in 2009 Provincial Drug Experts made a decision to organize a series of trainings for new communes which have launched the monitoring. The trainings were held in lodzkie province (three courses organized by the Regional Centre for Social Policy), mazowieckie province (three courses organized by Mazovian Centre for Social Policy) and malopolskie province (three courses organized by Juvenes Association). The staff of the Information Centre for Drugs and Drug Addiction (CINN) provided technical support and consultations during the trainings for communes joining the monitoring project. Training participants drafted first reports, which they sent for consultation by the CINN. Moreover, communal reports were presented at the conference organized by swietokrzyskie province, also for communes of podkarpackie and lubelskie provinces. The monitoring issues were presented at conferences in opolskie and zachodniopomorskie provinces. Apart from trainings and conferences in 2009, a publication on local monitoring was prepared in malopolskie province.

1.3. Economic Analysis

- **Public expenditure**

The total expenditure on the implementation of the National Programme for Counteracting Drug Addiction (KPPN) is determined on the expenses reported by respective ministries and subordinate governmental agencies and local governments.

In some institutions the expenses are not reported due to the difficulty in deriving the amount designated to counteract drug addiction from all the expenditure related to the performance of statutory tasks.

The table below shows the expenses of respective central institutions, provincial and communal governments incurred in the course of implementing the National Programme for Counteracting Drug Addiction in 2009. The amounts given do not represent all the expenditure incurred in the course of the National Programme due to incomplete data. Based on the information obtained, the overall expenditure related to the implementation of the National Programme for Counteracting Drug Addiction in 2009 stood at PLN 164 611 196.99 (EUR 42 878 665.54)[1]

Table 1.1. National Programme for Counteracting Drug Addiction (KPPN) expenditure in 2009 (in EUR).

No.	Institution	KPPN expenditure (EUR)
1.	Central Management Board of Prison Service	3 157 243.79
2.	Medical Centre for Postgraduate Studies	3 799.43
3.	Centre for Monitoring Quality in Health Care	0.00
4.	Military Police Headquarters	23 155.77
5.	National Bureau for Drug Prevention	2 605 518.59
6.	National AIDS Centre	6 722 453.76
7.	Ministry of National Education	5 933.02
8.	Ministry of Science and Higher Education	140 776.76
9.	Ministry of National Defence	24 113.05
10.	Ministry of Interior and Administration	46 416.88
11.	National Institute of Public Health - State Institute of Hygiene	1 462.90
12.	Branches of National Health Fund	11 711 054.70
13.	Centre for Educational Development	3 082.35
14.	Communal Governments	16 787 898.15
15.	Provincial Governments	1 632 130.43
16.	Provincial Pharmaceutical Inspectors	13 625.94
		Total: EUR 42 878 665.54

Source: Minister Zdrowia 2010

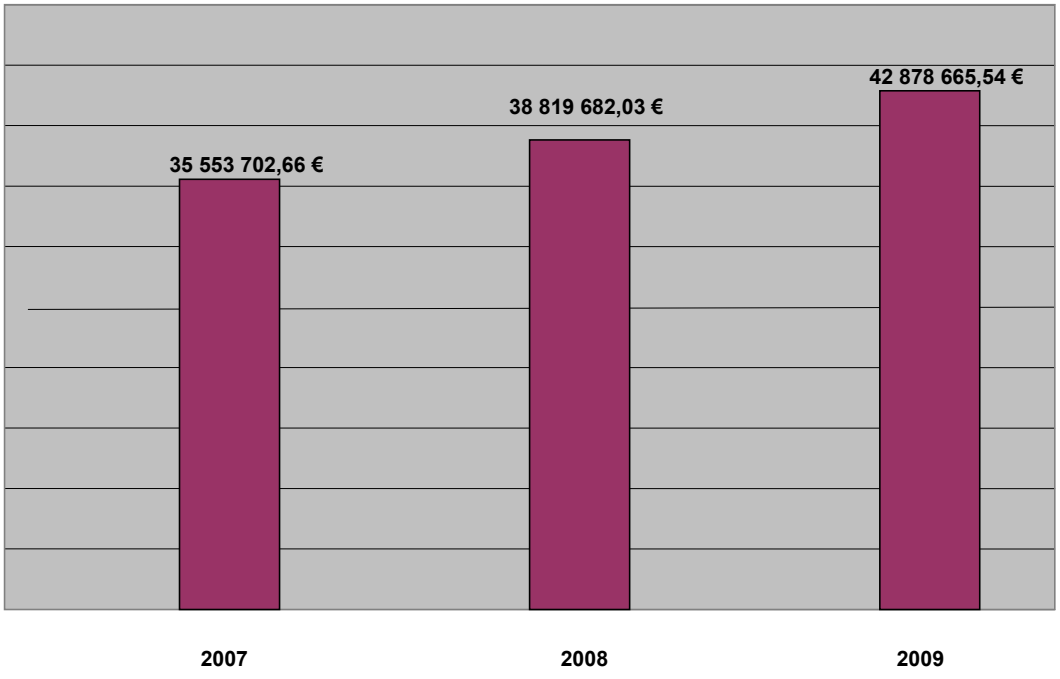
In 2010 the following institutions did not report the KPPN-related expenditure from 2009: General Inspector of Financial Information, Main Pharmaceutical Inspector, State Sanitary

Inspector, Inspector for Substances and Chemical Preparations, Military Health Service Inspectorate, Institute of Psychiatry and Neurology, Police Headquarters, Border Guard Headquarters, Ministry of Labour and Social Policy, Ministry of Justice, Supreme Medical Chamber, Supreme Chamber of Nurses and Midwives, Attorney General and Customs Service.

Some ministries and service reported lower KPPN-related expenses compared to 2008. One can list Ministry of National Defence (fall in expenses of PLN 152 thousand, i.e. EUR 39 593.64 EUR) or Military Police Headquarters (fall in expenses of nearly PLN 767 thousand, i.e. EUR 199 791.61). It must be stressed that the spending of the Minister of Justice in relation to the KPPP comprises expenses of respective subordinate departments and structures: prosecutor's offices, courts, probation officer's offices. None of these services singles out expenses related to the implementation of the KPPN.

The highest increase (of over three million zlotys = EUR 781 453.50) in the KPPN-related expenditure was reported by provincial branches of the National Health Fund (NFZ). However, it must be stressed that the expenditure is overestimated as it is impossible to accurately determine the amount of resources allocated by the NFZ to outpatient services intended for individuals dependent exclusively on illegal psychoactive substances. This estimate includes, to a large extent, NFZ expenses related to alcohol services.

Figure 1.2. Expenditure related to the implementation of the National Programme for Counteracting Drug Addiction 2007-2009 (EUR[9]).

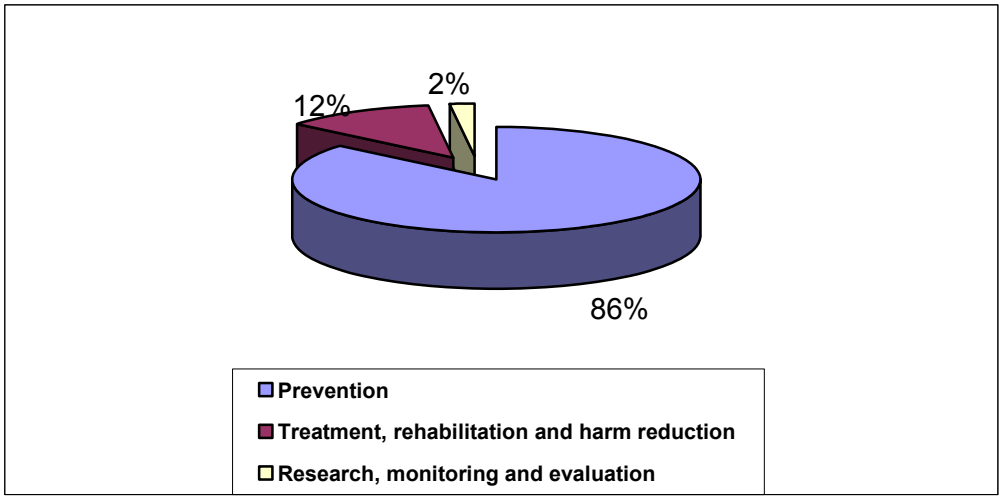


Source: Minister Zdrowia 2010

[9] Average conversion rate in 2009 according to the National Bank of Poland stood at EUR 1 = PLN 3.839;

The analysis of the local spending one can notice an increase in the resources allocated to the implementation of the KPPN by the marshal's offices. The expenditure stood at PLN 6 265 748.72 (EUR 1 632 130.43) in 2009 compared to PLN 4 795 366.58 (EUR 1 249 118.67) in 2008. By comparison with 2008, there has been a nearly 6-million rise in the expenditure on the National Programme for Counteracting Drug Addiction by communal governments (from PLN 58 689 240 i.e. EUR 15 287 637.41 EUR in 2008 to PLN 64 448 741 i.e. EUR 16 787 898.15 in 2009). In the case of communes we observe an annual share rise in the overall expenditure on counteracting drug addiction. The 2009 communal expenses accounted for 39% of all the total expenditure related to the implementation of the national programme for Counteracting Drug Addiction. Under the communal expenses the highest funds were earmarked for prevention i.e. PLN 55 462 940 (EUR 14 447 236.26). Figure 1.3. shows a percentage breakdown of the communal expenditure[10].

Figure 1.3. Percentage breakdown of funds earmarked by communes to respective components of the KPPN in 2009.



Source: Minister Zdrowia 2010

[10] Following documents constitute the legal basis for financing actions of counteracting drug addiction:
1) Act of Law of 29 July 2005 on counteracting drug addiction (Journal of Laws 2005.179.1485),
2) National Programme for Counteracting Drug Addiction 2006-2010 (Journal of Laws 2006.143.1033),
3) Regulation of the Minister of Health of 20 August 1996 on organizing and promoting mental health and preventing mental disorders (Journal of Laws 1996.112.537),
4) National Health Programme 2007-2015, Operational Goal No. 5,
5) Act of Law of 30 August 1991 on health care facilities (Journal of Laws of 1991 No 91 item 408 as further amended),
6) Act of Law of 27 August 2004 on health care benefits financed from public resources (Journal of Laws No. 210 of 2004, item 2135 as further amended),
7) Act of Law of 19 August 1994 on mental health care (Journal of Laws of 1994, No. 111, item 535 as further amended),
8) Regulation of the Council of Ministers of 20 December 2004 on way and mode of financing from the state budget health care benefits provided for uninsured beneficiaries (Journal of Laws No. 281, item 2789)
9) Act of Law of 26 November 1998 on public finances (Journal of Laws of 2003 No. 15 item 148 as further amended),
10) Regulation of the Minister of Health of 13 November 2000 on the National Bureau for Drug Prevention (Official Journal of the Ministry of Health of 2000, No. 2, item 44),
11) Act of Law of 24 April 2003 on public welfare and voluntary work (Journal of Laws No. 96 item 873).

2. Drug use in the general population and selected groups

prepared by Anna Strzelecka, Artur Malczewski

Introduction

Drug use in Poland is systematically monitored and researched. Data on the prevalence of illicit psychoactive substances are collected through qualitative studies (focus groups, interviews) and quantitative ones (surveys, polls). The studies are conducted on general population samples, including school adolescents. They are done systematically. Most drug-related research is commissioned or counducted by the National Bureau for Drug Prevention.

2.1. Drug use in the general population

- **"Social diagnosis 2009. Conditions and quality of life of Poles"**

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Report authors: Anita Abramowska-Kmon, Dominik Batorski, Piotr Białowolski, Piotr Błędowski, Isabela Buchowicz, Janusz Czapiński, Izabela Grabowska, Irena E. Kotowska, Paweł Kubicki, Tomasz Panek, Paweł Strzelecki, Antoni Sułek, Tadeusz Szumlicz, Dorota Węziak-Białowol
Implementing institution: Polish Statistical Association

Introduction and project aim

The study "Social diagnosis 2009", headed by Janusz Czapiński, professor at the Faculty of Psychology of Warsaw University and vice-president of the Higher School of Finances and management and Tomasz Panek, professor at the Institute of Statistics and Demography of the Warsaw School of Economics, is intended to provide comprehensive information on the conditions and quality of life of Polish people.

The first measurement under this project was conducted in 2000 and the next one three years later. Follow-up measurements were carried out in two-year gaps.

Due to the cross-cutting nature of the study, it covers significant aspects of household life and its members, i.e. economic aspects (e.g. income, savings, loans, etc.) and non-economic ones (e.g. education, coping methods, treatment, mental well-being, lifestyle, involvement in cultural life, pathological behaviour and many others).

Method

"Social diagnosis" is an example of a panel study. It means that researchers every few years return to the same study households and participants.

The study uses two questionnaires. One is related to the conditions and quality of life in households and it is completed by the interviewer during an interview with a household member. This questionnaire is a source of information on the household structure and life conditions. It also provides socio-demographic data of the respective members of the household. The other questionnaire provides information on the quality of life of the respective members of the household and is intended for self-completion by all present household members aged 16 and older.

The measurement is always taken in March by professional interviewers of the Central Statistical Office. In 2009, due to the sample size, the measurement was extended till mid-April. Organizational matters of the study were handled by the Office of Statistical Studies and Analyses of the Polish Statistical Association.

The first stage sampling units were census districts which were selected with the probability proportionate to the number of households therein. In the case of urban areas the following units were selected: large cities of over 100 000 population, medium-sized cities of 20-100 000 population and towns of less than 20 000 population. Additionally, in five biggest cities sampling units were boroughs. During the second sampling stage, 3 households were selected from census districts in four big cities, 4 households from medium-sized cities and 5 households from towns and 6 households in rural areas.

In 2009, 12 381 households (37 841 members) were studied. Individual interviews were conducted with 26 178 household members aged 16 and older. The respondents were asked, among other things, about drug consumption in the last 12 months (Czapiński, Panek 2009).

Outcome

In 2009 the prevalence of drug use in the last year stood at 1.2%, which is a slight increase compared to 2007 (1.0%). The distribution of answers to the question “Have you used drugs in the last year?” is presented in Table 2.1.

Table 2.1. Prevalence of drug use in the last year in 2003, 2005, 2007 and 2009 – by sex, age, place of residence, province education, income per capita and socio-demographic status.

Population	2009	2007	2005	2003
Total	1.16	1.03	1.31	0.96
Sex				
Male	1.78	1.67	1.91	1.51
Female	0.58	0.51	0.79	0.48
Age				
under 24	3.75	3.67	3.83	3.91
25-34	2.14	1.54	2.45	1.31
35-44	0.47	0.53	0.48	0.05
45-59	0.14	0.05	0.27	0.08
Place of residence				
Cities of 500k	2.60	1.54	2.64	2.03
Cities 200-500k	0.93	1.91	1.80	1.91
Cities 100-200k	1.74	1.28	1.91	0.60
Cities 20-100k	1.09	0.65	1.44	0.68
Towns <20k.	1.18	1.54	0.99	0.80
Rural areas	0.66	1.91	0.72	0.63

Source: Czapiński & Panek (2009), p. 215.

Similarly to previous years, the results of the "Social diagnosis 2009" study show that drug users are predominantly male. Among females there are almost three times fewer illegal substance users.

Another differentiating variable in drug use is age. The study results demonstrate that the group of young males under 24 is at the highest risk of drug addiction. With males and females aged 35 and older drug prevalence rates fall dramatically to zero. Individuals aged 45 and older use drug over ten times less often than the youngest study participants (aged 24 and younger).

Residents of the biggest cities (over 500 thousand population) use drugs nearly two times more often than residents of towns and villages. The highest drug prevalence rates were recorded in the following provinces: mazowieckie, zachodniopomorskie, wielkopolskie and dolnoslaskie.

The results of the 2009 study show that drug prevalence rates are increasing among businessmen, unemployed and other individuals not professionally active. At present, apart

from the above groups the risk of drug addiction is particularly high among school and university students.

Drug users also vary depending on their marital status. As the study results show married individuals use drugs four times less frequently than singles.

Summary

Statistically significant differentiating drug use variables include sex, age, and place of residence, socio-demographic status and marital status.

The population of drug users is still dominated by males and residents of big cities.

The results of the "Social diagnosis 2009" study show that the group at the highest risk of drug addiction is males under 24, including school and university students. Generally speaking, considering the age of Polish drug users, drug use prevalence is the highest among individuals under 30.

The only statistically insignificant differentiating variable among illicit psychoactive substance users is education.

- **„Substance use in general population – 2009 study results"**

Authors: Artur Malczewski, Michał Kidawa

Introduction

Under monitoring drug use prevalence in the general population Millward Brown SMG/KRC market research company was commissioned a qualitative study on a representative sample of 1001 Polish population. The study was concerned using psychoactive substances, particularly tranquilizers and sedatives. The questionnaire was prepared by the Information Centre for Drugs and Drug Addiction of the National Bureau for Drug Prevention (CINN KBPN) (Malczewski, Kidawa 2010).

The study was conducted face to face at respondents' homes by means of a computer. Drug use issues as being delicate were treated with care. Here, the respondents completed specially designed questionnaires by themselves.

This study was based on the Omnibus approach. This design has been used in marketing research for years, and a typical feature is that under one questionnaire respondents are asked questions regarding various aspects of life and respective thematic sections are commissioned by different institutions. Consequently, the questionnaire covers a number of research issues simultaneously and each commissioning institution introduces questions of their interest. Such projects are usually implemented by research companies on a regular basis within a timeframe and a sample planned in advance. Commissioning institutions do not have influence on the sample selection and the date of the study and just

contribute their questions. This method is well described by the saying ‘get on the bus’. The advantage of Omnibus is simplicity, short implementation time (results are available within approx. 1-2 weeks since the commission) and a low price. However, the study is not fully in line with methodological requirements of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) regarding general population surveys as the study sample should include at least 3000 respondents aged 15–64.

Study sample and analyses

The study conducted towards the end of last year covered a representative sample of Polish population aged 15-75 lat (N = 1001). The respondents were asked whether they had used respective substances in the last 30 days, 12 months and in a lifetime. These are typical and standard time frames in European surveys. Lifetime prevalence indicates the level of experimenting with drugs – the respondents might have dealt with a substance only once or might have used it many years before the survey. This question allows capturing the lifetime prevalence of most drugs whose rates are far higher compared to data for the last 12 months or 30 days prior to survey.

The outcome analysis four substances with the highest prevalence rates were in focus: tranquilizers and sedatives, legal highs (‘dopalacze’ in Polish), cannabis and amphetamines. The 2009 results were compared to the results of the 2008 Hungarian Civil Liberties Union study results.

Based on the 2009 data the relationships between drug use and the following variables were analyzed: sex, age (10-year ranges), size of the location (four categories: village, city up to 100 000, city 100 000 – 400 000 and city over 500 000) and education (primary, vocational, secondary, post-secondary). Additional calculations were performed by means of PASW Statistica 18 statistical software.

Prevalence of legal highs

“Dopalacze” is a Polish counterpart of psychoactive substances, which are not controlled by the Act on counteracting drug addiction and which are sold in special shops or on line. In EU reports these substances are called “spice products”, “legal highs”, or just “smarts”. “Dopalacze” is a name of a shops chain which sells legal highs and related accessories. The name is commonly used and is nowadays often associated with psychoactive substances sold as collectibles.

This study made the first attempt at measuring the scale of legal highs use in the whole Polish population. Earlier only selected groups were surveyed. In 2008 the survey included

final grades of post-middle schools. The CBOS Foundation survey featured questions about drug and legal highs consumption.

The results referred only to final grades of post-middle schools (18-19 years old) and they cannot be extrapolated to other age groups. 3.5% of the respondents admitted having ever used legal highs (lifetime prevalence question), 2.6% in the last 12 months and 1.6% in the last 30 days (Badora et al., 2008).

The 2009 national survey also included a question asking specifically about using legal highs or smarts (substances of psychoactive effects sold in special shops or on line). A question formulated in this way aimed at preventing answer errors e.g. declaring drinking energy drinks as using legal highs. In all three time ranges (lifetime prevalence, last 12 months and 30 days) the most prevalent substance were legal highs. 6% of the respondents admitted having used them at least once. Legal highs were more popular with men (7%) than women (5%). The variable is statistically significant ($p < 0.05$). In the age group 15-24, every tenth member reported using legal highs. The percentages of the respondents decrease, though slightly, in the case of using legal highs in the last 12 months (recent use indicator) – 5% of the respondents admitted using legal highs. Similarly to lifetime experience use, the discrepancy between men and women was 2%. 5% of men and 3% of women had used legal highs in the last year.

The respondents were also asked about using legal highs in the last 30 days. In this case 4% of the respondents had had contact with legal highs (5% of men and 3% of women). As for using psychoactive substances in the last 30 days legal highs were the only ones to rank above the statistical error bar. The prevalence of the remaining substances ranged from 0% to 1%.

Analyzing the place of residence of the respondents who reported at least a single episode of using legal highs, it must be noted that there were twice as many village residents as residents of cities over 500 000 population that had used legal highs. It is the only case where a higher substance prevalence rate was recorded in rural areas compared to big cities i.e. over 500 000 population. Such a distribution of answers can be interpreted with online sales of legal highs. Consequently, these substances can be available both in rural and urban areas.

Analyzing the distribution of answers concerning education we record the highest prevalence rates in respondents with secondary education – 8%.

Prevalence of tranquilizers and sedatives

Poland belongs to the countries with the highest prevalence of prescription tranquilizers and sedatives without medical indications. The latest ESPAD survey of 2007 (Ahlström et al., 2009) and CINN KBPN studies of 2002 and 2006 (Sierosławski 2006) show that these

psychoactive substances are more popular than cannabis, which is the most popular illegal substance. In the 2009 study the respondents were asked about using prescription tranquilizers and sedatives without medical indications. A new element, so far not used in national qualitative studies on drugs, was the question about giving names of medicines the respondents had used. It was meant to verify the validity of answers concerning medicines, which were to be exclusively OTC drugs. The response validation was conducted for the first time.

Analyzing the distribution of answers it must be noted that tranquilizers and sedatives were second (right after legal highs) most popular substance in the respondents. Lifetime prevalence rates stood at 4%, 2% had used the medicines in the last 12 months and 1% in the last 30 days. In the case of the first two indicators, identical rates were recorded form men and women – 4% (lifetime prevalence) and 2% (in the last 12 months). Only 1% of women admitted to having used prescription tranquilizers and sedatives without medical indications in the last 30 days prior to survey. Prevalence rates in individuals reporting at least a single contact with tranquilizersor sedatives are the highest in cities over 500 000 population. The highest was recorded in cities up to 100 000 population – 6%. Discrepancies in city sizes constituted a variable statistically significant ($p < 0.003$).

The results concerning tranquilizers and sedatives must be regarded as overestimated and not reflecting precisely the prevalence of tranquilizers and sedatives without medical indications. As it has been mentioned, in the survey the respondents were asked to give the name of the medicine that he or she had reported in the questionnaire. More than one medicine could be specified. More than half of the medicines specified by the respondents were actually not prescription medicines. Respondents mentioned such drugs as: Persen, lemon balm, Deprim, Valerian, Validol, Nervosol, Neospamina, Melatonina, Kalms, and even APAP noc (paracetamol). Despite a relatively precise question and emphasis on prescription medicines only, 15% of the respondents mentioned lemon balm, teas or herbs. 26% of the respondents who positively answered the question did not remember what substance they had used and 8% specified Persen or Kalms. In the case of actual prescription drugs, every fourth respondent used Relanium. The other tranquilizers or sedatives were much less prevalent. They were used by not more than 2-3% of the respondents who declared contact with such medicines e.g. Propranol (3%); Polsen (2%), Olzapin (3%), Oksazepam (3%).

The study yielded an interesting conclusion and a suggestion how to interpret results of previous studies on tranquilizers and sedatives. As one can see, they should be treated with care because when asked about prescription drugs respondents report using popular and widely available OTC drugs or even diet supplements.

Cannabis

Cannabis i.e. marijuana and hashish are the most prevalent drug in Poland and Europe (EMCDDA 2009). In this study lifetime prevalence was found in 5% of the respondents, 2% had used the drug in the last 12 months and none in the last 30 days. In the case of all the three questions (time ranges) men reported using cannabis more often than women. In experimental use the rates were 7% and 3% respectively and in the recent use 2% and 1%. Every tenth respondent aged 15-24 had used cannabis at least once in a lifetime.

Age is a statistically significant variable, the older the cohorts the lower the percentages of cannabis users ($p<0.000$).

The cannabis rates among the respondents were recorded in cities over 500 000 population – 9%, while in the country only 2%. Discrepancies between location sizes are statistically significant ($p<0.001$).

Among respondents with post-secondary education cannabis use was more prevalent (9%) compared to respondents with primary (4%) or vocational education (3%). Education is also a statistically significant variable ($p < 0.013$).

Amphetamine

Apart from the Netherlands and Belgium, Poland is one of the leading European manufacturers of amphetamine (EMCDDA 2009, p. 56). Amphetamine is the most popular stimulant drug in Poland as well as in Scandinavia. In Western European countries the dominant drug is cocaine. (EMCDDA 2008, p. 56).

Analyzing the results of the study in question we note that 3% of the respondents reported using amphetamine once in a lifetime, 1% in the last 12 months and 0% in the last 30 days.

Along with the rise in location size the lifetime prevalence rates for amphetamine use increase as well ($p< 0.001$). In the country the rate was 0%, and in cities over 500 000 population - 7%. The highest rates were recorded in respondents with secondary education and lower – 4% in each group.

In terms of age 4% of the respondents aged 15-24 and 5% aged 25-39 had used amphetamine. In older cohorts the rates fall steadily. Age is a statistically significant variable ($p < 0.05$).

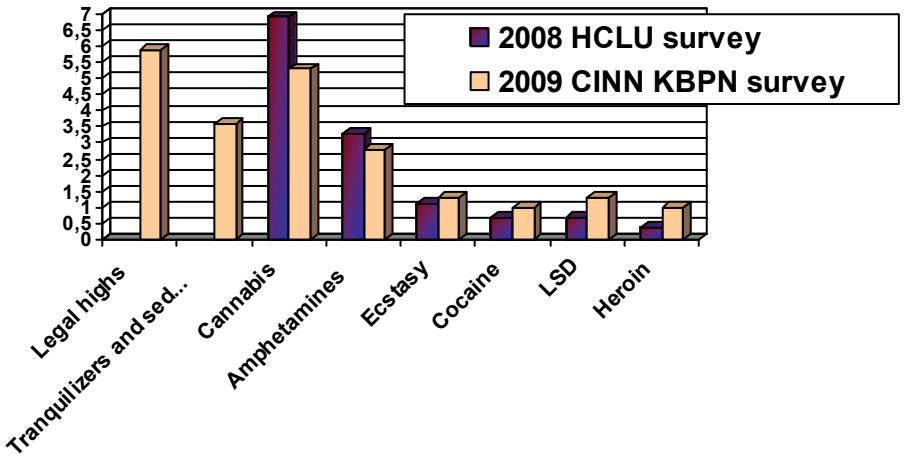
Comparing situation in Poland to the use of amphetamine across Europe we note that the prevalence in Poland is below the European average, which is 3.5% (amphetamine lifetime prevalence rate, age 15-64) (EMCDDA 2009, p. 58). In the Polish study we recorded 3% in the age group 15-75 lat. It must be stressed that in Europe a more popular substance is cocaine, whose prevalence rates are higher and stand at 4% for lifetime use (EMCDDA 2009, p. 70).

Comparison of 2008 and 2009 results

In 2008, Hungarian Civil Liberties Union (HCLU) commissioned Millward Brown SMG/KRC to conduct a study on drug use and attitudes towards the problem by supplementing Omnibus with over a dozen questions. The study was conducted in seven countries, including Poland; on a representative sample of 1003 respondents aged 15-75. The results were processed in request of the Open Society Institute. Consequently, we are able to compare the results of the 2009 SMG/KRC study commissioned by CINN KBPN with the 2008 study results as both studies were conducted according to the same methodology and within the same time frame (November/December). In the HCLU survey the respondents were asked about lifetime use.

The most prevalent substance was marijuana – 7%, which constitutes a fall of 2 percent point compared to 2009 (5%). Second came amphetamine – 3%, both in 2008 (Sieniawska 2009, p. 33) and 2009 (CINN study). In the 2008 study the respondents were not asked about consumption of medicines or legal highs. Prevalence rates of the remaining substances stood at approx. 1%. Comparing the situation in 2009 to 2008, we record a slight fall in cannabis use and the stabilization of amphetamine use.

Figure 2.1. Percentages of respondents aged 15-75 in 2008 & 2009 – lifetime prevalence of psychoactive substance use (N = 1003 – 2008; N 1001 = 2009).



Source: 2008 HCLU survey, 2009 private calculations

Discussion

New substances entered the Polish drug scene – 'legal highs'. The survey results show that they are the most prevalent psychoactive substance. A question arises: is it really the case and did the respondents, despite efforts to clearly formulate the question, not report using other substances, e.g. energy drinks, in the meaning of legal highs? The example of tranquilizers and sedatives shows that it cannot be ignored. Follow-up measures in general

population will be complemented with an additional question – a request to specify substances or products which a respondent considered legal highs. This way we will obtain information whether the respondents had included other substances, which are not legal highs.

Another vital conclusion from the study is the verification of previous results regarding tranquilizers and sedatives. Wrong definition of medicines by respondents requires supplementing the survey questionnaire with an additional question listing names of medicines a respondent has used. Analyzing results of the international ESPAD survey, where Poland ranks first in terms of medicine consumption, one must consider that respondents from other countries might also have reported using OTC drugs. In the latest study of 2007 18% of 15-16-year-olds declared that they had used medicines at least once in a lifetime. This result is threefold higher than the European ESPAD average (Ahlström et al., p. 113). Comparing the situation in Poland to the situation in other countries one must consider Polish tendency to frequent consumption of OTC drugs, especially painkillers.

Summary

The most prevalent drugs in Poland include cannabis (5%) and amphetamine (3%). Among legal psychoactive substances legal highs were the most popular (6%).

Based on the study results one can attempt at determining groups where substance use is more prevalent. Psychoactive substance use is particularly in residents of cities, especially big ones (over 500 thousand population).

The highest prevalence rates of substances use were recorded in respondents with post-secondary education aged 40 and younger.

Men use substances more often than women. Exceptions must be noted. In terms of medicine consumption higher rates were recorded in older age cohorts.

In the case of legal highs higher substance use prevalence is recorded in residents of rural areas compared to big cities. However, it must be stressed that the highest proportions of the respondents who admitted to using legal highs is recorded among residents of small and medium-sized cities.

2.2 Drug use in the school and youth population

No new information.

2.3 Drug use among targeted groups

See chapter 4

3. Prevention

prepared by Anna Radomska, Kamila Jarmołowska, Katarzyna Bonisławska, Danuta Muszyńska, Artur Malczewski

Introduction

The legal act regulating anti-drug issues in Poland is the Act of 29 July 2005 on counteracting drug addiction. The Act lays down principles and procedures in the field of counteracting drug addiction, specifies tasks and competences of governmental administration and local authorities and includes penal provisions regarding drug-related crime.

School respond to the problem of psychoactive substances use (alcohol, drugs) and offences committed by students by virtue of the binding legislation on education, particularly the Regulation of the Minister of Education of 31 January 2003 on specific forms of education and prevention in drug-endangered children and youth.

On 23 November 2009, a Memorandum of Understanding was signed between the Minister of National Education, Minister of Health and Minister of Sport and Tourism on the promotion of health and prevention in children and youth. The Memorandum includes the following provision:

- ensuring synergy of actions in health promotion and problem prevention in children and youth implemented by the parties in schools, institutions and the local community , including taking action in favour of health promotion programmes such as “Schools for Health in Europe”;
- spreading the idea of health promoting schools and consequent activities on local level;
- maintaining a school and educational institution certification system for the network of health promoting schools;
- sharing good practices and information between school and educational institutions in health promotion and problem prevention in children and youth;
- disseminating knowledge and experience resulting from international cooperation related to health promotion and problem prevention in children and youth ;
- disseminating the activities of health promotion and problem prevention in children and youth in the media (http://www.ore.edu.pl of 2.09.2010)

In 2009, a pilot assessment project of the recommendation system was conducted. Works on the recommendation system for prevention and health promotion programmes

were launched upon initiative of the National Bureau for Drug Prevention under the National Programme for Counteracting Drug Addiction 2006-2010.

The framework of the recommendation system was designed by the working team appointed by Order No. 2/2007 of the Director of the National Bureau for Drug Prevention. The team included representatives of institutions listed in the National Programme for Counteracting Drug Addiction 2006-2010 as responsible for implementing the recommendation system, i.e. the National Bureau for Drug Prevention, the Centre for Development of Education (former Methodological Centre for Psychological and Pedagogical Assistance) and the Institute of Psychiatry and Neurology. Due to the planned scope of standards, including use of psychoactive substances, a representative of the State Agency for Prevention of Alcohol Related Problems joined the team. The system implementation was coordinated by the National Bureau for Drug Prevention. The system aims include the following:

- Raising quality of prevention and mental health promotion programmes;
- Wider dissemination of evidence-based practices/prevention and health promotion programmes;
- Improving knowledge on effective prevention strategies and methods of programme formulation.

The recommendation system will cover the evaluation of mental health promotion programmes, substance prevention programmes (drug prevention, alcohol prevention) and other prevention programmes for problem (risky) behaviours in children and youth.

European drug prevention quality standards

Under activities aimed at raising quality of drug prevention programmes, the National Bureau for Drug Prevention is participating in an international project “European drug prevention quality standards”. The project document is intended to provide decision-makers and drug specialists with based uniform quality standards based on sound methodological foundations, which will be useful in disseminating or developing best practices in all areas of drug prevention. Thanks to the standards, prevention professionals will gain access to the evidence base, strategies and practical activities. Moreover, they will be able to effectively achieve aims of National Anti-Drug Strategies and the EU Drugs Action Plan. The project is funded by the European Commission (EC) under the Programme of Community Action in the field of Public Health (2003-2008). Project name: "European standards in evidence for drug prevention", Project No. 2007304. Six countries are involved in the European quality standards project: the United Kingdom (project leader), Spain, Italy, Hungary, Romania and Poland. It is worth stressing that standards are being developed by means of different research methods: *Delphi method, focus groups and field testing*. In the first stage of the project in 2009, documents containing standards, recommendations and guidelines were

collated and analyzed. This process was supported by the Reitox network of National Focal Points. Consequently, drug prevention guidance documents were identified in 12 EU Member States. International drug prevention institutions were contacted by email. Standards were also explored on the Internet. 20 documents were selected for the final analysis. They were divided into three types: guidelines, standards and recommendations in terms of their aims, content, design and status. Based on the documents a drug prevention project cycle was developed. It served as a starting point for further works. The analysis of the documents collected allowed for drawing up a long list of standards, which is a set for comparisons and the outcome of the analysis in itself. In the next stage of the project (January 2010) consultations will be held through the Delphi method and focus groups (Malczewski d-j 2010)

3.1. Universal prevention

- **School**

Activities related to preventing and counteracting problem behaviours in children and youth have been implemented since 1995. The governmental body responsible for implementing prevention activities for children and youth in Polish schools is the Ministry of National Education.

In selecting school prevention programmes school counsellors could refer to the Methodological Centre for Psychological and Pedagogical Assistance[11]. The Centre is a central level professional training facility for teachers established by the Minister of National Education. The Centre initiates systemic solutions for the benefit of child and youth development and designs, recommends and promotes programmes in this respect as well as trains pedagogical and psychological counselling personnel.

In 2009, the Methodological Centre for Psychological and Pedagogical Assistance disseminated the following programmes:

- „Golden Five" – this international programme was designed by specialists from Belgium, Spain, Norway, Poland and Italy. It is addressed to middle school teachers, especially first grade head teachers. In 2009, the European Year of Innovation and Creativity, the programme was awarded bronze medal by the European Commission for creative and innovative solutions in teacher training. In 2008, it was on the list of 12 projects selected for examples of good practice at European level.

[11] As of 1 January 2010 the Methodological Centre for Psychological and Pedagogical Assistance in Warsaw and the National Teacher Training Centre in Warsaw merged into a government agency called the Centre for Education Development in Warsaw.

The programme is designed to prepare teachers to effectively help students adapt to the new school environment and deal with class diversity. Teachers develop their practical skills in the following areas: how to manage class efficiently, how to build good relationships in students, how to generate good climate, how to build relationships with parents, how to motivate parents for cooperation and how to individualize teaching in order to increase students' motivation for learning (http://www.ore.edu.pl as at 2 September 2010).

- "Zippie's Friends" is an international mental health promotion programme addressed particularly to young children aged 5-7. The programme is implemented by the Methodological Centre for Psychological and Pedagogical Assistance (CMPPP) in cooperation with a British organization "Partnership for Children". The programme teaches children how to handle everyday problems, how to call emotions and talk about them and how to deal with difficulties. The Zippie's Friends programme encourages children to analyze life situations and self-reflect. It shows how important it is to talk with others when we feel sad or angry and how important it is to listen to others when they are going through difficult moments. In Poland, the programme had the widest coverage of all the international partners. In 2005-2009, it was extremely successful and has been enjoying permanent interest among teachers. Between 2004 and 2009, the programme was conducted in 1000 nursery and primary schools and reached 35 000 children (http://www.cmppp.edu.pl/node/580 as at 2 September 2010).
- Health Promoting School (SzPZ) has been implemented in Poland since 1991. The programme was launched with a three-year pilot version (1992-1995) entitled "Health Promoting School", which was initiated by WHO/EURO and implemented under the supervision of Prof. Barbara Woynarowska. The project caused an upward movement according to the strategy developed in 14 model schools. Subsequently, a network of health promoting schools at various levels started emerging. The first network was established in 1992 in the former ciechanowskie province. In Poland, this programme expanded within the European Network of Health Promoting Schools established in 1992 and from 1 January 2008 within the Schools for Health in Europe Network, as a result of the agreement between the WHO/EURO, the Council of Europe and the European Commission. Poland became a member of this network in the first group of eight countries. To further disseminate the programme and support the development of the Health Promoting Schools, the Team for Health Promotion was appointed along with the National Coordinator and provincial coordinators for health promotion in schools. At present, the school networks exist in all the provinces. In some provinces there are even district, county or municipal networks for better coordination

and more effective support for the schools activity. Apart from schools, provincial networks of health promoting schools include other educational institutions such as nursery schools, halls of residence, family vacation houses. Currently, the network of health promoting schools comprises 2 000 institutions.

- The Centre keeps the Database of Recommended Prevention Programmes (http://www.cmppp.edu.pl as at 2 September 2010) developed on modern knowledge of risk factors, protective factors and evidence-based models of prevention activities. At present, the Database lists 34 recommended programmes divided into 7 categories: to be implemented in class, large groups, high risk groups, programmes for youth leaders, teachers and parents, outreach programme and universal prevention programmes. The programmes refer to various addictions (alcohol, drugs), but also risky behaviours co-existing or resulting from addiction.
- The Minister of Science and Higher Education under the public tasks for NGOs commissioned education and prevention activities related to experimental drug use to be implemented in university student communities. The Minister also commissioned the 2nd edition of the "Don't do drugs – think of yourself and your family" programme (http://www.nauka.gov.pl).
- The Institute of Psychiatry and Neurology conducted trainings for teachers, pedagogues and head teachers in school preventive intervention and mental health promotion. There were also trainings in developing communal substance prevention strategies and specialist trainings for drug services professionals.
- Under peer education programmes, 12 NGOs operating across Poland received funding from the National Bureau for Drug Prevention in 2009. The tasks commissioned were aimed at preparing young people to implement activities of drug prevention and health promotion in peer environment or the local community. The leaders took part in informative and educational classes on addictions and methods of peer work, psycho-educational activities (trainings, workshops) which improved leaders' personal and social skills and consultations (National Bureau for Drug Prevention, 2010).
- In 2009, under the EDDRA programme (Exchange on Drug Demand Reduction Action) coordinated in Poland by the National Bureau, a new project was entered in the international database of quality programmes – "Fantastyczne możliwości" of the Institute of Psychiatry and Neurology. The project is the adaptation of an American programme called „Amazing Alternatives". At present, the international database of recommended programmes includes 6 Polish projects.

- **Family**

- Family Strengthening Programme

Family Strengthening Programme is a unique example of Polish prevention programmes. Its uniqueness is that trainers work both with children/youth and their parents. Parents are taught consistent parenting, how to set limits or show emotions. Adolescents learn to set and achieve goals, cope with stress, communicate with parents. The programme shows how to attractively spend time with your family and enjoy each other's company. Thanks to this, parents and children open up to each other and get internal motivation for the accomplishment of shared goals. The programme is successful in Polish conditions and positive changes are often observed during lasts sessions (e.g. better communication skills of participants according to observers).

Pursuant to the agreement of 27 April 2007 between "Maraton" Drug Prevention Foundation, Oxford Brookes University, which is responsible for all the professional adaptation and implementation issues in Polish conditions and DIAGEO PLC, which is the funding body of this two-year project (2007-2009), necessary materials in Polish version (manual, DVD with role plays) were prepared and implemented along with the presentation of the evaluation study results.

The feedback from parents and adolescents shows that the programme's strength is that it provides an opportunity for parents and children to spend time together in a nice and constructive atmosphere. They can get to know and understand each other better. Generally, the programme improves relationships within the family (National Bureau for Drug Prevention, 2010).

- **School for Parents and Educators Programme** targets anyone who seeks to make deeper and warmer relations with children or their charges. Its main goal is to support parents and educators in everyday contacts with children and youth. Communication training, reflection on one's parenting or educational approach, experience exchange are small steps towards deeper relationship which provides satisfaction and feeling of intimacy. The mission statement of the School for Parents and Educators is "Educate means love and demand". By teaching skills of open communication in the family, the programme contributes to strong ties between parents and children, which (according to J.D. Hawkins's research results) makes it a prevention programme. In 2009, works were in progress in collecting necessary information on the programme. Selected evaluation results of the "School for Parents and Educators" programme were also published (Sochocki 2009). Evaluation of "School for Parents and Educators" was conducted in 2008 on national level in the frame of government programme entitled "Safe and friendly school". The evaluation participants rated the usefulness of the Programme in developing skills helpful in contacts with children, spouses and other family members as well as the participants' satisfaction from the workshops (http://www.ore.edu.pl as at 2 September 201o)

- In 2009, upon commission of the National Bureau for Drug Prevention, the online counselling centre at www.narkomania.org.pl was continued. The aim of this online project is to provide assistance and reliable knowledge of drug addiction, drugs, forms of assistance etc. for problem drug users and co-dependent individuals. In 2009, the website was visited approx. 230 000 times, which makes about 629 visits daily. 989 answers were provided. The following specialists answered: a psychologist (637 consultations), a physician (279 consultations) and a lawyer (73 consultations). Based on the content, it is estimated that 736 questions (over 72%) were asked by family members, partners or friends of an individual with a drug problem, while 249 questions (approx. 25%) were asked by substance users (mainly drugs, but also alcohol, tobacco, medicines). 74% of the questions came from women (Praesterno Foundation, 2009).

- **Community**

Pursuant to the Act of 29 July 2005 on counteracting drug addiction, provincial and communal governments are obliged to develop and implement Provincial and Communal Programmes for Counteracting Drug Addiction. Drug prevention actions were intended to deepen the involvement of the stakeholders in counteracting drug addiction, both at the provincial and local level. Under the programmes local governments support local and regional initiatives related to drug prevention which include: school educational programmes, programmes for parents, trainings for drug prevention practitioners, school and extra-school programmes for at-risk adolescents and their parents as well as extracurricular activities.
In 2009, according to the reports submitted by provincial governments, all 16 provinces finances universal prevention programmes, which included 168 018 participants under school programmes and 40 995 participants from outside schools. The projects were conducted by 41 organizations at schools and 138 NGOs operating outside schools. In 2009, a total of 7 348 universal prevention projects were conducted, which constitutes an increase of 408 compared to the previous year. The projects were conducted in 10 961 institutions and included 2 203 677 participants (Malczewski 2010l).

Primary prevention is the area of counteracting drug addiction that is most frequently financed by communes. In 2009, almost 70% of communes supported universal prevention programmes (Figure 3.1.) with the total amount of PLN 36 million. Compared to 2008 (nearly 73% of communes) the percentage of communes financing universal prevention fell by approx. 3%.In 2009, the total number of universal prevention programmes in place stood at 7 348, which is 408 more compared to the previous year. Universal prevention actions were taken in 10 961 settings (10 199 settings in 2008). The programmes included the total number

of 2 203 677 beneficiaries (approx. 1 493 000 in 2008). The number of beneficiaries might be overestimated as the same person might have participated in more than one programme.

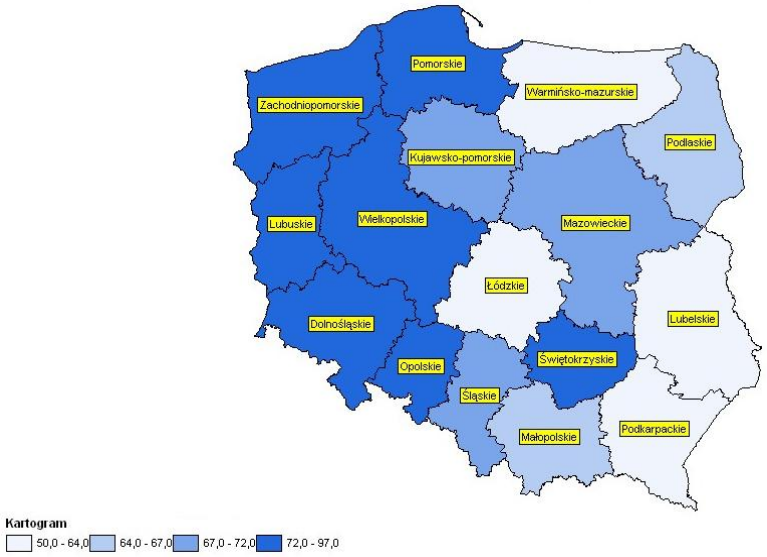
In 2009, the highest percentages of communes implementing universal prevention were recorded in opolskie, swietokrzyskie and dolnoslaskie provinces.

The lowest percentage – below national average – were recorded in mazowieckie, podlaskie, podkarpackie, lodzkie, warminsko-mazurskie, lubelskie and kujawsko-pomorskie provinces. Compared to the previous year (2008), in 10 provinces the percentages of communes financing universal prevention decreased. In 6 provinces the percentages of communes financing universal prevention activities increased compared to 2008. The highest increase was recorded in opolskie province (from 82% to 90% out of the communes which sent the reports), slaskie province (from 74% to 82%) and lubuskie province (from 73% to 80%).

Generally, the performance of universal prevention tasks by communes varies depending on geographical location of communes in respective provinces. According to analyses, this dependence is statistically significant (chi^2 at 0.000). Across the country an average ration of communed which did not perform universal prevention tasks to the number of communes which performed such tasks is 0.4.

There is also a strong relationship between the frequency of universal prevention tasks and the commune type (chi^2 at 0.000). Municipal communes and municipal-rural communes far more often perform tasks in the field of universal prevention. Across the country 91% of municipal communes and 78% of municipal-rural communes performed such tasks. In the case of rural communes the figure stood at 63% (Malczewski 2010l, p. 10).

Figure 3.1. Communes which in 2009 financed universal prevention programmes – percentage of communes which sent the reports.



Source: Malczewski 2010l, p. 9

- Workshop-based conference entitled “Drug prevention methodology in theory and practice”. The aim of the conference was to improve knowledge and skills of drug professionals, demonstrate different methods of drug prevention work. The conference was attended by 47 participants (National Bureau for Drug Prevention 2009, 2010).

3.2. Selective prevention in at-risks groups and settings

- **At-riskis groups**

In 2009, the National Bureau for Drug Prevention similarly to previous years supported prevention programmes for drug-endangered individuals and occasional drug users. A total of 73 programmes were conducted. The programmes targeted drug endangered children and adolescents, neglected children, children for disrupted families (including addictions) where they come into contact with drugs for the first time. The programmes featured the following activities: providing information, psycho-education (personal and psychosocial skill training), psychotherapy (social therapy, support groups), family counselling and specialist consultations. The programmes aimed at reducing the negative consequences of growing up in adverse family and peer environment, improving emotional and social functioning, shaping adequate normative beliefs regarding drugs, promoting healthy lifestyle, developing drug-free ways of spending leisure time and supporting families in solving drug-related problems by the child.

Another target group of the programmes were occasional drug users. This group received mainly interventions and psycho-corrective measures aimed to modify behaviours of children, adolescents and adults towards abstinence as well as better emotional and social functioning.

Moreover, the National Bureau continued the early intervention programme called “FreD goes net” addressed to adolescents who have come to notice in terms of drugs. The programme is being conducted under an international project financed by the European Union form the Public Health Programme. In the reporting year a pilot programme at local level was conducted in Bydgoszcz and Bartoszyce. The pilot programme included 142 participants - young drugs users. The programme enjoyed huge interest on the part of local authorities, police, schools, drug prevention practitioners as well as parents and adolescents. This huge interest in the programme proves that it bridges the gap on the Polish market of prevention programmes and directly responds to the needs of young drug users and local communities.

- **At-risks families**

In 2009, the National Bureau co-financed 31 programmes targeting families and relatives of individuals with a drug problem. The programmes featured individual psychological

support, legal counselling, workshops on parenting skills, support groups for families in drug-related crisis, acquisition and improvement of parenting skills, which substantially contributes to a better functioning of the family and strengthens its role in drug prevention and treatment. Moreover, more than 2 programmes for drug dependent parents were co-financed. The projects were aimed at improving functioning of drug dependent parents, building and improving relationships with children and improving parenting skills.

- **Recreational settings**

In 2009, 12 selective prevention programmes targeting occasional drug users were co-financed. The projects were implemented directly in the community of occasional drug users or individuals at risk of drug use and in high drug prevalence settings e.g. in clubs, discotheques, open air events or fitness centres. The programmes aimed at preventing drug initiation, changing attitudes towards drugs and reducing risk of occasional drug use. The programme covered outreach activities: education in drug-related risk, motivating for the change of behaviour and attitudes, interventions, providing information on places for drug users to get help and distributing informative materials.

Moreover, a drug prevention programmes for experimental users entitled “We don’t do drugs, we’re OK – preventive action at Woodstock Station” was co-financed. The programme was conducted during a youth open air music festival called Woodstock Station (Przystanek Woodstock). The programme involved providing information on drug-related risk as well as promoting healthy lifestyle and drug-free entertainment.

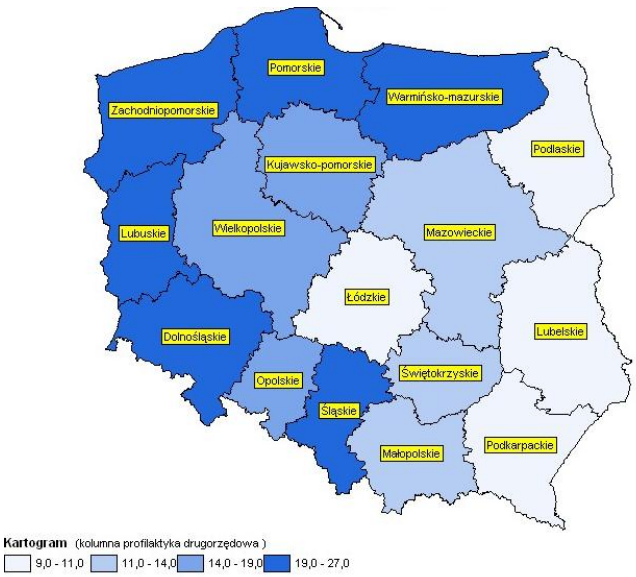
3.3. Indicated prevention

Analyzing tasks of selective and indicative prevention performed under the National Programme we note that 16.6% of Polish communes took action in this respect (18,3% of communes which sent the reports in 2008). In 2009, more than PLN 16 million was disbursed in this area.

Communal selective and indicative prevention programmes included 125 963 participants, which constitutes a fall of 25 911 compared to 2008. 1 026 programmes were implemented in 1 874 settings, which constitutes a fall compared to 2008 (1 040 programmes in 2 431 settings). Every fourth commune in slaskie and dolnoslaskie provinces performed selective and indicative prevention tasks and every fifth in the provinces of zachodniopomorskie, pomorskie, lubuskie and warmińsko-mazurskie. The least involved in selective and indicative prevention were communes of the following provinces: podkarpackie, lubelskie, podlaskie, lubelskie and lodzkie. In these provinces only every tenth commune financed selective and indicative prevention activities.

Similarly to universal prevention, in 10 provinces there were fewer communes which financed selective and indicative prevention (the biggest falls of 6% to 10% were recorded in the following provinces: malopolskie, podlaskie, opolskie and zachodniopomorskie. Only in 6 provinces were the percentages higher compared to 2008 (the highest increase (5%) was recorded in communes of podkarpackie and swietokrzyskie provinces). The division, mentioned before, into provinces frequently and infrequently supporting prevention activities for high risk groups is still maintained. The performance of selective and indicative prevention tasks, similarly to universal prevention, is strongly dependent on the commune type. Statistical analyses showed that municipal communes take such action much more often than rural and municipal-rural communes (chi^2 at 0.000). Among municipal communes as many as 59% performed selective and indicative prevention, 22% of municipal-rural communes and only 7% of rural communes. In the case of selective and indicative prevention, the domination of municipal communes as leading sponsors of prevention activities for high risk groups is clear (Malczewski 2010l, p 14).

Figure 3.2. Communes which in 2009 financed selective and indicative prevention programmes – percentage of communes which sent the reports.



Source: Malczewski 2010l, p. 12

3.4. National and local Media campaigns

In 2009 the National Bureau for Drug Prevention launched 2 national anti-drug campaigns. The campaign entitled **"Don't drug drive. When you're on drugs your brain is off!"** was the first in Poland to have placed emphasis on the risk of driving under the influence of drugs. The campaign targeted mainly young drivers and their passengers as well as party goers. The campaign met with understanding and found a number of media partners, who supported it by offering free TV/radio slots or advertising space. 17 TV stations, 13 radio stations and 14 press titles, 8 websites (mainly social networking and youth sites), Multikino cinema chain and outdoor advertising companies were involved in the campaign. Additionally, the campaign was supported with non-profit PR activities. The number of media publications (over 380 publications, radio and TV broadcasts) on the campaign and the qualitative analysis confirm that the issue of driving under the influence of drugs is important to society. As a result of the media campaign summary and considering the involvement of the media (over 60 different institutions) who provided free TV and radio slots as well as advertising space it can be concluded that the value of the campaign exceeded 17-fold the budget of the National Bureau for the 2009 campaign.

A clear message of the campaign as well as broad media coverage was appreciated and awarded in an international competition "Impact Awards 2009" organized by League of American Communication Professional (http://www.lacp.com/2009impact/8401A.HTM). The campaign success was also noted by the Pompidou Group of the Council of Europe, which decided to adopt and translate the TV spot into 6 languages (French, German, English, Russian, Italian and Slovenian). In 2010 the spot targeted young people in different European countries. The spot adaptation can be seen at http://www.coe.int/t/dg3/pompidou/

At the same time the National bureau launched an informative and educational campaign entitled **"Legal highs can burn you out – Face the facts"** in response to the current situation on the drug scene and an increasing prevalence of legal highs. The campaign was prepared for adolescents and focused on providing credible and reliable information on the substances along with their negative consequences. The campaign was conducted mainly through the website www.dopalaczeinfo.pl, whereas the campaign educational materials were posted on web portals, public transport, clubs, discotheques and schools. Thousands of campaign posters were distributed.

In 2009 most local governments were involved in national campaigns – 14 out of 16 provinces launched educational campaigns addressing negative consequences of drug use. At communal level 456 communes were involved, including 223 communes which conducted their own campaigns and 240 joined the existing campaigns of central institutions.

The majority of local governments cooperated with the media. The cooperation involved organizing press conferences, preparing media releases, press articles as well as local TV

and radio broadcasts. In 2009, local governments held 46 press conferences (97 in 2008) on drug-related issues. In 2009, local governments prepared 4 432 media releases on drug-related issues (215 in 2008). Local media featured 3 809 articles on drug-related subjects (4 143 in 2008). Additionally, 1 245 joint actions with local media were conducted in 2009.

4. Problem drug use *prepared by Artur Malczewski*

Introduction

The latest estimation of problem drug users conducted of 2007 shows that there were 100-125 thousand problem drug users in 2005 (including 25 000 – 27 000 problem opiate users). The Information Centre for Drugs and Drug Addiction conducted a survey of low threshold programme clients in 2008. 773 questionnaire interviews were held under the project. All the survey participants were problem drug users.

4.1. Data on PDUs from non-treatment sources

In 2008, a survey of low threshold programme clients was conducted in cooperation with the OFDT. Most results were presented in the previous National Report. This year's edition will feature complementary information and additional analyses. During the two weeks of the survey i.e. between 24 November and 7 December 2008, the staff of low threshold programmes (needle and syringe exchange programmes, drop-in centres) conducted questionnaire interviews with all clients of the programmes. Drug users made contacts to exchange the injecting equipment, receive advice, support or just to talk. The respondents were coded in order to avoid double counting and protect their privacy. A questionnaire interview was conducted with every individual who contacted the programme. The survey covered all needle and syringe exchange programmes in Poland. There were 13 of them in 11 Polish cities in 2008. Following the analysis, after excluding interviews with the same individual, 733 questionnaires were considered (Malczewski, Struzik, Jaśkiewicz 2009).

The most prevalent drug among the respondents were opioids – three quarters of the survey participants (76%) used opiate (heroin, Polish homemade heroin ('kompot'), methadone or buprenorphine) in the last 30 days prior to survey. Half of the respondents used the Polish variety of heroin. An average age of opioid user (34 years old) was slightly higher compared to the whole target population. In this group males accounted for 72% of the participants, similarly to the whole sample.

Second in terms of prevalence was amphetamine (61%), alcohol ranked third (60%). Cannabis and benzodiazepines are prevalent in the same extent (40%). Less than every third participant used methadone (30%). In the last 30 days barbiturates were used by 23% of the respondents. 13% reported using ecstasy. The remaining substances (cocaine, LSD and hallucinogenic plants) in the last 30 days were used by less than 10% of the respondents.

The frequency rates of using respective psychoactive substances varied. Daily use was mostly reported by opioid users, especially Polish homemade heroin ('kompot') and heroin –

62% and 53% respectively. Among amphetamine users, the biggest group were users between one and several times weekly (56%), a third of the respondents used amphetamine less frequently than once a week and only 11% reported daily use. A similar frequency rates among low threshold programme clients were observed in terms of alcohol use – the biggest group of alcohol users drank from one to several times a week (49%), 35% less than once a week and 16% daily.

More than half of barbiturate and benzodiazepine users used the substance between once and several times a week (45% and 47% respectively) and 30% and 26% of the users reported daily use.

Substances used generally less often than once a week included: hallucinogenic plants (97% used less often than once a week), LSD and acids (89%), cocaine and crack (84%), MDMA, ecstasy (78%), buprenorphine (69%), cannabis (48%) and methadone (47%). However, 41% of the respondents smoked cannabis between one and several times a week and 37% used methadone daily (including substitution treatment patients).

Opioids, besides methadone and buprenorphine used mainly orally, are mostly injected (94% of heroin users and 98% of 'kompot' users). The clients of low threshold programmes also used amphetamine intravenously (85%). Heroin is smoked by 8.5% of users.

Barbiturates and benzodiazepines are mostly used orally, however, 8% of barbiturate users and 29% of benzodiazepine users inject the drugs.

During the interviews the respondents were asked which of the substance they used caused the most serious harm. The respondents ranked opioids first (60% including methadone and buprenorphine), then amphetamine (17%) and third alcohol (13%).

The analysis of the relationship between the age of the respondents and the substance of the highest danger they indicated showed that in the youngest age group (15-19) the biggest problems were caused by amphetamine, according to 43% of the members of this age group. Among the respondents aged 20-49 heroin and Polish heroin were considered most harmful. It is worth noting that the percentage of users pointing to Polish heroin rises with age of the respondents. The respondents aged 50-54 indicated alcohol as most problematic (46% respondents at this age).

The interviewers were also asked about the most problematic substance. Their answers were similar to the respondents' answers; however they indicated amphetamine (21%) more often than alcohol (11%). Opioids were mentioned most often (53% including methadone).

38% of low threshold programme clients were hospitalized at least for a single night (excluding emergency ward visits) in the last 12 months prior to survey. The most frequent reason for hospitalization was drug rehabilitation (67%). Another reason was psychiatric disorders, as indicated by 24% of the respondents. In the case of 19% of the respondents hospitalization was related to HIV or HCV.

In the last year the drug rehabilitation centre admitted 77 respondents, which accounts for 11% of the group. A vast majority (72) stayed in drug centres less than 3 times in the last 12 months.

4.2 Drug Use among targeted groups / settings at national and local level

No new information

5. Drug treatment: demand and availability

prepared by Marta Struzik, Dawid Chojecki, Bożena Bajerowska, Kamila Gryn

Introduction

In Poland, data on drug treatment system are collected by the Institute of Psychiatry and Neurology. This institution annually collects information on the number of patients admitted to treatment (including first timers), diagnostic codes and the following types of treatment units: mental health counselling centres, mental health counselling centres for children and adolescents, substance therapy centres, day care centres and drop-in centres, psychiatric wards and addiction treatment facilities as well as detoxification wards. The Institute data below refer to 2008. The Institute does not have data for 2009.

Data on substitution treatment programmes and patients therein are collected by the National Bureau for Drug Prevention.

Moreover, every two years the National Bureau publishes an information booklet: "Drug addiction – where to seek help?" The booklet lists up-to-date operating drug-related treatment services. Another edition of the booklet was published in 2009. The database of drug treatment services is available on the website of the National Bureau www.kbpn.gov.pl under "Where to seek section?".

5.1. Strategy/policy

The basic legal acts regulating drug treatment issues in Poland include:

- Act of 29 July 2005 on counteracting drug addiction as further amended;
- Regulation of Minister of Health of 19 October 2007 on specific rules of conduct in substitution treatment as well as specific conditions which a health care centre providing substitution treatment must meet;
- Regulation of Minister of Justice of 21 December 2006 on specific conditions and rules of conduct in medical treatment, rehabilitation and reintegration in relation to drug addicted persons placed in Prison Service units;
- Regulation of Minister of Health of 1 December 2006 on specific conditions and rules of conduct in medical treatment, rehabilitation and reintegration in relation to individuals convicted of offences related to using narcotic drugs or psychotropic substances;
- Regulation of Minister of Justice of 18 October 1999 on specific conditions and rules of conduct in medical treatment, rehabilitation and reintegration in relation to drug dependent individuals remaining in youth detention centres;
- Regulation of Minister of Justice of 13 July 2006 on addictions-related training

In the section on drug treatment the Act of 29 July 2005 on counteracting drug addiction stipulates the following: rules of conduct in relation to drug dependent individuals and necessary conditions to be met by psychoactive substance treatment services. The Act also contains penal provisions on drug-related crime. Article 72.1, which directly concerns drug treatment, provides that in the event that an addicted person or a person using psychoactive substances in a harmful manner has been charged with committing an offence subject to the penalty of deprivation of liberty for a term up to 5 years, enters drug treatment and rehabilitation or participates in a drug prevention and treatment programme in a relevant health care centre or another service in the health care sector, the prosecutor may suspend the proceedings until the treatment is completed. While a number of services declare that they run such programmes, this instrument is applied to a very limited extent (see 9.3 „Interventions in the criminal justice system").

In the field of drug treatment, rehabilitation, harm reduction and social reintegration the National Programme for Counteracting Drug Addiction as the Regulation of the Council of Ministers stipulates courses of action for governmental bodies and institutions as well as local authorities. There are specific definitions of action types, lists of implementing and responsible entities (including funding sources of activities in respective areas), monitoring indicators and implementation schedules.

5.2. Treatment systems

- **Organization, quality assurance, availability and diversity of drug treatment**

According to Article 26.1 of the Act on counteracting drug addiction, drug treatment can be provided by public or non-public health care units and practising physicians, including groups of practising physicians. Provision of drug treatment services is performed through an extended network of inpatient and outpatient clinics i.e. substance addiction treatment centres, detoxification wards, day care wards, addiction treatment wards in hospitals, medium and long-term rehabilitation clinics, substance treatment wards at penal institutions and post-rehabilitation programmes. If there is no drug treatment unit in a given area there is an option of using services offered by a mental health counselling centre or an alcohol rehabilitation clinic as they are easily accessible (16 times more clinics compared to drug rehabilitation clinics, Institute of Psychiatry and Neurology, 2009). Moreover, opioid dependent individuals may receive treatment under substitution treatment programmes.

In Poland the most popular drug treatment model is total abstinence and therapeutic community-based residential therapy. In 2009 medium and long-term programmes (12 months and longer) were the universal forms of drug treatment; however, similarly to previous years, economic factors and changing patient profiles gradually make it necessary

to shorten the programmes. The programmes are conducted at health care units run by NGOs (associations, societies, foundations).

In Poland drug treatment is free of charge; however, there are a number of private rehab drug clinics and private practice services (paid).

Drug treatment, similarly to all health services, is financed by the National Health Fund. In recent years we have been observing an upward trend in NHF drug treatment-related spending and the rise in requirements imposed on the service providers (health care units).

Under the system, the following drug services are provided: diagnostic and therapeutic consultation; individual, group and family psychotherapy; psychoeducational psychotherapy; withdrawal treatment; maintenance therapy (relapse prevention), substitution treatment. These services are sponsored by the National Health Fund (NFZ) based on contracts concluded with public or non-public health care units. In recent years, we have been observing an increase in NFZ drug treatment funding along with an increase in demands on service providers.

Pursuant to Article 26.5 of the Act of 29 July 2005 on counteracting drug addiction, drug treatment, rehabilitation and reintegration services are free of charge, regardless of the beneficiary's place of residence. Moreover, there is an option to participate in a drug therapy provided in private clinics or by private therapists (paid). Drug treatment, rehabilitation or social reintegration is voluntary, excluding individuals under 18 and incapacitated clients, who might be obliged to enter treatment by the court order.

Table 5.1. Financing psychoactive substance treatment by the National Health Fund in PLN.

Year	Expenditure
2004	54 017 159.78
2005	60 089 521.57
2006	62 199 614.84
2007	64 047 046.10
2008	79 121 702.12
2009	110 950 136.50

Source: Narodowy Fundusz Zdrowia 2010.

Drug treatment (both drug free and substitution treatment) is provided in penal institutions and financed by the Central Management Board of Prison Service – an institution subordinate to the Ministry of Justice. For more information, see Chapter 9.4 Drug use and problem drug use in prisons, section: drug treatment.

"Drug-free" treatment

- **Inpatient treatment**

Similarly to previous years, inpatient clinics are mainly located outside urban areas as it is assumed that it "naturally" isolates patients from the drug community. In Poland, there are 87 inpatient drug rehabilitation clinics (as at 25 August 2010, based on the list of clinics at the website of the National Bureau for Drug Prevention) including clinics for patients with dual diagnosis. 33 clinics (i.e. 38%) out of the 87 were open to underage users (National Bureau for Drug Prevention, 2010). The above data do not include psychiatric hospitals where drug dependent and problem users are also treated, usually due to psychotic symptoms, not drug addiction.

- **Outpatient treatment**

In Poland, the outpatient assistance for users of illicit psychoactive substances is provided at mental health counselling centres and, in exceptional cases where no drug treatment unit listed above is available in the area, at outpatient drug rehabilitation clinics, which extend their offer to individuals with a drug problem.

Since 2006 we have been recording a rise in the number of outpatient drug clinics. In 2007, 102 clinics were in operation; 84 in 2006 and 89 in 2005 (Institute of Psychiatry and Neurology, 2008 & 2009). According to the National Bureau database available at www.kbpn.gov.pl, the number of outpatient clinics across Poland is 222 (including consultation settings, as at 23 August 2010).

Despite a clear rise in the number of outpatient clinics, the outpatient treatment network, especially in day care centres/wards is still insufficient. In 2008, there were only 14 day care centres for individuals dependent on psychoactive substances (including alcohol) operating in Poland (12 in 2006, 14 in 2007). The number of beds available was 390 (405 in 2007, 289 in 2006) (Institute of Psychiatry and Neurology, 2008 & 2009).

Medical treatment

- **Withdrawal treatment**

As at 23 August 2010, the National Bureau database listed 27 registered detoxification wards/subwards. An overall number of 6 224 detoxifications from psychoactive substances were performed (Institute of Psychiatry and Neurology, 2009). The wards targeted mainly opioid withdrawals.

In the case of opioids, the basic forms of withdrawal treatment at detoxification wards included symptomatic treatment through application of narcotic drugs (methadone, buprenorphine, etc.) and causal treatment (e.g. clonidine). Hospitalization usually lasts 8-14 days.

Data collection system does not cover private facilities / medical practices conducting detoxification from psychoactive substances. It is known that a method commonly applied in such cases is the so-called “rapid detoxification”, which is not conducted in public centres (Chmielewska, Institute of Psychiatry and Neurology, personal communication)/

- **Substitution treatment**

According to the Regulation of Minister of Health of 19 October 2007 on specific rules of conduct in substitution treatment as well as specific conditions which a health care centre providing substitution treatment must meet, the substitution treatment programme in Poland includes the following: dispensing substitute drugs to patients, abstinence control and also periodically: evaluations of the patient’s somatic and mental status, individual and group psychotherapy (approx. 2 hours per week), specialist consultations, treatment of other chronic drug-related diseases. In 2009, there were 17 substitution treatment programmes in operation across Poland. They provided services for approx. 1 900 patients (data from the National Bureau’s Registry of Substitution Treatment Patients). In 2009, only 7% of opioid addicts used this form of treatment and the existing programmes respond to the demand only to a very limited extent. A major reason for this situation is the lack of interest on the part of NFZ branches in financing substitution treatment in some provinces. Currently, there is no access to substitution treatment in the following provinces: pomorskie, opolskie, podkarpackie, podlaskie and warminsko – mazurskie. In slaskie and dolnoslaskie provinces the access is seriously limited.

- **Other forms of medical treatment of coexisting diseases**

In special cases drug dependent patients receive psychotropic medication. It is the case when a patient is diagnosed with drug-related psychotic disorders or mood disorders.

Treatment of patients with dual diagnosis was outlined more widely in Chapter 7 “Response to health correlates and consequences”, section “Activities related to coexistence of mental diseases”.

Treatment of coexisting drug-related infectious diseases was outlined in Chapter 7 “Response to health correlates and consequences” – prevention and treatment of drug-related infectious diseases, section “Treatment of infectious diseases”.

In case there is a need to treat other (than infectious and mental) diseases, drug dependent patients are referred to specialist health care units as drug rehab clinics do not hire other consultants.

- **Programmes taking into account type of addiction**

Up to now in Poland, there are no programmes oriented towards specific drugs, except substitution treatment programmes.

Quality assurance

- **Standards and accreditation**

Since 2004 a special team of experts appointed by the Minister of Health has been developing standards of conduct in treatment, rehabilitation and harm reduction towards psychoactive substance users.

In 2009, the activities of the National Bureau in this field focused on finalising the accreditation standards for inpatient/outpatient clinics and day care centres for drug and alcohol users. The standards along with the accreditation procedure were sent to Kraków-based Monitoring Centre for Quality in Health Care to be considered by the Accreditation Council. On 6 August 2009, the Minister of Health issued a regulation on the Accreditation Council. When the regulation took effect the Accreditation Council was appointed. The time frame for implementing the accreditation process for health care units providing psychoactive substance-related services is subject to the Accreditation Council’s decision.

In the reporting year, the Institute of Psychiatry and Neurology continued the implementation of the project “IATPAD – Improvement of access to treatment for people with alcohol- and drug-related problems”. The aim of the IATPAD project was to identify barriers to drug treatment through quality analyses of the treatment system, survey of medical personnel’s attitudes to substance users, assessment of drug treatment availability according to the clients and the evaluation of the system’s limitation. The study was conducted through questionnaire interviews and in-depth interviews with medical personnel of universal , psychiatric and specialist health care units. In Poland, 91 health care units, 132 representatives of medical personnel and 44 drug treatment patients took part in the study.

The study showed that the attitudes of health care staff might seriously hamper or largely facilitate access to drug treatment. In all types of "entry points" to the drug treatment system a similar trend was observed – the staff of universal health care and psychiatry clearly favoured patients with diabetes or depression over substance dependent patients. The most positive attitudes towards alcohol and drug problem users were demonstrated by the personnel of specialist substance treatment centres. According to the patients, the barriers to drug treatment include obligatory referral from a universal care physician, insufficient network of drug treatment units, waiting lists, and "office" hours at treatment units, bureaucratic requirements at admission to treatment, unclear admission rules and the staff's discriminatory attitude towards the patients. The factors for entering drug treatment include short period of time between the first contact with a treatment unit and the onset of treatment and effective though not excessively long treatment (Institute of Psychiatry and Neurology 2008, Operation report 2009, p. 74)

Evaluation

In 2009, the National Bureau along with the Institute of Psychiatry and Neurology continued implementing an evaluation of drug treatment and rehabilitation services with a view to improving their effectiveness. Works on the evaluation project of drug treatment and rehabilitation services included an ongoing analysis of evaluation questionnaires received by the National Bureau and designing an evaluation study protocol describing the concept, research tools, procedures, rules and the evaluation schedule. Moreover, activities were launched to evaluate harm reduction programmes. The National Bureau held a training course for harm and risk reduction practitioners on programme evaluation methods.

The Institute of Psychiatry and Neurology continued a project launched in 2008 "Senior drug addicts and care structures". The project is aimed at estimating the number of drug dependent individuals in older age groups, assessing needs in terms of care and treatment, and developing practical recommendations.

Trainings and conferences

In 2009, similarly to previous years, 2 training courses for the staff of Primary Health Care, especially general practitioners, family doctors, consultants in infectious diseases, obstetrics, paediatrics and nurses, were held. The courses included 118 participants.

The National Bureau commissioned the implementation of the following projects:

- A training seminar in evaluating harm and risk reduction programmes for 21 participants;
- A seminar "Harm reduction in psychotherapy" intended to improve knowledge and skills of drug therapists in harm reduction mode. It was attended by 28 participants;

- An annual conference entitled “Various drug psychotherapy models”. It was meant to present systemic family therapy methods, motivational therapy and harm reduction therapy and their usage in drug and alcohol treatment. The conference was attended by 62 participants;
- 2 training courses for substitution programme providers. The staff of 3 new substitution treatment programmes were trained (1 non-custodial setting and 2 custodial settings).

The National Bureau held a training course for NGOs dealing with harm reduction, particularly outreach programmes. The course was attended by 27 participants. The training courses on public health organized by the Medical Centre for Postgraduate Studies in cooperation with other entities involved 322 physicians.

Regional Chambers of Nurses and Midwives based in the city of Pila conducted 2 trainings in drug addiction for 172 nurses. Compared to the previous year, this number fell by 40%. In 2009, the Supreme Medical Chamber, similarly to previous years, did not conduct trainings for physicians and nurses in the abovementioned field.

In 2009, trainings in drug therapy and drug rehabilitation intended for drug instructors and specialists were continued. New editions of trainings were launched.

5.3. Characteristics of treated clients (TDI data included)

and

5.4. Trends of clients in treatment (incl. numbers)

In Poland it is still the Institute of Psychiatry and Neurology that collects data from the drug treatment system. The Institute keeps independent databases for the inpatient and outpatient treatment. Demand for drug treatment is covered by the statistical system of the inpatient psychiatric treatment. It also refers to the specialist treatment of pharmaceutical drug addictions, which exists under psychiatric health care. The inpatient treatment data cover all clients of psychiatric hospitals, including detoxification wards for clients addicted to psychoactive substances other than alcohol, and rehabilitation centres (including those run by NGOs) if they are health care units (ZOZ status). The statistical reporting system of the inpatient treatment is based on individual statistical questionnaires completed by the patient upon discharge from the treatment unit and on 31 December every year. Each questionnaire is coded. Consequently, it is possible to collect data on clients not cases (treatment episodes). Inpatient treatment data are aggregated at the database of the Institute of Psychiatry and Neurology. Therefore, it is possible to eliminate double counting of persons

who enter treatment several times in a year, frequently in many facilities. The statistical reporting system from the outpatient treatment is based on collective reports drawn up by outpatient clinics. In this case it is not possible to avoid double counting of the same individuals.

In Poland, work is in progress on introducing a new treatment demand data collection system compliant with the TDI protocol ("Treatment Demand Indicator (TDI). Standard Protocol 2.0"). The system is intended to ultimately cover inpatient and outpatient drug treatment units. The existing drug treatment demand data collection system in Poland does not meet the standards of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) because data available at present relate only to inpatient drug treatment units and in a number of cases information is missing on the primary drug underlying the problem of the person entering treatment. Moreover, there is no information on the route and frequency of drug administration. Consequently, the Information Centre for Drugs and Drug Addiction (CINN) launched works to establish a new statistical system that would meet the European standards. The following documents necessary to start monitoring have been developed and adapted to the Polish conditions:

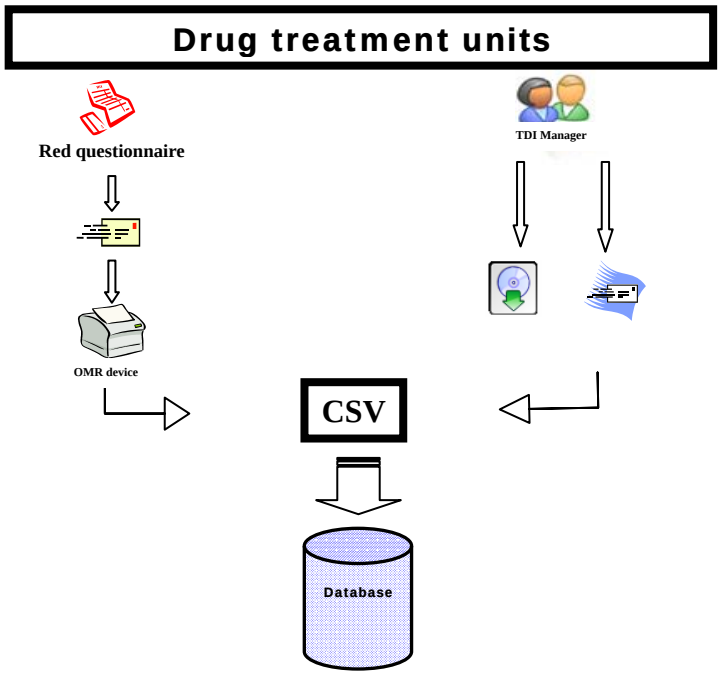
- monitoring protocol,
- paper version questionnaire,
- electronic version questionnaire,
- ancillary questionnaires for both versions of the tool,
- questionnaire instruction.

Collecting data under the new drug treatment demand monitoring system started in 2008 and has been performed as a pilot project which aims at identifying frequent problems in completing the questionnaire and verifying the reliability of data collection tools. In 2008, the project included 33 health care units (ZOZ) providing drug treatment and rehabilitation services for problem drug users: 14 counselling centres for drug addicts, 1 detoxification ward, 1 substitution treatment programme and 17 drug rehabilitation clinics.

The basic statistical unit in the pilot TDI system is a treatment episode defined as a single contact with a treatment centre that ended in entering treatment. A separate questionnaire is completed at every treatment episode. A single questionnaire contains the following data: socio-demographic patient profile (age, sex, education, place of residence, employment), patterns of drug use (type of substance, route and frequency of administration, drug initiation), sources and results of entering treatment (possibly previous treatments), diagnosis (ICD-10), risky behaviour (injecting drugs, sharing injecting equipment), HIV and HCV status. Two questionnaire items are critical in identifying each episode, namely the number of a treatment unit and the client ID. Each treatment unit in the TDI system has a unique ID code given by the CINN. Due to various stages of treatment units' technological development

in Poland a decision was made to apply two parallel data reporting solutions. One is a paper version of the questionnaire i.e. a card with relevant data. Following the collection of all questionnaires, the cards are posted to CINN. Then a trained CINN staff member enters cards by means of an OMR device[12]. Consequently, „csv"[13] files are created. The files contain all the data on treatment episodes presented in the questionnaires. The other solution is a TDI manager software, which was specially developed for the system. The National Bureau for Drug Prevention shares the software free of charge to any treatment unit that joins the system. The application is a client data collection tool. It also fulfils the function of a patient registration system useful for treatment units. Then during the reporting period so-called export files are generated. The export files can be sent as an email attachment or saved on any data carrier (CD-ROM, DIVD-ROM, USB flash drive) and then posted to the CINN office. The software makes it possible to email data sets directly from the application to a special CINN inbox.

Figure 5.1. Data collection flow chart.



Source: Sokołowska, E., Struzik, M., Kidawa, M. 2008

[12] Optical Mark Recognition (OMR) – capturing, frequently through scanning, marks such as check boxes, bar codes etc. It is often used in survey analyses. OMR devices ensure an automatic recognition of a questionnaire, check the correct completion of a questionnaire and enter the content into an electronic database (....). A single reader makes it possible to enter many thousands of forms per hour. (Source: Wikipedia – Wolna Encyklopedia; http://pl.wikipedia.org/wiki/OMR)

[13] Comma Separated Values (CSV) – data storage format in text files and the corresponding MIME text/csv. (Source: Wikipedia – Wolna Encyklopedia; link: http://pl.wikipedia.org/wiki/CSV)

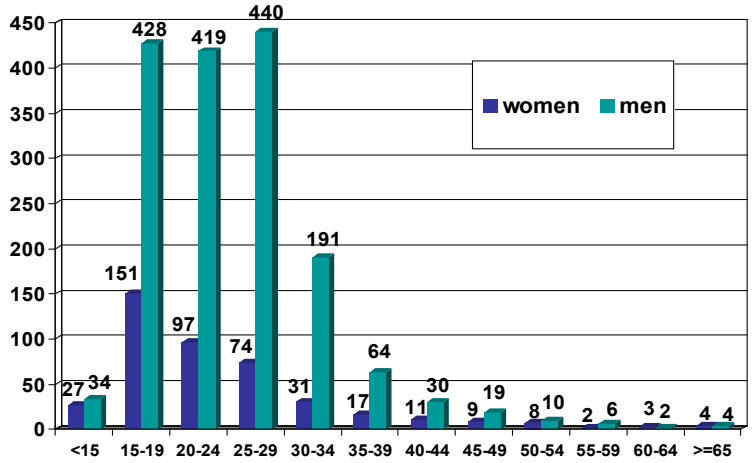
In order to ensure the best control of data sets, their quality and completeness a decision was made to apply a relatively complex and multi-stage data filtering process. The data control uses human potential as well as automated control processes of data quality and coherence. The databases will store data for the current period and previous years. The Information Centre for Drugs and Drug Addiction analyzes data and prepares necessary reports.

- **Treatment Demand Indicator Database – pilot version of the monitoring system introduced by the Information Centre for Drugs and Drug Addiction**

In 2008, drug treatment units, which took part in the Treatment Demand Indicator (TDI) pilot project, admitted 2 082 patients, including 851 first-time patients. There were 1 648 men (79%) and 434 women (21%), including the respective numbers of 668 (78%) and 183 (22%) among first-time patients.

Among men admitted to drug treatment in 2008, the largest group were patients aged 25-29 (440), 15-19 (428) and 20-24 (419). In the case of women, the most numerous groups were patients aged 15-19 lat (151), 20-24 (97) and 25-29 (74). Detailed data are presented in Figure 5.2.

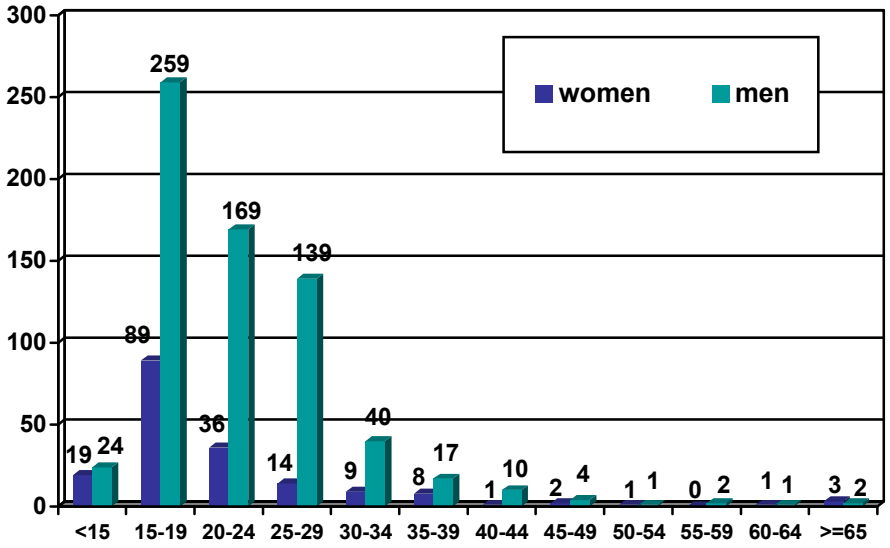
Figure 5.2. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – numbers of patients by sex and age group.



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)
** the age of one man was unknown*

In the case of first-time patients, a similar age structure among men and women was observed i.e. the most numerous were groups aged 15-19 lat (259 and 89 respectively), then 20-24 (169 and 36 respectively) and 25-29 (139 and 14 respectively) (Figure 5.3.).

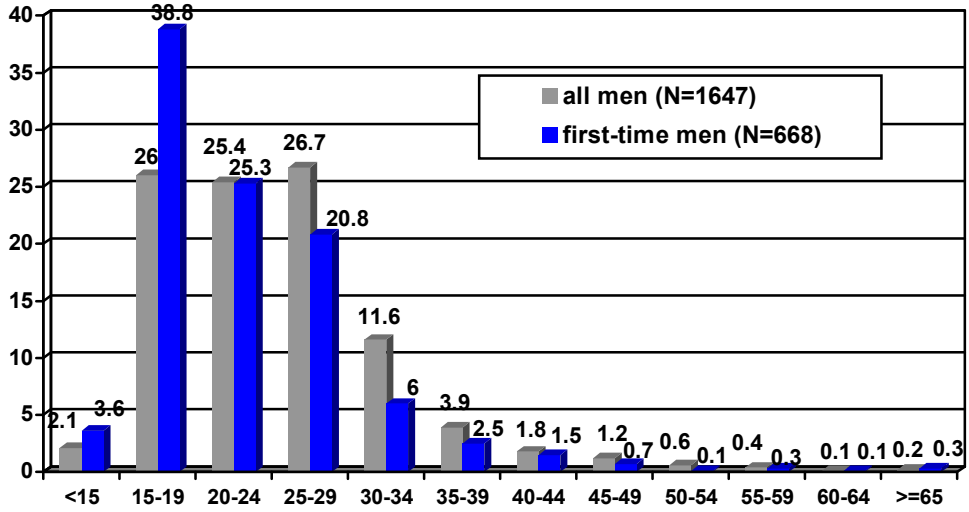
Figure 5.3. First-time admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – numbers of patients by sex and age group.



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)

Among men admitted to drug treatment for the first time in a lifetime in 2008 the largest group were patients aged 15-19 (38.8%). In the case of all men who entered drug treatment units there is a more balanced distribution of 3 age groups (25-29: 26.7%; 15-19: 26%; 20-24: 25.4%) (see Figure 5.4.).

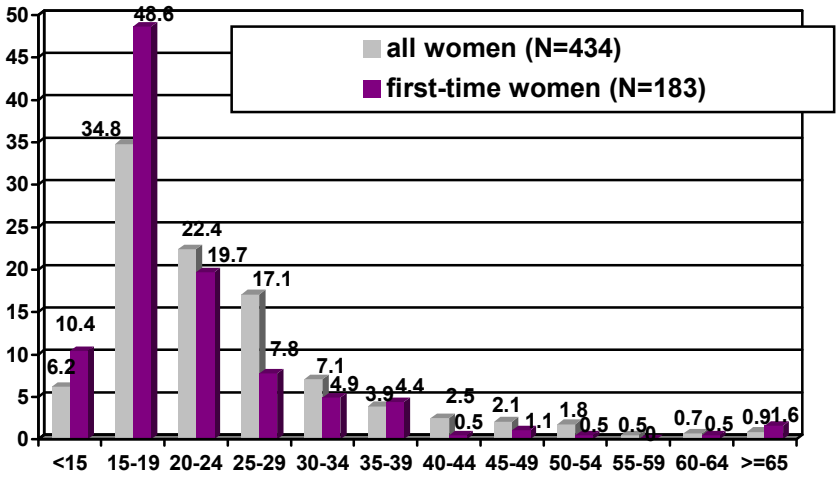
Figure 5.4. Men admitted to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – proportions of all patients and first-timers by age.



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)
** the age of one man was unknown*

The age of the majority of women admitted to drug treatment in 2008 concerned the age group 15-19, both among all and first-time female patients (34.8% and 48.6% respectively). It is worth noting a higher proportion of female first-time patients under 15 (Figure 5.5).

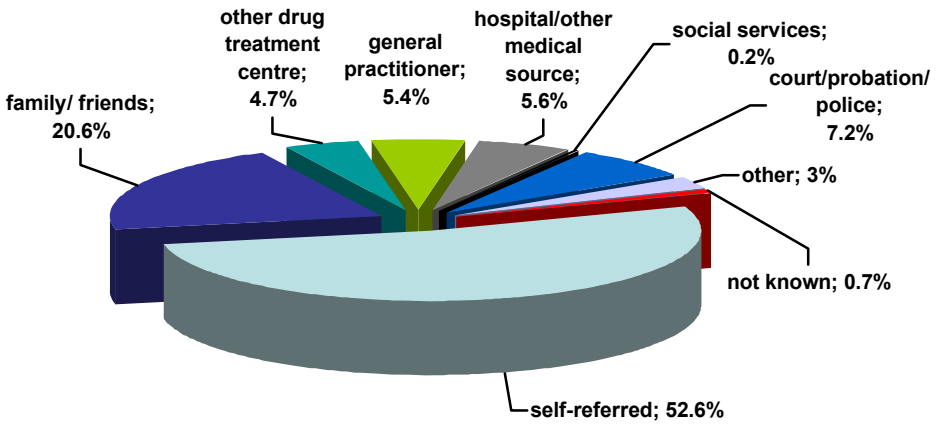
Figure 5.5. Women admitted to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – proportions of all patients and first-timers by age.



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)

Most patients (52.6%) declared that entering drug treatment was their own decision. Other referrals included family and friends (20.6%), police, court, probation officer (7.2%) and hospital or another medical source (5.6%). Full data are presented in the chart below.

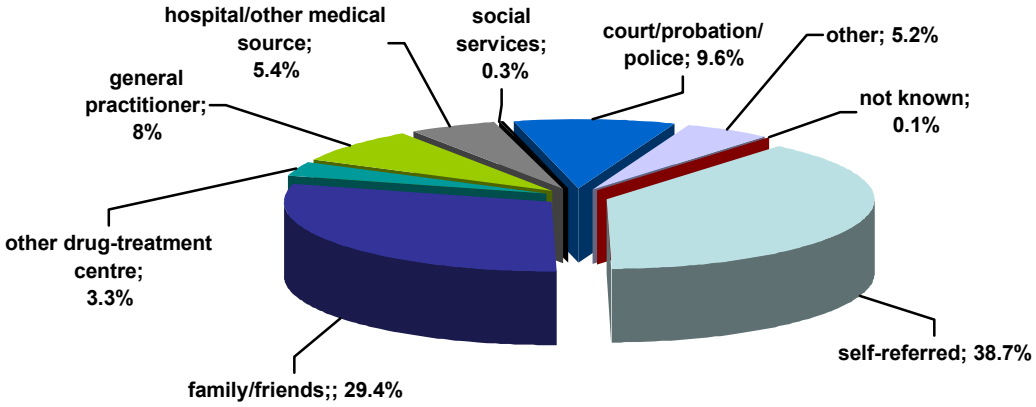
Figure 5.6. Referrals to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – proportions of all patients (N=2082).



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)

Analyzing the above measure among first-time patients one can notice a more balanced structure of personal decision (38.7%) and the impact of family and friends (29.4%) to enter drug treatment. A higher proportion of referrals from the police, court and probation officers (9.6%) and the general practitioners (8%) is noticeable (Figure 5.7.).

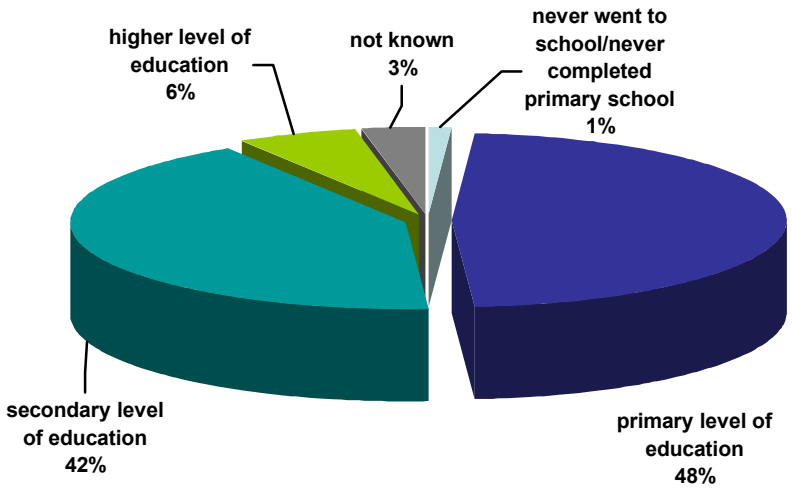
Figure 5.7. Referrals to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – proportions of first-time patients (N=851).



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)

The education structure of the patients admitted to drug treatment in 2008 was presented in Figure 5.8. Most patients had primary (48%) or secondary education (42%). Individuals with higher education accounted for 6 %.

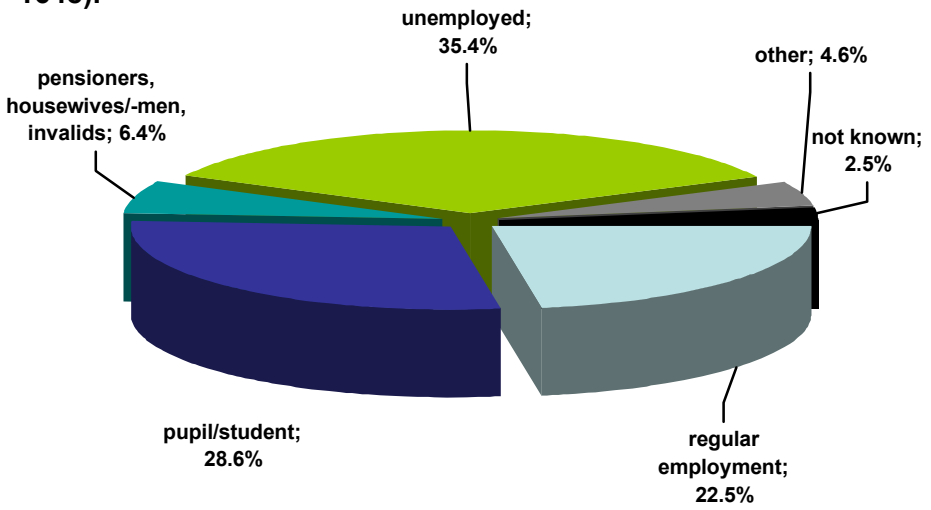
Figure 5.8. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – proportions of patients by education (N=2082).



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)

Among men admitted to drug treatment in 2008 there were mainly the unemployed (35.4%), then school and university students (28.6%) and individuals with steady jobs (22.5%).

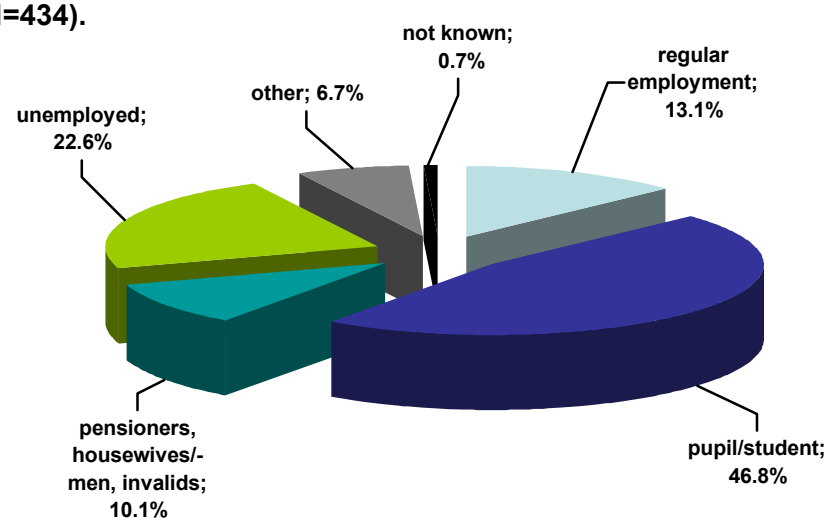
Figure 5.9. Men admitted to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – proportions of patients by employment status (N=1648).



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)

The majority of women admitted to drug treatment in 2008 were school or university students (46.8%), then the unemployed (22.6%) and individuals with steady jobs (13.1%).

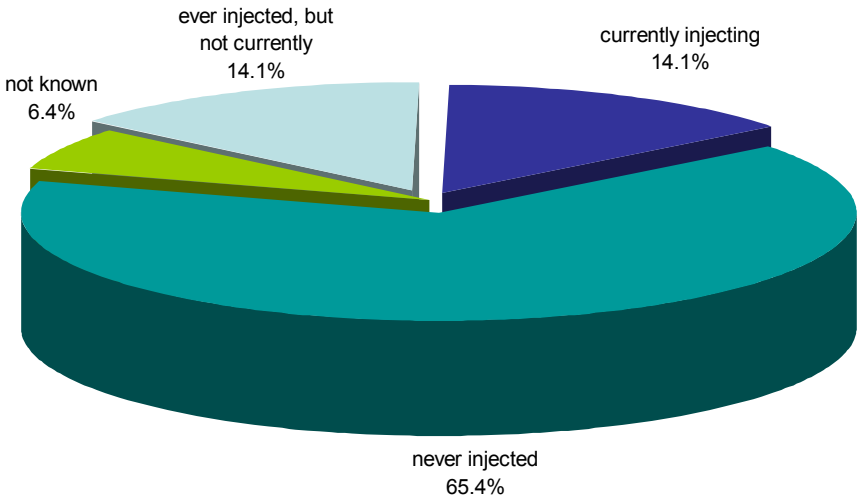
Figure 5.10. Women admitted to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – proportions of patients by employment status (N=434).



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)

The results of the monitoring of risky behaviour regarding injecting drug use are presented in the chart below. Most patients (65.4%) had never injected drugs, 14.1% of patients had injected drugs in a lifetime and 14.1% currently injected drugs.

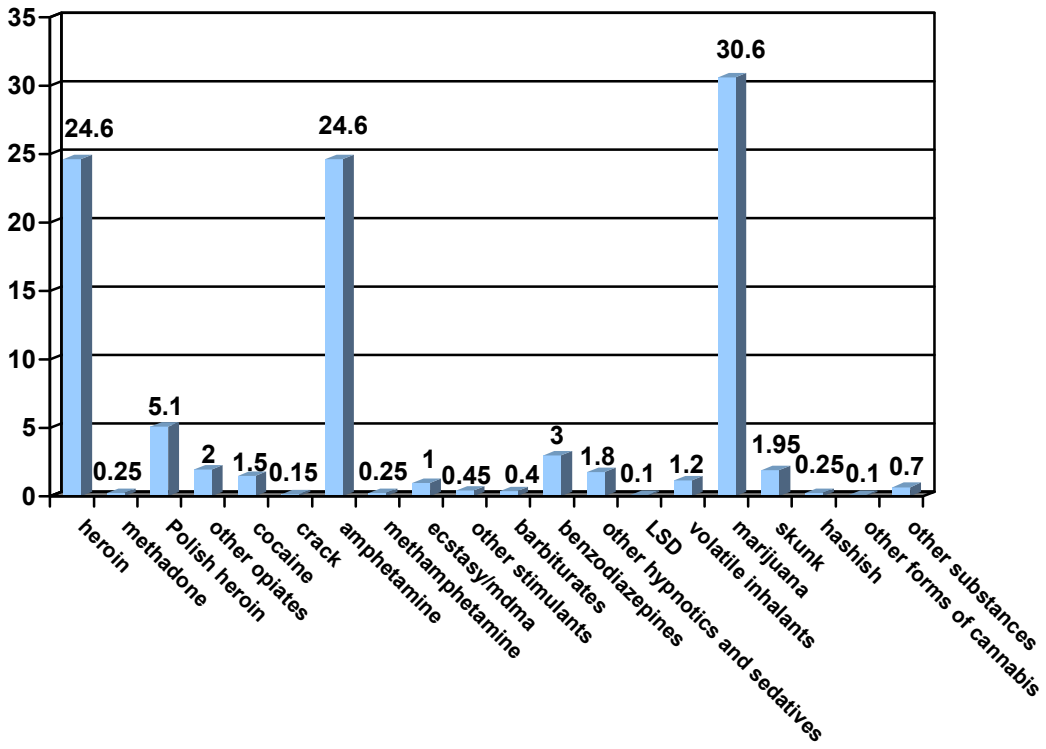
Figure 5.11. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – proportions of patients by categories of injecting drug use (N=2082).



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)

In 2008, the most prevalent primary drug among patients admitted to drug treatment was marijuana (30.6%), then came amphetamine (24.6%) and heroin (24.6%). Slightly more than 5% of patients entered treatment due to using Polish homemade heroin called 'kompot'. The rarest drug of choice was LSD (0.1%), other forms of cannabis (0.1%), crack (0.15%), methadone (0.25%), methamphetamine (0.25%) and hashish (0.25%).

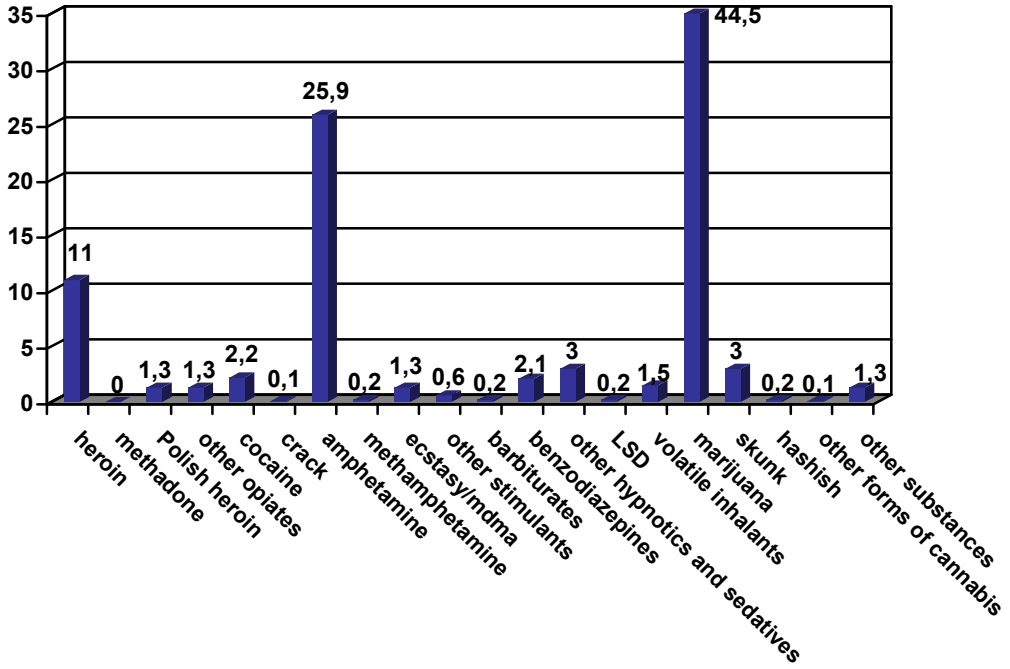
Figure 5.12. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – proportions of all patients by primary drug (N=1996).



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)

Analyzing the data on the primary drug among first-time patients, one can notice a higher share of marijuana (44.5%), a similar level of amphetamine (25.9%) and a lower level of heroin users (11%). The rarest primary drug among first-time patients was methadone (no reports), crack (0.1%), other forms of cannabis (0.1%), methamphetamine (0.2%), barbiturates (0.2%), LSD (0.2%), hashish (0.2%).

Figure 5.13. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2008 – proportions of first-time patients by primary drug (N=834).



Source: Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) (pilot project CINN KBPN 2008)

- **Drug-free inpatient treatment – system administered by the Institute of Psychiatry and Neurology**

Below, statistical data are presented regarding patients of the inpatient psychiatric treatment, including patients of specialist units for individuals addicted to psychoactive substances.

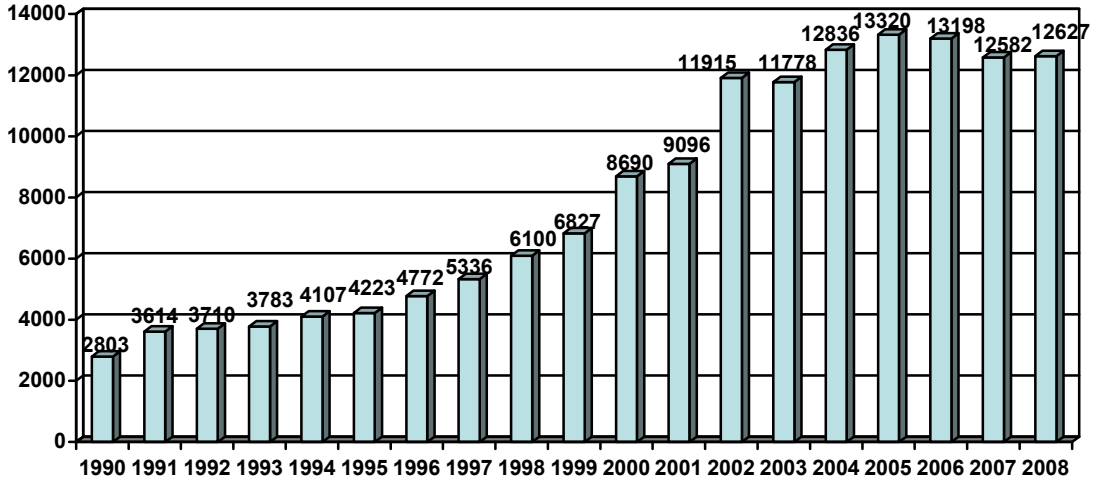
The most up to date information on inpatient treatment patients come from 2008. It will be presented in comparison to the previous years. Two indicators have been analyzed: overall number of patients admitted to inpatient clinics in 2008 (first-time or returning patients) and the number of first-time patients in 2008. The last indicator allows following changes in the number of new cases, never registered before, which is an important piece of information in the context of epidemiological trends in the population. Moreover, the description has been complemented with data on all clients of inpatient clinics in 2008 (including clients with previous treatment record, those continuing treatment and first timers).

In 2008, problem drug users reported to 257 out of the overall number of 358 inpatient treatment units. Most of the patients received treatment at specialist health care units for

drug users (86 units in Poland), and the remaining patients were treated at psychiatric hospitals or psychiatric wards of municipal hospitals.

In 1990-2002, there was a steady rise in the number of admissions to inpatient treatment (from 2 803 in 1990 to 11 915 in 2002). A slight fall compared to 2002 was recorded in 2003, where 11 778 patients were admitted to residential treatment. A the same time, between 2003 and 2005 the number of admissions rose by 1 542. Then by 2007 a downward trend was recorded in the number of admissions to inpatient treatment. However, the 2008 data show stabilization of the trend (Figure 5.14.). In 2008, inpatient clinics provided treatment for 14 897 patients. 12 627 of these patients were admitted in 2008. Compared to the previous year, the trend of people entering treatment in specialist clinics and hospitals levelled off (in 2007, 12 582 patients were admitted to inpatient clinics).

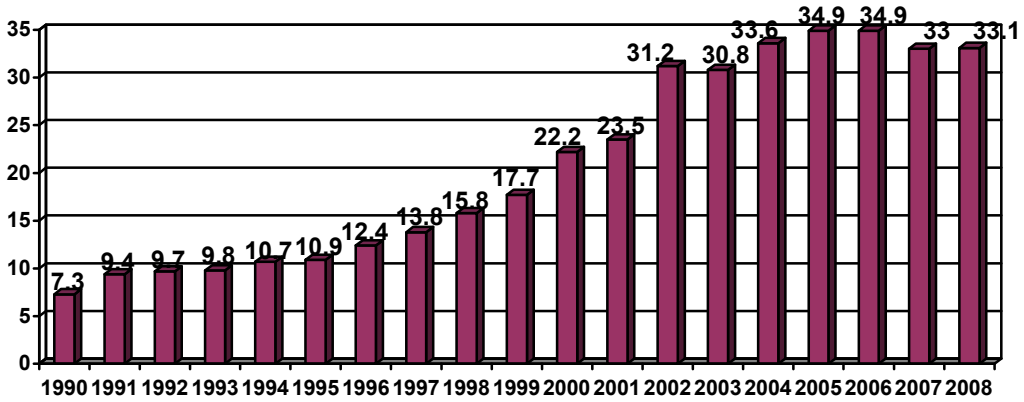
Figure 5.14. Admissions to inpatient treatment in 1990-1996 due to medical drug addiction or abuse (ICD-9: 304, 305.2-9) and in 1997-2008 due to mental disorders and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19) (numbers of patients).



Source: Insitute of Psychiatry and Neurology 2010.

The chart below shows the number of patients admitted to residential treatment per 100 000 inhabitants in 1990-2008. The data indicate an increase in the number of patients admitted to residential treatment till 2005. In 2006 the trend levelled off (indicator per 100 000 has the same value of 34.9 in 2005 and 2006). In the following year the indicator decreased to 33.0. The 2008 data show a stabilization of the trend (indicator stays at 33.1).

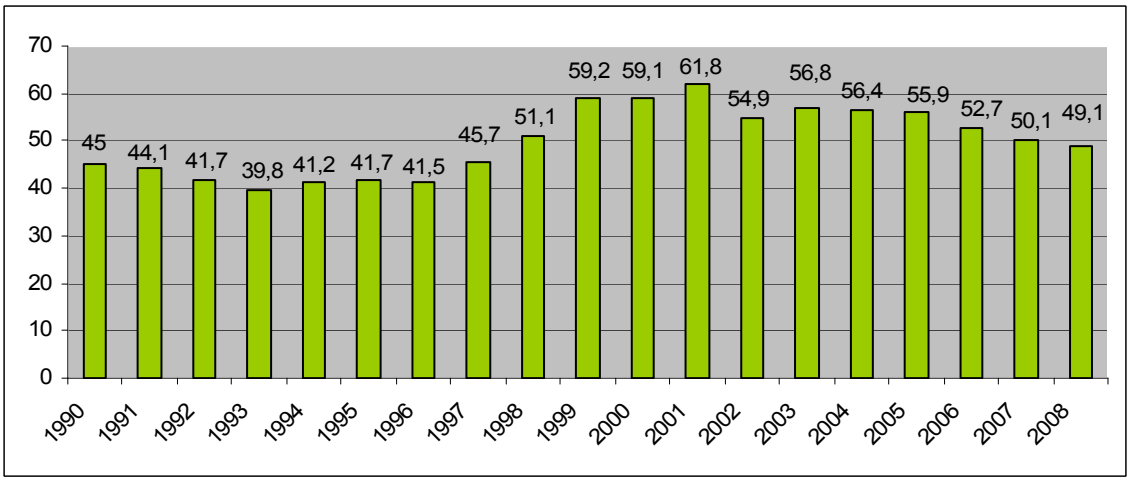
Figure 5.15. Admissions to inpatient treatment in 1990-1996 due to medical drug addiction or abuse (ICD-9: 304, 305.2-9) and in 1997-2008 due to mental disorders and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19) (per 100 000 inhabitants).



Source: Insitute of Psychiatry and Neurology 2010.

In 2008, 5 511 users entered inpatient treatment for the first time in their lives. The percentage of first-time patients stood at 49.1% and show a stabilization of the trend from 2007 on. In 2008, the trend in the number of admissions to residential treatment and the percentage of first-time patients levelled off.

Figure 5.16. Percentage of first-time patients admitted to inpatient treatment in 1990-1996 due to medical drug addiction or abuse (ICD-9: 304, 305.2-9) and in 1997-2008 due to mental disorders and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19).



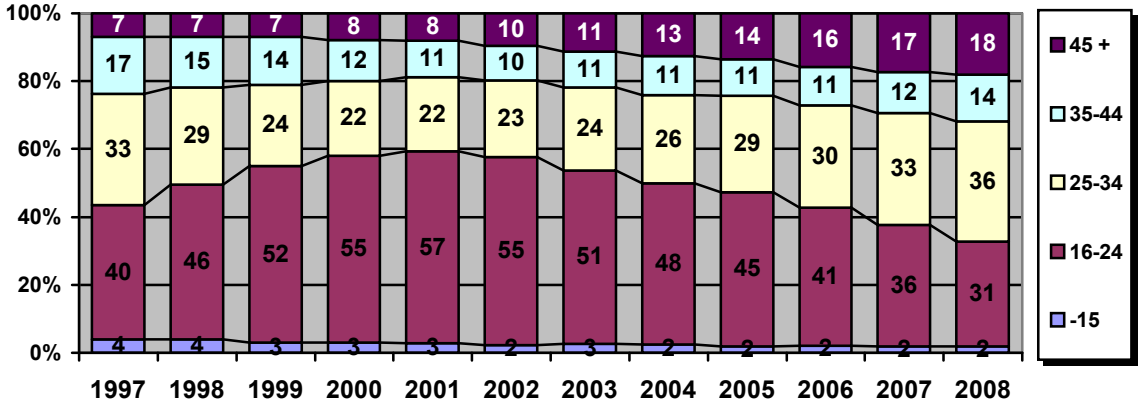
Source: Insitute of Psychiatry and Neurology 2010.

- **Patient sex and age**

Among users who stayed in inpatient drug treatment in 2008 the large majority were men (75%). The proportions remain the same in relation to patients who entered treatment in 2008, similarly to previous years the majority were men (74.1%). Among the first-time patients women accounted for 28.5%.

The most numerous group admitted to residential treatment in 2008 were patients aged 25-34 (36%) and 16-24 (31%). Patients aged 45 and older accounted for a numerous group (18%). Since 1997 there has been a steady rise in the percentage of patients aged 45 and older. At the same time, since 2001 the percentage of patients aged 16-24 admitted to inpatient treatment has been falling. A detailed breakdown of patients admitted to treatment in 1997-2008 is presented in Figure 5.17.

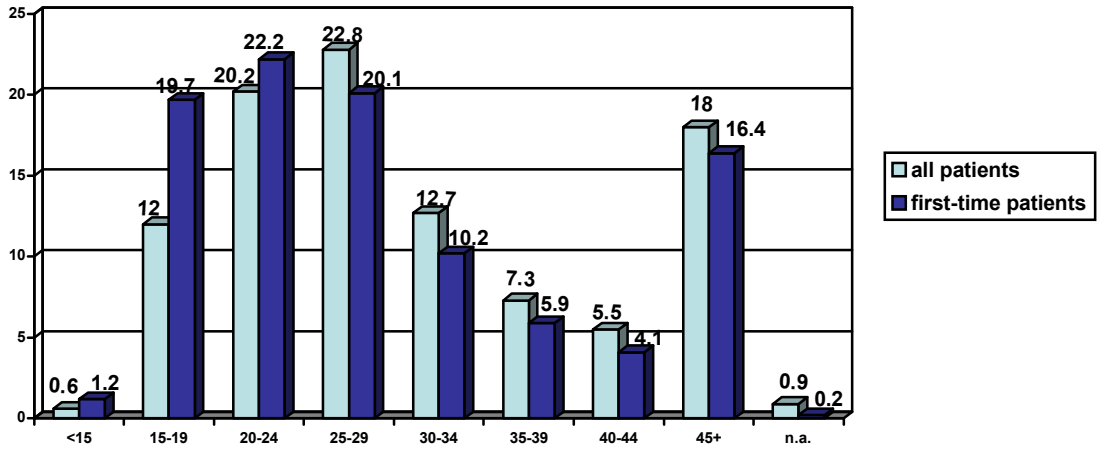
Figure 5.17. Percentages of patients admitted to inpatient treatment in 1997-2008 due to mental and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19), by age groups.



Source: Insitute of Psychiatry and Neurology 2010.

Comparing the age breakdowns of all patients admitted to treatment in 2008 and the first-time patients some differences can be noticed. Among the first timers, compared to the overall number of patients admitted to treatment, there are more patients aged 15-19 and 20-24. At the same time there are fewer patients in the age groups over 25. The figure below shows the differences.

Figure 5.18. Percentages of all patients admitted to treatment due to mental and behavioural disorders caused by using psychoactive substances (ICD-10: F11-F16, F18, F19) in 2008 and first-time patients, by age groups.

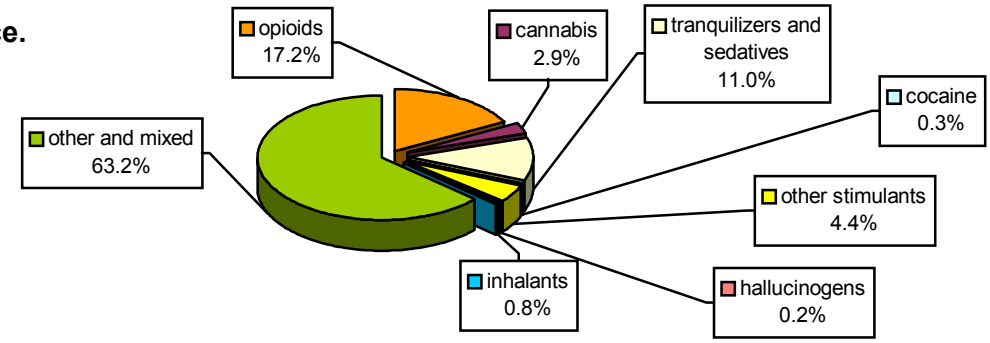


Source: Insitute of Psychiatry and Neurology 2010.

- **Inpatient treatment patients by substances**

Among inpatient treatment patients in 2008, similarly to previous years, the majority were opioid users (17.2%). One patient in eleven abused tranquilizers and sedatives. Over 4% were diagnosed with addiction to other stimulants. In 2008, as well as in 2007, there were few cannabis users (2.9%), inhalants (0.8%) and hallucinogens (0.2%). A very small percentage was made up by cocaine users (0.3%). These data do not reflect the full picture of drug treatment admissions as 63.2% of patients fall into the category "other and mixed" (F19 diagnosis). The existing system does not allow for verifying which substances are used by F19 patients. The specific data are shown in Figure 5.19.

Figure 5.19. Patients admitted to residential treatment in 2008 due to mental and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19), by substance.



Source: Insitute of Psychiatry and Neurology 2010.

Comparing data of 2008 and 2007 slight changes can be noticed in reporting to treatment due to respective drug problem. Among patients admitted to inpatient treatment in 2008 a stabilization of the number of opioid users was recorded (a rise of nearly 1 percentage point compared to 2007). The “other and mixed” category trend also levelled – 63.2% in 2008 and 2007. Another stable trend is the steady percentage of cannabis patients – for the sixth consecutive year (2003-2008) it did not exceed 3%.

A detailed breakdown, including data from 1997, is shown in Table 5.2.

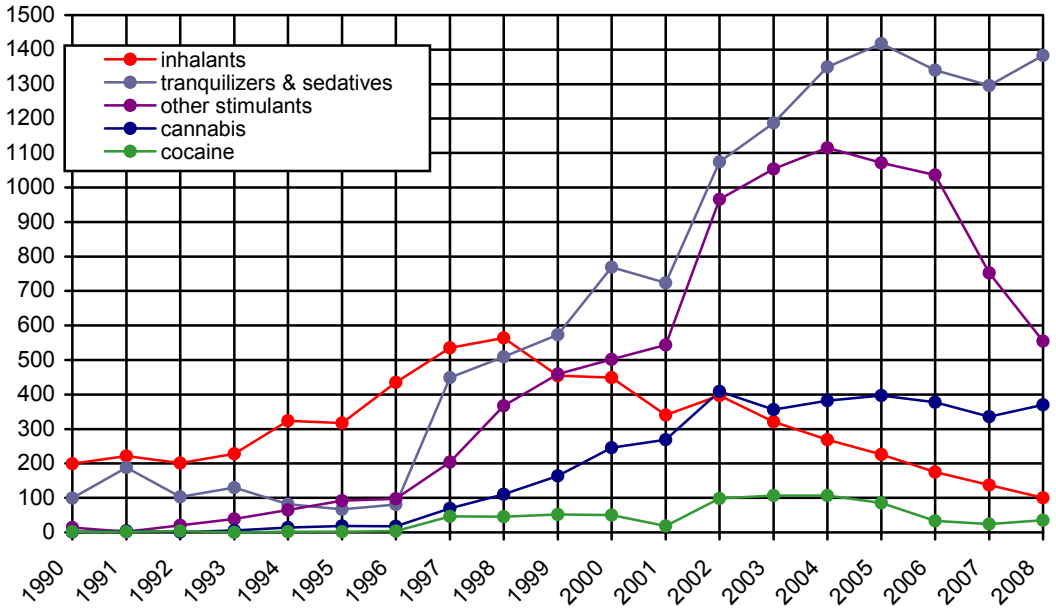
Table 5.2. Patients admitted to inpatient treatment in 1997-2008 due to mental and behavioural disorders caused by psychoactive substance use (ICD 10: F11-F16, F18, F19), by substance.

	Opioids	Cannabis	Tranquilizers and sedatives	Cocaine	Other stimulants	Hallucinogens	Inhalants	Other and mixed
1997	43.3	1.3	8.4	0.9	3.8	1.3	10.0	30.9
1998	42.3	1.8	8.3	0.7	6.0	1.2	9.2	30.5
1999	38.8	2.4	8.4	0.8	6.7	1.3	6.7	34.9
2000	39.4	2.9	9.0	0.6	5.8	0.7	5.2	36.4
2001	40.4	3.0	8.0	0.2	6.0	0.7	3.7	38.1
2002	30.3	3.4	9.0	0.8	8.1	0.5	3.3	44.5
2003	23.3	3.0	10.1	0.9	8.9	0.6	2.7	50.4
2004	20.0	3.0	10.5	0.8	8.7	0.4	2.1	54.5
2005	18.7	3.0	10.6	0.6	8.0	0.4	1.7	57.0
2006	17.1	2.9	10.2	0.3	7.8	0.4	1.3	60.1
2007	16.3	2.7	10.3	0.2	6.0	0.3	1.1	63.2
2008	17.2	2.9	11.0	0.3	4.4	0.2	0.8	63.2

Source: Insitute of Psychiatry and Neurology 2010.

The analysis of selected substances used by patients admitted to residential treatment in 1990-2008 (Figure 5.20.) shows that from 2002 the number of inhalant users was decreasing and the same was true for stimulant users from 2004. In recent years the trends regarding cannabis and cocaine users held steady. In 2008, there was a slight increase in the number of non-prescription tranquilizers and sedatives patients. Figure 5.20. shows that from 2003, among residential treatment patients, the most numerous group were cannabis rather than cocaine or inhalant users. At the same time, it can be observed that since the beginning of the drug treatment monitoring system there are fewer cannabis than stimulant patients in 24-hour treatment units.

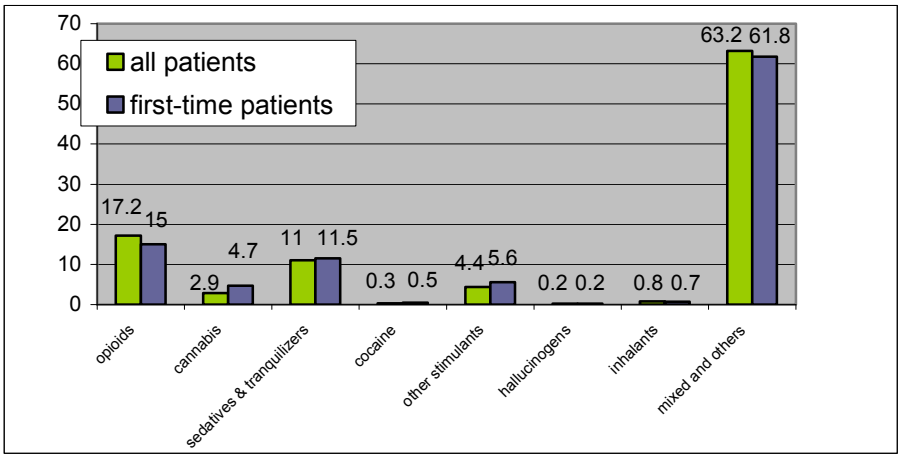
Figure 5.20. Patients admitted to inpatient treatment in 1990-2008 due to mental and behavioral disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19) – selected substances (numbers of patients).



Source: Insitute of Psychiatry and Neurology 2010.

Among first-time patients of residential treatment units in 2008, the percentages of users of respective substance are similar to all patients admitted to drug treatment. The most numerous group of first timers were F19 patients (61.8%). 15% of the patients reported problems related to opioid-related problems (the percentage is lower compared to all patients admitted). Higher percentages of patients with cannabis and stimulant-related problems were recorded in first-time patients than all patients admitted to residential drug treatment. A detailed breakdown of data on first-time patients and all patients admitted to residential drug treatment in 2008 are presented in the figure below.

Figure 5.21. Percentage of all patients admitted to treatment due to mental and behavioural disorders caused by using psychoactive substances (ICD-10: F11-F16, F18, F19) in 2008 as well as first-time patients, by substance.



Source: Insitute of Psychiatry and Neurology 2010.

- **Harm reduction programmes (in drug dependent individuals)**

In 2009, 12 900 participants, including 1 051 aged under 19, took part in 16 harm reduction programmes commissioned by the National Bureau for Drug Prevention. 3 798 participants were new to the programmes and probably had not benefited from this form of assistance before. 3 569 participants (approx. 27%) were in employment and 6 150 (approx. 47%) were school or university students. Approx. 12% were characterized by the programme implementers as harmful users while 50% were considered experimenting drug users (National Bureau for Drug Prevention 2010). The proportions of harm reduction programme participant groups changed compared to the previous year. In 2008, the biggest participant group were drug dependent individuals (85%) while harmful users accounted for 7%. In 2009, drug dependent individuals accounted for approx. 30%.

A rising problem of non-injecting synthetic drug use generates a greater demand for educational and motivational activities addressed to drug dependent individuals and necessitates the modification of programmes focused exclusively on the exchange of injecting equipment.

More on harm reduction programmes in Chapter 7 “Response to health consequences”.

- **Substitution treatment**

In 2009, there were 22 substitution programmes operating in Poland (including 17 non-custodial and 5 custodial programmes). Compared to the previous year, there was a rise of 1 non-custodial programme and 1 within the structure of the Prison Service. An overall number

of patients in substitution treatment in 2009 was 1 945 patients (data from the National Bureau's Register of Substitution Patients). In 2009, only 7% of opioid dependent individuals used this form of treatment, including 508 women.

Substitution treatment patients are severely dependent on drugs. They usually suffer from physical diseases (including HCV, HBV, HIV/AIDS, DVT, overall poor health).To a lesser or greater degree patients are motivated for treatment. The number of substitution treatment patients is stable and shows a visible upward trend. A major drug used in substitution treatment in Poland is methadone along with increasingly popular buprenorphine.

- **Drug treatment in correctional institutions**

In 2009 in organizational units of the Prison Service, 6-month structured drug-free treatment programmes were being conducted with a broadened spectrum of rehabilitation goals (abstinence and crime relapse prevention). The programmes were based on the psychosocial intervention model and the theory of social learning, and included elements of the Minnesota model, therapeutic community and the cognitive-behavioural interventions.
The activities were performed in 16 therapeutic wards of correctional institutions. The therapeutic wards offered 584 beds (549 in 2008 and 513 in 2007), which allowed for including 1 654 inmates (1 534 in 2008). (Krajowe Biuro ds. Przeciwdziałania Narkomanii 2009)

One of the programmes co-financed by the National Bureau in 2009 was a harm reduction programme for inmates of the Krakow-based "Ruszcza" female correctional institution. 102 inmates were included in the programme. Major psychoactive substances used by the inmates (except alcohol) were amphetamine (35 inmates), Polish homemade heroin (22 inmates), cannabis (7 inmates), inhalants (2 inmates). Most inmates used at least 2 drugs (Parasol Social Prevention Centre, 2010).

For more information see Chapter 9.5 Responses to drug-related health issues in prisons; prevention and reduction of drug-related harm.

For several years we have been observing a downwards trend in the number of patients addicted to a single substance in all the forms of drug treatment. At the same time the number of poly drug dependent patients is rising. The most frequent combinations include cannabis and alcohol; amphetamines and cannabis; opioids and benzodiazepines or painkillers (e.g. Tramal); opioids and amphetamines.

6. Health correlates and consequences

prepared by Marta Struzik, Magdalena Rosińska, Artur Malczewski

Introduction

The information at national level on HIV infection and AIDS cases related to injecting drug use is obtained through the reports sent to the National Institute of Public Health – National Institute of Hygiene by provincial Sanitary and Epidemiological Stations (SANEPID) under the system of collective reporting the cases of infectious diseases.

In Poland the system of treating patients with dual diagnosis is based on psychiatric treatment facilities and substance rehabilitation clinics. Epidemiological information on patients with dual diagnosis, along with data on the scale of co-morbidity, is estimated on the basis of statistical records on patients admitted to psychiatric residential treatment in a given year. The above information is collected annually by the Institute of Psychiatry and Neurology in Warsaw. The estimations are significantly biased due to the fact that data come exclusively from residential facilities as diagnosing co-morbidity still remains difficult or is not systematically reported.

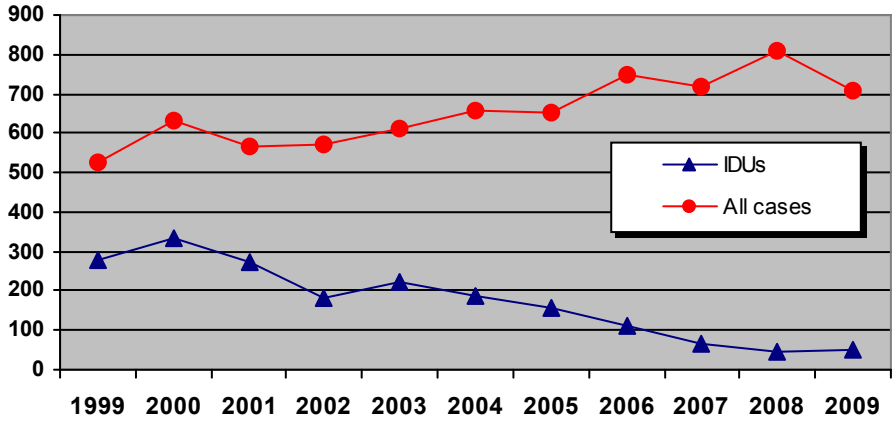
The source of information on drug-related deaths is the Central Statistical Office database. Deaths are selected according to the national definition, which includes the following ICD-10 codes: F11-12, F14-16, F19, X42, X44, X62, X64, Y12 and Y14.

6.1. Drug-related infectious diseases

Between 1985, i.e. the moment of introducing in Poland the routine epidemiological monitoring system for HIV/AIDS and the end of 2009, 12 784 HIV infections were recorded. Out of these infections 5 750 (45%) were injecting drug users (IDUs), including 4 309 men (76%) and 1 392 women (24%). Analyzing the above monitoring period in terms of AIDS prevalence, 2 313 cases of the diseases recorded. Out of these 1 164 (50,3%) were IDUs, including 920 men (79%) and 244 (21%) women.

The IDU-induced HIV infection analysis for 2003-2008 shows a continuation of the downward trend. In 2006, 112 new HIV infections among IDUs were recorded, whereas in 2007 there were 66 such cases and 45 in 2008. The 2009 data indicate a stabilization of the trend (49 new cases recorded). The analysis should consider the likelihood of the data being underestimated due to the high proportion of HIV infections with no infection route specified.

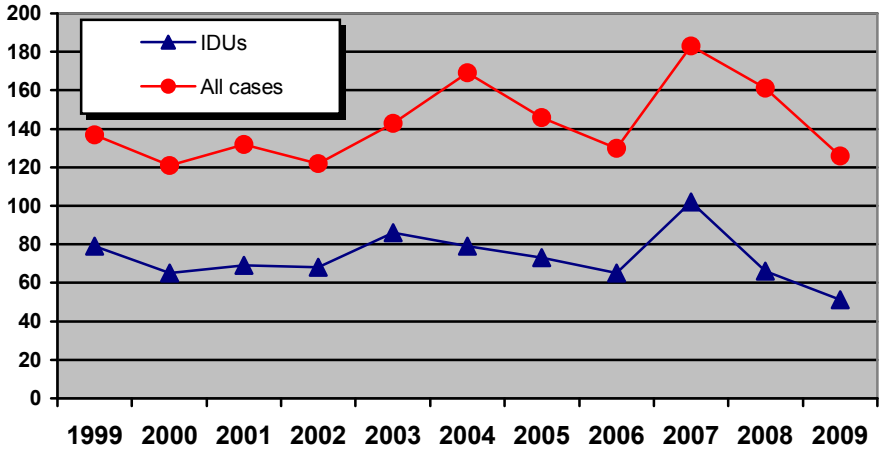
Figure 6.1. New HIV infections, including injecting drug users, in 1999-2009 (by date of detection).



Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)
Data for 2009 – Number of registered cases by the end of 2009.

AIDS incidence among IDUs showed a downward trend in 2003-2006. The number of new AIDS cases fell from 86 in 2003, to 79 in 2004, 73 in 2005 and further down to 65 in 2006. In 2007, 183 AIDS cases were recorded altogether (130 in 2006), including 102 among IDUs (65 in 2006). In 2008, 161 AIDS cases were recorded in total, including 66 among IDUs. The data for 2008 show an upward trend in all cases of AIDS incidence compared to 2006. Simultaneously, incidence rates among IDUs levelled off assuming that the 2007 rise was just a temporary fluctuation of the trend. The 2009 data show a downward trend compared to 2008 (out of 126 new AIDS cases 51 referred to IDUs).

Figure 6.2. New AIDS cases, including injecting drug users, in 1999 – 2009 (by date of detection).



Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)
Data for 2009 – Number of registered cases by the end of 2009.

In 2009, 709 new cases of HIV infections were recorded, including 49 (7%) IDU-related. However, the likelihood of data being underestimated must be stressed as in 523 new HIV infections (74%) in 2009 no probable infection route was specified.

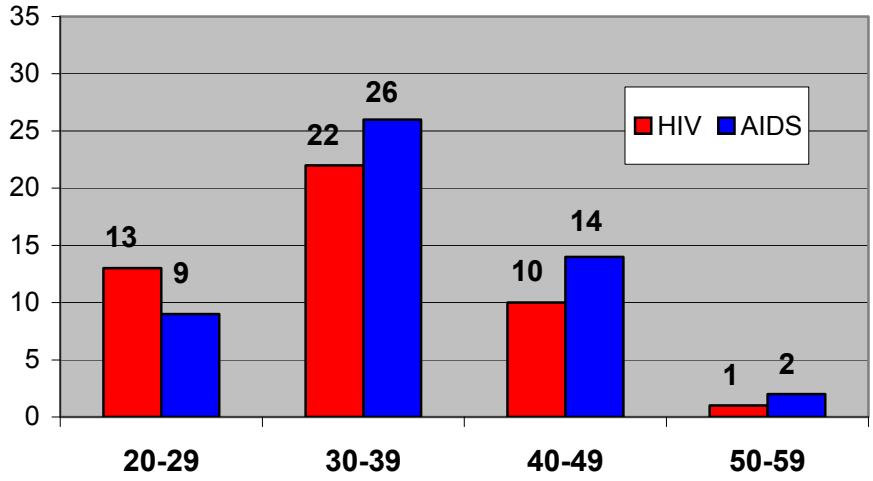
New AIDS cases in 2009 concerned 51 IDUs, which accounts for 40% of all AIDS cases in the reporting year. No data as to the likely transmission route refer 25 cases (20%).

Among HIV-positive IDUs in 2009 there were 41 men (84%) men and 8 women (16%). Newly registered AIDS cases among IDUs in 2009 referred to 43 men (84%) and 8 women (16%).

Figure 6.3. HIV/AIDS cases in IDUs in 2009 by sex (numbers of people).

Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)

Figure 6.4. HIV/AIDS cases in IDUs in 2009 by age group (numbers of people).



Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)
** in the case of 3 men the age is unknown.*

In 2009, among HIV-positive IDUs the largest group were users aged 30-39 (22 individuals, 48%), then came 20-29-year-olds (13 individuals, 28%), 40-49 (10 individuals, 22%), 50-59 (1 individual, 2%).

In 2009, out of the reported new AIDS cases in IDUs the largest group were persons aged 30-39 (26 individuals, 51%), then 40-49-year-olds (14 individuals, 27%), 20-29 (9 individuals, 18%) and 50-59 (2 individuals, 4%).

In Poland in 2004-2008, there was a steady fall in HIV incidence rates among IDUs per 100 thousand population. The data for 2009 show a stabilization of the trend. HIV incidence varies across provinces. In 2004-2008, the highest HIV incidence rates were recorded in dolnoslaskie, lodzkie and warminsko-mazurskie provinces. In 2004-2007, the fewest cases were recorded in swietokrzyskie, lubelskie and podkarpackie provinces. In 2008 in the above provinces there was no new case of HIV infection recorded. In opolskie and zachodniopomorskie provinces the situation was similar. The data for 2009 show that the highest HIV incidence rates are still recorded in dolnoslaskie, lodzkie and warminsko-mazurskie provinces. High rates were also recorded in lubuskie province. In 2009, no HIV infections were registered in swietokrzyskie province (5th consecutive year), opolskie province (3rd consecutive year) and pomorskie province.

Table 6.1. HIV incidence rates in IDUs in 2004-2009 (per 100 000 population) (infections registered by place of residence).

Province	2004		2005		2006		2007		2008		2009	
	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate
Dolnoslaskie	59	2.04	49	1.70	32	1.11	15	0.52	15	0.52	8	0.28
kujawsko-pomorskie	5	0.24	6	0.29	4	0.19	3	0.15	2	0.10	4	0.19
Lubelskie	1	0.05	1	0.05	1	0.05	2	0.09	0	0.00	1	0.05
Lubuskie	2	0.20	4	0.40	1	0.10	1	0.10	1	0.10	7	0.69
Lodzkie	30	1.16	18	0.70	14	0.55	8	0.31	7	0.27	9	0.35
Malopolskie	2	0.06	3	0.09	7	0.21	2	0.06	1	0.03	1	0.03
Mazowieckie	11	0.21	9	0.17	4	0.08	2	0.04	3	0.06	1	0.02
Opolskie	6	0.57	1	0.10	3	0.29	0	0.00	0	0.00	0	0
Podkarpackie	2	0.10	3	0.14	1	0.05	0	0.00	0	0.00	3	0.14
Podlaskie	5	0.42	3	0.25	1	0.08	1	0.08	1	0.08	1	0.08
Pomorskie	5	0.23	9	0.41	3	0.14	4	0.18	1	0.05	0	0
Slaskie	10	0.21	3	0.06	1	0.02	5	0.11	6	0.13	1	0.02
Swietokrzyskie	2	0.16	0	0.00	0	0.00	0	0.00	0	0.00	0	0
warminsko-mazurskie	7	0.49	12	0.84	10	0.70	7	0.49	4	0.28	3	0.21
Wielkopolskie	8	0.24	4	0.12	5	0.15	3	0.09	2	0.06	5	0.15
Zachodniopomorskie	3	0.18	3	0.18	2	0.12	3	0.18	0	0.00	1	0.06
POLAND	**187**	**0.49**	**157**	**0.41**	**112**	**0.29**	**66**	**0.17**	**45**	**0.12**	**49**	**0.13**

Source: National Institute of Public Health - National Institute of Hygiene(Epidemiology Department)

AIDS incidence rates in IDUs in 2004-2007 fluctuated. However, since 2007 a downward trend can be observed. In 2004-2007, the highest AIDS incidence rates were recorded in dolnoslaskie, kujawsko-pomorskie and podlaskie provinces. In 2008, the highest rates were recorded in the provinces dolnoslaskie, podlaskie, warminsko-mazurskie and lubuskie. In 2009, the most new AIDS cases were registered in dolnoslaskie, warminsko-mazurskie and lubuskie. In 2004-2007, the lowest AIDS incidence rates were registered in the provinces podkarpackie and swietokrzyskie. In 2008, the lowest AIDS incidence rates referred to the following provinces: wielkopolskie, podkarpackie, lubelskie, kujawsko-pomorskie, swietokrzyskie, mazowieckie, lodzkie, malopolskie and pomorskie. In the provinces of kujawsko-pomorskie and swietokrzyskie no new AIDS case was recorded in 2009.

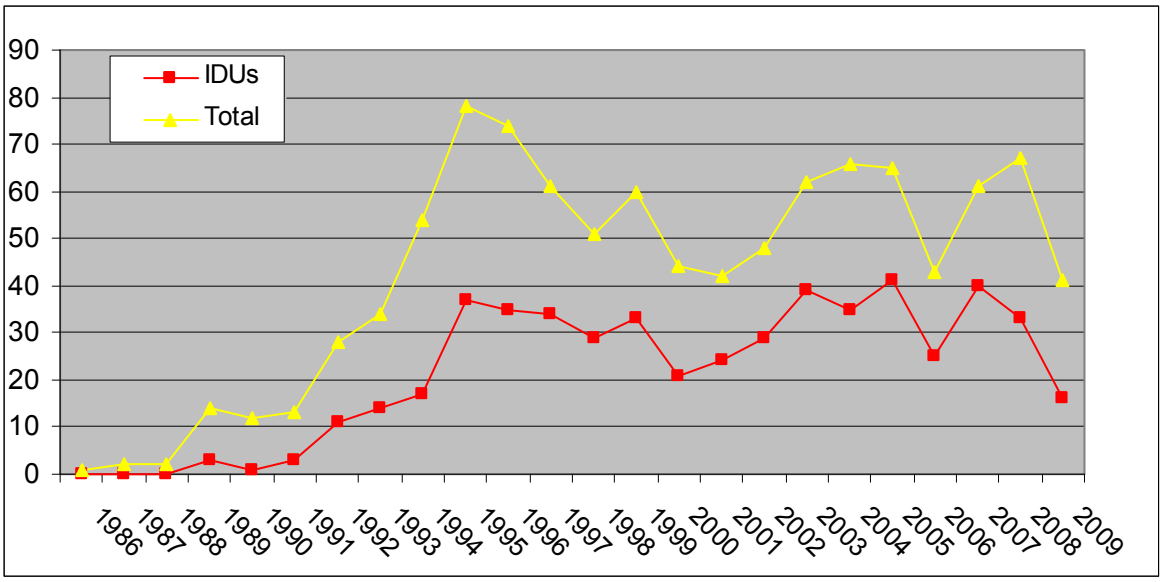
Table 6.2. AIDS incidence rates in IDUs in 2004-2009 (per 100 000 population) (infections registered by place of residence).

Province	2004		2005		2006		2007		2008		2009	
	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate
Dolnoslaskie	22	0.76	42	1.45	20	0.69	43	1.49	28	0.97	15	0.52
kujawsko-pomorskie	9	0.44	3	0.15	8	0.39	2	0.10	1	0.05	0	0
Lubelskie	4	0.18	2	0.09	4	0.18	4	0.18	1	0.05	4	0.18
Lubuskie	2	0.20	1	0.10	0	0.00	6	0.59	2	0.20	3	0.30
Lodzkie	5	0.19	5	0.19	3	0.12	6	0.23	2	0.08	6	0.24
Malopolskie	3	0.09	2	0.06	2	0.06	2	0.06	3	0.09	2	0.06
Mazowieckie	4	0.08	3	0.06	0	0.00	4	0.08	4	0.08	2	0.04
Opolskie	4	0.38	1	0.10	1	0.10	2	0.19	1	0.10	2	0.19
Podkarpackie	2	0.10	0	0.00	0	0.00	0	0.00	1	0.05	3	0.14
Podlaskie	3	0.25	3	0.25	4	0.33	4	0.34	4	0.34	0	0
Pomorskie	3	0.14	2	0.09	5	0.23	6	0.27	2	0.09	1	0.04
Slaskie	11	0.23	1	0.02	6	0.13	8	0.17	8	0.17	2	0.04
Swietokrzyskie	0	0.00	1	0.08	0	0.00	1	0.08	1	0.08	0	0
warminsko-mazurskie	2	0.14	2	0.14	4	0.28	8	0.56	5	0.35	5	0.35
Wielkopolskie	3	0.09	4	0.12	5	0.15	5	0.15	1	0.03	4	0.12
zachodniopomorskie	2	0.12	0	0.00	2	0.12	1	0.06	2	0.12	1	0.06
POLAND	**79**	**0.21**	**73**	**0.19**	**65**	**0.17**	**102**	**0.27**	**66**	**0.17**	**51**	**0.13**

Source: National Institute of Public Health - National Institute of Hygiene(Epidemiology Department)

According to the statistics collected since 1986, 1 023 AIDS-related deaths had been recorded, including 520 among IDUs (51%) by 31 March 2010.

Figure 6.5. AIDS-related deaths recorded in Poland by 31 March 2010, including IDUs, by date of death.



Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)

In 2009, there were 41 deaths of AIDS-positive individuals, including 16 (39%) in IDUs. The deaths of IDUs were related to 14 (87.5%) men and 2 (12.5%) women. The highest mortality rate in AIDS-positive IDUs referred to individuals aged 40-49 (9 cases), then 30-39 (5 cases), 20-29 (1 case) and 50-59 (1 case).

To sum up, it must be stressed that the figures above have been calculated on the basis of the most recent data available. However, due to delays in infection and morbidity reporting the figures are likely to change.

Every year the National Institute of Public Health - National Institute of Hygiene conducts a survey among HIV testing laboratories to monitor HIV prevalence among the tested IDUs. This group does not include persons who were known to be positive before. The study results show an overall downward trend in this indicator in the years 2004-2009 (Table 6.3.).

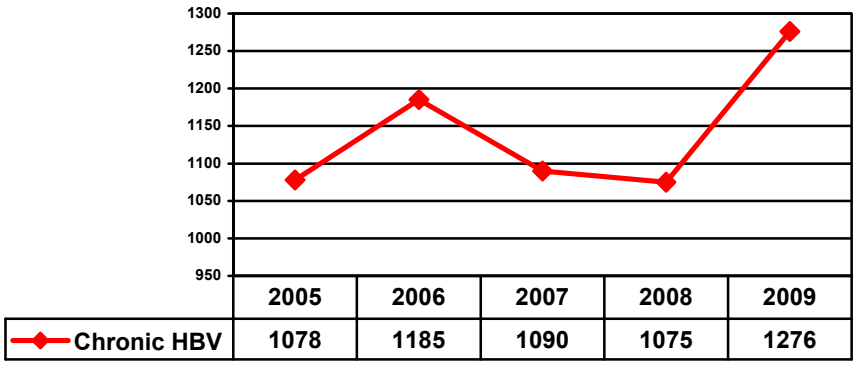
Table 6.3. HIV prevalence in diagnostic testing in IDUs in 2004 – 2009.

	2004	2005	2006	2007	2008	2009
Number of HIV-positive IDUs	261	154	107	121	101	65
Number of all IDUs tested for HIV (valid tests)	2047	1350	1012	1064	1084	1176
HIV prevalence rate	0.128	0.114	0.106	0.114	0.093	0.055

Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)

The National Institute of Public Health - National Institute of Hygiene also collects data on chronic HBV. In 2009, there were 1 276 cases recorded, which constitutes an increase compared to 2008, when the total number of 1 075 were recorded. The trend fluctuated in 2005-2009 in Poland. The data on chronic HBV incidence among IDUs are available only for 2009. 6 individuals were diagnosed with the disease then (data might be underestimated because in approx. 40% of cases IDUs status was not known).

Figure 6.6. New chronic HBV cases in 2005-2009.

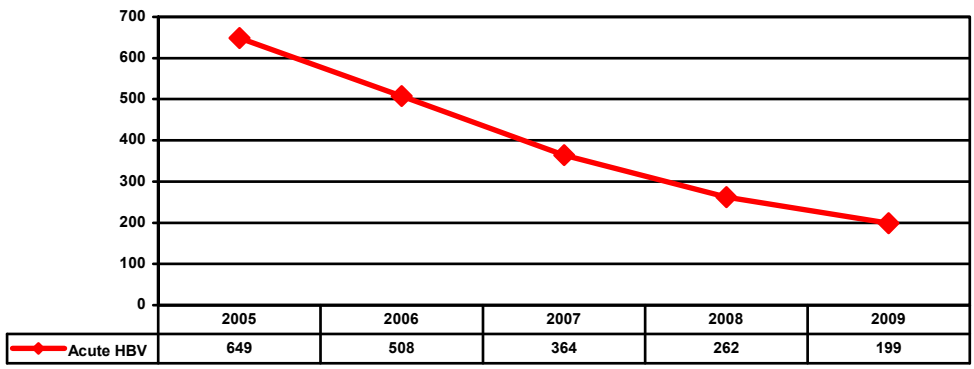


	2005	2006	2007	2008	2009
Chronic HBV	1078	1185	1090	1075	1276

Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)

In 2005-2009, a downward trend in the total number of acute HBV was observed (Figure 6.7.). The data concerning acute HBV incidence among IDUs are only available for 2009. 3 individuals were diagnosed with the disease then (data might be underestimated because in approx. 50% of cases IDU status was not known).

Figure 6.7. New acute HBV cases in IDUs in 2005-2009.



	2005	2006	2007	2008	2009
Acute HBV	649	508	364	262	199

Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)

- **Estimation of the prevalence of infectious diseases (HCV, HBV and HIV) in injecting drug users in Gdansk and Krakow**
  Author: dr Magdalena Rosińska, National Institute of Public Health – National Institute of Hygiene

Injecting drug use is one of the main transmission routes of infectious diseases such as hepatitis or HIV/AIDS.

According to collective diagnostic data in Poland HIV infections have been detected in 10-12% of injecting drug users and the number is falling[14]. Unfortunately, such data have not been collected with reference to hepatitis. In the surveys of 2004-2005 HIV prevalence rate was 18% (9.2% – 26.8%) while HCV prevalence rate stood at 58.9% (48.6 – 69.1%)[15].

The surveys were part of the monitoring system for the prevalence of infectious diseases in connection with the prevalence of risky behaviours and they are necessary in the evaluation of the National Programme for Counteracting Drug Addiction.

The surveys were conducted between October 2008 and September 2009 in the cities of Krakow and Gdansk. They included lifetime injecting drug users. The recruitment of the survey participants was based on Respondent Driven Sampling[16]. The survey participants were asked to hand out survey coupons among their friends. Blood sample-based laboratory tests for HIV, HCV, HBV (HBsAg, anti-HBc) and syphilis (VDRL) were conducted.

The survey included 193 participants, 81 in Gdansk and 112 in Krakow. An estimated proportion of male injecting drug users in both cities is 74.8% (95% confidence interval: 64.0%-85.0%) while participants under 25 accounted for 16.9% (95% confidence interval: 12.1% - 24.6%). During the survey for 34.2% (95% confidence interval: 25.6% - 44.0%) of the target population the main activity was employment or education. 55.8% (95% confidence interval: 44.3% - 69.4%) had a stable source of income. About 34.3% (95% confidence interval: 20.7% - 45.2%) of the users in both cities had been homeless at least once in a lifetime and 47.9% (95% confidence interval: 35.2% - 56.4%) had an incarceration record.

The participants who had used a drug intravenously not longer than two years prior to the survey accounted for 4.2% in Krakow and 32.2% in Gdansk. The proportion of current injecting drug users (last 30 days) stood at 67.7% in Gdansk and 8.3% in Krakow.

[14] Czarkowski MP, Cielebak E, Kondej B, Dacka P, Staszewska E. Yearly bulletins: Infectious diseases and poisonings in Poland in 2005, 2006, 2007, 2008. National Institute of Public Health–National Institute of Hygiene, Epidemiology Department and Main Sanitary Inspectorate, Anti-epidemic Department. http://www.pzh.gov.pl/oldpage/epimeld/index_p.html

[15] Research reports entitled "Estimation of the prevalence of infectious disease (HBV, HCV and HIV) among injecting drug users in cities of various extent of harm reduction programme implementation, 2004" and "Estimation of the prevalence of infectious disease (HBV, HCV and HIV) in injecting drug users with particular emphasis on international migration, 2005" available at the National Bureau for Drug Prevention.

[16] Method was originally presented in *Douglas D. Heckathorn. Respondent-Driven Sampling: A New Approach to the Study of Hidden Populations. Social Problems, 1997*. Full list of references can be found at www.respondentdrivensampling.org

Considering only the current injecting drug users, 14% shared syringes/needles, 29% did not share needles/syringes, however, they shared other injecting equipment while 57% did not share any injecting equipment. The survey participants who shared injecting equipment in the last 30 days had done it with a single person – a close friend or a steady partner. The survey participants mentioned pharmacies (90%) and syringe and needle exchange facilities (70%) as the two major sources of sterile needles and syringes in both cities. For 12 months prior to the survey 43% of the Krakow-based participants received substitution treatment.
The median number of sexual partners of survey participants in a lifetime was 10 while in the last 12 months it was 1. Only half of the participants had always or frequently used condoms in random sexual contacts in the last 12 months.

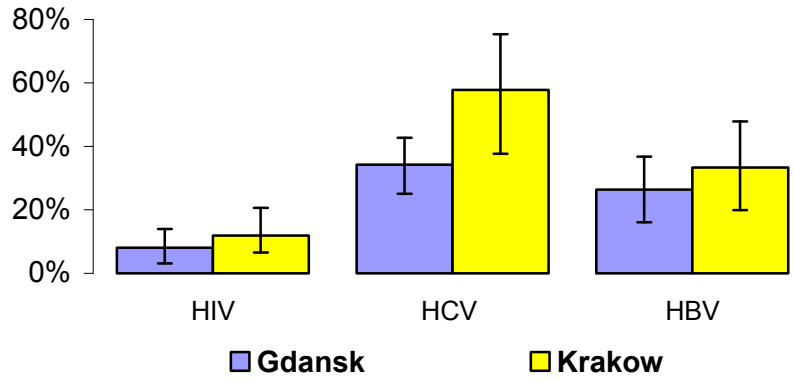
Table 6.4. Prevalence of infectious diseases in the population of injecting drug users.

Infection	Marker	Prevalence in the target population (95% confidence interval)
HIV	HIV antibodies (confirmed infection)	10.3% (6.1% - 15.3%)
HCV	HCV antibodies (present or previous infection)	47.6% (34.2% - 56.7%)
HBV	HBc antibodies (present or previous infection)	30.1% (21.2% - 37.8%)
	HBs antigen (present infection)	2.0% (0.6% - 3.8%)
Syphilis	TP antibodies (antibody test)	0.3% (0.1% - 0.8%)

Source: "Estimation of the prevalence of infectious disease (HBV, HCV and HIV) among injecting drug users in cities of Krakow and Gdansk, 2009",Epidemiology Department of the National Institute of Public Health–National Institute of Hygiene

The prevalence of infectious diseases is shown in Table 6.4. and Figure 6.8. The key factors for the increased prevalence of HIV were: total time of injecting drug use >10 years, lifetime homelessness; for HCV: sex (females > males), total time of injecting drug use >10 years, sharing needles, syringes, periods of daily intravenous drug use, history of surgical operations; for HBV: total time of injecting drug use >10 years, failure to vaccinate against HBV, lower education levels (primary or vocational).
Approx. 15% of HIV-positive and 30% of HCV-positive survey participants were not aware of their infection. Only 31.0% had tested for HIV in the last year prior to survey. The estimated HBV vaccination rates were the following: 52.9% (95% confidence interval: 38.2% - 67.0%) in total; 40.4% (95% confidence interval: 21.7% - 60.8%) in Krakow and 75.7% (95% confidence interval: 63.0% - 83.8%) in Gdansk.

Figure 6.8. Estimated prevalence of HIV, HCV and HBV in injecting drug users in Gdansk and Krakow.



Source: "Estimation of the prevalence of infectious disease (HBV, HCV and HIV) among injecting drug users in cities of Krakow and Gdansk, 2009", Epidemiology Department of the National Institute of Public Health–National Institute of Hygiene

Summary

The results of the survey show a significant, especially in Gdansk, proportion of individuals who have started injecting drugs recently, which is indicative of continuous trends in the population of drug users and the necessity to continue educational actions on health risk related to injecting drug use, including information on infectious disease prevention methods along with the risk of sexual transmission.

The study reveals a considerable extent of social problems such as homelessness, incarceration record and unemployment. It calls for updating structural solutions regarding the social situation of drug users. However, the assessment of the target population's social situation in this survey is more optimistic than the available data on the clients of low threshold programmes[17] simultaneously indicating that the programmes reach out to the most marginalized group of drug users. On the other hand it might mean that the message on safe behaviours fails to adequately get through to the population who function better in society. Among active injecting drug users almost 40% shared injecting equipment in the last 30 days prior to survey. It particularly concerned the equipment other than needles and syringes. It must be stressed that it is an effective transmission route of hepatitis B and C virus and in some countries of low level of needles and syringes sharing it is the main transmission route of the virus. In the context of infectious disease prevention among injecting drug users, apart from risky behaviour reduction interventions, there is a need for more testing for chronic, frequently asymptomatic for a long time, infections as well as

[17] "First national survey of threshold programmes and clients in 2008. French-Polish project." (2009) Information Centre for Drugs and Drug Addiction (CINN), http://www.cinn.gov.pl/portal?id=166055

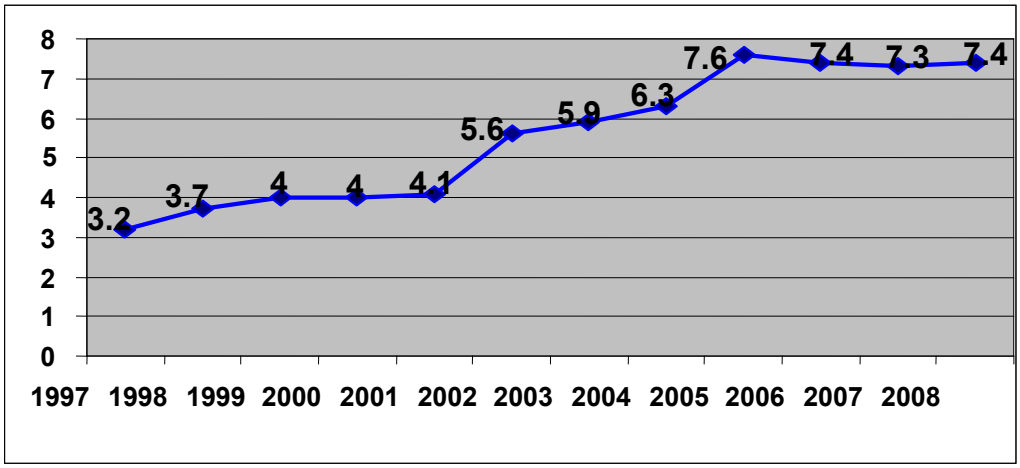
preventive actions against HBV through vaccinations[18]. Intensification of such actions in Poland should be considered in view of relatively poor usage of such options in the survey cities.

The survey was conducted at the Epidemiology Department of the National Institute of Public Health – National Institute of Hygiene in cooperation with the MONAR counselling centre in Krakow and the MONAR Prevention and Drug Rehabilitation Clinic in Gdansk.

6.2. Other drug-related health correlates and consequences

Between 1997 and 2005 there was an increase in the percentage of patients with dual diagnosis in the overall number of patients admitted to inpatient psychiatric treatment (see Figure 6.9.). In 1997 the percentage of patients with dual diagnosis stood at 3.2% and in 2005 at 7.6%. Within 8 years the number of patients increased by 4.4 percentage points. Following 2005 the upward trend was stopped. In 2006 the percentage of patients with dual diagnosis admitted to inpatient psychiatric treatment was 7.4% whereas in 2007 it reached 7.3%. Data for 2008 confirms the trend stabilization (7.4%).

Figure 6.9. Patients with dual diagnosis in all admissions to inpatient psychiatric treatment in 1997-2008 (*percentages of patients*).

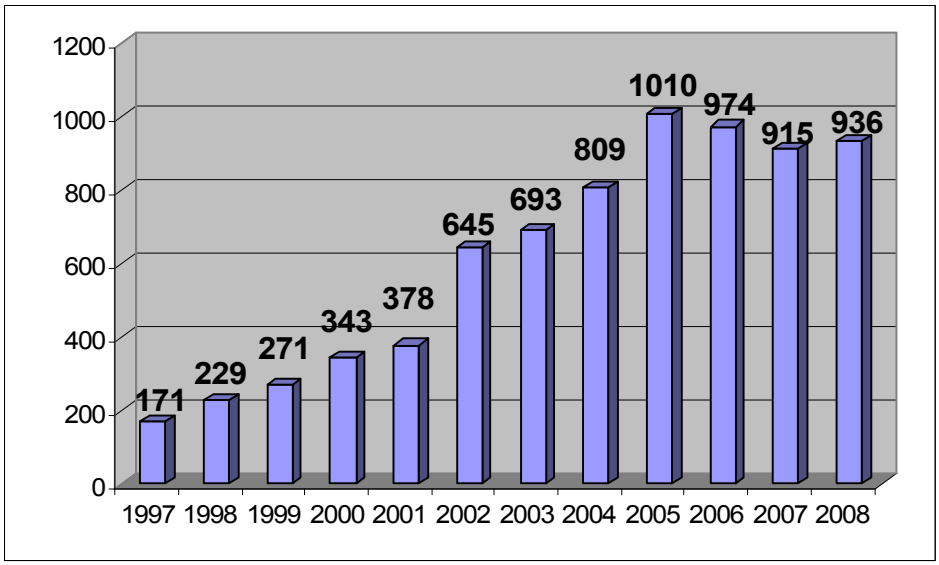


Source: Insitute of Psychiatry and Neurology 2010.

Between 1997 and 2005 the number of hospitalized patients with dual diagnosis rose from 171 in 1997 to 1010 in 2005. In 2006, 974 patients with dual diagnosis were admitted, which constitutes a fall of 36 patients compared to 2005. In 2007, 915 dually diagnosed patients were registered (fall of 59 compared to 2006). In 2008, a slight rise (by 21 patients compared to 2007) in the number of admissions was recorded.

[18] Blystad H, Wiessing L. (2009) Guidance on Provider-initiated Voluntary Medical Examination, Testing and Counselling for Infectious Diseases in Injecting Drug Users. Pre-final unedited version 5.5. Lisbon, EMCDDA.

Figure 6.10. Total number of patients with dual diagnosis admitted to inpatient psychiatric treatment in 1997-2008.



Source: Insitute of Psychiatry and Neurology 2010.

Table 6.5. shows statistical figures on patients with dual diagnosis admitted to inpatient psychiatric treatment.

Table 6.5. Percentages of patients with drug problems admitted to inpatient psychiatric treatment between 1997 and 2008, according to ICD-10 and the total number of patients.

ICD-10 diagnosis	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Personality disorders	46%	32%	48%	37%	39%	50%	39%	39%	33%	26%	24%	20%
Depression	7%	7%	7%	9%	5%	4%	5%	7%	5%	8%	9%	6%
Other affective disorders	5%	5%	0	2%	1%	2%	2%	2%	1%	2%	2%	1%
Anxiety disorders	0	5%	8%	6%	5%	6%	7%	7%	7%	6%	7%	7%
Other mental disorders	42%	51%	37%	46%	50%	38%	47%	45%	54%	58%	58%	66%
Total number of patients with dual diagnosis	171	229	271	343	378	645	693	809	1010	974	915	936

Source: Insitute of Psychiatry and Neurology 2010.

At inpatient psychiatric clinics in Poland in 2008 the most numerous groups were patients of the category “other mental disorders” (66%). This group comprises psychotic disorders, including hallucinations and delusions, schizophrenia and behavioural disorders. A considerable number of patients manifested symptoms of personality disorder (20%). Moreover, the patients showed symptoms of anxiety disorders (7%), depression (6%) and other affective disorders (1%).

There is a visible upward trend regarding patients diagnosed with ”other mental disorders”. A rise in this category might explain e.g. a fall in the percentage of patients with personality disorders.

Table 6.6. Percentages of patients with dual diagnosis admitted to inpatient psychiatric treatment in 2008, by type of drug addiction.

Type of drug addiction	No dual diagnosis	Personality disorders	Depression	Other affective disorders	Anxiety disorders	Other mental disorders
Opioids	98.0	0.7	0.1	0.0	0.0	1.2
Cannabis	91.1	1.9	0.3	0.0	0.0	6.7
Tranquilizers and sleeping pills	91.5	0.8	1.0	0.1	3.3	3.3
Cocaine	91.4	0.0	0.0	0.0	0.0	8.6
Amphetamines	95.0	1.3	0.0	0.4	0.2	3.1
Hallucinogens	86.4	13.6	0.0	0.0	0.0	0.0
Inhalants	93.0	1.0	0.0	0.0	0.0	6.0
Poly-drug addiction	91.2	1.9	0.4	0.1	0.3	6.1

Source: Insitute of Psychiatry and Neurology 2010.

In patients diagnosed with drug addiction, admitted to inpatient treatment, the highest rate of co-morbidity was found in users addicted to hallucinogens (dual diagnosis concerned 13.6% of cases).The lowest rate of dual diagnosis referred to opioid users (2% of patients with dual diagnosis). Personality disorders were more frequently observed in users of hallucinogens (13.6%). Depression or anxiety disorders were most often diagnosed in patients addicted to tranquilizers and sedatives (1% and 3.3% respectively). Other mental disorders were frequently diagnosed in patients addicted to cocaine, cannabis, inhalants and multiple drugs (=poly-drug addiction).

6.3. Drug-related deaths and mortality of drug users

- **Drug-related deaths in Poland – analysis of trends and geographical variations**

Data on drug-related deaths in Poland are collected by the Central Statistical Office (GUS). Every year the Information Centre for Drugs and Drug Addiction (CINN) of the National Bureau for Drug Prevention (KBPN) processes the GUS information for domestic and EMCDDA purposes. Data on drug-related deaths are one of the EMCDDA five key epidemiological indicators which comprise the European monitoring system for drugs and drug addiction.

The data reported by the GUS to the CINN contain the location of death, socio-demographic details of the individual who overdosed drugs and the type of substance that caused death (according to ICD codes). Until 1996, ICD 9th revision was used and since 1997 data have been codified in compliance with ICD 10th revision. The basic limitation for obtaining information about drug-related deaths is entering only one code into the GUS database, i.e. the underlying cause of death. There are works under way at the Central Statistical Office (GUS) to expand the database so that it includes also the direct and indirect cause of death according to Eurostat requirements. In such a situation, national definitions are developed and applied independently by countries, based on the EMCDDA recommendations. In 2005, codes that form the national definition of drug-related deaths were chosen. The following codes were selected from the general ICD database: F11-12, F14-16, F19, X42, X62, Y12, X44, X64, Y14. The Polish definition of drug-related deaths was elaborated based on Selection B of the EMCDDA protocol as well as on the basis of the national methodology in order to continue the previous trend. .

Data in Table 6.7. show a stable trend in the number of drug-related deaths in Poland in recent years. While analyzing data since 1987 we can see that in 1987-1996 drug-related deaths fluctuated between 145 and 213 cases. In 1997 there was an increase of 40% compared to 1996. At that time 10th ICD revision came into force. Coding changes might have influenced the number of the deaths generated by the system. In 1998, there was a decrease in the number of deaths (235) but over the following two years the figure rose to 310 in the year 2000. The years 2000-2002 demonstrate the highest drug-related death figures since 1987, from the lowest number of 294 in 2001 to the highest number of 324 in 2002. The death rates per 100 000 inhabitants are also the highest from 0.77 in 2001 to 0.85. It must be stressed that this rate has never reached 1 per 100 000 (in the period 1987-2008). In the years 2003-2008, drug-related deaths fluctuate between 214 (2007) and 290 (2005), only approaching the values from the beginning of the 21st century in 2005. Analyzing the latest 2008 data, we notice a slight increase in comparison to 2007 – from 214 to 244 cases.

However, it integrates in the stable trend of slight falls and rises we have been observing in recent years.

In 2008, among fatal drug overdose victims 44% were female (36% in 2007). The average fatal overdose age is relatively high and it is 44 (47 in 2007). The youngest person who fatally overdosed drugs in Poland in 2008 was 15. Whenever the primary cause of death was fatal poisoning, the most frequent type of substance was opioids – 7 individuals. A single death was recorded due to cocaine overdose (F14) (Malczewski 2010k, p. 28).

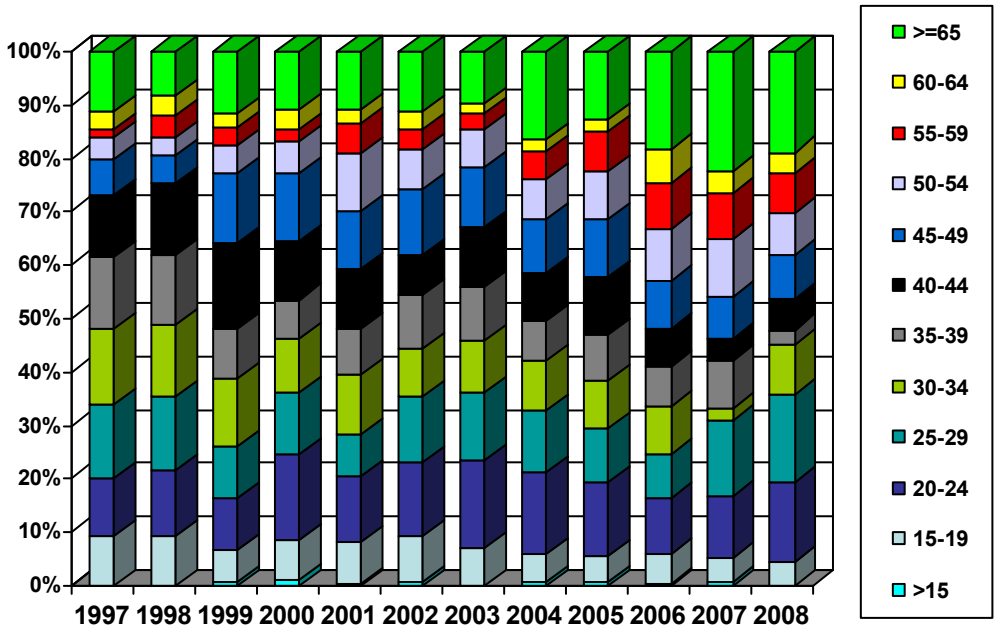
Table 6.7. Deaths due to drug overdose in 1987-2008 –GUS data.

Year	Total number	Deaths per 100 thousand inhabitants
1987	156	0.41
1988	145	0.38
1989	181	0.48
1990	155	0.41
1991	213	0.56
1992	199	0.52
1993	211	0.55
1994	185	0.48
1995	175	0.45
1996	179	0.46
1997	253	0.65
1998	235	0.61
1999	292	0.76
2000	310	0.81
2001	294	0.77
2002	324	0.85
2003	277	0.73
2004	231	0.61
2005	290	0.76
2006	241	0.63
2007	214	0.53
2008	244	0.64

Source: Malczewski 2010 n, pp. 2-3

Analyzing the age of fatal drug overdose victims we record the highest numbers among individuals aged over 65. (Figure 6.11.). It might be the result of including in the statistics the medical application of drugs e.g. opioid painkillers. The percentage of individuals in this age cohort has been increasing in recent years. The next in terms of the number of deaths is the group aged 25-29. There were 40 cases in 2007 and 30 in 2008. In previous years there were only single cases of individuals who fatally overdosed drugs at the age of 14. In 2008, the youngest victim recorded was 15 years old. It must be stressed that the number of drug-related deaths in the 15-19 age cohort has been declining since 2002. In 2008, 11 cases were recorded, which is two times lower compared to 2002.

Figure 6.11. Drug-related deaths in 1997-2008 by age (GUS data).



Source: Malczewski 2010 n, p. 4

Geographical variations

If we look at the number of drug-related deaths in 2008 with breakdown into provinces (see Table 6.8.) then we will notice that the most fatal drug overdoses took place in mazowieckie province (71 deaths). Other provinces included slaskie (42) and pomorskie (23). In the remaining provinces the number of deaths did not exceed 20 annually.

The fewest deaths, (below 3) were recorded in opolskie, swietokrzyskie and podkarpackie provinces. No single drug-related death was recorded in podlaskie province.

Analyzing trends in fatal drug overdoses in Poland this indicator values vary depending on the geographical location. Let us consider the provinces with the highest numbers of drug-related deaths.

The highest number and a dramatic increase have been recorded in mazowieckie province since 2006. 71 deaths (29% of all deaths in Poland) were recorded in this province in 2008. Since 2004, slaskie province witnessed a downward trend, with the lowest value of 26 deaths in 2007. A dramatic increase up to 42 cases in 2008 caused that slaskie province ranked high among provinces with high numbers of drug-related deaths. In pomorskie province we have been recording a systematic rise in the number of drug-related deaths from 13 cases in 2004 to 23 in 2008. It is worth looking at the situation in lodzkie province, which in 2006 had one of the highest figures of drug-related deaths and has been witnessing a decline ever since. In 2008, only 17 deaths (half of the 2006 figure) were identified. It is worth mentioning that the number of drug-related deaths was lower in other provinces: kujawsko-pomorskie, lubelskie, podkarpackie, podlaskie, swietokrzyskie.

Table 6.8. Deaths due to drug overdose (according to national definition: F11-12, F14-16, F19, X42, X62, Y12, X44, X64, Y14) in 2004-2008, by province (GUS data).

Province	Number of deaths according to national definition				
	2004	2005	2006	2007	2008
Dolnoslaskie	18	33	17	9	14
Kujawsko-pomorskie	14	19	13	13	10
Lubelskie	9	9	7	4	7
Lubuskie	8	6	8	9	4
Lodzkie	19	23	34	25	17
Malopolskie	3	5	10	5	5
Mazowieckie	47	61	37	46	71
Opolskie	4	5	3	0	3
Podkarpackie	4	4	9	4	3
Podlaskie	4	13	7	7	0
Pomorskie	13	17	20	21	23
Slaskie	48	44	38	26	42
Swietokrzyskie	4	3	6	7	2
Warminsko-mazurskie	6	9	4	10	10
Wielkopolskie	13	17	19	13	14
Zachodniopomorskie	17	22	9	15	19
Poland	**231**	**290**	**241**	**214**	**244**

Source: Malczewski 2010 n, p. 5

In order to compare situations in respective provinces numbers of drug-related deaths were converted into death rates per 100 000 (Table 6.9.). This way we avoid distortions caused by differences in the populations of respective regions of Poland.

Analyzing this indicator we notice that the highest drug-related death rate was in mazowieckie province (1.36). A high drug-related death rate in mazowieckie province is mainly caused by the presence of Warsaw where in 2008 there were 70% of all deaths recorded in the whole province (50 cases). Zachodniopomorskie province ranked second with the highest number of drug-related deaths in the last three years. In 2008, the rate stood at 1.12. Pomorskie province also witnessed a rise at 1.03.

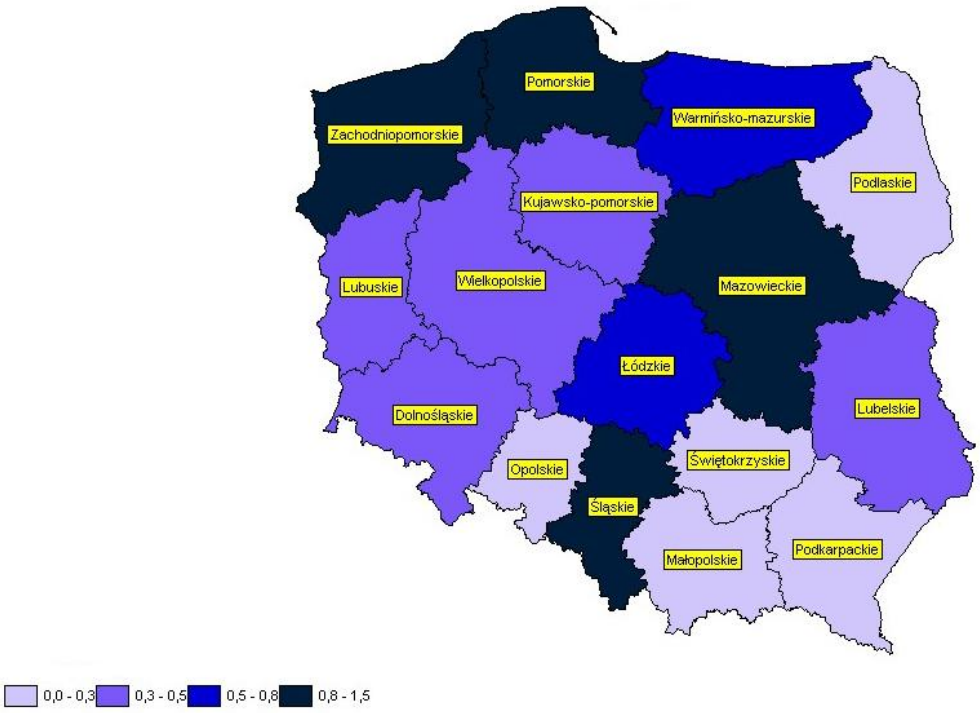
In all the three provinces high rates were also recorded in 2007 (Figure 6.12). The lowest rates were found in provinces in the east and south-east of Poland i.e. podlaskie (0.0), podkarpackie (0.14) and malopolskie (0.15).

Table 6.9. Drug overdose death rates per 100 000 population (according to national definition: F11-12, F14-16, F19, X42, X62, Y12, X44, X64, Y14) in 2004-2008, by province (GUS data).

Province	Death rate per 100 000 population:				
	2004	2005	2006	2007	2008
Dolnoslaskie	0.62	1.14	0.59	0.31	0.49
Kujawsko-pomorskie	0.68	0.92	0.63	0.63	0.48
Lubelskie	0.41	0.41	0.32	0.18	0.32
Lubuskie	0.79	0.59	0.79	0.89	0.40
Lodzkie	0.73	0.89	1.32	0.98	0.67
Malopolskie	0.09	0.15	0.31	0.15	0.15
Mazowieckie	0.91	1.18	0.72	0.89	1.36
Opolskie	0.38	0.48	0.29	0.00	0.29
Podkarpackie	0.19	0.19	0.43	0.19	0.14
Podlaskie	0.33	1.08	0.59	0.59	0.00
Pomorskie	0.59	0.77	0.91	0.95	1.03
Slaskie	1.02	0.94	0.81	0.56	0.91
Swietokrzyskie	0.31	0.23	0.47	0.55	0.16
Warminsko-mazurskie	0.42	0.63	0.28	0.70	0.70
Wielkopolskie	0.39	0.5	0.56	0.38	0.41
Zachodniopomorskie	1	1.3	0.53	0.89	1.12
POLAND	**0.61**	**0.76**	**0.63**	**0.56**	**0.64**

Source: Malczewski 2010 n, p. 7

Figure 6.12 Drug overdose death rates per 100 000 population in 2009, by province (GUS data)



Source: Malczewski 2010 n, p. 8

Drug overdoses among survey participants

Under the survey of low threshold programme clients in 2008 (see Chapter 4 for method description) the issue of drug overdose was touched upon. Drug overdose has been recorded in 17% of the low threshold programme clients one year prior to survey. Drugs were overdosed far more frequently by men (77% of overdoses). Almost a third of overdoses referred to the survey participants aged 25-29 and a fifth (21%) referred to the age group 30-34. Frequently overdosed substances included heroin (85%), benzodiazepines (32%), Polish heroin (27%) and alcohol (24%), but also barbiturates (17%) and amphetamines (15%) and other drugs (10%). The percentages do not add up to 100% as three substances could be listed.

Table 6.10. Frequency of drug overdose by substance in 2008.

Overdosed drug		
Substances	**Number of person**	**Percentage***
Heroin	70	85%
Benzodiazepines	26	32%
Polish heroin	22	27%
Alcohol	20	24%
Barbiturates	14	17%
Amphetamine	12	15%
Methadone	3	4%
Inhalants	1	1%
Opioids	1	1%
Cannabis	1	1%
Buprenorphine	1	1%
Antidepressants	1	1%
Other medical drugs	8	10%

*Percentages do not add up to 100 as more than one answer could be given.

Source: Malczewski, Struzik, Jaśkiewicz 2009, p. 21

7. Responses to health correlates and consequences

prepared by Dawid Chojecki, Bożena Bajerowska, Artur Malczewski, Łukasz Jędruszak

Introduction

Harm reduction programme have been conducted in Poland since 1996. However, needle and syringe exchange programmes were launched already in 1989 as additional services at selected outpatient clinics and not as independent programmes. Since the beginning harm reduction programmes were conducted mainly by NGOs in large cities, night shelters for the homeless, meeting spots of drug addicts (dealers' dens, railway stations, streets, and parks), sex service premises. In 2008, the National Bureau co-financed 9 outreach programmes (National Bureau for Drug Prevention, 2010). Needles and syringes were exchanged at 5 drop-in centres and 2 night shelters for drug (National Bureau for Drug Prevention, 2010).

In the reporting year, the National Bureau co-financed 15 harm reduction programmes addressed to psychoactive substance users, reluctant to enter treatment, including custodial settings such as prisons and remand centres (however without exchange of the injecting equipment as it is prohibited by law) and in an infectious disease hospitals – at the ward designated for HIV/AIDS drug addicts.

In 2009, the National Bureau sponsored distribution of 187 625 needles and 131 138 syringes. There were approx. 18 423 working hours of outreach and 1 747 interventions (National Bureau for Drug Prevention, 2010). In 2009, similarly to previous years, the National Bureau co-financed the "Monar na bajzlu" magazine addressed to drug users and providers of drug treatment programmes, especially harm reduction programmes.

Apart from the National Bureau such programmes are also supported by local governments. In 2009, 36 harm reduction programmes were co-financed by 27 communal governments: 6 syringe and needle exchange programmes (6 302 participants), 9 outreach programmes excluding needle and syringe exchange (13 963 participants), 3 drop-in centres for active drug users (534 participants), 6 night shelters for addicts (47 participants), 6 discotheque-based programmes (18 939 participants) and 6 substitution treatment programmes (858 participants). In 2009, the total number of participants included in harm reduction programmes co-financed by local governments stood at 40 643.

The total expenditure of communal governments on harm reduction programmes stood at PLN 1 296 601. In the previous year it stood at a similar level of PLN 1 317 814 (National Bureau for Drug Prevention, 2010).

7.1. Prevention of drug-related emergencies and reduction of drug-related deaths

Due to the increased popularity of synthetic drugs in Poland, for several years harm reduction programmes targeting occasional and recreational drug users have been developed. Such programmes are conducted in recreational settings (dance clubs, discotheques, concerts, open air events, etc.). They are outlined in Chapter 3.2 Selective prevention in at-risks groups and settings (Recreational settings incl. reduction of drug and alcohol related harm).

Under the harm reduction programmes for psychoactive substance addicts described above in Section 7, trainings in “safer” injections and first aid (with particular emphasis on overdoses) were conducted. The programmes covered the following aspects:

- education and information on psychoactive substances, drug addiction and consequences of drug use as well as drug treatment options. These goals were achieved through distribution of leaflets and brochures and talks with drug users:
  - motivating to change attitudes and behaviour;
  - first aid training courses in case of overdose;
  - distribution of condoms;
  - critical interventions.

- **Life-saving drugs in overdose treatment**

Antagonists*:* No changes in comparison to the report of 2008.

In Poland the following drugs are used:

- naloxon, in acute opiate poisoning
- naltrexon, in maintaining abstinence or preventing relapse. In Poland, the drug is registered to support opioid treatment following detoxification. The drug is applied by physicians in non-public drug treatment clinics. Naltrexon is not refunded by the National Health Fund.

Both drugs are used by physicians working with opioid addicts. Naloxon is part of ambulance equipment. Naloxon is not available on prescription and it is not distributed through pharmacies. Naltrexon is imported exclusively as bearer prescription medicinal product subject to approval by the Provincial Chief Psychiatrist (personal communication, Bogusław Habrat and Karina Chmielewska, Institute of Psychiatry and Neurology).

7.2. Prevention and treatment of drug-related infectious diseases

- **Prevention: vaccinations, testing and counselling**

In Poland all citizens have the option of taking a free HIV test. It also refers to uninsured drug addicts. Testing centres in Poland are obliged to offer counselling before and after the test.

In 2009, the National Health Fund activities of increasing the availability of drug-related infectious disease prevention programmes included financing HBV vaccinations and HCV and HIV tests (National Bureau for Drug Prevention, 2010).

The National AIDS Centre reported that in 2009 it co-financed 28 facilities where it was possible to take a free and anonymous HIV test. 317 individuals tested positive for HIV. Out of this number, 61 admitted to injecting drug use. Likely routes of infection: 12 through injecting drugs use; 43 through injecting drug use + heterosexual intercourse; 5 through injecting drug use + homosexual intercourse; 1 through injecting drug use + bisexual intercourse (National Bureau for Drug Prevention, 2010).

- **Infectious diseases treatment**

In 2009, the National Health Fund activities of increasing the availability of drug-related infectious disease treatment included financing health services provided in specialist antiretroviral treatment facilities.

14 facilities performed complex antiretroviral treatment. Out of 1 660 drug users treated with the ARV method approx. 14% (230 patients) also participate in substitution treatment programmes. Compared to the previous year, there was a rise of approx. 23% in the number of detected HIV infections in the course of HIV tests (317 cases). A major route of infection were heterosexual contacts (National AIDS Centre & National Bureau for Drug Prevention 2010).

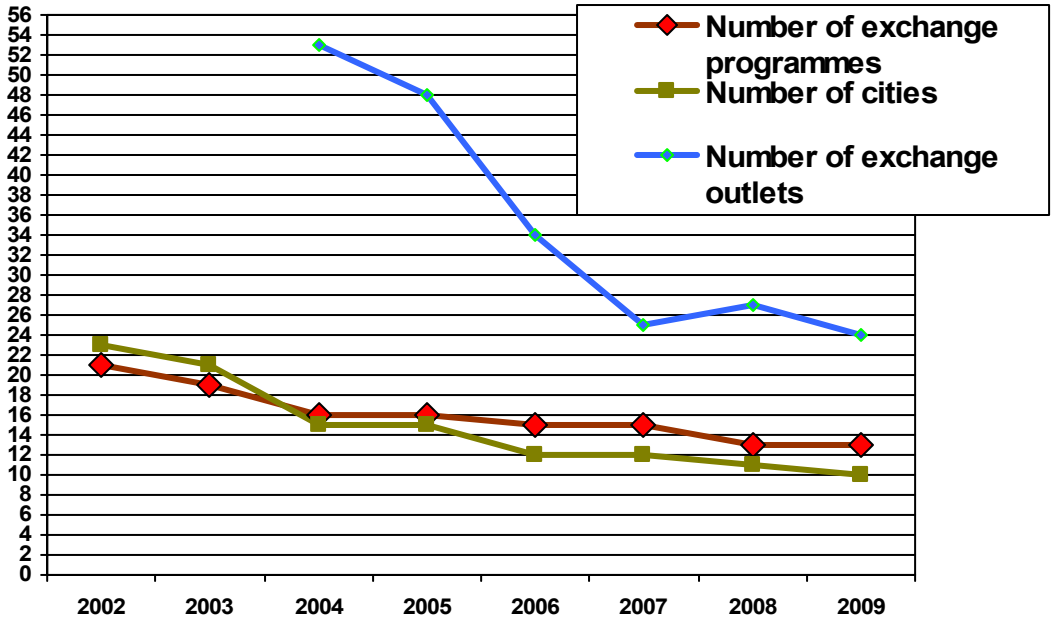
- **Needle and syringe exchange programmes in Poland**

Under the task of monitoring harm reduction activities, every year data are collected from the exchange programmes, including bi-yearly surveys (2008, 2010). Most needle and syringe exchange programmes are financed by the National Bureau for Drug Prevention; however, some programmes are financed by municipalities e.g. Warsaw.

In the period of monitoring harm reduction activities i.e. since 2002, we noticed a fall in the number of needle and syringe exchange programmes from 21 down to 13 in 2009. The number of cities where the programmes are available dropped from 23 to 11. Almost all programmes were building-based (12) and 9 were street-based. The latest data (Figure 7.1.) show that the availability of sterile needles and syringes decreased only slightly in 2009. The

2009 data received from the programmes indicate that the availability of needle and syringe exchange programmes remained at the same level in 2009 compared to 2008.

Figure 7.1. Number of needle and syringe exchange programmes and cities where they were present in 2002-2009 and exchange outlets in 2004-2009.

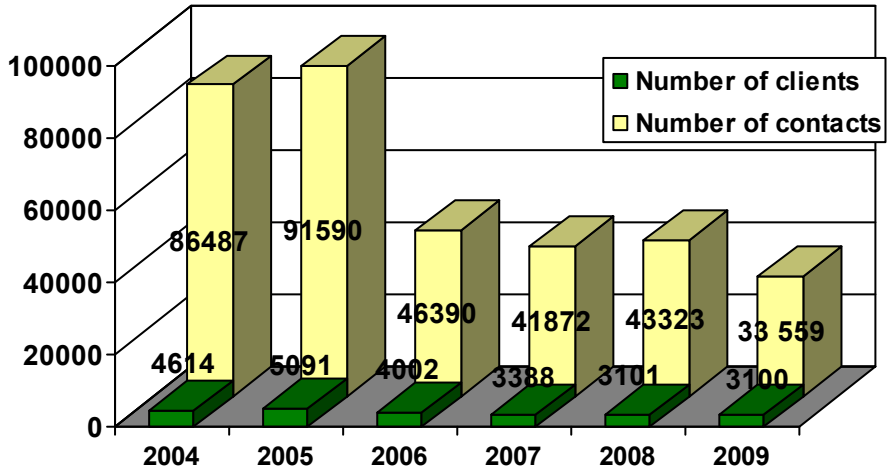


Source: Centurm Informacji o Narkotykach i Narkomanii KBPN

Harm reduction activities are performed on a large scale in Warsaw and Krakow. In the capital the most exchange programme are run by three entities: Monar Association, Social Care Association (Stowarzyszenie Pomoc Socjalna) and SPZOZ Substance Treatment Centre (SPZOZ Centrum Odwykowe). Apart from building and street-based exchange, outreach workers use bikes. There is also a drop-in centre up and running. In Krakow, apart from building and street-based exchange there is also a bus which reaches other cities e.g. Katowice, where Czestochowa-based Monar outreach workers also operate. Exchange programmes were implemented in ten Polish cities altogether: Warsaw, Krakow, Katowice, Chorzow, Czestochowa, Gdansk, Pulawy, Zgorzelec, Jelenia Gora and Olsztyn.

The survey data show that in 2009 approx. 3 130 individuals (3 101 in 2008) benefited from the programmes. The staff of building and street-based programmes recorded 33 559 contacts (43 323 in 2008), which constitutes a fall of 22%.

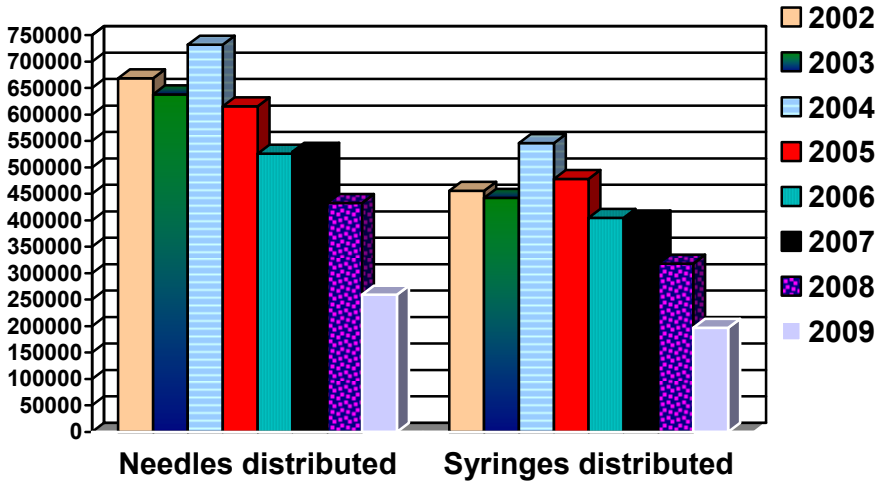
Figure 7.2. Clients of needle and syringe exchange programmes and contacts made in 2004 – 2009.



Source: Centurm Informacji o Narkotykach i Narkomanii KBPN

Along with a fall in the number of the exchange programmes and outlets, the number of distributed needles and syringes is going down as well. Figure 7.3. shows numbers of distributed needles and syringes in 2002-2009. The most needles (731 832) and syringes (545 738) were distributed in 2004. In 2009, we record a decline in the distribution of needles and syringes with the lowest figure since 2002: 259 220 needles and 196 960 syringes. The number of needles distributed per user fell to 80 pieces a year while in 2008 it was approx. 140.

Figure 7.3. Needles and syringes distributed in 2002 – 2009.



Source: Centurm Informacji o Narkotykach i Narkomanii KBPN

In 2008, the content and types of Polish low threshold programmes were surveyed. The survey included 12 operating low threshold programmes. The programmes were established in 1995-2007. The great majority (11) were run by NGOs (Malczewski, Struzik, Jaśkiewicz 2009, p. 25). 10 needle and syringe exchange programmes were building-based, 7 programmes were street-based and in 2 facilities the injecting equipment was exchanged through mobile platforms (e.g. vans).

Out of 12 programmes, 9 operated in big city centres and 3 in other urban areas. The local drug scene profile where most programmes operate is open and dispersed (7 programmes), 3 drug scenes were identified as hidden and the remaining 2 as open-concentrated.

The total number of opening hours per week ranged between 12 and 168 with the average of 59 hours. 4 programmes stayed open between 8pm and 8am and 6 programmes offered help at weekends.

All low threshold programmes focus on opioid users. For the majority of programmes an important target population were stimulant users and the homeless (as indicated by 9 and 8 programmes respectively). Half of the programmes target women. 5 programmes also target sex workers. A third of the programmes targets minors and gay men and lesbians. 3 programmes provided services for inmates of correctional facilities or remand centres and also 3 programmes provided services for migrants or ethnic minorities. 2 programmes targeted other populations.

10-40% of the programme clients were female. On average, 22% of the clients were female. Considering the age groups of the low threshold programmes, 11% were under 20, the largest group were clients aged 21-40 (69% on average), 18% were aged 41-50 and only 2% of the clients were over 50.

The proportion of problem drug users in 5 programmes was estimated at more 91% and in other 5 programmes ranged from 51% to 90%. One programme reported a proportion of problem drug users ranging from 11% to 50%.

The most prevalent psychoactive substances used by the programme clients were (in order of prevalence): opioids, amphetamines and cannabis.

The staff of eight programmes included active or former drug users. A written training policy exists only in one programme. In the majority of programmes (10) staff are provided with training on various subjects e.g. sexual risk assessment, sexual risk reduction education, drug risk assessment, drug-related interventions.

Staff in 10 programmes were regularly informed on the importance of HBV vaccinations and in 10 programmes there are written Codes of Conduct in needle cuts. Staff in 4 programmes are regularly vaccinated against HBV.

All 12 programmes exchanged needles and syringes, the majority offered alcowipes, dry wipes and medical disposal containers.

Drop-in centres or common rooms were found in 5 programmes, however, in none of the rooms were clients offered meals. 8 programmes provided personal hygiene services: 8 programmes distributed condoms; 6 programmes distributed clothes; and only 2 programmes it was possible to have a shower or do the laundry. Only one programme out of 12 offered overnight accommodation (30 beds).

3 out of 12 programmes provided services in the total of 9 penal institutions.

Only 1 programme, according to the survey, offered a drug consumption room.

The most popular social welfare services included assistance in handling personal paperwork, referring to other facilities, legal and welfare benefits counselling.

In terms of medical care the programmes offer mainly direct and emergency drug-related services e.g. interventions in drug overdoses, dressing wounds, drug use risk assessment and sexual risk assessment. Far fewer programmes offer other medical services. None of the programmes offered the option of receiving infectious disease, gynaecological or dental treatment.

Discussion

The above data show that we are still observing a narrowing availability of needle and syringe exchange programmes.

The number of clients in 2009 was similar to 2008; however, there was a fall in the number of outlets and equipment distributed. The fall in the number of programmes and the consequent narrower availability might be due to several factors. Firstly, new substitution treatment programmes are being developed. In Warsaw, in 2008 three new substation treatment programmes were established. There is no clear evidence that he number of injecting drug users is falling. The ICD-10 classification used in medical statistics makes it impossible to determine the number of injecting drug users. However, it can be assumed on the basis of the information received from the exchange programmes that injecting drug use is not gaining in popularity on the drug scene. In Gdansk, where an open drug scene existed, in 2008 during the survey of low threshold programmes i.e. two weeks, only 15 interviews with injecting drug users were held. In some cities (e.g. Poznan) exchange programmes are hard to implement as there is no open drug scene while in other locations where programmes could be implemented because there are injecting drug users there are no adequate resources (e.g. zachodniopomorskie province). It must be stressed that needle and syringe exchange programmes are not the only source of injecting equipment. Needles and syringes are sold at pharmacies. There is no answer to the question how many needles and syringes are sold to drug users. The availability of needles and syringes at pharmacies

requires research and analysis. There are signals that not all pharmacies sell injecting equipment. A letter from the Marshal Office of zachodniopomorskie province to pharmacies which raised the issue of selling needles and syringes along with the survey of Gdansk-based pharmacies a few years ago (Monar na Bajzlu 2007) show that not all pharmacies are willing to sell needles and syringes to drug users. Despite these reservations pharmacies constitute one of the main sources of clean injecting equipment and with the downward trend in the number of needle and syringe exchange programmes they are becoming important sources of such products.

7.3. Responses to other health correlates among drug users

- **Activities related to coexistence of mental diseases**

In 2009, there were several dozens of drug treatment units operating in Poland. Under their statutory services they also offered psychiatric treatment. However, the number of facilities specializing in treating patients with dual diagnosis is far lower. In 2009, in Poland there were only two wards in psychiatric hospitals and 2 drug rehabilitation clinics which offered comprehensive both psychiatric and substance treatment. The four abovementioned facilities had 69 beds. 384 hospitalizations were performed. (Boguszewska, Institute of Psychiatry and Neurology, personal communication).

Outpatient clinics (excluding day care centres) admitted the total number of 2 710 patients with dual diagnosis in 2009 (2008: 2 536). 1 165 of these patients were treated in mental health counselling centres (including mental health counselling centres for children and adolescents). 1 054 found treatment in outpatient alcohol clinics and 491 at outpatient drug clinics (Institute of Psychiatry and Neurology, 2009).

Most drug treatment units are not ready for treating patients with dual diagnosis. Such patients are referred to mental health counselling centres and in the case of acute psychotic disorders to psychiatric hospitals. Most inpatient drug clinics admit such patients upon prior stabilization of mental state in a psychiatric unit. Staff of the facilities ensure that patients with dual diagnosis constitute a substantial minority so that their additional problems will not destabilize the functioning of a therapeutic community.

See also Chapter 5 Drug treatment: demand and availability, Section: Medical treatment, Sub-section: Other forms of medical treatment of coexisting diseases.

- **Prevention and reduction of drug-related road accidents**

Issues of reducing risk related to driving vehicles under the influence of psychoactive substances (legal and illegal) are regulated by the following legal acts:

- Article 128 of the Act of 20 June 1997 – Road traffic law (Journal of Laws No. 108 item 908 as further amended). It defines the methodology of testing a driver who is

involved in a road accident wherein there is a fatality or somebody inured for alcohol or another drug with effects similar to alcohol,

- Regulation of the Minister of Health of 11 June 2003 on the list of drugs with effects similar to alcohol as well as conditions and procedure for performing drug and alcohol tests (Journal of Laws No. 116, item 1104 as further amended).
- Ordinance No. 496 of the Police Commander-in-Chief of 25 May 2004 on testing for alcohol or another drug with similar effects to alcohol (Official Journal No. 9 of 15 June 2004 item 40).

Illegal substance detection and law enforcement

Article 178a.1 of the Penal Code provides that whoever being intoxicated or under the influence of a narcotic drug is found to be driving a mechanical vehicle in road, water or air traffic is subject to a fine or penalty of limitation of liberty or imprisonment for a period of up to two years.

Policemen are equipped with drug test kits, pursuant to Article 4.5 of the Regulation of the Minister of Health of 11 June 2003 on the list of drugs with effects similar to alcohol as well as conditions and procedure for performing tests for the presence thereof (Journal of Laws No. 116, item 1104 as further amended). Currently, the Police have 70 000 drug test kits, which were purchased thanks to the financial support from the European Regional Development Fund (under the Sectoral operating programme – Transport). Since 2002 basic and specialist trainings have been conducted for policemen in detecting symptoms of narcotic drug use. Moreover, the Police Headquarters developed "*principles of police conduct with drivers suspected of driving under the influence of a substance with similar effects to alcohol*". Based on these materials the Provincial Police Headquarters in Szczecin designed a manual for policemen which has been distributed across the country *(Information obtained from the Department of Prevention and Road Traffic of the Police Headquarters, 2009)*.

Prevalence

The police do not conduct independent research into the prevalence of cannabis and BZP use in drivers. Consequently, there are no national police statistics which would provide a detailed profile of drivers (age group, sex, criminal record, etc.) caught driving under the influence of substances with similar effects to alcohol.

The Police conduct routine checks for the presence of a narcotic drug with similar effects to alcohol, if there are substantial grounds that the driver is under the influence thereof and after excluding alcohol intoxication. Such tests are most often performed around discotheques, pubs and access roads thereto.

In 2009, road traffic policemen performed 16 760 tests for substances with similar effects. During 6 months of 2010 1 378 such tests were performed.

In 2009 policemen of all departments identified 1 010 driver who were under the influence of substances with similar effects to alcohol (Article 178.1 & 178.2 of the penal code) and during 8 months of 2010 there were 491 such detections

The above data have been obtained from the Department of Prevention and Road Traffic of the Police Headquarters, 2010.

Prevention

In 2009 the National Bureau for Drug Prevention launched a national informative campaign addressed to drivers under the influence of a substance with similar effects to alcohol. The campaign entitled "Don't drug drive. When you're on drugs, your brain is off!" was the first such an initiative implemented across the whole country. The campaign featured a website http://www.rozumwysiada.pl/. In 2010, another step of the campaign is being implemented. This time it also covers alcohol problem. More information is provided in Chapter 3 of the National Report.

Since 2004 the Police Headquarters (KGP) has been taking part in the 6th Framework Programme for Research Studies in the European Union, whose one of the components is the DRIUD research programme – "Driving under the influence of drugs, alcohol and medicine". The project is aimed at determining the influence of drugs with similar effects to alcohol on drivers. It is conducted in cooperation with the Automotive Transport Institute. Checks were carried out on different category roads across the country to find out sobriety levels and take saliva samples. During 2 years of the research the police detained 4 276 drivers, out of whom agreed to take part in the DRUID project. This group included 3 860 drivers (90.3%) of passenger cars and 386 drivers (9%) of commercial vehicles. The project participants also included drivers of large goods vehicle, but only when they were stopped by the police while driving a passenger car.

The DRUID study results show that there might be two times more drivers under the influence of a drug with similar effects to alcohol. Moreover, the study results demonstrate that the most prevalent illegal substances among drivers are cannabis and amphetamines. Assuming that approx. 13 million Polish drivers hold category B driving licence then based on the study results it can be estimated that approx. 130 thousand drivers of commercial and passenger vehicles drive under the influence of alcohol.

In the group of 4 026 drug tested study participants, 102 individuals tested positive for legal and illegal psychoactive substances (2.53% of the entire sample). Applying previous estimations it can be stated that there are approx. 330 thousand drivers on Polish roads who

drive under the influence of a substance other than alcohol. A detailed report on this matter will be available at the end of 2010.

8. Social correlates and social reintegration

prepared by Dawid Chojecki, Bożena Bajerowska

Introduction

Drug use, especially opioids, substantially contributes to social exclusion of the users. Apart from health problems they experience social problems e.g. unemployment, homelessness, poverty or commit crime.

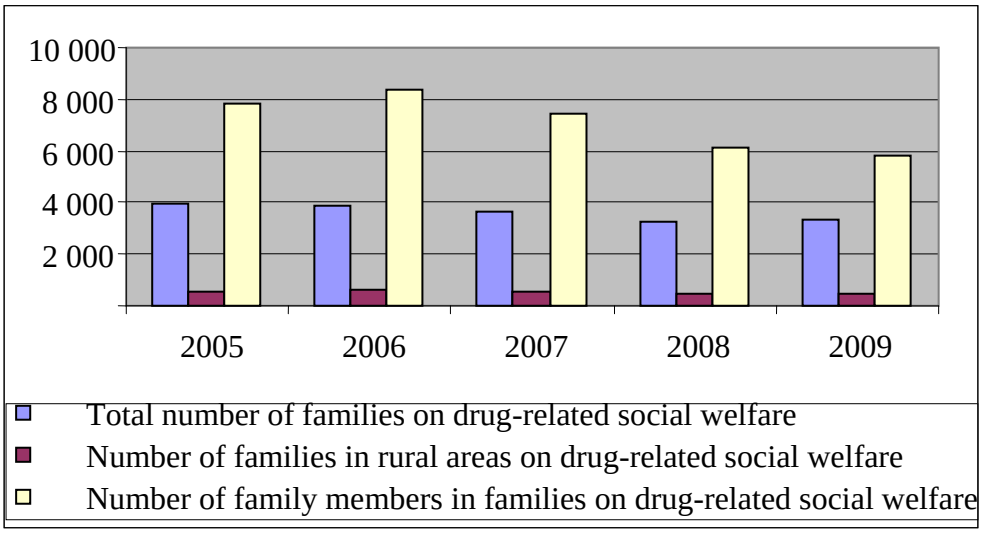
It is confirmed by numerous statistics and studies. The results of the research project in the Institute of Psychiatry and Neurology entitled "Social costs incurred by drug users. Survey of six European cities" clearly indicates that opioids are the most powerful in generating social exclusion. Insufficient knowledge of the forms of social welfare, ways of getting it and the related legislation causes that drug users are reluctant to seek help at social welfare centres. The above situation increasingly deepens their broadly understood social exclusion.

8.1. Social exclusion and drug use

- **Social exclusion among drug users**

In 2009, social welfare centres across Poland provided drug-related assistance for 3 320 families (2008: 3 287 and 2009: 3 671); including 448 in rural areas (499 in previous year). The assistance was provided for 5 778 individuals, including co-dependent individuals (2008: 6 106, 2007: 7 410). The most beneficiaries came from mazowieckie province – 1 247 individuals (690 families) and the fewest from świętokrzyskie province (101 individuals, 66 families) and podkarpackie province (107 individuals, 54 families) (Ministry of Labour – Department of Social Welfare and Integration, 2009).

Figure 8.1. Drug-related assistance for families 2005 - 2009.



Source: *Ministry of Labour – Department of Social Welfare and Integration, 2009*

In 2008, a survey of low threshold programme clients was conducted and in 2010 there will be another edition. Interviews with 733 drug users were held. The basic data along with analyses and the survey methodology were presented in Chapter 4 of National Report 2009. Below there is a socio-demographic profile of drug users who participated in the survey. Most of them are unemployed and some are homeless (Malczewski, Struzik, Jaśkiewicz 2009, p. 12).

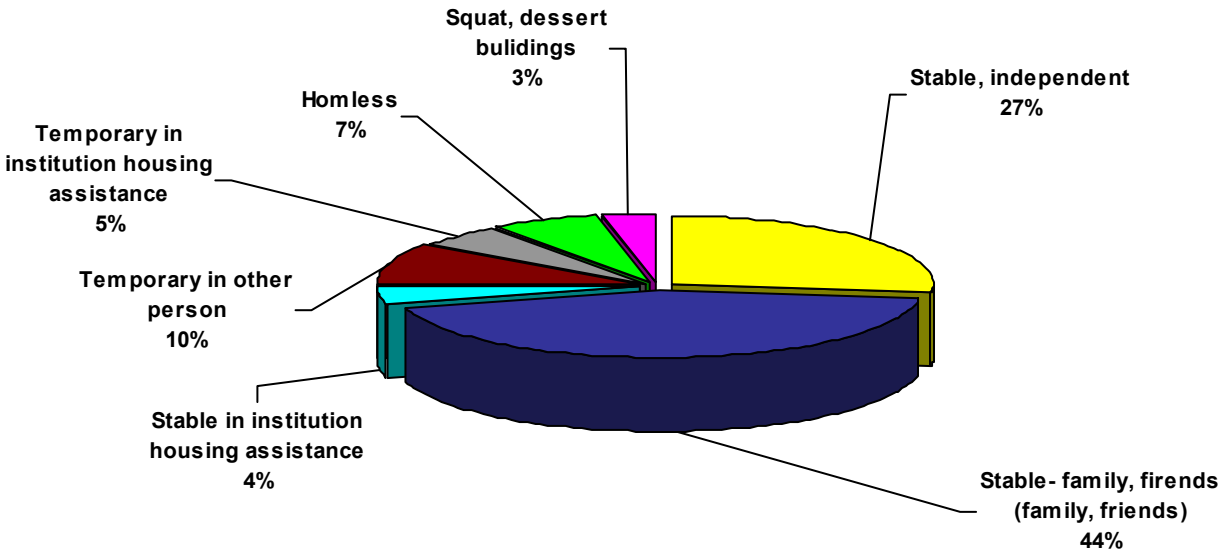
The majority of the survey participants were male (69%). The median age was 33, 34 for men and 30 for women. The most participants were male aged 30-34 (23% of all men). Among women this age group was slightly younger 25-29 (31% of all women). The oldest participant was 85 and the youngest 15.

Analyzing the education of the target population we notice that every third respondent had primary education (33%) or secondary (32%). Among the remaining respondents the largest group were vocational education graduates (27%). Far lower percentages of the respondents were recorded for individuals with middle school (4%) or higher education (3%). In the case of 1% there is no information on education.

The respondents were asked about their housing status. The majority i.e. almost three quarters had permanent place of residence defined as the option of spending at least 6 months in the same location. 15% of the respondents had temporary residence. More than a quarter of the respondents (27%) lived independently; however, far more respondents (44%) lived with someone e.g. family, friends. In total, 9% of the respondents benefited from institutional housing assistance, including 4% on a permanent basis and 5% on a temporary

basis. Every tenth respondent was staying temporarily with someone and a similar group squatted in deserted buildings (3%) or were homeless (7%).

Figure 8.3. Place of residence of client of low threshold programmes 2008 (n=733)



Source: Malczewski, Struzik, Jaśkiewicz 2009, p. 12

The respondents were asked to tick one of the sources of income. 23% of the respondents declared living off employment, nearly the same percentage reported living off mainly social welfare benefits and allowances (23%). Some respondents were maintained by other individuals (16%). Slightly more than a tenth of the respondents reported no source of income (12%), which might as well have meant that they lived off begging. The remaining group of the respondents (23%) had other sources of income, including illegal and unofficial ways of earning.

- **Drug use among socially excluded groups**

Drug use, job loss, homelessness, law-breaking might underlie social exclusion. In Poland, there is no single data collection system on drug users who are homeless, unemployed or come from ethnic minorities. It is known that psychoactive substances are often used by sex workers. To combat the phenomenon welfare and harm reduction programmes for prostitutes are being developed in Poland.

In 2009, the National Bureau for Drug Prevention co-financed a harm reduction programme for prostitute drug users. The programme was conducted by the Krakow Centre for Prevention and Social Education "Parasol". Approx. 143 sex workers (including 35 aged under 19) received assistance. The programme settings included: the street, night clubs and escort agencies – the last ones thanks to good cooperation of the programme implementer with the owners of clubs and agencies. Under the programme, educational and informative materials on infectious diseases and safe sex were handed out as well as condoms (2 020), lubricants (210) and other personal hygiene products. The programme also featured interventions and referrals to relevant facilities (e.g. social welfare centres where material assistance was provided, employment agencies and treatment units). (Centre for Prevention and Social Education "Parasol", 2010).

- **Homelessness**

The assessment "Homelessness in Poland" (as at 31 January 2010) conducted by the Department of Social Welfare and Integration of the Ministry of Labour assumes that the number of the homeless in Poland stands at approx. 30 thousand. The number of registered homeless individuals is closely related to the number of inhabitants in a given province.

The higher the population of a province the higher the homeless number. The most homeless people are located in the biggest city areas and "richest" provinces (e.g. mazowieckie, śląskie, wielkopolskie).

We do not have data on the number of homeless drug users. It is commonly known that a lot of addicts, particularly opioid users, are homeless. Such conclusions might be drawn upon the data analysis on clients of night shelters for homeless active drug users. The majority are addicted to opioids (mainly 'kompot' - Polish homemade heroin).

Most night shelters in Poland do not admit homeless drug users. Few night shelters in big cities make an exception from the rule and provide accommodation. For more information see Chapter 7: Responses to health consequences.

In 2009, the National Bureau sponsored a programme implemented by the Krakow Society for Drug Related Help entitled "Night Shelter for Drug Addicts – FENIKS". 75 people benefited from the programme including 19 women and 56 men. 20% of the programme beneficiaries used Polish heroin and 61% were poly drug users. The programme featured

outreach activities (600 hours), critical interventions (62 hours), education on safe drug injecting and exchange of injecting equipment. Thanks to motivational activities 14 individuals were referred to detoxification units and 9 more to HIV/AIDS treatment units.

In 2009, the National Bureau also co-financed 2 Warsaw-based hostel programme run by the Monar Association. One of them targeted substitution treatment clients, including 7 women and 37 men. The other programme, entitled “Early rehabilitation programme for drug addicts, permanent or temporary homeless, HIV/AIDS positive, with particular emphasis on clients in acute immunosuppression”, was conducted through outreach work and social interventions. The programme included 64 clients: 14 were referred to detoxification units, 1 to an infectious disease hospital and 39 people dropped out.

8.2. Social reintegration

Post-rehabilitation programmes for drug rehabilitation graduates are conducted in hostels, re-entry flats, inpatient and outpatient clinics. They aim to reintegrate a drug user into society by filling in the social gap which was caused by drug use in such fields as education, employment as well as relationships with family and relatives. Therefore, apart from therapeutic actions aimed at preventing a patient from relapse, the programmes feature vocational and skill training or assistance in finishing school. The programmes often recruit social workers who support drug addicts in handling paperwork (unemployment benefit, disability benefit, address registration, court matters, employment assistance, completion of relevant courses etc.)

Post-rehabilitation programmes mainly include the following:

- counselling on solving everyday problems,
- group sessions on information and education,
- personal development groups (coaching, training courses, workshops) aimed at raising self-esteem, improving functioning in social roles,
- relapse prevention groups,
- critical interventions,
- group and individual psycho-educational classes for families, aimed at changing behaviour and habits related to living with a drug addict.

These activities help drug users to maintain abstinence and fully re-enter society.

In 2009, the National Bureau for Drug Prevention commissioned 32 programmes supporting abstinence in drug treatment graduates. The programmes were conducted by 22 entities upon completion of drug treatment. 10 entities implemented the programmes in

counselling centres and day care centres, 15 organizations implemented the programmes in re-entry flats and hostels.

In 2009, 2 580 people entered National Bureau-sponsored post-rehabilitation programmes for abstainers and their families (including 1 786 residents of hostels and re-entry flats). 1 531 programme participants were abstinent drug addicts (after completed treatment). 709 participants were in school and 1 151 worked. 574 had social problems, 367 legal problems and 409 health problems. The programmes also admitted children below the age of 15 (65). (National Bureau for Drug Prevention, 2010).

Local governments and social welfare centres are bound by the Act on social employment and the Act on social care to run social reintegration programmes for addicts under the social integration strategy. Unfortunately, post-rehabilitation services for full drug treatment graduates can be considered insufficient. There are not enough re-entry flats and hostels.

In 2009, 52 communes (2.3% all communes in Poland) financially supported the implementation of social reintegration programmes for drug addicts. Communes co-financed 28 social reintegration programmes for drug addicts, including 12 outpatient reintegration programmes and 13 inpatient programmes. Moreover, in the reporting year communal governments granted funding to 81 NGOs operating in the field of social reintegration of drug addicts as well as 12 hostels and 11 re-entry flats where drug addicts resided after they had completed drug treatment. The social reintegration programmes included 896 clients (National Bureau for Drug Prevention 2010).

Based on the data obtained from the NGO's which programs were co-ofinanced from the sources of NBDP it may be concluded that the number of social reintegration programmes, the participants thereof, and NGOs operating in this field has increased compared to the previous year. In 2009, job offers alternative to the free job market were taken up by 388 participants, which constitutes a rise of 337 compared to 2008 (51 participants).

Moreover, NGOs implementing such activities can apply for co-financing from EU funds (European Social Fund).

- **Housing**

In 2009, the National Bureau for Drug Prevention co-financed social reintegration programmes addressed to drug rehabilitation graduates. The programmes were conducted in 13 re-entry flats and 22 reintegration hostels across the country (National Bureau for Drug Prevention, 2010).

In the reporting year, 4 provincial governments co-financed post-rehabilitation programmes. However, only 1 hostel and 2 re-entry flats were sponsored by provincial governments.

In 2009, financial resources earmarked by provincial governments for these activities amounted to PLN 111 897. However, the expenditure varied across provinces. The highest expenditure in the field of social reintegration was incurred in lodzkie province (PLN 61 490) and the lowest in opolskie province (PLN 2 000). It is worrying that in 2009 the social reintegration expenditure was down by over PLN 100 000 compared to the previous year. It is another year when the expenditure decreases.

In 2009, communal governments co-financed 12 reintegration hostels and 19 re-entry flats for drug rehabilitation graduates (National Bureau for Drug Prevention, 2010).

Moreover, there is a possibility that a person struggling with difficult housing situation applied for a social flat. Social flats are awarded by housing commissions (operating by city councils) based on an approval of a social welfare centre and health care units. However, there is no information on the number of drug treatment graduates who moved to such flats in 2009.

- **Education, trainings**

In order to increase the likelihood of finding employment after completing drug treatment, the graduates do vocational courses. It is crucial to complete or start education as most drug users show serious deficiencies in this respect.

Vocational courses and various forms of education are financed from a number of sources, including provincial and communal governments. In the reporting year, only 27 drug treatment graduates were able to benefit from provincial government-sponsored courses. (National Bureau for Drug Prevention, 2010) Little involvement of provincial governments in sponsoring vocational courses might be due to the fact that with every year NGOs are more and more effective in obtaining EU funds.

- **Employment**

In Poland there is no single data collection system on unemployed drug addicts.

The Act of 13 June 2003 on social employment provides for re-entering drug treatment graduates to the job market. One of the groups at risk of social exclusion therein is “individuals dependent on drugs or other psychoactive substances who completed a drug treatment programme at a health care unit”. The Act provides lays down rules for establishing and operating Social Integration Centres. Upon request of the Centre head, social worker and the very participant of the Centre activities a county employment office may provide a drug addict with a job or even refer him or her to work at the Centre. Job provision is done through an agreement concluded between the county governor competent for the location of the Centre and an employer. In the agreement the employer undertakes to

employ a participant for the period not shorter than 12 months and the county governor will refund part of the participant's salary to the employer.

Moreover, participants of the Social Integration Centre activities may start their own business and the costs of the related consultation, legal advice and counselling can be obtained from the Labour Fund.

Another form of employment is establishing (e.g. under the Vocational Stimulation Programme) the so-called social companies. Non-governmental organizations which assist in setting up such companies recruit prospective employees at mental health counselling centres, social welfare centres, vocational integration centres and county employment offices. The recruitment also covers persons at risk of social exclusion and unemployment (mostly physically disabled and mentally ill). Substance dependence is not a criterion which makes it easy or difficult to get recruited for a social company, however, a mental illness or disorder which co-exists in drug addiction is such a criterion. Establishing social companies can be performed under priority VII of the Operational Programme Human Capital 2007-2010: Promotion of Social Integration.

9. Drug-related crime, prevention of drug-related crime and prison

prepared by Artur Malczewski, Dawid Chojecki

Introduction

Several Police units are responsible for combating drug-related crime:

- Central Bureau of Investigation (CBŚ) of the Police Headquarters (KGP) mainly deals with combating organized crime syndicates which manufacture and smuggle drugs on a massive and international scale. The CBŚ plays a leading role in the Police in terms of training, strategy and concept.

- Criminal Service Units of the local police are responsible for performing intelligence, operational activities and prosecution within their designated areas. These units take action mainly against local criminal groups that manufacture, distribute and possess drugs. Within the Criminal Department there are anti-drug units. In 2008, at the level of Municipal and Communal Police Departments (Miejskie & Rejonowe Komendy Policji) special sections, subdivisions and teams were created. In County Police Department (Powiatowe Komendy Policji) teams and independent posts were established. Almost all Police units feature an anti-drug section. 1 000 more policemen were delegated to combat drug-related crime, especially at the local level. In the Criminal Department of the Police Headquarters under the Criminal Division a 3-member Drug Enforcement Team was appointed to coordinate actions of criminal police officers at the national level.

- Prevention Service Units of the local police are responsible for performing basic tasks in terms of intelligence and law enforcement in the course of their regular preventive duties. They also launch preventive operations under self-developed programmes and in cooperation with society.

Apart from the Police, combating drug-related crime, especially in terms of intelligence and operational activities, involves several other state agencies: Internal Security Agency (ABW), Border Guard, Customs Service and Military Police.

While analyzing data on drug-related crime one must take into account that the official statistics do not fully reflect the illicit drug market. A number of offences are not recorded and the real number of violations of the Act on counteracting drug addiction is far higher. Another important issue is the impact of police activities on the number of offences recorded. These numbers reflect the activities of the crime syndicates and the scale of the institutional response to the drug supply. In times of intensified law enforcement activity, the number of crimes recorded goes up, which does not always have to indicate a rise in drug manufacturing or an increased activity of drug dealers or manufacturers.

In Poland drug-related offences fall into two basic categories (Malczewski, Struzik, 2009a):

- common offences defined in the penal code and other criminal legislation (e.g. mugging, theft, burglary, forgery),

- offences defined in the Act on counteracting drug addiction e.g. illegal drug manufacture, trafficking, introducing to trade, possession as well as illicit cultivation of plants for the purposes of drug manufacture. This chapter contains the overview of the latter kind.

Police data on drug-related crime come predominantly from the TEMIDA system, which contains law violations of the Act on counteracting drug addiction. Statistical units used by the Police include: suspects, launched investigations and recorded crimes. They are reported to the Police database on special statistical forms. The data allow for analyses of trends and geographical variations. Since 2001 the Information Centre for Drugs and Drug Addiction has been receiving data from the TEMIDA system with breakdown into municipal and county police departments. The data are used to monitor the drug problem at local and provincial level.

9.1. Drug-related Crime

- **Drug Law Ofencess - Crime**

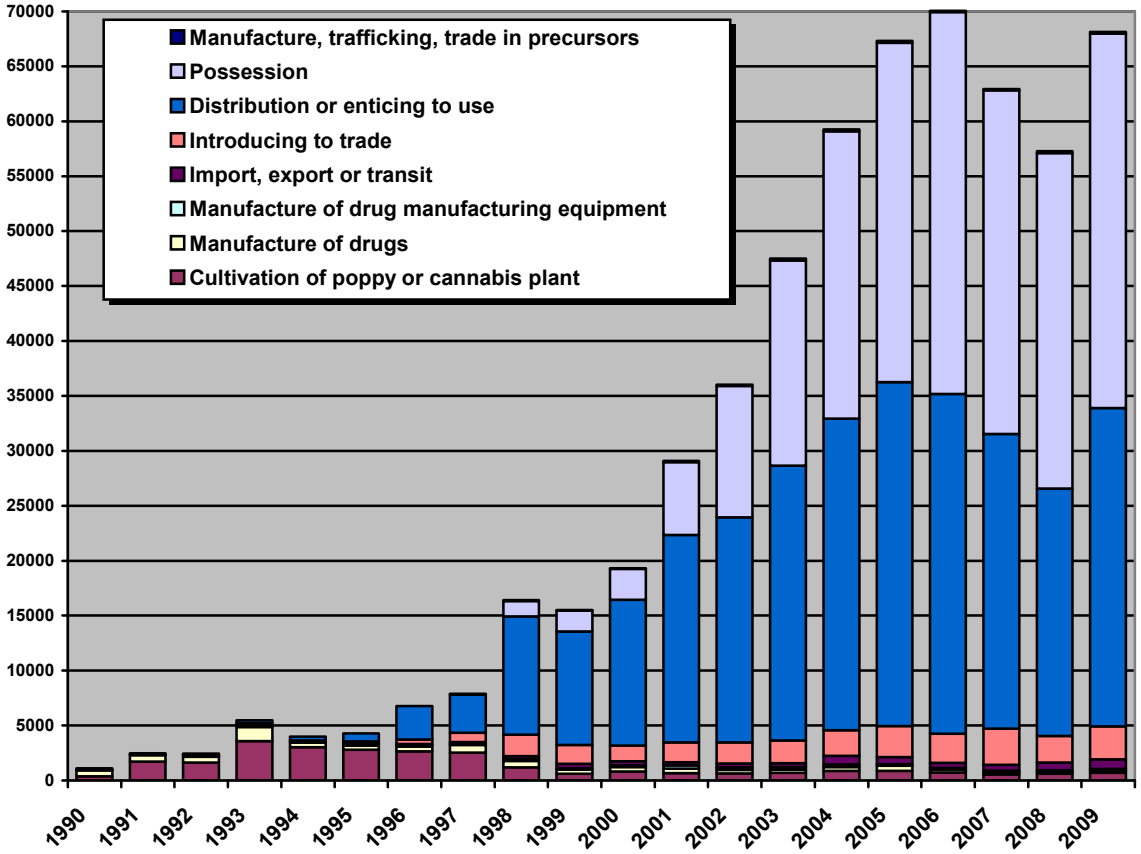
Table 9.1. shows recorded crimes under the Act of 1985 on drug prevention and the Acts of 1997 and 2005 on counteracting drug addiction. In 2007, for the first time since 1997, we recorded a fall of 10% in the number of drug-related crimes. This trend continued in 2008 (further fall of 9%). A dynamic upward trend in the number of crimes, which started in 1999, was stopped as early as 2006, when the number of crimes rose by fewer than 3 000 compared to 2005. In 2008, there was a fall down to 57 382 crimes, i.e. below the number of 2004. Then the Police recorded 59 356 punishable acts. In 2009, the number of recorded crimes rose nearly to the level of 2006 i.e. 68 288. As a reminder, in 2006 the Police identified 70 202 drug-related crimes, which is the highest figure ever recorded. The latest rise of 19% in drug-related crime is mainly due to the increase in the offences against Articles 58, 59 and 62 of the Act on counteracting drug addiction. These offences account for 92% of all drug-related crimes recorded in 2009 (Figure 9.1.). The number of drug possession offences increased by 12%.

Table 9.1. Recorded crimes against Acts of 1997 and 2005 on counteracting drug *addiction* in 1997-2009, data of Police

Articel	Year												
	97	98	99	00	01	02	03	04	05	06	07	08	09
Illicit cultivation (Art. 26; Art. 49.1; Art. 63.1)	2518	1195	615	814	663	653	687	886	875	726	562	625	688
Illicit manufacture (Art. 27; Art. 40. 1 & 2; Art.53)	701	574	361	400	408	319	297	350	456	270	198	183	174
Production, storage of tools (Art. 28; Art. 41; Art.54)	116	190	143	152	292	230	230	220	144	127	137	118	192
Illicit import, export or transit (Art. 29; Art. 42; Art. 55)	148	252	406	383	295	336	354	795	643	486	537	697	880
Illicit introduction to trade (Art. 30; Art. 43; Art.56)	847	1957	1714	1417	1809	1931	2064	2323	2814	2627	3268	2431	2969
Illicit distribution and enticing to use (Art. 31; Art. 45 & Art. 46; Art. 58 & Art. 59)	3507	10762	10305	13278	18873	20482	25036	28351	31332	30940	26845	22507	28981
Manufacture, trafficking and trade in precursors (Art. 47; Art. 61)	11	88	61	66	115	104	159	178	151	107	121	189	126
Possession of narcotic drugs (Art. 48; Art. 62)	32	1380	1896	2815	6651	11960	18681	26163	30899	34778	31260	30548	34122
Illegal harvest of poppy milk, opium, poppy straw, cannabis resin or plant (Art. 49. 2; Art. 63. 2)	26	112	113	83	78	73	69	42	49	34	31	39	41
Unlawful taking of poppy milk, poppy straw, cannabis resin or plant (Art. 50; Art. 64)	9	22	14	241	24	14	17	15	31	41	17	25	42
Failure to report a crime (Art. 46.a; Art. 60)					22	76	11	33	163	55	19	11	40
Promotion and advertising (Art. 68)									3	11	12	9	33
Total	**7915**	**16532**	**15628**	**19649**	**29230**	**36178**	**47605**	**59356**	**67560**	**70202**	**63007**	**57382**	**68288**

Source: KGP

Figure 9.1. Police data on crimes under the Act on counteracting drug addiction in 1990 – 2009.

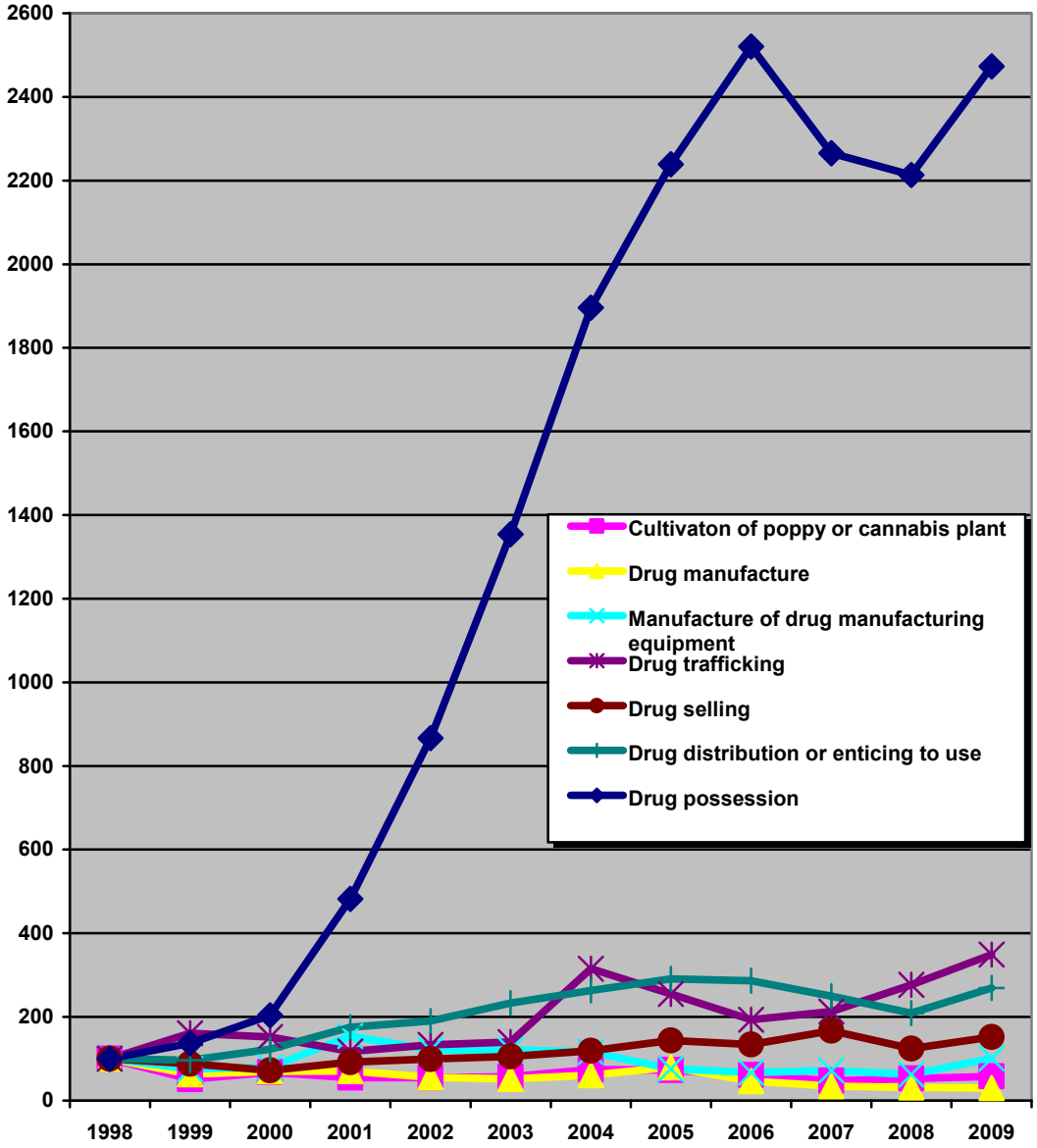


Source: Malczewski 2010m, p. 8

The mist dramatic rise concerned Article 54 (Manufacture and storage of drug manufacturing equipment). However, the Police identified a small number of such crimes (192) in 2009. A sharp increase from 25 to 42 offences also refers to Article 64 (Unlawful taking of poppy milk, poppy straw, cannabis resin or plant). In turn, the number of the precursor offences fell from 189 to 126 (Article 61).

It is worth noting the rising number of crimes against Article 63.1 (cultivation) since 2007 to the level of 688 and the rising number of crimes against Article 55 (trafficking) since 2006 to the level of 880. However, they account for a small percentage of recorded crimes. Figure 9.2. shows the trend of drug-related crimes between 1998 and 2009. In 1998 the Act of 1997 on counteracting drug addiction took effect. The sharpest increase concerns drug possession (Article 62) while the number of drug manufacture-related crimes (article 53) decreased.

Figure 9.2. Trends in drug-related crime in 1998 – 2009 (1998 =100). Police data



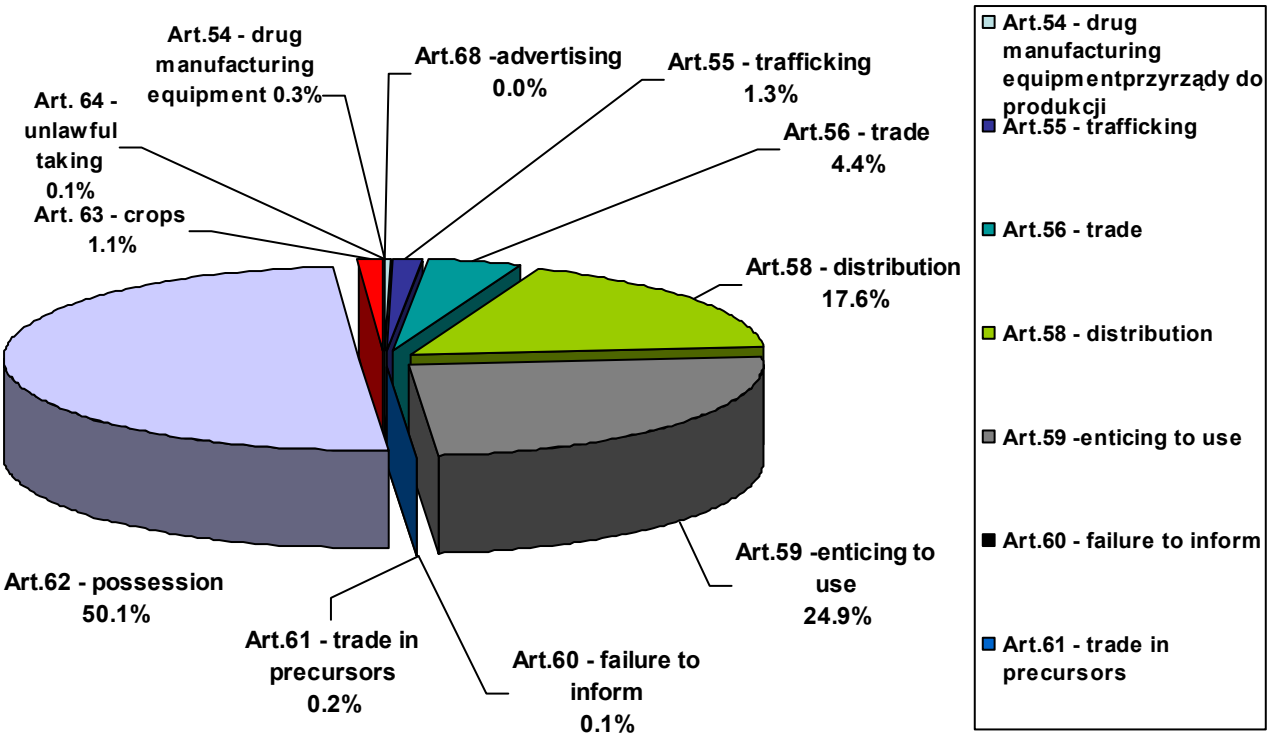
Source: Malczewski 2010m, p. 9

- **Drug Law Ofencess - Suspects**

In 1999-2006 the number of suspects under the Acts of 1997 and 2005 increased every year. The analysis of the trend in the number of drug possession suspects under the Acts of 1997 and 2005 on counteracting drug addiction since 1999 shows a substantial growth (2.5 times), which occurred in 2001 compared to 2000. The year 2001 was the first full year of the operation of the amended Act of 1997, which took effect in 2000. An important change was the deletion of Section 4 from Article 48 which provided that the punishment might not be imposed if the amount was intended for private use.

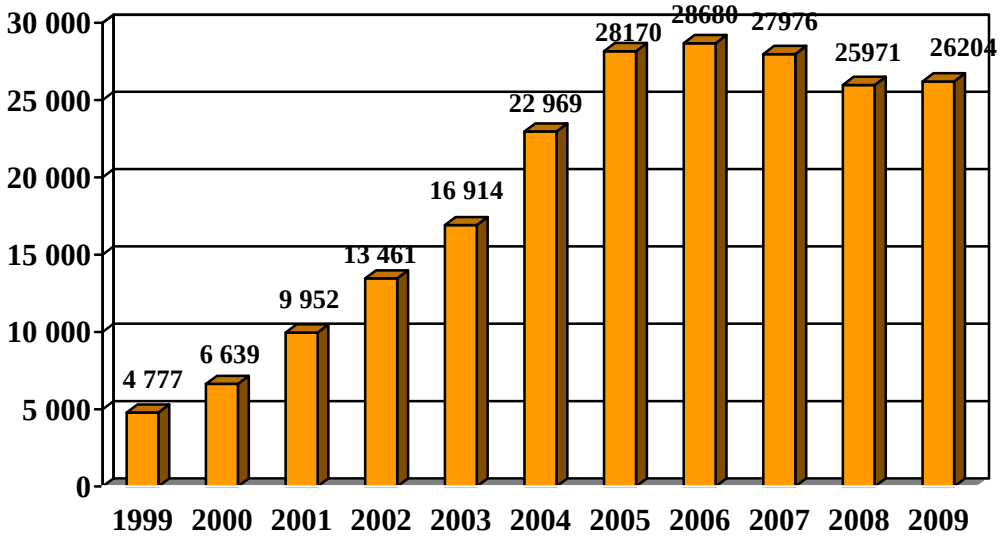
In 2007, the number of recorded crimes and suspects under the Act on counteracting drug addiction decreased for the first time ever. The downward trend was still observed in 2008. In 2009, we notice a slight increase of 1.2% in the number of suspects under the Act. Among 26 204 suspects 72% referred to Article 62. The percentage has been steady for several years. Suspects under Article 62 predominantly (17 954 individuals) faced charges under Section 1 and 3, which means that they possessed a small amount of drugs or it was an offence of lesser gravity. Analyzing the number of drug-related crimes (table 9.1) and suspects (figure 9.3) we notice that the percentage of crimes under Articles 58, 59 and 62 among the suspects is the same as the percentage of recorded crimes i.e. 92%. However, in 2009 a single suspect committed an average of 2.5 drug-related offences.

Figure 9.3. Suspects under respective Articles of the Act on counteracting drug addiction – Police data



Source: Malczewski 2010m, p. 10

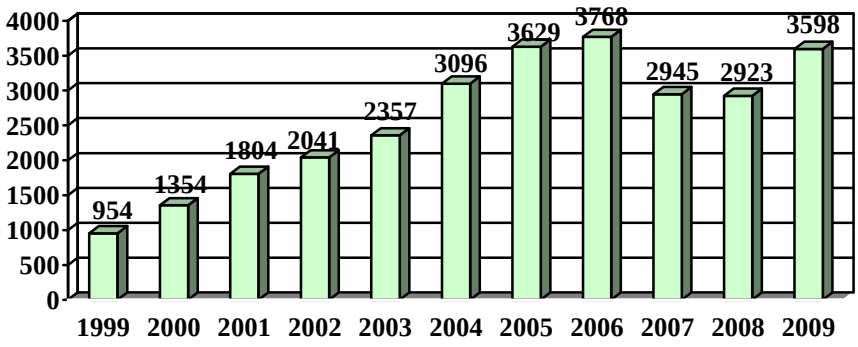
Figure 9.4. Suspects against Acts of Law of 1997 and 2005 in 1999 – 2009.



Source: *Source: Malczewski 2010m, p. 11*

Figure 9.5. shows numbers of underage suspects against the Act on counteracting drug addiction. In 1999, 954 adolescents aged 13-17 committed an offence under the Act. In 1999-2006, we recorded an upward trend, similarly to all the suspects trend (Figure 9.5.). In 2007, the number of underage suspects fell to 2 945. The decrease of 22% was far deeper compared to the total number of suspects. In 2008, the number of underage suspects held steady. However, in 2009 there was a sharp increase in the number of underage suspects under the Act. The majority of the underage suspects were under Article 62 (69%). In the case of adults the percentage was lower and stood at 50% (Figure 9.3).

Figure 9.5. Underage suspects against Acts of 1997 and 2005 on counteracting drug addiction in 1999 – 2009.



Source: Data of Police Headquarters processed by CINN

- **Drug Law offences – Convictions**

Criminal cases for violating the Act are heard by circuit courts (sądy rejonowe) corresponding to the place of committing the crime. Data breakdown into final custodial sentences between 1989 and 2006 is presented in Table 9.2. The data were compiled by the Ministry of Justice. It is difficult to compare them to the Police statistics as late as in 2006 suspects were still convicted by virtue of the Act of 1985 on drug prevention. It means that the suspects under the Act, who were recorded by the Police at the beginning of 1997 (i.e. by the time of the new Act of 1997 coming into force) could be sent to prison by way of final sentences even after 9 years. Analyzing the latest data available it must be noted that in 2007 - 20 801were convicted and in 2008 – 20631. In the structure of all convictions the proportion of those convicted under the Act was the same in both years 4.9%. Analyzing changes in time we note that in 2009 the number convicts with final sentences convictions under the Act fell for the frist time. Upward tren observed in the last 10 years was stoped.

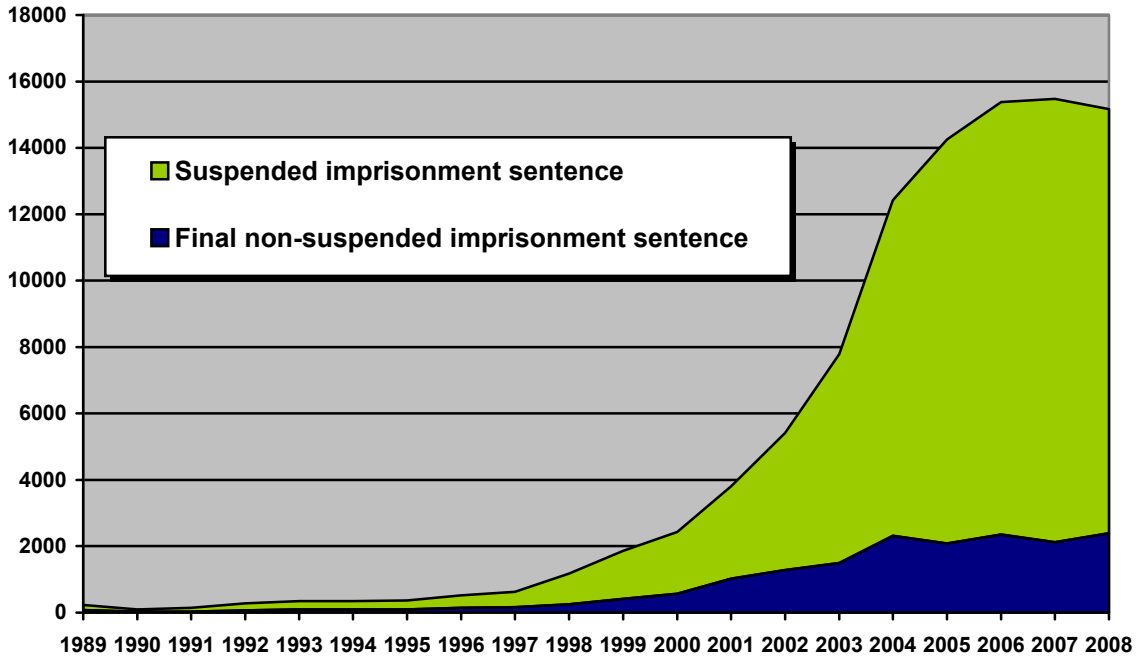
Table 9.2 also shows the number of convicts sentenced to imprisonment. In 2008 the rise was small decreased - 15165. Out of all convicts sentenced to imprisonment under the Act, 84% received suspended sentences -12775 (Figure 9.6).

Table 9.2. Convicts finally sentenced to imprisonment in total and under Acts of 1997 and 2005 on counteracting drug addiction and Act of 1985 on drug prevention, between 1990 and 2008, by suspended and non-suspended sentences.

Years	Convicts with final sentences, including convictions under the Act			Convicts sentenced to imprisonment		
	Convicts in total	Convicts under the Act	Percentage of convicts under the Act	Total	Non-suspended sentence	Suspended sentence
1990	106 464	231	0.22	92	30	62
1991	152 333	421	0.28	143	32	111
1992	160 703	993	0.62	282	72	210
1993	171 622	2235	1.30	347	97	250
1994	185 065	1862	1.01	346	97	249
1995	195 455	1864	0.95	368	100	268
1996	227 731	1739	0.76	520	141	379
1997	210 600	1457	0.69	629	165	464
1998	219 064	1662	0.76	1173	252	921
1999	207607	2264	1.09	1865	420	1445
2000	222815	2878	1.29	2428	572	1856
2001	315013	4300	1.36	3802	1024	2778
2002	365326	6407	1.75	5417	1282	4133
2003	415533	9815	2.36	7785	1489	6296
2004	512969	16608	3.30	12417	2308	10109
2005	503909	20164	4.00	14249	2085	12164
2006	462937	20381	4.40	15383	2355	13028
2007	426377	20801	4.90	15475	2118	13357
2008	421051	20631	4.90	15165	2390	12775

Source: Ministerstwo Sprawiedliwości

Figure 9.6. Final suspended and non-suspended imprisonment sentences under Acts of 1997 and 2005 on counteracting drug addiction in 1989-2008.



Source: Ministerstwo Sprawiedliwości

9.2. Prevention of drug-related crime

In 2009, the Ministry of Internal Affairs and Administration co-financed 5 anti-drug projects under the governmental prevention strategy for crime and social pathology entitled "It's safer together".

The strategy "It's safer together" is the first governmental plan whose primary goal is active support for local initiatives for the improvement of public safety and order. The strategy areas include assessing the safety status and the related needs, educating for safety, preventing family violence, preventing and reducing crime in children and adolescents, including peer violence, promoting technological developments (e.g. CCTV), protecting mass events (Ministry of Interior and Administration, 2010).

The Criminal Department of the Police Headquarters in cooperation with the Police Academy in the city of Pila developed a series of training workshops on detecting and combating drug-related crime. For example, the workshops focused on identifying new narcotic drugs. 30 police officers were trained (Police Headquarters, 2010).

The training course financed under "It's safer together" prepares members of county safety and order commissions to identify dangers, organize crime and misdemeanour

prevention actions and design county crime prevention programmes (Ministry of Internal Affairs and Administration, 2009).

In the reporting period, the respective strategy areas featured a number of actions performed by ministries, Police, Border Guard, State Fire Service, provincial governors and NGOs.

9.3. Interventions in the criminal justice system

No new data.

9.4. Drug use and problem drug use in prisons

In 2008, a survey of low threshold programme clients was conducted. Questionnaire interviews were held with 733 beneficiaries of the programmes at the turn of November and December (more information on study in Chapter 4). The survey included all needle and exchange programmes (13) in Poland in 2008. The survey participants were asked about incarceration in the last 12 months. 19% admitted that they had been in prison or custody in the last year prior to survey. This group were predominantly male (81%). If we consider age, the largest group were individuals aged 30-34 (27%). The individuals aged 25-39 accounted for three-thirds of all the incarcerated (69%).

Most individuals had been incarcerated only once in the last year prior to survey (71%); however, 14% had been incarcerated twice and 6% three and more times.

Almost half of the incarcerated admitted to using drugs in prison (44%). Almost every third used drugs intravenously (28%), and over a fifth (21%) shared syringes. 32% of the survey participants inhaled drugs in prison in the last year prior to survey.

If we analyze the group of the participants who had used drugs in prison, 62% injected drugs, and 73% of them shared syringes. 65% of drug users in prison inhaled drugs. (Malczewski, Struzik, Jaśkiewicz 2009, p. 20).

9.5. Responses to drug-related health issues in prisons (and other custodial settings)

- **Drug treatment (including substitution treatment)**

In 2009, in organizational units of the Prison Service the following programmes were implemented: abstinence-based programmes, substitution treatment programmes and drug prevention programmes. In 2009, 5 substitution treatment programmes were operational in

15 penal institutions (2 programmes were launched in the reporting period). Substitution treatment under these programmes was provided for 134 patients (60 in the previous year). They usually continued treatment started at liberty.

- **Drug prevention and harm reduction**

In Polish penal institutions there are no typical harm reduction programmes such as needle and syringe exchange. Officially, in Polish penal institutions there is no access to drugs. Consequently, there is no access to the injecting equipment. On the other hand, there are non-governmental organizations which upon approval of the management of penal institutions may enter the premises and conduct educational harm reduction programmes for psychoactive substance users. In 2009, the National Bureau co-financed 2 such programmes: one conducted by the Monar Association at Czestochowa prisons and remand centres in katowickie province; the other conducted by the Centre for Prevention and Social Education “Parasol” at the “Ruszcza” prison for women in Kraków. The above programmes included 225 participants. The programmes featured individual consultations, motivating for behaviour change, informative and educational classes in harm reduction, support groups and group sessions for patients of in-prison treatment wards. Moreover, there was cooperation with families of inmates, prosecutors, courts and personnel of penal institutions (Centre for Prevention and Social Education “Parasol” & Mrugasiewicz, Monar Association – Czestochowa branch, personal communication).

- **Prevention, treatment and care in infectious diseases**

In 2009, in organizational units of the Prison Service, 6-month structured drug-free therapy programmes were conducted. The programme goals were extended and included abstinence and relapse prevention. The programmes were based on the psychosocial intervention model and the social learning method. They also featured elements of the Minnesota model, the therapeutic community model and cognitive-behavioural interventions.

The abstinence-based programmes were conducted in 16 treatment wards. The wards offered 584 beds (549 in 2008, 513 in 2007), which allowed for including 1 654 inmates in the programmes (1 534 in 2008).

The therapeutic services were supplemented with prison-based drug prevention programmes conducted outside the treatment wards. In the reporting year 291 drug prevention programmes were conducted for 12 893 inmates (Health Office of Central Management Board of Prison Service, 2010)

In Polish penal institutions all inmates in need of treatment for infectious diseases are provided with antiretroviral therapy, regardless whether they have used drugs or not. In 2009,

antiretroviral treatment was provided for 181 inmates, including 134 with intravenous route of infection (188 and 152 respectively in 2008).

The Health Office of the Central Management Board of Prison Service does not have data on the number of performed tests for HIV, HCV, HBV, TB or the number of inmates diagnosed with drug-related infectious diseases. It is known that in 2009, there were 4 510 HIV lab analyses or tests. Tests proved positive in 251 cases, including 72 new cases. Moreover, in the reporting year laboratory analyses were carried out to detect HBV (8 407) and HCV (8 585). TB was detected in 781 inmates (Strzelecka, Health Office of Central Management Board of Prison Service, personal communication).

For more information on activities at penal institutions see Chapter 5. Drug treatment: availability and demand, Section 3: Characterization of patients in treatment, Sub-section: Drug treatment in penal institutions.

- **Prevention of overdose risk after release from prison**

In Polish penal institutions no such activity is performed.
See also Section “Drug prevention and harm reduction”.

9.6. Reintegration of drug users after release from prison

In Polish penal institutions drug addicts participate in vocational training programmes along with other inmates. In the Polish correctional system there are no statistics on the numbers of drug treatment graduates who were included in prison-based social reintegration programmes. It is known that most inmates who complete drug treatment are included in social reintegration programmes and many participants of social reintegration programmes are drug treatment graduates.

In social reintegration of inmates a post-correctional assistance is of key importance. There have been noticeable quality changes in the distribution of Post-correctional Assistance Fund, especially in the active forms of assistance. Approx. 60% of the overall costs of the assistance are earmarked each year for the implementation of tasks of raising social reintegration effectiveness in inmates released from prison. The resources were used to conduct specialist social rehabilitation programmes intended to improve legal competence of inmates, promote employment, vocational activity, prevention and treatment. Moreover, prisons obtained EU structural funds at PLN 84 million and started implementing the following programmes: raising effectiveness of institutions dealing with the labour market, social policy and social security; increasing vocational activity of disadvantaged or excluded

groups on the job market, preventing further social disruption in inmates and teaching coping skills. These programmes are expected to help inmates re-enter society smoothly.

The network of prison schools provides inmates, including minors under statutory obligation to learn, with an opportunity to pursue education. There are 10 prison centres of ongoing education and 9 school groups. Education is provided at 5 levels: primary, middle, vocational, secondary and post-secondary. An important element of education is vocational training provided in vocational schools. Education focuses on jobs that inmates are likely to perform after release from correctional facility. They are mainly service jobs popular on the job market such as small food and beverage business cook, painter, wallpaperer, wall tiler, floor tiler and many such like. Industrial jobs include mechanics, assembler of machinery and devices, mechanical fitter, shoemaker, electromechanical technician.

The educational offer for inmates are local market-specific training courses organized by penal institutions. They are mainly addressed to inmates completing their sentences in order to increase their chance of finding paid employment upon release from prison and prevent them from returning to crime. In 1 172 training courses organized in 2009 included 13 303 inmates.

Each year prison authorities conduct a number of social rehabilitation programmes aimed at reducing recidivism rates. In 2009, 1 941 such programmes were organized for the total number of 83 640 inmates, including:

- 338 drug prevention programmes for 14 127 inmates,
- 255 aggressive behaviour prevention programmes for 5 523 inmates,
- 288 vocational training programmes for 9942 inmates
- 55 Work Clubs for 1847 inmates.

10. Drug markets *prepared by Artur Malczewski*

Introduction

Drug seizures are reported by several services in Poland. Drug enforcement agencies have not worked out a single data collection system, which makes it difficult to conduct estimations of drugs seized in the whole country. However, in 2008 the Border Guard introduced a new system of collecting data which is capable of listing drug seizures performed not only by the Border Guard officers. This way, by using the Police and the Border Guard data, the total quantity of all drugs seized in Poland is estimated. Data are annually reported to the Information Centre for Drugs and Drug Addiction under the task of reporting the implementation of the National Programme for Counteracting Drug Addiction, annual questionnaires for the UNODC and EMCDDA. The Police do not collect data on the number of drug seizures. The information on prices of drugs is obtained from the Police and through surveys among drug users. Data on the purity of psychoactive substance comes from the Central Forensic Science Laboratory.

10.1. Availability and supply

Stemming the growth of trafficking in drugs and precursors to the internal market id one through regular operational cooperation between proper services internationally and across the country's borders. In 2009, the Police Headquarters cooperated internationally under several controlled shipment operations and the Barter operation connected with the trafficking in heroin from Turkey to the EU and synthetic drugs from Europe to the Middle East. The Main Pharmaceutical Inspectorate cooperated in the international control of precursors, specifically the control of export-import permits. In 2009, Pre-export Notification provisions were executed (Ministry of Health 2010). Last available data about perceived availability of drug was reported in National Report 2009.

- **Trafficking patterns and production**

Major drug trafficking routes go through the Polish territory. Drugs are transited or they are directly exported from Poland to the Western European markets.

Removing borders upon Poland's accession to the Schengen area made trafficking in Polish amphetamine to Western Europe easier. Moreover, high economic migration of Polish citizens to the United Kingdom and Ireland is used by crime syndicates for amphetamine trafficking. Polish amphetamine reaches such countries as Germany, France, Sweden, the United Kingdom and Ireland. Drugs, especially amphetamine, are smuggled to Scandinavian countries by sea from Polish ports. They are hidden in commercial vehicles or special

passenger car compartment. To ease drug trafficking crime syndicates place their residents in Scandinavian countries. Apart from being smuggled in cars or lorries, amphetamine is trafficked to Western Europe by train. The drug is also smuggled in liquid form (217 ml was seized in 2009 by Police). Shipment and post agencies are sued to smuggle amphetamine to the USA and Australia.

Cocaine is trafficked from South America to Poland to by sea e.g. in containers. It is also shipped by air. Citizens of Poland and other countries are also used as cocaine couriers. By swallowing specially prepared cocaine capsule they can smuggle even up to 1kg of the drug. In December 2009 a Nigerian citizen was caught smuggling 0.5 kg of cocaine in 33 capsules. Cocaine is also trafficked to Poland by air in luggage-based hidden compartments.

Heroin reaches Poland mainly from Afghanistan trafficked by the Balkan route (Turkey-Bulgaria-Romania-Hungary) or the silk route (former Soviet Union republics). Turkish citizens and Turkish shipping companies are involved in heroin trafficking. There are also citizens of the Commonwealth of Independent States from Uzbekistan, Tajikistan and Kirgizstan. In recent years a rise in heroin seizures at Poland-Ukraine border crossings has been recorded. From Poland heroin is trafficked to Germany and the United Kingdom. Ecstasy is smuggled from Poland to the Netherlands and Belgium. In turn, from the Netherlands cannabis is trafficked to Poland (Raczkowski 2009, pp. 116-118). In recent years a rise in the domestic cannabis crops by crime syndicates has been recorded. It may be concluded that cannabis on the Polish market is increasingly originating from domestic production. Heroin on the Polish market comes from manufacture in Poland, which was substantially reduced by the introduction of low morphine poppy and to a large extent from trafficking. The domestic manufacture is evidenced by ‘kompot’ seizures. This Polish homemade type of heroin is manufactured exclusively in Poland. Amphetamine on the Polish market comes from Polish clandestine labs. However, ecstasy containing MDMA, MDE, and MDEA is unlikely to originate in Poland and reach the Polish market from other countries.

10.2. Seizures

In Poland drug seizures are revealed by the Police, Customs Service (by the Ministry of Finance), Border Guard, Military Police, Internal Security Agency and Prison Service in penal institutions. All the above institutions have not developed a single data collection system, which makes it difficult to estimate the quantities of drugs seized across the country. As in some cases there are at least two institutions involved in revealing data, double counting occurs. Due to high discrepancies in drug seizure quantities and the considerable role of the random factor, the trend analysis is seriously hampered. It must be remembered that certain quantities of drugs seized by Polish services were destined for foreign markets. In 2008, the Border Guard introduced a new data collection system thanks to which it is possible to

extract drug seizures performed only by the Border Guard officers. The introduction of the system substantially reduced double counting of the same seizures in Poland.

In 2009, the Police completed the process of establishing drug enforcement structures within the criminal department. The respective drug enforcement units are mainly responsible for combating drug-related crime on local markets. In 2008-2009, the Police increased drug enforcement workforce by nearly 1 000 officers. Police seizures in 2009 are presented in Tables 10.1. (with Border Guard), 10.2. and Figure 10.1. In 2009, there was a twofold increase in marijuana seizures (883 kg), a record high since 2000. However, hashish seizures fell more than sixfold (17 kg). The quantities of heroin seized rose to 85 kg (from 79 kg in 2008). Cocaine seizures increased almost fourthfold (117 kg). Amphetamine seizures reached the level of 2007 i.e. 422 kg (2009) after a drop in 2008. In the case of two drugs, a fall was recorded – hashish and ecstasy. There have been small LSD seizures in recent years. Numbers of revealed LSD pieces were far higher five, six years ago.

Table 10.1. Drug seizures in Poland in 2000 – 2009.

Drug	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Hashish (kg)	181.863	104.554	794.516	46.568	41.495	19.292	35.401	33.128	114.681	17.142
Marijuana (kg)				233.164	232.646	227.124	401.659	352.934	492.725	883.053
Heroin (kg)	216.782	388.66	585.705	6.913	255.214	41.151	155.401	123.623	78.915	85.873
Cocaine (kg)	80.664	50.549	423.48	800.558	28.029	16.871	21.932	160.981	28.710	117.491
Amphetamine (kg)	1051.36	195.651	172.588	203.299	242.034	344.578	333.038	423.65	356.196	421.65
Methaphetamine(kg)							0.163	5.712	0.124	10.069
Ecstasy (tablets)	139133	239124	64452	102520	272198	492531	145344	610383	651 985	218616
LSD (dose)	3809	672	797	20602	34288	2226	1453	327	353	642

Sources: Malczewski 2010m, p 20.

Moreover, the Police in 2009 (Table 10.2.) located 99 illegal high-morphine poppy plantations of the total area of 85 953.53 m², 4 illegal plantations of plants containing psychoactive substances including 17 plants of dream herb, 2 home plantations of hallucinogenic mushrooms and 7 plants of Diviner's Sage (Table 10.2).

Table 10.2. Police seizures in 2008 and 2009 – Police Headquarters data.

	2008	2009
poppy straw	2 098 kg	995.85 kg
„Polish heroin"	14601 cm³	4 295 cm³
hallucinogenic mushrooms	6 020 mushrooms	4 404.3 g
liquid amphetamine	-	417.4 ml
BZP	-	5 tablets
BMK	20 l	74 l
Diviner's Sage	-	1 800 g and 7 plants
Dream Herb (calea acatechichi)		17 plants
Metadon	3711 cm³	-
Khat	1709 g	-
Rohypnol	24015 tablets	-

Sources: KGP

A great majority of Border Guard seizures were jointly listed with Police seizures in Table 10.1. Apart from these seizures, the Border Guard located 3 illegal Indian hemp plantations of low area and 2.5 litres of hash oil 6 litres of BMK (Ministry of Health, 2010).

Table 10.3. Border guard seizures in 2009 – data of the Border Guard.

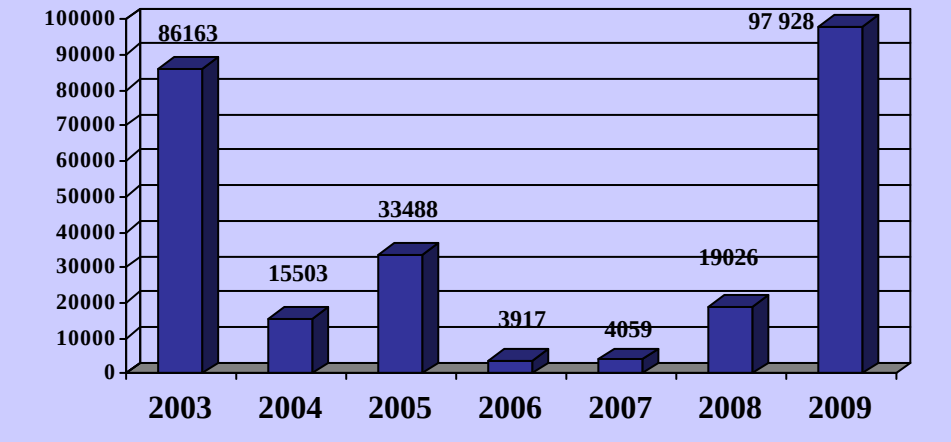
	2008	2009
Hash oil	-	2 500 ml
BMK	-	6 l
PIKO (methamphetamine)	-	2 g
Nitrazepam	-	11 298
Poppy straw	-	50 kg
„Polish heroin"	-	700 ml and 20 g
Hallucinogenic mushrooms	-	36.3 g and 466 mushrooms
barbiturates	-	5.69 g
Morfina	0.4 ml and 1.29 g	-
Testosteron „Enanthate 250"	3 250 mg	-

Sources: Straż Graniczna

Raids of illegal marijuana plantations are recorded in the statistics of services combating illegal drug markets. Most plantations are detected by the Police. Police data for 2006-2009 raids of illegal marijuana plantations under combating retail trade presented in Table 10.4. are reported in the course of the implementation of the National Programme for Counteracting Drug Addiction. The highest number of marijuana plantations was recorded in 2009 – 422 plantations of the area of 31 246 m^2. In 2009, the highest number of seized

marijuana plants was recorded (97 928), which constitutes an increase of nearly 500% compared to 2008.

Figure 10.1. Police marijuana seizures in Poland in 2003 – 2009: plants.



Sources: Malczewski 2010m, p 20.

Table 10.4. Police raids of illegal marijuana plantations in 2006-2009: Police Headquarters data.

	Number of detected plantations	Area of detected plantations (m^2)	Number of detected marijuana plants
2006	10	n.a.	5899
2007	128	7408	23900
2008	123	18435	16335
2009	422	31246	97928

Sources: Malczewski 2010m, p 21.

Detailed data on Police raids of illegal marijuana plantations in 2009 and the total quantity of the drug seized are presented in Table 10.5. The available information refers to 52 raids of illegal plantations both indoor and outdoor in 2008 and 54 in 2009.

The 2008 data were reported by the Police for the purposes of a special chapter of National Report 2009. The 2009 data are the result of following the Police Headquarters website, where the Police provide information on drug seizures, including illegal marijuana plantations.

At present, there is no data collection system for cannabis cultivation. However, developing and implementing the monitoring system for illegal cannabis cultivation is planned under the National Programme for Counteracting Drug Addiction 2011-2016.

In the majority of the raided plantations (30) in 2008 and 2009, the quantity of marijuana output ranged between 1 kg and 50 kg The total quantity of marijuana seized in 2009 was 383 kg (on the plantations from 1 kg to 50kg). In the case of 11 plantations an individual seizure ranged between 150 g and 1 kg and the total quantity of the drug seized was almost 6 kg. Only on 4 plantations a single seizure was not more than 150 g with the total quantity of less than 0.5 kg.

The available data show that in 2008 there was only one raid of marijuana plantation in Poland with more than 50 kg of the drug output; however, in 2009 there were five such raids. The quantity of marijuana likely to be produced from the raided plantations exceeded more than twofold.

Table 10.5. Number of illegal marijuana plantations and the total quantity of marijuana seized in 2008-2009 (detailed data: 54 seizures in 2008 and 52 in 2009) – Police headquarters data.

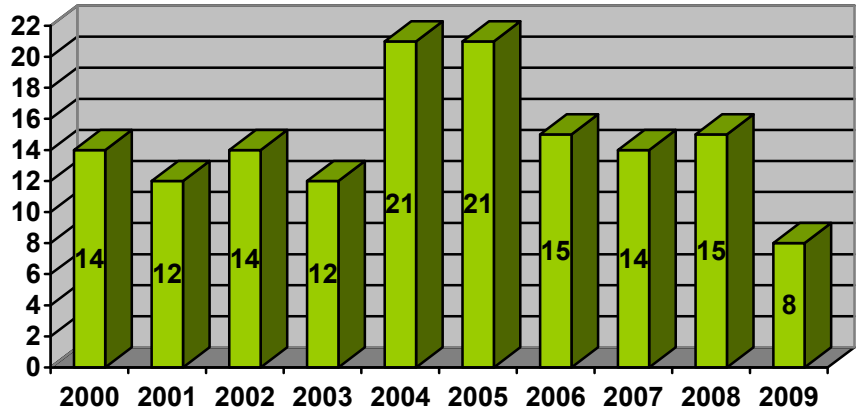
Quantity range of marijuana seized	2008		2009	
	Number of plantations raided	Total quantity of marijuana seized (kg)	Number of plantations raided	Total quantity of marijuana seized (kg)
0-150g	4	0.4	4	0.308
more 150g - 1kg	19	7.6	11	5.852
more 1 kg - 50kg	30	305.7	32	383.196
over 50kg	1	88	5	538.318
Total:	54	401.7	52	927.674

Sources: Malczewski 2010m, p 22.

In 2009, 80 litres of BMK were secured (74 litres by the Police and 6 litres by the Border Guard). BMK is a precursor used in amphetamine manufacture. Poland, along with Belgium and the Netherland, is a leading amphetamine manufacturer. In 1995-2009, 179 clandestine laboratories were raided in Poland. The most clandestine labs were detected in 2004-2005 (21 in each year). Since then, 15 clan labs were raided each year (Figure 10.2.) till 2009, when the number almost halved to eight. In 2008, 257 amphetamine profiles were carried out and 190 in 2009. Polish clan labs are not big drug manufacturing sites with 2-5 technological lines, sometimes more.

Amphetamine in Poland is most frequently manufactured using Leuckart method. The manufacturing process and distribution of the drugs is handled by organized crime syndicates. Only one small scale MDMA laboratory and one GHB laboratory were detected in Poland in 2005. In 2007 and 2009 methamphetamine manufacture was revealed (a single lab each year). The Police record various modi operandi of criminal groups, which started to share the respective amphetamine manufacturing stages. Consequently, the stages take place in various locations. Moreover, there is greater self-control and secrecy in order to prevent detection by the Police. In recent years no manufacturing of MDMA, MDA or MDEA has been revealed. However, tableting machines are confiscated. They are most likely used to produce tablets containing amphetamine, PMMA or methamphetamine (Raczkowski 2009, pp. 113-114).

Figure 10.2. Number of clandestine laboratories raided in 2000–2009 – Police Headquarters data.



Sources: Malczewski 2010m, p 23.

10.3. Price/purity

- **Price of illicit drugs at retail level**

Data on prices of drugs are recorded by the Police. However, there is no system which would ensure regular collection of data on drug prices according to the European standards. Polish prosecutor's offices or courts do not require reporting the value of drugs secured so drug prices are not significant from the perspective of the proceedings or trial. The information on the value of drug seizures is often reported by the media. Thanks to such information it is easier for the public to imagine what loss has been incurred by the criminal world as result of the Police actions. The information on seizing PLN 90 000 worth of drugs is more suggestive than the information on seizing 3kg of marijuana. Therefore, drug prices are collected mainly for the purposes of international reporting.

Analyzing drug prices it is worth noting that the price of a drug is affected by a number of factors e.g. geographical location, drug purity, intensity of police actions and the international situation. In order to obtain relatively reliable data on drug prices they must be collected according to a specific methodology from as many sources as possible.

The Police data collection system does not provide data which would precisely reflect retail prices on the drug scene. Consequently, these data must be regarded as estimates. Despite these limitations, data interpretation seems feasible; however, the information provided in the chart must be regarded as approximate.

The most recent available data on average prices of drugs on the illegal market come from 2008. The Police do not have data for 2009 on retail drug prices according to the EMCDDA definition. There is only information on minimum and maximum price and the most prevalent price (modal price). As a result, the 2009 data cannot be compared to the data from previous years. The data on drug prices are also collected under research conducted by the Information Centre for Drugs and Drug Addiction (CINN).

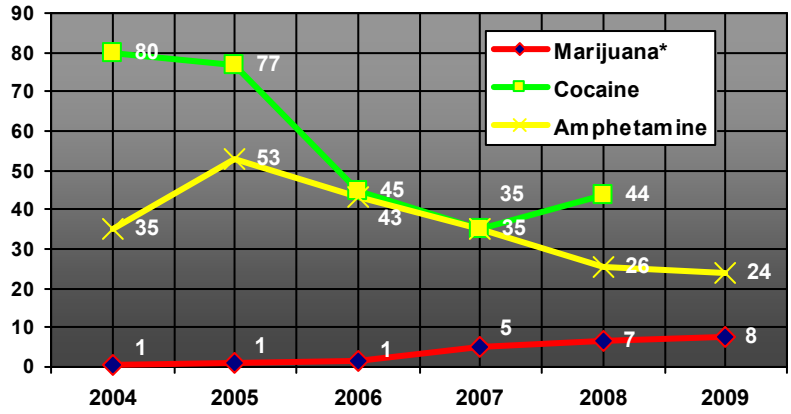
In 2008, for the first time it was possible to obtain drug prices under the survey of client of needle and syringe exchange programmes. The measurement will be repeated in 2010. However the information for 2009 is not available. This year the information on drug prices will be complemented with the results of the analysis of the drug user's online forum. Coming back to the Police data the following minimum, maximum and modal retail prices of drugs in 2009 should be noted: marijuana - EUR 7 (minimum 4 – maximum 12), hashish - EUR 7 (4-13), heroin EUR 50 (25-90), cocaine - EUR 60 (32-65), amphetamine - EUR 9 (5-25), ecstasy - EUR 3 (2-7), LSD - EUR 6 Euro (3-11).

- **Purity/potency**

Based on the Police data and qualitative research conducted in drug users, we know that the purity of drugs sold on the illegal market varies substantially. The lack of a single data collection system on drug purity hampers the interpretation of data. Figure 10.3. shows data obtained from the Central Forensic Science Laboratory. The average purity of cocaine and amphetamine in 2007 was approximately 35%. The most recent data indicate a fall in the purity of amphetamine (24% in 2009). However, it must be stressed that the information from the previous years, especially concerning cocaine, seems to be based on large seizures, where purity is much higher compared to substances sold in retail trade. THC concentration in marijuana in Poland is similar to Western Europe. According to EMCDDA data the concentration of THC in marijuana in western European countries ranges from 6 to 8% (King 2004). The 2009 Polish data show that the average THC concentration stood at 8%. We have been recording a rise in THC concentration for several years. It must be stressed here that the low THC level of approx. 1% in the 2004-2006 period might have been caused by

including samples of fibrous hemp in the average. THC concentration in fibrous hemp is very low. Consequently, it resulted in low THC concentration in marijuana. Since 2007, apart from the minimum and maximum purity of drugs, we have had modal value i.e. the most prevalent. In 2009, it was 6% for marijuana, 17% for amphetamine (in 2008, 4% for marijuana and 30% for amphetamine). According to the 2009 data, 27% of ecstasy tablets contained MDMA, MDEA, MDA; 33% contained amphetamine with MDMA, 12% only amphetamine, 5% other scheduled substances and 7% miscellaneous substances (Figure 10.4.).

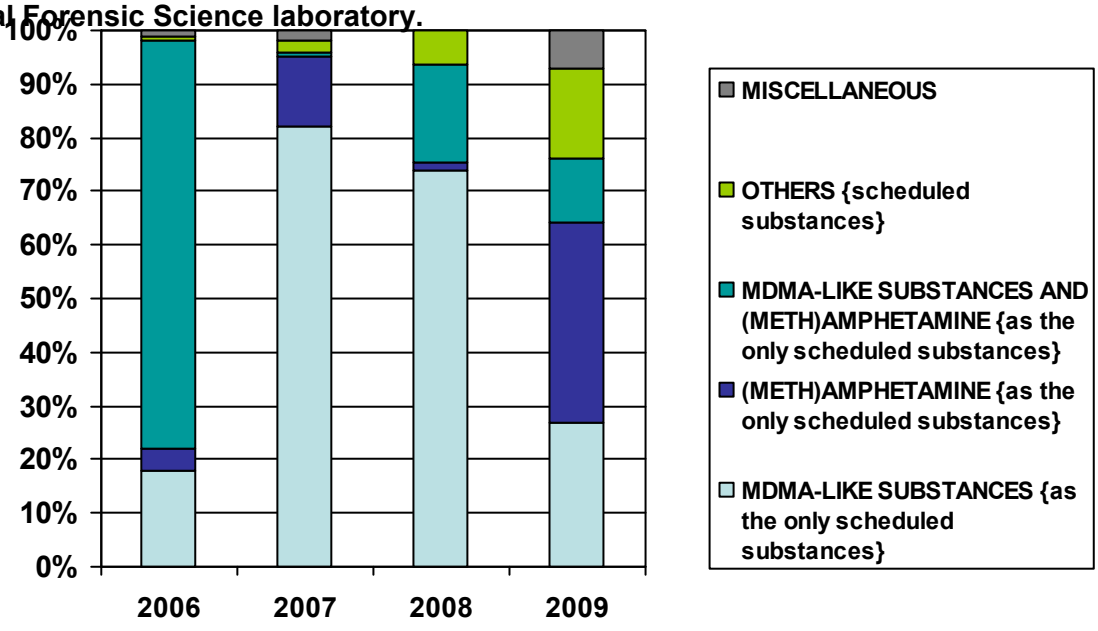
Figure 10.3. Drug purity and THC concentration in marijuana on the illegal market in 2004–2009 (%) – data of Central Forensic Science Laboratory.



Source: Central Forensic Science Laboratory data processed by CINN

*percentage value of THC concentration in marijuana

Figure 10.4. Percentage composition of ecstasy tablets in 2006 – 2009 – data of Central Forensic Science laboratory.



Source: Central Forensic Science Laboratory data processed by CINN

Part B: Selected issue.

11. History, methods and implementation of national treatment guidelines

Preapered by Marta Struzik

In Poland, the system of specialist substance dependence treatment is part of the health care system for individual with mental disorders. Running programmes for individuals dependent on psychoactive substances is not ruled by guidelines or readymade standards of therapeutic conduct. Substance treatment in Poland is based on the model of learning through practice and a number of strategies developed by non-governmental organizations are successfully implemented in treatment units.

The system of drug treatment is based on a wide range of services and therapeutic methods that fit the patient's needs. Health care services are provided through inpatient and outpatient clinics, which hold the status of public or non-public health care units. Assistance methods for drug dependent individuals fall within two main areas: psychosocial methods and pharmacological treatment. Psychosocial methods include a therapeutic community, cognitive-behavioural psychotherapy, 12 steps therapy, case management and self-help groups. In practice, treatment units combine these approaches. Pharmacological treatment is mainly provided through substitution treatment programmes and detoxification. Specific requirements regarding the conduct of substitution treatment are defined in the regulation of the minister competent for health matters.

Despite the lack of clear guidelines concerning the medical conducts in Poland, efforts are made to maintain the high quality of services provided. Consequently, standards in drug treatment, rehabilitation and harm reduction programmes as well as the accreditation system of treatment units have been developed. The accreditation in health care covers the examination of a health care unit in terms of meeting the requirement set out by the accreditation standards and, if successful, awarding accreditation to the unit. Standards in drug treatment, rehabilitation and harm reduction programmes have been developed by the expert team of the Minister of Health. Standards of countries which enjoy a long tradition of quality assurance, especially the United Kingdom and the United States, were used in the process. The standards refer to the issues of patient's rights, ensuring the continuity of treatment, improving quality of services, controlling infections and meeting standards on medical drugs.

In Poland, the system of training professionals in drug therapy and rehabilitation has been put in place. It is based on the requirement of completing a specialist training course approved and certified by the minister competent for health matters.

An additional element is the introduction of the Drug Therapist's Code of Ethics. It was developed in response to the needs of the community of drug therapists regarding increasing the control of ethical matters among staff of the drug treatment system. The Code does not constitute universal law; however, the consent of a therapist to be listed as a member of the Code obliges him or her to follow principles and standards defined therein.

12. Mortality related to drug use: a comprehensive approach and public health implications

prepared by Janusz Sierosławski

Introduction

Drug addiction has always been related to a number of health and social problems. In recent years, they have been augmented by AIDS epidemics. It is widely evidenced (Willie 1981, Perucci et al 1991, Brenner, Hernando-Briongos, Goos 1991, Papaevangelou and Richardson 1995, Uitzinger 1994, Moskalewicz, Sierosławski 1984, 1992). A number of studies show upward mortality trends among drug dependent population. The trends vary greatly depending on the region.

Death is the gravest and most dramatic consequence of drug addiction. The issue of high mortality is raised in public debates devoted to this problem.

Drug-related mortality has been the subject of three studies in our country.

The first study included all patients diagnosed with ICD 9 code 304 (drug dependence) in residential treatment in Poland in 1974 (Moskalewicz, Sierosławski 1984). The next study included patients treated in 1984 (Moskalewicz, Sierosławski 1992). In both studies, the follow-up period was 4 years.

The issue of drug-related mortality became the subject of international studies launched in 1992 by the World Health Organization. The studies were coordinated by the Lazio Department of Epidemiology based in Rome. It collected and processed data from six project partner countries. The aim was to measure the trends and regional variations of mortality among injecting drug users. Nine cities of six European and American countries were included in the study: Liverpool and Glasgow (United Kingdom), Barcelona (Spain), Torino, Rome and Naples (Italy), Moscow (Russia), Warsaw (Poland), New Heaven (United States). The study was longitudinal and retrospective. The follow-up period was 10 years, in most cases since the beginning of the 1980s up to 1992. The study participants included patients of selected drug treatment units, who entered treatment in the study period.

The study featured a different sample selection method. Instead of a national study of all patients hospitalized in a single year, the study included all patients in one treatment unit over the period of 10 years. The fixed follow-up period was replaced with a varied one. This methodology change does not preclude outcome comparison; however, it reduced the cost of the study implementation.

The application of the new approach allowed for following mortality trends over longer periods. In the 10-year follow-up period, crude mortality rates increased from 12 cases per 1000 person-years to over 30 in 1991-1992, which is compliant with the trends in Poland and

worldwide. Higher mortality rates were contributed by progressing social exclusion of the drug community, the emergence of new and more potent substances and the outbreak of HIV. The follow-up studies of 1974-1978 and 1984-1988 mean yearly mortality rates stood at 16-17 per 1 000 population, in the whole follow-up period of 1983-1992: 23 per 1 000 population and in 1991-1992: as many as 30 per 1 000 population.

What is intriguing in our studies is not the upward trend but a momentary twofold fall in mortality rates, which took place in 1989-1990. In 1991-1992 the rates increased to a level not recorded before. The fall might have been the reflection (and the confirmation) of the decreasing prevalence of drug addiction in Poland, which was recorded in medical and police statistics in the second half of the 1980s. A momentary fall in mortality among drug addicts might have been affected by profound economic and social transformation, which (at least initially) strengthened social bonds and weakened repressive role of the state and law enforcement agencies. Another outbreak of drug addiction, which took place at the beginning of the 1990s, was dramatically reflected in the sharply rising number of deaths.

12.1. Recent follow up mortality cohort studies among PDUs

- **Overall mortality among PDUs**

Aim

The study was aimed at estimating mortality rates with reference to problem drug users. Moreover, the study was to compare the mortality expected in problem drug users to the analogous parameter in the general population and to identify predictors for the risk of death among drug addicts.

Method

The study adopted the methodology recommended by the EMCDDA in “Mortality of drug users in the EU: coordination of implementation of new cohort studies, follow-up and analysis of existing cohorts and development of new methods and outputs. EMCDDA Scientific Report 2002”.

The study was implemented by means of the longitudinal and retrospective method. It included all residential drug treatment patients between 2000 and 2004. The observation period covered the years 2000-2006 i.e. all deaths in the study group in this period were recorded. The beginning of observation period is case specific and it is defined as date of first treatment entry. The end of observation period is set to 31.12.2006 or date of deaths if it happened.

Crude mortality rates per 1 000 person-years of observation, standardized mortality rates and standardized mortality ratios were calculated. By means of Kaplan-Meier survival analysis the risk of death in respective points in time was determined. The logistic regression analysis was applied to identify predictors that might increase the risk of death.

The study input data came from residential psychiatric drug treatment (ICD 10 codes: F11-F16, F18, F19). It means that the study included any drug users. Unfortunately the information on drug use pattern is not the treatment data.

The first step was to prepare a set of all patients admitted to drug treatment in 2000-2004. It required the elimination of double counting in different periods. While the residential treatment data were free from double counting, it only referred to respective years. If the same patient emerged over the years, the set always included only his or her first stay in the study period.

In 2000-2004, the total number of 54 215 residential treatment patients admitted due to drug problem was recorded (ICD 10 codes: F11-F16, F18, F19). The elimination of double counting of the same patients over the five-year study period decreased this number to 41 359.

The next step was the analysis of the state electronic database of residents (PESEL) to find out whether the selected individuals were alive or dead. The identification used a code which consisted of initials (first two letters of first name and first two letters of surname), date of birth and gender. The input data and the data obtained in the course of the study were kept confidential. Upon closing the output database, the identification elements such as initials were removed from the set. The data obtained in the course of the study are used in statistical analyses and they are presented only in the form of aggregated breakdowns, which prevents personal identification. Individual data are strictly confidential.

Outcome

Out of 41 359 residential drug patients in 2000-2004, 11 915 (28.8%) could not be identified in the state database of residents (PESEL). The fact of being dead or alive was clearly determined in 22 984 patients (55.6%). In such cases there was full conformity of all the input data and the PESEL data. In the remaining 6 460 patients, only some elements of the PESEL database could be identified as not all elements of the identification code conformed. The mortality analysis included only 22 984 fully identified cases. The inability to identify so many patients in the PESEL database seems to have several reasons such as changes to the personal identification code (women who changes surnames after getting married, the problem of two first names or surnames, etc.), lifestyle of individuals with a drug problem who do not care about their proper legal or administrative status, inefficiencies in patient registers and presumably incorrect data in databases. Consequently, such a

considerable reduction of the sample seriously hampers the study's reliability and the representative quality of its outcome.

Numbers of patients entering treatment grew substantially over the years. However, due to the reappearance of the same patients, the numbers of the respective cohorts are fairly balanced and range from 3 811 in 2001 to 4 961 in 2004.

The study group included mostly males – females accounted for only 25.3%. The age distribution of patients under study at the onset of treatment is strongly skewed; the median age is 25-29. More than half of the patients fall within the ten-year range of 20-29 (52.1%). Younger patients accounted for only 5.4% while the older – 56.5%. As the age grew, the proportions of patients fell. In the oldest age group (65 and older) there were 2.1% of the study participants.

As for marital status, the study participants were mainly single (70.7%) and 19.2% were married. The proportion of divorced participants was 6.8% and only 0.2% declared living with a partner as if being married.

The education distribution is partly connected with the age distribution and seems to be related to the lifestyle – nearly 70% of patients had primary education while only 3.1% graduated from college.

The participants were largely supported by family (44.2%), only 9.7% had a job. A considerable proportion lived off disability benefit (14.0%) or unemployment benefit (9.9%).

According to treatment units, the last treatment episode in the follow-up period, which served as the cohort placement criterion, in most cases resulted in improvement. Only 6.7% of the patients were considered fully recovered.

Most of the study participants entered residential treatment for the first time before turning 25 (58.6%). A considerable group first entered treatment after turning 35 (18.5%). Consequently, in the majority of the study participants the period since the first treatment episode was not longer than 4 years. The proportion of patients who entered treatment for the first time 9 or more years ago stood at 13.1%.

In the 7-year observation period (2000-2006) of the five cohort of patients admitted to treatment in 2000-2004, 1 744 died i.e. 7.6% of the study population. As Table 12.1 shows, the most deaths were recorded among patients admitted in 2000 (632) and the fewest in the 2004 cohort (188). Comparing death numbers in the respective cohorts might be confusing as the number depends on both the cohort population and the duration of the observation period. Therefore, for comparison purposes the mortality rate per 1 000 person-years of the observation must be used. It is also called the crude mortality rate. The last column of the table shows a clear downward trend in 2000-2002, the trend decline in 2003 and another fall in 2004. We may speak of a fall in the indicator in the whole period, from 23 deaths per 1 000 person-years to nearly 16 deaths per 1 000 person-years.

Table 12.1. Distribution of deaths in respective cohorts 2000-2004 and the observation period 2000-2006.

Cohorts	Number of patients	Number of person/years	Number of deaths	Crude mortality rate per 1000 person/years
2000	4677	27789	632	22.74
2001	3811	19900	333	16.73
2002	4727	20335	317	15.59
2003	4808	16080	274	17.04
2004	4961	11933	188	15.75
Total	22984	96038	1744	18.16

The assessment of the mortality trends in the respective years of the observation for each cohort is possible through the application of the survival analysis. Simultaneous inclusion of the observation length variable in the analysis and the different onset of observation allows for eliminating distortions and determining the proportion and probability of death in the respective years in each cohort.

Table 12.2 shows that the numbers of deaths in the following years decrease in each cohort, despite the longer observation length in the respective years.

Table 12.2. Life Table (Survival analysis).

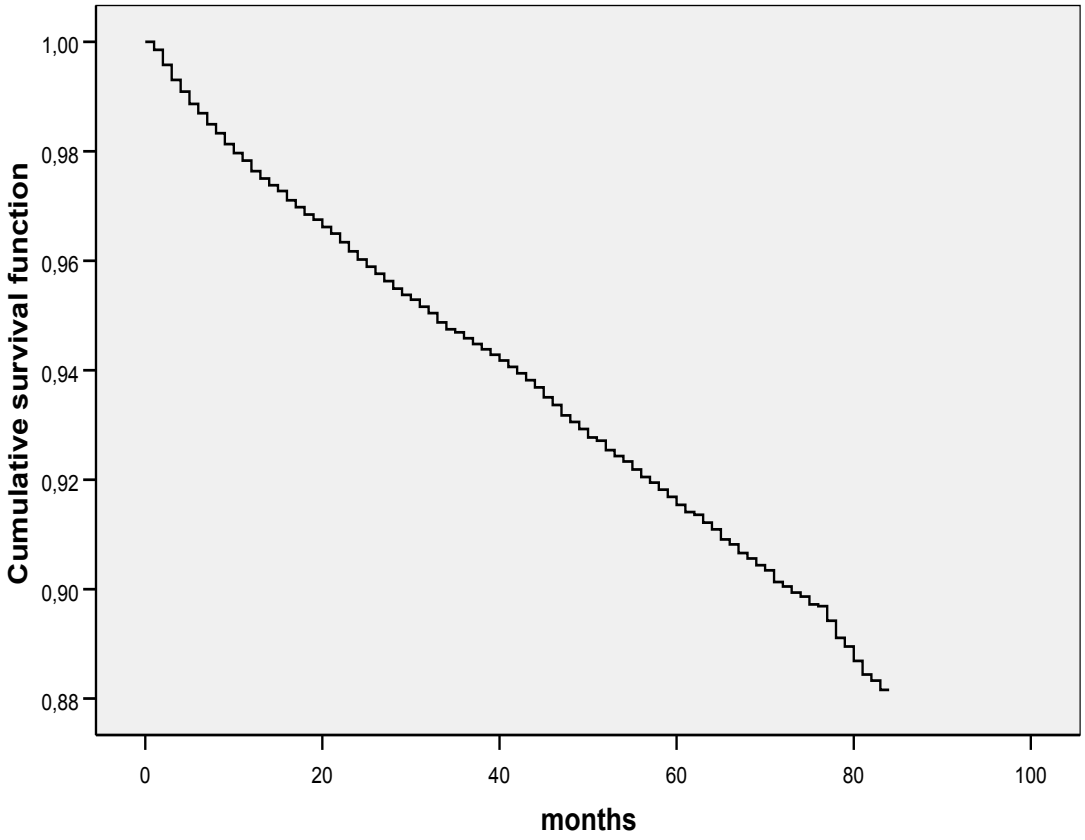
Interval Start Time (years)	0	1	2	3	4	5	6
Number Entering Interval	22984	22428	22053	16996	12232	7749	4085
Number Withdrawing during Interval	0	0	4767	4535	4319	3571	4043
Number Exposed to Risk	22984,0	22428,0	19669,5	14728,5	10072,5	5963,5	2063,5
Number of Terminal Events	556	375	290	229	164	93	37
Proportion Terminating	0,02	0,02	0,01	0,02	0,02	0,02	0,02
Proportion Surviving	0,98	0,98	0,99	0,98	0,98	0,98	0,98
Cumulative Proportion Surviving at End of Interval	0,98	0,96	0,95	0,93	0,92	0,90	0,89
Std. Error of Cumulative Proportion Surviving at End of Interval	0,00	0,00	0,00	0,00	0,00	0,00	0,00
Probability Density	0,02	0,02	0,01	0,01	0,02	0,01	0,02
Std. Error of Probability Density	0,001	0,001	0,001	0,001	0,001	0,001	0,003
Hazard Rate	0,02	0,02	0,01	0,02	0,02	0,02	0,02
Std. Error of Hazard Rate	0,001	0,001	0,001	0,001	0,001	0,002	0,003

The fall in the numbers of deaths was irregular across the cohorts. In the 2003 and 2004 cohorts in the second year of the observation there was a slight increase in the numbers of deaths to be followed by a decrease after that period.

As Table 12.2 shows, the death rates range from 0.01 to 0.02, which means that they are fairly stable in the study period. After the whole observation period 89% of the study participants survived.

The survival function in Figure 12.1 shows a relative risk by month of observation. The relatively stable downward trend is noted.

Figure 12.1. Survival function (cumulative proportions of participants who survived following months of observation).



The function of death risk by moths of observation (Figure 12.2) indicates a lightly higher risk in the period of first 18 months following treatment and after 70 months following treatment entry.

Figure 12.2. Function of deaths risk.

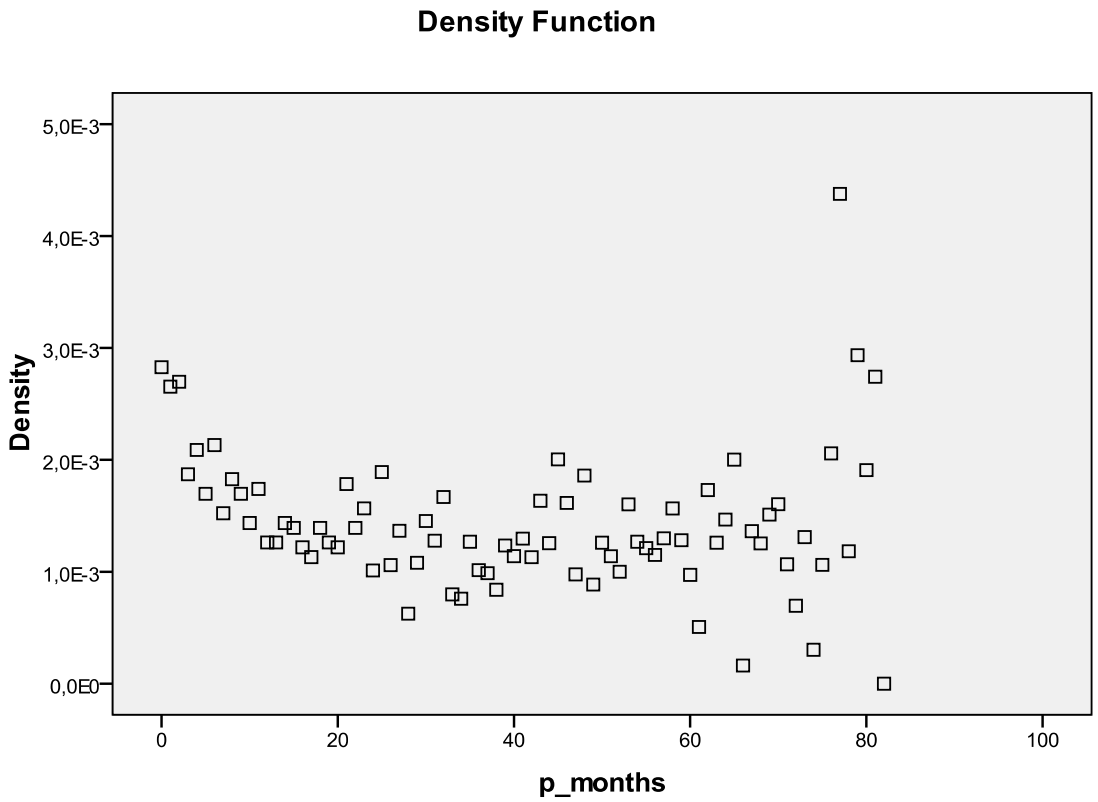
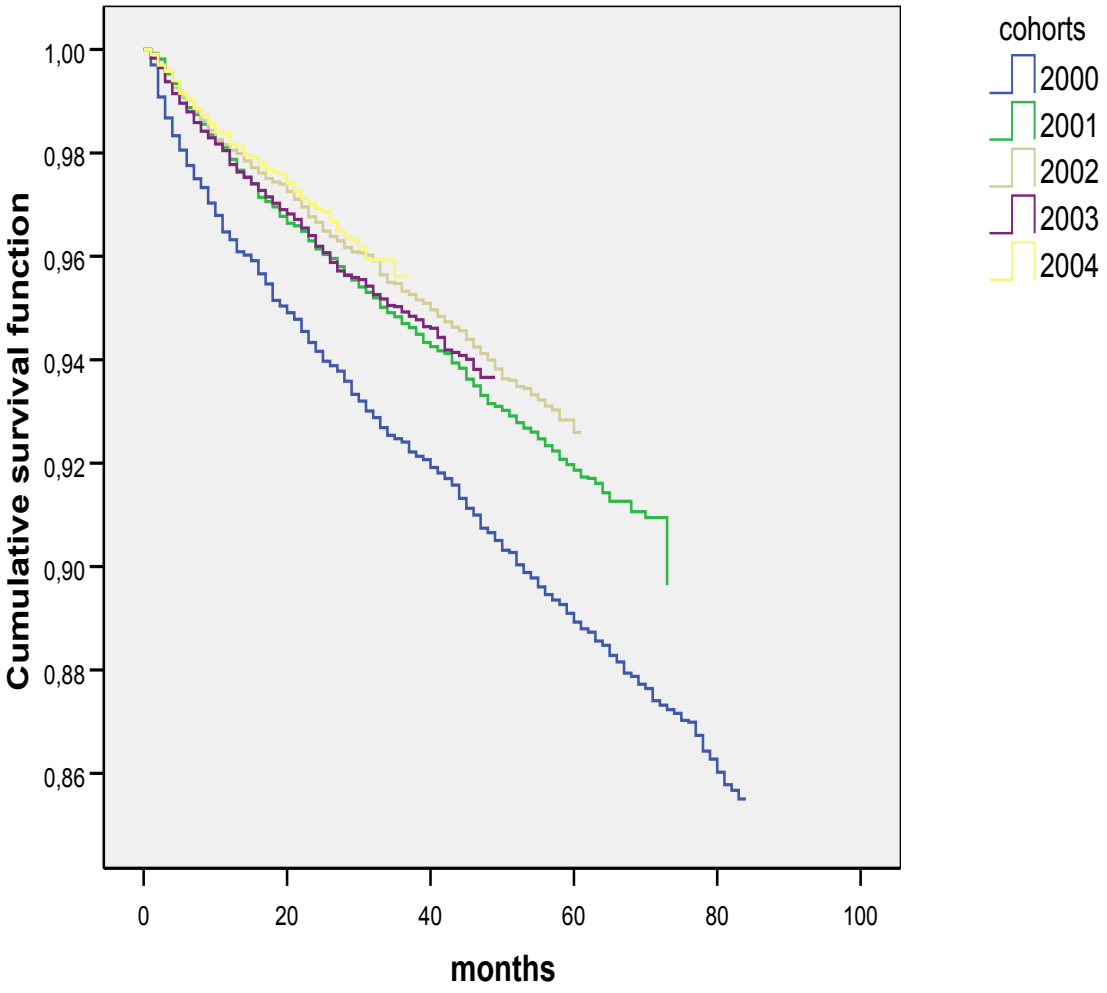


Figure 12.3 shows that the proportions of patients who survived at least 3 years of the observation in the older cohorts are lower compared to the cohorts included in the study later – 90% of patients admitted to treatment in 2000 survived at least 3 years, 93% of those admitted in 2001 and 94% admitted later on.

Figure 12.3 shows that patients included in the study in 2000 present far higher mortality rates compared to the patients admitted in the following years.

The distribution of probability of death measures and the risk of death measures in the respective years for each cohort confirm the thesis of a downward mortality trend in drug addicts in 2000-2005 and a rise in 2006.

Figure 12.3. Survival function by cohorts.



The distribution of deaths in the respective years is presented in Table 12.3. The number of deaths rises over the years from 99 in 2000 to 358 in 2004. In the following years the death figure fell to 341 in 2005 and further down to 308 in 2006. The death trend in the respective years does not reflect changes in the mortality as in that period the number of individuals in observation changes as well as the length of observation for particular participants and the resulting probability of death was different.

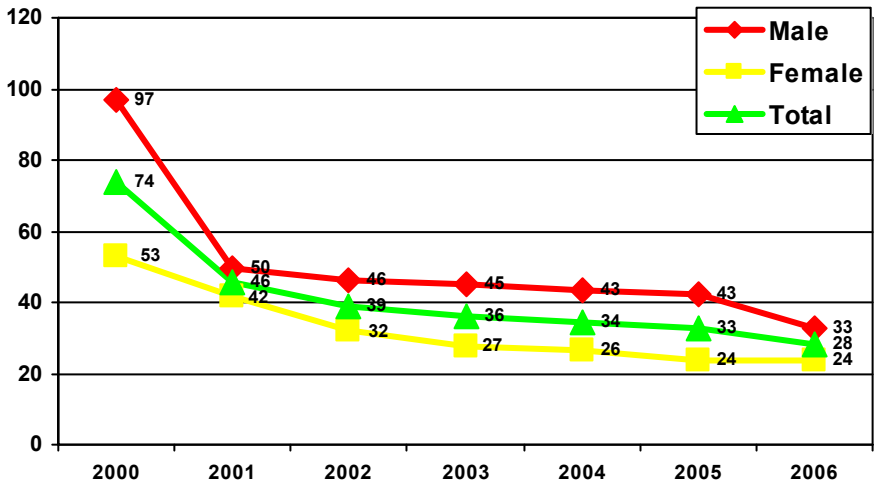
Standardized mortality rates (Table 12.3 and Figure 12.4) demonstrate a downward trend. A sharp fall occurred in 2001 and than in 2005.

The differences between males and females were rather high in 2000 and decreased significantly in 2001. During period of 2001-2005 these differences gradually were increasing and in 2006 again decreased.

Table 12.3. Standardized mortality rate by gender and year of deaths.

	Males			Females			Total		
	Per-years obs.	Number deaths	Std. rate	Per-years obs.	Number deaths	Std. rate	Per-years obs.	Number deaths	Std. rate
Overall	72244	1326	50,7	23793	418	32,5	96038	1744	41,2
2000	1603	84	96,9	449	15	52,8	2051	99	73,9
2001	4948	123	49,7	1398	34	41,8	6346	157	45,6
2002	7886	177	46,3	2419	44	32,2	10305	221	38,9
2003	11171	199	44,9	3625	61	27,4	14795	260	35,8
2004	14502	259	43,1	4926	99	26,4	19428	358	34,4
2005	16190	256	42,5	5529	85	23,6	21719	341	32,6
2006	15945	228	32,6	5448	80	24,1	21393	308	28,1

Figure 12.4. Standardized mortality rate by gender and year of deaths.



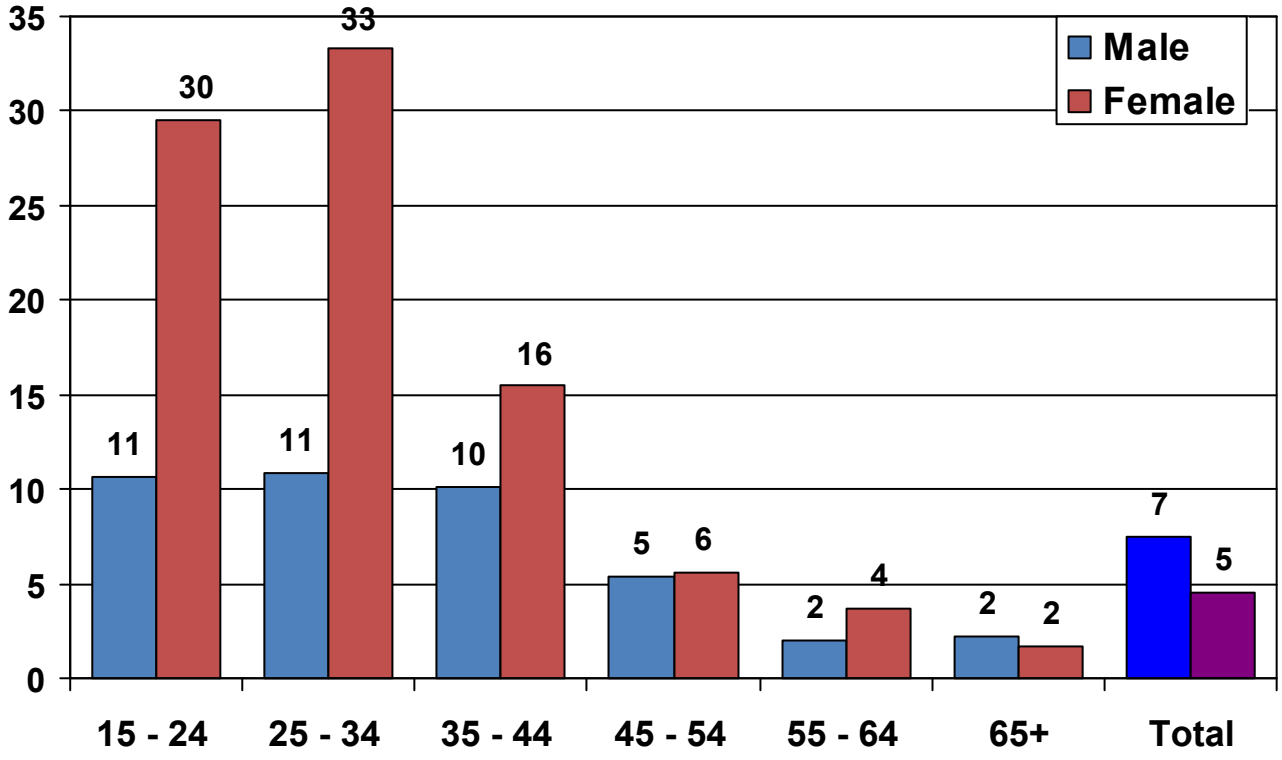
Standard mortality ratio for whole period and all cohorts is 6.5 (table 12.4). That means the probability of deaths among drug addicts is 6.5 times higher than in general population. SMR is lower for females 4.6 than for males 7.5.

Table 12.4. Standard mortality ratio.

	Males	Females	Total
Observed number of deaths	1326	418	1744
Expected number of deaths	177,44	91,24	268,68
SMR	7,47	4,58	6,49
SMR (95% CI)	*7,08-7,89*	*4,15-5,04*	*6,19-6,80*

The breakdown of SMR by gender and age groups (figures 12.5) suggests that it is highest among female age 25-34 and that 15-34. Very high SMR for young female is at least partially related to very low mortality rate for this category of general population.

Figure 12.5. Standardized mortality ratio by age and gender.



- **Cause specific mortality**

The data on cause specific mortality are unavailable due to data protection rules in Poland. The data about causes of deaths are collected by Central Statistical Office. According to Polish statistical low individual data collected for statistical purposes are strictly protected and cannot be made accessible even for scientific study.

- **Risk/protective factors among PDUs**

For the identification of predictors for the risk of death, the model of logistic regression was applied. In the model independent variables included socio-demographic characteristics and treatment indicators. The analysis controlled for the impact of the observation length by inclusion the onset of treatment in the model i.e. the study.

The regression analysis differentiated five predictors (gender, age, inclusion in study, time elapsed since first treatment episode and treatment outcome) that affected the risk of death in a statistically significant manner. According to the results of the multi-variable analyses, education of the participants is not relevant as the factor for the risk of death. This characteristic was not included in the model although it was included in the analyses. As we remember, the crude mortality rate varied in terms of education. This variability was explained by other predictors present in model.

As Table 12.5 shows a relative risk of death in males is 70.1% higher than in females. The risk of death rises with age. If adopt the risk of death for the youngest patient as benchmark we will notice the risk of death rises by 6.2% yearly.

The risk of death varies considerably among cohorts. Its sharp increase towards the participants placed in cohorts early results from shortening the observation length. If we adopt the latest cohort of 2004 as benchmark we will see that the risk of death in the 2003 cohort is 8 times higher and 48 times higher in the 2000 cohort.

In the multi-variable model, a curvilinear relationship was observed between the time that elapsed since the first treatment episode in a lifetime. Adopting the longest time (9 years and longer) as benchmark, we first observe the fall of the odds ration and then its rise. The participants who were treated for the first time in a lifetime 5-6 years before demonstrate 4-fold lower risk of death. The participants with the first treatment episode not longer than two years before report a risk of death 10-fold higher than the benchmark patients.

A significant factor in the risk of death is the effect of the latest treatment episode. Patients who graduated from the latest treatment with improvement or without improvement are two and a half times more likely to die than the patients who were considered fully recovered. It is worth noting that the division is not between patients with and without improvement but between the recovered patients recovered and the rest.

Table 12.5. Drug-related mortality determinants – logistic regression model.

	Odds ratio Exp(B)	Significance	95% C.I. for EXP(B)
Gender			
Females	1.000		
Males	1.705	0.000	1.464-1.986
Age			
8 years	1.000		
Increase by 1 year	1.062	0.000	1.057-1.067
Cohort			
2004	1.000		
2003	8.668	0.000	6.862-10.948
2002	12.967	0.000	10.257-16.393
2001	30.990	0.000	24.313-39.500
2000	48.006	0.000	37.907-60.796
Time elapsed since first treatment episode in lifetime (years)			
9 and more	1.000		
7-8	0.590	0.000	0.749-1.084
5-6	0.283	0.000	0.234-0.343
3-4	0.901	0.269	0.749-1.084
<2	10.850	0.000	8.985-13.103
Treatment outcome			
Recovered	1.000		
With improvement	2.435	0.000	1.667-3.557
With no improvement	2.927	0.000	1.981-4.325

12.2. Complementary sources with drug-related mortality information

- **Mortality among AIDS cases**

According to data of National Institute of Public Health – National Institute of Hygiene the number of deaths due to AIDS. Unfortunately we are not in position to link this data with data from our mortality study due to data protection rules.

Table 12.6. Deaths due to AIDS among IDUs.

Year of death	Number of deaths among IDUs
2000	21
2001	24
2002	29
2003	39
2004	35
2005	41
2006	25
2007	40
2008	33
2009	16
Total	520

Source: National Institute of Public Health – National Institute of Hygiene

There were not specific studies on mortality due to AIDS in Poland.

12.3. Mortality due to diseases (in particular hepatitis C, hepatitis B, and TB infections) and external causes of death (in particular suicide, accidents and violence)

There were not specific studies on mortality due to diseases like hepatitis C, hepatitis B, and TB infections in Poland with identification of IDUs. The same is with external causes of death (in particular suicide, accidents and violence). Also relevant statistical data with identification of IDUs are not collected.

- **Public health perspectives**

The mortality analysis in 2000-2006 among patients admitted to residential drug treatment in 2000-2004 has shown decreasing trend in mortality rates. The downward trend in 2000-2006 suggests progress in reaching goals of the National Programme for counteracting Drug Addiction 2000-2005. There are probably also other factors of decreasing trend like process of change of drug use pattern in direction of less destructive one. But

probably the implementation of National Drug Program, especially harm reduction part, co tribute to this trend.

The results of the multi-variable analyses point to gender, age, time elapsed since the first treatment episode in a lifetime and the outcome of treatment as the predictors of the risk of death.

Over a two-fold lower risk of death in the group of patients considered recovered as a result of the latest treatment episode compared to the group of patients who completed treatment with or without improvement indicates the importance of the full recovery factor. It might be concluded then that full recovery in this context constitutes a protective factor and that the improvement is not sufficient

Relatively high risk of deaths during first year after treatment entry suggests need for harm reduction measures focused on drug addicts leaving treatment, especially detoxification ward.

Part C:
13. Bibliography

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1) Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) pilot project of the Information Centre for Drugs and Drug Addiction (CINN) of National Bureau for Drug Prevention.
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Alphabetic list of relevant Internet addresses

1) Centrum Metodyczne Pomocy Psychologiczno-Pedagogicznej http://www.cmppp.edu.pl/node/580 z dnia 2.09.2010 -z dniem 1 stycznia 2010 Centrum Metodyczne Pomocy Psychologiczno - Pedagogicznej w Warszawie oraz Centralny Ośrodek Doskonalenia Nauczycieli w Warszawie, połączone zostały w jednostkę budżetową o nazwie: Ośrodek Rozwoju Edukacji z siedzibą w Warszawie - strona www. CMPPP nadal funkcjonuje.
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4) Ministerstwo Nauki i Szkolnictwa Wyższego - http://www.nauka.gov.pl
5) Ośrodek Rozwoju Edukacji - http://www.ore.edu.pl
6) Poradnia internetowa - www.narkomania.org.pl

14. Annexes

List of Figures and Tables used in the text

List of abbreviations used in the text

1) ABW – Agencja Bezpieczeństwa Wewnętrznego (Internal Security Agency)
2) CBOS – Centrum Badań Opini Społecznej (Foundation of the Public Opinion Research Centre)
3) CBŚ - Centralne Biuro Śledcze (Central Bureau of Investigation) of the Police Headquarters (KGP)
4) CeCLAD-M - project concerning combating drug trafficking in the Mediterranean region
5) CMQ - Centre for Monitoring Quality
6) CND - Commission on Narcotic Drugs
7) DRID – Drug-related infectious diseases
8) DRUID - Driving under the Influence of Drugs, Alcohol and Medicines project
9) EDDRA - Exchange on Drug Demand Reduction Action
10) EDPI - European Drug Policy Initiative
11) EMCDDA – European Monitoring Centre on Drug and Drug Addiction
12) ESPAD – European School Survey Project on Alcohol and other Drugs
13) GHB - Gamma-Hydroxybutyric acid
14) GPS – General Population Survay
15) GUS – Główny Urząd Statystyczny (Central Statistical Office)
16) HCLU – Hungarian Civil Liberties Union
17) IATAP - Intramural AIDS Targeted Antiretroviral Program
18) ICD – International Classification of Diseases
19) IDI - Individual In-Depth Interviews
20) IDU – Injecting Drug Users
21) MCPPA - Methodological Centre for Psychological and Pedagogical Assistance
22) NBDP – National Bureau for Drug Prevention
23) NFP – National Focal Point
24) NGOs – Non-governmental organizations
25) NHF – National Health Fund
26) NPCDA – National Programme for Counteracting Drug Addiction
27) OTC - Over-the-counter drugs
28) PMA - p-methoxyamphetamine
29) PMMA p-methoxy-methamphetamine
30) UNDOC – United Nations Office on Drugs and Crime

List of full references of laws in orginal language

1) Rozporządzenie Ministra Zdrowia z dnia 13 listopada 2000 roku w sprawie Krajowego Biura ds.. Przeciwdziałania Narkomanii (Dziennik Urzędowy Ministerstwa Zdrowia 2000 Nr 2, poz. 44).
2) Rozporządzenie Ministra Zdrowia z dnia 20 sierpnia 1996 roku w sprawie sposobu organizowania i prowadzenia działalności w dziedzinie promocji zdrowia psychicznego
   i zapobiegania zaburzeniom psychicznym (Dz.U. 1996 Nr 112, poz. 537).
3) Rozporządzenie Rady Ministrów z dnia 27 czerwca 2006 r. w sprawie Krajowego Programu Przeciwdziałania Narkomanii na lata 2006-2010.
4) Rozporządzenie Rady Ministrów z dnia 20 grudnia 2004 roku w sprawie sposobu i trybu finansowania z budżetu państwa świadczeń opieki zdrowotnej udzielanych świadczeniobiorcom innym niż ubezpieczeni (Dz.U. Nr 281, poz. 2789).
5) Ustawa z dnia 14 marca 1985 o Państwowej Insepkcji Sanitarnej (“Dz. U. 2006 Nr. 122, poz 851 z późniejszymi zmianami
6) Ustawa z dnia 26 listopada 1998 roku o finansach publicznych (Dz.U. 2003 Nr 15, poz. 148) z późniejszymi zmianami.
7) Ustawa z dnia 19 sierpnia 1994 roku o ochronie zdrowia psychicznego (Dz.U. 1994 Nr 111, poz. 535) z późniejszymi zmianami.
8) Ustawa z dnia 27 sierpnia 2004 roku o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych (Dz.U. 2004 Nr 210, poz. 2135) z późniejszymi zmianami.
9) Ustawa z dnia 30 sierpnia 1991 roku o zakładach opieki zdrowotnej (Dz.U. 1991 Nr 91, poz. 408) z późniejszymi zmianami.
10) Ustawa z dnia 20 marca 2009 o zmianie ustawy o przeciwdziałaniu narkomanii (Dz.U. Nr 63 poz. 520).
11) Ustawa z dnia 27 kwietnia 2006 r. o zmianie ustawy o przeciwdziałaniu narkomanii oraz ustawy o odpowiedzialności podmiotów zbiorowych za czyny zabronione pod groźbą kary (Dz.U. Nr 120, poz. 826). http://www.narkomania.gov.pl/poz826.htm
12) Ustawa z dnia 29 lipca 2005 r. o przeciwdziałaniu narkomanii (Dz. U. Nr 179, poz. 1485) z późniejszymi zmianami.
13) Ustawa z dnia 24 kwietnia 1997 r o przeciwdziałaniu narkomanii z 1997 (Dz.U. Nr 75 poz. 468).
14) Ustawa z dnia 13 czerwca 2003 roku o zatrudnieniu socjalnym http://www.abk.gumed.edu.pl/attachment/attachment/4723/Ustawa_z_dn._13.06.2003_r._o_zatrudnieniu_socjalnym.pdf

15) Part D: Standard Tables and Structured Questionnaires

Standard Table 02	Methodology and results of school surveys on drug use
Standard Table 03	Characteristics of persons starting treatment for drugs
Standard Table 05	Acute/direct related deaths
Standard Table 06	Evolution of acute/direct related deaths
Standard Table 09	Prevalence of hepatitis B/C and HIV infection among injecting drug users
Standard Table 10	Syringe availability
Standard Table 11	Arrests/Reports for drug law offences
Standard Table 13	Number and quantity of seizures of illicit drugs
Standard Table 14	Purity at street level of illicit drugs
Standard Table 15	Composition of tablets sold as illicit drugs
Standard Table 16	Price in Euros at street level of illicit drugs
Standard Table 24	Access to treatment