



European Monitoring Centre
for Drugs and Drug Addiction



2012 NATIONAL REPORT (2011 data) TO THE EMCDDA by the Reitox Polish Reitox Focal Point

“POLAND” New Development, Trends and in-depth information on selected issues

REITOX

Krajowe Biuro ds. Przeciwdziałania Narkomanii – National Bureau for Drug Prevention

Warsaw, Poland 2012

Editors:

Artur Malczewski, Marta Struzik

Authors:

Centrum Informacji o Narkotykach i Narkomanii – Reitox Polish National Focal Point Poland

Artur Malczewski - Head of RPNFP

Michał Kidawa

Marta Struzik

Anna Strzelecka

Katarzyna Sollich

Anna Misiurek

Łukasz Jędruszek

Krajowe Biuro ds. Przeciwdziałania Narkomanii - National Bureau for Drug Prevention

Piotr Jabłoński Ph.D. – Director of NBDP

Bogusława Bukowska – Deputy Director of NBDP

Anna Radomska

Elżbieta Stawecka

Piotr Jurkowski

Kamila Gryn

Dawid Chojecki

External expert:

Magdalena Rosińska Ph.D.

Marta Niedźwiedzka – Stadnik

Marta Walichnowska

Translation:

Paweł Nowocień

List of Contents

	Page
Summary.....	4
Part A: New Developments and Trends.....	16
1. Drug policy: legislation, strategies and economic analysis.....	16
2. Drug use in the general population and specific targeted-groups.....	41
3. Prevention.....	59
4. Problem Drug Use.....	76
5. Drug-Related Treatment: treatment demand and treatment availability.....	77
6. Health Correlates and Consequences	97
7. Responses to Health Correlates and Consequences.....	118
8. Social Correlates and Social Reintegration	130
9. Drug-related crime, prevention of drug-related crime and prison.....	136
10. Drug Markets.....	153
Part B: Selected Issue.....	166
11. Residential treatment for drug users in Poland	166
12. Drug policies of large European cities.....	177
Part C	191
13. Bibliography.....	191
o Alphabetic list of all bibliographic references used	191
o Alphabetic list of relevant data bases	195
o Alphabetic list of relevant Internet addresses.....	195
14. Annexes.....	196
o List of tables and graphs used in the text.....	196
o List of abbreviations used in the text.....	200
o List of full references of laws in original language.....	201
Part D: Standard Tables and Structured Questionnaires	202

Summary

Drug Policy

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 that 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 (NPCDA) 2011-2016. Since 2006 the National Programme has been a legal act of a regulation status. 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".

In 2011 and the first half of 2011 the anti-drug law was subject to a major modifications. April 2011 amendment to the Act on counteracting drug addiction was passed. The amendment introduced a number of crucial changes in the Polish anti-drug law. Probably the most important and frequently discussed was the deregulation of small possession of drugs for private use. The amendment introduces Article 62a which gives the prosecutor and the judge an option to discontinue the criminal procedure towards individuals caught in possession of small amounts of narcotic drugs and psychotropic substances for private use. Additionally article 70a of the amended anti-drug law imposed on prosecutors in preparatory proceedings and the court in jurisdiction proceedings the obligation to collect information on the use of narcotic drugs and psychoactive substances by the accused. The amendment was described in details in Polish National Report 2011.

In January 2012, the Minister of Justice issued the Regulation on collecting information on the use narcotic drugs, psychotropic substances and substitutes thereof by the suspect. This executive act defines specific conditions and the manner of collecting data on suspects drug use as well as sets conditions to be met by the data collectors. In principle, this regulation is intended to exclude accidental selection of individuals responsible for assessing the status of drugs use and its consequences for the suspect and harmonise and further specify the assessment criteria. The Regulation in question constitutes an important step in adapting the Polish legal system to effective implementation of the 'rather treat than punish' principle. Furthermore, it provides judges and

prosecutors with decision-making tools based on an independent and professional analysis of the accused's situation.

The 2011 was also first year of implementation of new National Programme for Counteracting Drug Addiction 2011-2016. The data collection on the implementation of the strategy showed some short comes in the existing data system in several institutions necessary to evaluate the action undertaken in the process of implementation of strategy. Remedial measures were taken to set up data collection systems and introduce necessary changes to the Strategy. A broad evaluation is planned in the middle of the strategy term i.e. 2014 and upon its completion in 2016.

In 2011 the activities Council for Counteracting Drug Addiction, which is a coordinating and advisory body focused on preparation for Polish presidency in EU in the field of drugs. Additionally Councils activity were mainly devoted to the problem of limiting access to OTC medicines containing pseudoephedrine and discussing possible measures to more efficient control of new psychoactive substances. In case of pseudoephedrine, introducing the option of determining a dose to be sold as an obligation imposed on the pharmacy keeper based in the pharmaceutical law is currently under investigation. In the case of new psychoactive substances the possibility of control measures basing on generic definition in Polish legal system is also being investigated. The Council also accepted the further extension of list of control substances to several new substances. At present the amendment is in the process of interdepartmental consultations.

Moreover in 2011 substantial changes took place in the structure of working groups operating by the Council. The new psychoactive substances/designer drugs group was established in order to better coordinate actions in the field of new drugs.

General population studies

Under monitoring drug use prevalence in the general population in November and December 2010 there was survey conducted by the National Bureau for Drug Prevention on a randomly selected sample of Polish residents aged 15-64 (n=3900). The survey was conducted by the National Bureau for Drug Prevention in cooperation with 8 provinces. Such a considerable sample of provinces was the result of collaboration between the National Bureau and the Provincial Information Experts on Drugs and Drug Addiction, who in the case of most provinces were responsible for implementing the project. The survey questionnaire was designed based on the first national survey conducted by the National Bureau for Drug Prevention in 2002. The survey adopted the methodology of the European Monitoring Centre for Drugs and Drug Addiction. The questionnaire was modified in the course of follow-ups of 2006 and 2010.

The project was conducted in the course of studying attitudes and behaviours related to psychoactive substances on a national sample and provincial samples. Field studies were implemented by General Projekt Sp. z o.o.

The most prevalent substance among adult Poles is cannabis followed by sedatives and hypnotics used without doctor's prescription. 17.6% stated they had used cannabis. There were 9.6% of recent users (last 12 months) and 5.4% of current users (last 30 days). There were 22% of male and 13% of female lifetime cannabis users.

Amphetamine is ranked third and ecstasy fourth. 19.3% of the respondents admitted to having used an illegal substance at least once (24.5% of men and 14.1% of women). In the last 12 months the percentage stood at 15% (16.5% of men and 13.5% of women). Experimenting with sedatives and hypnotics fell over the years 2006-2010. The results of the 2010 survey show that 5.1% of adult Poles had used sedatives and hypnotics without doctor's prescription in a lifetime. In the last 12 months such experience was reported by 3.5% while the current use was recorded among 2.1% of the respondents.

In the case of cannabis, amphetamine, ecstasy we record a rise in prevalence both in terms of experimenting and current use. Prevalence of amphetamine and ecstasy use remains at a similar level both in experimenting and current use.

Analyzing lifetime prevalence it must be noted that rates for adolescents (15-24) and young adults (25-34) are similar (31.2% and 32.4% respectively). Comparing these two age groups in the case of recent use (last 12 months) we observe higher percentages among adolescents (20.9%) than young adults (16.0%). The results of the survey show that illegal substance use is nearly as popular among young adults as adolescents.

Every third respondent reported easy access to sedatives and hypnotics and every fourth has a friend who uses these substances without doctor's prescription. The availability of cannabis is not as wide. Every fourth respondent reported easy access to cannabis. The oldest respondents (35-64) frequently have a friend who uses sedatives and hypnotics. In terms of easy access to drugs, ecstasy belongs to the same group as hallucinogenic mushrooms, LSD and anabolic steroids.

Health behaviour surveys in School-aged children (HBSC. WHO Collaborative Study) are part of international surveys conducted every four years and had a uniform procedure of research into young population aged 11, 13 and 15. The aim of the survey is to identify conditions for health and health behaviour among school students, including subjective perception of health and wider social context. For the purposes of the Polish questionnaire, obligatory questions about drug use were placed in one module and referred to the prevalence of cannabis use in students aged 15-16 in a lifetime, last 12 months and last 30 days. In Poland, the 2010 survey also included 2nd graders of secondary schools aged 17-18.

The 2010 survey was based on a modified sample of the two previous editions to ensure comparability of data. Eventually, in the 2006 survey included 6 162 school students (48% of boys and 52% of girls) from 152 schools and 307 classes.

In 2010, 80.5% of 3rd graders of middle schools reported that they had never used cannabis, which corresponds to the 2006 measurement results (81.5%). Among those who admitted to using the substance, the highest proportion (9%) reported using it 1-2 times in a lifetime (10% of boys and 8% of girls). Lifetime prevalence rates for cannabis use are higher in school students aged 17-18. Similarly to middle school students the highest number of answers referred to the category 1-2 times in a lifetime, where the overall rate stood at 13.5%, including 16% of boys and almost 12% of girls. In the case of the older students, the rates for boys and girls differ to a lesser degree compared to the students aged 15-16. Proportions of students aged 15-16 who reported using cannabis in the last 12 months – similarly to lifetime prevalence rates – remain at the level comparable to 2006 and are higher for boys than for girls. The highest last 12 months prevalence rates were recorded for the category 1-2 times. The last 12 months prevalence rates for cannabis use are higher among students aged 17-18. Over 15% of boys reported using the substance 1-2 times in the last 12 months (compared to 8.5% of boys aged 15-16). Among girls aged 17-18 this rate stood at 9% compared to 6.5% in the younger group.

The 2010 proportions of respondents aged 15-16 who reported using cannabis in the last 30 days are slightly lower compared to the 2006 measurement. The results of the latest survey showed that in 2010 approx. 92% of students had not used cannabis in the last 30 days while in 2006 this rate stood at 94%. In 2010, almost 5% of the younger students reported using cannabis in the last 30 days, including over 6.5% of boys and 3% of girls while in 2006 these rates stood at 3.5%, nearly 5% and 2.5% respectively. The rates for the last 30 days prevalence of cannabis use among 2nd graders of secondary schools remain at the level similar to the group of the younger respondents.

Another source of information on the drug use is the national questionnaire survey on alcohol and drug use in school youth conducted according to the methodology of ESPAD studies. The study was conducted by the Institute of Psychiatry and Neurology in May and June 2011 on a national sample of 3rd graders of middle schools and 2nd graders of secondary schools. Data refer prevalence of substance use among 3rd grader of middle schools.

The most prevalent substances include cannabis (24.3%), hypnotics and sedatives taken without doctor's prescription (15.5%) and inhalants (8.7%). Compared to previous studies, in 2011 an upward trend in the prevalence rates for almost all substances can be observed. In the case of cannabis the proportion of experimenters in 1995-2011 rose by 14 percentage points. In the case of prevalence of sedatives and hypnotics used without

doctor's prescription as well as inhalants, a slight systematic fall is observed. In the case of almost every substance the drug experimenting rates are higher for boys. However, no difference was noticed with regard to inhalants (proportions for boys and girls of 8.7% and 8.6% respectively) and cocaine. Higher rates for the use of sedatives and hypnotics used without doctor's prescription are observed in girls. In 2001, the difference was almost 10 percentage points.

In the 2011 survey, the number of psychoactive substances examined for the last 12 months and last 30 days prevalence was limited to three (cannabis, inhalants, ecstasy). 20.1% of middle school students reported using cannabis occasionally while the rates for inhalants and ecstasy stood at 4% and 2% respectively. Over 10% of middle school students reported using cannabis in the last 30 days prior to survey. In the case of inhalants it was almost 3% and for ecstasy the rate stood at 1.5%.

Similarly to experimenting, occasional use and last 30 days prevalence rates for boys are higher than for girls.

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 November 2010, the Minister of Education signed a package of regulations concerning the education of students with special educational needs, including legislation pertaining to the organization and provision of psychological and pedagogical assistance. In 2010, changes were introduced to the education law concerning the evaluation of the quality of education. The basic idea of the new model, introduced with the Regulation of the Minister of National Education of 7 October 2009 on the pedagogical supervision, is to strengthen the pedagogical supervision with the emphasis placed on the analysis and quality evaluation of education in school and centres. To ensure high quality of prevention programmes a special tool has been developed called Recommendation System for Prevention and Mental Health Promotion Programmes. The general aim of the system is to raise quality of prevention and mental health promotion programmes and disseminate evidence-based prevention strategies and programme design methods. In 2010, similarly to previous years, the programme's implementation continued.

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.

The most frequent activity conducted by communes is supporting universal prevention. In the first year of the NPCDA implementation 1 496 communes (66%) carried out 8 040 universal prevention programmes in 15 574 settings. In 2011, the total number of children and adolescents who participated in universal prevention programmes stood at 1 345 131.

Problem drug use

The nationwide surveys conducted in Poland in 2010 provided data to estimate the number of problem drug users. In Polish estimations this term refers to a regular drug user (of illegal substances) who encounters serious problems as a consequence of using. The latest estimation of problem drug users conducted of 2011 shows that there were 57 000-103 000 problem drug users in 2010.

Residential treatment data

The inpatient treatment data collected by the Institute of Psychiatry and Neurology 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 public health care units. In 2010 (the latest data available), 14 444 patients were admitted to residential treatment due to problems related with use of psychoactive substances, which is an increase compared to 2009. This group included 6 439 first-time patients (increase of 757 compared to 2009). In 2010, similarly to previous years, male patients constituted the vast majority in residential drug treatment units (75%). Opioid users were accounted for 12.5% of all admissions to drug treatment. Slightly less, i.e. 11.9%, were diagnosed with dependence on sedatives and hypnotics. Approx. 3% of patients were problem cannabis and stimulants users. The proportions of individuals dependent on cocaine, hallucinogens and inhalants remains at the level which does not exceed 1%. The reporting system administered by the Institute of Psychiatry and Neurology does not provide a full and precise picture of drug use patterns among drug treatment patients as 65% of patients fall within the category 'mixed and other' (Code F19). In 1997-2010 there was a significant fall in the proportion of opioid-dependent patients and this proportion in 2010 reached its lowest value ever. The proportions of cannabis, cocaine and hallucinogen users remain at similar and relatively low levels. We are still observing a rise in the proportion of

individuals falling within the category 'mixed and other', where no primary psychoactive substance is specified.

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 Counseling 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 in 2011 (latest data) there were 79 residential clinics and 212 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 2011 substitution treatment included 2 200 patients in 25 programmes run at health care units and 7 programmes in prisons.

Drug related infectious diseases

Data on HIV infections and AIDS cases related to injecting drug use at the national level are obtained through routine infectious disease notification system. In this system clinicians and laboratories notify cases of infection to the provincial Sanitary and Epidemiological Stations (SANEPID). The reports are then forwarded to the National Institute of Public Health – National Institute of Hygiene. The analysis of IDU-related HIV infections for 2006-2011 indicates a downward trend.

Data on HIV infections among injecting drug users are also available directly from the network of consultation and testing sites (PKD) that provide anonymous and free HIV testing combined with preliminary consultation. The PKD is run by NGOs closely collaborating with drug treatment units and is coordinated and co-financed by the National AIDS Centre. The main route of HIV transmission among PKD clients is sexual intercourse. The number of new

HIV infections recorded due to injecting drug use is falling every year and in 2011 less than 1% of the clients got infected in this manner. However, combining both injecting drug use and risky sexual behaviour the rate reached 10% in 2011.

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. Analyzing the latest available data for 2010, we notice the level similar to 2009. Out of 261 deaths, most cases (61%) were male.

Social correlates and social reintegration

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

It is confirmed by numerous statistics and studies. The results of the research project by the Institute of Psychiatry and Neurology entitled "Social costs incurred by drug users. Survey of six European cities" clearly shows that opioids are the most powerful in generating social exclusion. Insufficient knowledge of social welfare options, 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.

In 2011, social welfare centres across Poland provided drug-related assistance for 3 309 families (2010: 3 497); including 397 in rural areas (462 in previous year). The assistance was provided for 5 286 clients, including co-dependent individuals (2010: 5 791).

In 2011, the National Bureau for Drug Prevention i.a. co-financed 4 harm/risk reduction programmes for prostitute drug users, sponsored 2 night shelter programmes, co-financed reintegration programmes in hostels and re-entry flats, co-financed relapse prevention programmes in inpatient and outpatient clinics, pro-abstinence programmes.

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

In 2011 the number of crimes recorded reached the highest figure ever recorded – 74535. The highest proportion of crimes was related to drug possession: 49% of the overall number of crimes were related to Article 62. The number of offenders increased from 26865 (2010). to 29146. In the record year of 2010, one suspect committed an average of 2.5 crimes. Let us take a look which articles of the Act the crimes violated. The highest number

of crimes referred to Article 62 (72%), then came Article 58 (7%) and Article 58 (11%). In total, these three articles accounted for 90% of all suspects under the Act.

Analyzing the latest data available it must be noted that in 2010 there was a slight rise to 20 601 in the number of convictions under the Act and a return to the value of 2008. The highest number of convicts since 1997 was recorded in 2007 (20 801).

In 2011, 3 714 inmates were provided with the programme of short-term interventions (including 358 problem drug users). It must be noted that this programme became widespread in no time. In 2011, short-term interventions were conducted in 128 out of 156 Polish correctional institutions.

6-month abstinence-based programmes for 1 611 inmates (1 658 in 2010) were conducted in 15 (16 in 2010) therapeutic wards (6-month programmes). The capacity of these wards fell by 57 places (521 in total) compared to the previous year. The fall in the number of places at drug therapeutic wards and the number of patients were caused by lower demand for therapy in first-time juvenile delinquents and adult inmates.

Moreover, in 2011 in 22 therapeutic wards for inmates with non-psychotic mental disorders or mentally disabled inmates there were 291 patients with dual diagnosis (mental disorders and addiction to psychoactive substances other than alcohol).

In 2011, 7 substitution treatment programmes were conducted in 23 correctional units of Prison Service (in 2011 substitution treatment programme in Warsaw Division was extended to Bialoleka Prison). 283 patients (237 in 2010) were treated in the 23 correctional facilities.

Drug market

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 across 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. In 2011, we record a fall in hashish seizures (59 kg) and marijuana (1 265 kg). However, it must be stressed that in 2010 drug enforcement services seized record quantities of cannabis. Despite the fall, the 2011 marijuana seizure remains one of the highest in the last decade. Compared to 2010, a fall was also recorded in the seizures of amphetamine (395 kg) and cocaine (78 kg). In contrast, there was a twofold rise in the seizures of heroin (51 kg) and a nearly threefold one in the seizures of ecstasy (75 thousand tablets). the Police and Border Guard revealed seizures of other illegal substances. In the category of opioids, 4 674 cm³ of Polish homemade heroin ("kompot") as well as 12 241 cm³

of methadone was seized. 243 ml of GHB was also confiscated. In the category stimulants, the Police seized 53 kg of mephedrone, 325 g of methedrone, 40 kg of khat and 610 g of ephedrine. In 2011, the highest number of illegal plantations (609) was recorded (382 indoor and 227 outdoor) at the total area of 10 593 m². In 2011, in the course of reducing domestic production of amphetamine, Police officers, especially staff of the Central Bureau of Investigation, performed a number of operational activities aimed at combating organized crime groups producing amphetamine. 50 drug producing crime groups were dismantled, 13 clan labs. Comparing the 2004 and 2010 data (latest data available for average prices) we notice a nearly twofold decrease in the average price of ecstasy from PLN 15 to PLN 8. However, there was a rise in the price of LSD from PLN 21 to PLN 28. Prices of amphetamine (PLN 39 per gram) and cannabis (PLN 27 per gram) did not change. Following the period of fall in the purity of amphetamine (2005-2010), the latest data indicate a slight increase to 8% in 2011. In the case of marijuana, we have been recording a systematic rise in THC concentration to 10% in 2011. In 2011, the purity level of amphetamine ranged from 1% to 78% and the purity of half of the seizures under scrutiny stood at more than 13% (median). THC concentration in marijuana ranged from 2% to 37% (median 7%).

Residential drug treatment in Poland

The oldest and most common component of the Polish substance abuse treatment system is residential treatment. The centres include health care units which, within the meaning of the Act, provide drug rehabilitation and reintegration free of charge. The broadly understood therapy and any other benefits are financed by the National Health Fund. The NFZ regulates minimum guaranteed service quotas in residential treatment centres. The programmes offered are divided into short, medium and long-term. Out of 79 residential treatment units in 2011, over a half offered long-term treatment ranging from 12 to 24 months.

Residential rehabilitation, provided by centres which remain within the domain of the government or NGOs, is nearly everywhere in the country based on the therapeutic community approach as the primary intervention. According to the national drug information brochure (2011), this method was reported by 70 centres, out of which 59 used it as the only approach. In principle, the foundation of the Polish model of therapeutic community and the related specialist training do not differ from the commonly accepted worldwide standards. It contrasts with the traditional hospitalization where the patients felt alienated and deprived of the opportunities to actively participate in the recovery process. Referring to residential treatment centres or detoxification wards is done through ambulatory drug services. Ambulatory units also provide post-rehabilitation for residential treatment graduates.

In order to improve quality and effectiveness of therapeutic services, a set of standards in drug treatment and rehabilitation was developed in Poland in 2004-2009 whereas in 2007, Code of Practice for Addiction Therapists was adopted. It is a set of standards in the therapist's conduct.

Pursuant to the Act of 29 July 2005 on counteracting drug addiction, a certification system for drug therapy instructors and specialists is in place whereby the instructors and specialists are granted the right to provide services for drug-dependent individuals, harmful users and their families.

Drug policies of large European cities

Anti-drug policy in Poland is pursued on two levels: national and local. At national level the policy framework is based on the National Programme for Counteracting Drug Addiction (NPCDA) developed by the National Bureau for Drug Prevention and respective ministries. Apart from activities to be implemented by specific central institutions, the KBPN recommends areas and tasks to be taken care of by local governments. At local level drug prevention is performed based on communal drugs strategies. Local drug prevention programmes are implemented by municipal or communal authorities and their partners such as NGOs, drug treatment centres or the police.

This chapter analyses anti-drug policy in ten biggest Polish cities: Warsaw, Wrocław, Krakow, Bydgoszcz, Lublin, Łódź, Gdańsk, Katowice, Poznań and Szczecin. According to the EMCDA guidelines, only cities with population over 300 thousand were included. A special emphasis was placed on the local anti-drug policy in the city of Warsaw.

The analyses show that all the aforementioned cities hold drugs strategies. Some of them combined a drugs strategy and an alcohol strategy and established a joint substance prevention strategy. It must be stressed that, according to the NPCDA recommendations, the cities under study performed activities in three areas: drug prevention, treatment and research/monitoring. The most common activities included universal, selective and indicated drug prevention programmes. It must be pointed out that the strategies were predominantly financed from the cork tax, while in two cities (Krakow and Lublin) additional funding sources were reported.

The Drugs Strategy 2012-2015 is part of social policy of the city of Warsaw. The aim of the strategy is to improve the social potential and integrate social policy. The strategy developed by the Social Policy Department (currently Social Welfare Assistance and Projects Department). The Department finances and coordinates major drug prevention and treatment activities.

Drug prevention at Warsaw level remains in the domain of Substance Abuse Prevention Division. It is responsible for collaborating with non-governmental organizations

under the Social Dialogue Commission for Drug Addiction and HIV/AIDS (KDS). It initiates new solutions, provides advice and expert reports on projects, legal regulations and competition topics. The collaboration with NGOs beyond the KDS is done through commissioning tasks, for example in harm reduction. The city also finances needle and syringe exchange programmes and partyworking programmes for rave and festival goers.

Part A: New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

prepared by Michał Kidawa, Anna Strzelecka, Artur Malczewski, Łukasz Jędruszek

1.1. Introduction

The basic anti-drug legal act remains the Act of 29 July 2005 on Counteracting Drug Addiction¹. 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 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.

The executive act that 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 (NPCDA)² 2011-2016^{3, 4}. Since 2006 the Programme has been a legal act of a regulation status. 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 existing Programme has replaced the National Programme for Counteracting Drug Addiction 2006-2010. The Programme’s structure remained the same.

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 integrated with the EU Drugs Strategy and Action Plan. Under the Programme 110 actions were formulated to be implemented by 7 ministries and 22 central level institutions, Provincial Pharmaceutical

¹ Act of 29 July 2005 of counteracting drug addiction (Journal of Laws “Dz.U.” No. 179, item 1485).

² Later in the text the following terms are also used to refer to National Programme: NPCDA, the Programme

³ Ordinance of Council of Ministries from 22nd of March 2011 on National Program for Counteracting Drug Addiction 2011-2016 (Journal of Laws „Dz. U.” No. 78, item 428).

⁴ More information under 1.2. National action plan, strategy, evaluation and coordination.

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 of antidrug actions in Poland. The coordinating role in implementing the Programme is fulfilled by the Council for Counteracting Drug Addiction⁵.

1.2. Legal framework

- **Laws, regulations, directives or guidelines in the field of drug issues (demand & supply)**

In the first half of 2011 the antidrug law was broadly amended⁶ (Kidawa et al. 2011a). Antidrug legislative initiatives in the second half of 2011 and first half of 2012 focused on developing secondary legislation, which was directly related to a broad scope of changes the abovementioned amendment brought about. Article 70a of the amended antidrug law imposed on prosecutors in preparatory proceedings and the court in jurisdiction proceedings the obligation to collect information on the use of narcotic drugs and psychoactive substances by the accused. In January 2012, the Minister of Justice issued the Regulation on collecting information on the use narcotic drugs, psychotropic substances and substitutes thereof by the suspect. This executive act defines specific conditions and the manner of collecting data on suspects drug use as well as sets conditions to be met by the data collectors. In principle, this regulation is intended to exclude accidental selection of individuals responsible for assessing the status of drugs use and its consequences for the suspect and harmonise and further specify the assessment criteria.

According to the regulation, assessors can be only certified addiction therapists who enjoy full civil rights and have clean criminal record. Moreover, the assessors must be listed in a central database, the so-called register of specialists. The register is administered by the National Bureau for Drug Prevention. Specialists are placed within the jurisdiction of relevant district courts upon the request of which they prepare the reports in question. The directory of specialists is regularly updated and sent to the Ministry of Justice, which posts it on its website. The assessors produce reports depending on the demand from the court or the prosecutor's office. The report is based on the questionnaire, as scheduled to the Regulation. Information about the accused is collected in an interview. The interview is held without presence of third parties. The accused has the right to refuse to take part in the interview

⁵ more information on the Council and its activity is presented 1.3.National action plan, strategy, evaluation and coordination. Coordination arrangements p.28.

⁶ Act of 1 April 2011 on amending the Act of counteracting drug addiction and other acts (Journal of Laws "Dz.U." No. 117, item 678).

or enter treatment. The assessors collect information on the legal status under the proceedings in progress, analyse the family situation, social and housing conditions, employment, history of the use of narcotic drugs, psychotropic substances and substitutes thereof. The assessor also examines the harm and delivers a preliminary assessment of dependence on the abovementioned substances and produces a possible treatment plan, recommends procedures such as consultation at an addiction counseling centre, psychiatric consultation or participation in awareness and prevention activities, substitution treatment or tests for infectious diseases. Moreover, it is recommended that, under the assistance provided, the assessor make an appointment for the accused at a specialist facility. The assessor is entitled to a fixed rate fee for producing the report. The Regulation in question constitutes an important step in adapting the Polish legal system to effective implementation of the 'rather treat than punish' principle. Furthermore, it provides judges and prosecutors with decision-making tools based on an independent and professional analysis of the accused's situation.

1.3. National action plan, strategy, evaluation and coordination

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

The National Programme for Counteracting Drug Addiction 2011-2016 (NPCDA)⁷, similarly to the previous Programme provides grounds for drug prevention activities in Poland. The Programme defines the schedule, actions, aims and implementation methods as well as specifies implementing institutions and entities responsible to take specific actions.

The Programme contains anti-drug aims to be reached by local governments which then should be reflected in provincial programmes for counteracting drug addiction (pursuant to Article 9.1 of the Act on counteracting drug addiction⁸) and communal programmes for counteracting drug addiction (pursuant to Article 10.2 of the above mentioned Act).

Reducing drug use and the related social and health problems, which is the general aim of the Programme, concerns the five following areas:

- 1) Prevention,
- 2) Treatment, rehabilitation, harm reduction and social reintegration,
- 3) Supply reduction,
- 4) International cooperation,
- 5) Research and monitoring.

Each of the above five areas has its own general aim whose achievement contributes to the general aim of the Programme.

⁷ Ordinance of Council of Ministries from 22nd of March 2011 on National Program for Counteracting Drug Addiction 2011-2016 (Journal of Laws „Dz. U.” No. 78, item 428).

⁸ Act of 29 July 2005 of counteracting drug addiction (Journal of Laws „Dz. U.” No. 179, item 1485).

In the area of drug prevention it is reducing drug demand in Polish society. It can be achieved through coordinated institutional action addressed to the whole society and selected target populations such as school children and youth or groups at risk of drug use. An important difference between the previous and the existing Programme is greater emphasis placed on raising the quality of drug prevention programmes and their implementing staff. Poor effectiveness of drug prevention programmes results from the improper development of programmes, poor quality of implementation and insufficient staff training.

In drug treatment, rehabilitation, harm reduction and social reintegration the existing Programme focuses mainly on the improvement of the quality of life of harmful drug users and drug dependent individuals. Reaching this aim is planned through the professional upgrade of treatment programmes, increasing availability of substitution treatment, development of harm reduction programmes, combating homelessness and unemployment among harmful and dependent drug users. A significant change in the NPCDA 2011-2016 is providing substitution treatment for at least 25% of opioid users by increasing the number of substitution programmes and ensuring sufficient funding by the National Health Fund. Although planned in the previous programme this action failed to be implemented. Only 7% of opioid users were provided with substitution treatment (compared to expected 20%).

In drug supply reduction the existing Programme mostly corresponds to the previous edition. New actions respond to alarming trends on the illegal drug market. As the latest drug-related data show there has been a rise in the number of illegal cannabis plantations in Poland. Consequently, measures have been taken to limit domestic cultivation of cannabis other than hemp. Moreover, the crackdown on domestic manufacture of amphetamine, which is the most prevalent stimulant, has been intensified. The measures included operations against the use of precursors in the manufacture of drugs. A new element of the NPCDA 2011-2016 is the incorporation of the online transactions and illegal trade both in drugs and precursors.

In international cooperation the main goal is strengthening the international position of Poland in combating drugs and drug addiction. The Programme to a large extent continues the activities started in the previous edition. Unlike in the previous edition, the new NPCDA clearly divides actions into the following fields: cooperation within the EU, cooperation with international institutions and organizations from outside the EU and cooperation with third countries (non-EU members). Moreover, the NPCDA 2011-2016 specifies new types of actions: implementation of national initiatives in the course of Polish presidency in the EU including the Trio Presidency (Poland, Cyprus, Denmark) and implementation of national initiatives under the EU Eastern Partnership.

The area of Research and monitoring constitutes support for planned actions in prevention, rehabilitation and harm reduction. The horizontal character of the proposed actions in this area has not changed substantially. However, a few extensions have been added. The new Programme has been extended by the following actions:

- research into abstinence periods among graduates of drug rehabilitation clinics,
- research into problem drug use,
- disseminating information on the epidemiology of drugs and drug addiction and responses to drugs and drug addiction,
- evaluation of the NPCDA.

The importance of monitoring the market of new narcotic drugs, psychotropic substances and substitute drugs has been stressed as well.

In the course of implementing the EMCDDA Treatment Demand Indicator a system of monitoring demand for treatment has been developed.

- **Implementation and evaluation**

The National Bureau for Drug Prevention (KBPN) is responsible for evaluating the National Programme for Counteracting Drug Addiction. A broad evaluation is planned in the middle of the strategy term i.e. 2014 and upon its completion in 2016.

The Polish Focal Point annually monitors the implementing measures taken by ministries and other central level institutions as well as provincial and communal authorities. It is performed through collecting information on the way of implementing the Programme's specific task by means of a standardised questionnaire designed by the NFP. The reporting obligation is specified in the Act on counteracting drug addiction. The questionnaires are sent to ministries and central institutions and to all provinces and communes in Poland. Data at communal level are collected through provincial drug information experts closely collaborating with the Polish NFP.

Moreover, the Polish Focal Point annually collects data on the prevalence of drug use, social and health correlates, availability of psychoactive substances, drug markets and response to drug problem. Upon analysis of the above data the KBPN annually provides information on the implementation of the National Programme for Counteracting Drug Addiction. This information is presented to the Minister of Health and then to the Council of Ministers in statutory terms. The NPCDA information is finally submitted to the Parliament.

The NPCDA lists 110 tasks to be implemented by 7 ministers, 22 central institutions and local governments at provincial and communal level⁹. The implementation of the Programme by respective ministers and central institutions practically meant the involvement

⁹ Results of the analyses of tasks to be implemented at provincial and communal level have been presented in a separate section „Courses of action for local and regional governments”.

of a number of subordinate units. Reports for 2011 were submitted by nearly all central level institutions. However, in some of the reports there was no information on the implementation of some tasks and not all reporting institutions listed drug-related expenditure in 2011. Moreover, the analysis of the reports of central institutions showed that there are shortages of the Programme implementation data. A number of operational changes at central level (e.g. excluding prosecutor's office from the jurisdiction of Minister of Justice) and no data collection systems caused NPCDA data deficits in the first year of the Programme operation. Remedial measures were taken to set up data collection systems and introduce necessary changes to the Programme. The NPCDA amendments are being drafted.

In the course of annual monitoring of the Programme a report containing summary and conclusions is prepared. This section of the National Report contains summary and conclusions regarding three most important components of the Programme i.e. prevention, treatment, rehabilitation and harm reduction. The implementation of the NPCDA in 2011 was undertaken by ministries and competent entities in all courses.

On 1 April 2011, Sejm¹⁰ amended the Act on counteracting drug addiction. The amendment contained provisions regarding the option of discontinuance of the criminal proceedings by the prosecutor as long as the accused enters drug treatment or rehabilitation. It must be stressed that the amendment came into force in 9 December 2011 that is why the presentation of the results of the amendment will be feasible in the report on the implementation of the NPCDA in 2012.

In 2011, drug **prevention** measures included promotion of healthy lifestyle. The measures focused on health education, the need to support the process of pursuing constructive interests and shaping normative beliefs. This was reflected in the nationwide campaign entitled "Drugs? What do I need them for?" conducted by the National Bureau for Drug Prevention. The above goals are listed in the new core curriculum and through the network of Health Promoting Schools (in 2011 the National Certificate was awarded to 20 schools). The Ministry of National Education announced a call for tenders to perform a public task entitled "LIVE WITH PASSION".

A number of measures were implemented in the field of prevention of new substance use the so-called legal highs. In consequence to the activities of the State Sanitary Inspection, which included mainly training, helpline launch, preparation and distribution of education and information materials and legal changes, there was a fall in the number of hospitalizations due to consumption of new psychoactive substances. The Ministry of National Education coordinated works on materials for headmasters of schools and educational facilities which were related to the prevention of new substance use, especially among adolescents. The following measures might have improved knowledge of legal highs-

¹⁰ Lower house of the Polish parliament

related risks: the pilot project entitled “Drug Prevention and You” implemented in 3 provinces, the website www.dopalaczeinfo.pl launched under the National Bureau’s campaign “Legal highs (=afterburners in Polish) can burn you out. Face the facts” and the project “ReDNet” along with the Polish version of the website www.rednetproject.eu. (run by the Institute of Psychiatry and Neurology).

In 2011, the following programmes were being implemented across the country: “School for Parents and Educators”, “FreD goes net” and “School Preventive Intervention”. These are evidence-based universal and selective drug prevention programmes. More certified trainers, providers and instructors were trained to improve their qualifications along with the requirements of the programmes, which widened the coverage of the programmes. In addition, first trainers of the “Unplugged” drug prevention programmes were prepared. This programme may contribute to bridge the gap in the access to universal drug prevention for middle school students.

To sum up the measure of ministries and entities competent to act at central level, one must stress wide use of the Internet in education and information provision. Although all courses of action were pursued the data reported by respective ministries varied in terms of details.

At provincial level, all actions under the National Programme for Counteracting Drug Addiction addressed to local governments were being implemented. It is worth appreciating the activity of those Marshal Offices which despite insufficient funding were trying to implement drug-related programmes by means of their own contacts or by relying on the capacity of their staff. Provincial governments were mostly involved in the development of universal drug prevention programmes while the least effort was made in relation to the improvement of qualifications of the prevention staff. Only four provinces supported prevention and education at the level of sociotherapeutic centres and education clubs as well as prevention camps. The programmes recommended by the National Bureau for Drug Prevention are implemented across provinces: early intervention FreD goes net programme, universal prevention Unplugged programme, and the School Preventive Intervention. Some local governments implemented antidrug actions under Provincial Strategies for Prevention and Solution and Alcohol Related Problems. It is also impossible to ignore how little revenue from alcohol excise tax was earmarked for drug prevention. In 2011, alcohol excise revenue stood at PLN 35 577 468, 69 while only PLN 3 725 139, 28 was allocated to drug prevention. It constitutes 10.5% of the overall alcohol excise tax revenue. Such scarce resource might affect the scope of drug prevention actions in respective provinces. Raising these drug prevention funds in respective provinces could widen the range of services for groups at risk of drug addiction or those experimenting with drugs as well as better assistance for their families. However, it must be noted that local governments allocate their own resources

to drug prevention, which means that the alcohol excise tax revenue is not the only source of funding in this respect. Moreover, some drug prevention actions are financed under Provincial Strategies for Prevention and Solution of Alcohol Related Problems. However, it must be recognized that this is funding earmarked particularly on universal prevention while there is a great need for selective and indicated prevention programmes addressed to problem substance users and their families. The results of the 2010 general population surveys conducted by the National Bureau indicate a considerable increase in the prevalence of cannabis use. Consequently, it would be justified for communal authorities to take this problem into consideration and develop drug prevention programmes for this target group i.e. occasional and experimenting adolescent cannabis users.

Under the section **drug treatment, rehabilitation, harm reduction and social reintegration**, in order to meet the expectations of problem drug users and considering the specificity of different target groups, the National Bureau for Drug Prevention organized a training seminar and a conference which featured presentations of various evidence-based approaches to work with a drug dependent client.

In order to widen access to outpatient health care for drug users, the National Health Fund increased the outpatient funding from approx. PLN 37 000 000 to PLN 40 664 467.

Considering the improvement of health of harmful and dependent drug users, the National Bureau for Drug Prevention co-financed the implementation of 10 harm reduction programmes for drug dependent individuals, 3 programmes for women who experiment with drugs, use drugs in a harmful way or have developed drug addiction as well as 3 substitution treatment programmes.

Every year we observe improvement in the availability of substitution treatment programmes although these programmes are not able to meet the needs of all opioid users. Despite 4 more licences issued for substitution treatment programmes 2011, still only about 15% of drug dependent population are reached with this form of treatment. It also must be stressed here that the real amount of funding allocated to this goal by the National Health Fund fell by PLN 3 859 083 (approx. 23%). However, it is difficult to specifically report what funding was contracted in 2011 in this respect as the cost calculation procedure at the Headquarters of the National Health Fund is still in progress.

In order to provide access to substitution treatment programmes for at least 25% of opioid users in each province, it is necessary to launch such programmes in the provinces where in 2011 they were not operational: pomorskie province, warminsko-mazurskie province, podlaskie province and podkarpackie province. The services in the provinces of slaskie and zachodniopomorskie should also be extended. It is worth stressing that substitution treatment is listed in the catalogue of guaranteed services, which means that

every year the National Health Fund should secure necessary funding in this respect and launch substitution treatment bidding procedure.

Substitution treatment is also provided at correctional settings. In 2011, the substitution treatment services in Warsaw District were extended to Bialoleka Correctional Unit. The number of drug dependent inmates participating in the methadone programme rose by approx. 19% compared to 2010. In order to continue substitution treatment which started before an inmate was sent to prison it is recommended to launch substitution treatment programmes at all correctional facilities in every province.

The National AIDS Centre reported that in 2011, comprehensive antiretroviral treatment was provided by 14 drug treatment units. The ARV treatment covered all HIV and AIDS patients who met specific medical criteria. The ARV treatment was provided at 20 hospitals which act as reference centres for HIV and AIDS patients in Poland.

As at 31 December 2011, the ARV treatment was being provided for 5 606 patients, including 1 771 whose probable HIV transmission route was injecting drug use or risky sexual behaviour. In 2010, the number of such patients stood at 1 928.

Moreover, in 2011 there 30 facilities (3 more compared to 2010) which provided anonymous and HIV tests for HIV. 5 130 test participants were also drug users, which constitutes 20.2% of all participants at diagnostic and consultation centres.

In 2011, Prison Service provided such programmes as total abstinence programmes, substitution treatment programmes, antiretroviral programmes, drug prevention programmes and from 2010 a short-term intervention programmes for substance abusers. Moreover, substitution treatment staff were trained and inmates were vaccinated against HBV.

In the reporting year, the National Bureau commissioned post-rehabilitation programmes in 22 hostels and 9 re-entry flats across Poland. The programmes included 1 838 participants. Unfortunately, only 5 Provincial Branches of the National Health Fund (NFZ) funded the programmes in 37 hostels. The total NFZ post-rehabilitation spending stood at PLN 32 012 046. A slight increase in the spending was reported only by the NFZ branch in mazowieckie province. The remaining branches which financed post-rehabilitation health services reported decreases in the spending.

In the reporting year, 12 Marshal Offices financed measures aimed at widening access to drug treatment and rehabilitation. The total of PLN 1 085 835 was allocated to this goal. Under provincial public benefit competitions, 27 facilities received funding.

It is alarming that in the reporting year Marshal Offices were to a very limited extent engaged in improving the availability of harm reduction and substitution treatment programme. Only 5 Marshal Offices financed HIV prevention programmes in the amount of PLN 97 482. In the reporting year, only Marshal Offices of lubelskie province and lubuskie province financed needle and syringe exchange programmes. Night shelters for drug users did not receive any

funding from Marshal Offices. In the reporting year, only 4 Marshal Offices financed substitution treatment programmes in the amount of PLN 220 265.

In 2011, 2 274 communes reported the implementation of the National Programme for Counteracting Drug Addiction, which accounted for 92% of all communes. Drug treatment, rehabilitation, harm reduction and social reintegration were financed by 616 communes (27%) in the overall amount of PLN 18 836 611, with an average of PLN 30 579 per commune. Local governments, to a varied extent, were involved in the implementation of respective actions depending on the geographical location and the type of commune. Drug treatment and rehabilitation was sponsored most often (31 communes) while the implementation of social exclusion reduction programmes for drug users were sponsored by 77 communes. These actions were financed in the amounts of PLN 5 564 574 and PLN 11 033 621 respectively. Provinces which were particularly involved in these and other activities were pomorskie and lubuskie while the least effort in this respect was observed in the provinces of podkarpackie and podlaskie. The most communes in 2011 (392) financed the dissemination of information on drug services. However, only 11 communes financed actions aimed at raising the availability of substitution treatment. 126 local governments supported the professional development of staff at drug treatment and rehabilitation services as well as other groups dealing with drug users. Analyzing the functioning of drug treatment services it can be observed that they are mainly sponsored by urban communes. Some activities in 2011 were only implemented there; others were financed by them even to the extent of 40% (out of all communes which filed reports). The discrepancy might have been caused by the fact that social problem budgets of urban communes, their infrastructure and human resources were far higher. Moreover, urban communes provide a lot of wide-ranging drug services for residents of urban-rural communes and rural communes, which means that the latter do not have to develop and finances such services in their area.

- **Courses of action for local and regional governments**

The NPCDA places special emphasis on the role of local governments. Important tasks of the entities involved in the implementation of the Programme include developing their own programmes, i.e. strategies which are based on the NPCDA and the Act of 2005 on counteracting drug addiction¹¹. In the course of the programme implementation, provincial and local governments develop their own ministerial, provincial or communal programmes.

In the NPCDA, communes are given three courses of action which should be incorporated in a communal drug prevention strategy:

- 1) Supporting universal prevention programmes

¹¹ Act of 29 July 2005 of counteracting drug addiction (Journal of Laws "Dz.U." No. 179, item 1485).

- 2) Supporting selective and indicated prevention programmes.
- 3) Raising public awareness of drug-related problems and ways of preventing the phenomenon.
- 4) Improving professional qualifications of prevention staff

Under drug treatment, rehabilitation, harm reduction and social reintegration, the following courses of action have been defined:

- 1) Increasing access to drug therapy and rehabilitation for harmful users and drug-dependent individuals
- 2) Increasing access to harm reduction programmes for harmful users and drug-dependent individuals
- 3) Providing access to substitution treatment for at least 25% of opiate-dependent individuals
- 4) Reducing social exclusion of harmful drug users and drug-dependent individuals
- 5) Supporting professional development of drug treatment and rehabilitation staff and other professional groups dealing with drug-dependent individuals: policemen, social workers, probation officers, physicians and NGOs.

Counteracting drug addiction within the meaning of the Act of 2005 on counteracting drug addiction is part of the commune's statutory obligations. Under both the Act and the NPCDA, local governments develop Communal Drugs Strategies. It must be noted that in the case of communes and provinces, they might be joint programmes covering also alcohol problems. The majority of provinces developed separate provincial drugs strategies. The province of kujawsko-pomorskie failed to develop a provincial drugs strategy or a provincial addiction strategy although relevant measures were taken in this area. NPCDA reports were submitted by 2 274 out of the total number of 2 479 communes, which constitutes a submission rate of 89%. The highest report submission rates were recorded in opolskie province, where all communes provided the data and dolnoslaskie province (97.7%). The lowest rate was recorded in podkarpackie province (76.2%). In the course of the strategy implementation 92% of all communes developed local antidrug strategies in 2011 (Malczewski 2012e, p.23).

- **Marshal Offices**

In 2001, most provincial governments implemented prevention activities. 14 provincial governments implemented universal prevention while 15 supported indicated and selective prevention. The same number of provincial governments performed activities aimed at raising public awareness of drug-related problems. The lowest number of provincial governments (11) supported professional development of prevention staff.

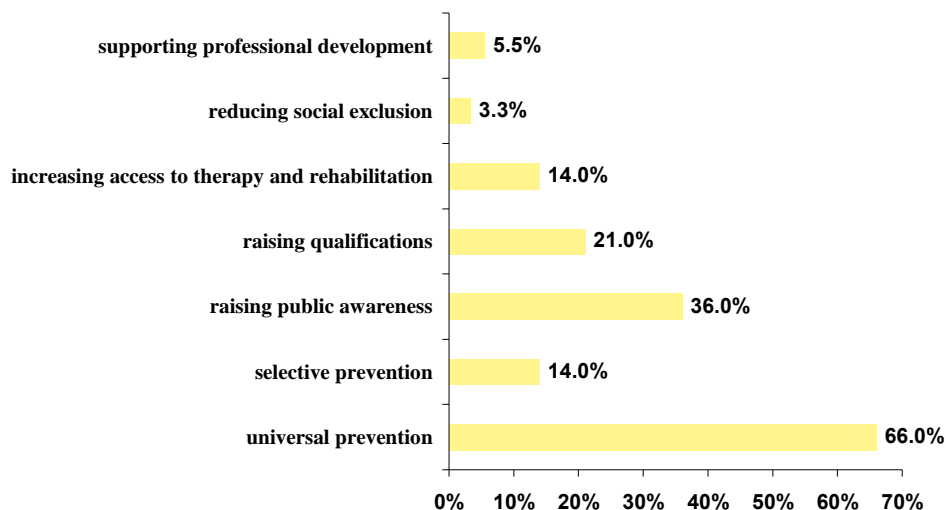
Compared to prevention, provincial governments were more infrequent to engage in drug treatment. 13 governments supported activities aimed at increasing access to treatment. Only 9 governments raised access to harm reduction programmes and 8 increased access to substitution treatment. Even fewer governments (6) counteracted social exclusion of drug-dependent individuals.

- **Communes**

In 2011, local governments most frequently implemented prevention activities. They concentrated on drug treatment much less often. (see Figure 1.3.1.).

Communal governments most often supported universal prevention programmes. Out of all communal governments which sent reports in 2011, 66% performed such activities, frequently at school. Much fewer governments (14%) supported indicated and selective prevention programmes. Approx. 36% of the governments raised public awareness of drug-use and the related problems. Approx. 21% also supported programmes aimed at improving professional qualifications of prevention staff.

Figure 1.3.1. Proportions of communes which implemented NPCDA activities related to prevention and treatment.



Source: KBPN reports on NPCDA implementation in 2011, as completed by communes

In the field of treatment, communal authorities most frequently increased access to therapy and rehabilitation for harmful drug users and drug-dependent individuals. The proportion in this respect stood at 14%. A lot fewer communes (5.5%) supported actions aimed at supporting professional development of drug treatment and rehabilitation staff. Only 3.3% of communes reduced social exclusion of drug-dependent individuals. The tasks of increasing access to substitution treatment and harm reduction were performed by even

far fewer communes. Poor activity in the field of drug treatment, especially substitution treatment and harm reduction should not come as a surprise. Negative phenomena such as drugs and drug addiction still dominate large urban areas and it is there where drug therapy and other responses to problem drug use concentrate. Poland to a large extent is composed of rural, urban-rural and small urban communes. That is why the above proportions are relatively low.

Due to the fact that this is the first year of the operation of the new NPCDA it is hard to formulate definite conclusions or change assessments. However, these data will be the source of information for comparisons and NPCDA implementation analyses in the coming years.

- **Coordination arrangements**

Council for Counteracting Drug Addiction

The Council for Counteracting Drug Addiction is a coordinating and advisory body which came into being in 2001. The tasks of the Council for Counteracting Drug Addiction include: 1) monitoring and coordinating state policy actions in the field of narcotic drugs, psychotropic substances and precursors; 2) addressing the minister competent for health matters with issues related to creation, changes or amendments to national strategies and plans of counteracting problems caused by trade and use of narcotic drugs, psychotropic substances and precursors; 3) monitoring information on the implementation of National Program for Counteracting Drug Addiction; 4) monitoring the implementation of the National Programme; 5) commissioning organizational solutions in the scope of counteracting drug addiction; 6) cooperating with the bodies implementing tasks in the field of counteracting drug addiction in the scope of issues related to the Council's operation.

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 4 work teams operate under the auspices of the Council: precursors team, international cooperation team, implementing team for the National Programme for Counteracting Drug Addiction and created in 2011 new psychoactive substances team. The teams play an advisory role and provide technical support for the Council.

In 2011, the Council held three sessions. It mainly dealt with: 1) preparation and conduct of the Polish Presidency in the European Council in the field of drugs, 2) arrival of new synthetic drugs, 3) monitoring designer drugs and combating the illegal trade in these substances, 4) implementation of the new NPCDA 2011-2016, 5) performance and assessment of Polish leadership of the Horizontal Drugs Group of the Council of the

European Union, 6) state of works on the implementation of actions against non-medical use of drugs containing pseudoephedrine, 7) preparation for EURO 2012 in terms of substance-related issues.

In 2011, Chairman of the Council with the experts in new psychoactive substances visited the EMCDDA. The purpose of the Lisbon visit was to develop collaboration principles between the Polish presidency, the European Commission and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The visit was also devoted to the discussion of joint action regarding new psychoactive substances. One of the issues discussed was the evaluation of Council Decision 2005/387 on new psychoactive substances. The European Commission concluded that 5 years had passed since the introduction of the decision and it was high time to confront it with current challenges in the light of rapid growth of designer drugs. The Commission reported that the evaluation outcome was likely to be available in July 2011. The Commission concluded that it was necessary to organize a thematic debate on the evaluation of Council Decision 2005/387¹². Similarly to the European Commission, Poland recognizes the need to update the Decision in order to make it better correspond to the reality. Moreover, Polish delegation formulated an opinion that more effective mechanisms against production and trade in new psychoactive substances (including designer drugs) must be put in place at the EU level.

Furthermore, representatives of the National Bureau for Drug Prevention and the Central Bureau of Investigations held informal consultation regarding the participation of the Polish presidency in symposium devoted to drugs in road traffic organized in Montreal. The EMCDDA suggested that Polish Presidency participate in the opening of the symposium and present the EU "DRUID" project (Driving under the Influence of Drugs, Alcohol and Medicines). The EU involvement is of particular importance as Canada and the US are interested in EU experience regarding drug driving prevention. Poland promised to take part in the Montreal conference.

As a result of joint consultations, the European Commission and the EMCDDA accepted the priorities of the Polish Presidency and promised full support in the implementation of the initiatives presented. The outcome of the visit was presented to the Council.

Apart from above mentioned international activity, the Council also active at the national level. It issued an opinion on controlling substances found in designer drugs under the Act on counteracting drug addiction basing on the expert report of Warsaw Medical University. The proposition of placing new substances on the list of controlled substances

¹² Council Decision 2005/387/JHA of 10 May 2005 on the information exchange, risk-assessment and control of new psychoactive substances.

under the Act met with positive response. At present, the amendment is in the process of interdepartmental consultations.

In addition, a current state of works on the implementation of actions against non-medical use of drugs containing pseudoephedrine was discussed. Due to parliamentary election, all projects, including limitations concerning trade in drugs containing pseudoephedrine¹³ (Kidawa et al. 2011b) were discontinued. Consequently, a need for a new amendment in this respect emerged. Three concepts to resolve the problem of non-medical use of drugs containing pseudoephedrine were discussed:

1. 1 packet per 1 transaction in a pharmacy.
2. change of the availability category – allocation to respective categories, OTC – availability without prescription, RTW – return-to-work prescription. It was demonstrated that this approach has weaknesses: the self-treatment ability is reduced. Moreover, not all doctors are equipped with return-to-work prescriptions while the systemic costs are bound to rise (frequent doctoral appointments, absenteeism).
3. introducing a systemic solution in the pharmaceutical law (including dextromethorphan). Introducing the option of determining a dose to be sold as an obligation imposed on the pharmacy keeper. Such a solution would not limit to drugs containing pseudoephedrine but would also provide an opportunity to create a list of psychoactive substances, which consequently would extend the list of banned substances. The Provincial Pharmaceutical Inspectorate could request pharmacy keepers to supply data concerning sales of medicines containing psychoactive substances, which in turn would improve the phenomenon monitoring. It was also concluded that intensified educational campaigns on trade in psychoactive substances reduce the retail sale of the medicines in question.

The Council ordered an analysis of the third solution based on the pharmaceutical law and the Department of Public Health at the Ministry of Health was provided with potential solutions for further legislative work.

In the framework of the Council meeting the information of the Minister of Justice on the possibility of applying generic solutions to new psychoactive substances/designer drugs, which would enable the control of substance groups was presented. The Ministry of Justice pointed to large limitations and weaknesses of the generic approach as definition-related difficulty emerges, e.g. how to identify new psychoactive substance and how the changes should be incorporated: in an act or a regulation. The Ministry also showed other obstacles related to the generic solutions, e.g. the difficulty in creating the generic definition. Works on the generic definition should be conducted in cooperation with experts

¹³ Government proposal reduced medical products containing pseudoephedrine down to 720mg available without prescription (1 packet).

in chemistry. This way a proper definition should be worked out to be later accepted from the legal perspective. The Council for Counteracting Drug Addiction recommended that a preliminary package of solutions be prepared and submitted to the Council for consideration.

Moreover, in the reporting period, substantial changes took place in the structure of working groups operating by the Council. A new Council Working Group on new psychoactive substances/designer drugs was established. Thus the new psychoactive substance-related issues were removed from the Narcotic Precursor Group.

Furthermore, the Council adopted a 2012 work schedule. It covered issues related to 1) monitoring consequences of the amended Act of 1 April 2011 on counteracting drug addiction¹⁴ from the legal and epidemiological perspective, 2) narcotic precursors – adapting the national law to EU legislation, 3) new synthetic drugs - including continuation of generic solution considerations, 4) evaluation of the NPCDA – information from respective ministries and local governments, 5) monitoring impact of the Polish presidency in the Horizontal Drugs Group.

The Council working group on international cooperation focused on current coordination of actions concerning the Polish presidency in the EU. The meetings were devoted to the preparations for the 54th session of the Commission on Narcotic Drugs during the Polish presidency. The work schedule for 2012 was planned. The working group on monitoring the implementation of the National Programme for Counteracting Drug Addiction in 2011 held three meetings. The aim was to summarise and evaluate the implementation of activities under the NPCDA 2006-2010. Issues were discussed in relation to the extent of the implementation of respective tasks and the emergence of problems in such areas as: prevention, rehabilitation, treatment and supply reduction. Works on the system of collecting drug supply data according to international standards and domestic needs were also discussed. Information was also presented on new drug prevention and rehabilitation programmes implemented by the National Bureau for Drug Prevention pursuant to Article 70.1 of the Act of 1 April 2011 on amending the Act on counteracting drug addiction¹⁵.

¹⁴ Act of 1 April 2011 on amending the Act of counteracting drug addiction and other acts (Journal of Laws "Dz.U." No. 117, item 678).

¹⁵ New Article 70a imposes on the prosecutor in preliminary proceedings and the court in jurisdiction proceedings an obligation to collect information on the use of narcotic drugs or psychoactive substances by suspects. This provision constitutes a starting point for the smoother application of the existing regulations regarding sanctions alternative to prison such as prevention, education or treatment.

Development and consolidation of provincial monitoring systems

Under the consolidation of national systems, emphasis was placed on the improvement of provincial and local drug monitoring. In the reporting period, the National Bureau along with the Marshal Office of Wielkopolskie Province organized the 20th Conference of Provincial Drug Information Experts. The Network of Provincial Drug Information Experts is an example of good collaboration between local governments (Marshal Offices) and the central institution. It is also an example of using the European experience in monitoring the phenomenon for national and regional purposes.

In 2011, experts of malopolskie, wielkopolskie and pomorskie provinces as well as a staff member of the Polish Focal Point participated in a training seminar organized by the Italian Focal Point. The seminar was devoted to establishing regional drug monitoring centres. The meeting attended by representatives of the EMCDDA, Poland, Italy and Israel was a follow-up to a previous seminar organized by the EMCDDA in Lisbon. During the meeting Polish experts presented their experiences in monitoring drugs and drug addiction at provincial level while the representative of the Polish Focal Point presented the framework of the national drug monitoring system.

In the reference period most Provincial Experts produced reports on the risk of drug addiction in respective provinces with the support of the Polish Focal Point and in line with the Polish NFP manual. In 2011, four provinces failed to compile the reports. The reports contained information on the current epidemiological situation and the overview of drug addiction at regional level. There were also estimates of drug-related resources in respective provinces as well as the extent to which drug prevention and treatment needs are met therein. The reports also provided suggestions and recommendations on the future development of provincial drugs strategies.

Launch of local drug monitoring system

In 2008, the local drug monitoring system was launched in collaboration with Spain . The Polish Focal Point developed and conducted a first training course on the local monitoring methodology for towns and cities. A series of training seminars were aimed to show how to implement monitoring as well as collect and analyse data by local staff. The consequence of local drug monitoring is a report collating and describing all the data on the drug situation in a commune. The main goal of the report is to characterise the local drug scene in an articulate and understandable way along with the actions taken within the commune. This way the local authorities will be provided with information on the scale of drug use and the related problems and measures taken along with conclusions and recommendations for further action. Following the first trainings in 2008, after which 40 cities produced drug monitoring reports, a decision was made to provide further support

communes that would like to implement local drug monitoring. In 2009, a national conference was organized for staff of communes participating in the local drug monitoring project. The aim of the conference was to share experiences connected with local drug monitoring and present results of the measures taken. The local drug monitoring experiences were summarised and communal reports were presented. In 2009, due to the interest in the new project on the part of the local authorities, the Provincial Drug Information Experts decided to organise trainings for new communes as well as conferences and meetings for the staff of local authorities from their areas. First training courses were conducted in lodzkie province in 2008 by the Regional Centre for Social Policy (RCPS). Later editions were conducted by the Mazovian Centre for Social Policy (MCPS) and Juvenes Society in malopolskie province. The NFP staff provided technical support and consultations during later training courses for local authorities which joined the local monitoring project. Up to now more than 20 training courses and several conferences have been conducted for new communes. The latest conference was held in collaboration with the municipal office of the city of Wroclaw in March 2012. It was combined with a training seminar for communes of dolnoslaskie province. In 2012, more training seminars for communes were conducted in the provinces of dolnoslaskie, slaskie, mazowieckie and wielkopolskie (Malczewski 2012c, p.38).

- **Polish Presidency in the EU/ HDG 2012**

Polish Presidency of the Council of the European Union in the second half of 2011

On 1 July 2011 Poland started the first ever Presidency of the Council of the European Union. During that time Polish representatives chaired the Horizontal Working Party on Drugs. The top priorities of the Polish Presidency of the HDG included:

- Prevention of drugs and driving phenomenon,
- Prevention of synthetic drugs use, including the so-called legal highs,
- Developing cooperation in the field of drug prevention with the countries of Eastern Europe and the Caucasus.

In the first week of July a European Action on Drugs conference was held in Warsaw. It was organized by the European Commission along with the Polish Presidency. The conference was devoted to the European action on new synthetic drugs, with particular emphasis placed on legal highs. The conference agenda included presentation of actions of the European Union as well as institutions and organizations supporting civil society in the field of drug prevention. Poland presented her experiences in legal highs prevention (e.g. nationwide campaign entitled 'Legal highs can burn you out') as well as epidemiological research into the phenomenon. Apart from Mr. Adam Rapacki, the Undersecretary of State in the Ministry

of Internal Affairs and Administration the conference was attended by Mr. Andrzej Włodarczyk, the Undersecretary of State in the Ministry of Health.

Representatives of the Polish Presidency also representing the European Union took part in the International Symposium on Drugs and Driving, which was organized on 17-18 July 2011 in Montreal, Canada. The symposium was a first international event of this type. It allowed for exchanging information and developing cooperation in the field of drug driving. Apart from representatives of governments and NGOs, the symposium was attended by scientists, experts at road traffic and psychoactive substances.

An important priority of the Polish Presidency was the development of collaboration with Eastern European countries. This goal was promoted through "European Union and Eastern Europe Conference" organized on 26-27 October. Apart from representatives of EU Member States and institutions the conference was attended by visitors from Russian Federation, Ukraine and Moldova. The conference focused mainly on the issues related to drug supply reduction; however, issues related to drug demand reduction were also touched upon.

Another top priority of the Polish Presidency was the preparation of "EU pact against synthetic drugs". Upon the initiative of Poland, the proposal to adopt this document was previously incorporated in the European pact to combat international drug trafficking – disrupting heroin and cocaine routes. The European pact against synthetic drugs covers the following areas: 1) countering production of synthetic drugs, 2) countering trafficking in synthetic drugs, 3) tackling new psychoactive substances (including legal highs), 4) training drug enforcement services. The document calls on EU Member States, institutions and agencies to intensify measures against production and illegal trade in synthetic drugs and precursors. The Pact against synthetic drugs contains provisions related to countering production and trafficking in synthetic drugs and precursors, combating new psychoactive substances and conducting trainings for law enforcement agencies in detecting and dismantling clandestine laboratories. The document was adopted during the session of the Justice and Home Affairs Council chaired by Poland on 27 October in Luxembourg.

One of major HDG events promoted by the Polish Presidency was the meeting of National Drug Coordinators. It was held on 21-22 November 2011 in Poznan. The meeting's top agenda item was discussion on the future of drugs and drug addiction in the European Union as seen from the perspective of potential changes in the problem's epidemiology, social perception, attitudes, including legal and ethical changes. Considering that the existing EU Drugs Strategy will expire in 2012, during the session Poland initiated discussion on the future shape of EU drugs strategies and action plans. Apart from two National Coordinators, the meeting was attended by the representatives of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, European

Commission, General Secretariat of the Council, Pompidou Group of the Council of Europe, European Police Office (EUROPOL) and United Nations Office on Drugs and Crime (UNODC).

During monthly sessions of the Horizontal Working Party on Drugs Poland organized four thematic debates. The first debate took place on 12 July and was devoted to the problem of drugs and road traffic. Apart from illegal psychoactive substances, the issue of substitution drugs was discussed. The European Commission presented information on the DRUID (Driving under Influence of Drugs) programme, which the Police Headquarters and Motor Transport Institute are part of. Poland presented the nationwide campaign “Don’t drug drive! When you’re high on drugs, your brain gets out!” The campaign was implemented in Poland in 2009 and 2010.

The second debate was devoted to the problem of new synthetic drugs with particular emphasis placed on legal highs. Poland presented her experiences with the reduction of trade and use of these substances. Moreover, new legislative solutions and preventive measures were presented. During the debate, a staff member of the National Medicines Institute, which represented the Polish Presidency, delivered a comprehensive presentation on laboratory analyses of the substances seized during the nationwide closure operation of legal highs shops in October 2010.

The remaining two thematic debates were concerned with combating synthetic drug production and trafficking as well as regional collaboration platforms for drug enforcement services.

During the Polish Presidency, under the Political Dialogues in the drug field (previously in the HGD-TROIKA format) a first ever meeting with the Caucasus countries (Armenia, Azerbaijan, Georgia) and Moldova was organized. The aim of the meetings was the exchange of information between the EU and these countries as well as the formulation of plans for the coming years. Denmark, which took over the Presidency from Poland, also held consultation with the Caucasus countries and Moldova.

According to Poland, the top challenge before Poland and the European Union is new synthetic drugs such as legal highs. Routine actions taken at the EU or national level in this respect have proved insufficient; therefore Poland made it one of the top priorities during her presidency.

Polish contribution to the Horizontal Working Party on Drugs in 2012

During monthly sessions of the Horizontal Working Party on Drugs (HDG) in 2012, Poland representatives participated in the discussion on the framework of the new EU Drugs Strategy 2014-2020. Polish delegation backed the proposal to incorporate in the future strategy the provisions regarding the problem of illegal trade in precursors used

in the production of illegal drugs. Poland also proposed that the new strategy focus more deeply on specific and feasible priorities rather than set a broad spectrum of actions which are bound to be unsuccessful.

The HDG sessions also featured discussions on issues such as the need for European quality standards in drug prevention as well as indicators for drug prevention, treatment and harm reduction. Poland participated in this discussion and stressed the relevance of standards development as well as the contribution of the European evidence base to the formulation of international standards, which are currently being developed by the UNODC. Working out minimum standards in drug prevention under the EQUUS project was supported by the results of another project entitled “European drug prevention quality standards”. The standards in this project were developed by six EU Member States, including Poland. The standards were published by the European monitoring Centre for Drugs and Drug Addiction in the form of a manual for professionals towards the end of previous year.

In 2013, the Drug Prevention and Information programme expires. The next EU budget 2014-2020 does not feature the continuation of this programme. Numerous delegations pointed that the issues related to drug demand reduction should be incorporated in EC programmes. It was recommended that provisions in this respect be incorporated in the Health for Growth Programme, the third multi-annual programme of EU action in the field of health for the period 2014-2020. The discussion on this topic has been going on in the Working Party on Public Health. Poland, both in the HDG and Working Party on Public Health, proposed that the Health for Growth programme be extended by issues related to drug demand reduction (Drug prevention, rehabilitation, monitoring and research into new psychoactive substances).

1.4. Economic analysis

- **Expenditure**

Table 1.4.1. shows information on 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 2011.

The figures given do not include all the Programme-related expenditure due to lack of information from some institutions. Due to failure to extract the NPCDA expenses, some institutions reported only data regarding the overall expenditure.

Table 1.4.1. NPCDA expenditure in 2011

No.	Institution	NPCDA expenditure in PLN	Total expenditure on counteracting drug addiction in PLN
1.	Central Management Board of Prison Service	12 212 415.10	12 212 415.10
2.	Institute of Psychiatry and Neurology	772 241	n/a
3.	Police Headquarters ¹⁶	n/a	1 204 938
4.	Military Police Headquarters	106 426.76	463 139.94
5.	National Bureau for Drug Prevention	9 510 000	9 510 000
6.	Ministry of National Education	b.d.	1 500 000
7.	Ministry of National Defence	122 345	122 345
8.	Ministry of Internal Affairs and Administration	93 285	93 285
9.	National Institute of Public Health–State Institute of Hygiene	7 581.72	7 581.72
10.	State Agency for Prevention of Alcohol Related Problems	31 833.30	31 833.30
11.	National Health Fund ¹⁷	25 325 958.8	92 331 860.60
12.	Centre for Education Development	17 443	17 443
13.	Communal governments	79 790 471	79 790 471
14.	Provincial governments	6 184 134.24	6 184 134.24
	Total:	134 174 134.90	203 469 446.90

Source: National Bureau for Drug Prevention.

The failure to extract the expenditure on counteracting drug addiction by some institutions results from the lack of a separate budget for such activity.

Some ministries and institutions reported higher NPCDA spending compared to 2010, including Institute of Psychiatry and Neurology (rise of almost PLN 49 000), Ministry of National Defence (rise of almost PLN 25 000) and Centre for Education Development (rise of nearly PLN 14 000). Ministry of National Education reported the highest rise of almost PLN 2 million.

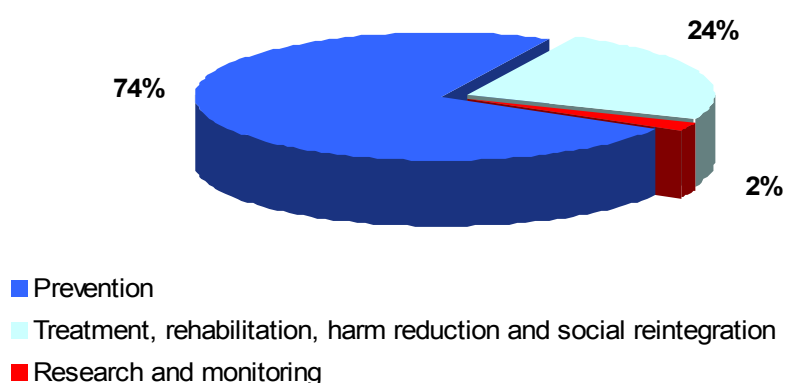
¹⁶ Police reported only expenditure incurred by the Central Forensic Science Laboratory.

¹⁷ NPCDA Expenditure of the National Health Fund as at 21 May 2012 and the total expenditure as at 29 February 2012

Some ministries and institutions reported lower NPCDA spending compared to 2010, including Central Board of Prison Service (fall of over PLN 65 000); National Bureau for Drug Prevention (fall of PLN 236 000), Ministry of Internal Affairs (fall of nearly PLN 6 000) and National Institute of Public Health (fall of over PLN 1 300).

The analysis of the local and regional government spending reveals an increase in the resources allocated to the NPCDA implementation by Marshal Offices. In 2011, the expenditure stood at PLN 6 184 134.24 compared to PLN 5 217 518.09 in 2010. By comparison with 2010, there was a rise in the expenditure on the implementation of the National Programme for Counteracting Drug Addiction by communal governments (from PLN 65 090 949 in 2010 to 79 790 471 in 2010). Within the communal expenditure the highest share was prevention i.e. PLN 59 749 060. The percentage distribution of the communal expenditure is shown in Figure 1.4.1.

Figure 1.4.1. Percentage breakdown of funds earmarked by communal governments to respective components of the NPCDA in 2011.



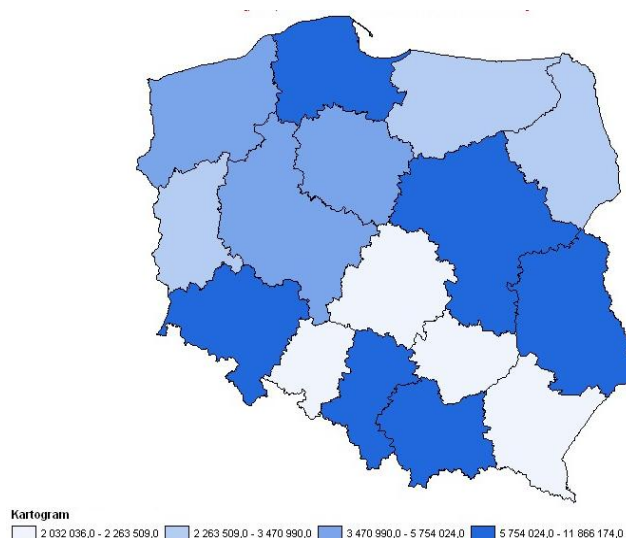
Source: National Bureau for Drug Prevention.

- **Communal NPCDA expenditure**

The analysis of the communal NPCDA expenditure in 2011 will first include overall communal spending in respective provinces. In 2011, communes spent PLN 79 million in the course of the NPCDA implementation, which accounts for 59% of all NPCDA costs. For comparison, Marshal Offices allocated PLN 6 148 134 to NPCDA activities while the National Health Fund PLN 25 325 957. Most communal spending was earmarked on prevention (PLN 59 748 726). Much less was spent on drug treatment and rehabilitation (PLN 18 836 611) and research and monitoring (PLN 1 204 800). The total expenditure including prevention, treatment, research and monitoring varied depending on the province. Over PLN 10 million was spent in the provinces of malopolskie and slaskie. Third came dolnoslaskie province with the amount of PLN 7 million. The lowest spending was recorded

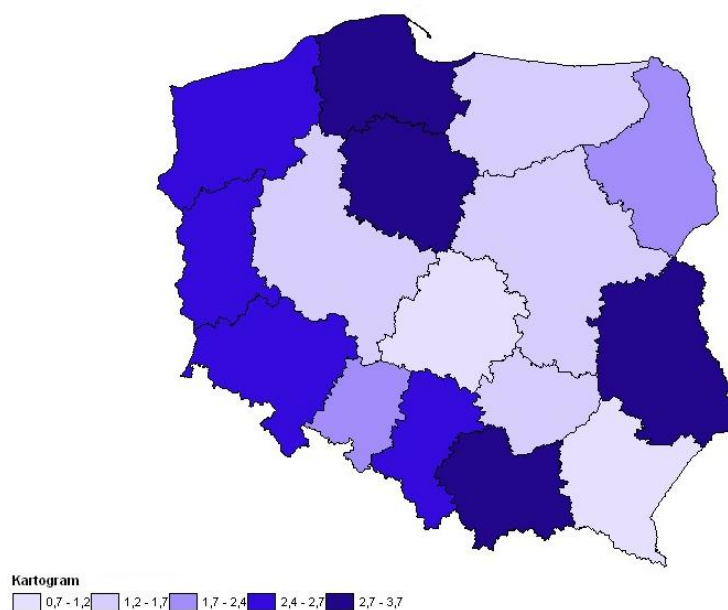
in the provinces of swietokrzyskie, lodzkie and podkarpackie i.e. over PLN 2 million. It must be noted that the spending of malopolskie province was five times as high as the spending in the provinces of podkarpackie or lodzkie. Let us take a look what areas (i.e. prevention, treatment, research and monitoring) attracted the biggest expenditure. Detailed information on the NPCDA expenditure in respective provinces is presented in Table 1.4.2. Prevention spending was the highest in the provinces of malopolskie and slaskie. As far treatment is concerned they were slaskie and lubelskie provinces. Research and monitoring enjoyed the highest expenditure in the provinces of malopolskie and wielkopolskie. It must be stressed that large proportion of the expenditure incurred in malopolskie province was made up by the Krakow city spending. For comparison reasons, the NPCDA expenditure in respective provinces was converted into spending per capita. This way we can eliminate distortion due to province populations. The highest NPCDA spending per capita of PLN 3.6 was recorded in the communes of malopolskie province followed by pomorskie province (PLN 2.8) and lubelskie and kujawsko-pomorskie provinces (PLN 2.7). Communes with the lowest NPCDA expenditure per capita included lodzkie province (PLN 0.8) and podkarpackie province (PLN 1). The national average stood at PLN 2.

Figure 1.4.2. Communal NPCDA expenditure in 2011



Source: Polish Focal Point

Figure 1.4.3. Communal NPCDA expenditure per capita in 2011



Source: Polish Focal Point

Table 1.4.2. Communal expenditure in PLN

	Communal expenditure in PLN				
	Prevention	Treatment	Research and monitoring	Total	Communal NPCDA expenditure per one person in 2011
dolnoslaskie	6050814	917308	115896	7084018	2.46
kujawsko-pomorskie	4063576	1437229	105230	5606035	2.71
lubelskie	2868564	2925605	107844	5902013	2.74
lubuskie	1832505	824315	13954	2670774	2.64
lodzkie	1622208	328792	104340	2055340	0.81
malopolskie	9911048	1705556	207634	11824238	3.58
mazowieckie	5375405	954142	74272	6403819	1.23
opolskie	1560194	663965	10817	2234976	2.17
podkarpackie	1925910	58878	47248	2032036	0.97
podlaskie	1879220	933611	19680	2832511	2.38
pomorskie	4898862	1336526	77665	6313053	2.83
slaskie	8269097	3502761	94316	11866174	2.56
swietokrzyskie	1985692	59282	28852	2073826	1.63
warminsko - mazurskie	1461508	802356	28178	2292042	1.61
wielkopolskie	3759243	626909	103660	4489812	1.32
zachodniopomorskie	2284880	1759376	65214	4109470	2.43
Total	59748726	18836611	1204800	79790137	2.07

Source: Malczewski 2012e, p. 27

2. Drug use in the general population and specific targeted groups

Prepared by Artur Malczewski, Marta Struzik, Anna Strzelecka, Anna Misiurek

2.1. Drug use in the general population in Poland

The following survey was conducted by means of face to face questionnaire interviews conducted with respondents in their place of residence. The survey questionnaire was designed based on the first national survey conducted by the National Bureau for Drug Prevention in 2002. The survey adopted the methodology of the European Monitoring Centre for Drugs and Drug Addiction. The questionnaire was modified in the course of follow-ups of 2006 and 2010. The latest survey included a battery of questions related to legal highs and gambling. This way, the study which was previously concerned mainly with psychoactive substance use (tobacco, alcohol, drugs) was extended to behavioural addictions. The questionnaire contained mainly closed questions. In some cases the respondents were asked to name substances they used e.g. sedatives and legal highs. The survey was conducted in November and December 2010 on a randomly selected sample of Polish residents aged 15-64 (n=3900). The project was conducted in the course of studying attitudes and behaviours related to psychoactive substances on a national sample and provincial samples. Field studies were implemented by General Projekt Sp. z o.o. The survey included a three-level structure of sample selection. First, communes were selected out of all Polish communes based on the size and the province they belonged to. Then, based on the PESEL register, home addresses were randomly selected in the pre-selected communes. Later, the respondents were chosen based on the Kish grid. Consequently, the survey covered a national sample and 8 provincial samples. Additionally, in order to eliminate distortions due to sample bias, weights were applied to balance disproportions in basic variable distributions i.e. gender, age, province and place of residence (rural or urban). The survey was conducted by the National Bureau for Drug Prevention in cooperation with 8 provinces. Such a considerable sample of provinces was the result of collaboration between the National Bureau and the Provincial Information Experts on Drugs and Drug Addiction, who in the case of most provinces were responsible for implementing the project. This material presents results regarding specific psychoactive substances (marijuana, amphetamines, pharmaceutical drugs, ecstasy) but also public perception of drug addiction as a social problem. The most important results of the survey were published in *Serwis Informacyjny NARKOMANIA* (Malczewski, Struzik 2012) and *Remedium* (Malczewski b,d).

- **Drug addiction as a social problem**

The survey respondents were asked to rank the importance of each of 14 social problems on a 5-grade scale nationally and locally (Table 2.1.1). The scale extremes were

named “very important” and “unimportant”. The respondents could also mark the answer “hard to say”. Then they were asked to select one problem which they considered most important.

Out of all the social problems at national level in the questionnaire, unemployment was given top priority. The highest percentage of respondents considered it very important (58.9%) and 27.7% regard it as most important (see Table 2.1.2).

Second in terms of absolute choices came violence in family (43.9%). In terms of the importance this problem was ranked third (8.3%) preceded by economic crime, which was considered second most important social problem nationally (10.5%).

Third place in terms of absolute choices was taken by street violence and aggression (41%); however, with regard to the selection of the most important problem according to the respondents it was ranked ninth (5.6%).

Drug addiction in the eyes of the respondents is not treated as a particularly threatening phenomenon. The respondents ranked it eleventh in the category “very important” (26.4%) and tenth in the category “most important” (4.4%). Alcoholism was ranked seventh with reference to the first indicator (32.1%) and sixth with reference to problems considered most important nationally by the respondents (6.1%).

Table 2.1.1. Importance of social problems at national level (percentages of respondents)

	Very important	Important	Not so important	Little important	Unimportant	Hard to say
1) Economic crime	29.1	32.0	22.1	10.4	2.9	3.5
2) Common crime	28.7	39.7	19.9	7.8	1.7	2.1
3) Drug addiction	26.4	37.0	24.3	8.7	2.0	1.6
4) Pollution	22.0	34.6	26.9	11.7	3.1	1.7
5) Alcoholism	32.1	39.3	19.9	6.5	1.2	1.0
6) Moral crisis	21.3	33.1	26.8	12.2	3.5	3.2
7) Bad public health	31.9	33.2	21.8	9.0	2.5	1.8
8) Low standard of living	36.7	35.6	18.3	6.6	1.3	1.4
9) Poor housing	35.0	36.9	19.3	6.2	1.3	1.2
10) Family violence	43.9	34.3	15.9	4.2	0.7	1.0

11) Street violence and aggression	41.0	38.8	14.9	3.8	0.7	0.8
12) Youth drinking	35.1	36.4	18.6	6.4	2.6	0.9
13) Unemployment	58.9	27.9	9.0	2.9	0.8	0.5
14) AIDS	22.0	29.7	22.0	13.1	5.8	7.5

Source: Polish Focal Point

Table 2.1.2. The most important social problem in Poland according to the respondents (percentage of respondents)

1) Economic crime	10.5
2) Common crime	7.0
3) Drug addiction	4.4
4) Pollution	2.3
5) Alcoholism	6.1
6) Moral crisis	2.9
7) Bad public health	6.0
8) Low standard of living	7.7
9) Poor housing	5.7
10) Family violence	8.3
11) Street violence and aggression	5.6
12) Youth drinking	3.2
13) Unemployment	27.7
14) AIDS	2.5

Source: Polish Focal Point

- **Cannabis use**

The respondents were asked about drug use experience. They answered questions about substance use in the last 30 days prior to survey (current use), the last 12 months (recent use) and in a lifetime (lifetime experience). Individual who have used drugs in the last

12 months are called occasional users and the ones who have used drugs in a lifetime are referred to as experimental users. The respondents were also asked to say how many times they had used a psychoactive substance. If the respondent did not remember the number or did not know how frequently he or she had used the drug, however, they admitted they had used it was also considered substance use. The most prevalent substance among the respondents was cannabis. 17.6% stated they had used it. There were 9.6% of recent users (last 12 months) and 5.4% of current users (last 30 days). There were 22% of male and 13% of female lifetime cannabis users. Age is a differentiating factor. The highest percentages of cannabis users were recorded in the age group 15-24 (29.1%) and 25-34 (28.6%). If we look at the recent use (last 12 months) cannabis use was two times more prevalent among males (12.4%) than females (6.8%). Every fifth respondent aged 15-24 had used cannabis in the last 12 months.

- **Availability of cannabis**

The survey attempted at determining the availability of psychoactive substances. It was measured with the question about the difficulty to get hold of a drug. The possible answers ranged from “Impossible” to “Very easy”. There was also an “I don’t know” option. It must be noted that in the case of cannabis, which are most prevalent in Poland, the respondents pointed that it was easier to get hold of it compared to other substances. Similar percentages of the respondents considered the access to cannabis impossible and easy. Nearly every third (30.8%) regarded the access to cannabis as impossible and not much less respondents as easy (27.9%). The respondents aged 15-24 had the least difficulty getting cannabis. In this group half of the respondents (49.9%) considered the access to cannabis easy or very easy. Lifetime users consider it easier to get drugs compared to those who have never used drugs. In this case more than a half of lifetime users considered it easy to access drugs (63.9%) while only 14.9% of the individuals who have never used cannabis shared this view. The level of drug availability among the respondents can be estimated based on contacts with drug users. It can be assumed that the respondents who report having friends who use drugs have better access to psychoactive substances compared to individuals who do not know any drug users. The vast majority of respondents do not have any drug using friends, however, the lowest figure relates to cannabis (65%) and sedatives and hypnotics (73.5%). In the case of the remaining substances the ‘nobody’ answers reach over 80%. More than several friends who use cannabis were reported by 28.2% of the respondents. One of the measurements of drug availability applied in the survey was the question about the time needed to get drugs. About every fifth respondent (21%) could get cannabis in less than one day. 14% of the respondents would need at least several days. Every third

considers getting hold of cannabis impossible or they are unable to determine the time (33.3%).

Moreover, the cannabis users were asked how, from whom and where they came into possession of cannabis the last time they used the substance.

Out of various ways of getting cannabis, the respondents most frequently pointed to being supplied (12.2% in the whole survey population; 69.2% in the group of cannabis users) or to purchasing it (7.2% in the whole survey population; 44.9% in the group of cannabis users). It can be noted that private cultivation of cannabis was scarce (0.8% in the whole survey population; 4.7% in the group of cannabis users) compared to being supplied or purchasing. As for the location of getting hold of cannabis, the respondents reported three places: for more than a half of the respondents it was private home (59.2% of cannabis users), for 33.4% it was a bar, a discotheque, a youth concert, etc. while for 29.1% it was an open public place such as a park, a station or a street.

- **Use of sedatives and hypnotics without medical indications**

The results of the 2010 survey show that 5.1% of adult Poles had used sedatives and hypnotics without doctor's prescription in a lifetime. In the last 12 months such experience was reported by 3.5% while the current use was recorded among 2.1% of the respondents. The prevalence of sedatives and hypnotics use is ranked second following cannabis use. Comparing the results of the 2010 and 2006 surveys, there is a considerable fall in experimenting with sedatives and hypnotics (lifetime prevalence of 18.2% in 2006) and in recent use (7.7% in 2006). The narrowest gap was recorded in current use. In 2006, 4.1% reported using drug in the last 30 days prior to survey.

- **Availability of sedatives and hypnotics without doctor's prescription**

Every third respondent (31.9%) regarded access to sedatives and hypnotics as easy and more than a half reported difficulty getting these substances (55.5%). Only 12.4% of the respondents could not give answers, however, it is the lowest percentage of "I don't know" answers (in the case of all the remaining psychoactive substances whose availability was estimated, the percentages of respondents finding it hard to answer this question were higher). It is interesting that there were slight differences between three age groups regarding "easy" answers to the question about the availability of hypnotics and sedatives (15-24: 35.0%, 25-34: 33.1% and 35-64: 30.2%)

In hypnotics and sedatives the abovementioned trend was confirmed. Individuals who had drugs before considered access to these substances easier than non-users (40.3% and 29.9% respectively).

Over 70% of the respondents (73.6%) do not have friends who use sedatives or hypnotics. It is a high proportion; however, compared to other substances it is second lowest after cannabis. It means that approx. every fourth respondent knows a friend who uses sedatives and hypnotics. Rates for having friends who use sedatives and hypnotics are highest in the age group 15-24 (36.6%), followed by 25-34-year-olds (34.1%) and then in the oldest age group 35-64 (27.2%). It must be noted that in the group of the oldest respondents (35-64), the most numerous group of friends includes users of hypnotics and sedatives.

- **Amphetamine use**

The most prevalent illegal substance following cannabis is amphetamine. 4.0% of the respondents admitted to using this substance. Recent users (last 12 months) accounted for 1.9% of the respondents while there was 1% of current users (last 30 days). Among the respondents there were 6.5% of male lifetime users and only 1.8% of females. A differentiating factor is age. The highest percentages of amphetamine user were recorded in the age group 15-24 (7.2%) and 25-34 (9.1%). Let us take a look the prevalence of amphetamine use among recent users (last 12 months prior to survey). Men used amphetamine three times as frequently (2.7%) as women (0.8%). In the age group 15-24 the prevalence of amphetamine use in the last 12 months was reported by 4.2% of the respondents while in the older cohort (25-34) it was 3.7%.

- **Availability of amphetamine**

Less than half of the respondents (41.6%) considered it impossible to get hold of amphetamine while every tenth found it easy (9.7%). Respondents aged 15-24 had least difficulty getting amphetamine. In this age group every fifth (19.1%) regarded access to amphetamine as easy or very easy. Questioned lifetime users find it easier to get hold of amphetamine than non-users. In this case, every fourth user found the access easy (26.5%) while in the group of non-users this percentage stood at 5.7%. The availability of psychoactive substances can be measured based on contacts with individuals who use the drug. 13.6% of the respondents confirmed that they had friends who used amphetamine.

- **Ecstasy use**

Ecstasy is the fourth most prevalent psychoactive substance used by adult Poles. Lifetime prevalence of ecstasy use stood at 3.4% in 2010, which is slightly more compared to 2006 (1.2%). 1.5% of the respondents reported using ecstasy in the last 30 days prior to survey in 2010, which is 1.2 percentage points more compared to 2006. The percentage of current users did not exceed 1% in 2006 and 2010 (0.1% and 0.6% respectively). More men

(5.1%) than women (1.7%) admitted to experimenting with ecstasy and these experiences mostly relate to the age group 25-34 (7.1% of all respondents) and 15-24 (5.9% of all respondents). Prevalence of ecstasy use in the last 12 months was recorded among 2.1% of men and 0.5% of women and the highest percentage was observed in the age group 15-24 (3.5%) followed by 25-34-year-olds) 2.0%. It is interesting that current ecstasy use refers mostly to men aged 15-24.

- **Availability of ecstasy**

Every fourth respondent (25.1%) was unable to answer the question about the availability of ecstasy. In terms of availability, ecstasy belongs to the group including hallucinogenic mushrooms, LSD and anabolic steroids. In the case of these substances the percentages of respondents who considered it easy to get the drug ranged from 7% to 9%, with ecstasy at 8.5%.

Mostly young respondents find it easy to get ecstasy (17.9% aged 15-24) compared to 12.4% in the group 25-34 and 3.5% aged 35-64. There are different opinions of the availability of ecstasy between lifetime users and non-users (23.8% and 4.9% respectively). Nearly 90% of the respondents (88.1%) stated that they had no friends who used ecstasy and if it was the case, it was recorded in the age group 15-24 (22.6%) followed by 25-34 (18.6%) and finally by 35-64-year-olds (4.0%). Over 80% of the respondents (81.6%) find it impossible or cannot determine how much time they would need to get ecstasy.

- **2006 and 2010 results – rise in prevalence**

Table 2.1.3 shows the results of drug use prevalence for 2006 and 2010. The surveys were conducted by means of the same methodology so their results are comparable. In the case of most substances there was a rise in prevalence. Lifetime prevalence rates doubled for cannabis, LSD, hallucinogenic mushrooms. Experimenting with ecstasy increased to larger extent than amphetamine. Analyzing the last 12-month prevalence it must be noted that there was a threefold increase in cannabis use and almost a threefold one in amphetamine use. The interpretation of the results is hampered by the rates being near margin of error. It must also be noted that in 2010 5.4% of the respondents had used cannabis in the last month while in 2006 it was under 1%.

Table 2.1.3. Prevalence of drug use in a lifetime, last 12 months and last 30 days

	2010			2006		
	Lifetime	Last 12 months	Last 30 days	Lifetime	Last 12 months	Last 30 days
Cannabis	17.6	9.6	5.4	9.0	2.7	0.9
LSD	2.0	0.7	0.4	0.9	0.1	0.0
Amphetamine	4.0	1.9	1.0	2.7	0.7	0.2
Hallucinogenic mushrooms	2.0	0.6	0.4	1.0	0.1	-
Ecstasy	3.4	1.5	0.6	1.2	0.3	0.1
Crack	0.2	0.1	0.0	0.2	0.0	-
Cocaine	1.2	0.7	0.5	0.8	0.2	0.1
Astrolit	0.1	0.0	-	-	-	-
Heroin	0.2	0.1	0.1	0.1	0.1	0.0
Methadone	0.1	0.0	-			
"Kompot"	0.6	0.2	0.1	0.2	-	-
GHB	-	0.0	0.0	-	-	-
Anabolic steroids	1.7	0.7	0.5	0.4	0.1	0.0
Inhalants (e.g. glues, paints)	1.6	0.5	0.3	-	-	-
Sedatives and hypnotics without doctors prescription	5.1	3.5	2.1	18.2	7.7	4.1

Source: Polish Focal Point

- **Summary:**

1. The most prevalent substance among adult Poles is cannabis followed by sedatives and hypnotics used without doctor's prescription. Amphetamine is ranked third and ecstasy fourth. 19.3% of the respondents admitted to having used an illegal substance at least once (24.5% of men and 14.1% of women). In the last 12 months the percentage stood at 15% (16.5% of men and 13.5% of women).
2. Amphetamine is ranked third followed by ecstasy. 19.3% of the respondents reported using any illegal substance in a lifetime (24.5% of men and 14.1% of women). In the last year prior to survey this figure stood at 15.0% (16.5% of men and 13.5% of women)
3. Experimenting with sedatives and hypnotics fell over the years 2006-2010. In the case of cannabis, amphetamine, ecstasy we record a rise in prevalence both in terms of experimenting and current use. Prevalence of amphetamine and ecstasy use remains at a similar level both in experimenting and current use.

4. Analyzing lifetime prevalence it must be noted that rates for adolescents (15-24) and young adults (25-34) are similar (31.2% and 32.4% respectively). Comparing these two age groups in the case of recent use (last 12 months) we observe higher percentages among adolescents (20.9%) than young adults (16.0%). The results of the survey show that illegal substance use is nearly as popular among young adults as adolescents.
5. Every third respondent reported easy access to sedatives and hypnotics and every fourth has a friend who uses these substances without doctor's prescription. The availability of cannabis is not as wide. Every fourth respondent reported easy access to cannabis.
6. The oldest respondents (35-64) frequently have a friend who uses sedatives and hypnotics.
7. In terms of easy access to drugs, ecstasy belongs to the same group as hallucinogenic mushrooms, LSD and anabolic steroids.

2.2. Drug use in the school and youth population

- **HBSC survey 2010**

Authors of the study: Mazur, J., Wojnarowska, B., Małkowska-Szcutnik, A., Kołolo, H., Tabak, I., Kowalewska, A., Dzielska, A.

Introduction

Health behaviour surveys in School-aged children (HBSC. WHO Collaborative Study) are part of international surveys conducted every four years. The surveys were first launched in 1990 and had a uniform procedure of research into young population aged 11, 13 and 15. The aim of the survey is to identify conditions for health and health behaviour among school students, including subjective perception of health and wider social context. The research in Poland has been coordinated by Joanna Mazur, MD, PhD of the Institute of Mother and Child in Warsaw since 2004.

For the purposes of the Polish questionnaire, obligatory questions about drug use were placed in one module and referred to the prevalence of cannabis use in students aged 15-16 in a lifetime, last 12 months and last 30 days. In Poland, the 2010 survey also included 2nd graders of secondary schools aged 17-18.

Methodology

The 2010 survey was based on a modified sample of the two previous editions to ensure comparability of data. For organizational reasons, the number of provinces was

reduced from 11, where in 2006 all three age groups were examined, to 8. The survey included students from the following provinces: dolnoslaskie, kujawsko-pomorskie, lodzkie, mazowieckie, podkarpackie, slaskie, warminsko-mazurskie and zachodniopomorskie. In the event a school which participated in the 2006 survey ceased to exist or refused to participate again, a substitute school was selected based on the up-to-date list of the schools available on the website of the Ministry of National Education.

Eventually, in the 2006 survey included 6 162 school students (48% of boys and 52% of girls) from 152 schools and 307 classes. The response rate stood at 89.3% (81.8% in 2006), which makes it highly representatives.

Cannabis use prevalence

Tables below show data on the prevalence of drug use in school students in the following categories: lifetime, last 12 months and last 30 days.

Table 2.2.1. Lifetime prevalence rates for cannabis use.

GRADE AGE	SEX	NEVER	1-2 TIMES	3-5 TIMES	6-9 TIMES	10-19 TIMES	20-39 TIMES	40 TIMES AND MORE
3rd grade of middle school (15-16)	Total	80.5	9.1	3.2	2.0	1.9	1.4	1.9
	Boys	75.1	10.1	4.6	2.5	2.6	2.0	3.0
	Girls	85.7	8.1	1.9	1.5	1.1	0.9	0.8
2nd grade of secondary school (17-18)	Total	69.1	13.5	5.5	2.9	2.8	1.9	4.3
	Boys	61.7	15.8	6.5	3.4	2.7	2.3	7.6
	Girls	75.0	11.6	4.8	2.6	2.8	1.5	1.7

Source: Mazur, Woynarowska, Małkowska-Szcutnik, Kołoto, Tabak, Kowalewska, Dzielska (2011), p. 143

In 2010, 80.5% of 3rd graders of middle schools reported that they had never used cannabis, which corresponds to the 2006 measurement results (81.5%). Among those who admitted to using the substance, the highest proportion (9%) reported using it 1-2 times in a lifetime (10% of boys and 8% of girls). These 1-2 times proportions held steady compared to the 2006 measurement when they stood at 10.8% for boys and 7.8% for girls.

Next most frequently checked category of answers was the category of 3-5 times in a lifetime. 3.2% of the respondents checked this answer, including 4.6% of boys and nearly 2% of girls. Slightly more girls reported using cannabis 3-5 times in lifetime in the 2006

survey (2.3%). The proportions of students who reported using cannabis 6 and more times in a lifetime did not exceed 2%.

Lifetime prevalence rates for cannabis use are higher in school students aged 17-18. Similarly to middle school students the highest number of answers referred to the category 1-2 times in a lifetime, where the overall rate stood at 13.5%, including 16% of boys and almost 12% of girls.

In the case of the older students, the rates for boys and girls differ to a lesser degree compared to the students aged 15-16. It refers to the frequency of use from 3 to 39 times in a lifetime. In the case of the 6-9 times, the proportion of girls and boys choosing this answer is almost the same and stands at nearly 3%.

However, the exception is observed in the cannabis use at the frequency of 40 times and more in a lifetime. This answer was checked by approx. 8% of boys and only 2% of girls aged 17-18 out of the overall proportion of 4.3%.

Table 2.2.2. Last 12 months prevalence rates for cannabis use.

GRADE AGE	SEX	NEVER	1-2 TIMES	3-5 TIMES	6-9 TIMES	10-19 TIMES	20-39 TIMES	40 TIMES AND MORE
3rd grade of middle school (15-16)	Total	84.9	7.4	2.3	1.9	1.6	0.8	1.0
	Boys	80.1	8.4	3.3	2.7	2.1	1.6	1.7
	Girls	89.4	6.5	1.3	1.1	1.1	0.1	0.4
2nd grade of secondary school (17-18)	Total	76.9	11.8	3.5	2.6	2.2	0.6	2.4
	Boys	70.4	15.2	3.5	3.1	2.6	0.8	4.3
	Girls	82.1	9.1	3.6	2.1	1.9	0.4	0.8

Source: Mazur, Woynarowska, Małkowska-Szcutnik, Kołoto, Tabak, Kowalewska, Dzielska (2011), p. 144

Proportions of students aged 15-16 who reported using cannabis in the last 12 months – similarly to lifetime prevalence rates – remain at the level comparable to 2006 and are higher for boys than for girls. The highest last 12 months prevalence rates were recorded for the category 1-2 times. For example, in 2006, nearly 7% of respondents admitted to using cannabis 1-2 times in a lifetime while in 2010 this rate stood at 7.4%. Considering the sex of the respondents using this substance 1-2 times in the last 12 months there were fewer boys and slightly more girls compared to the 2006 measurement – 9% in 2006 and nearly 8.5% in 2010 for boys and 5% in 2006 and 6.5% in 2010 for girls.

In 2010, almost 85% of students aged 15-16 reported never using cannabis in the last 12 months, including 80% of boys and almost 90% of girls. The overall rate for this category of answers in 2006 stood at 86.6% (82% of boys and 91% of girls).

The last 12 months prevalence rates for cannabis use are higher among students aged 17-18. Nearly 77% of the respondents denied having used cannabis in the last 12 months, including 70.5% of boys and 82% of girls. Over 15% of boys reported using the substance 1-2 times in the last 12 months (compared to 8.5% of boys aged 15-16). Among girls aged 17-18 this rate stood at 9% compared to 6.5% in the younger group.

Cannabis use of 40 times and more in the last 12 months was reported only by 2.5% of older students, including slightly more than 4% of boys.

Table 2.2.3 Last 30 days prevalence rates for cannabis use.

GRADE AGE	SEX	NEVER	1-2 TIMES	3-5 TIMES	6-9 TIMES	10-19 TIMES	20-39 TIMES	40 TIMES AND MORE
3rd grade of middle school (15-16)	Total	91.7	4.8	1.6	0.8	0.5	0.1	0.5
	Boys	87.9	6.6	2.0	1.6	0.9	0.1	0.8
	Girls	95.3	3.1	1.1	0.1	0.0	0.1	0.3
2nd grade of secondary school (17-18)	Total	90.1	5.7	1.4	0.9	0.4	0.7	0.7
	Boys	87.9	6.3	1.7	1.0	0.5	1.2	1.5
	Girls	91.9	5.2	1.2	0.8	0.4	0.4	0.1

Source: Mazur, Woynarowska, Małkowska-Szkućnik, Kołoto, Tabak, Kowalewska, Dzielska (2011), p. 145

The 2010 proportions of respondents aged 15-16 who reported using cannabis in the last 30 days are slightly lower compared to the 2006 measurement. The results of the latest survey showed that in 2010 approx. 92% of students had not used cannabis in the last 30 days while in 2006 this rate stood at 94%.

Similarly to the prevalence rates for cannabis use in a lifetime and last 12 months, the students most frequently reported using cannabis 1-2 times. In 2010, almost 5% of the younger students reported using cannabis in the last 30 days, including over 6.5% of boys and 3% of girls while in 2006 these rates stood at 3.5%, nearly 5% and 2.5% respectively. The rates for the last 30 days prevalence of cannabis use at the frequency of 3-5 times slightly exceeded 1.5% in the younger age group (1.1% in 2006) while the rates referring to 6 times and more in this age group did not exceed 1%, which is similar to

the 2006 values. The rates for the last 30 days prevalence of cannabis use among 2nd graders of secondary schools remain at the level similar to the group of the younger respondents.

In the case of the older students, except for the category of 20 times and more, the discrepancies between the proportions of boys and girls who reported using cannabis in the last 30 days are very narrow.

- **„Alcohol and drug use prevalence in school students. National survey report of 2011.” by Janusz Sierosławski**

Poland has been participating in the ESPAD study (European School Survey Project on Alcohol and Drug Addiction) for 16 years. The first measurement was taken in 1995 while the following editions took place in 1999, 2003, 2007 and the latest one in 2011.

The study was conducted by the Institute of Psychiatry and Neurology in May and June 2011 on a national sample of 3rd graders of middle schools and 2nd graders of secondary schools.

Aim

The main aim of the project was to collect data on the prevalence of substance use among school students. The survey listed questions on the availability of psychoactive substances (including alcohol and tobacco), opinions on their harmfulness and drug use-related experiences.

The object of the study was to monitor trends in substance use at international level. These data might be useful in developing drugs strategies and policies at national and local level.

Methodology

The survey included two cohorts of adolescents – students born in 1995 (age during study: 15-16) and 1993 (age during study: 17-18). The measurement was based on two-step sample selection. The sampling unit was a school class. First, schools were selected and then classes. The survey included all students present, regardless of the year of birth. Data presented in the national report differ slightly from the European report data. It is due to the fact that for international comparison the sample excluded two categories of students: repeating students and those who started education a year earlier. In the national report the results cover all 3rd graders of middle schools and 2nd graders of secondary schools, regardless of the year of birth.

The study was implemented by random selection method. In the latest edition, the questionnaire was extended by legal highs questions. The survey was anonymous. Anonymity was provided not only for respondents but also schools which took part in the survey.

The national sample included 2 623 middle school students and 2 693 secondary school students. Among 3rd graders of middle school there were 51% of girls and 49% of boys. In the older cohort the proportions were 48.3% and 51.7% respectively.

Lifetime prevalence of substance use

Data shown in Table 2.2.4. refer to lifetime prevalence of substance use among 3rd grader of middle schools. The most prevalent substances include cannabis (24.3%), hypnotics and sedatives taken without doctor's prescription (15.5%) and inhalants (8.7%). Lifetime prevalence rates for amphetamine use stood at 4.6%. Approx. 3% of the students reporting ever using LSD, hallucinogens, cocaine, anabolic steroids, Polish homemade heroin and crack.

Compared to previous studies, in 2011 an upward trend in the prevalence rates for almost all substances can be observed. In the case of cannabis the proportion of experimenters in 1995-2011 rose by 14 percentage points. However, it must be stressed that in 2007 there was a fall in this category (from 19% in 2003 to 15.7% in 2007). In 1995, every tenth student reported using cannabis at least once in a lifetime while in 2011 almost 25% of middle school students experimented with cannabis.

In the case of prevalence of sedatives and hypnotics used without doctor's prescription as well as inhalants, a slight systematic fall is observed. In 1995, 18.5% of middle schools students reported using pharmaceuticals without doctor's prescription while in 2007 this rate fell to 15.6% and keeps holding steady. A similar trend was observed in inhalants. Over 16 years the prevalence of inhalants use in the group in question fell by nearly 2 percentage points.

In 1995, prevalence rates for amphetamine use stood at 3% while in the following measurement an upward trend was recorded - the proportion rose to over 7%. In the next two editions of the survey amphetamine experimenting rates fell to 3.8% and rose again in 2011.

Table 2.2.4. Lifetime prevalence rates, by year of study

Grade level	Substance	1995	1999	2003	2007	2011
3rd graders of middle schools	Cannabis	10.1	15.1	19.2	15.7	24,3
	Amphetamine	2.9	7.4	6.0	3.8	4.6
	Crack	0.5	1.0	1.6	0.9	2.1
	Cocaine	0.8	1.9	2.2	1.8	3.3
	LSD or other hallucinogens	1.9	4.0	2.5	1.8	3.3

	Ecstasy	0.8	2.8	2.8	2.5	3.0
	Hallucinogenic mushrooms	-	-	3.5	2.0	3.1
	GHB	-	-	0.8	0.5	1.2
	Heroin	0.8	5.7	1.8	1.4	1.3
	Polish homemade heroin (kompot)	-	-	2.3	1.8	2.4
	Inhalants	10.4	9.1	9.3	8.2	8.7
	Anabolic steroids	2.8	3.4	2.9	2.1	2.7
	Sedatives and hypnotics without doctor's prescription	18.5	18.3	17.3	15.6	15.5

Source: Sierostawski (2011)

Table 2.2.5. shows lifetime prevalence rates by sex. In the case of almost every substance the drug experimenting rates are higher for boys. The difference between sexes in lifetime cannabis use prevalence is 11 percentage points (29.9% of boys and 18.9% of girls). Apart from cannabis, boys also more frequently use amphetamine, LSD, hallucinogenic mushrooms, anabolic steroids, crack and Polish homemade heroin. However, no difference was noticed with regard to inhalants (proportions for boys and girls of 8.7% and 8.6% respectively) and cocaine (3.2% and 3.5%). Higher rates for the use of sedatives and hypnotics used without doctor's prescription are observed in girls. In 2001, the difference was almost 10 percentage points.

Table 2.2.5. Lifetime prevalence rates, by sex.

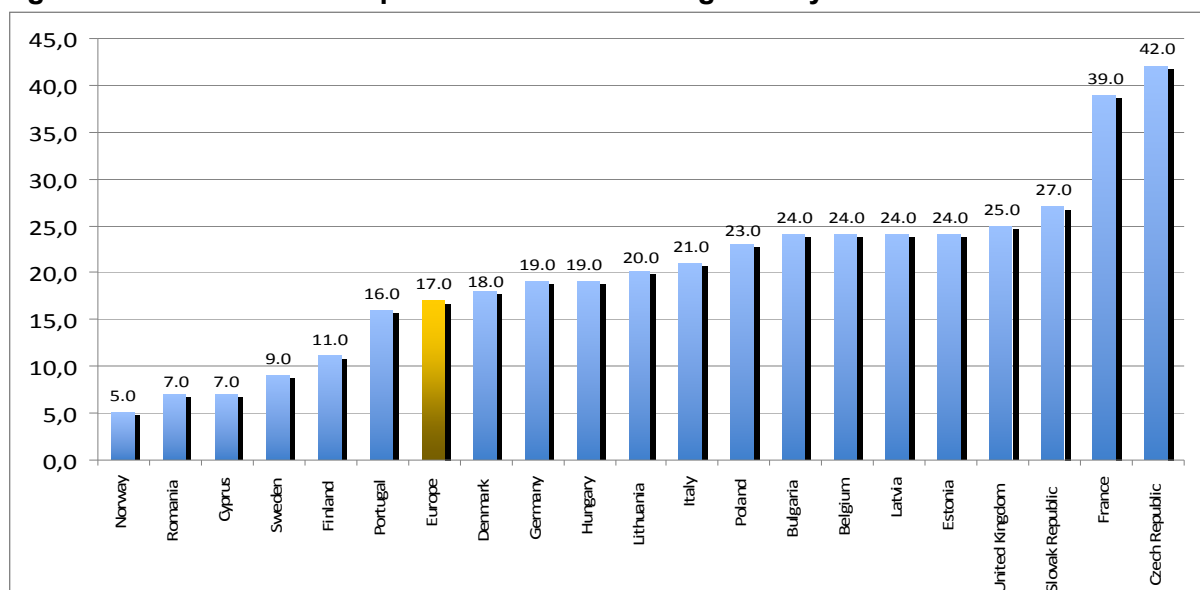
Grade level	Substance	Girls	Boys
3rd graders of middle schools	Cannabis	18.9	29.9
	Amphetamine	3.9	5.2
	Crack	1.1	3.0
	Cocaine	3.2	3.5
	LSD or other hallucinogens	2.4	4.2
	Ecstasy	2.2	3.8
	Hallucinogenic mushrooms	1.9	4.3
	GHB	0.9	1.6
	Heroin	0.9	1.7

	Polish homemade heroin (kompot)	1.7	3.2
	Inhalants	8.7	8.6
	Anabolic steroids	1.2	4.3
	Sedatives and hypnotics without doctor's prescription	20.3	10.6

Source: Sierosławski (2011)

Figure 2.2.1. shows data on the prevalence of cannabis use in respective countries. The lowest rates are observed in Norway (5%), Romania (7%) and Cyprus (7%) while the highest in the Czech Republic (42%), France (39%) and Slovakia (27%). The Polish rate of 23% is higher than the European average by 5 percentage points. Higher prevalence rates than the European average are also observed in the United Kingdom (25%) and Bulgaria, Latvia, Belgium and Estonia (24% each). Italy and Lithuania record slightly lower prevalence rates (21% and 20% respectively) compared to Poland.

Figure 2.2.1. Cannabis use prevalence rates among 15-16-year-olds

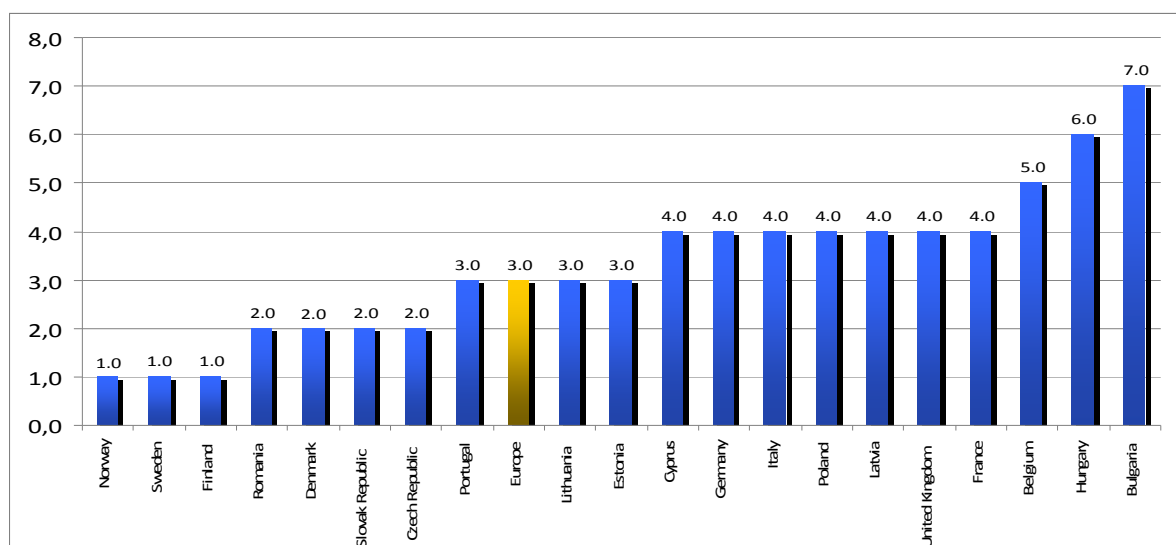


Source: Hibell, Guttormsson, Ahlström, Balakireva, Bjarnason, Kokkevi, Kraus (2011)

Figure 2.2.2. shows data on the lifetime prevalence of amphetamine use in respective countries. The European average stood at 3% and such a rate was observed in Lithuania, Estonia and Portugal. In Poland, this rate stood at 4%.

The lowest prevalence rates were observed in Norway, Sweden and Finland (1% each) while the highest in Bulgaria (7%), Hungary (6%) and Belgium (5%).

Figure 2.2.2. Amphetamine use prevalence rates among 15-16-year-olds.



Source: Hibell, Guttormsson, Ahlström, Balakireva, Bjarnason, Kokkevi, Kraus (2011)

Last 12 months prevalence of substance use

Table below shows data on the occasional use of psychoactive substances. In the 2011 survey, the number of psychoactive substances examined for the last 12 months prevalence was limited to three (cannabis, inhalants, ecstasy). 20.1% of middle school students reported using cannabis occasionally while the rates for inhalants and ecstasy stood at 4% and 2% respectively.

Compared to previous studies an upward trend for cannabis and ecstasy is observed. In 1995, 7% of middle school students reported using cannabis in the last 12 months and this rate rose systematically till 2003. In 2007, there was a fall (from 14.5% to 10.9%). The proportions of occasional inhalants users and ecstasy users held steady.

Table 2.2.6. Last 12 months prevalence rates, by year of study

Grade level	Substance	1995	1999	2003	2007	2011
3 rd graders of middle schools	Cannabis	6.9	12.3	14.5	10.9	20.1
	Inhalants	4.3	4.3	4.1	3.5	4.6
	Ecstasy	-	-	1.7	1.4	2.2

Source: Sierosławski (2011)

Table 2.2.7. shows the last 12 months prevalence rates by sex. Similarly to experimenting, higher rates are observed in boys (except for inhalants). The proportion of boys how reported using cannabis in the last 12 months stood at 24% compared to 16% for girls. The difference in ecstasy rates is almost 2 percentage points.

Table 2.2.7. Last 12 months prevalence rates, by sex

Grade level	Substance	Girls	Boys
3 rd graders of middle schools	Cannabis	15.8	24.6
	Inhalants	4.4	4.8
	Ecstasy	1.3	3.1

Source: Sierosławski (2011)

Last 30 days prevalence of substance use

Data below show last 30 days prevalence rates. Over 10% of middle school students reported using cannabis in the last 30 days prior to survey. In the case of inhalants it was almost 3% and for ecstasy the rate stood at 1.5%.

Compared to 1995, the proportion of current cannabis users rose by 7 percentage points (from 3% in 1995). There was also a slight increase for inhalants (from 1.8% in 1995) while the current prevalence rates for ecstasy use held steady.

Table 2.2.8. Last 30 days prevalence rates, by year of study

Grade level	Substance	1995	1999	2003	2007	2011
3 rd graders of middle schools	Cannabis	3.1	7.4	8.3	6.4	10.5
	Inhalants	1.8	1.9	2.5	2.3	2.8
	Ecstasy	-	-	1.0	0.9	1.5

Source: Sierosławski (2011)

Table below shows data on the prevalence of substance use in the last 30 days by sex. Similarly to experimenting and occasional use, last 30 days prevalence rates for boys are higher than for girls. The rates for cannabis use among middle school male students are 6 percentage points higher compared to female students. In the case of ecstasy this difference is almost 2 percentage points.

Table 2.2.9. Last 30 days prevalence rates, by sex

Grade level	Substance	Girls	Boys
3 rd graders of middle schools	Cannabis	7.5	13.6
	Inhalants	2.5	3.3
	Ecstasy	0.5	2.4

Source: Sierosławski (2011)

3. PREVENTION

prepared by Anna Radomska, Elżbieta Stawecka, Piotr Jurkowski, Artur Malczewski

3.1. Introduction

The legal act regulating anti-drug issues in Poland is the Act of 29 July 2005 on counteracting drug addiction (Journal of Laws of 2011, No. 179, item 1485). The most significant amendment is the option of discontinuing the proceedings for the possession of narcotic drugs or psychotropic substances for personal use. The proceedings might be dropped prior to issuing a decision to instigate an investigation or an inquiry if the punishment would be pointless due to the circumstances of committing the offence or the degree of social harm. Moreover, in the case where an addicted person or a problem user accused of a drug-related crime subject to the penalty of up to 5 years in prison enters drug treatment, rehabilitation or an education and prevention programme, the prosecutor may suspend the proceedings till the treatment, rehabilitation or the programme is completed.

A regulation was added which states that in the case of a well-grounded suspicion that the perpetrator is addicted to psychoactive substances or is a problem user, the court, and the prosecutor in the course of preparatory proceedings, may order to collect information on the perpetrator's drug use. This amendment was followed by the Regulation of the Minister of Justice of 5 January 2012 which specifically sets out conditions and procedure for the data collection. A NBDP-administered registry was established. It lists persons authorised to collect the information on the perpetrator's drug addiction (136 specialists).

3.2. Environmental prevention

- **Alcohol policies**

Preventing alcohol use and solving alcohol-related problems is the mission of the State Agency for Prevention of Alcohol Related Problems. The agency operates pursuant to the Act on Upbringing in Sobriety and Counteracting Alcoholism. The Act obliges both governmental institutions and local authorities to implement measures aimed at reducing alcohol consumption. Activities within the scope of counteracting alcoholism are carried out by contributing to the appropriate shaping of social policy, especially by:

- providing education and information,
- determining the appropriate level and correct structure of the production of alcoholic beverages destined for consumption in Poland,
- reducing alcohol availability,
- providing alcohol treatment, rehabilitation and reintegration,
- preventing alcohol abuse and eliminating its negative consequences,

- counteracting domestic violence,
- supporting social employment by financing social integration centres.

The above activities are incorporated in the **National Programme for Prevention of Alcohol-Related Problems**, which is approved by the Council of Ministers. The implementation of the National Programme is financed with 1% of alcohol excise tax. The resources are allocated to different services for alcohol-dependent individuals and their families, alcohol-related information, education, training of professionals and research into alcohol problems. Moreover, a special Student Sport Activity Fund is established and managed by the Minister competent for the matters of physical education. It is a state special fund. The Fund resources come from alcohol advertising, which is 10% of VAT in this field. The Fund serves to co-finance sport activities for school students in clubs run by NGOs, which within their statutory operation promote physical culture among children and adolescents which is also in the domain of local authorities.

Governmental administration and local authorities are responsible for initiating and supporting activities aimed at changing alcohol use patterns, advocating sobriety at work, counteracting and eliminating consequences of alcohol abuse. These activities are supported by establishing and developing social organizations which promote sobriety and abstinence and which target alcohol abusers and provide assistance for their families.

At **provincial** level, alcohol prevention is defined by the Provincial Programme for Prevention of Alcohol-Related Problems. The provincial government is responsible for the coordination of development and implementation of the provincial programme. It provides technical assistance for institutions and individuals performing programme activities and collaborates with other bodies of governmental administration in the field of solving alcohol-related problems. Provincial anti-alcohol programmes are implemented by Regional Social Welfare Centres and other agencies specified in the programme.

Communal authorities are responsible for preventing and solving alcohol-related problems as well as reintegrating alcohol-dependent individuals. These tasks are performed through Communal Programmes for Preventing and Solving Alcohol-Related Problems. In order to increase the programme funding, communal authorities collect alcohol licence fees. The fee rates are dependent on the content of alcohol in a licensed alcoholic beverage. The Communal Council may, by way of ordinance, determine the number of outlets selling alcoholic beverages containing over 4.5% of alcohol (excluding beer), destined for consumption beyond point of sale and on the premises. Locations of points of alcohol sale and service are also determined. In towns where military units are located the number of alcohol outlets and the location thereof are determined by the communal council upon the opinion of the military unit commander. Moreover, the communal authorities may impose

a temporary or a permanent ban on alcohol sale or possession on certain grounds within the communal borders. The communal authorities may adopt regulations regarding opening days and hours of food and service enterprises. In the event of breaching thereof a financial penalty is imposed.

In Poland, **wholesale trade** in alcoholic beverages containing over 18% of alcohol may be performed only on the basis of a licence issued by the minister competent for the matters of economy. However, wholesale trade in alcoholic beverages containing up to 18% of alcohol may be performed based on the licence issued by the marshal of the province. The above licences are issued separately regarding wholesale trade in alcoholic beverages containing:

- up to 4.5% of alcohol and beer,
- between 4,5% and 18% of alcohol, excluding beer;
- over 18% of alcohol.

Alcohol licences are valid for the period of up to 2 years. Licences are provided with a time limit. It can be prolonged upon a trader's request. Fees are collected for issuing licences for wholesale trade in alcoholic beverages. The fee rates depend on the annual revenue from alcohol sale.

A licence can be revoked by the minister competent for the matters of economy or the marshal of the province if:

- a trader sells illegal alcoholic beverages
- a trader commits a crime with intent to gain material benefit through a person responsible for performing the business activity of a licence holder,
- an applicant provides false statement in the course of applying for a licence;
- an alcohol trader is banned from pursuing economic activity covered by the licence,
- a trader commissions, on the basis of agreements, wholesale trade in alcoholic beverages to other traders by;
- there is repeated disturbance of public order in the point of trading.

Retail sale of alcoholic beverages containing more than 4.5% of alcohol (except for beer) may be performed in designated shops selling alcoholic beverages, self-service outlets and other sales facilities where the seller performs direct sale of alcoholic beverages. In the case of self-service sales outlets with sales space exceeding 200 m² the sale is performed in designated areas.

Selling, serving or consuming alcoholic beverages is prohibited on the premises of schools and other educational institutions, adoption and care centres and students' dormitories, at the venue of and during mass gatherings, in vehicles and facilities of public transportation (except for restaurant and buffet cars where the sale and service of beer and alcoholic beverages containing up to 4.5% of alcohol. It is also prohibited to bring alcoholic

beverages into stadiums and other places where mass sport and entertainment events take place. Persons in possession of alcoholic beverages shall be obliged to place the beverages in deposit or they shall be refused entry or removed from the premises. Sale of alcoholic beverages is banned on the premises occupied by military forces and internal affairs authorities as well as in barracks and temporary military quarters. Bringing and consuming alcohol at work is also banned. The manager of the workplace or a person appointed by him/her for this purpose shall be obligated to prevent employees from work if there is a reasonable suspicion that the employee arrived at work under the influence of alcohol or consumed alcohol at working hours. It is also possible for the manager of the workplace or a person appointed by him/her for this purpose to arrange for examination of the employee's sobriety.

In the case of open-air events, the sale and service of alcoholic beverages containing up to 4.5% of alcohol may be performed only on the basis of a permit and in designated areas only.

It is prohibited to sell and serve alcohol to individuals under the age of 18 and to individuals whose behaviour indicates that they are under the influence of alcohol. When in doubt as to whether a customer is of legal drinking age, an individual serving or selling alcoholic beverages is entitled to demand a document confirming the age from the customer. According to the Penal Code, driving vehicles in the state of alcohol intoxication is punishable. A person is in the state of intoxication within the meaning of the Penal Code is when the blood alcohol content exceeds 0.5 o/oo or leads to the content which exceeds this value.

The excise duty rate for alcoholic beverages is defined in the Act on excise duty. The excise duty rate varies depending on the type of alcohol. According to the Act, alcoholic beverages include ethyl alcohol, beer, wine, fermented drinks and intermediary products. The excise duty rate for 1 hectolitre of ethyl alcohol in 100% volume of an end product stands at PLN 4 960. The excise duty for beer is PLN 7 379 from 1 hectolitre per each Plato degree of an end product. In the case of fermented drinks and wine it is PLN 158 whereas in the case of intermediary products it is PLN 318 from 1 hectolitre of an end product.

- **Tobacco policies**

A legal act which regulates issues related to tobacco policy in Poland is the Act of 9 November 1995 on the protection of health against the consequences of use of tobacco and tobacco products (Journal of Laws "Dz. U." of 30 January 1996). It provides that state administration and local governments are obliged to take action to protect health of the public from the consequences of tobacco use. They may also support similar activities of medical

professional associations, social organizations, foundations, institutions and companies as well as collaborate with churches and other religious associations.

The protection of health against the consequences of tobacco use is achieved by adopting health, economic and social policies that comprise:

- 1) protection of the right of non-smokers to live in a smoke-free environment
- 2) health promotion by promoting a smoking and tobacco-free life style
- 2a) education and information activities
- 3) creating legal and economic conditions aimed at reducing tobacco use
- 4) informing the general public about the adverse effects of smoking and the content of harmful substances on the packages of tobacco products and in advertisements
- 5) decreasing the maximum permissible levels of harmful substances in tobacco products
- 6) treatment and rehabilitation of tobacco-dependent patients.

According to the law, smoking is forbidden, with the exception of designated areas. Smoking is prohibited in the following places: 1) in health care establishments, 2) in educational units referred to in the education law and organizational units of social welfare referred to in the law on social welfare, 3) at universities, 4) in the rooms of work establishments other than listed, 5) in the rooms of public cultural and recreational establishments, 7) on public transport and buildings intended for travellers, 8) at public transport stops, 9) at sport establishments, 10) at public playgrounds, 11) in other rooms available for the general public.

An owner or an administrator may designate a smoking area in the following places: social welfare units or nursery homes, hotels, travel service grounds, universities, work establishments, food and beverage establishments and entertainment venues. An owner or an administrator of a food and beverage and entertainment establishment which has at least two rooms intended for consumption may exclude a closed consumption room from the ban as long as it is equipped with ventilation that prevents tobacco smoke from permeating other rooms.

It is forbidden to sell tobacco products in Poland to individuals under the age of 18. When in doubt as to the age of the buyer a seller may demand a document which will prove the age of the buyer. It is forbidden to sell tobacco products at health care establishments, schools and other education establishments as well as sports and recreation facilities. It is also forbidden to sell tobacco products through tobacco vending machines. It is also forbidden to sell cigarettes in packets containing fewer than 20 items and in bulk without a packet. It is forbidden to retail tobacco product in a self-service framework, except for duty-free shops. It is forbidden to manufacture and introduce to trade smokeless tobacco products, except for snuff. In the process of manufacturing tobacco products it is forbidden to

use additives which enhance the addictive qualities of nicotine. It is forbidden to place on packets of tobacco products inscriptions, names, trademarks, symbols and other signs suggesting that this product is less harmful than others.

In Poland, it is forbidden to advertise or promote tobacco products and accessories as well as products imitating tobacco products and accessories and tobacco-related symbols. The ban refers to advertisements released on television, radio, at health care establishments, schools and education facilities, in newspapers and magazines for children and adolescents, at sports facilities, in public places, in the press, on posters and IT services. Tobacco companies are also forbidden to sponsor sports, cultural, education, health, social and political activities. It is forbidden to display tobacco imitating packets in retail outlets.

Every single packet of cigarettes and other tobacco products to be sold in Poland should contain the following information printed clearly, legibly and permanently: at least two different warnings in terms of wording against the adverse effects of tobacco use and information about the levels of tar, nicotine and carbon monoxide per one cigarette.

The Minister competent for the matters of Health shall specify by way of regulation the permissible level of tar substances, nicotine and carbon monoxide in tobacco smoke, manner of determining thereof, a list of control laboratories authorized to define the content thereof as well as the content, graphic design and the way of placing the warnings and information, considering the division into general and additional warnings against adverse effects of tobacco use as well as considering the aims of health policy governed by relevant legal acts.

Treatment of smoking dependence in public health care facilities is free of charge.

The Council of Ministers develops a strategy of health, economic and social policies aimed at reducing tobacco use. This strategy is financed from the state budget at the level of 0.5% of the value of the excise tax on tobacco products.

Excise tax rates for tobacco products stipulated in the Act on excise tax are the following:

- 1) cigarettes – PLN 170.97 per 1 000 items and 31.41% of the maximum retail price;
- 2) smoking tobacco – PLN 115.86 per kilogram and 31.41% of the maximum retail price;
- 3) cigars and cigarillos – PLN 254.20 per 1000 items.

The minimum excise tax rate for cigarettes stands at 100% of the total excise tax amount calculated on the basis of the price equal to the weighted average retail selling price of cigarettes.

3.3. Universal prevention

- **SCHOOL**

Raising quality of education, especially through providing support for schools and related facilities in the performance of their duties and changes in the field of teacher training

belongs to the statutory activities of the Centre for Education Development, which is an institution supervised by the Ministry of National Education.

In 2011, the Ministry of National Education and the Centre for Education Development implemented actions aimed at strengthening the system of values of children and adolescents, especially in terms of shaping normative beliefs and psychosocial skills as protective factors for drug use.

One of the actions to this end is the extension of the network of Health-Promoting Schools under the European project of Schools for Health in Europe - SHE). Health Promoting Schools implement systemic and innovative solutions in health promotion and prevention. These solution help to increase effectiveness and range of pro-health activities by targeting students, parents and the environment they live in.

The network of Health-Promoting Schools includes 2 200 units such as schools, educational centres: nursery schools, boarding houses, children vacation facilities.

The Centre for Education Development organized a 20-hour training which featured presentations of research conducted in the schools network and a discussion on the strategy of implementing the SHE-recommended HEPS project (Healthy Eating and Physical Activity in Schools). The training was attended by provincial and regional coordinators of Health-Promoting Schools, representatives of schools and support teams (50 participants).

Moreover, in 2011 two sessions of the National Certification Committee of Health-Promoting School were held. The sessions were devoted to awarding HPS certificates to applicant schools. In 2011, 23 educational units applied to the National Network of Health-Promoting Schools for certificates. In recognition of systemic activities compliant with the concept of health-promoting schools, the National Certificate was awarded to 20 schools

The activity of the school in terms of health education, promotion and prevention is performed pursuant to the Act of 7 September 1991 on the Education System and is defined through:

- 1) a set of school curricula which covers the whole activity of the school from the didactic perspective,
- 2) an education strategy of the school, which covers all educational contents and aspects,
- 3) a prevention programme adapted to developmental needs of students and needs of a particular environment. It covers preventive activities addressed to students, teachers and parents.

The new core curriculum emphasises education, including counteracting drug-related social maladjustment among children and adolescents. A new solution is tight combination of pro-health education and physical education. It is compliant with the model recommended by the World Health Organization: primary object (physical education) and incorporating education-related content in many classes. At present, all schools and kindergartens provide

health promotion and prevention classes. Upon initiative of the Ministry of National Education 8 auxiliary packages on prevention and health promotion were created.

In 2011, the monitoring of actions aimed at incorporating legal highs-related contents in the core curriculum was completed.

In 2011, the Centre for Education Development supported implementation and promotion of evidence-based universal prevention programmes in primary schools. It was conducted through the Prevention Programme Bank at www.ore.edu.pl and telephone consultations with decision-makers, headmasters or school counsellors.

The Ministry of National Education continued preparation of the package for headmasters and educational facilities entitled *Legal highs prevention among adolescents. Prevention solutions for headmasters, teaching staff, students and educational units*. The package includes actions planned by the Centre for Education Development, National Bureau for Drug Prevention, Chief Sanitary Inspectorate and Police Headquarters. The materials along with the letter from the Minister of National Education to headmasters and educational units can be found at the website of the Ministry of National Education and the Centre for Education Development as well as the Scholaris site.

In 2011, the National Bureau for Drug Prevention in order to implement the activity on promotion of evidence-based universal drug prevention programmes in middle schools (*gimnazja*) launched the *Unplugged* programme. It is a universal psychoactive substance prevention programme (alcohol, tobacco, drugs) developed and implemented in many European countries under the international *EU-Drug Abuse Prevention* project, co-financed by the European Union. In 2011, 18 trainers and 61 teachers were trained by the National Bureau to implement the programme in Poland. The programme is implemented in a cascade-like manner.

In 2011, the programme trainers conducted first training courses for 40 teachers.

- **FAMILY**

In 2011, the National Bureau commissioned a second phase of the evaluation of the “*Family Strengthening Programme*”. It is a universal prevention programme addressed to whole families. The aim of the programmes is to reduce drug and alcohol consumption among children and adolescents aged 10-14. The effectiveness of the programme in terms of alcohol prevention was corroborated by the US evaluation. The programme was introduced to Poland in 2008 by the Maraton Foundation. The evaluation was conducted by the Institute of Psychiatry and Neurology. The evaluation aimed at determining the impact of the programme on risky behaviours among adolescents, mostly alcohol and other substance use as well as other mediators such as parent and child relationships (e.g. spending time together) and parenting practices (e.g. showing love, setting and exercising rules).

In 2011, the Centre for Education Development continued the implementation of the prevention programme entitled *“School for Parents and Educators”*. The aim of the programme is to improve parenting skills and shaping attitudes which facilitate building a solid relationship and ties between parents (guardians) and children.

The School for Parents and Educators was implemented in a cascade-like manner by the right preparation of trainers who will then be responsible for coordinating and implementing the programme in a local area. The task of the trainers will be to prepare programme leaders who will work directly with teachers and parents. In 2011, 83 trainers were trained, who went on to prepare 799 programme leaders. 376 editions of the programmes were conducted for 4 425 teachers and parents.

In 2011, the National Bureau continued the operation of the online drug counselling centre at www.narkomania.org.pl. The aim of this online project is to provide assistance and reliable knowledge on drug addiction, drugs, forms of assistance etc. for dependent and co-dependent drug users. At the website parents could find numerous articles and publications on drug addiction, how to identify symptoms of drug use in children and how to talk to a child and where to seek help (database of drug services). In 2011, the website was visited 596 570 times.

The National Anti-drug Hotline at 801 199 990 also continued its operation. It targets substance abusers, drug addicted individuals and their families. The hotline operators provide information on drug treatment options and addresses of specific units. They also provide drug-related legal advice; however, they mostly provide counselling and psychological support.

- **LOCAL 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 Antidrug Strategies. In 2011, Marshal Offices got involved in supporting universal drug prevention programmes. Activities were performed at primary, middle and secondary schools. The total number of schools which took part in universal prevention programmes across the country stood at 131. The programmes included 13 659 participants. The programmes featured prevention workshops, theatre plays, competitions and information meetings for adolescents. Some provincial governments financed recommended programmes such as “Unplugged” or “School Preventive Intervention”. Moreover, other drug prevention programmes were implemented, including Social Competence Workshops, Anger Management Trainings or Taste of Life: legal highs debate. The programmes were to prevent drug initiation and reduce risky behaviours in adolescents.

National Programme for Counteracting Drug Addiction 2011-2016 (NPCDA) has its fourth edition. It is based on the principle of balanced approach according to which solving drug problems involves equally demand reduction (prevention and treatment) and supply reduction which is manifested in combating illegal drug market by relevant services. The general aim of the new NPCDA is "Reduction of drug use and the related social and health problems". Under the monitoring of the NPCDA implementation, data from implementing bodies are collected. An important role in the NPCDA implementation is played by communes (gminy) and Marshal Offices (urzędy marszałkowskie). This chapter presents selected data on the implementation of the NPCDA by local and regional authorities. Data provided by communes are processed by the SPSS statistical software. In 2011, reports on the NPCDA implementation were submitted by all Marshal Offices and 2 274 communes out of the overall number of 2 479, i.e. 89%. In the course of the NPCDA implementation 92% of all communes developed local antidrug strategies in 2011. In the process of developing the local strategy every fourth commune conducted drug problem assessment (23.4%) (Malczewski 2012e, p. 23).

Universal drug prevention at communal level

The most frequent activity conducted by communes is supporting universal prevention. In the first year of the NPCDA implementation 1 496 communes (66%) carried out 8 040 universal prevention programmes in 15 574 settings. In 2011, the total number of children and adolescents who participated in universal prevention programmes stood at 1 345 131. The programmes were present at all educational levels (nursery schools, primary schools, middle schools and secondary schools). The activities also targeted adults, however, there were mainly children and adolescents. Table 3.3.1 presents 2011 data.

Table 3.3.1. Universal drug prevention programmes conducted by communes in 2011.

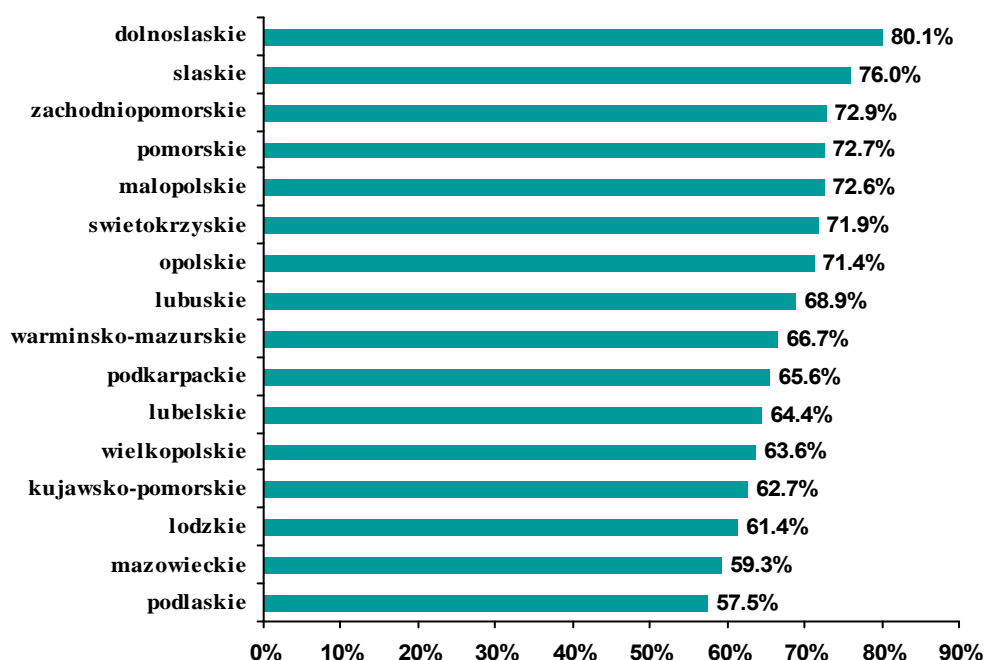
	School-based prevention programmes	Programmes targeting parents	Extramural programmes
Total of programmes	5 301	1 102	2 468
Total of implementing centres	8 686	2 388	4 500
Total of beneficiaries	1 238 830	202 330	405 435

Source: Reports of National Bureau for Drug Prevention on the implementation of NPCDA as completed by communes

The highest percentages of communes which financed universal prevention programmes were recorded in the provinces of dolnoslaskie (80.1%) and slaskie (76.0%). A deep involvement of local authorities in universal prevention is also recorded in the provinces of zachodniopomorskie (72.9%) and pomorskie (72.7%). The lowest percentage of communes sponsoring universal prevention was recorded in the provinces of mazowieckie (59.3%) and podlaskie (57.5%). Among communes financing universal prevention who submitted reports on the NPCDA implementation, there were 263 urban communes (90% of all urban communes), 402 urban and rural communes (76% of the total) and 829 rural communes (nearly 605 of the total). The data show that the great majority of cities supports universal prevention whereas in the case of rural communes it is over a half.

The highest expenditure incurred by communes in the course of sponsoring universal prevention programmes was recorded in the provinces of malopolskie (PLN 5 636 449), slaskie (PLN 4 244 882) and dolnoslaskie (PLN 3 084 172). The lowest spending was reported by the provinces of lubuskie (PLN 592 805), zachodniopomorskie (PLN 795 467) and swietokrzyskie (PLN 1 024 317).

Figure 3.3.1. Percentage of communes in provinces which financed universal drug prevention programmes (based on the number of communes which sent reports)



Source: Reports of National Bureau for Drug Prevention on the implementation of NPCDA as completed by communes

3.4. Selective prevention in at-risk groups and settings

- **Drug endangered groups**

In 2011, the National Bureau for Drug Prevention similarly to previous years supported prevention programmes for drug-endangered individuals and occasional drug users. The programmes targeted children and adolescents with (individual, family and environmental) factors for risky behaviour, i.e. “children of the street”, minors at risk of delinquency and depravity, juvenile delinquents at risk of social exclusion, drug addiction and children and adolescents experimenting with drugs or using them occasionally.

The programmes aimed at reducing risk factors in family and peer environment. The programmes were intended to improve emotional and social functioning of children and adolescents and help to solve drug-related critical situations. They were also aimed to shape adequate normative beliefs regarding drugs and promote healthy lifestyle. The programmes targeted 10 393 participants.

The National Bureau also supported drug prevention programmes for occasional users. They were intended to change attitudes to drug use and reduce risk related to occasional drug use. The activities were implemented directly in the community of occasional drug users or groups at risk of drug use, including entertainment settings (clubs, discotheques, open air events). The programmes covered outreach activities: education in drug-related risk, motivating for the change of behaviour and attitudes, interventions, providing information on drug services. The activities targeted over **9 thousand** beneficiaries.

Moreover, the National Bureau in 2011 continued the implementation of an early intervention programme – FreD goes net. The programme targets occasional and problem drug users aged 14-21, excluding addicted individuals. It is implemented in the form of 8-hour workshops based on motivational interviewing. The workshops are intended to stimulate self-reflection, improve knowledge of drug use, encourage risk assessment and responsibility, change drug-related attitude and behaviour and present local drug service options. The programme was implemented by qualified trainers according to FreD standards. It attracted 1 000 participants. In 2011, the National Bureau trained 71 programme providers across the country. 47 facilities were prepared to run the programme. Moreover, the National Bureau organized a seminar for the providers as part of the programme implementation quality improvement process.

In 2011, the Centre for Education Development along with the Institute of Psychiatry and Neurology implemented a programme entitled *School Preventive Intervention*. The programme can be run at all levels of education (primary, middle and secondary). The programme is aimed to prevent students from using drugs and help those who already

experiment. Under the programme, school teachers are trained to perform interventions among students using psychoactive substances (tobacco, alcohol, drugs, legal highs). It has the form of preventive intervention which can be applied in students caught experimenting with psychoactive substances or suspected of such risky behaviour. One of the intervention components is collaboration with the student's parents. It is based on emotional support for the parents, substance abuse education and joint assistance to the child.

The programme is implemented in a cascade-like manner through training instructors who then coordinate the programme implementation in their local communities (76 instructors listed in the Recommended Instructors Register). The instructors train teachers who later become programme providers. 74 teachers were trained in 2011.

- **Families at risk of drug addiction**

In 2011, the National Bureau co-financed programmes addressed to families and relatives of individuals with a drug problem. The programmes featured education and information courses on mechanisms of drug dependence and codependence, workshops on parenting skills, support groups, counselling for families, and legal assistance. Participants of family support programmes received assistance in critical situations, gained and improved their parenting and psychosocial skills. These skills considerably improve the functioning of families. In 2011, the programmes included 4 000 participants.

- **Indicated prevention**

In 2011, as every year, the National Bureau co-financed indicated prevention programmes addressed to drug users. The aim was to increase the availability and widen the range of indicated drug prevention programmes by supporting the establishment of prevention projects in locations or communities which lack such services or the number is insufficient compared to the needs. The aim was also to support the existing indicated drug prevention programmes. The programme beneficiaries included non-dependent individuals, drug users with first symptoms of drug-related disorders, individuals at risk of developing problems due to substance use or biological, psychological or social problems. Indicated prevention programmes target drug dependent users or harmful users charged with a drug-related offence. Pursuant to the Act on counteracting drug addiction, the prosecutor may suspend the criminal proceedings by the time drug treatment, rehabilitation or participation in an indicated prevention programme as long as the offence in question is subject to the penalty of up to 5 years in prison. Over **300 thousand participants** took part in the indicated drug prevention activities.

- **Campaigns**

In 2011, the National Bureau for Drug Prevention for the first time in Poland launched a campaign which stressed that most young people do not use drugs. The campaign was to model young people's behaviour through the promotion of healthy lifestyle and showing that legal highs or drug-free recreation, learning or work is possible. The main slogan of the campaign "Narkotyki? Na co mi to?" (Drugs? What do I need them for?) and the supporting one ("Most young people in Poland do not use drugs. Face the facts"), which reflects research among young people served to shape the belief that drug abstinence has become a norm among teenagers.

A lot of attention in the campaign was attached to an attractive campaign website, which enabled young people to actively take part in the campaign. The website www.nacomito.com.pl was open to all visitors. Anybody could present their passion ("I" section), post an inspirational hyperlink ("YOU" section) or promote an important event ("WE" section). An important element of the website was information and education. A visitor could check his or her knowledge of psychoactive substances in a special quiz and get familiar with the latest research into substance use among adolescents. The campaign had a profile on Facebook where competitions and discussions were organized. Young people could share their passions. Visitors could also press the like button to support a given message, comment on it or share it. Between the launch on 20 June and 15 December 2011 the campaign website was visited 19 858 times and the Facebook profile was liked by 1 130 visitors. In August the campaign was introduced to 122 music clubs and discotheques across the country (AdMirror campaign).

Thanks to numerous partners, the campaign "Narkotyki? Na co mi to" was visible at various websites and Internet discussion groups, TV and the radio. The campaign featured 556 TV spots, 825 radio spots, 13 press advertisements, 15 547 280 impressions of the Internet banners and approx. 700 publications. The size of the campaign's target population reached through the press and the Internet is estimated at 6 978 527 (based on the report by PR – Partner of Promotion agency). Similarly to previous years, the campaign was widely supported by regional and local partners who promoted the materials of the National Bureau and launched their own projects. At regional and local level, the campaign involved close collaboration with Marshal Offices, town halls and city halls.

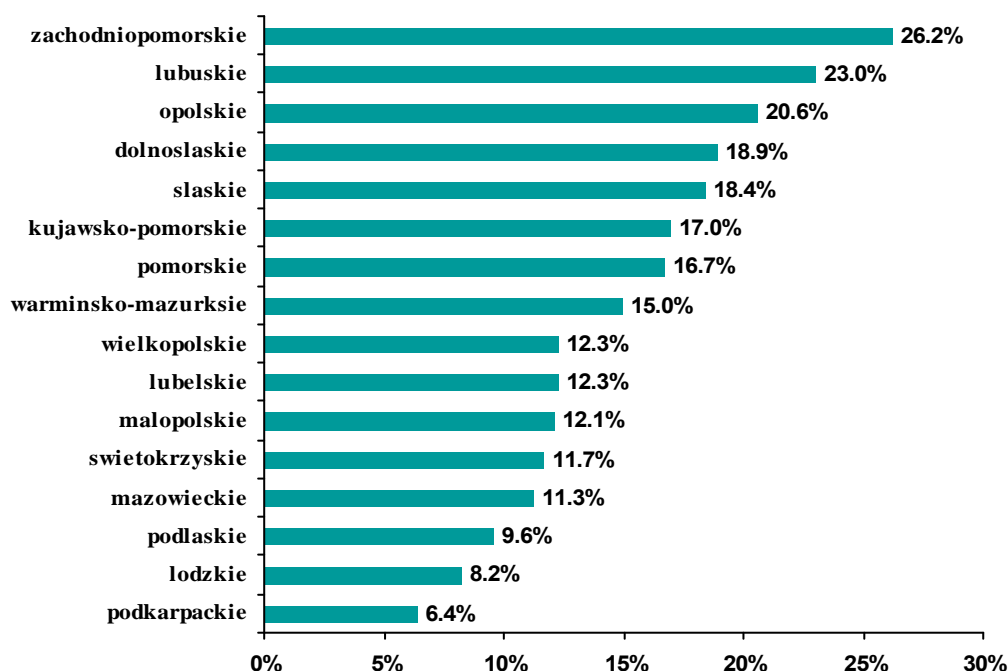
- **Selective and indicated drug prevention at communal level**

Communes much less often sponsored prevention aimed at individuals at risk of drug use or individuals experimenting with drugs. In 2011, 314 communes (14%) financed 1 445 selective prevention programmes. The programmes were conducted by 3 486 providers for

146 210 children and adolescents. For example, in 2011 there were 165 early intervention programmes conducted at 8 686 centres for 40 958 participants (e.g. FreD project).

Figure 3.4.1. shows percentages of communes in respective provinces which financed selective and indicated prevention programmes in 2011.

Figure 3.4.1. Percentage of communes in provinces which financed selective and indicated drug prevention programmes (based on the number of communes which sent reports).



Source: Reports of National Bureau for Drug Prevention on the implementation of NPCDA as completed by communes

The highest percentage of communes which sponsored selective and indicated prevention programmes was recorded in the provinces of zachodnio-pomorskie (26.2%), lubuskie (23.0%) and opolskie (20.6%) and the lowest one in the province of podlaskie (9.6%), lodzkie (8.2%) and podkarpackie (6.4%).

Out of 2 274 communes which reported on the NPCDA implementation and sponsorship of selective and indicated prevention programmes there were 142 urban communes (nearly 50% of all reporting urban communes), 101 urban and rural communes (19.5% of all reporting urban and rural communes) and 70 rural communes, which was slightly over 5% of all rural communes who sent the 2011 NPCDA implementation reports.

The highest expenditure incurred by communes on financing selective and indicated prevention programmes in 2011 was recorded in the province of malopolskie (PLN 4 044 893), slaskie (PLN 3 648 295) and mazowieckie (PLN 2 960 603). The lowest

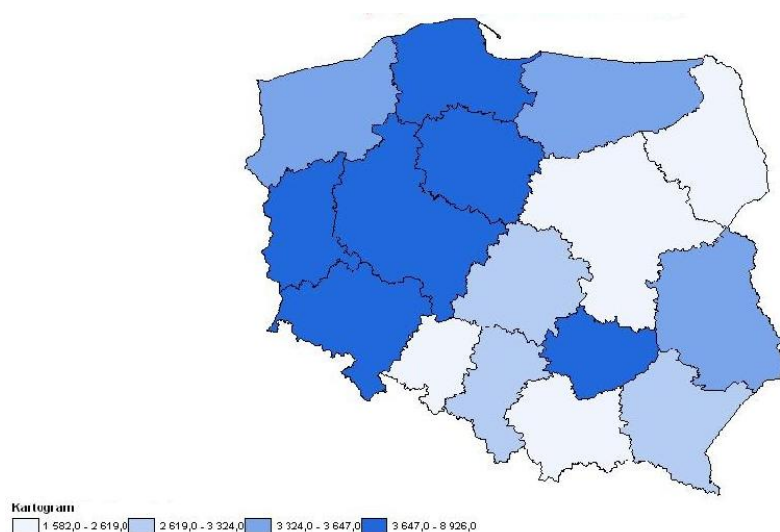
spending in this field was recorded in the provinces of warminsko-mazurskie (PLN 211 891), podkarpackie (PLN 277 966) and opolskie (PLN 367 017).

- **Children and adolescents in drug prevention programmes**

As it has been mentioned, in 2011, 1 345 131 children and adolescents participated in universal prevention programmes and 146 210 were covered by selective and indicated prevention. Depending on the province the number of participants in prevention activities varied. Let us take a look at provinces which involved the highest numbers of children and adolescents in prevention programmes and where the highest rates per 100 000 population are recorded. Universal prevention programmes attracted the highest numbers of children and adolescents in the provinces of kujawsko-pomorskie (184 707), slaskie (150 610) and dolnoslaskie (139 587). Selective and indicated prevention programmes attracted most children and adolescents in the provinces of dolnoslaskie (25 854), lubelskie (15 236) and wielkopolskie (14 471).

The situation might differ if we convert the participant numbers into rates per 100 000 population. This way we will remove population differences among provinces. The highest rates per 100 000 population for universal prevention were recorded for the provinces of kujawsko-pomorskie (8 925), pomorskie (5 199), dolnoslaskie (4 850) and lubuskie (4 767). High rates were also noted in the provinces of wielkopolskie (3 917) and swietokrzyskie (3 800).

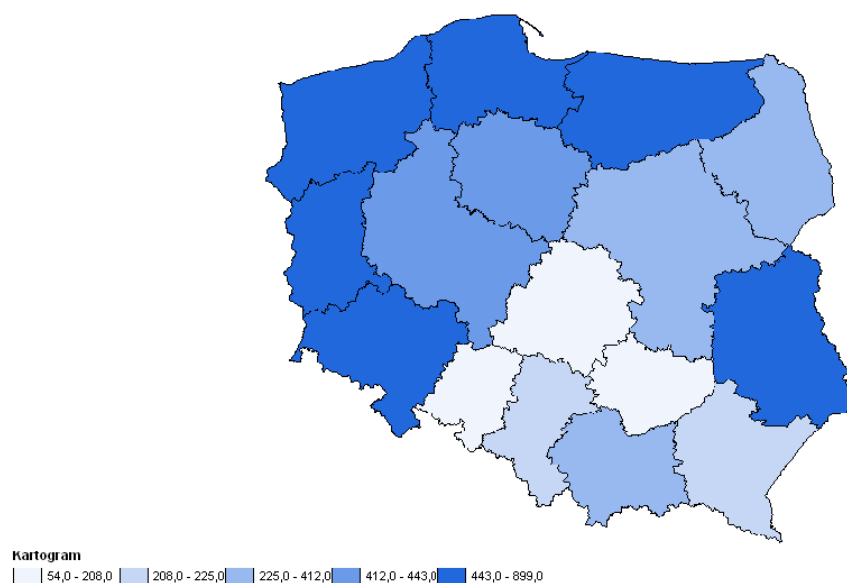
Figure 3.4.2. Rates per 100 000 population for children and adolescents in universal drug prevention programmes in 2011



Source: Polish Focal Point, (Malczewski 2012e, p. 25)

Rates per 100 000 population for indicated and selective prevention were the highest in the following provinces: dolnoslaskie (898), lubelskie (708), lubuskie (585), warminsko-mazurskie (566). High values were also recorded for the provinces of zachodniopomorskie (463) and pomorskie (537).

Figure 3.4.3. Rates per 100 000 population for children and adolescents in selective and indicated drug prevention programmes in 2011



Source: Polish Focal Point, (Malczewski 2012e, p. 25)

4. Problem drug use

prepared by Michał Kidawa

The most recent available estimation of number of problem drug users is from 2011. In Polish estimations the definition of problem drug users refers to a regular drug user (of illegal substances) who encounters serious problems as a consequence of using (Sierośławski 2011). This definition does not correspond to the EMCDDA's definition of problem drug use. The estimation of problem drug users in Poland that was conducted through the application of GPS survey data and was conducted through the benchmark method. In the survey the respondents were asked to provide some information on each problem drug user they knew. The questions concerned the residential or ambulatory treatment attempts in 2009. The quantitative material obtained in this way along with the statistical data from the drug treatment system allows for estimations. According to this estimation method, the first step is to determine the share of drug treatment patients in the overall population of problem drug users. It is done on the basis of data collected in the field studies e.g. by asking respondents to provide information on problem drug users they know. Next step is to convert this share into the estimation rate which is then multiplied by the number of registered residential and ambulatory drug treatment patients listed in the database of the Institute of Psychiatry and Neurology. According to this estimates the number of problem drug users ranges from 57 000 to 103 000.

5. Drug treatment: treatment demand and treatment availability

Kamila Gryn, Dawid Chojecki, Marta Struzik, Katarzyna Sollich, Artur Malczewski

5.1. 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 time patients), diagnostic codes and the following types of treatment units: mental health outpatient clinics, mental health outpatient clinics for children and adolescents, substance therapy centres, day care centres, psychiatric wards, addiction treatment units as well as detoxification wards. The Institute data below refer to 2010. The Institute does not provide data for 2011.

The Polish Focal Point is collecting data compliant with the TDI protocol ("Treatment Demand Indicator (TDI). Standard Protocol 2.0") as a pilot project.

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 operating drug services. The latest edition of the booklet was published in 2011. The database of drug treatment services is available on the website of the National Bureau www.kbpn.gov.pl under section "Where to seek help?".

5.2. Strategy and policy

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

- Act of 29 July 2005 on counteracting drug addiction as further amended;
- Notice of Speaker of the Sejm of 10 January 2012 on the promulgation of consolidated text of the Act on counteracting drug addiction
- Act of 6 November 2008 on patient rights and the Patient Ombudsman
- Regulation of Minister of Health of 6 October 2010 amending the Regulation on specific rules of conduct in substitution treatment and 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 of individuals convicted of offences related to the use of narcotic drugs or psychotropic substances;

- Regulation of Minister of Justice of 17 May 2007 on specific conditions and rules of conduct in medical treatment, rehabilitation and reintegration of drug dependent individuals remaining in youth detention centres;
- Regulation of Minister of Health of 13 July 2006 on addictions-related trainings.

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. This 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 of up to 5 years enters drug treatment, rehabilitation or participates in a drug prevention and treatment programme run by a relevant health care centre or another entity 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.

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 government units and institutions as well as local authorities. It defines in detail types of actions and lists responsible implementing entities (including funding sources of activities in respective areas), monitoring indicators and implementation schedules. In the reporting year, the NPCDA 2011-2016 was adopted. In drug treatment and rehabilitation, measures have been designed to increase the availability of outpatient drug services, substitution treatment programmes, HIV and HCV-related infectious disease treatment programmes as well as specialist treatment programmes in penitentiaries (including substitution programmes). Moreover, a wide range of other operations have been designed to improve the quality of drug treatment services such as disseminating good practice both in inpatient and outpatient facilities, implementing accreditation procedure in psychoactive substance treatment centres, conducting specialist trainings for various groups of professionals and developing as well as distributing evidence-based drug treatment manuals. A new challenge in the NPCDA is patient's rights, which is reflected in the following two sentences: "Developing and incorporating the aspects of patient's rights in the addiction training programmes conducted by entities recommended by the Director of the National Bureau for Drug Prevention" and "Disseminating information on patient's rights e.g. via the Internet and information and education materials for patients and programme providers".

5.3. Drug treatment systems - organization, quality assurance, availability and diversity of drug treatment

According to Article 26.1 of the Act of 29 July 2005 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 a wide network of inpatient and outpatient clinics i.e. substance treatment centres, detoxification wards, day care wards, rehab 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 outpatient clinic or an alcohol rehabilitation clinic as they are easily accessible compared to drug rehabilitation clinics. Moreover, opioid dependent individuals may receive treatment under substitution treatment.

In Poland the most popular drug treatment model is total abstinence and therapeutic community-based residential therapy. The programmes are conducted at health care units run by NGOs (associations, societies, foundations).

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 the NFZ-sponsored drug treatment; however, there has also been an increase in requirements for service providers.

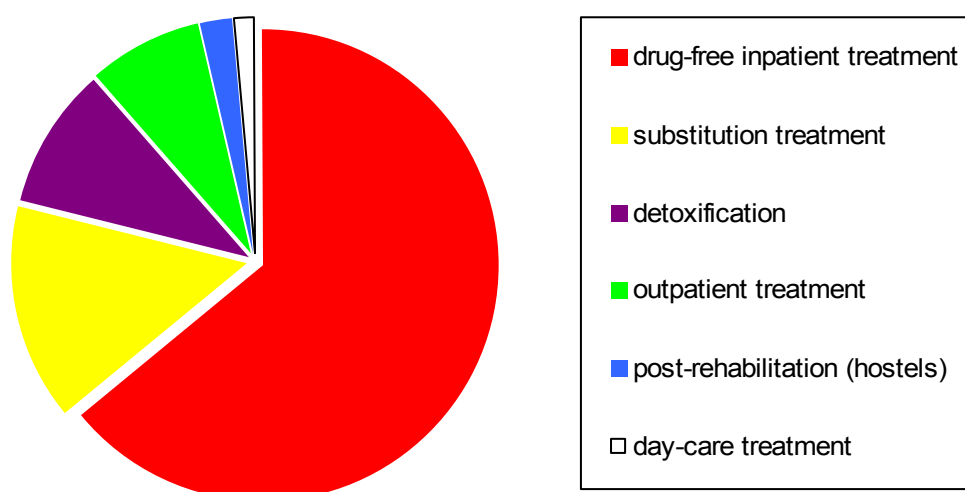
Pursuant to Article 26.5 of the Act of 29 July 2005 on counteracting drug addiction, drug treatment, rehabilitation and reintegration services are free of charge, regardless of the patient's place of residence. Moreover, there is an option to participate in a drug therapy provided in private clinics or by private therapists (paid). No data on the private drug treatment sector are available. Drug treatment, rehabilitation or social reintegration is voluntary, excluding individuals under 18 and incapacitated patients, who might be obliged to enter treatment by the court order.

Table 5.3.1. Drug treatment sponsored by the National Health Fund in 2004-2011

Year	Drug addiction treatment expenditure
2004	54 017 159 PLN
2005	60 089 521 PLN
2006	62 199 614 PLN
2007	64 047 046 PLN
2008	79 121 702 PLN
2009	111 125 110 PLN
2010	111 281 201 PLN
2011	114 209 870 PLN

Source: National Health Fund, as at March 2012

Figure 5.3.1. Drug treatment sponsored by the National Health Fund in 2011. Respective types of treatment, detoxification and post-rehabilitation.



Source: National Health Fund, as at 6 June 2011

Moreover, 616 communal governments (27%) financed drug treatment, rehabilitation, harm reduction and social reintegration at the amount of PLN 18 836 611, with average spending of PLN 30 579 per commune.

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. Responses to drug-related health issues 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 mainly long-term and medium-term treatment programmes (up to 12 months); however, economic reasons and new patient profiles necessitate the shortening of programmes. In 2011, there were 87 inpatient drug rehabilitation clinics (based on the information booklet: Drug Addiction – where to seek help?”, KBPN 2011), including clinics admitting patients with dual diagnosis. The above data do not include psychiatric hospitals where dependent and problem drug users are also treated; however, 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 outpatient clinics and, in exceptional cases where no drug treatment unit listed above is available in the area, at outpatient alcohol 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 2010 (the latest data available) there were 104 clinics in operation, whereas in 2006, the first year of the NPCDA, the figure stood at 84 (Institute of Psychiatry and Neurology, 2007 & 2010). According to the electronic 2012 edition of “Drug Addiction – where to seek help?”, the number of outpatient clinics across Poland stands at 224 (including consultation settings).

Despite a clear rise in the number of outpatient clinics, assistance in the form day care centres/wards is still insufficient. In 2011, similarly to previous years, there were only 15 day care centres for individuals dependent on psychoactive substances (including alcohol) operating in Poland. The number of places available was 314 (390 in 2008, 405 in 2007) (Institute of Psychiatry and Neurology, 2008 & 2009).

In order to improve the availability of outpatient health care for problem drug users, the National Health Fund increased the funding allocated to outpatient health services from approx. PLN 37 000 000 to PLN 40 664 467.

- **Medical treatment**

Withdrawal treatment

In 2011, the National Bureau database listed 27 registered detoxification wards/sub-wards. According to the Statistical Yearbook of the Institute of Psychiatry and Neurology, in 21 detoxification wards operating in 2010 and providing services for individuals dependent on psychoactive substances other than alcohol, there were 5 164 detoxifications performed (5 678 in 2009). These units offered a total of 224 beds (Institute of Psychiatry and Neurology, 2010). The wards targeted mainly opioid withdrawals.

The basic form of withdrawal treatment at detoxification wards is the administration of decreasing doses of opioids. The basic substance used in Poland is methadone. Symptomatic treatment and clonidine therapy are far less frequent. Detoxification at hospitals usually lasts 8-14 days (B. Habrat, Institute of Psychiatry and Neurology, personal communication).

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 naltrexone-based “rapid detoxification”, which is not conducted in public centres (B. Habrat, Institute of Psychiatry and Neurology, personal communication)

Substitution treatment

According to the amended Regulation of Minister of Health of 6 October 2010 *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 evaluations of the patient’s somatic and mental status (periodically) as well as individual or group psychotherapy (approx. 2 hours per week), specialist consultations, treatment of other chronic drug-related diseases.

In 2011, there were 25 non-prison substitution treatment programmes across Poland and 7 prison ones. They provided services for 2 200 patients (data from the National Bureau’s Registry of Substitution Treatment Patients). In 2011, only 15% of opioid addicts used this form of treatment. The number of all problem opioid users in Poland is estimated at 15 000 (according to the 2011 data of the Institute of Psychiatry and Neurology which mentions the figure ranging between 10 400 and 19 800; Janusz Sierosławski „*Estimation of problem opioid users*”). Currently, there is still no access to substitution treatment in the following provinces: podkarpackie, podlaskie and warminsko-mazurskie. In pomorskie province, due to prolonging unsuccessful measures of local drug services to establish a

substitution treatment programme, the substitution facility in Bydgoszcz decided to admit more patients in Gdansk, pomorskie province. Thanks to this convenience, pomorskie province patients were provided the opportunity to meet a basic goal of substitution treatment, which is social reintegration understood as slow return to roles in work and family life.

The analysis of the data shows that efforts are needed to extend the range of substitution treatment services to slaskie province and zachodniopomorskie province as well as in provinces where no substitution treatment provision contract was concluded in 2011: pomorskie, warminsko-mazurskie, podlaskie and podkarpackie.

Substitution treatment patients suffer from severe addiction. They also suffer from somatic diseases such as HCV, HBV, HIV/AIDS, vein thrombosis and general poor health. However, to a greater or lesser extent they are motivated for treatment. Their number is stable and clearly rising. The main substitute drug administered in Poland is methadone; however, buprenorphine and Suboxone are becoming widely used.

- **Other forms of medical treatment of co-occurring 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” – responses to other health correlates among drug users, 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 “Infectious diseases treatment”.

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 generally hire consultants other than a psychiatrist.

- **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 for psychoactive substance users. In 2009, works on the standards for inpatient/outpatient clinics and day care centres were completed. Due to the changes in the patient’s rights regulations, it was necessary to revise the standards developed in previous years. In 2010 the Krakow-based Monitoring Centre for Quality in Health Care was presented with the

revised standards to be later considered by the Accreditation Council. On 14 October 2011, the Accreditation Council took a decision to recommend the Accreditation Standards for Drug Treatment Units to the Minister of Health. The Accreditation Standards will form grounds for the accreditation of inpatient drug treatment centres. On 20 December 2011, draft Accreditation Standards were sent to the Department of Health Care Management in the Ministry of Health to be presented to the Minister of Health and approved pursuant to Article 2.5 of the Act of 6 November 2008 on accreditation in health care.

Evaluation

In 2010, the National Bureau for Drug Prevention along with the Institute of Psychiatry and Neurology completed the pilot project of the evaluation of drug treatment and rehabilitation services. The project was intended to increase the effectiveness of therapeutic programmes. Works on the evaluation 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 implementation schedule.

Trainings and conferences

In 2011, the National Bureau for Drug Prevention (KBPN) held a number of training courses in evidence-based drug treatment methods. The trainings were aimed to familiarize and train different groups of professional who work with problem drug users in the effective methods of treatment and help. In 2011, along with the State Agency for Prevention of Alcohol-related Problems (PARPA), a conference entitled “Work with drug dependent and drug endangered adolescents”. The conference is an annual venture of the KBPN and PARPA and intends to make drug professionals familiar with various alcohol and drug treatment approaches. The latest edition was attended by 90 participants: addiction therapy/psychotherapy specialists, addiction therapy instructors and certificate applicants.

In 2011, a number of successful evidence-based drug treatment programmes and models were promoted. A particular emphasis was placed on the promotion of cannabis treatment programme which is disseminated in Poland and across Europe under the name CANDIS. The programme targets adolescent aged 16 and older who use cannabis in a harmful manner. The promotion of CANDIS in Poland constitutes an important goal due to a rising number of cannabis users and the necessity to provide access to a treatment offer adequate for this target group. Cannabis treatment efforts also include the *FRED goes net* programme, which is an early intervention programme to be applied in early stages of cannabis experimenting and use. The programme continued to be implemented in 2011

through trainings for more programme providers. Both CANDIS and Fred goes net can be used within the meaning of Article 72a of the Act on counteracting drug addiction.

„Training for substitution treatment staff in penitentiaries”. The course was held by the National Bureau in collaboration with the Central Management Board of Prison Service at Prison Service Staff Training Facility in Sucha. The training was completed by 46 participants, including physicians, nurses and counsellors at new substitution programmes. The training covered such topics as harm reduction, pharmacological treatment of opioid addiction, psychotherapy, patient motivation and aspects of infectious diseases. The training was highly appreciated by the participants. The training graduates received the certificates necessary to perform duties in a drug substitution programme.

“17th Conference on HIV in family and society” and the session on drug addiction organized by the Polish Humanitarian Foundation Res Humanae. The conference featured 2 problem sessions on drug addiction. The 389 participants therapists, physicians, representatives of central institutions, local authorities, sanitary inspection and NGOs, scientists, journalists and volunteers, graduates of reintegration and methadone programmes as well as HIV/AIDS individuals,

The preparation and organization of the training course for the staff of the drug hotline as well as information and consultation centres by the Foundation for the Development of Alcohol Prevention, Education and Therapy ETOH. The training, attended by 105 participants, aimed at improving the competence of the drug hotline staff.

Moreover, 5 Marshal Offices financed supervisions of drug therapists or drug specialist or instructor trainings conducted pursuant to the Act of 29 July 2005 on counteracting drug addiction.

126 communes (5.5%) sponsored professional development measures among various drug-related professional groups. The trainings included a total of 5 151 participants. The highest percentages of communes which financially supported drug-related professional development measures were recorded in the provinces of zachodniopomorskie (12.5%), lubuskie (9.5%) and pomorskie (8.9%). The lowest percentages were recorded in the provinces of podlaskie and podkarpackie (less than 2.5%).

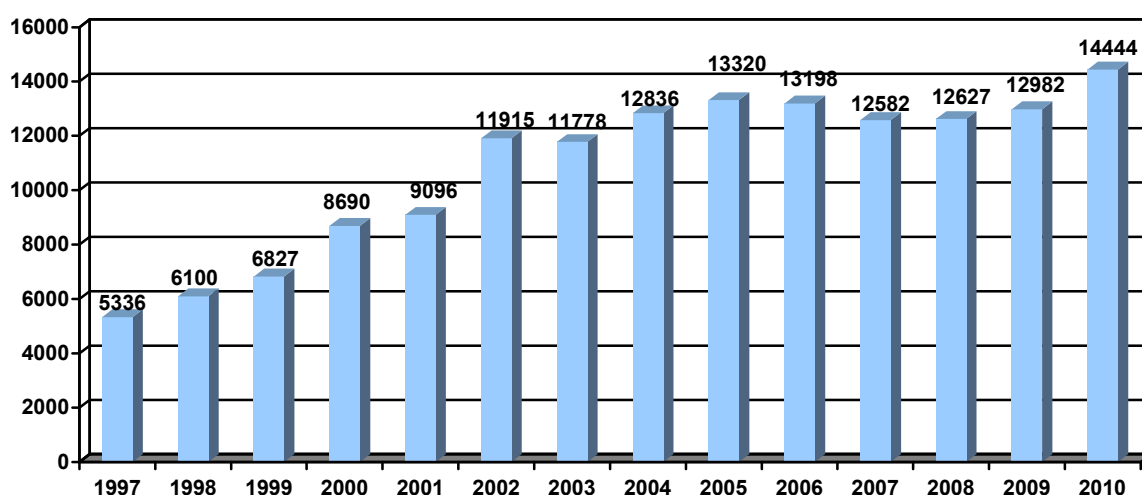
The total amount of co-financing disbursed on the staff professional improvement in 126 communes stood at PLN 470 000.

5.4. Characteristics of treated clients (TDI data included) and trends of treated population and treatment provision (incl. numbers).

5.4.1. Residential drug-free treatment – system administered by the Institute of Psychiatry and Neurology in Warsaw.

Below there are statistical data of the residential treatment concerning patients of psychiatric units including specialist substance treatment facilities. In 2010 (the latest data available), 14 444 patients were admitted to treatment due to problems related with use of psychoactive substances, which is an increase compared to 2009 (Figure 5.4.1.1). This group included 6 439 first-time patients (increase of 757 compared to 2009).

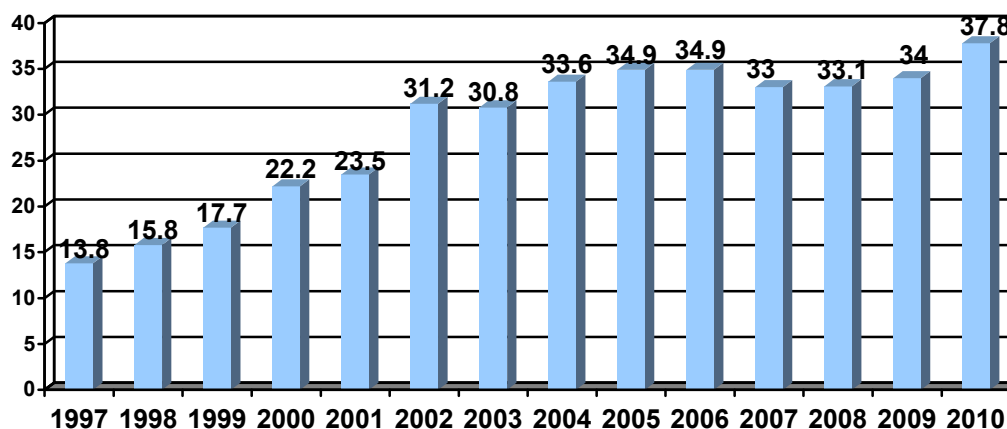
Figure 5.4.1.1. Admissions to residential drug treatment in 1997-2010 due to mental and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19) (numbers of patients).



Source: Institute of Psychiatry and Neurology (2012)

Analyzing the admissions to residential treatment per 100 000 population (37.8 in 2010) we can observe an upward trend in 2010 compared to 2009.

Figure 5.4.1.2. Admissions to residential drug treatment in 1997-2010 due to mental disorders and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19) (numbers of patients per 100 000 population).

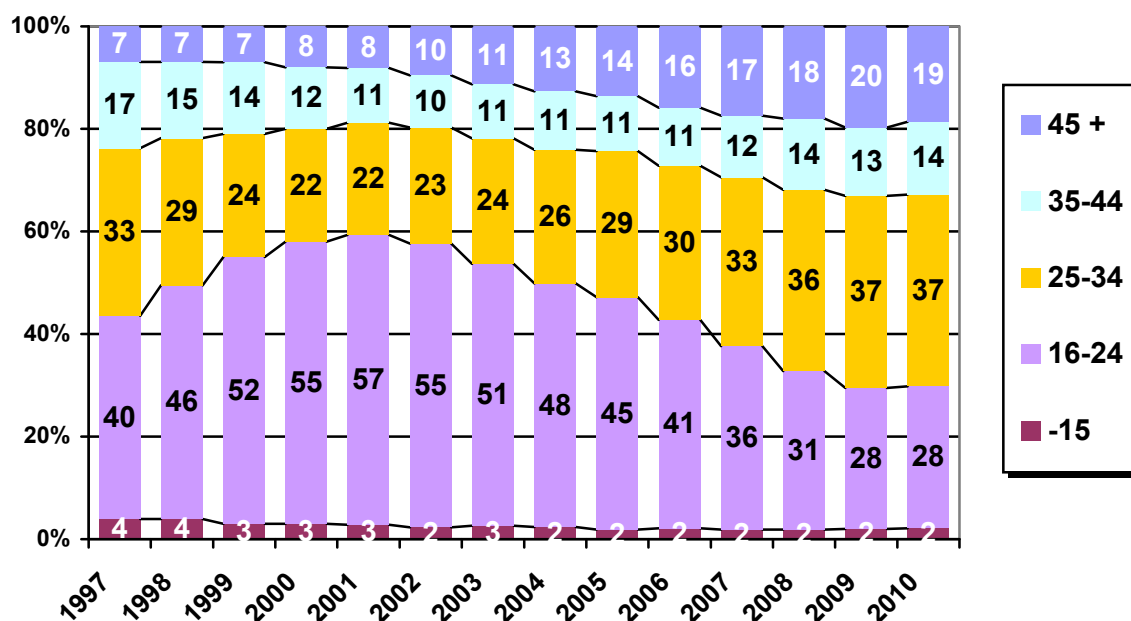


Source: Institute of Psychiatry and Neurology (2012)

In 2010, similarly to previous years, male patients constituted the vast majority in residential drug treatment units (75%). In terms of age groups, the biggest group were patients aged 25-34 (37%) followed by patients aged 16-24 (28%). A third group was made up by patients aged over 45 (19%). The share of 35-44-year-olds is slightly lower (14%) whereas admissions of individuals aged 15 and younger constituted less than 2% of all admissions.

Between 1997 and 2010 the proportions of the two age groups in residential treatment (under 15 and 35-44) were holding steady. Since 2001 there was a steady fall of the patients aged 16-24, however, the 2010 data indicate that the downward trend stopped (28% and equalled the 2009 figure). In the same period, i.e. since 2001, there has been a rise in the share of 25-34-year-olds and in this case the 2010 data equal those of 2009 (37%). Moreover, there was a rise in the oldest age group (over 45) from 7% in the 1990s to 19% in 2010.

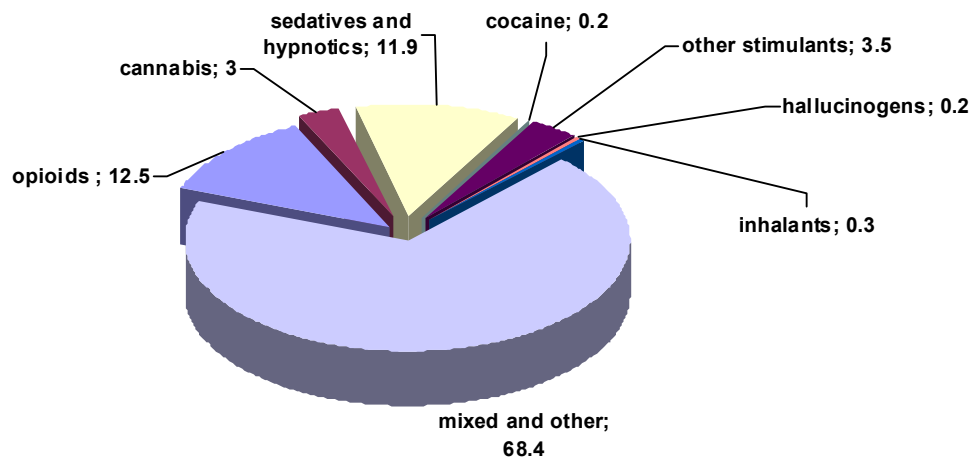
Figure 5.4.1.3. Admissions to residential drug treatment in 1997-2010 due to mental disorders and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19), numbers of patients by age.



Source: Institute of Psychiatry and Neurology (2012)

Opioid users were accounted for 12.5% of all admissions to drug treatment. Slightly less, i.e. 11.9%, were diagnosed with dependence on sedatives and hypnotics. Approx. 3% of patients were problem cannabis and stimulants users. The proportions of individuals dependent on cocaine, hallucinogens and inhalants remains at the level which does not exceed 1%. The reporting system administered by the Institute of Psychiatry and Neurology does not provide a full and precise picture of drug use patterns among drug treatment patients as 65% of patients fall within the category 'mixed and other' (Code F19). The existing system does not make it possible to verify what substances specifically are used by patients with this diagnosis. Detailed data are presented in Figure 5.4.1.4.

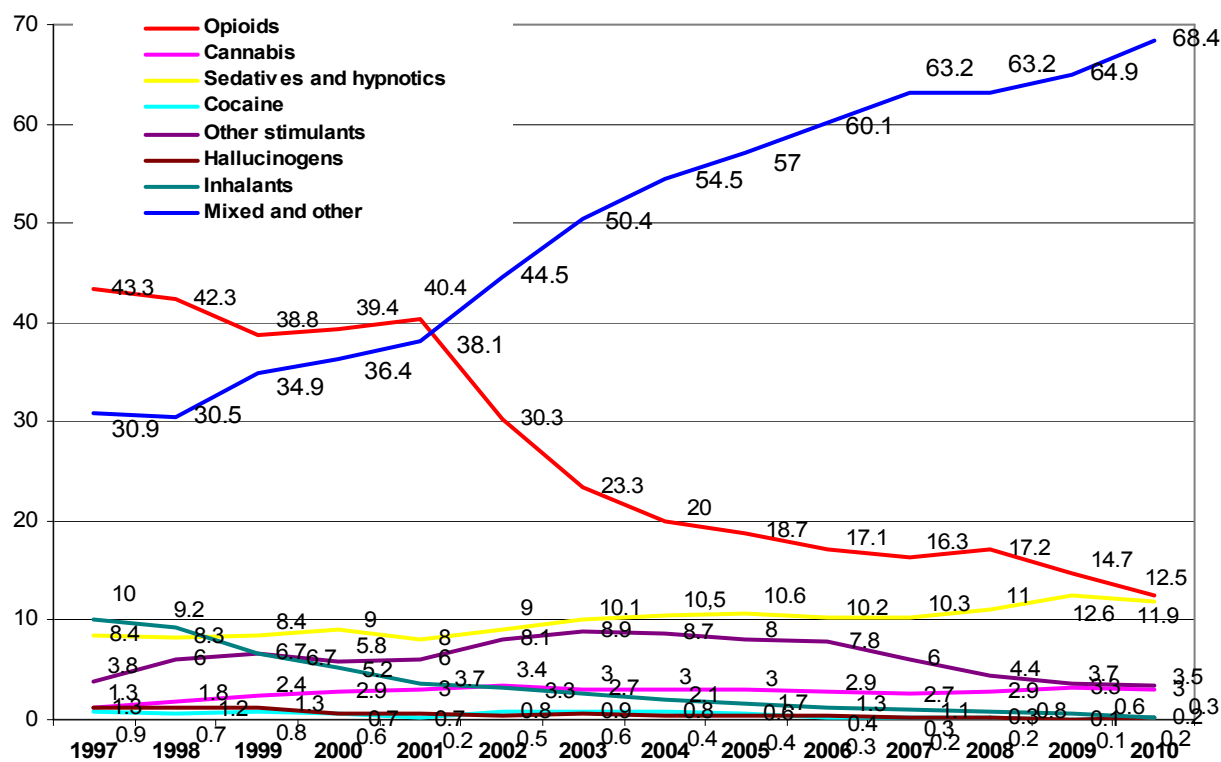
Figure 5.4.1.4. Proportions of patients admitted to residential drug treatment in 2010 due to mental and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19), by substance.



Source: Institute of Psychiatry and Neurology (2012)

Among patients admitted to residential drug treatment in 2010 there were changes concerning the type of primary psychoactive substance. There were similar proportions of individuals dependent on opioids (12.5%) as well as sedatives and hypnotics (11.9%). In 1997-2010 there was a significant fall in the proportion of opioid-dependent patients and this proportion in 2010 reached its lowest value ever. The proportions of cannabis, cocaine and hallucinogen users remain at similar and relatively low levels. We are still observing a rise in the proportion of individuals falling within the category 'mixed and other', where no primary psychoactive substance is specified.

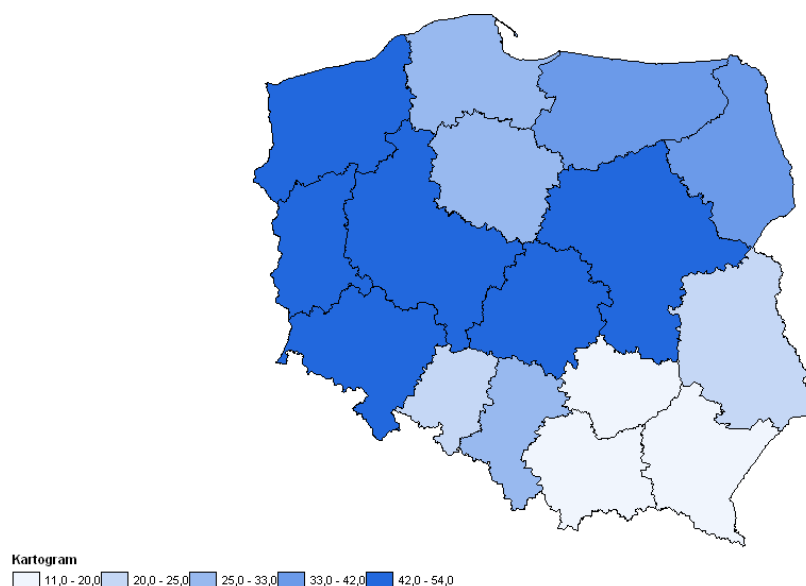
Figure 5.4.1.5. Proportions of patients admitted to residential drug treatment in 1997-2010 due to mental and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19), by substance.



Source: Institute of Psychiatry and Neurology (2012)

According to the Institute of Psychiatry and Neurology in 2010, 14 444 individuals reported to drug treatment with the highest numbers recorded in the provinces of mazowieckie (2 681), wielkopolskie (1 623) and dolnoslaskie (1 351). The fewest admissions were recorded in the provinces of swietokrzyskie (213), opolskie (245) and podkarpackie (251). For comparison, the data will be presented as rate per 100 000 population. The highest rate was recorded in the provinces of zachodniopomorskie (53) and lubuskie (53). The rate for mazowieckie province was not much lower (51). High rates are also recorded in the provinces of dolnoslaskie, wielkopolskie and lodzkie (47). The lowest rates were recorded in the provinces of podkarpackie (12), swietokrzyskie (17) and malopolskie (17).

Figure 5.4.1.6. Rates per 100 000 population for residential drug treatment demand in 2010



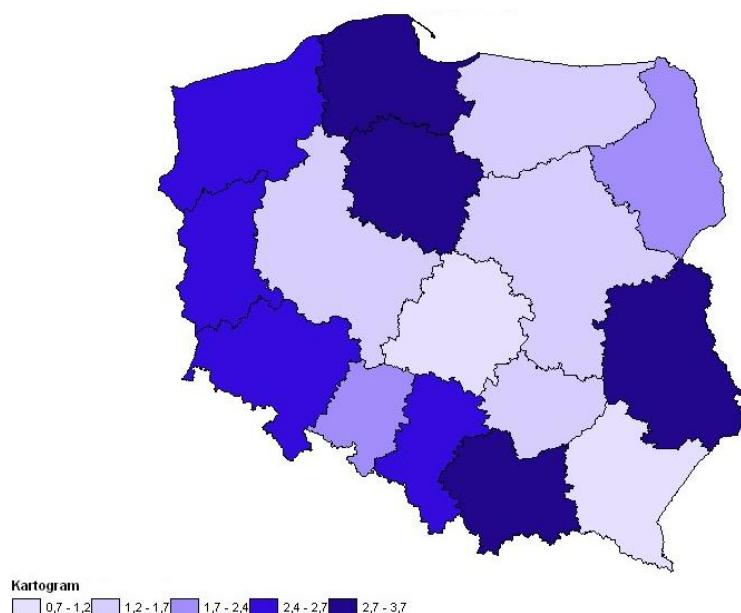
Source: Sierosławski 2012, Institute of Psychiatry and Neurology

- **Availability of drug treatment**

The analysis of drug treatment availability must consider mainly outpatient facilities or drug counselling centres but also consultation centres which provide help for problem users. According to the latest 2011 Fact Book of the National Bureau For Drug Prevention there were 212 drug treatment units in Poland (both drug counselling centres and consultation centres). The highest numbers were recorded in the province of mazowieckie (32) followed by slaskie province (22) and lubuskie province (21). In the provinces of mazowieckie and slaskie there were also the most inpatient drug treatment units (17 in mazowieckie province and 10 in slaskie province). However, patients have the right to enter drug treatment at any centre in the country therefore these units might have admitted individuals from other provinces. Moreover, mazowieckie province features the highest number of detoxification facilities: 3 out of the total of 19 in Poland, 2 in the provinces of slaskie, dolnoslaskie and kujawsko-pomorskie each. In total, there are 80 inpatient drug treatment units in Poland. They are run mainly by NGOs but the providers also include psychiatric hospitals. Substitution treatment programmes complement drug treatment services. The highest number of operational programmes was recorded in mazowieckie province (7). There are two programmes in dolnoslaskie and kujawsko-pomorskie provinces each. In order to compare the situation in respective provinces (outpatient drug treatment units, consultation

centres, detoxification facilities and substitution treatment programmes) the data were converted into rates per 100 000 population. The highest rate was recorded in lubuskie province (2.37 units per 100 000 residents). It must be stressed that out of 22 outpatient clinics in this province, 14 include consultation centres. Nevertheless, there is relatively high availability of drug services in lubuskie province even if it is not in the area drug treatment it is in drug counselling. Opolskie province comes second. There is more than one drug service per 100 000 population (1.54). More than a half of drug services in this province include consultation centres. High rates are also recorded in the provinces of lubuskie (0.84) and mazowieckie (0.80). In mazowieckie province 21 out of 32 outpatient drug clinics are located in Warsaw. In the case of this province Warsaw improves the situation a lot. The lowest rates are observed in the provinces of podkarpackie (0.24) and malopolskie (0.27).

Figure 5.4.1.7. Rates per 100 000 population for drug treatment units in 2011



Source: 2011 Fact Book of the National Bureau for Drug Prevention

5.4.2. Treatment Demand Indicator Database – results of the TDI pilot project in 2009 – 2011

In 2011, similarly to previous years, treatment demand monitoring was performed as a pilot project. In 2011, the National Bureau for Drug Prevention received data from 1 detoxification unit, 1 day care centre and 9 ambulatory treatment units (including 1 providing substitution treatment) and 15 residential treatment units.

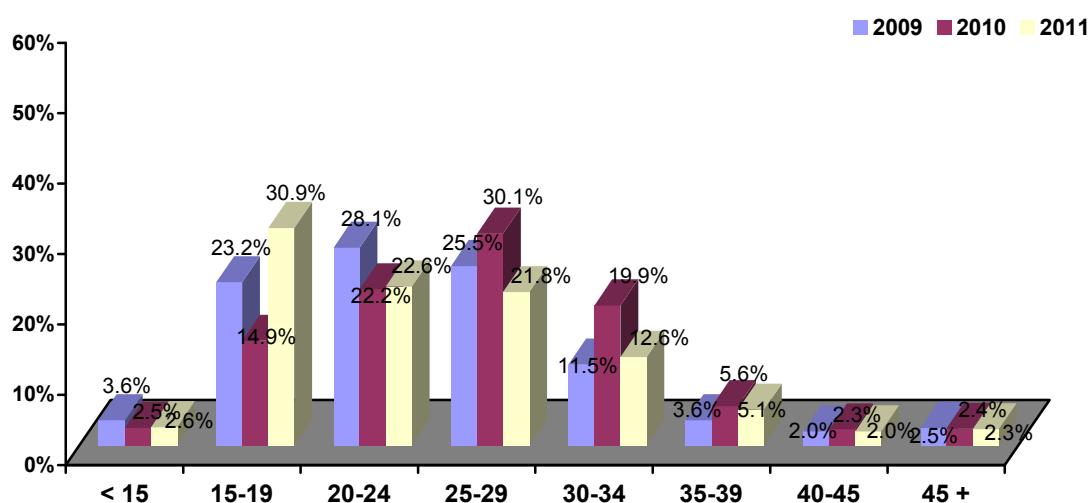
Table 5.4.2.1. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2011.

Number of patients in respective years	2009	2010	2011
All patients	1426	1342	1831
First-time patients	570	364	788
Number of reporting units	26	21	26

Source: NFP 2012.

In 2011, drug treatment units, which took part in the pilot Treatment Demand Indicator (TDI) project, admitted 1 831 patients, including 788 first-time patients. There were 1 461 men and 369 women. In one case it was impossible to determine the patient's sex.

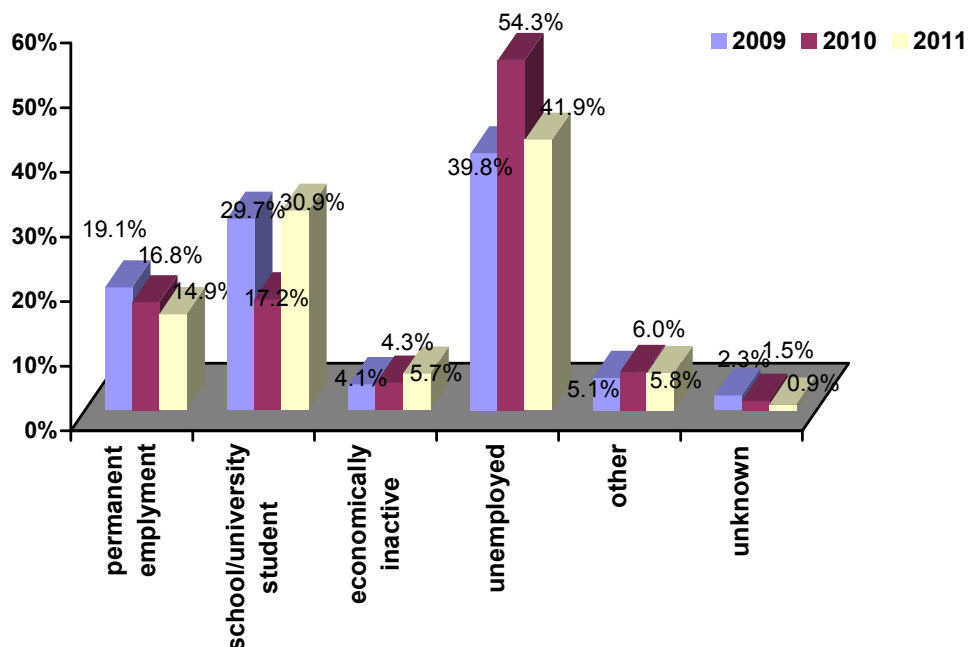
Figure 5.4.2.1. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2011 – proportions of patients, by age.



Source: NFP 2012.

In 2011, the biggest group of problem drug users were individuals aged 15-29. There is a fall in admissions concerning the age group 25-29 and 30-34. In 2010, these groups accounted for 30.1% and 19.9% of all admissions respectively. In 2011, these proportions stood at 21.8% for the age group 25-29 and 12.6% for the age group 30-34. There was a twofold rise in the age group 15-19. Men aged 15-29 accounted for nearly 90% of all drug treatment admissions.

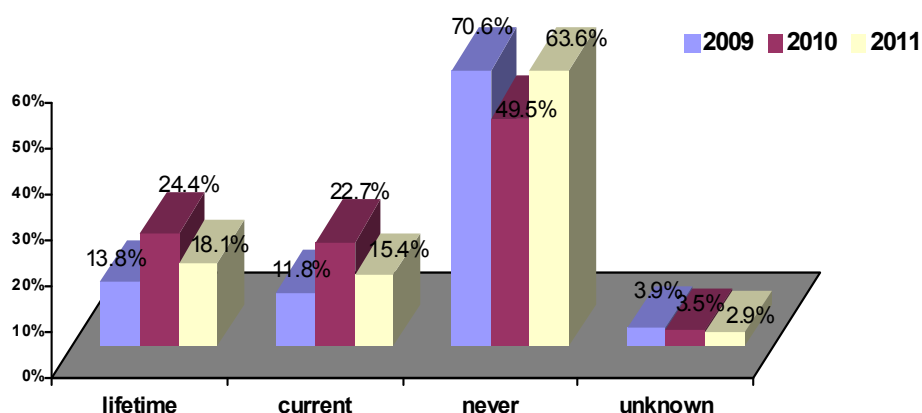
Figure 5.4.2.2. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2011 – proportions of patients, by employment status.



Source: NFP 2012.

Over 40% of drug treatment registrations in 2011 concerned the unemployed. Although this proportion is quite high there was a fall in this category compared to the previous year. Another substantial group was made up by school or university students (about 30% in 2009 and 2011 and half less in 2010).

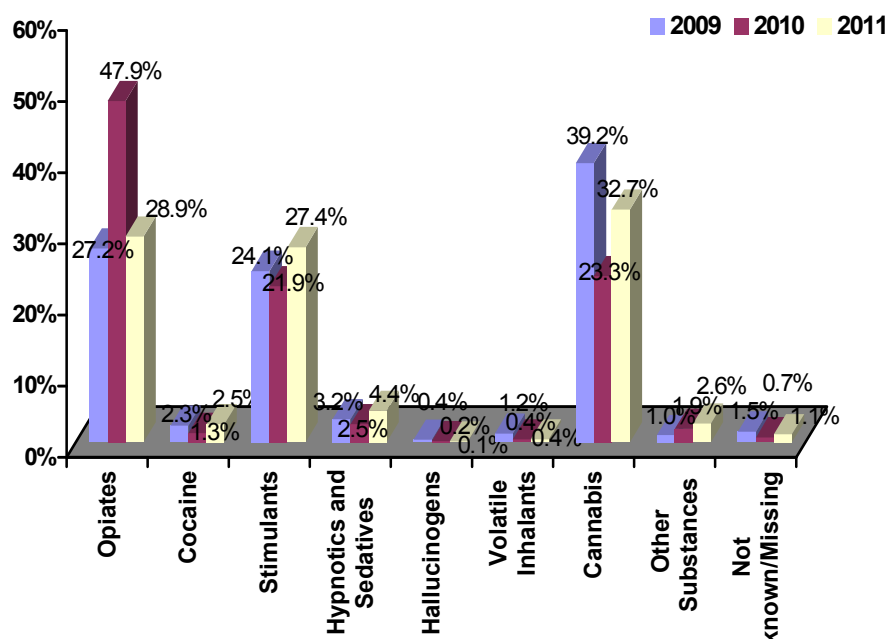
Figure 5.4.2.3. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2010 – proportions of patients, by injecting drug use.



Source: NFP 2012.

There was a considerable drop in the number of lifetime and current injecting drug users reporting to treatment. At the same time there was a rise to 63.6% in the proportion of individuals who had never used psychoactive substances in this way.

Figure 5.4.2.4. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2011 – proportions of patients, by primary drug.

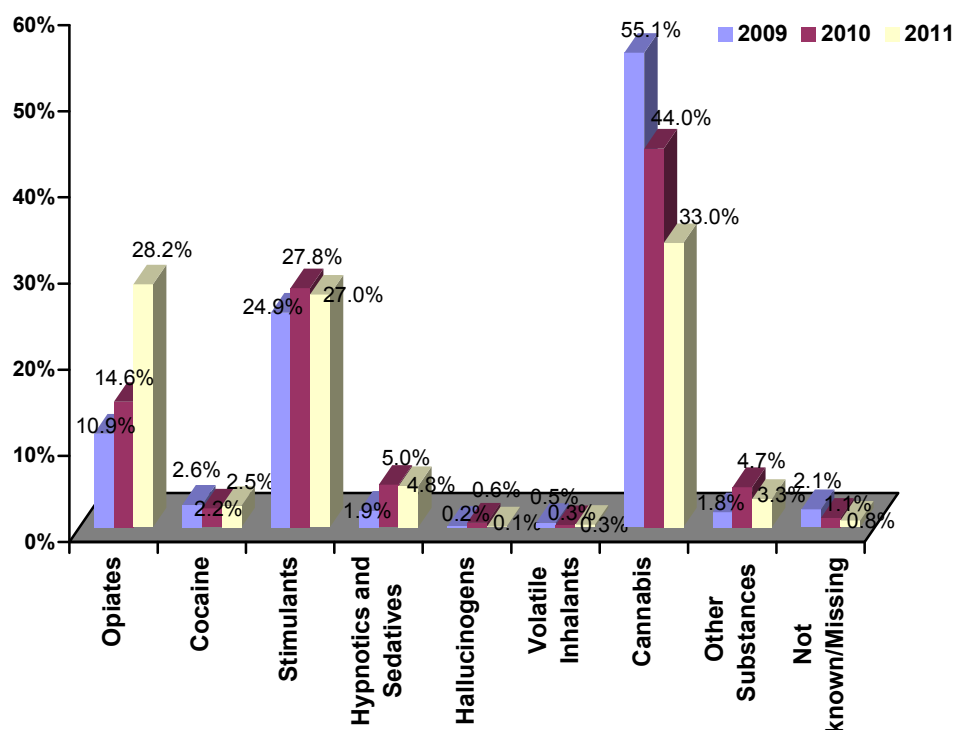


Source: NFP 2012.

Among drug treatment patients the biggest group (over 30%) were individuals who reported cannabis as the primary drug and this stands in contrast to the previous year. Other primary drugs included opiates (28.9%) and stimulants (27.4%).

For several years, substances such as cocaine, stimulants, sedatives/hypnotics, hallucinogens, inhalants and others have been reported as primary drug in less than 5% of patients.

Figure 5.4.2.5. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2011 – proportions of first-time patients, by primary drug.



Source: NFP 2012.

The analysis of primary drugs specified by first-time patients in 2011 shows little difference compared to all drug treatment patients. First-time patients most often reported cannabis, stimulants and opiates as primary drugs.

6. Health correlates and consequences

prepared by Magdalena Rosińska, Marta Niedźwiedzka – Stadnik, Marta Walichnowska, Marta Struzik, Artur Malczewski

6.1. Introduction

Data on HIV infections and AIDS cases related to injecting drug use at the national level are obtained through routine infectious disease notification system. In this system clinicians and laboratories notify cases of infection to the provincial Sanitary and Epidemiological Stations (SANEPID). The reports are then forwarded to the National Institute of Public Health – National Institute of Hygiene.

Data on HIV infections among injecting drug users are also available directly from the network of consultation and testing sites (PKD) that provide anonymous and free HIV testing combined with preliminary consultation. The PKD is run by NGOs closely collaborating with drug treatment units and is coordinated and co-financed by the National AIDS Centre.

In Poland the system of treating patients with dual diagnosis is based on psychiatric treatment facilities and drug 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 biased significantly due to the fact that data come exclusively from residential facilities as diagnosing co-morbidity still remains difficult or is not systematically reported. The latest available data date back to 2010.

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.

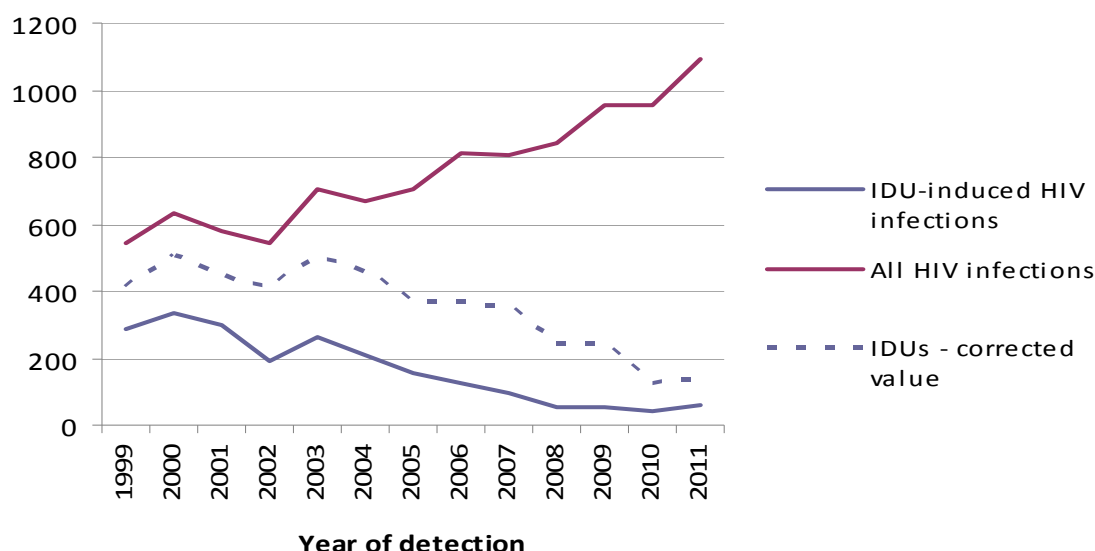
6.2. Drug related infectious diseases

- **Data from the national routine infectious disease notification system (National Institute of Public Health – National Institute of Hygiene)**

Between 1985, i.e. the moment of introducing in Poland the routine epidemiological monitoring system for HIV/AIDS and the end of 2011, 15 452 HIV infections were diagnosed. Out of these infections 5 907 (38%) were injecting drug users (IDUs), including 4 423 men (75%) and 1 428 women (24%) (in 56 cases the information on sex is missing). Analyzing the above monitoring period in terms of AIDS, 2 742 cases were diagnosed,. Out of these 1 350 (49%) were IDUs, including 1 061 men (79%) and 289 (21%) women.

The analysis of IDU-related HIV infections for 2006-2011 indicates a downward trend. In 2006, there were 125 IDU-related HIV infections detected in Poland, in 2007 the figure fell to 95 and in 2008 to 53. The 2009 data show that the trend levelled off (54 new cases). In 2010, 39 new IDU-induced HIV infections were detected and in 2011 the number of new IDU-induced HIV infections increased to 58. The interpretation of these data should consider a notification delay and the fact that a considerable number of infections where no likely route of HIV transmission was reported (in 2011 it referred to 59% of infections). The information on the route of transmission can also be provided later if the report is submitted by the head doctor. The figure below presents the number of new HIV infections reported by the end of July 2012 by year of detection with the corrected graph where no data on the route of infection transmission was given. Approximately 70-90% of all cases are reported in the year of detection or in the following year, usually in its first half. It means that the 2011 data are still underestimated. However, it does not affect the downward trend in the number of newly detected IDU-induced HIV infections with the overall rise in the new infections, especially regarding men who have sex with men (MSM). On the other hand it should be noted that the surveillance data do not distinguish sexually acquired HIV infections among IDU from other sexually transmitted HIV infections.

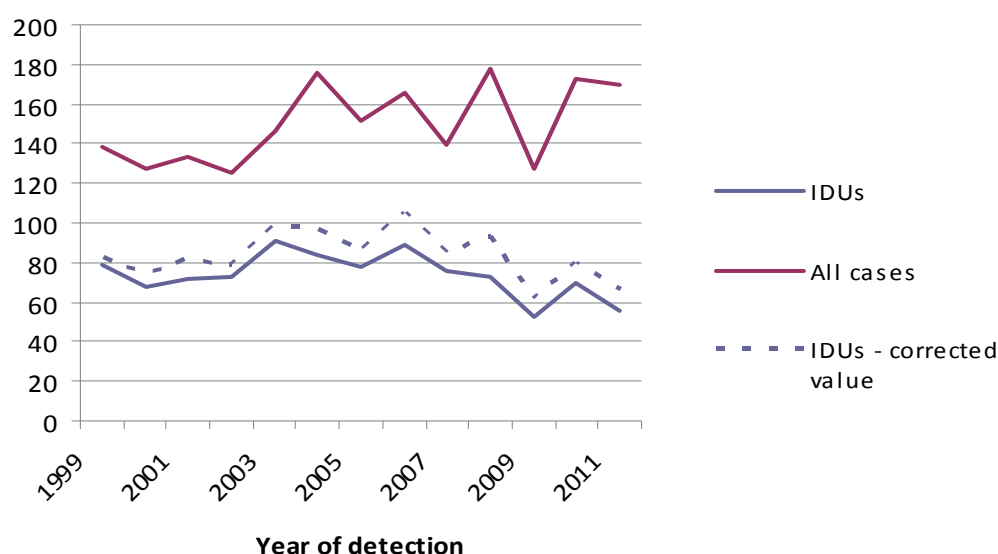
Figure 6.2.1. Number of new HIV infections, including injecting drug use (recorded number and corrected value considering no data on route of transmission) detected in 1999-2011



Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)
By date of detection, registered by 31 July 2012.

AIDS incidence among IDUs held steady in 2003-2006 ranging from 91 cases in 2003 to 89 in 2006. In 2007, 139 AIDS cases were detected altogether, including 76 among IDUs. In 2008, 178 AIDS cases were recorded in total, including 73 among IDUs. The data for 2009 included the total of 127 cases, including 53 among IDUs and 173 and 70 respectively in 2010. In 2011 the total number of AIDS cases were 170, including 56 among IDUs. AIDS incidence rates in recent years have been fluctuating while preserving comparable values. Simultaneously, incidence rates among IDUs fell from 55% to 33% between 2007 and 2011. It is related to a slight downward trend in AIDS incidence among drug users and a rising number of late detections of HIV infections in other groups. Similarly to HIV infections one must consider the reporting delay, which means that the 2011 incidence statistics will be higher.

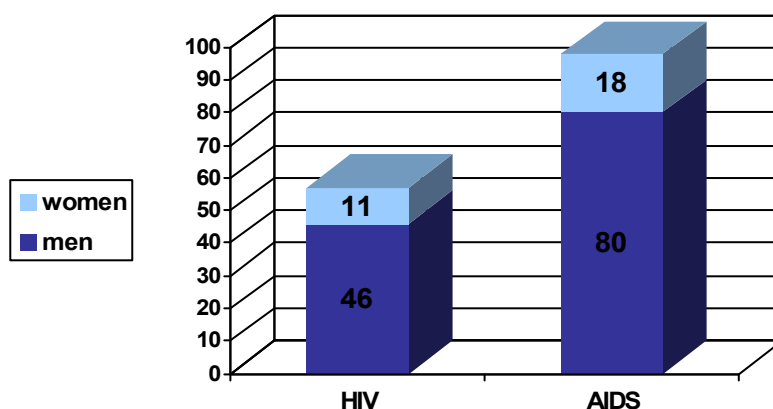
Figure 6.2.2. Number of new AIDS cases, including injecting drug users in 1999-2011



Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)
By date of detection, registered by 31 July 2012.

The below analysis of HIV/AIDS incidence includes cases registered in 2011. Among HIV IDU patients registered in 2011 there were 46 men (77%) and 11 women (18%) (in 3 cases no information on sex was given). Newly registered AIDS cases among IDUs in 2011 referred to 80 men (82%) and 18 women (18%).

Figure 6.2.3. HIV/AIDS cases in IDUs registered in 2011, by sex (numbers of people)*



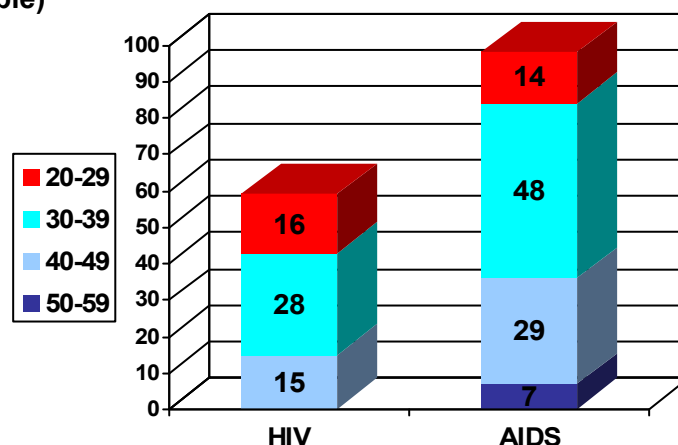
Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)

* For HIV infections in 3 cases no information on sex was given.

In 2011, among registered HIV-positive IDUs the largest group were users aged 30-39 (28 individuals, 47%), then 20-29 (16 individuals, 27%) and 40-49 (15 individuals, 25%).

In 2011, out of the reported new AIDS cases in IDUs the largest group were users aged 30-39 (48 individuals, 49%) and 40-49 (29 individuals, 30%), then 20-29 (14 individuals, 14%) and 50-59 (7 individuals, 7%).

Figure 6.2.4. HIV/AIDS cases in IDUs registered in 2011 by age group (numbers of people)*



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

* For HIV infection in 1 case there is no information on age.

In Poland in 2006-2007, there was a steady fall in HIV incidence rates among IDUs per 100 thousand population. The data for 2008 and 2011 show that the trend had levelled off. However, the HIV incidence varies across provinces. In 2006-2007, the highest HIV incidence rates were recorded in dolnoslaskie, warminsko-mazurskie and lodzkie provinces. In 2006-2007, the fewest cases were recorded in podkarpackie, lubelskie and slaskie

provinces. In the next year the situation was similar in this provinces. The data for 2009 show that the high HIV incidence rates are still recorded in dolnoslaskie, warminsko-mazurskie and lodzkie provinces, but the highest rate was recorded in lubuskie province. In 2010, the most cases were recorded in dolnoslaskie provinces and in the next year the highest rate was in lubuskie and podlaskie provinces. In the provinces of lubelskie and swietokrzyskie no new HIV case was recorded in 2011. Between 2006-2011 no HIV infections were registered in swietokrzyskie province (4 times), podkarpackie (3 times), opolskie and pomorskie province (2 times).

Table 6.2.1. HIV incidence rates in IDUs in 2006-2011 (per 100 000 population) (infections registered by place of residence)

Province	2006		2007		2008		2009		2010		2011	
	number	rate	number	rate	number	rate	number	rate	number	rate	number	rate
dolnoslaskie	41	1.42	36	1.25	19	0.66	8	0.28	14	0.49	6	0.21
kujawsko-pomorskie	5	0.24	4	0.19	2	0.10	4	0.19	0	0.00	4	0.19
lubelskie	1	0.05	2	0.09	1	0.05	1	0.05	1	0.05	0	0.00
lubuskie	4	0.40	1	0.10	4	0.40	9	0.89	2	0.20	5	0.49
lodzkie	15	0.58	9	0.35	8	0.31	9	0.35	6	0.24	3	0.12
malopolskie	6	0.18	3	0.09	1	0.03	1	0.03	0	0.00	1	0.03
mazowieckie	5	0.10	7	0.14	3	0.06	3	0.06	11	0.21	9	0.17
opolskie	3	0.29	1	0.10	0	0.00	0	0.00	1	0.10	2	0.20
podkarpackie	1	0.05	0	0.00	0	0.00	3	0.14	0	0.00	2	0.09
podlaskie	1	0.08	1	0.08	1	0.08	1	0.08	3	0.25	4	0.33
pomorskie	3	0.14	4	0.18	1	0.05	0	0.00	0	0.00	5	0.22
slaskie	2	0.04	7	0.15	7	0.15	1	0.02	2	0.04	13	0.28
swietokrzyskie	0	0.00	0	0.00	1	0.08	1	0.08	0	0.00	0	0.00
warminsko-mazurskie	13	0.91	9	0.63	4	0.28	4	0.28	1	0.07	3	0.21
wielkopolskie	6	0.18	3	0.09	2	0.06	7	0.21	4	0.12	1	0.03
zachodniopomorskie	2	0.12	3	0.18	1	0.06	3	0.18	1	0.06	1	0.06
POLSKA	128	0.34	98	0.26	56	0.15	59	0.15	50	0.13	60	0.16

Source: National Institute of Public Health - National Institute of Hygiene. For HIV infection in 38 cases there is no information on place of residence

AIDS incidence rates in IDUs in 2006-2008 fluctuated. However, in 2009-2010 there was a fall but in 2011 an increase is observed. In 2006-2008, the highest AIDS incidence rates were recorded in dolnoslaskie, kujawsko-pomorskie, warminsko-mazurskie and lubuskie provinces. In 2009, the highest rates were recorded in the provinces of dolnoslaskie, and warminsko-mazurskie and in 2010 the highest rates were in the dolnoslaskie and lubuskie province. Between 2006-2010 the highest rate was in dolnoslaskie but in 2011, the most new AIDS cases were registered in the provinces of lubuskie. In 2006-2008, the lowest AIDS incidence rates were registered in the provinces of podkarpackie, lubelskie and

swietokrzyskie. In 2009-2010, the lowest AIDS incidence rates referred to the following provinces: kujawsko-pomorskie, mazowieckie, malopolskie, slaskie and zachodniopomorskie. Between 2006-2011 no AIDS cases were registered in swietokrzyskie province (3 times), podkarpackie (2 times) and pomorskie province (2 times). The 2011 data indicate an increase in AIDS incidence rates in the provinces of lubuskie, lodzkie, podlaskie and zachodniopomorskie. No new AIDS case was recorded in the malopolskie province.

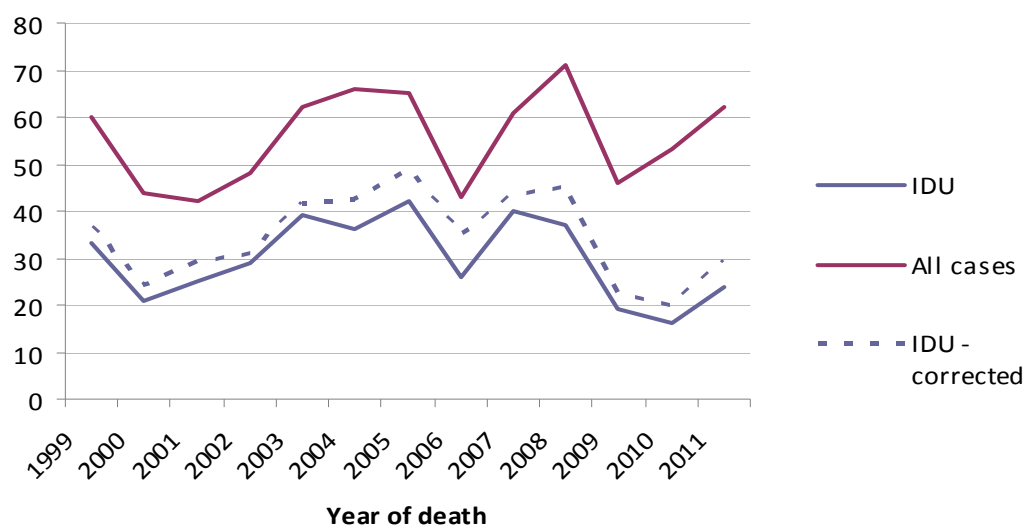
Table 6.2.2. AIDS incidence rates in IDUs in 2006-2011 (per 100 000 population) (infections registered by place of residence)

Province	2006		2007		2008		2009		2010		2011	
	number	rate	number	rate	number	rate	number	rate	number	rate	number	rate
dolnoslaskie	22	0.76	44	1.53	30	1.04	17	0.59	27	0.94	20	0.69
kujawsko-pomorskie	8	0.39	2	0.10	1	0.05	1	0.05	1	0.05	1	0.05
lubelskie	5	0.23	4	0.18	1	0.05	4	0.19	3	0.14	2	0.09
lubuskie	0	0.00	6	0.59	2	0.20	3	0.30	6	0.59	13	1.27
lodzkie	3	0.12	6	0.23	2	0.08	6	0.24	7	0.28	15	0.59
malopolskie	3	0.09	2	0.06	3	0.09	2	0.06	3	0.09	0	0.00
mazowieckie	0	0.00	4	0.08	5	0.10	3	0.06	1	0.02	6	0.11
opolskie	2	0.19	2	0.19	1	0.10	2	0.19	4	0.39	1	0.10
podkarpackie	0	0.00	0	0.00	1	0.05	3	0.14	2	0.10	1	0.05
podlaskie	3	0.25	4	0.33	4	0.34	0	0.00	1	0.08	4	0.33
pomorskie	3	0.14	6	0.27	2	0.09	0	0.00	0	0.00	12	0.53
slaskie	3	0.06	8	0.17	9	0.19	2	0.04	0	0.00	9	0.19
swietokrzyskie	0	0.00	1	0.08	1	0.08	0	0.00	0	0.00	2	0.16
warminsko-mazurskie	4	0.28	8	0.56	6	0.42	6	0.42	1	0.07	4	0.28
wielkopolskie	3	0.09	5	0.15	1	0.03	4	0.12	4	0.12	2	0.06
zachodniopomorskie	2	0.12	1	0.06	2	0.12	1	0.06	0	0.00	6	0.35
POLSKA	61	0.16	103	0.27	71	0.19	54	0.14	60	0.16	98	0.25

Source: National Institute of Public Health - National Institute of Hygiene.

According to the statistics collected since 1986, 1 147 AIDS-related deaths had been recorded by 31 July 2012, including 572 (around 50%) among IDUs.

Figure 6.2.5. AIDS-related deaths recorded in Poland by 31 July 2012, including IDUs, by date of death



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

In 2011, 62 AIDS-related deaths were recorded, including 24 deaths of IDUs (39%). The monitoring of AIDS-related mortality in IDUs reveals that deaths in 2011 related to 17 men (71%) and 7 women (29%). The highest mortality among IDUs diagnosed with AIDS in 2011 concerned the age group 30-39 (12 deaths), then 40-49 (7 deaths) and 50-59 (3 deaths) but also in the age group 20-29 (2 deaths).

To sum up, it must be stressed that the above figures have been calculated on the basis of the most recent data available. However, due to delays in HIV and AIDS data reporting, the figures are likely to change. Moreover, one must remember that the number of newly detected HIV infections depends on the number of tests conducted. Every year the National Institute of Public Health - National Institute of Hygiene conducts a survey among HIV testing laboratories to monitor HIV frequency in diagnostic testing. The study results show an overall upward trend in this indicator in the years 2006-2009 but also a huge decrease between 2009-2010. However, the analysis of 2010 and 2011 data shows that the downward trend has halted and recently the number of all IDUs tested for HIV infection increase in last year. (Table 6.1.3). Although the change in testing patterns is noticeable a lot of infections remain undetected in this group and the number of HIV-positive IDUs is lower in recent years. The reason of this may be, as similarly to most data from routine data collection systems, that the HIV infection data might be underestimated due to incomplete reporting. However, as the monitoring system operated in a similar way throughout the whole reporting period this underestimation is no likely to affect the trends observed.

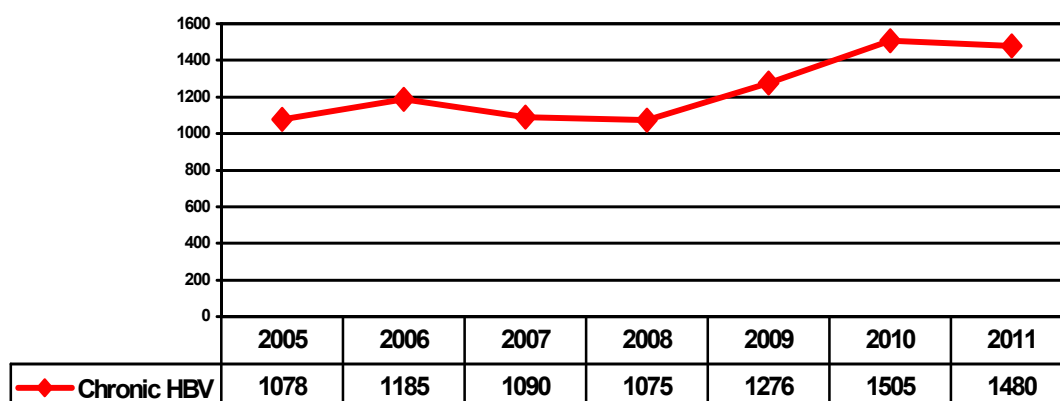
Table 6.2.3. HIV frequency in diagnostic testing in IDUs in 2006 – 2011

	2006	2007	2008	2009	2010	2011
Number of HIV-positive IDUs	107	121	101	65	45	26
Number of all IDUs tested for HIV (valid tests)	1012	1064	1084	1176	657	884
HIV frequency rate	0.1057	0.1137	0.0932	0.0553	0.0685	0.0294

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

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 2011 data display stabilisation with respect to 2010. The data on 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, the IDU status was not known).

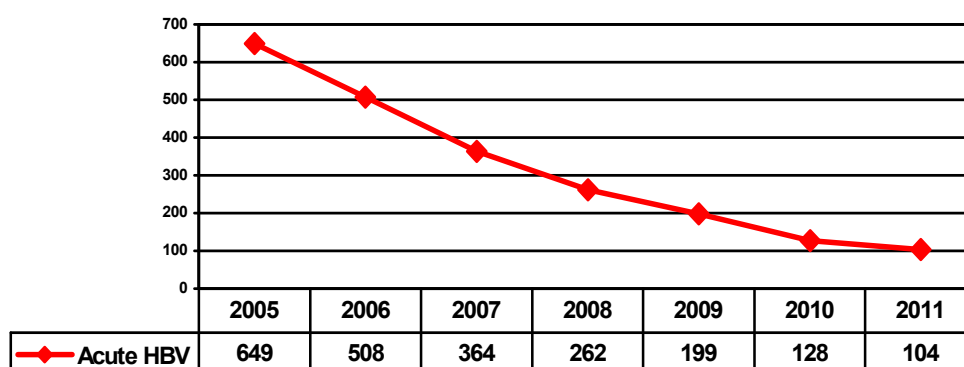
Figure 6.2.6. New chronic HBV cases in 2005-2011



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

In 2005-2011, a downward trend in the total number of acute HBV was observed (Figure 6.2.7). The percent of injecting drug users among cases with known IDU status increased from 3.4% in 2009 to 8.8% in 2011. However, this trend may be non-significant due to small number of cases attributed to IDU (2009-3, 2010-5, 2011-8).

Figure 6.2.7. New acute HBV cases in IDUs in 2005-2011



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

The data of the National Institute of Public Health - National Institute of Hygiene on acute HCV incidence show that the total number of infections varied from 66 in 2009 to 78 in 2010. The proportion of injecting drug users among acute HCV cases is very low, but it shows an increasing tendency from 1 case (3%) in 2009 up to 9 cases (13.8%) in 2011. Information on chronic HCV covers the overall number of 2 027 cases in 2010 and 2121 in 2011. As for HCV infection in IDUs, there were 138 registered cases in 2010 (10.1% of cases with known transmission route) and 148 in 2011 (7.3%).

- **Data from the network of consultation and testing sites - PKD (based on the report “Data analysis of surveys conducted at consultation and testing sites in 2010” produced by IBCGROUP Central Europe Holding S. A. and commissioned by National AIDS Centre)**

Since 1996 a network of consultation and testing sites (PKD) has been operational in Poland. The sites provide anonymous and free HIV testing combined with counselling. The PKD is run by NGOs closely collaborating with drug treatment units and is coordinated and co-financed by the National AIDS Centre. Basic tasks performed by the sites include:

- providing anonymous and free HIV testing for risky behaviour individuals who wish to keep it private without giving personal data. It allows early detection of HIV infections, which prevents further transmission. It also allows providing timely medical care and disease-specific therapy, which consequently constitutes preventive anti-epidemic measures.

- providing professional counselling, which is important from the education and prevention perspective. The counselling is about making PKD clients aware of risky behaviours and the possibility of reducing or eliminating the risk of infection by changing one's behaviour. Such action might reduce the incidence of HIV infections in the general population,

– collecting epidemiological data on routes of HIV transmission in Poland based on the information provided by the testees.

At present there are 31 consultation and testing sites in operation.

Map 6.2.1. Number of consultation and testing sites (PKD) in Poland.

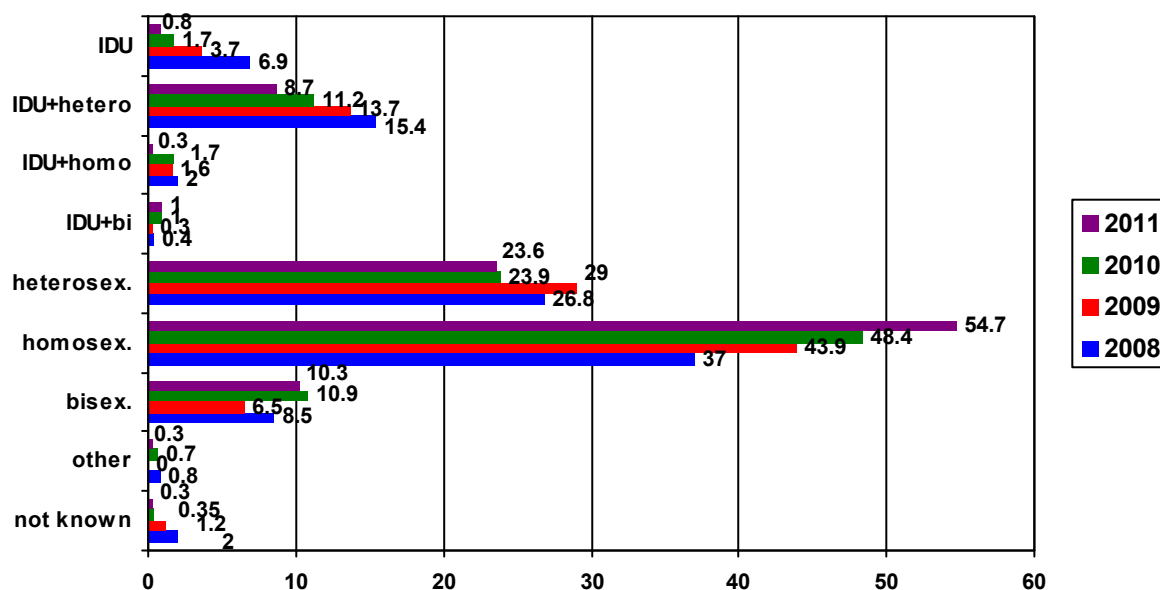


Source: National AIDS Centre.

From the beginning of the PKD till 31 December 2011 a total of 178 996 people get tested for HIV and positives results were recorded in 2039 cases. All PKD clients receive information on sexually transmitted diseases as well as contact details of institutions and organizations providing medical and social care for HIV-positive people.

HIV TRANSMISSION ROUTES AMONG PKD CLIENTS

Figure 6.2.8. Proportions of PKD clients in 2008-2011, by route of HIV transmission



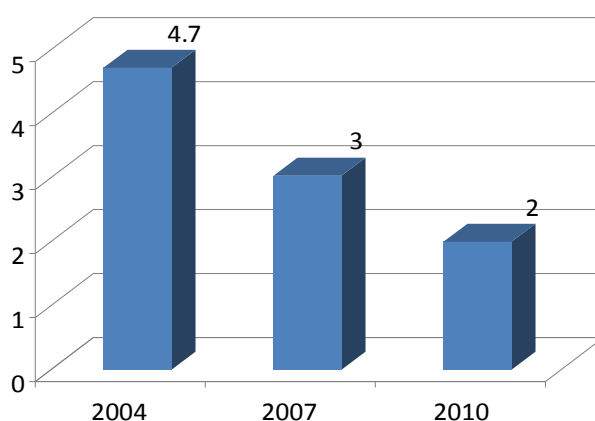
Source: Based on the report "Data analysis of surveys conducted at consultation and testing sites in 2010" produced by IBCGROUP Central Europe Holding S. A. and commissioned by National AIDS Centre.

The main route of HIV transmission among PKD clients is sexual intercourse. The number of new HIV infections recorded due to injecting drug use is falling every year and in 2011 less than 1% of the clients got infected in this manner. However, combining both injecting drug use and risky sexual behaviour the rate reached 10% in 2011.

INJECTING DRUG USERS AS PKD CLIENTS

Comparing data from three time intervals (Figure 6.2.9.) it turns out that the proportion of PKD clients who reported injecting drugs stands at less than 5%. It is also worth noting this proportion is constantly decreasing. In 2004, which serves as the baseline, the proportion stood at 4.7% and it fell by 1.7 percentage points in 2007 and by 1 percentage point between 2007 and 2010.

Figure 6.2.9. Proportions of PKD clients who reported injecting drugs.

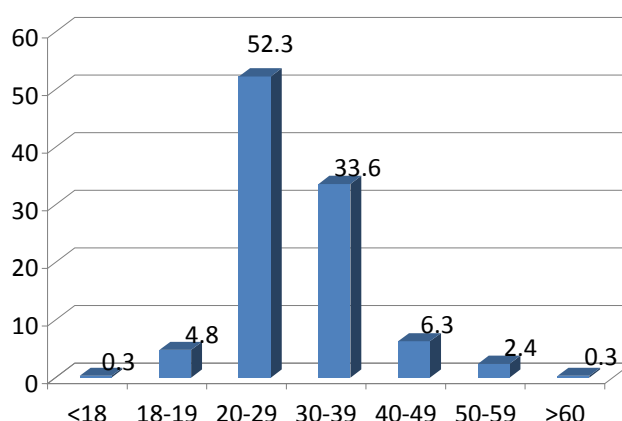


Source: Based on the report "Data analysis of surveys conducted at consultation and testing sites in 2010" produced by IBCGROUP Central Europe Holding S. A. and commissioned by National AIDS Centre.

The 2010 data show clearly that the sex of the testees is a key differentiating factor for drug use. Drug users are mainly male (74.5%) and only 24.9% are women.

Analyzing IDU population age distribution (Figure 6.2.10.) a certain pattern can be observed. Namely, PKD IDUs are primarily aged 20-29 (over a half of all IDUs). In the older cohorts the proportion of IDUs systematically decreases.

Figure 6.2.10. IDU population in 2010, proportions by age



Source: Based on the report "Data analysis of surveys conducted at consultation and testing sites in 2010" produced by IBCGROUP Central Europe Holding S. A. and commissioned by National AIDS Centre.

Testees often do not specify their jobs (42.6% provided no answers). If such information was reported the jobs fell within the broad category of services: barmen, shop assistants, cook or office workers. It is worth noting that every second respondent was unemployed (54.7%) while students accounted for mere 5.7% and school students 3%.

Over a half of the respondents (53.6%) had tested for HIV before. One time was reported by 24.3% of the respondents, two times 11.1% and three times 5.4% while more than three times less than 10%.

The comparison of HIV test positive results in the IDU population and the whole population of PKD clients indicates a significant discrepancy (Figures 6.2.11. and 6.2.12.). In 2010, the proportion of positive results of all PKD clients stood at 1.12% and has been holding steady for several years. However, in the population of injecting drug users the proportion stands at 8.1% and is the highest in all the populations analyzed. For comparison, the proportion of positive test results in the population of homosexual men, where HIV infection is detected most frequently in the PKD, stood at 4.7%.

Figure 6.2.11. Proportion of positive test results in IDU population in 2010 (N=333)

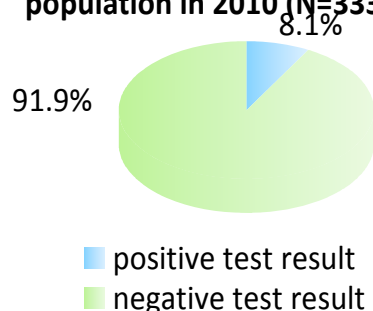
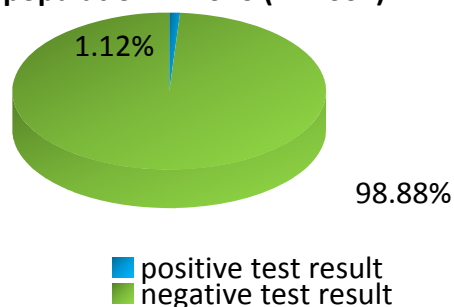


Figure 6.2.12. Proportion of positive test results in PKD population in 2010 (N=1001)



Source: Based on the report “Data analysis of surveys conducted at consultation and testing sites in 2010” produced by IBCGROUP Central Europe Holding S. A. and commissioned by National AIDS Centre.

IDU is the group where previous HIV tests were conducted slightly more often in testing centres other than the PKD (25.5%) – most frequently they were hospitals (5.7%), drug therapy centres (4.2%) and NFZ units (3.9%).

More than every fourth respondent (27.6%) reported that his partner had tested for HIV.

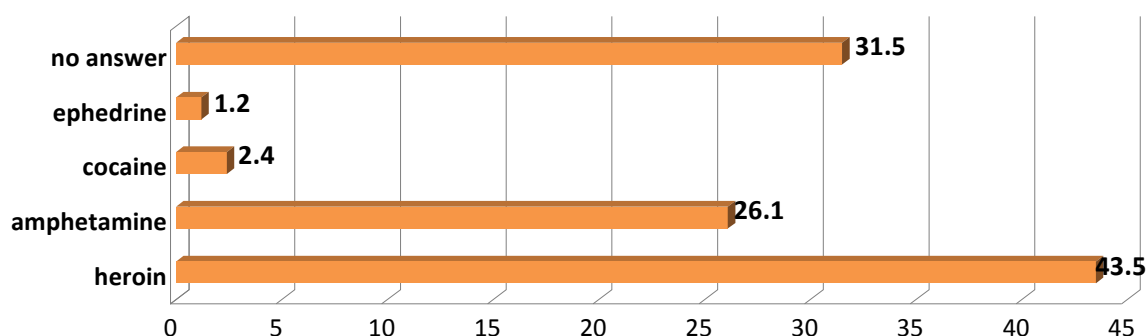
IDUs’ sexual partners are predominantly heterosexual 88.9% (less than 5% are homosexual or bisexual). The majority had steady sexual relationships, 22% reported having 2-5 sexual partners in the last 12 months.

IDUs reported the following condom use frequencies: always (10.2%), often (14.4%), sometimes (20.7%) and never (12.6%). Condoms were mainly used in vaginal intercourse (50.8%). Every tenth IDU testee (12.3%) thought that the condom had been damaged during the intercourse. 2 out of three testees (67.3%) had sexual intercourse under the influence of drugs, not much fewer (63.7%) under the influence of alcohol. The most prevalent drugs in this context included amphetamine and heroin (21.6% and 21% respectively).

The most common injecting drug was heroin (43.5% including Polish homemade heroin ‘kompot’) and amphetamine (26.1%).

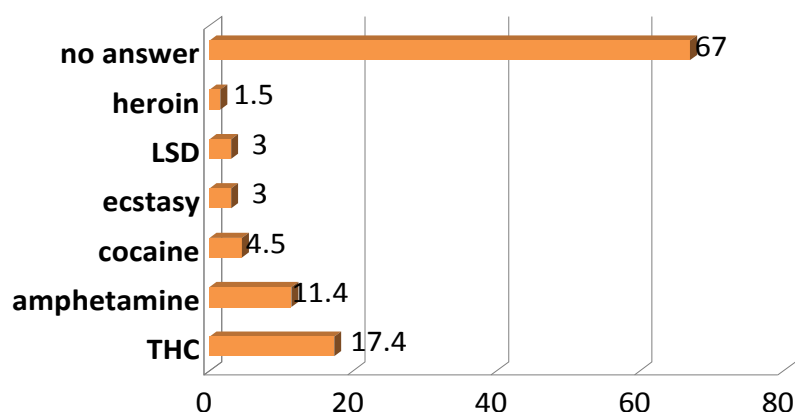
Figures 6.2.13. and 6.2.14. show drugs used by IDUs – both intravenously and in a different manner. The figures include no-answer data due to no answer given by the respondent or the failure to include this question by the interviewer. It was possible to give multiple answers.

Figure 6.2.13. Drugs used intravenously in IDU population (proportions of answers in 2010).



Source: Based on the report "Data analysis of surveys conducted at consultation and testing sites in 2010" produced by IBCGROUP Central Europe Holding S. A. and commissioned by National AIDS Centre.

Figure 6.2.14. Drugs used in way other than intravenously in IDU population (proportions of answers in 2010).



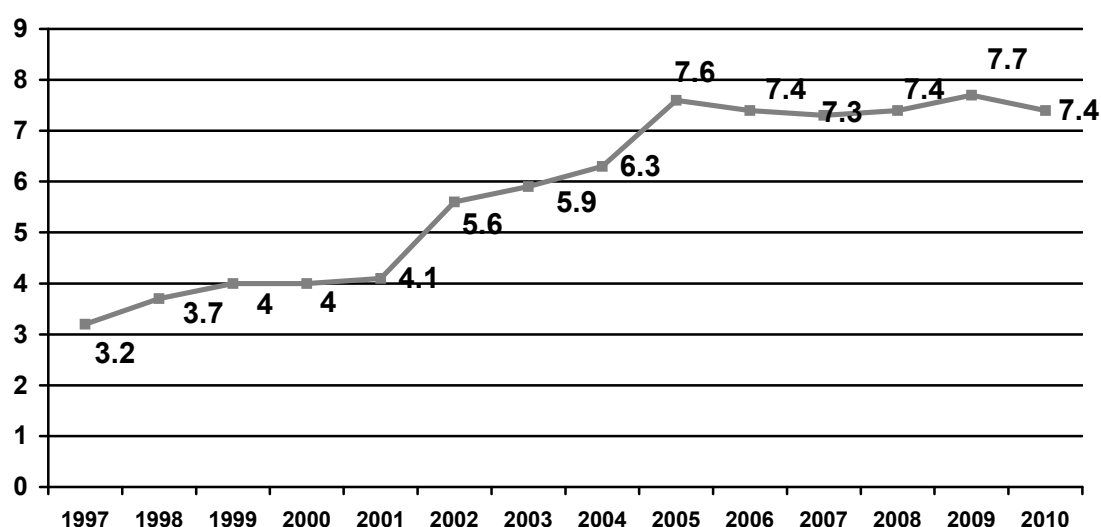
Source: Based on the report "Data analysis of surveys conducted at consultation and testing sites in 2010" produced by IBCGROUP Central Europe Holding S. A. and commissioned by National AIDS Centre.

44.1% of the respondents share syringes/needles. 38.7% of the IDU respondents had a tattoo and 28.5% had piercing. 6% had had their blood transfused in the past. HCV was recorded in every fifth HIV testee.

6.3. Other drug-related health correlates and consequences (dual diagnosis)¹⁸

Up to 2005 the percentage of patients with dual diagnosis in the overall number of patients admitted to residential treatment due to drug abuse was on the rise and reached the rate of 7.6% in 2005. Since 2006 the upward trend has been stemmed and the percentage of patients with dual diagnosis in the overall number of all patients admitted to residential treatment has been holding steady at 7.4-7.7%.

Figure 6.3.1. Patients with dual diagnosis in all admissions to residential psychiatric treatment in 1997-2010 (percentages of patients).

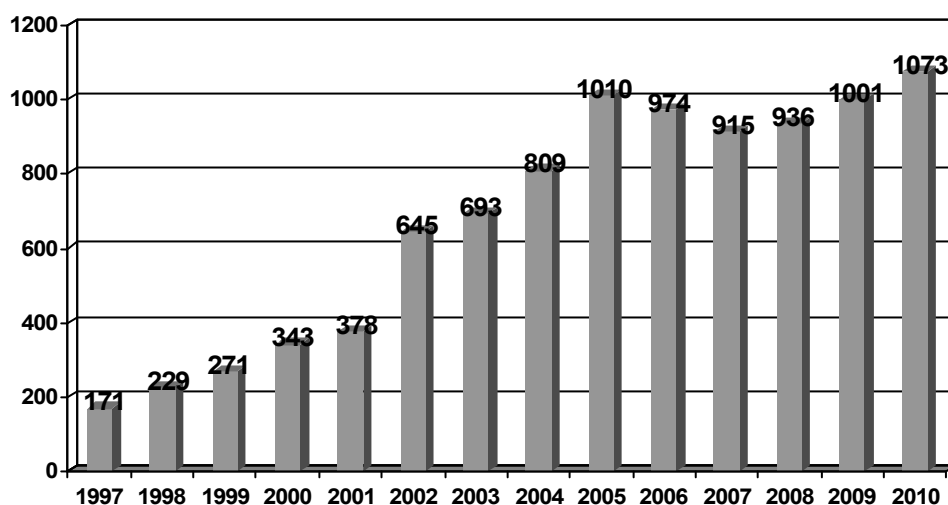


Source: Institute of Psychiatry and Neurology in Warsaw (2012)

Between 1997 and 2005 the number of hospitalized patients with dual diagnosis rose from 171 in 1997 to 1010 in 2005. Between 2006 and 2009, it ranged from 974 patients in 2006 through 915 in 2007 to 936 in 2008. In 2009, a similar number of patients was recorded as in 2005 (1 001). In 2007-2010 an upward trend was observed again, though less dynamic as previously. In 2010, the highest number of dual diagnosis admissions was recorded i.e. 1 073 patients, which might have been caused by the fact that in 2010 a generally high number of residential drug treatment admissions was recorded .

¹⁸ Data on dual diagnosis was published in: Struzik, M. (2012) Problemy związane z używaniem substancji psychoaktywnych a występowanie zaburzeń psychicznych – charakterystyka zjawiska podwójnej diagnozy w Polsce i w Europie. Serwis Informacyjny NARKOMANIA 3 (59) 2012

Figure 6.3.2. Total number of patients with dual diagnosis admitted to inpatient psychiatric treatment in 1997-2010.



Source: Institute of Psychiatry and Neurology in Warsaw (2012)

At residential psychiatric clinics in Poland in 2010 the most numerous groups were patients of the category “other mental disorders” (62%). This group comprises psychotic disorders, including hallucinations and delusions, schizophrenia and behavioural disorders. A considerable number of patients manifested personality disorder symptoms (26%). Moreover, the patients showed symptoms of anxiety disorders (6%), depression (5%) and other affective disorders (1%).

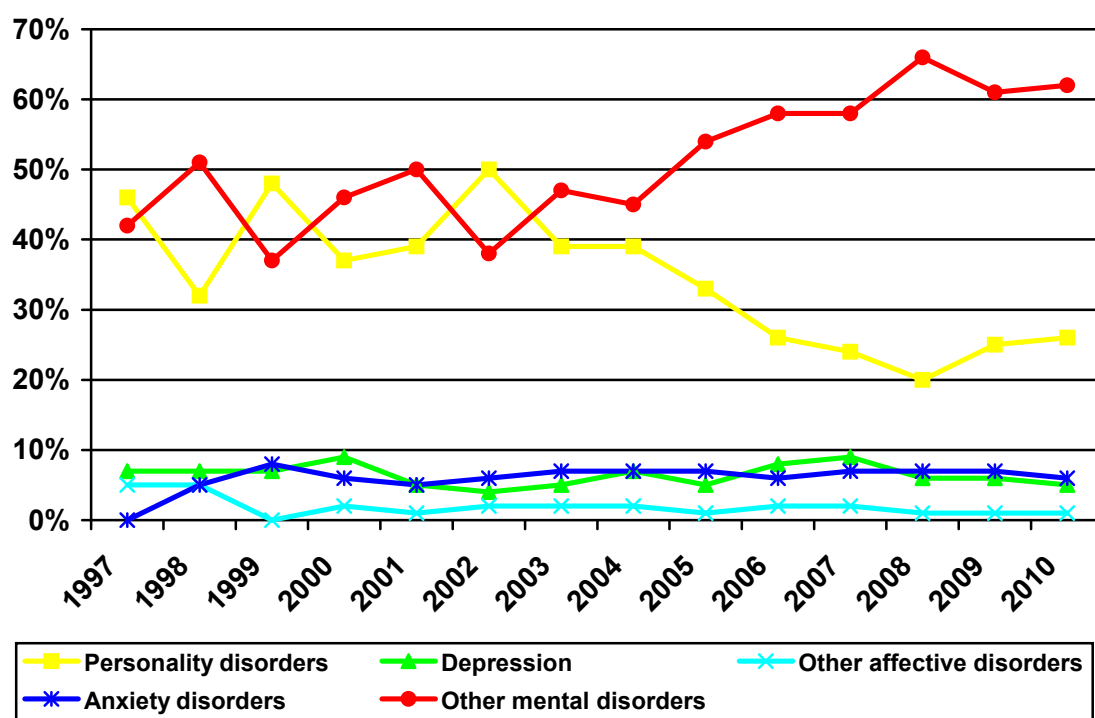
Table 6.3.1. Percentages of patients with dual diagnosis admitted to residential psychiatric treatment in 1997-2010, by ICD-10 diagnosis.

ICD-10 diagnosis	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Personality disorders	46%	32%	48%	37%	39%	50%	39%	39%	33%	26%	24%	20%	25%	26%
Depression	7%	7%	7%	9%	5%	4%	5%	7%	5%	8%	9%	6%	6%	5%
Other affective disorders	5%	5%	0	2%	1%	2%	2%	2%	1%	2%	2%	1%	1%	1%
Anxiety disorders	0	5%	8%	6%	5%	6%	7%	7%	7%	6%	7%	7%	7%	6%
Other mental disorders	42%	51%	37%	46%	50%	38%	47%	45%	54%	58%	58%	66%	61%	62%

Source: Institute of Psychiatry and Neurology in Warsaw (2012)

Analyzing data on what mental disorders are manifested by patients admitted to residential treatment in 1997-2010 there is a visible upward trend regarding patients diagnosed with “other mental disorders”. Since a fall of 2006 in the number of patients with personality disorders, this percentage has been holding quite steady. A stable trend of admissions related to anxiety disorders, depression and other affective disorders can also be noticed.

Figure 6.3.3. Percentages of drug problem patients admitted to residential psychiatric treatment in 1997-2010, by ICD-10 diagnosis.



Source: Institute of Psychiatry and Neurology in Warsaw (2012)

The 2010 data analysis indicates that dual diagnosis most often concerned inhalants users (lack of dual diagnosis occurred in 85.4% of cases) and cocaine (lack of dual diagnosis occurred in 89.3% of cases). The fewest cases of co-morbidity were recorded in opioid patients (98.8% of patients without dual diagnosis). Other mental disorders i.e. the diagnostic category which most often refers to drug problem patients is mainly identified in users of inhalants (8.3%), cocaine (7.1%), hallucinogens (6.9%) and poly-drug use (5.7%). Personality disorders are most frequently observed in inhalants-dependent individuals (6.3%), though a relatively considerable percentage referred to polydrug users (2.3%). Anxiety disorders were most often diagnosed in cocaine-dependent patients (3.6%) and users of sedatives and hypnotics (2.7%).

Table 6.3.2. Percentages of patients with dual diagnosis admitted to residential psychiatric treatment in 2010.

Type of drug addiction	Lack of dual diagnosis	Personality disorders	Depression	Other affective disorders	Anxiety disorders	Other mental disorders
opioids	98.8	0.5	0.1	0.0	0.2	0.4
cannabis	95	1.6	0.2	0.0	0.0	3.2
sedatives and hypnotics	91.1	1.3	1.0	0.2	2.7	3.7
cocaine	89.3	0.0	0.0	0.0	3.6	7.1
amphetamines	96.2	1.8	0.0	0.0	0.0	2.0
hallucinogens	93.1	0.0	0.0	0.0	0.0	6.9
inhalants	85.4	6.3	0.0	0.0	0.0	8.3
polydrug use	91.4	2.3	0.4	0.0	0.2	5.7

Source: Institute of Psychiatry and Neurology in Warsaw (2012)

6.4. Drug-related deaths and poisonings

Data on drug-related deaths in Poland are collected by the Central Statistical Office (GUS). Every year the Polish Focal Point (CINN) at the National Bureau for Drug Prevention (KBPN) processes the GUS information for domestic and EMCDDA purposes. The data reported by the GUS to the CINN specify 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). The national definition of drug-related deaths is based on the following ICD 10 codes: F11-12, F14-16, F19, X42, X62, Y12, X44, X64, Y14. The lack of another code in specifying the cause of death results in the failure to determine a lethal substance in most cases.

- **Situation in Poland**

The analysis of data between 2001 and 2010 shows the beginning of the century witnessed the highest number of drug-related deaths as well as the highest rates per 100 000 population ranging from 0.77 in 2001 to 0.85 in 2002. It must be stressed that this rate has never reached 1 per 100 000 (in the period 1990-2008). 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 available data for 2010, we notice a slight increase to 261 cases. In 2010, the average age of drug-related death was 41. Out of 261 deaths, most cases (61%) were male. Throughout all the years, most fatal drug overdoses were recorded in men (Malczewski 2012 h, p. 28).

Table 6.4.1. Number of drug-related deaths in 2001 – 2010.

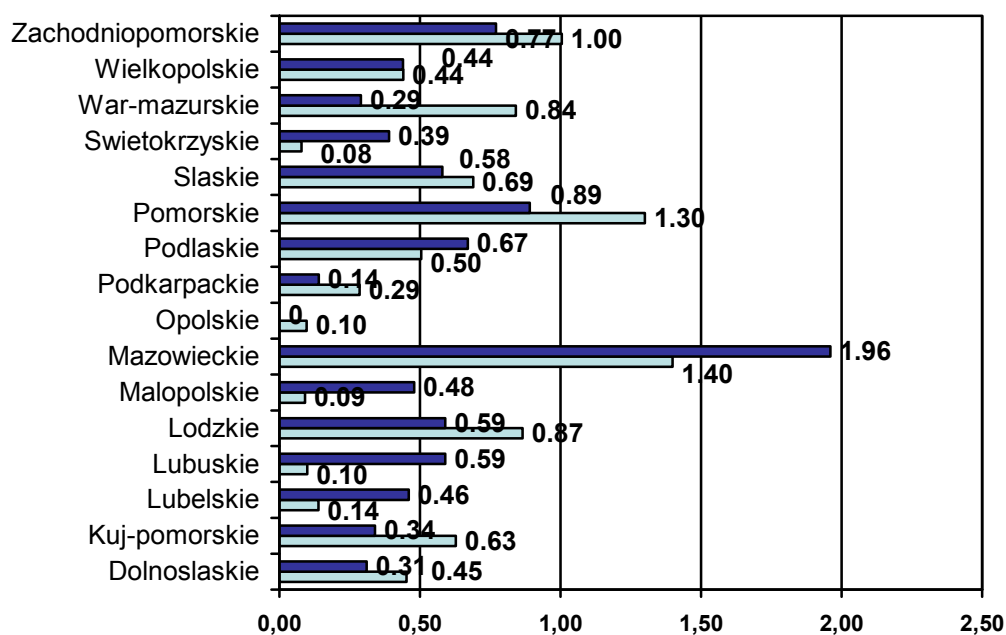
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Men	184	186	187	143	172	145	137	142	174	160
Women	110	138	90	88	118	96	77	102	73	101
Total	294	324	277	231	290	241	214	244	247	261

Source: GUS.

- Situation in provinces**

In 2010, the highest drug-related death rate was recorded in mazowieckie province (1.96; 1.40 in 2009), pomorskie (0.89; 1.30 in 2009) zachodniopomorskie (0.77; 1.0 in 2009) and the lowest in opolskie province (0.00; 0.08 in 2009) podkarpackie (0.14) and warminsko-mazurskie (0.28). The data from regions are presented on Figure 6.4.1 and 6.4.2

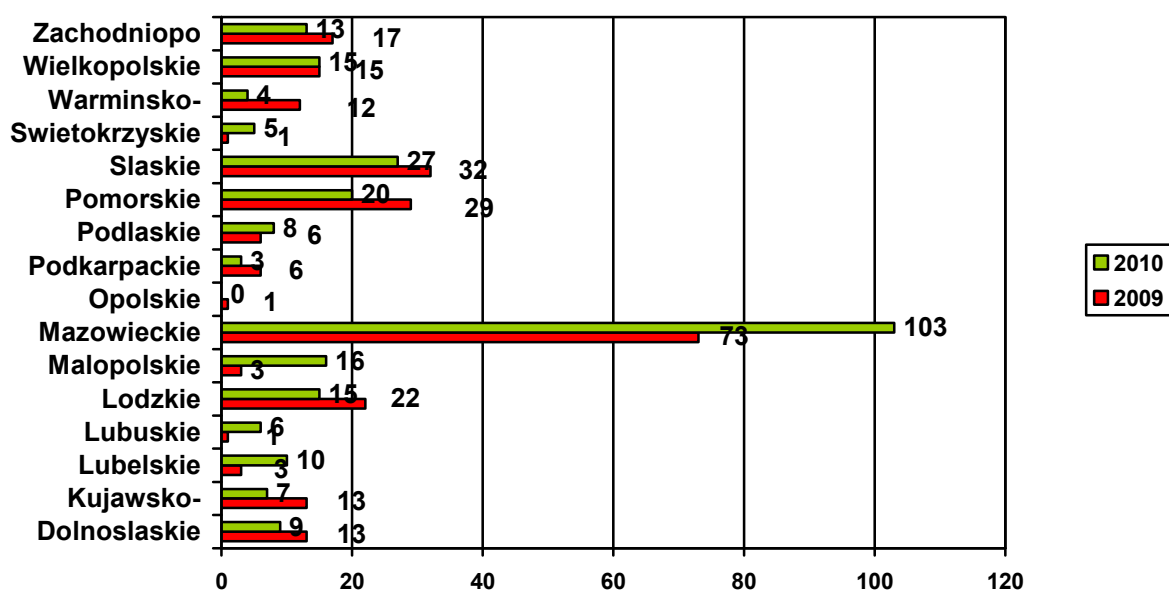
Figure 6.4.1. Drug-related death rates in 2009 and 2010, by province.
Poland's average – 0.68.



Source: GUS.

The highest number of deaths was recorded in the provinces of mazowieckie (103; 72% recorded in Warsaw), slaskie (27) and pomorskie (20). No death was in opolskie province.

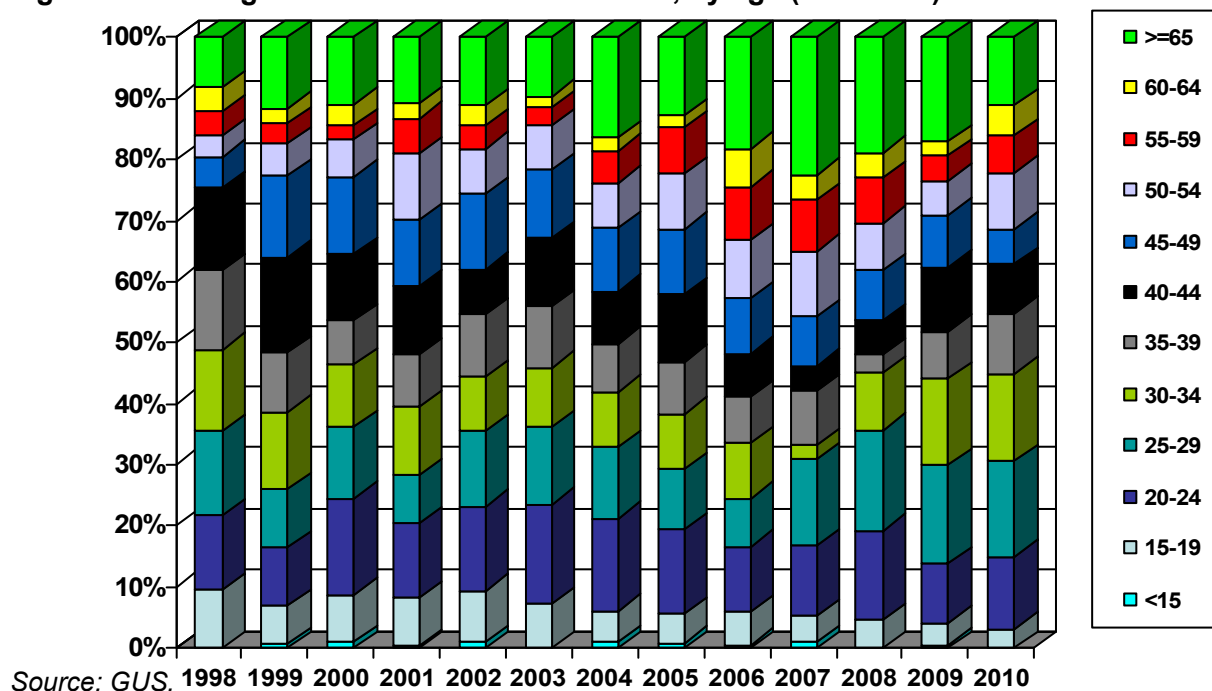
Figure 6.4.2. Numbers of drug-related deaths in 2009 and 2010, by province.



Source: GUS.

Analyzing the age of fatal drug overdose victims in 2010, we record the highest numbers among individuals aged 25-29 (41), see Figure 6.4.3 and 30-34 (37). Records of drug-related deaths among individuals aged 65 and older might be the result of including in the statistics the medical application of drugs e.g. opioid painkillers. However, analyzing the latest data a fall can be noticed. In 2010, the youngest drug-related death victim recorded was 17 years old.

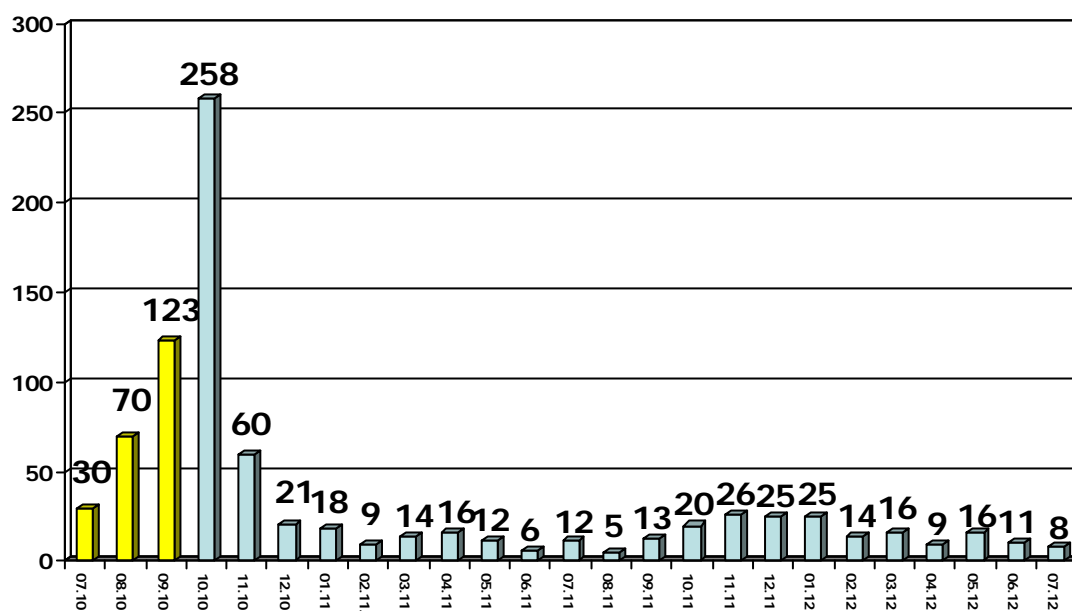
Figure 6.4.3. Drug-related deaths in 1998 – 2010, by age (GUS data).



- **Legal highs-related deaths and poisonings**

In Poland no officially recorded death caused by the use of legal highs was found. In 2010, 258 legal highs-related poisonings were recorded. The number of poisonings after the closure of legal highs stores in November fell dramatically and according to the latest data of July 2012 stood at 8 cases.

Figure 6.4.4. Medical interventions related to new psychoactive substances.



Source: Piotr Burda PhD, National Clinical Toxicology Consultant

7. Responses to health correlates and consequences

prepared by Dawid Chojecki, Kamila Gryn, Artur Malczewski

7.1. Introduction

Harm reduction programmes have been conducted in Poland since 1996. However, needle and syringe exchange programmes were launched as early as 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, streets, night shelters for the homeless, meeting spots of drug addicts (dealers' dens, railway stations, streets, and parks), and sex service settings.

Another form of drug prevention is outreach-based harm reduction programmes. One of the aims of such projects, carried out in pubs, clubs, discotheques or mass events is preventing drug overdoses, risky behaviour (unprotected casual sex, dangerous poly-drug use, driving mechanical vehicles under the influence of psychoactive substances) as well as moving from occasional use to abuse or dependence. These programmes also deal with the so-called date rape drug.

The following section discusses life-saving medications in drug overdoses, infectious diseases and dual diagnosis.

The need to improve access to risk reduction programmes targeting occasional drug users, harm reduction programmes targeting drug dependent clients unmotivated to change their behaviour as well as infectious disease treatment programmes has been incorporated in the National Programme for Counteracting Drug Addiction 2011-2016 (NPCDA).

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

Due to the increased popularity of synthetic drugs in Poland, harm reduction programmes targeting occasional and recreational drug users have been developing for several years. Such programmes are conducted in recreational settings (dance clubs, discotheques, concerts, open air events, etc.). They are outlined in Chapter 3.4. Selective prevention in at-risks groups and settings (Drug endangered groups).

Under the harm reduction programmes for psychoactive substance users (described in Section 7.3), safe injection and first aid trainings (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 medications in drug overdose treatment**

In Poland the following drugs are used:

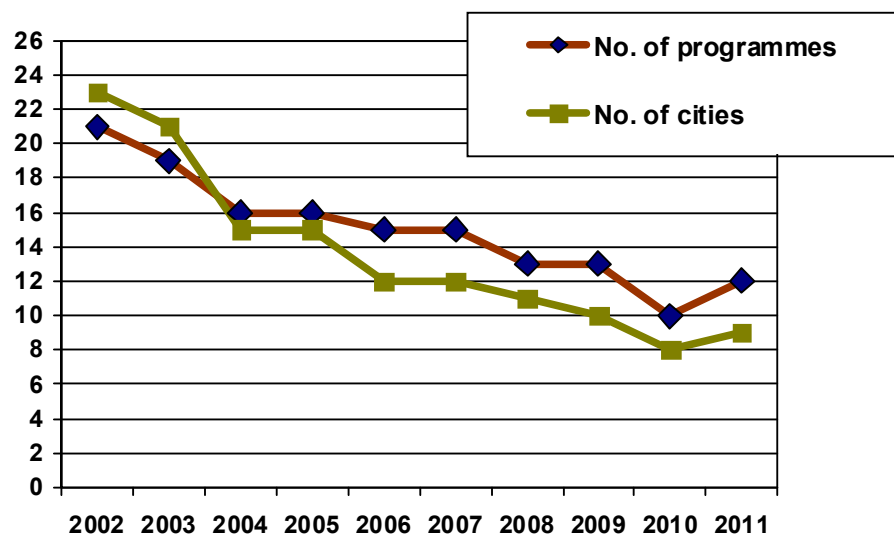
- Naloxone, in acute opioid poisoning
- Naltrexone, in maintaining abstinence or preventing relapse. In Poland, the drug is registered to support opioid treatment following detoxification. The drug is applied by physicians in non-public drug treatment clinics. Naltrexone is not refunded by the National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

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

- **Harm reduction**

The first pilot syringe and needle exchange programme was launched in 1988 by Monar Society. A year later all MONAR consultation centres across the country were distributing Sterile injecting equipment. According to IPiN data, in 1989 66 000 needles and syringes were handed out and in 1993 the figure rose to 360 thousand. In the next two years, needle distribution halved (Kulka, Z.; Moskalewicz, J. 1998). More information on the distribution of needles and syringes was collected under harm reduction monitoring performed by the Polish Focal Point. In 2002, 21 SNEPs were operational in 23 cities. That year more than 668 thousand needles were distributed, which was over ten times more compared to 1998. However, since 2002 the number of programmes and host cities has been falling. Although the number of needles and syringes in distribution held steady for more three years or even reached the record 731 thousand in 2004, for the last 10 years the scope of distribution in Poland has been narrowing. Since 2002 the number of SNEPs has dropped from 21 to 12 in 2011 while the number of host cities has gone down from 23 to 9.

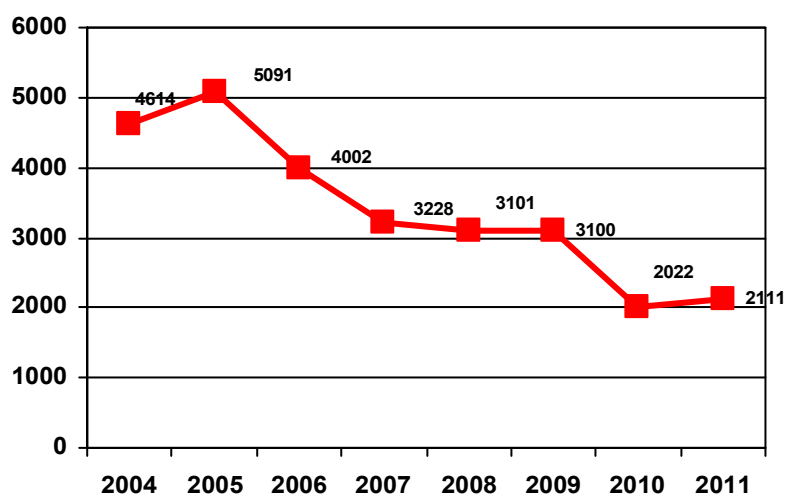
Figure 7.2.1. Number of SNEPs and host cities



Source: Malczewski (2012a)

Figure 7.2.2. shows numbers of SNEP clients in 2004-2011. Since 2005, the number of SNEP clients has been falling systematically. The highest number of clients i.e. 5 000 was recorded in 2005. The latest data stand at 2 111 syringe and needle exchange service beneficiaries.

Figure 7.2.2. Numbers of SNEP clients

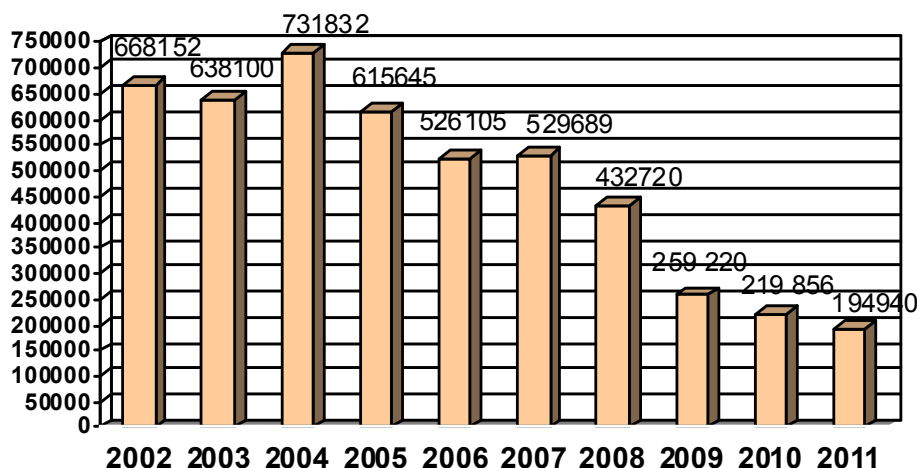


Source: Malczewski (2012 a)

Along with the decline in the number of SNEPs, there was a fall in the number of syringes and needles in distribution. Figure 7.2.3. shows how many syringes and needles were distributed in 2002-2011. The most syringes (545 738) and needles (731 832) were

distributed in 2004. Till 2008 the number of syringes and needles in distribution was falling systematically: (318 054 syringes and 432 720 needles). Despite the fall in distribution, an average number of needles per user in 2004 was not much higher than in 2008 i.e. 159 in 2004 and 140 in 2008. A considerable fall in the average and the overall number of needles distributed was noted in 2009 (83 needles per user). The next two years witnessed further fall while the trend levelled off at over 2 000 programme clients per year.

Figure 7.2.3. Numbers of needles in distribution in 2002 - 2011



Source: Malczewski (2012a)

Situation in 2011

In 2011, harm reduction activities were conducted mainly in Warsaw and Krakow. In Krakow there are two programmes run by Monar Society and Krakow Association of Drug-related Assistance. These centres provide street and residential exchange. A minibus was used in mobile exchange. A drop-in centre was open for active drug users in Krakow. Another active harm reduction centre is Warsaw, where syringes and needles are exchanged by Social Care Society, SPZOZ Drug Rehabilitation Centre ("Safe Grochow" programme), Monar Harm Reduction Centre. Similarly to Krakow, sterile injecting equipment can be found in a drop-in facility at Monar Harm Reduction Centre. In the "Safe Grochow" programme bicycle were used for street exchange. Unfortunately, 2011 was the final year of the five-year operation of this programme. Apart from syringes and needles Social Care Society also hands out Christmas food parcels. Syringes and needles are offered in several other Polish cities, mainly by Monar Society (Gdansk, Olsztyn, Czestochowa, Katowice, Pulawy). In Wroclaw, apart from syringe and needle exchange there is a drop-in centre, just as in Warsaw and Krakow. Drop-in centres and street exchange are have been provided in this city by Dolnoslaskie Return Psycho-prevention Society. To complement the picture of active

SNEPs there is a programme run in the city of Zgorzelec by Subsidiary Association. A new PTZN-run programme in Zielona Gora is also worth noting. One of the programmes offers harm reduction services in prison. At present, street exchange is not an easy task as the drug scene is dispersed and traditional meeting spots of drug users the so-called “bajzle” have disappeared. Drop-in centres in Krakow, Warsaw and Wroclaw represent a new service where drug users apart from syringes and needles can obtain assistance and support. The Krakow drop-in centre stopped operating for some time due to some opposition from the neighbours, which resulted in terminating the rent agreement. In Warsaw, the centre staff and its clients were even assaulted. The perpetrators were probably local residents who were not satisfied with the existence of such a facility in that area.

Reasons for change

The abovementioned data show that the number of SNEPs in Poland is decreasing. At the end of the 20th century programmes in Szczecin, Poznan, Chorzow or Jelenia Gora were still operational. The decrease has been affected by several factors. In 2000, the Act of 1997 on counteracting drug addiction was tightened and the possession of any amount of drugs (even for personal use) was subject to penalty (removal of Article 48.4). In consequence, open drug scenes in some cities such as Poznan disappeared. Traditionally, they were the operating grounds for outreach workers. However, it must be stressed that in 2001 in the course of another amendment of the Act harm reduction was incorporated as a component of state antidrug policy. Another reason for the decline is insufficient funds which would allow such programmes along with extending the available services to social care and client support. The National Health Fund does not finance harm reduction programmes other than substitution treatment. Harm reduction activities should be sponsored mainly by local governments. However, local authorities are interested mainly in supporting universal prevention and only in selected areas such as Warsaw such activities are given more attention. Moreover, the beginning of the 21st century marks the development of new harm reduction services addressed to dance club and concert goers, the so-called party working programmes. The beneficiaries include predominantly synthetic drug users such as ecstasy or amphetamines. Party working programmes are often conducted by the staff of street working programmes. Street work is usually performed in the community of problem users and it requires a great deal of involvement and commitment. Consequently, it is not easy to find permanent staff and charity workers for syringe and needle exchange programmes. Analyzing the situation it is worth noting that the lack of interest in establishing new SNEPs on the part of the programme providers. The last and probably the most influential reason for the decline in SNEPs is the fall in the number of injecting drug users. We do not have estimates of the population of IDUs in Poland, however, the reports sent by the programme

providers state that in the last ten years there has been a drop in injecting drug use. In 2008 and 2010 the Polish Focal Point conducted a survey of SNEPs. For two weeks all SNEPs held questionnaire interviews with their clients. Both surveys were conducted at the same time. In 2010, there were 30% less interviews compared to 2008. This is another signal that the population of IDUs is falling.

7.3. Prevention and treatment of drug-related infectious diseases

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

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

In 2011, the National Health Fund activities of improving the availability of drug-related infectious disease prevention programmes included financing HBV vaccinations and HCV and HIV tests. Moreover, in 2011 there were 30 testing sites (3 more compared to 2010) which provided anonymous and free HIV tests. 5 130 test takers were also drug users. They account for 20.2% of all test takers.

- **Infectious diseases treatment**

The National AIDS Centre reported that 14 health care units provided complex antiretroviral treatment in 2011. The ARV treatment was provided for all HIV/AIDS patients who met specific medical criteria and whose treatment did not contravene the existing regulations. The ARV programmes also covered HIV-positive pregnant women and newborn children, according to the existing standards.

The ARV treatment was performed in 20 hospitals which serve as reference treatment centres for HIV/AIDS patients in Poland.

As at 31 December 2011, the ARV treatment was provided for 5 606 patients, including 1 771 cases where the likely route of HIV transmission was injecting drug use or unprotected sex. In 2010, the number of patients stood at 1 928.

The ARV treatment was also provided at correctional facilities. Inmates continued the treatment they had started before they were sent to prison or they started the treatment while in prison.

7.4. Responses to other health correlates among drug users

- **Harm reduction programmes for drug users**

In 2011, the National Bureau for Drug Prevention co-financed 12 health and social harm reduction programmes for drug-dependent individuals unmotivated to enter treatment, including prisons and remand centres (without injecting equipment exchange as it is

prohibited) and at drug and HIV/AIDS ward of an infectious disease hospital. The programmes were conducted in major Polish cities such as Warsaw, Czestochowa, Gdansk, Jelenia Gora, Krakow, Olsztyn, Wroclaw, Zgorzelec, Zielona Gora. The National Bureau co-financed 6 outreach-based harm reduction programmes. Needles and syringes were also exchanged in all drop-in centres in Poland (6 operational in 2011) and 2 night shelters for drug users (National Bureau for Drug Prevention, 2012). The above programmes included the total of 5 463 clients. 193 955 needles and 139 508 syringes were distributed.

The tables below show the client profile of the Polish needle and syringe exchange programmes, the most prevalent psychoactive substances and figures of the equipment exchanged. The most prevalent drug used by the clients of such programmes is the Polish homemade heroin. On average every third client (32%) is dependent on more than one psychoactive substance.

Table 7.4.1. Client profile of KBPN-financed health and social harm reduction programmes for drug dependent users in 2011

CLIENT PROFILE – 2011 REPORT	
Action – Health and social harm reduction in drug-dependent population	
Types of clients	Total
Pupils	121
Students	55
Employed clients	111
Clients with social problems	1516
Clients with legal problems	1295
Clients with health problems	1559
Parents, families	19
Women only	208
Men only	710
Ethnic groups	3
Other	150

Source: National Bureau for Drug Prevention.

Table 7.4.2. Equipment distributed and collected under KBPN-financed health and social harm reduction programmes for drug-dependent individuals in 2011

EQUIPMENT DISTRIBUTED AND COLLECTED – 2011 REPORT	
Action – Health and social harm reduction in drug-dependent population	
Equipment	Total number
Needles distributed	193955
Syringes distributed	139508
Condoms distributed	30456
Water for injecting distributed	9905
Cotton pads distributed	27321
Antiseptic liquids distributed	3462
Other equipment distributed	485
Other distributed	8663
Needles collected	99131
Syringes collected	70837

Source: National Bureau for Drug Prevention.

Table 7.4.3. Substances used by clients of KBPN-financed health and social harm reduction programmes for drug-dependent individuals in 2011

LIST OF (PRIMARY) DRUGS USED BY CLIENTS OF HEALTH AND SOCIAL HARM REDUCTION PROGRAMMES IN DRUG-DEPENDENT POPULATION – 2011 REPORT	
Action – Health and social harm reduction in drug-dependent population	
Primary drug	Total number
Alcohol	406
Amphetamines	656
Crack	0
Ecstasy	0
Hallucinogenic mushrooms	1
White heroin	0
Brown heroin	890
Polish homemade heroin	482
Cocaine	7
Tranquilizers/sedatives	377

LSD	1
Mixed	1793
Cannabis	147
Inhalants	3
Other	341
Total number of clients	5104

Source: National Bureau for Drug Prevention.

In 2010, similarly to previous years, the National Bureau co-financed “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. However, in the reporting year out of 16 Marshal Offices, only 2 supported needle and syringe exchange programmes: street syringe and needle exchange in Pulawy and a residential exchange programme in Zielona Gora. In 2011, communal governments provided funding for 76 drug-related harm reduction programmes, including syringe and needle exchange programmes, outreach programmes dealing with HIV, HBV and HCV prevention, drop-in centres for active drug users, night shelters for addicts, discotheque-based programmes as well as rehabilitation camps (National Bureau for Drug Prevention, 2012).

Moreover, the National Bureau co-financed 3 programmes for female harmful drug users and 3 substitution treatment programmes.

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

In 2010 (latest data), similarly to 2009, there were 3 wards in psychiatric hospitals (58 beds) and 2 drug rehabilitation clinics (35 beds) which offered comprehensive psychiatric and substance treatment. In addition, there was 1 ward in general hospital (26 beds). 726 hospitalizations were performed therein. (Boguszezewska, Institute of Psychiatry and Neurology, personal communication).

In 2010 (latest data) outpatient clinics (excluding day care centres) admitted the total number of 1 794 patients with dual diagnosis (2 536 in previous year). 1 501 of these patients were treated in mental health counselling centres (including 4 patients in mental health counselling centres for children and adolescents). 215 found treatment in outpatient drug clinics and 78 in outpatient alcohol clinics. (Institute of Psychiatry and Neurology, 2012). Two things are of import here. Firstly, there has been a fall in the overall number of ambulatory patients with dual diagnosis. Secondly, there has been a rise in the number of such patients treated at mental health counselling centres. However, there was a sharp

decrease in the number of patients at outpatient alcohol clinics (from 1 054 to 78) while the number of patients at outpatient drug clinics dropped twofold.

Most drug treatment units are not ready to treat 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. The staff try to limit admissions of patients with dual diagnosis to a narrow minority. This is to prevent additional problems which could destabilize the functioning of a therapeutic community.

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

- **Reducing risk related to driving vehicles under the influence of psychoactive substances**

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

1. 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 injured for alcohol or another drug with effects similar to alcohol,
2. 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).
3. 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 2011, road traffic policemen performed 10 594 tests for the presence of substances with similar effects to alcohol. During 8 months of 2012, 3 915 such tests were performed. In 2012 policemen of all departments identified 918 drivers 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 2012 there were 470 such detections (Source: TEMIDA system).

In 2011, road traffic policemen conducted 6 one-day control and prevention operations coded “Alcohol and Drugs”. During these operations they performed 2 356 tests for drugs and alcohol and detected 50 drivers under the influence of narcotic drugs. In 2012, similar operations were conducted four times and they targeted 1 196 drivers. As a result of the 2012 operations, 45 drivers under the influence of substances with similar effects to alcohol were detected.

The above data were obtained from the Department of Prevention and Road Traffic of the Police Headquarters, 2012.

Prevention

In 2009 and 2010, the National Bureau for Drug Prevention launched a national awareness campaign addressed to drivers under the influence of substances 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/>.

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 4 328 drivers, out of whom 4 276 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 a 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.

8. Social correlates and social reintegration

Prepared by Dawid Chojecki

8.1. Introduction

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

It is confirmed by numerous statistics and studies. The results of the research project by the Institute of Psychiatry and Neurology entitled “Social costs incurred by drug users. Survey of six European cities” clearly shows that opioids are the most powerful in generating social exclusion. Insufficient knowledge of social welfare options, 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.

8.2. Social exclusion and drug use

- **Social exclusion among drug users**

In 2011, social welfare centres across Poland provided drug-related assistance for 3 309 families (2010: 3 497); including 397 in rural areas (462 in previous year). The assistance was provided for 5 286 clients, including co-dependent individuals (2010: 5 791). Similarly to previous years, the highest proportion of beneficiaries came from mazowieckie province – 976 individuals (602 families) and the lowest from swietokrzyskie province (135, 69 families), podkarpackie province (102, 61 families) and podlaskie province (107, 69 families) (Ministry of Labour – Department of Social Welfare and Integration, 2012).

- **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 2011, the National Bureau for Drug Prevention co-financed 4 harm/risk reduction programmes for prostitute drug users. One of the programmes was conducted by the Krakow-based Centre for Prevention and Social Education “Parasol”. A total of 157 sex workers (including 19 aged under 19) received assistance. The programme settings included: streets, night clubs and escort agencies, thanks to good cooperation between the programme provider and the owners of clubs and agencies. The programme featured

distribution of awareness materials on infectious diseases and safe sex. Condoms, lubricants and other personal hygiene products were handed out. The programme also included interventions and referrals to relevant facilities e.g. social welfare centres where material assistance was provided; employment agencies and drug treatment units (Centre for Prevention and Social Education “Parasol”, 2012). In Szczecin, a similar programme under the name “Harm reduction among female prostitutes-occasional drug users – Safer workplace” was conducted by the DA-DU Charity Workers Association. The programme included 103 women. The outreach was primarily provided in the work environment of the programme participants. 62 escort agencies were reached (DA-DU Charity Workers Association, 2012).

A typical programme targeting drug using sexual minorities commissioned by the National Bureau for Drug Prevention is the Lambda programme entitled “Don’t let yourself be sedated”. It was a Warsaw-based harm reduction programme for gay men. The programme settings included gay clubs and one sauna. GHB and ketamine tests, condoms and lubricants were distributed. The programme targeted 1 099 individuals (Lambda Society, 2012).

The programme of the Dolnoslaskie Psychoprevention Association “Return” entitled “Outreach in Wroclaw music clubs” featured actions targeting gay population (Dolnoslaskie Psychoprevention “Return” Association, 2012).

- **Homelessness**

The number of registered homeless individuals is closely linked to the number of residents in a given province. The higher the population of a province, the higher the homeless population. The most homeless people are located in the largest urban areas and “richest” provinces (e.g. mazowieckie, slaskie, wielkopolskie).

However, we do not have data on the number of homeless drug users. It is widely 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). Moreover, a lot of homeless drug users are dependent on at least 2 substances.

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 correlates and consequences. In 2011, the National Bureau sponsored 2 night shelter programmes implemented by the Krakow-based Society for Drug Related Help and the Monar Association. 164 clients benefited from the programmes. Most of the programme clients were polydrug users and many were dependent on the Polish homemade heroin. The programmes featured outreach activities, critical

interventions, education on safe drug injecting and exchange of injecting equipment. Thanks to motivational activities, the programme clients were referred to detoxification units and HIV/AIDS clinics.

In 2011, the National Bureau also co-financed reintegration programmes in hostels and re-entry flats. 20 hostels and 15 re-entry flats received funding. The programmes target drug rehab graduates, including children of addicted mothers, who can stay in a special hostel or re-entry flat upon completion of drug treatment.

Unfortunately, in the reporting year none of the provincial governments financed hostels. Communal authorities financed hostels (10) and re-entry flats (9) (National Bureau for Drug Prevention, 2012).

8.3. Social reintegration

Post-rehabilitation programmes for drug rehabilitation graduates and substitution treatment patients are conducted in hostels, re-entry flats, inpatient and outpatient clinics. They aim to reintegrate a drug user into society by providing education, employment as well as taking up social roles. Apart from therapeutic actions aimed at preventing a patient from relapse, the programmes feature vocational and skills trainings 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,
- awareness group sessions,
- 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-dependent individual.

These activities are vital for the success of drug treatment, help drug dependent individuals to maintain abstinence and fully re-enter society.

In 2011, the National Bureau for Drug Prevention co-financed relapse prevention programmes in inpatient and outpatient clinics. These programmes offered counselling to drug rehabilitation graduates who return home or try to become independent in another city as well as their families. The settings of the programmes included outpatient clinics, hostels and re-entry flats. In 2011, the National Bureau co-financed a total number of 34 pro-abstinence programmes conducted by 18 organizations. Post-rehabilitation programmes

targeted a total number of 1 838 clients, including 193 aged under 19. More than a half of the programme participants (54%) were employed. The table below shows the target groups of the National Bureau-financed social reintegration programmes.

Table 8.3.1. Client structure of KBPN-financed abstinence-based post-rehabilitation programmes in 2011

TARGET GROUPS – 2011 REPORT	
Action – Abstinence-based post-rehabilitation programmes	
Target groups	Total
Pupils	306
Students	115
Employed clients	986
Clients with social problems	651
Clients with legal problems	512
Clients with health problems	382
Parents, families	234
Women only	126
Men only	227
Other	5

Source: National Bureau for Drug Prevention, 2012

TARGET GROUPS BY AGE – 2011 REPORT	
Action – Abstinence-based post-rehabilitation programmes	
Age group	Total
Under 12	36
12–15	24
16–19	133
20–24	410
25–34	725
over 34	510
Total number of participants	1838
New participants	618

Source: National Bureau for Drug Prevention, 2012

The Act of 13 June 2003 on social employment (Journal of Laws 2003.122.1143) obliges local authorities and social welfare centres to conduct social reintegration programmes for drug users under social policy and integration strategies. Unfortunately,

post-rehabilitation services for graduates of full-time drug treatment programmes are insufficient. There are still too few re-entry flats and hostels.

In the reporting year, 6 provincial governments co-financed post-rehabilitation and social reintegration programmes including 1 hostel and 3 social inclusion centres. It is difficult to specify reasons for such insufficient hostel and re-entry flat funding by marshal offices. Representatives of marshal office of mazowieckie province suggest that NGOs were not interested in obtaining funding as they are financed from other sources. In another province, the hostel and re-entry flat funding applications failed to meet the minimum qualification criteria and consequently they were rejected.

In the reporting year none of the offices financed hostels while the number of sponsored re-entry flats rose from 2 to 3. 9 social reintegration programmes included a total number of 349 participants (67 more compared to 2009). 77 drug-dependent individuals received vocational training and 30 participants found alternative employment.

In 2011, 77 communes (3.3%), including 40 urban communes, 15 rural communes and 22 urban-rural communes, co-funded the implementation of social reintegration programmes for harmful users and drug-dependent individuals. 19 communes co-financed hostels and re-entry flats while 13 communes supported vocational training for harmful users and drug-dependent individuals. 60 communes co-financed social inclusion centres. A total of 338 social reintegration facilities and 130 training programmes received funding. Social reintegration programmes targeted 5 248 clients at the amount of PLN 11 033 621, which constitutes a considerable increase compared to 2010 when the funding allocated by 42 communal authorities to this end stood at PLN 1 419 751 (National Bureau for Drug Prevention, 2012).

- **Housing**

It is possible for a person struggling with difficult housing situation to apply for a social flat. Council 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.

For more information, see section 8.2. Social exclusion and drug use – Homelessness and 8.3. Social reintegration.

- **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.

For more information, see section 8.3. Social reintegration.

- **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 defined therein is “users dependent on drugs or other psychoactive substances who completed a drug treatment programme at a health care unit”. The Act lays down rules for establishing and operating Social Integration Centres. Upon request of the Centre head, social worker or the Centre’s client, a county employment office may provide a drug dependent user with a job or 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 pay to the employer.

Moreover, participants of the Social Integration Centre activities may start their own businesses and the costs of the related consultation, legal advice and counselling can be covered by 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 individuals 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 2007-2013: Promotion of Social Integration.

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

prepared by Artur Malczewski, Dawid Chojecki

9.1. Introduction

This chapter presents the latest data on drug-related crime in Poland provided by the Police and the Ministry of Justice. The second part of the chapter presents data on the illegal drug market: seizures, availability, prices and purity of psychoactive substances.

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

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

- Criminal Departments 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.

- Prevention Department 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.

- Road Police Departments are responsible for preventing drug addiction and drug-related crime among drivers.

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 actual 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:

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

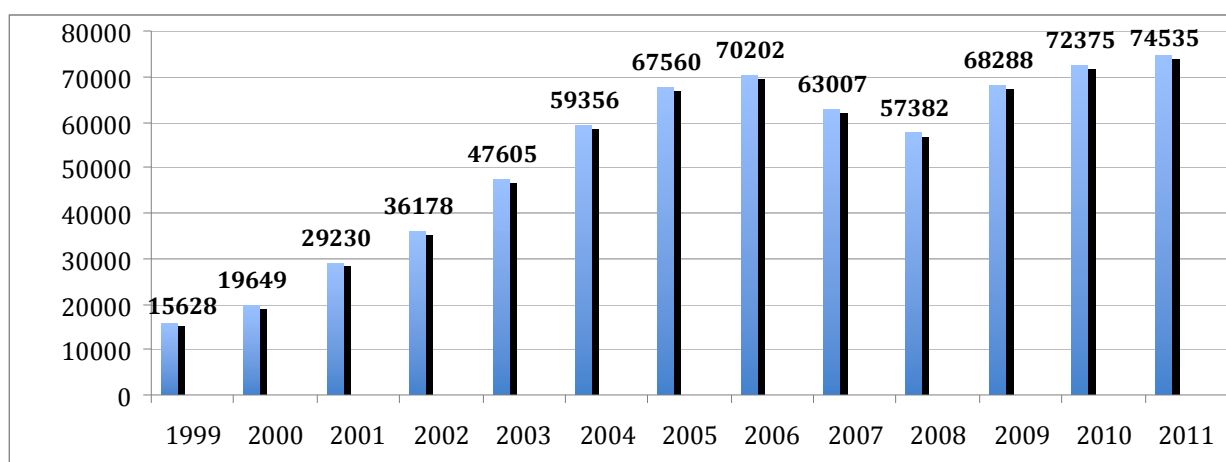
- offences defined in the Act of 2010 on counteracting drug addiction, e.g. illegal drug manufacture, trafficking, introducing to trade, possession as well as illicit cultivation of plants for the purposes of drug manufacture. This chapter contains the overview of the latter type. Police data on drug-related crime come predominantly from the police and prosecution TEMIDA database, which contains violations of the Act on counteracting drug addiction. Only in the case of recorded crimes are we able to specify the drug which was the object of the punishable act. A primary illegal substance is entered in the database. No such information is available as to the number of instigated proceedings or recorded crimes. A single individual commits an average of 2.5 recorded crimes. Antidrug law related data are reported to the Police database on special statistical forms. The data allow for analyses of trends and geographical variations.

9.2. Drug related crime

- **Recorded crimes**

In 2007, for the first time since 1999, we recorded a fall of 10% in the number of drug-related crimes. This trend continued in 2008 (further fall of 9%). In 2009, the number of recorded crimes rose nearly to the level of 2006 i.e. 68 288 and this number reached a record of 74 535. Figure 9.2.1 shows recorded crimes under the Acts of 1997 and 2010 on counteracting drug addiction.

Figure 9.2.1. Crimes against Acts of 1997 and 2005 on counteracting drug addiction in 1999 – 2011



Source: Police Headquarters

In 2010, the highest proportion of crimes was related to Article 62 (drug possession): 35 064 (48% of all crimes). In the structure of 2010 crimes there are offences under Articles 58 and 59 (supplying drugs). Altogether they account for 42% (30 803) of all the offences recorded. In general, only three Articles of the Act make up 90% of all recorded crimes. In 2011, there was a rise of 3% in the overall number of crimes, which is the continuation of the 2009 upward trend.

Let us take a look at what criminal acts increased the scale of drug-related crime. In 2011, compared to 2010, there were 2 629 more crimes under Articles 58, 59 and 62. There was also a rise in the number of crimes under Article 63 (illegal cultivation) and Article 61 (manufacture and trafficking in precursors). Similarly to 2010, crimes under Article 58 and 59 constituted 42% of crimes against the Act. 49% of the overall number of crimes were related to Article 62. Detailed data are listed in Table 9.2.1. Analyzing types of psychoactive substances in relation to which the highest number of crimes were committed, cannabis takes priority, especially marijuana but also hashish. Such crimes made up 70% of all crimes recorded in 2011. Every fifth crime was committed in relation amphetamines (19%). 2% of all crimes were connected with opioids (Malczewski 2012h, p.39).

Table 9.2.1. Recorded crimes against Acts of 1997 and 2005 on counteracting drug addiction in 1998-2011

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Illicit cultivation (Art. 26; Art. 49.1; Art. 63.1)	1195	615	814	663	653	687	886	875	726	562	625	688	1122	1145
Illicit manufacture (Art. 27; Art. 40. 1 & 2; Art.53)	574	361	400	408	319	297	350	456	270	198	183	174	202	181
Production, storage of instruments (Art. 28; Art. 41; Art.54)	190	143	152	292	230	230	220	144	127	137	118	192	422	254
Illicit import, export or transit (Art. 29; Art. 42; Art. 55)	252	406	383	295	336	354	795	643	486	537	697	880	803	752
Illicit introduction to trade (Art. 30; Art. 43; Art.56)	1957	1714	1417	1809	1931	2064	2323	2814	2627	3268	2431	2969	3797	3484
Illicit distribution and inducement to use (Art. 31; Art. 45 & Art. 46; Art. 58 & Art. 59)	10762	10305	13278	18873	20482	25036	28351	31332	30940	26845	22507	28981	30803	31650
Manufacture, trafficking and trade in precursors (Art. 47; Art. 61)	88	61	66	115	104	159	178	151	107	121	189	126	68	114
Possession of narcotic drugs (Art. 48; Art. 62)	1380	1896	2815	6651	11960	18681	26163	30899	34778	31260	30548	34122	35064	36846

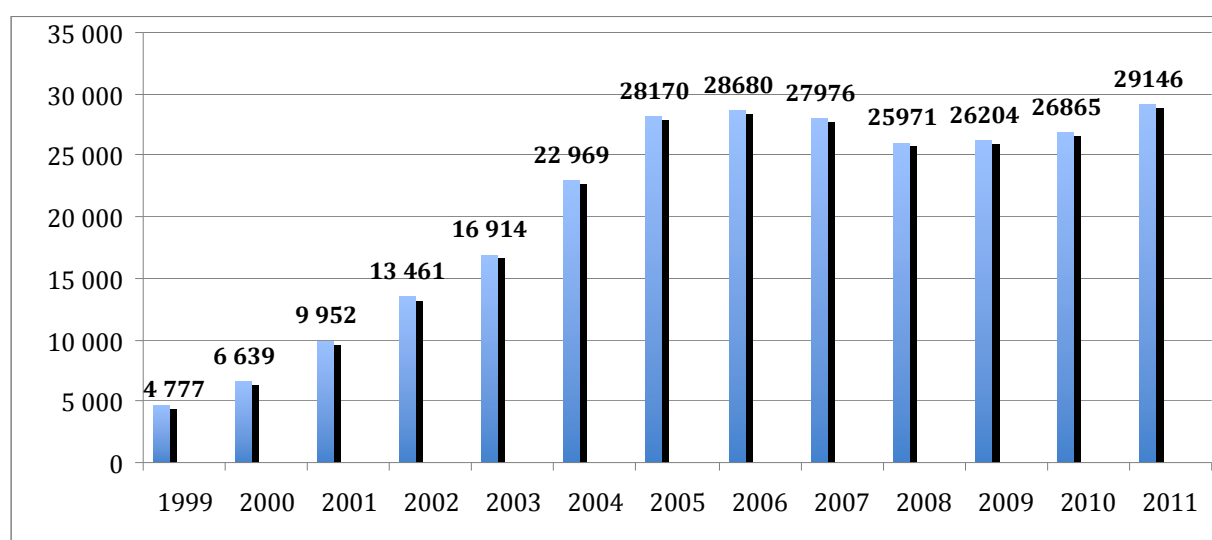
Illegal harvest of poppy milk, opium, poppy straw, cannabis resin or plant (Art. 49. 2; Art. 63. 2)	112	113	83	78	73	69	42	49	34	31	39	41	42	54
Unlawful capture of poppy milk, poppy straw, cannabis resin or plant (Art. 50; Art. 64)	22	14	241	24	14	17	15	31	41	17	25	42	16	18
Failure to report a crime (Art. 46.a; Art. 60)				22	76	11	33	163	55	19	11	40	20	20
Promotion and advertising (Art. 68)								3	11	12	9	33	16	17
Total	16532	15628	19649	29230	36178	47605	59356	67560	70202	63007	57382	68288	72375	74535

Source: Police Headquarters.

- **Suspects**

In 1999-2006 the number of suspects under the Acts of 1997 and 2005 on counteracting drug addiction increased every year. The analysis of changes in the number of drug possession suspects from 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 personal 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, which rose by another 2.5% in 2010. In 2011, the Police detained the highest number of suspects (29 146), which translates into an average of 2.5 per individual. The number of suspects rose by 8.5%. Let us take a look at which articles of the Act on counteracting drug addiction constituted grounds for Police arrests. The highest number of crimes was related to Article 62: 72% (72% in 2010), then came Article 58: 7% (8% in 2010) and Article 59: 11% (11% in 2010). In total, these three articles accounted for 90% of all suspects under the Act in 2011. 15% of the suspects were minors. The share of crimes under Article 62 in this age group was also the highest (68%) (Malczewski 2012h, p. 41).

Figure 9.2.2. Suspects under Acts of 1997 and 2005 on counteracting drug addiction in 1999 – 2011

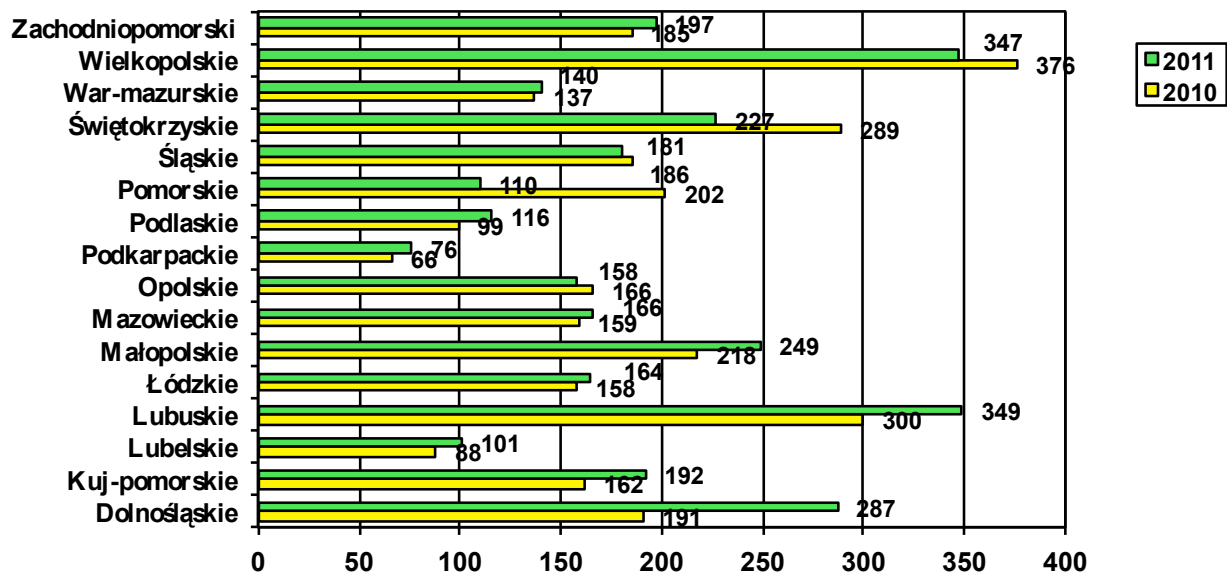


Source: Police Headquarters.

- **Drug-related crime at provincial level**

In 2011, the Police recorded 74 535 crimes across the country; however, there might be considerable regional discrepancies. The highest figure in 2011 (11 878, 16% of all crimes) was recorded in wielkopolskie province. A similar situation occurred in 2010 when 12 855 crimes were recorded (16%). Second came slaskie province (8 372, 11%; in 2010: 8 628, 12%) followed by mazowieckie province (8 348, 12%; in 2010: 8 348, 12%). Most crimes in mazowieckie province were detected by the Warsaw Police Department, which in 2011 recorded 5 322 crimes, which is more than a half of all crimes in the province. Provinces with the lowest crime record included podlaskie (1 379; in 2010: 1 179, less than 2% of all crimes), podkarpackie (1 599; in 2010: 1 392) and opolskie (1 624; in 2010: 1 711). In order to compare the situation among provinces the crime numbers have been converted into rates per 100 000 population. The highest rate was recorded in the provinces of lubuskie (349; in 2010: 300) followed by wielkopolskie (347; in 2010: 376) and dolnoslaskie (287; in 2010: 191). The lowest crime rate was recorded in podkarpackie province (76; in 2010: 66) followed by lubelskie province (101; in 2010: 88).

Figure 9.2.3. Drug-related crime rates in 2010 and 2011 under the Act of 2005 on counteracting drug addiction, by province (per 100 000 population).



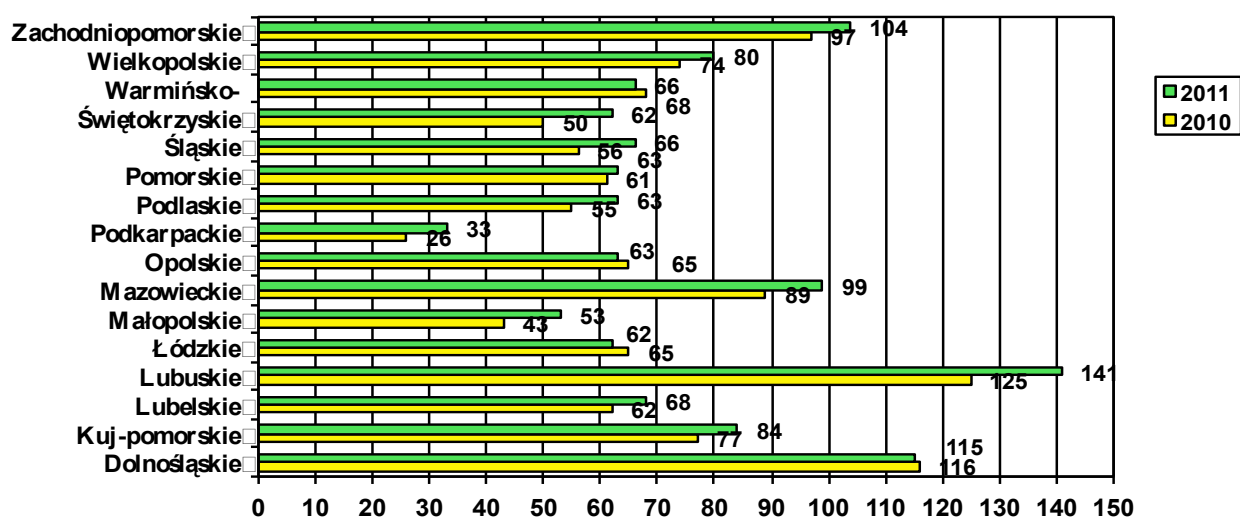
Source: Police Headquarters

Let us take a look at the suspect numbers in particular provinces. As it has been mentioned, the number of suspects is always lower than the number of offences. In 2011, the number of suspects under the Act on counteracting drug addiction stood at 29 146, which translated into 2.5 crimes per suspect. The highest number of drug-related suspects was

recorded in mazowieckie province (5 190; in 2010: 4 678), dolnoslaskie province (3 299; in 2010: 3 325) and slaskie province (3 050; in 2010: 2 610). The lowest number was recorded in podlaskie province (743; in 2010: 648), podkarpackie provinces (697; in 2010: 544) opolskie province (643; in 2010: 669).

Considering the rate per 100 000 population, the ranking was topped by lubuskie province (141; in 2010: 125), dolnoslaskie province (115; in 2010: 116) and zachodniopomorskie province (104; in 2010: 97), i.e. Poland's western provinces .

Figure 9.2.4. Drug-related crime suspects in 2010 and 2011 under the Act of 2005 on counteracting drug addiction, by province (per 100 000 population).



Source: Police Headquarters

Given the number of crimes and suspects, one must notice that a rise in the number of recorded crimes does not necessarily have to equal a rise in the number of suspects. For example, in dolnoslaskie province there was a considerable rise in the recorded crimes from 5 507 in 2010 to 8 258 in 2011 while the number of suspects fell slightly from 3 325 in 2010 to 3 299 in 2011. It means that the a rise in the number of drug-related crimes is caused by a rise in an average number of crimes per suspect, which in 2010 stood at 1.6 while in 2011 it reached the value of 2.5 in dolnoslaskie province.

- **Drug law offences - convictions**

Criminal cases for violating the Act are heard by district courts (sadly rejonowe) corresponding to the place of committing the crime. Data concerning final custodial sentences as well as convicts conditionally and unconditionally sentenced to deprivation of liberty between 1997 and 2010 are presented in Table 9.2.2. The data were collated by the Ministry of Justice. It is difficult to compare them to the Police statistics as the suspect against whom criminal proceedings had been brought might have been sentenced a few years later. Analyzing the latest data available it must be noted that in 2010 there was a slight rise to 20 601 in the number of convictions under the Act and a return to the value of 2008. The highest number of convicts since 1997 was recorded in 2007 (20 801). Out of all convicts sentenced to imprisonment, the percentage of those sentenced under the Act decreased in 2010 to 4.75%. It is predominantly the result of the sharper 2010 increase in the number of all convictions, which stood at 432 891 (415 272 in 2009). It must be stressed that the number of all convictions was the highest since 2005. Let us take a look at Table 9.2.2 data on convictions under the Act of 1997 on counteracting drug addiction and the Act of 1985 on drug prevention. The total number of convictions under the Act on counteracting drug addiction in 2010 stood at 20 601, out of whom 72% received prison sentences (14 837). These figures are not much lower than in 2009. That year, 74% of all drug-related convicts were sentenced to prison. However, not all were actually imprisoned. The imprisonment number stood at 2 278 in 2010, which constitutes an increase compared to 2009 (2 188). The share of conditional prison sentences in relation to all prison sentences increased slightly (18% in 2010) compared to 2009 (17%).

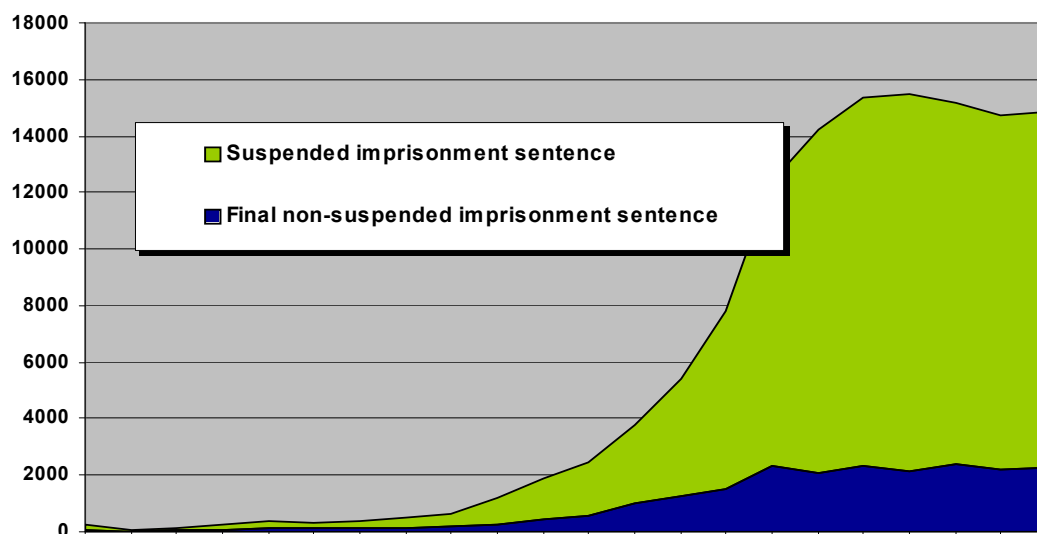
The highest share, almost twofold higher, was recorded in 2001. Out of 1 024 prison sentences, 2 778 were unconditional (37%). The breakdown of final prison sentences are shown in Figure 9.2.5. Let us take a look at the reasons for prison sentences in 2010 under the Act of 2005. The most sentences were passed under Article 62 (possession). In 2010, Article 62 provided grounds for the conviction of 7 963 individuals (54% of all convicts with final prison sentence), out of whom 7.6% were unconditionally sentenced to prison (659 individuals). Another article which provided grounds for prison sentences was Article 59 (distribution of drugs with intent to gain material benefit). In 2010, Article 59 provided grounds for the conviction of 2 924 individuals (20% of all convicts with final prison sentence), out of whom 20% were unconditionally sentenced to prison. To a lesser extent, there were also 1 446 prison sentences (including 76 unconditional ones, 5%) under Article 58 (distribution) as well as 1 265 prison sentences (53% unconditional) under Article 56.

Table 9.2.2. Convicts finally sentenced to prison in total and under Acts of 1997 and 2005 on counteracting drug addiction and Act of 1985 on drug prevention, between 1997 and 2010, by conditional and unconditional sentence.

Years	All convicts with final sentences, including convictions under the Act			Convicts sentenced to prison		
	Convicts in total	Convicts under the Act	Percentage of convicts under the Act	Convicts in total	Convicts with unconditional prison sentences	Convicts with conditional prison sentences
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	4.87	15475	2118	13357
2008	421051	20631	4.89	15165	2390	12775
2009	415272	20024	4.82	14739	2188	12551
2010	432891	20601	4.75	14837	2278	12559

Source: Ministry of Justice.

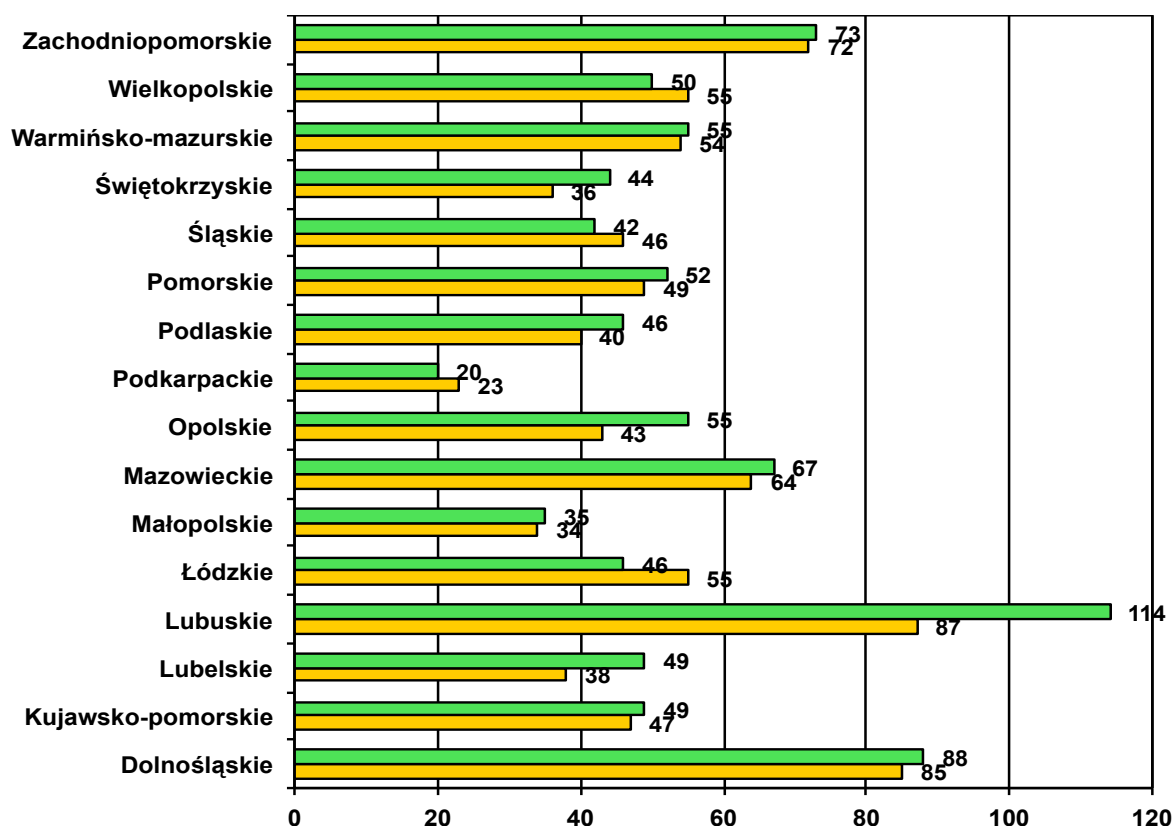
Figure 9.2.5. Final conditional and unconditional prison sentences under Acts of 1997 and 2005 on counteracting drug addiction in 1989-2010, by place of committing crime.



Source: Ministry of Justice

Analyzing the geographical variations one must note the highest numbers (over 2 000) of final sentences in the provinces of mazowieckie and dolnoslaskie. For comparison, the data have been converted to rates per 100 thousand population. The highest rates were recorded in the provinces of lubuskie (114), dolnoslaskie (88) and zachodniopomorskie (73). More than 70 residents per 100 000 population were sentenced in these provinces. The lowest rates were recorded in the provinces of podkarpackie (20) and malopolskie (35). Comparing the data of 2009 and 2010, one must notice a sharp increase from 87 to 11 in lubuskie province (Malczewski 2012h, p. 43).

Figure 9.2.6. Final prison sentences in 2009 and 2010 under the Act on counteracting drug, by province (Poland average of 53 in 2010).



Source: Ministry of Justice.

9.3. Interventions in the criminal justice system

Trainings

The Office of Prison Health Service in collaboration with the National Bureau for Drug Prevention conducted a certifying training for the staff of prison methadone programmes, including doctors, nurses and Prison Health Service counsellors:

1. aims of drug-related harm reduction,
2. discussion of substance use and related health consequences,
3. harm reduction and substitution treatment,
4. principles of substitution treatment, its effectiveness and cooperation of prison programmes with civil centres,
5. existing related legislation.

Moreover, the Penitentiary Bureau conducted 15 trainings for inmates and prison staff (94 participants in total).

The 2011 programme of drug demand reduction trainings in prisons covered the following issues:

1. existing legislation,
2. presentation of drug-related threats: health, family, existential and social issues, law-breaking,
3. presentation of the risk and problems related to HIV, HBV, HCV among injecting drug users,
4. crime and addictions,
5. psycho-educational classes for drug-related inmates: assistance in making constructive choices, mechanism of developing addiction, motivation to overcome addiction,
6. drug testing methods, defining groups of inmates vulnerable to drug use,
7. rudiments of abstinence and drug prevention,
8. substitution treatment programmes,
9. promoting healthy lifestyle – increasing responsibility for one's life,
10. rules of conduct in case of finding drugs in a remand centre or prison,
11. acquiring and improving skills among prison staff in recognizing drugs, drug smuggling methods and identifying behaviours under the influence of drugs.

Short-term interventions

Not all drug dependent inmates can be offered long-term rehabilitation due to short-term sentencing and limited capacity of therapeutic wards. Moreover, not all inmates who have used drugs are addicted and consequently they do not require long-term therapy although drinking alcohol or using other narcotic drugs has become a major risk factor for criminal behaviour. Consequently, correctional actions aim at diversifying drug services, including drug therapy for risky, harmful and dependent users. Considering considerable needs in terms of drug prevention and therapy in prison, the Penitentiary Bureau developed and implemented a short-term intervention programme for substance abusers in Polish prisons. Short-term interventions are intended to assessing a problem and motivate an inmate to change the existing destructive behavioural pattern related to substance abuse. The overall goal of such intervention is the reduction of likely harm which might result from substance abuse as well as generation of motivation for change. In correctional settings, a short-term intervention is recommended in the following categories of inmates:

- risky or harmful alcohol/substance users (as independent and sufficient from of intervention),

- dependent individuals qualified for therapy in relation to their dependence (as preliminary intervention which increases readiness to enter drug therapy in prison therapeutic ward),
- dependent individuals who have not qualified for therapy in prison therapeutic ward due to short sentencing (as alternative to such therapy or preparation for therapy upon discharge from a correctional facility or independent change).

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

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

In 2011, 3 714 inmates were provided with the programme of short-term interventions (including 358 problem drug users). It must be noted that this programme became widespread in no time. In 2011, short-term interventions were conducted in 128 out of 156 Polish correctional institutions.

In the pool of 3 714 inmates provided with short-term intervention there were 1 959 alcohol or drug dependent individuals. They received short sentences, which prevented them from entering prison therapeutic wards. Short-term intervention, which was developed for risky or harmful alcohol or drug users, was applied in such cases as alternative to long-term therapy.

This new approach has been implemented in correctional settings for merely 2 years. It complements long-term options in therapeutic wards. Thanks to short-term intervention, it is possible to initiate behavioural change process in response to substance abuse, also in the case of long-term prisoners. Further development of short-term intervention model should be a priority in the future.

Table 9.4.1. Profile of patients in prison drug-free therapeutic wards in 2011.

TOTALS OF PATIENTS IN PRISON DRUG-FREE THERAPEUTIC WARDS IN 2011	
Women in treatment	112
Men in treatment	1 499
Dual diagnosis patients	291
Lifetime injecting drug users	301 (20.9%)
HIV/AIDS patients	37 (2.3%);
First-time patients of prison therapeutic wards	699 (43.4%)

Source: Central Board of Prison Service.

Table 9.4.2. Profile of patients in prison drug-free therapeutic wards in 2011, according to ICD-10

TOTALS OF PATIENTS IN PRISON DRUG-FREE THERAPEUTIC WARDS IN 2011, ACCORDING TO TYPE OF ADDICTION (ICD-10)	
F-11 patients	178
F-12 patients	117
F-13 patients	11
F-14 patients	7
F-15 patients	291
F-16 patients	0
F-18 patients	7
F-19 patients	460

Source: Central Board of Prison Service.

Type of substance data are generally very similar to the previous year's data. It must be noted that there has been a clear fall in the number of opioid-dependent inmates, which accounted for 16.5% of all admissions to therapy in 2011 (20.2% in 2010).

6-month abstinence-based programmes for 1 611 inmates (1 658 in 2010) were conducted in 15 (16 in 2010) therapeutic wards (6-month programmes). The capacity of these wards fell by 57 places (521 in total) compared to the previous year. The fall in the number of places at drug therapeutic wards and the number of patients were caused by lower demand for therapy in first-time juvenile delinquents and adult inmates.

Moreover, in 2011 in 22 therapeutic wards for inmates with non-psychotic mental disorders or mentally disabled inmates there were 291 patients with dual diagnosis (mental disorders and addiction to psychoactive substances other than alcohol).

In 2011, 7 substitution treatment programmes were conducted in 23 correctional units of Prison Service (in 2011 substitution treatment programme in Warsaw Division was extended to Bialoleka Prison). 283 patients (237 in 2010) were treated in the 23 correctional facilities.

- **Prevention and reduction of drug-related harm**

In Polish correctional facilities there are no typical harm reduction programmes such as needle and syringe exchange. Officially, in Polish correctional facilities there is no access to drugs. Consequently, there is no access to the injecting equipment. However, there are non-governmental organizations which, upon approval of the management of correctional

institutions, may enter the premises and conduct educational harm reduction programmes for psychoactive substance users. In 2011, the National Bureau co-financed 2 such programmes: one conducted by the Monar Association at Czeszochowa 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 Krakow. The above programmes included 126 participants. The programmes featured individual consultations, motivating for behavioural change, information and education 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 correctional institutions (Centre for Prevention and Social Education "Parasol" & Mrugasiewicz, Monar Association – Czeszochowa branch, personal communication).

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

In Polish correctional institutions, all inmates in need of treatment for infectious diseases are provided with antiretroviral therapy, regardless whether they have used drugs or not. In 2011, antiretroviral treatment was provided for 200 inmates. However, the Health Office of the Central Management Board of Prison Service does not have data on the number of HIV, HCV, HBV and TB tests performed or the number of inmates diagnosed with drug-related infectious diseases. It is known that there were 4 468 HIV lab analyses or tests. Tests proved positive in 171 cases, including 48 new cases. Moreover, in the reporting year, laboratory tests were carried out to detect HBV (7 733) and HCV (8 208). TB was detected in 830 inmates.

- **Prevention of overdose-risk upon prison release**

In Polish correctional institutions no such activity is performed. See also "Drug prevention and harm reduction".

9.5. Reintegration of drug users after release from prison

In Polish correctional institutions psychoactive substance-dependent individuals along with other inmates participate in vocational training programmes. In the Polish prison 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.

Post-correctional assistance is of key importance in social reintegration of inmates. 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 and implemented programmes to raise the effectiveness of institutions dealing with the labour market, social policy and social security, improve vocational activity of disadvantaged or excluded groups on the job market, prevent further social disruption in inmates and teach them 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. In 2011, there were 9 prison centres of ongoing education and 9 prison school complexes. 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 the correctional facility. They are mainly service jobs popular on the job market such as short order cooks, painters, wallpaperers, wall tilers, floor tilers and many such like. Industrial jobs include mechanics, assemblers of machinery and devices, mechanical fitters, shoemakers and electromechanical technicians.

The educational offer for inmates is supplemented by 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. 1 104 training courses organized in 2011 included 12 547 inmates.

Each year prison authorities conduct a number of social rehabilitation programmes aimed at reducing recidivism rates. Similarly to previous years, in 2011, the following programmes were conducted:

- drug prevention programmes,
- programmes for inmates sentenced under Article 207 of the Penal Code,
- aggression management programmes,
- other aggression prevention programmes,
- vocational training programmes,
- Employment Clubs.

10. Drug Markets

prepared by Artur Malczewski

10.1. Introduction

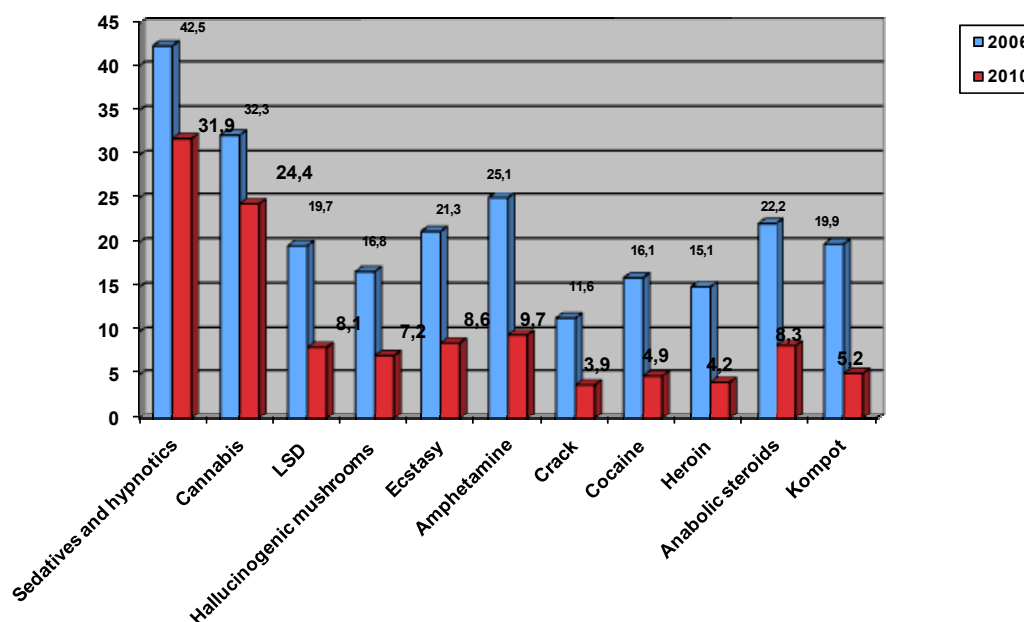
Drug seizures are reported by several services in Poland. Drug enforcement agencies have not worked out a single data collection system, which makes it difficult to conduct estimations of drugs seized in the whole country. However, in 2008 the Border Guard introduced a new system of collecting data which 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.

10.2. Availability and supply

- **Perceived availability of drugs according to population surveys**

One of the assessment indicators of illegal drug market is the results of population surveys on drug availability. The following analysis included the results of the general population surveys on the availability of psychoactive substances in 2006 and 2006 among adolescents and adults aged 15-64. This indicator provides information on the perceived availability of psychoactive substances and trends over time as both studies were based in the same methodology. Compared to 2006, the 2010 data show a fall in the perceived availability of all psychoactive substances. The deepest falls were observed in the responses connected with the 'easy' or 'very easy' access to amphetamine (fall of 15.4 percentage points), Polish homemade heroin 'kompot' (fall of 14.7 percentage points) and anabolic steroids (fall of 13.9 percentage points).

Figure 10.2.1. Perceived availability of psychoactive substances ('easy' or 'very easy' responses to question about access to listed substances) – proportions of respondents in 2006 and 2010, by age (15-64) (%).



Source: General Population Survey.

Analysing the availability of psychoactive substances it is worth to make a distinction between individuals who have used a substance in the last 12 months and those who have not done it. The opinion of the former group is likely to be more credible as this group of respondents will share their experiences. In both groups the proportions of respondents who considered access to psychoactive substances easy or very easy decreased. The deepest decrease was recorded in the group of respondents who have not used psychoactive substances in the last 12 months.

Table 10.2.1. Perceived availability of psychoactive substances ('easy' or 'very easy' responses to question about access to listed substances) – proportions of respondents in 2006 and 2010, by last 12 months prevalence of substance use (%).

	Positive last 12 months prevalence of substance use		Negative last 12 months prevalence of substance use	
	2006	2010	2006	2010
Sedatives and hypnotics	45.4	41.7	42.4	30.8
Cannabis	81.2	73.6	30.7	18.7
LSD	35.9	29.8	19.1	5.6
Hallucinogenic mushrooms	35.8	24.2	16.2	5.3
Ecstasy	52.3	30.6	20.2	6.0
Amphetamine	59.7	35.4	23.9	6.8
Crack	17.5	13.2	11.4	2.8
Cocaine	21.3	16.7	16.0	3.5
Heroin	14.1	13.3	15.2	3.1
Anabolic steroids	46.1	26.4	21.4	6.3
Polish homemade heroin "Kompot"	24.2	10.7	17.7	4.6

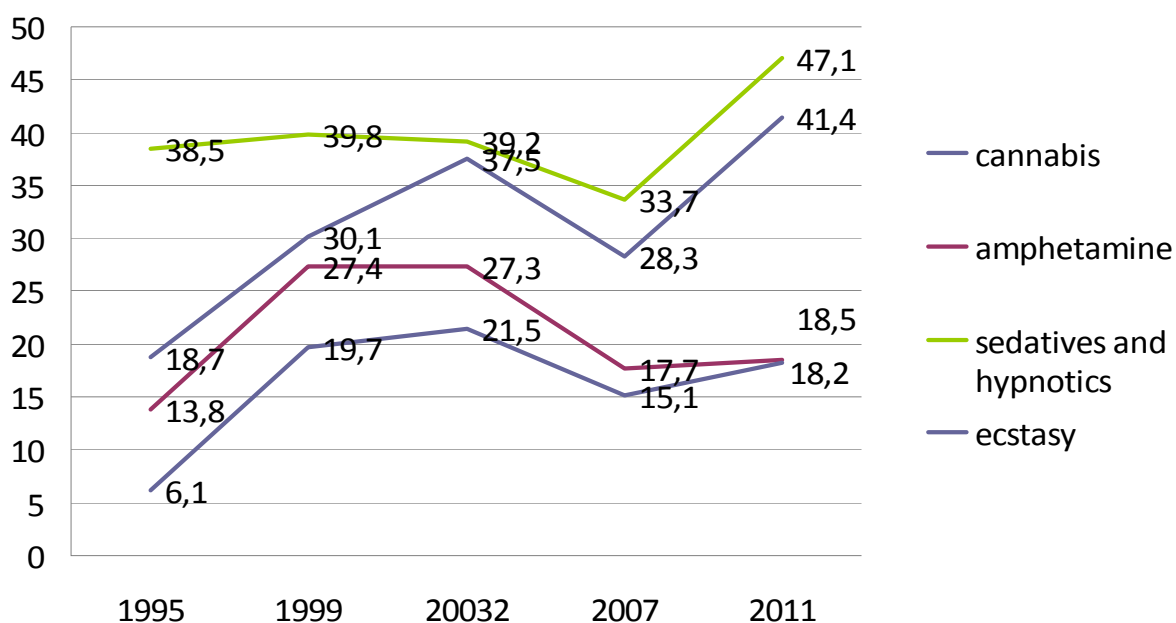
Source: Polish Focal Point.

Among non-users there were deeper falls in the rates for perceived availability of sedatives and hypnotics, cannabis, LSD, crack, cocaine and heroin while drug users more frequently reported difficulties in getting hold of ecstasy, amphetamine and anabolic steroids. The discrepancies in the responses in both measurements were similar for hallucinogenic mushrooms and 'kompot', i.e. the rates for both drug users and non-users fell in the case of hallucinogenic mushrooms by approx. 11 percentage points and 13 percentage points for 'kompot'.

Every four years under the ESPAD study, school students at two levels of education are asked about access to respective substances. Figures 10.2.2 and 10.2.3 show data concerning the students' 'easy' or 'very easy' responses to the questions about access to cannabis, amphetamine and ecstasy. The results concern two age groups: 3rd graders of middle schools and 2nd graders of secondary schools. According to the respondents, cannabis is the easiest to buy (41%) followed by amphetamine and ecstasy (18% each). In the case of sedatives and hypnotics, nearly half of the respondents considered it easy or

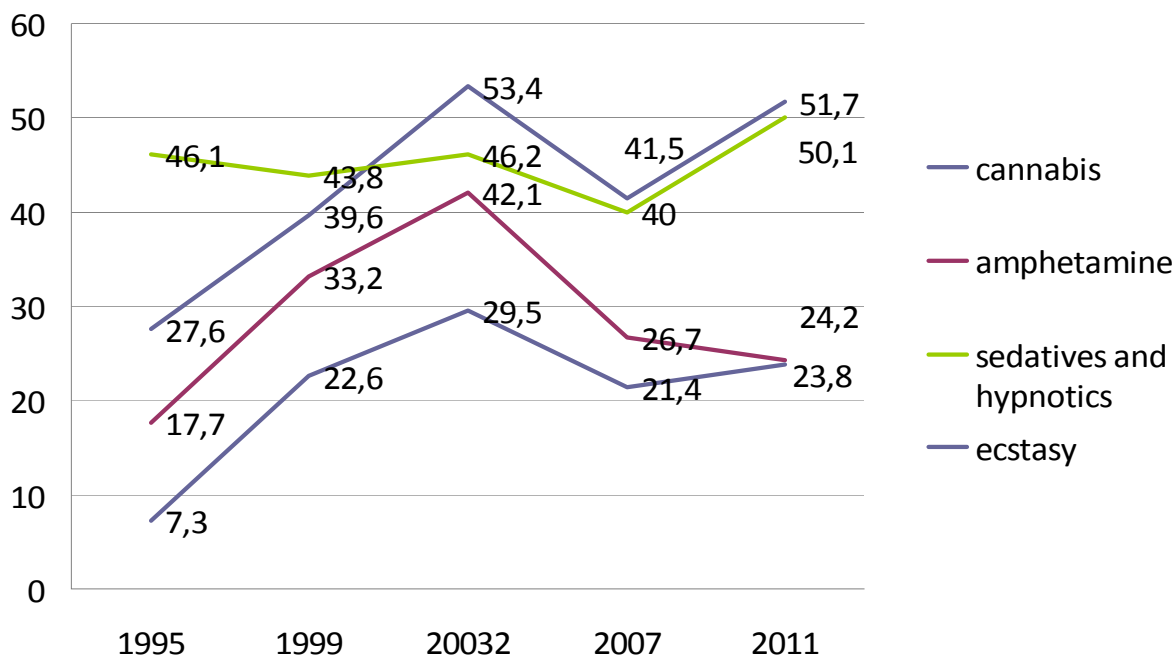
very easy to get them (47%). In 1995-2011, there was an increase in the perceived availability of the above substances in both age groups. However, the increase rates differed. Among 15-16-year-olds, the perceived availability rate for ecstasy was the highest i.e. it increased threefold. The rates for cannabis increased twofold while the rates for ecstasy and sedatives/hypnotics increased the least. Analyzing the data for the younger age group it is worth noting that except the 2007 fall the perceived availability rate for cannabis was constantly on the rise. In the case of amphetamine and ecstasy, the 2003 measurement revealed a halt in the upward trend and the 2007 survey showed a further decrease. The results of the latest measurement of 2011 indicate a slight increase in the perceived availability of ecstasy and stabilization of the amphetamine trend. Similar trends are observed in the older age group (Figure 10.2.3). There was almost a twofold increase in the perceived availability of cannabis between 2005 and 2011. In 2011, half of 17-18-year-olds found it easy or very easy to get hold of cannabis and every fourth shared this opinion with regard to ecstasy and amphetamine. The perceived availability trends in the older and younger age groups converged.

Figure 10.2.2. Perceived availability of respective psychoactive substances ('easy' or 'very easy' responses to question about access to listed substances) – proportions of respondents aged 15-16 (%).



Source: ESPAD 2011.

Figure 10.2.3. Perceived availability of respective psychoactive substances ('easy' or 'very easy' responses to question about access to listed substances) – proportions of respondents aged 17-18 (%).



Source: ESPAD 2011.

- **Drug 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 market. 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 compartments. To streamline 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. In 2010, the Police seized 1 679 ml of liquid amphetamine. Shipment and post agencies are used to smuggle amphetamine to the USA and Australia.

Cocaine is trafficked from South America to Poland 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 capsules they can smuggle even up to 1kg of the drug. Cocaine is also trafficked to Poland by air in luggage-based hidden compartments. Heroin, mainly from Afghanistan, is trafficked to Poland through the Balkan route (Turkey-Bulgaria-Romania-Hungary) or the silk route (former Soviet Union republics). From Poland heroin is trafficked to Germany and the United Kingdom. Ecstasy is smuggled from Poland to the Netherlands and Belgium. From the Netherlands cannabis is trafficked to Poland (Raczkowski 2009, pp. 116-118). In recent years a rise in domestic cannabis plantations grown by organized crime syndicates has been recorded. Moreover, cannabis is grown at home for personal use. It may be concluded that cannabis on the Polish market is increasingly originating from domestic production. Heroin available on the illegal Polish market comes from domestic manufacture which was substantially reduced by the introduction of low morphine poppy. However, to a large extent, heroin originates from trafficking. Domestic manufacture is evidenced by poppy straw and 'kompot' seizures. This Polish homemade type of heroin is manufactured exclusively in Poland by organized crime syndicates. Apart from Belgium and the Netherlands, Poland remains one of the leading amphetamine manufacturers in Europe. Amphetamine produced in Polish clan labs is a major stimulant on the Polish drug market. In recent years, methamphetamine has arrived in Poland. It is a leading stimulant in one European country i.e. the Czech Republic. Recently, it has also emerged in Scandinavian countries. It is still not certain if methamphetamine will become as prevalent in Poland as amphetamine. In Poland, there are no restrictions regarding medicines containing pseudoephedrine, which may be used to produce homemade methamphetamine. On the other hand, organized crime groups may see no interest in placing on the market on a wide scale a psychoactive substance which can be homemade i.e. without profits for organized crime syndicates. In 2011, two clandestine labs producing pseudoephedrine-based methamphetamine were detected. Therefore, there are signals of domestic methamphetamine production.

10.3. 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 across penal institutions. All the above institutions have not yet 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. The highest quantities of psychoactive substances are seized by the Police and Border Guard. All Police seizures (Central Bureau of Investigation and Criminal

Police) are presented as the overall quantity of drugs seized. Due to high discrepancies in drug seizure quantities and the considerable role of the random factor, the trend analysis is seriously hampered. A single substantial seizure might cause a considerable rise in illegal drug seizures in a given year. It must be remembered that certain quantities of drugs seized by Polish services were destined for foreign markets. Table 10.3.1 shows seizures revealed by the Police and Border Guard. Let us take a close look at the latest available data. In 2011, we record a fall in hashish seizures (59 kg) and marijuana (1 265 kg). However, it must be stressed that in 2010 drug enforcement services seized record quantities of cannabis. Despite the fall, the 2011 marijuana seizure remains one of the highest in the last decade. Compared to 2010, a fall was also recorded in the seizures of amphetamine (395 kg) and cocaine (78 kg). In contrast, there was a twofold rise in the seizures of heroin (51 kg) and a nearly threefold one in the seizures of ecstasy (75 thousand tablets) (Malczewski 2012g, p. 46).

Table 10.3.1. Drug seizures in Poland in 2002–2011.

Illegal drug	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Hashish (kg)	794.516	46.568	41.495	19.292	35.401	33.128	114.681	17.142	85.445	59.139
Marijuana (kg)		233.164	232.646	227.124	401.659	352.934	492.725	883.053	1501.801	1265.403
Heroin (kg)	585.705	6.913	255.214	41.151	155.401	123.623	78.915	85.873	24.871	51.359
Cocaine (kg)	423.48	800.558	28.029	16.871	21.932	160.981	28.710	117.491	111.084	78.121
Amphetamine (kg)	172.588	203.299	242.034	344.578	333.038	423.65	356.196	421.65	534.299	394.77
Methamphetamine (kg)					0.163	5.712	0.124	10.069	1.234	0.517
Ecstasy (tablets)	64452	102520	272198	492531	145344	610383	651 985	218616	26984	75082
LSD (blotters)	797	20602	34288	2226	1453	327	353	642	1353	0

Source: Polish Focal Point.

Apart from the Table 10.3.1. data, the Police and Border Guard revealed seizures of other illegal substances. In the category of opioids, 4 674 cm³ of Polish homemade heroin (“kompot”) as well as 12 241 cm³ of methadone was seized. 243 ml of GHB was also confiscated. In the category stimulants, the Police seized 53 kg of mephedrone, 325 g of methedrone, 40 kg of khat and 610 g of ephedrine. In 2009, the first synthetic cannabinoid called JWH-018 was delegalized under the Act on counteracting drug addiction. The following year other synthetic cannabinoids were delegalized. New psychoactive substances were entered in the list of seized psychoactive substances. In 2010, 1 596.6 g of synthetic THC and 11 621 packets containing synthetic cannabinoids were confiscated. In 2011, the Police detected 2 844 g of this substance. Moreover, drug enforcement services seized 423 g of hallucinogenic mushrooms. In 2011, 31 (53 in 2010) high morphine poppy plantations of the total area of 18 000 m² were dismantled.

- **Marijuana seizures**

Seizures of illegal marijuana plantations are recorded by services combating illegal drug markets. Most plantations are detected by the Police. Police data for 2006-2011 on illegal marijuana plantations seized in the course combating drug dealing presented in Table 10.3.2. are reported in the course of the implementation of the NPCDA. As a result of the 2010 Criminal Police actions, 505 of 583 plantations of marijuana were dismantled (183 outdoor plantations, 130 adapted indoor plantations and 192 flat based plantations). In Łódzkie province, the most marijuana plantations were dismantled i.e. 53 (15 outdoor, 15 adapted indoor (greenhouse, shack, cellars) and 23 in flats). 82 suspects were detained. Not fewer plantations were dismantled in malopolskie province (50) (15 outdoor, 10 adapted indoor, 25 in flats). 47 suspects were detained. The lowest number of dismantled plantations was recorded in kujawsko-pomorskie province (13) and pomorskie province (18). The highest number of suspects in 2010 (199) was recorded in the age group 23-30 (Sikora, Safjański, Gołębiewski 2011).

In 2011, the highest number of illegal plantations (609) was recorded (382 indoor and 227 outdoor) at the total area of 10 593 m². The 2011 data on the area of illegal plantations are provided by the Criminal Office of the Police Headquarters.

Table 10.3.2. Police seizures of illegal marijuana plantations in 2006-2010 as revealed by the Police Headquarters

	NUMBER OF DETECTED PLANTATIONS	AREA OF DETECTED PLANTATIONS (M ²)	NUMBER OF SEIZED MARIJUANA PLANTS
2006	10	n/a	5899
2007	128	7408	23900
2008	123	18435	16335
2009	422	31246	97928
2010	583	24 415	68584
2011	609	10 593	43232

Source: Information on NPCDA implementation – Police Headquarters.

- **Synthetic drugs**

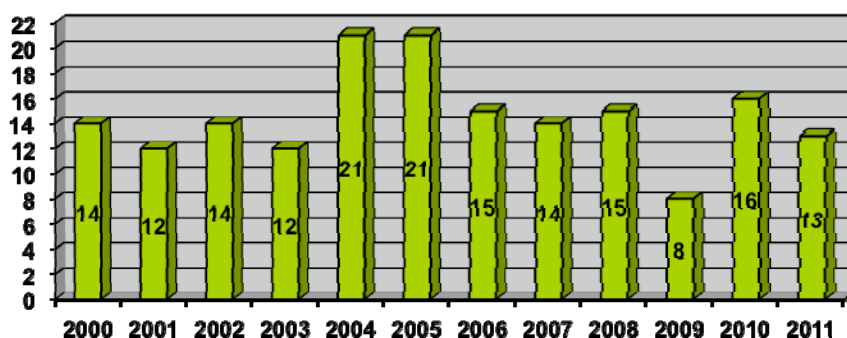
Amphetamine in Poland is most frequently manufactured through the Leuckart method. The manufacturing process and distribution of the drug is handled by organized crime syndicates, which establish, equip and supply clandestine laboratories. The Police record changes in modi operandi of criminal groups, which started to divide respective stages of amphetamine manufacture. 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 manufacture 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).

In 2011, in the course of reducing domestic production of amphetamine, Police officers, especially staff of the Central Bureau of Investigation, performed a number of operational activities aimed at combating organized crime groups producing amphetamine. 50 drug producing crime groups were dismantled, 13 clan labs (9 amphetamine, 2 mephedrone and 2 methamphetamine). In 2011, the Police profiled amphetamine and BMK. 1 081 amphetamine and 6 BMK samples were tested. 13 amphetamine profile cases were connected with 84 seizures in the overall number of 327 expert reports provided by the Central Forensic Laboratory. The Police participated in three international operations combating trafficking in precursors:

- collaboration with the Europol and the Dutch, German and Belgian Police in relation to trafficking in amphetamine and MDMA precursors to Poland from the Netherlands;
- collaboration with the German and Dutch Police in terms of controlled delivery of chemicals and precursors from China and India to Europe;
- collaboration with the Latvian, Lithuanian, Dutch and German Police in terms of controlled delivery of precursors from Latvia to the Netherlands.

Figure 10.3.1. Number of clandestine laboratories dismantled in 2000–2011 (Police Headquarters data).



Source: Information on NPCDA implementation – Police Headquarters.

10.4. Price/purity

- **Retail prices of drugs**

More information on the ways of getting drugs is provided by data on the prices of drugs on the illegal market. Retail prices make it possible to follow trends on the drug scene. A rise or fall in drug prices might signal a rise or fall in drug supply. It is worth noting that the price of drugs is affected by a number of factors such as geographical area, drug purity, intensity of police operations as well as international situation. Comparing the 2004 and 2010 data (latest data available for average prices) we notice a nearly twofold decrease in the average price of ecstasy from PLN 15 to PLN 8. However, there was a rise in the price of LSD from PLN 21 to PLN 28. Prices of amphetamine (PLN 39 per gram) and cannabis (PLN 27 per gram) did not change. Apart from an average price of drugs, in 2009 and 2011, the Police reported the modal price (most frequent) as well as maximum and minimum prices (see Table 10.4.1). Modal prices did not change much between 2009 and 2011. Slight falls in the prices of amphetamine and LSD were recorded. It is also worth noticing a nearly twofold rise in the minimum prices of heroin and a 40% rise in the price of cocaine.

Table 10.4.1. Minimum, maximum and modal prices of drugs in 2009 and 2011 (PLN).

	MARIJUANA (GRAM)		HEROIN (GRAM)		COCAINE (GRAM)		AMPHETA MINE (GRAM)		ECSTASY (TABLET)		LSD (BLOTTER)	
	2009	2011	2009	2011	2009	2011	2009	2011	2009	2011	2009	2011
minimum	16	20	100	190	128	180	20	25	8	8	12	15
maximum	52	30	360	300	260	250	100	35	28	15	44	30
modal (most frequent)	28	25	200	200	200	202	36	30	12	11	24	19

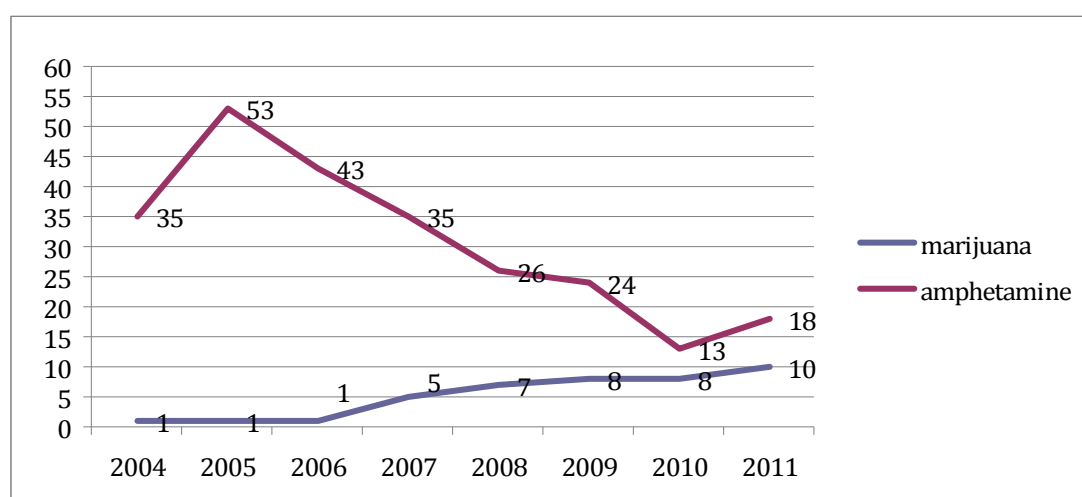
Source: Police Headquarters.

- **Purity of drugs**

Based on the Police data and surveys conducted among drug users, we know that the purity of drugs sold on the illegal market varies substantially. According to the 2012 EMCDDA Annual Report the concentration of THC in marijuana in 2010 ranged from 1% to 12%. In the case of the 'skunk' variety it ranged from 1% to 16%. Average THC concentration levels for 'skunk' were reported only by Sweden (8%), Germany (15%) and the Netherlands (16.5%) (EMCDDA 2012). In Poland, THC concentrations and purity of seized amphetamine are analysed by the Central Forensic Laboratory. THC levels have been rising for several years. It must be stressed that the low THC concentration levels of 1% in 2004-

2006 might have been the effect of including fibrous hemp, which contains only traces THC. According to Polish law, hemp which contains more than 0.2% of THC is considered a narcotic drug. As a result of including fibrous hemp in the calculations, the average level received a very low value. Following the period of fall in the purity of amphetamine (2005-2010), the latest data indicate a slight increase to 8% in 2011. In the case of marijuana, we have been recording a systematic rise in THC concentration to 10% in 2011. In 2011, the purity level of amphetamine ranged from 1% to 78% and the purity of half of the seizures under scrutiny stood at more than 13% (median). THC concentration in marijuana ranged from 2% to 37% (median 7%) (Malczewski 2012 h).

Figure 10.4.2. Purity of amphetamines and THC concentration in marijuana in 2004-2011 (%).



Source: Central forensic Laboratory.

Discussion

The last two years witnessed an intensification of Police activity. In 2011, the highest number of individuals suspected of drug-related crime was recorded (29 146). Most drug-related offences were committed in relation to cannabis. Moreover, the drug monitoring results reveal new alarming cannabis trends i.e. a rise in the prevalence of cannabis use. In 2011, 1 265 kg of marijuana and 59 kg of hashish was seized, which is less compared to 2010, when 1 502 kg of marijuana and 85 kg of hashish was confiscated. It must be stressed that the 2010 seizures were the largest in recent years. Police are detecting increasingly more cannabis plantations. In 2011, a record number of 609 plantations (10 593m²) were dismantled. It is worth noting that the marijuana sold on the Polish market is becoming more potent. An average THC concentration level is rising. In the case of synthetic drugs, the drug use prevalence trend levelled off. Every year Police dismantle 13-16

clandestine laboratories, which are becoming increasingly difficult to detect. Previous year, two small methamphetamine labs were dismantled and about 0.5 kg of the drug. The Polish drug scene is still dominated by amphetamine.

A new challenge for law enforcement services combating synthetic drugs is the arrival of a pre-precursor called APAAN 2-phenylacetoacetonitrile i.e. a substance used to produce BMK, which is later used to manufacture amphetamine. APAAN is a legal substance and it is used exclusively to produce BMK. According to general population surveys, the prevalence of cocaine use in Poland is small. In the case of this substance Poland is a transit country and Polish criminal groups are involved in cocaine trafficking through Poland. Analysing the drug market, heroin must also be taken into consideration. It reaches the European market primarily from Afghanistan. Heroin use in Poland is in decline. The number of problem heroin users is estimated at 10 400 – 19 800 in 2009. Opioids are most prevalent among problem drug users. In 2010, 70% of syringe and needle exchange programmes were opioid users. In 2010, in some European countries including Poland, there was a fall in the availability of heroin. In 2011, 51 kg of this drug were seized in Poland. Data from the Police TEMIDA system indicate a fall in the number of recorded heroin-related crimes from 2 416 in 2008 to 1 165 in 2011 and they accounted for approx. 1.5% of all drug-related crimes recorded in 2011.

Part B: Selected Issue

11. Residential treatment for drug users in Poland

11.1. History and policy frameworks

11.1.1. History of residential treatment (*Piotr Jablonski, Katarzyna Pulawska – Popielarz, Jolanta Koczurowska*)¹⁹

In the 1960s and 1970s drug-dependent individuals, if they found medical care, were treated under the existing health care system. Drug treatment offered only 90 beds across the country and it was provided almost exclusively by psychiatrists. One of the first and leading drug treatment centres was Polydrug Treatment Ward by Provincial Specialist Psychiatric Hospital in Lubiaz near Wroclaw (1971-1976). In the health care community, drug treatment was considered very difficult, and the outcome of treatment and post-rehabilitation in Poland and the world were not encouraging and optimistic enough (Andrzejewska, 1974). The success of drug therapy was aided by the experience of Garwolin Sanatorium for Children and Adolescents, which was promising for the drug-dependent population and innovative across the public health care. At that time the facility was headed by dr Ewa Andrzejewska. In 1972, the sanatorium started admitting adult patients dependent on drugs. Here, the professional career of many drug practitioners and researchers began with Marek Kotanski topping the list. Drug therapy models offered to drug-dependent patients at psychiatric care facilities failed to generate satisfactory outcome. Treating both alcohol and drug abusers in a single ward mostly was completely disruptive for the whole unit and discouraged both service providers and patients from further work (Swiatkiewicz, Moskalewicz & Sieroslowski, 1988). The awareness of the inadequacy of the proposed solutions was becoming universal and prevented drug therapy efforts. Consequently, for example, in Pruszkow Hospital drug treatment at alcohol abuse wards was found unnecessary and ineffective (Leczycka and Steffen-Kusz, 1986). A revolutionary change in drug treatment approach was initiated by Marek Kotanski in 1978. Behind the change was not only willingness to provide care for substance abusers but also disappointment with previous therapy models and their results: "We all deluded ourselves into thinking that they are recovering and we are helping them to do so" (Kotanski, 1984). Together with some patients and staff of Garwolin Sanatorium he established in Gloskow the first therapeutic community-based drug rehabilitation centre (for approx. 30 patients) called MONAR. Basis principles of this variety of therapeutic community combine the American and European

¹⁹ The history of treatment was published in: red. Jabłoński, P., Bukowska, B., Czabała, J. Cz. (2012) Uzależnienie od narkotyków. Podręcznik dla terapeutów. Krajowe Biuro ds. Przeciwdziałania Narkomanii.

experience and the Polish specificity. The rules included charismatic leadership, equality of community members, total abstinence, limited influence of outside role models, developing one's norms (Siczek, 1994).

In 1981, a Catholic therapeutic community 'Betania' was set up. For several years it operated without the awareness and consent of the authorities. In 1981, the first Polish after-war anti-drug non-governmental organization was registered – MONAR Youth Association. It was the aforementioned Gloskow centre that became a first step towards the establishment of the association with Marek Kotanski as its creator and a spiritual leader. The same year MONAR entered into a historic memorandum of agreement with the Ministry of Health regarding principles of conducting and financing drug prevention and treatment programmes. In 1981-1983 MONAR opened 11 therapeutic communities, including a pioneer Matarnia house for children and adolescents in Gdansk, upon initiative of Jolanta Koczurowska. Between 1982 and 1990, 20 MONAR centres were established across Poland. In 1987, the Catholic Anti-Drug Movement KARAN was founded. Soon a centre for youth at risk of drug addiction was opened. The Drug Prevention Society established a facility for children and adolescents under 18 in Wolka Przybojewska near Warsaw. In the south, upon initiative of father Czeslaw Cekiera, professor at Lublin Catholic University, the Catholic Youth Education and Post-Rehabilitation Centre was established while in Grzmiaca near Warsaw - a first public substance abuse treatment facility (Koczurowska, 2008).

Residential drug rehabilitation facilities were mainly established by NGOs, which like MONAR, started sprouting up across Poland. The drug-free therapeutic community model was followed with minimum or even none pharmaceutical support. Rapid spread of HIV among drug users dramatically changed the public perception of the phenomenon, affected health of Polish drugs users and 'forced' society to find new ways of addressing the problem. A first infection of HIV was identified in 1985 and a first AIDS case in 1986 (HIV i AIDS w Polsce, 2008). In April 1993, out of 2 548 registered HIV-positive people, over 70% were drug users. Facing substantial public anxiety and the lack of services for HIV-positive people, Marek Kotanski opened a MONAR community for HIV-positive drug addicts in Zbick near Opole in 1984. Soon it became clear that this HIV-determined community was too homogenous, which hampered therapy. As a result of this experience, in 1988, all MONAR centre and the majority of other centres started admitting any users regardless of their health status. It was a step that increased drug therapy success rates among HIV-positive users in communities of mixed member composition, which prevented them from being stigmatised. In the face of HIV epidemic among drug users, atmosphere of the related social intolerance and aggression, the Ministry of Health and Social Care made an important decision. Under the auspices of the Ministry, father Arkadiusz Nowak established first two centres in

Konstancin and Piastow (1991) and then another one in Anielin (1998) for individuals with HIV/AIDS.

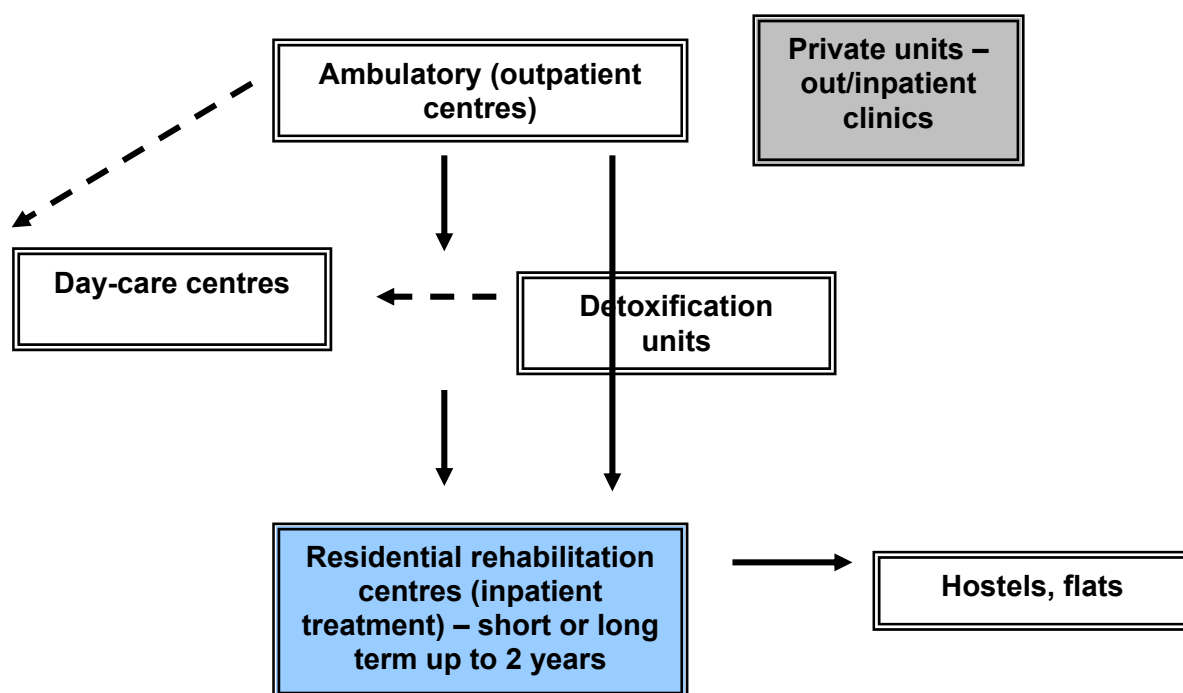
Growing mental disorders among drug addicts necessitated the development of a new adequate drug treatment model. The response was Faimilia centre in Gliwice for patients with dual diagnosis. The centre founder, dr Andrzej Maj-Majewski, and his team enriched the therapeutic model with their psychiatric treatment experience.

The contemporary Polish drug therapy model has been based on the dominating role of long-term secure residential treatment with therapeutic community as a primary type of intervention.

11.1.2. Strategy and policy frameworks for residential treatment

The system of specialised help for people addicted to psychoactive substances is part of a healthcare system aimed at people with mental disorders. In Polish drug treatment and rehabilitation system, apart from outpatient consultation centres, drug prevention and therapy ambulatory clinics, ambulatory substitution programmes, detoxification wards, day-care centres, hostels and flats there is a broad range of residential treatment services. This form is the oldest and most developed part of Polish drug treatment system.

Figure 11.1.2.1. Structure of treatment facilities for drug users



Source: Jablonski, P. National Bureau for Drug Prevention.

Pursuant to the Act on counteracting drug addiction residential treatment centres must be health care units which within the meaning of the Act provide rehabilitation and reintegration of drug dependent individuals free of charge, regardless of the patient's place of residence or therapy duration. A drug treatment unit (residential treatment clinic) is defined as a facility which admits problem drug users for voluntary treatment to live and fulfil all obligations such as school or court orders (if necessary). Drug rehabilitation is defined as a process in which a person with a drug-related mental disorder reaches an optimum health status, social and mental functioning. Treatment and rehabilitation or social reintegration by the drug dependent individual is voluntary excluding, inter alia, individuals younger than 18 years of age and incapacitated individuals. In those cases, the treatment may be enforced by means of a court order.

A broadly understood therapy and all accompanying services under confinement are financed from public sources (National Health Fund – NFZ). The NFZ also provides minimum service quotas guaranteed at these sites.

The drug treatment is available both for insured and uninsured patients. In case of uninsured patients the treatment is funded by the Ministry of Health.

The organization and range of services at residential drug treatment clinics are regulated by the Act on counteracting drug addiction, Act on patients' rights and patient ombudsman, Act on public benefit and charity work, Act on mental health protection, Regulation of Minister of Health on types and scope of medical documentation and manners of processing thereof, Regulation of Minister of Health on specific conduct in substitution treatment and specific conditions to be met by a health care unit providing substitution treatment, Regulation of Minister of Health in specific conditions and conduct in treatment or rehabilitation of drug-dependent individuals sentenced for committing crimes related to the use of narcotic drugs or psychotropic substances, Regulation of Minister of Health on professional and sanitary requirements for rooms and equipment at health care units, Regulation of Minister of Health on drug treatment training.

11.2. Availability and profile. Residential treatment availability assessment. Basic features of services provided. (Katarzyna Sollich)

11.2.1. National availability and accessibility

Residential treatment units are mostly located outside urban areas, which is intended to provide patients with 'natural' separation from active drug users and those who supply drugs. The latest information brochure (2011) published by the National Bureau for Drug Prevention shows that 79 clinics providing residential drug treatment (excluding alcohol) offer

programmes ranging from 6 weeks to 24 months, which are divided into three types of treatment varying in terms of duration: short-term (6-12 weeks), mid-term (3-12 months) and long-term (12 to 24 months). In 2 out of 79 clinics patients as young as 7 years old are admitted. The remaining clinics are divided into two types: those for patients 13 or 16 and older (they also offer programmes for adolescents) and those for patients 18 or 21 and older, the so-called clinics for adults.

The National Health Fund as the sponsor specifies the residential treatment admission criteria in contracting regulations. They provide that residential treatment fall within the hospital benefits pool and just as other hospital patients drug treatment patients must be referred by the health insurance physician, private doctor or court of law. For many years the most popular practice in Polish conditions has been the referral given by a psychiatrist or a counsellor in an ambulatory drug treatment unit.

In residential treatment the service provider is mandated to offer free and necessary diagnostic testing, medication and some medical products. A patient with mental disorders caused by psychoactive substance use is admitted upon his or her written consent while the admission of a minor or an incapacitated individual is done based on the legal guardian's consent. An important fact is that regarding residential treatment clinics as hospitalization, results in a situation that the funding procedure takes the form of the so-called 'persondays', whereupon the patients hospitalization is financed on a 24-hour basis regardless of the type of action taken. According to the information brochure on drug services, in 2011 in Poland, there were 79 residential drug treatment units and they offered around 2600 beds. The number of units per province ranged from 1 to 13. Under the framework of the National Mental Health Protection Strategy 2011-2015 (Regulation of Council of Ministers of 28 December 2010), a minimum residential substance abuse treatment availability rate should stand at 0.7 per 10 000 population. Based on the 2011 drug services brochure data, the substance abuse treatment in Poland complies with the Strategy requirements²⁰.

Residential drug treatment data, including data on residential treatment facilities, are systematically collected by the Institute of Psychiatry and Neurology. The latest available data go back to 2009. They show that in 2009, the clinics offered a total of 2 599 beds while the number of stays stood at 7 819 with a total of persondays of 786 054.

11.2.2. Types and characteristics of residential treatment units

Residential rehabilitation is performed by rehabilitation or rehabilitation and reintegration centres under public health care and NGOs. Despite structural and formal

²⁰ The National Mental Health Protection Strategy. Regulation of 28 December 2010 of Council of Ministers.

variations, virtually all clinics decided to adopt a therapeutic community model as the leading model of intervention. Out of 79 units (according to the national information brochure on drug services) this form of assistance was provided by 70 clinics, out of which 59 used it exclusively, 5 combined it with the Minnesota model, 8 combined it with other forms of intervention such as social therapy, motivational interviewing or problem-solving oriented therapy.

The foundation of the Polish variety of therapeutic community in terms of theoretical framework and training basically do not differ from the widely accepted international standards. It contrasts with traditional hospitalization where a patient most often felt isolated and deprived of the ability to actively participate in the recovery process (Koczurowska, 2001). Daily meetings of patients and staff are the source of feedback and are useful in decision-making at all levels, co-leading the meetings and social learning by social 'here and now' interaction. Moreover, in every correctly functioning therapeutic community democracy principles are imposed, which means that every member has equal rights and obligations in management and decision-making. The principles of consensus is also observed, which means that decisions are made based on joint and universal agreement regarding any action. The following principles are also present: the principle of permissiveness which promotes acceptance, understanding and tolerance, the principle of participation and community which means that all matters of members become shared matters in a community and the principle of realism which says that the community members must be exposed to direct experience of confronting the newly mastered skills with the reality (Koczurowska, 2012).

In 2011, the Minnesota model was reported as the core model in 7 residential drug treatment units in Poland (based on the information brochure on drug services). It is used as one of the models in alcohol and drug treatment facilities. Minnesota model facilities base their strategy on: task force groups which are intended to help patients solve personal problems and make decisions related to addiction; partner groups initiated by patients without therapist participation and educational lectures on symptoms of addiction, behaviour of the dependent individual, biological and social factors for addiction and assistance techniques to be used in behavioural change (Rachowska, 2012).

Internship centres which provide training for addiction therapy specialists and instructors also report combining the following intervention models:

- bio-psycho-social model explaining the etiology of addiction and other mental disorders, theory of psychosocial development according to E.H. Erikson, cognitive therapy according to A.T. Beck, systemic family therapy, psychopathology of children and adolescents,

- concept of therapeutic community, intensive addiction therapy, 12-Step Programme, coping skills training according to Peter Monti, cognitive and behavioural theory, motivational psychology,
- cognitive-behavioural model, Gestalt therapy, insight therapy, role playing, psychological mechanisms of addiction, therapeutic community model,
- addiction psychotherapy based on democratic treatment community and psychotherapy oriented on an individual, cognitive-behavioural therapy and elements of structural-strategic addiction therapy,
- integrated approach, cognitive-behavioural systems combining motivational interviewing,
- therapeutic and educational programmes within therapeutic community model in centres for children and adolescents,
- elements of cognitive-behavioural theories, humanistic-existential theories and systemic theories,
- cognitive-behavioural therapy, motivational psychology, critical intervention, therapeutic community, 12-step programme, Conti's social skill training, joint rehabilitation of individuals with and without mental disorders in a single group
- modified therapeutic community therapy integrating three treatment models: therapeutic community, 12-step programme and medical-psychiatric model.

This year a first therapeutic community-based rehabilitation centre in Poland combining methadone maintenance and total abstinence was opened. In all the remaining centres, despite frequent variations and changes in treatment approach total abstinence has been the basic residential treatment principle. Substance abstinence does not refer to cases when prescription drugs must be administered.

Life skill training, vocational improvement and school obligation are performed in most units according to financial and infrastructural capacity and needs of the target group. All residential centres for minors provide schooling on the premises or sign agreements with local schools. Most centres which in their philosophy are guided by the work ethic as a therapeutic factor provide their charges with vocational training opportunities. It often happens that in the residential centres which admit patients with co-occurring disorders there are training programmes for assertiveness, anger management and social skills. Patients at risk of HIV are sent from an ambulatory facility to independent consultation centres for testing and counselling in this matter. Providing drug treatment at one place and other services at HIV testing sites does not create formal problems as in such cases financing comes from separate sources.

Health care benefits provided in Polish therapeutic communities are divided into: preliminary benefits including treatment onset-related procedures (medical and psychological assessment, interviews, consultations, social interventions), daily benefits (individual and group therapy, critical interventions, nursing activities, other rehabilitation) and periodical benefits (medical and psychological tests, treatment progress evaluation, rehabilitation terms) (Moskalewicz, 2006). All benefits are regulated by the norms guaranteed in the contract between the unit and the NFZ.

In 2011 in Poland there were 212 ambulatory substance treatment centres (Information brochure 2011). They provide a wide range of post-rehabilitation services for patients who upon completing residential treatment need support while re-entering society. They offer individual and group therapy, social assistance or training to get adapted to new conditions.

11.3. Quality management (*Katarzyna Sollich*)

11.3.1. Availability of guidelines and service standards for residential treatment

In order to improve quality and effectiveness of therapeutic services in Poland, drug treatment and rehabilitation standards were developed in 2004-2009. A special expert team was appointed by the Minister of Health for developing standards of drug treatment, rehabilitation and harm reduction and accreditation of health care units providing drug treatment, rehabilitation and harm reduction (Bukowska, 2012). The works involved such institutions as the National Bureau for Drug Prevention, Institute of Psychiatry and Neurology, State Agency for Prevention of Alcohol-Related Problems, Centre for Monitoring Quality in Health Care as well as therapists from drug services. The standards have not been formally approved; however, they are presented at conferences, training seminars and widely available publications. They can be used in everyday practice and contribute to steady improvement of the quality of services provided. The guidelines based on American and British publications and the experience of the Centre for Monitoring Quality in Health Care that since 1997 has been implementing in Poland the system of accreditation of health care units. The guidelines were divided into sections including patient's rights, continuity of treatment, patient's care, general management, information management and infections control (Bukowska, 2012).

The residential drug treatment standards are divided into three sections: quality structure, quality of care process and quality of treatment outcome. It is assumed that in order to ensure solid quality of services there must be components such as number and education of staff, proper service infrastructure, procedures related to hygiene and broadly understood organizational structure.

Patient's rights section of the standards contains the following principles:

- granting written consent by patients to be admitted to treatment,
- evaluating patient status while respecting their privacy,
- informing all patients of their rights and obligations,
- respecting patients' rights by staff,
- patients' written approval of the rights limitation which in any case is preceded by previous discussion of relevance thereof,
- developing individual treatment plans which include patients' needs, objectives and are then accepted in writing,
- providing a patient with clear and easy to understand information on his or her health,
- holding a list of procedures requiring additional consent, e.g. participation in tests,
- holding a list of correctional interventions in line with patient's rights,
- holding a procedure for securing patient's property,
- in treatment units admitting minors, holding procedures in line with child protection regulations.

In order to receive accreditation regarding continuity of treatment, the standards must contain:

- procedures for admitting patients and referring them inside and outside,
- specific excluding criteria,
- procedures for handling a patient in special circumstances and planned discharge of a minor, an incapacitated patient or an individual obliged to complete treatment by court's order,
- procedures for unauthorised self-discharge from treatment,
- principles of providing patients with information on further conduct upon discharge from facility, deadline of receiving his or her medical history file and its content.

Patient's care section lists activities aimed at improving patient's mental and physical condition:

- determining drug treatment unit's target group,
- providing services for children and adolescents in place and time other than for adults,
- procedures for diagnostic and psychotherapeutic conduct,
- procedures for conduct with addicted individuals requiring special interventions,
- information which must be passed to a patient upon admission to treatment unit and time of physician consultation,
- developing a preliminary plan of care and a plan of individual therapy,

- collaboration with patients' families and relatives,
- education on harm reduction,
- access to programmes for vocational training and alternative leisure time activities,
- qualification of staff providing specific services and regularity of staff training at all levels.

The standards also to large extent refer to organizational issues:

- defining mission statement known to all staff,
- holding an updated organizational structure plan,
- defining qualifications for all positions,
- developing and implementing a staff training plan,
- staff's clinical supervision options,
- organization of clinical meetings,
- adaptation programmes for charity workers and interns,
- guidelines on content of medical records and procedures ensuring completeness thereof,
- hands hygiene, tidying rooms and conduct after professional exposure.

In June 2012, upon acceptance of the Accreditation Council, a revised package of standards in residential drug treatment was re-submitted to the Ministry of Health and is awaiting approval.

In 2007, Code of Practice for Addiction Therapists was adopted. It contains principles on therapist conduct. The code is supervised by the Ethics Commission by the National Bureau for Drug Prevention. The National Bureau publishes the list of therapists who accepted the code and a list of treatment units whose staff accepted the principles. The code was developed on the basis of the Code of Practice for Psychotherapist of the Polish Psychiatric Association and the Code of Practice for Psychologists. It is not a universally binding law. General principles include performing professional duties while respecting the patients' rights, providing services according to existing standards and professional competences, not using therapeutic relationship for personal and material gain as well as raising professional qualifications. Specific provisions include questions such as moral judgement of individuals in therapy, abiding by the Act on patient's rights and Ombudsman for patient's rights, Act on personal data, determining therapy methods, duration and setting, providing information on therapy objective and progress, ensuring adequate conditions for therapy, responsibility and principles in keeping professional secrecy, aspects concerning violence towards patients and forming private relationships, over-interference with patient's

private life, judging and commenting on other therapists' work and consultation with other specialists if needed.

Pursuant to the Act of 29 July 2005 on counteracting drug addiction, there is also a certification system for drug therapy instructors and specialists. The instructors and specialists are granted the right to provide services for harmful drug users, drug-dependent individuals and their families. Legal regulation of this issue makes it possible to introduce norms regarding the knowledge of drug treatment staff. The requirements which should be met by drug treatment training entities, framework of training programmes, mode and manner of holding final exams, composition of the examining panel and specimens of certificates for drug therapy instructors and specialists are appended to the Regulation of the Minister of Health on addiction treatment training.

In 2010, a report of the Helsinki Foundation for Human Rights was published on monitoring patient's rights in drug treatment centres. The foundation staff monitored residential centres and assessed their infrastructure, principles and methods of therapeutic work, use of coercive measures, therapy payment and duration, rules for rights and obligations of patients, consequences for failing to abide by the rules as well as legal framework for residential drug treatment. Out of 20 units visited by the foundation, 18 agreed to take part in the project, which accounts for almost 25% of all residential drug treatment facilities in Poland. The visitors studied internal rules and activity plans, held interviews with patients, staff and treatment graduates. The final report pointed out frequent discrepancies between the rules and procedures in respective centres, their vagueness and lack of clarity, no diversity concerning the range of therapeutic offer as well as unclear and inadequate application of penalties and enforcement of consequences for rules breaking. The Ministry of Health considered the report valuable contribution to the assessment of current state of patient's rights and found it in line with the National Programme for Counteracting Drug Addiction. The Ministry also argued that the formal introduction of the abovementioned standards would remove most of the irregularities.

12. Drug Policies of large European cities

prepared by Artur Malczewski, Anna Misiurek

12.1. Large cities

- **Functions and responsibilities of large cities in drug policy**

One of the four key reforms introduced in Poland in 1999 was the reform of local administration, which aimed at raising competencies of local governments. Moreover, the National Programme for Counteracting Drug Addiction 1999-2001 for the first time specified tasks for local governments. Another step in deeper involvement of local authorities, including large municipalities in Poland was the adoption of the Act of 2005 on counteracting drug addiction whereby communes started using alcohol licence resources for local drug prevention activities. Local governments were also obliged to develop and implement communal drugs strategies. Alcohol licence revenue, the so-called 'cork tax' could be used as of that year for the implementation of communal drugs strategies. Apart from the cork tax revenue, communes can utilise other resources for the purposes of drug prevention programmes. In Bialystok, the whole alcohol licence revenue is allocated to alcohol prevention and problem-solving programme. The anti-drug programme is financed from other sources. In Gdansk, the situation was similar till 2005. Since the introduction of the new law, the cork tax revenue has been allocated to alcohol and drug prevention programmes. In fact, it meant that addiction funds decreased. However, it must be stressed that Gdansk is an exception as in the large majority of Polish communes the new regulations allowed higher drug prevention funding. In 2011, Polish communes spent a total of PLN 80 million on drug prevention under local drugs strategies.

According to the Act of 2005, counteracting drug addiction is one of statutory tasks of communes and it covers:

- 1) increasing the availability of drug therapy and rehabilitation for drug-dependent and drug-endangered individuals;
- 2) providing drug-related families with psychosocial and legal assistance;
- 3) implementing drug prevention through informing, educating and training, especially children and youth, including sport and recreational classes for pupils and actions aimed at feeding children who participate in extracurricular custodial and upbringing as well as socio-therapeutic programmes;
- 4) supporting institutions, non-governmental organizations and natural persons in solving drug-related problems;

- 5) providing welfare services to drug addicts and drug-related poverty-stricken families stricken by poverty and social exclusion and integrating these persons with the local community through social work and social contracts.

The NPCDA provides a framework for a number of activities in drug prevention, treatment, harm reduction, post-rehabilitation as well as research and monitoring:

Pursuant to the Act and the NPCDA, the Commune Head (mayor, city president) drafts Communal Drugs Strategy in order to implement tasks listed in the Act and NPCDA. The communal strategy is approved by the council of the commune and then implemented by the unit stipulated therein. The communal strategy is part of the wider strategy of solving social problems. Additionally, the commune head (mayor, city president) may appoint an attorney to perform anti-drug tasks. The executive body of the communal or provincial government produces a report on the implementation and outcome of the Communal Drugs Strategy and submits it to the provincial parliament or the council of the commune by 31 March the year following the reporting year.

In order to perform Communal Drugs Strategy tasks, the municipal office announces competitions to support drug prevention activities. One of the key stakeholders involved in drug prevention in Poland are NGOs. They are chief applicants under the communal competitions.

In 2008, the communal drug monitoring network was created. Since 2008, the Polish Focal Point has been organizing annual conferences on drugs and drug addiction as well as training seminars for new participant communes. Large cities (over 500 thousand population) such as Wroclaw, Gdansk and Lodz are involved in the network.

Table 12.1.1. shows areas of the National Programme for Counteracting Drug Addiction 2011-2016 included in municipal drugs strategies. The NPCDA lists three areas for local governments: drug prevention; treatment, rehabilitation and harm reduction; and research and monitoring. Additionally, each area was provided with courses of action. Among cities under scrutiny, only Wroclaw implemented all three courses of action under the communal strategy.

All cities supported primary and secondary drug prevention programmes. Almost all cities raised public awareness of substance-related problems and the ways of preventing this phenomenon. More than half included in their strategies tasks of raising qualifications of drug prevention professionals. In the case of drug treatment and harm reduction all cities responded within the first area of widening the availability of drug therapy and rehabilitation for harmful users and drug-dependent individuals. However, the cities were less active in the remaining areas. Under research and monitoring, the cities were mainly concerned with the epidemiological studies of drugs and drug addiction.

Table 12.1.1. NPCDA areas included in municipal strategies .

Area and course of action	Cities									
	Wroclaw	Bydgoszcz	Lublin	Lodz	Krakow	Warszawa	Gdansk	Katowice	Poznan	Szczecin
PREVENTION										
Support for universal prevention programmes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Support for selective and indicated prevention programmes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Raising public awareness of substance-related problems and ways of preventing the phenomenon	yes	yes	yes	yes	yes	yes	yes	no	yes	yes
Raising qualifications of drug prevention professionals	yes	yes	no	yes	no	no	yes	no	yes	yes
TREATMENT, REHABILITATION, HARM REDUCTION AND SOCIAL REINTEGRATION										
Widening availability of drug therapy and rehabilitation for harmful users and drug-dependent individuals	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Widening availability of harm reduction programmes for harmful users and drug-dependent individuals	yes	no	yes	yes	yes	yes	yes	no	no	yes
Ensuring access to substitution treatment for at least 25% of opioid users	yes	no	no	no	no	yes	yes	no	no	yes
Reducing social exclusion of harmful drug users and drug-dependent individuals	yes	yes	yes	yes	no	no	no	no	yes	yes
Supporting professional development of drug treatment and rehabilitation staff and other professional groups working with drug-dependent individuals, e.g. police officers, social workers, probation officers, physicians, NGOs	yes	yes	no	yes	no	yes	yes	no	yes	yes
RESEARCH AND MONITORING										
Epidemiological monitoring of drugs and drug addiction at local level	yes	yes	no	yes	yes	yes	yes	no	yes	yes
Monitoring public attitudes to drugs and drug addiction	yes	yes	no	no	yes	no	no	no	no	yes
Development and consolidation of drug information system	yes	no	no	no	no	no	yes	no	no	no

Source: NPCDA implementation report 2011.

Most cities held municipal drugs strategies and in the case of Wrocław, Bydgoszcz and Kraków the strategy covered both alcohol and drugs. The highest annual spending in 2011 was recorded in the city of Kraków (PLN 7.9 million) and Warsaw (nearly PLN 5 million). The lowest expenditure was recorded in the cities of Szczecin and Bydgoszcz (approx. PLN 1.5 million) and Lublin (less than PLN 300 thousand). In the course of developing municipal drugs strategies and the assessment of drug situation, seven cities²¹ conducted an ESPAD survey or commissioned their own research. The cities which did not conduct such research included: Lublin, Łódź and Katowice.

Table 12.1.2. Municipal drugs strategies.

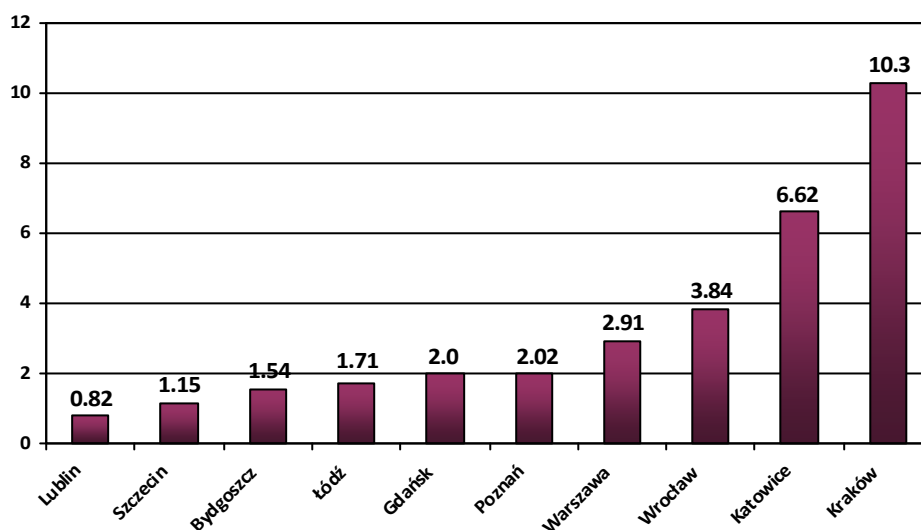
City	Province	Separate/joint programmes	Cost	Diagnosis on drug problem
Wrocław	dolnośląskie	joint, 2010-2011	2 417 553.80	yes
Bydgoszcz	kujawsko - pomorskie	joint, 2011	560 000.00	yes
Lublin	lubelskie	separate, since 2005	285 000.00	no
Łódź	łódzkie	separate, 2011	1 250 000.00	no
Kraków	małopolskie	joint, 2011	7 807 096.00	yes
Warszawa	mazowieckie	separate, 2012-2015	4 949 966.65	no
Gdańsk	pomorskie	separate 2008-2012	921 522.00	yes
Katowice	śląskie	separate, 2011	2 056 545.81	no
Poznań	wielkopolskie	separate, 2011	1 120 000.00	yes
Szczecin	zachodniopomorskie	separate, 2011	471 875.00	yes

Source: NPCDA implementation report 2011

The drug prevention expenditure in large cities was converted in rate per 100 000 population. The *per capita* spending stood at PLN 10 in Kraków, PLN 6.5 in Katowice and almost PLN 4 in Wrocław. The lowest spending was recorded in Lublin (less than PLN 1).

²¹ Wrocław, Bydgoszcz, Kraków, Gdańsk, Poznań, Szczecin

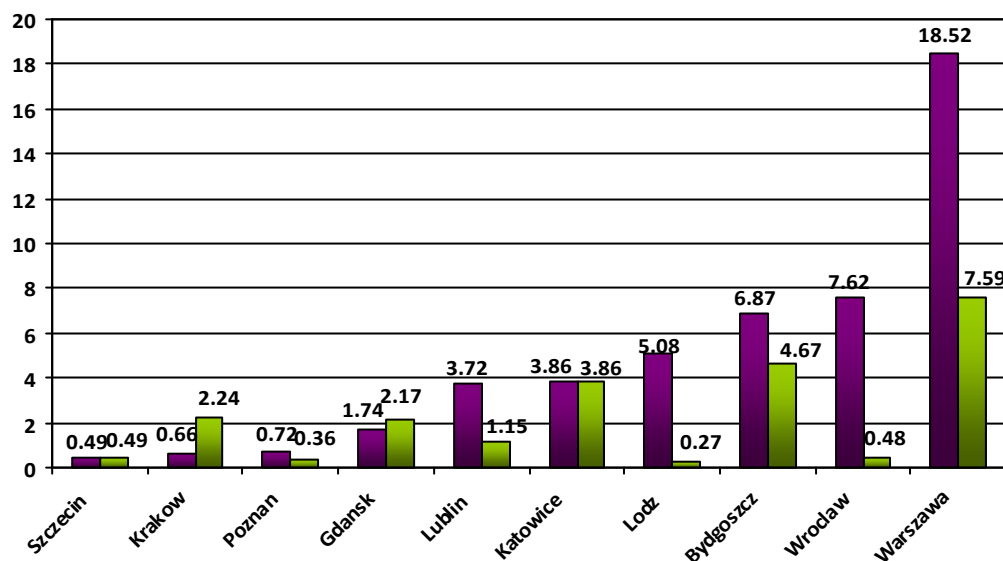
Figure 12.1.1. Cost of drugs strategy per capita (PLN).



Source: NPCDA implementation report 2011.

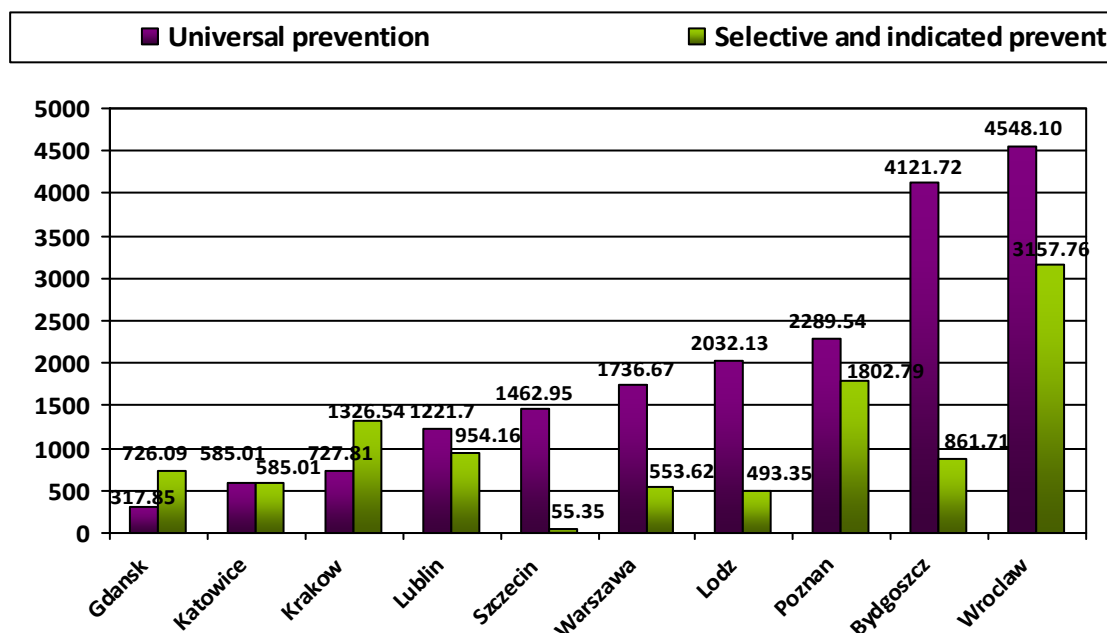
Under the municipal strategies, municipal offices co-finance universal, selective and indicated drug prevention programmes. Let us take a look at the situation in 2011 in 10 largest Polish cities. Data in Figures 12.1.1 and 12.1.2 and Table 12.1.1 were processed based on the NPCDA implementation report by the National Bureau for Drug Prevention. The highest number of universal prevention programmes were financed by the city of Warsaw (315) and the lowest by the city of Szczecin (2). Universal prevention targeted 300 thousand children and adolescents in Warsaw and not fewer in Wrocław. Both cities co-financed mainly universal prevention programmes. To compare the situations in respective cities, the numbers regarding programmes and recipients were converted into rates per 100 000 population. The highest programme rate was recorded in Warsaw (18.5) and Wrocław (7.6) and the lowest in Krakow (0.66) and Szczecin (0.49). The highest participant rates were recorded in Wrocław (4 548) and Bydgoszcz (4 127). Let us take a look at the coverage of indicated and selective prevention in the cities. The number of co-financed programmes varied a lot, similarly to universal prevention, and it ranged from 129 in Warsaw to two in Poznań, Łódź and Szczecin. The highest participant numbers were recorded in Wrocław (nearly 20 000) and half fewer in Krakow and Poznań (approx. 10 000). The highest participant rates were recorded in Wrocław (3 157) and Poznań (1 807) and the lowest in Szczecin (55).

Figure 12.1.2. Universal, selective and indicated prevention – co-financed programme rate



Source: NPCDA implementation data for 2011

Figure 12.1.3. Universal, selective and indicated prevention programme participant rate*



Source: NPCDA implementation data for 2011

* Universal prevention – figure shows rates for children and adolescents covered by prevention activities,
 Selective and indicated prevention – figure shows rates for numbers of individuals covered by prevention activities.

Table 12.1.3. Universal, selective and indicated prevention – numbers of programmes and participants.

No.	City	Universal prevention		Selective and indicated prevention	
		Total of supported programmes	Total of children and adolescents	Total of supported programmes	Total of children and adolescents
1	Wroclaw	48	28659	3	19898
2	Bydgoszcz	25	15000	17	3136
3	Lublin	13	4265	4	3331
4	Lodz	37	14812	2	3596
5	Krakow	5	5514	17	10050
6	Warszawa	315	29534	129	9415
7	Gdansk	8	1463	10	3342
8	Katowice	12	1818	12	1818
9	Poznan	4	12700	2	10000
10	Szczecin	2	6000	2	227

Source: NPCDA implementation data for 2011

Table 12.1.4. Drug Strategies of the big cities in Poland

No.	Title	Years	Province	joint/ separate	Strategic aim	Framework (only sections regarding drug addiction)
1	Communal strategy for preventing and solving alcohol-related problems and counteracting drug addiction in the city of Wroclaw	2012	dolnoslaskie	joint	<ul style="list-style-type: none"> • reducing health and social harm related to alcohol and other substance abuse through • raising public knowledge and awareness and • conducting coordinated activities in prevention, therapy and rehabilitation 	<ul style="list-style-type: none"> • strategy structure • legal grounds • substance abuse assessment in the city of Wroclaw • institutional capacity of the city of Wroclaw • aim and goals of the strategy • strategy financing • strategy implementation • monitoring substance abuse problems and strategy evaluation
2	Communal strategy for counteracting drug addiction in the city of Lublin	n/a	lubelskie	separate	<ul style="list-style-type: none"> • deepening public awareness of drug prevention and making prevention activities professional • improving health and quality of life of drug-dependent and co-dependent individuals • updating knowledge on drug addiction the related problems 	<ul style="list-style-type: none"> • main strategy goals • implementing entities in the field of drug addiction • strategy activities • final conclusions (strategy financing; principles of commissioning strategy activities to respective entities)
3	Municipal Drugs Strategy 2012 (Lodz)	2012	lodzkie	separate	<ul style="list-style-type: none"> • reducing scale of substance use-related harm • reducing disruptions in family and social life caused by substance use • preventing substance use, especially among children and adolescents • monitoring drug problems and drug addiction in the city of Lodz 	<ul style="list-style-type: none"> • introduction (including assessment of substance abuse in the city of Lodz) • major goals • ways of implementations and indicators of achievement thereof (including specifying coordinators responsible for implementing respective strategy activities) • appendices

4	Communal strategy for preventing and solving alcohol-related problems and counteracting drug addiction in the city of Krakow (2012)	2012	malopolskie	joint	objectives related to the Krakow strategy: <ul style="list-style-type: none"> • providing residents with proper health security • improving perception of public security • enabling individuals and groups at risk of social exclusion to participate in community development 	<ul style="list-style-type: none"> • substance abuse prevalence in the city of Krakow • goals and priorities • activities to be implemented • ways of implementing • work schedule and monitoring indicators
5	Municipal Drugs Strategy 2008-2012 (Gdansk)	2008-2012	pomorskie	separate	<ul style="list-style-type: none"> • reducing the number of substance users in the city of Gdansk and the related social problems 	<ul style="list-style-type: none"> • introduction (target groups; Acts and articles; partners; definitions); • assessment-based overview of the phenomenon; • defined problem areas; • definition of GPPN goals; • strategy activities; • anticipated major outcome; • monitoring and evaluation system; • appendices;
6	Municipal Drugs Strategy 2012 (Katowice)	2012	slaskie	separate	<ul style="list-style-type: none"> • preventing narcotic drug use; • reducing social and health harm caused by substance use 	<ul style="list-style-type: none"> • goals and activities of the strategy • principles of implementing and financing the strategy • financing framework
7	Municipal Drugs Strategy 2012-2014 (Poznan)	2012-2014	wielkopolskie	separate	<ul style="list-style-type: none"> • stemming growth of drug use prevalence in the city of Poznan and reducing the scale of the related health and social problems 	<ul style="list-style-type: none"> • assessment of substance abuse in the city of Poznan; • resources; • target group; • goals; • strategy activities; • expenditure schedule • final conclusions

Source: Data collected from cities by NFP

12.2. Case study: the capital city

Drugs Strategy 2012-2015 for the city of Warsaw was developed by the Social Policy Department²² of the Municipal Office of the capital city of Warsaw. The strategy, along with alcohol and HIV prevention documents, comprises the so-called *Warsaw Social Strategy. Strategy for Solving Social Problems 2009-2020*²³. The general aim is to increase social potential and conduct an integrated social policy which leads to social and professional integration of Warsaw residents. The document defines social policy areas, drug addiction-related issues.

The Social Welfare Assistance and Projects Department is a unit at the Municipal Office responsible for developing and implementing social policy activities at local level.

Drug prevention at Warsaw level remains in the domain of Substance Abuse Prevention Division. It is responsible for producing reports and analyses; developing municipal strategies for drug, alcohol and HIV prevention (including processing results and conducting evaluations); collaborating with governmental institutions; city administration units and research centres; commissioning projects to NGOs and health care units; and participating in the Social Dialogue Commission²⁴.

In the course of developing and implementing the municipal drugs strategy, the Substance Abuse Prevention Division collaborates with Warsaw drug services and organizations. This collaboration involves reviewing and consulting the strategy and receiving observations and concepts – the strategy stakeholders act as experts and assess the strategy in terms of technical content and practical solutions.

The strategy is divided into four sections. Section 1 contains data on occasional and problem drug users; numbers of HIV, HBV and HCV infections as well as methadone programmes financed by the city of Warsaw. Section 2 sets specific and operational goals of the strategy, Section 3 lists implementing bodies while Section 4 provides the strategy funding sources. The appendix contains specific tasks, implementers, indicators and strategy target populations (Drugs Strategy 2012-2015).

The general aim of the strategy is reduction of prevalence of drug use and other psychoactive substances and the related social and health problems. This aim is achieved in three areas: treatment, rehabilitation, harm reduction; post-rehabilitation; and social welfare. The strategy lists operational goals such as improving access to treatment for substance-dependent individuals and their families; improving public awareness of drug-related problems; reducing health harm related to drug use among school youth and adults of

²² currently: Social Welfare Assistance and Projects Department

²³ <http://politykaspoleczna.um.warszawa.pl/> (available at 16 December 2012)

²⁴ <http://politykaspoleczna.um.warszawa.pl/> (available at 16 December 2012)

Warsaw; improving effectiveness of drug prevention programmes; support for organizations and societies providing drug treatment, rehabilitation and counselling; improving knowledge of staff of education, social welfare, local administration, health care, police, municipal police, criminal justice system, NGOs and leaders of self-support groups and local communities on drug prevention, legislation, problem interventions and psychosocial skills (Drugs Strategy 2012-2015).

The cost of the strategy in 2011 stood at nearly PLN 5 million while PLN 3 million was incurred by respective administrative divisions of Warsaw. The amount solely comes from the cork tax i.e. alcohol licence revenue pursuant to the Act of 26 October 1982 on raising in sobriety and counteracting alcoholism. The cork tax revenue within communal budgets should be allocated exclusively to counteracting alcoholism and drug addiction.

Apart from the cork tax revenue, the Warsaw strategy can be financed from the provincial governor's subsidies, donations from legal or natural persons and EU structural funds (Drugs Strategy 2012-2015). The budget allocated to specific tasks under the municipal strategy is approved yearly and it comprises expenditure on multiyear NGO contracts as well as ad hoc resources, especially prevention, therapy and rehabilitation. However, the budget resources do not suffice to conduct research and analyses, which results in a situation that Warsaw does not run a local drug monitoring system.

- **Local drug coordination bodies / local drug coordinator in the capital city**

The Social Welfare Assistance and Projects Department is the main unit at the Municipal Office responsible for developing an anti-drug policy. It coordinates actions in respective districts, finances NGOs and addiction counselling centres and makes room for information exchange among the relevant stakeholders. The Department collaborates with central level institutions (State Agency for Prevention of Alcohol-Related Problems, National Bureau for Drug Prevention, National AIDS Centre), representatives of administration units, research centres, health care units and NGOs – based on the Act of 2003 on public benefit and charity work.

District heads collaborate with the Department in terms of planning and developing the drugs strategy as well as the ways of implementing it in respective districts.

In the field of collaboration with the NGOs the Department participates in the Social Dialogue Commission on Counteracting Drug Addiction and HIV/AIDS. The Commission operates pursuant to the City Council approved strategy of cooperation with NGOs. It provides initiatives and advice and comprises representatives of the city and non-profit organizations. The aim of the Commission is to develop new solutions, provide consultations and expert reports regarding projects, legal acts and competition topics, assess social needs and cooperate with the Warsaw Council of Public Benefit, district social dialogue

commissions and the Social Dialogue Forum. The commission sessions are held monthly and constitute an information exchange platform²⁵.

The collaboration between the Department and NGOs is connected with commissioning projects. The municipal drugs strategy defines activities which must be implemented in three areas (prevention, treatment/rehabilitation, post-rehabilitation), beneficiaries of respective programmes and implementers thereof. They can be commissioned in the form of competitions or the so-called small grants, i.e. subsidies awarded to non-profit organizations beside an open competition. Under the collaboration with the city, NGOs operate on two levels: firstly, it is an advisory and assessing body regarding projects and strategies, it has the potential to propose certain tasks or solutions. Secondly, NGOs implement specific tasks and at the same time provide information on the needs of drug-dependent individuals and their community.

12.2.1. Four areas of drug policy in capital cities

- **Local policing strategies against drug scenes/drug trafficking**

In the field of counteracting drug addiction, the Security and Critical Management Department of the Municipal Office collaborates with law enforcement agencies under Warsaw Crime Prevention Strategy. The Department is responsible for implementing tasks regarding security, public order, critical management and public protection.

The strategy 2011-2014 aims at reducing the number of committed crimes and petty offences, improving perception of security among Warsaw residents, developing a system for monitoring threats as well as managing municipal services effectively²⁶. The strategy defines major problems and provides solutions to reduce the number of crimes and eliminated their reasons and consequences. In the area of drug addiction, the strategy points out a high level of drug-related crime, especially among minors and driving under the influence of alcohol and other psychoactive substances. The strategy also defines bodies responsible for implementing tasks leading to the reduction of crimes committed under the influence of psychoactive substances. The bodies mainly include divisions of the Warsaw Police Department and other institutions specified as auxiliary units.

- **Interventions in recreational nightlife setting. Low threshold services for drug users**

The Warsaw Drugs Strategy features harm reduction activities. The National Drugs Strategy, described in the first part of this chapter, lists five types of drug-related harm reduction programmes:

²⁵ Ibidem

²⁶ <http://bezpieczna.um.warszawa.pl/> (available at 16 December 2012)

- Needle and syringe exchange;
- Streetworking programmes for HIV, HCV, HBV prevention (excluding needle and syringe exchange);
- Medical and social daycare programmes for active drug users;
- Partyworking programmes;
- Rehabilitation camps.

In 2011, the Social Welfare Assistance and Projects Department co-financed two needle and syringe exchange programmes as well as streetworking programmes for HIV, HCV, HBV prevention and 2 partyworking programmes (conducted by MONAR Association and Warsaw Lambda Society). It must be stressed that the strategy activities align with recommendations of the HIV Prevention and Action for HIV/AIDS Population Strategy 20012-2015. NGOs which receive funding in the course of contracts or competitions, apart from syringe and needle exchange, also provide counselling in the field of HIV/AIDS and other sexually transmitted diseases.

In the area of harm reduction, MONAR Association conducts low threshold programmes for active drug users and harm reduction programmes. MONAR streetworking functioning includes pro-health counselling, education and information provision and needle and syringe exchange²⁷.

A type of partyworking programme financed by the Municipal Office is *Alternative Dance* conducted by MONAR Association in Warsaw dance clubs and discotheques. The aim of the programmes is to reduce the number of individuals at risk of drug addiction and those already addicted, raise public awareness of drug-related harm, provide pro-health education and promote drug-free recreation. It must be stressed that *Alternative Dance* is an education intervention which must provide its participants with knowledge on substance use and the related threats and consequences. The project targets dance club community, especially synthetic drug users²⁸.

• Responses to head/smart shops

In 2010, upon initiative of the Social Policy Department²⁹, a designer drug awareness campaign ('Designer drugs kill your brain') was conducted. The campaign targeted 14-28-year-olds, mainly Internet users. It used instant messaging services and social networks. The Department also joined the national campaign "Designer drugs can burn you out – face the facts" held by the National Bureau for Drug Prevention (Drugs Strategy 2012-2015).

²⁷ <http://www.monar.pl> (available at 16 December 2012)

²⁸ <http://alternativedance.org/> (available at 16 December 2012)

²⁹ currently: Social Welfare Assistance and Projects Department

At present, the Department is not implementing any activities regarding designer drugs. It is mainly due to insufficient funding in the city budget for research into the prevalence of the problem and the development of strategic actions.

Part C:

13. Bibliography

Alphabetic list of all bibliographic references used

Ahlström, S., Hibell, B., Guttormorsson, U., Balakireva, O., Bjarnason, T., Kokkevi, A., Kraus, L. (2012), The 2011 ESPAD Report. The Swedish Council for Information on Alcohol and others Drugs; Stockholm.

Bukowska, B., (2012), Standardy akredytacyjne w opiece nad pacjentem uzależnionym od substancji psychoaktywnych. Serwis Informacyjny Narkomania nr 2 (58), str. 27-30

Bukowska, B., (2009), Integracja leczenia substytucyjnego i modelu społeczności terapeutycznych - nowe wyzwania i szanse. Serwis Informacyjny Narkomania nr 3 (47), str. 8-12

Czabała, Cz.,(2008), Typologia pacjentów korzystających z instytucjonalnej pomocy w związku z używaniem narkotyków. Serwis Informacyjny Narkomania nr 4 (43), str. 2-6

EMCDDA (2012), Annual report 2012: the state of the drugs problem in Europe, Publications Office of the European Union, Luxembourg.

Helsińska Fundacja Praw Człowieka, (2010), Monitoring przestrzegania praw pacjentów i dostępu do stacjonarnego leczenia uzależnień od narkotyków.

IBCGROUP Central Europe Holding S. A. (commissioned by Krajowe Centrum ds. AIDS). „Analiza danych uzyskanych z ankiet przeprowadzonych w punktach konsultacyjno – diagnostycznych w 2010 roku”

Instytut Psychiatrii i Neurologii (2012) Dane statystyczne dotyczące pacjentów z podwójną diagnozą wśród wszystkich przyjętych do stacjonarnego leczenia psychiatrycznego (informacje niepublikowane).

Instytut Psychiatrii i Neurologii, Zakład Organizacji Ochrony Zdrowia (2009), Rocznik Statystyczny 2009, Tabela 3.5

Jabłoński, P. Puławska – Popielarz, K. (2012), Zarys historii rozwoju terapii uzależnień od substancji psychoaktywnych innych niż alkohol. W: red. Jabłoński, P., Bukowska, B., Czabała, J. Cz. (2012) Uzależnienie od narkotyków. Podręcznik dla terapeutów. Krajowe Biuro ds. Przeciwdziałania Narkomanii.

Kidawa M., Strzelecka A., Malczewski A., Jędruszkowski Ł. (2011a), 1. Drug policy: legislation, strategies and economic analysis. In: Malczewski A. *2011 NATIONAL REPORT (2010 data) TO THE EMCDDA by the Polish Reitox Focal Point*. Warsaw: National Bureau for Drug Prevention. str. 13-17.

Kidawa M., Strzelecka A., Malczewski A., Jędruszkowski Ł. (2011b), 1. Drug policy: legislation, strategies and economic analysis. In: Malczewski A. *2011 NATIONAL REPORT (2010 data) TO THE EMCDDA by the Polish Reitox Focal Point*. Warsaw: National Bureau for Drug Prevention. str. 25.

Koczurowska, J. (2012), Społeczność terapeutyczna w rehabilitacji uzależnień. W: red. Jabłoński, P., Bukowska, B., Czabała, J. Cz. (2012) Uzależnienie od narkotyków. Podręcznik dla terapeutów. Krajowe Biuro ds. Przeciwdziałania Narkomanii.

Koczurowska, J. (2001), Model stacjonarnej pomocy psychologicznej osobom uzależnionym., *Problemy Narkomanii, Biuletyn* 3/2001, str. 50 - 58

Kodeks Etyki Terapeuty, (2007),

Kowalewicz T. (2008), 30 lat z Monarem. *Serwis Informacyjny Narkomania* nr 3 (42), str. 2-6

Krajowe Biuro ds. Przeciwdziałania Narkomanii (2011), *Narkomania, Informator* na temat placówek udzielających pomocy osobom z problemem narkotykowym. (Informator 2011)

Kruk, M. (2008), Struktura osobowości i kompetencje społeczne osób korzystających z pomocy w ośrodkach Monar. *Serwis Informacyjny Narkomania* nr 1 (40), str. 19-24

Malczewski A, (2012 a), Programy wymiany igieł i strzykawek w Polsce, *Kontra* 2 (52) , str. 6-7

Malczewski, A. (2012 b), Substancje psychoaktywne – używanie oraz ich dostępność, *Remedium* nr 6 (231), str. 28-29.

Malczewski, A. (2012 c), Monitorowanie problemu narkotyków i narkomanii na poziomie lokalnym. Świat Problemów nr 6 (233), str. 19 -22.

Malczewski, A. (2012 d), Postawy i opinie dotyczące substancji psychoaktywnych, Remedium nr 7/8 (232-233), str. 50-51.

Malczewski, A. Struzik, M (2012), Używanie substancji psychoaktywnych w Polsce, Serwis Informacyjny NARKOMANIA nr 2 (58), str. 29-31.

Malczewski, A. (2012 e), Problem narkotyków i narkomanii oraz jego zróżnicowanie terytorialne cz. II Serwis Informacyjny NARKOMANIA nr 3 (59), str. 23-28.

Malczewski, A. (2012 f), Przestępczość narkotykowa oraz nielegalny rynek narkotyków – trendy oraz rozmiary zjawiska cz. I Serwis Informacyjny NARKOMANIA nr 3 (59), str. 38-47.

Malczewski, A. (2012 g), Przestępczość narkotykowa oraz nielegalny rynek narkotyków – trendy oraz rozmiary zjawiska cz. II Serwis Informacyjny NARKOMANIA nr 4 (60), str. 23-28

Malczewski, A (2012 h), Zgony i zatrucia z powodu narkotyków, Remedium nr 11 (236). str. 28-29.

Malczewski, A (2012 i), Problem narkotyków i narkomanii w Europie i w Polsce nr 12 (237) str. 28-29.

Mazur, J., Wojnarowska, B., Małkowska-Szkućnik, A., Kołło, H., Tabak, I., Kowalewska, A., Dzielska, A. (2011), Wyniki badań HBSC 2010. Raport techniczny.

Moskalewicz, J., Sierosławski, J., Dąbrowska, K. (2006), Ocena systemu leczenia i rehabilitacji osób uzależnionych od substancji psychoaktywnych w Polsce. Alkoholizm i Narkomania, tom 19, nr 4, str. 327 – 355.

Nawara, F., (2011), Przestrzeganie praw pacjentów w ośrodkach stacjonarnych. Serwis Informacyjny Narkomania nr 3 (55), str. 43-44.

Rachowska, E. (2012), Model Minnesota. Podręcznik dla terapeutów, Krajowe Biuro ds. Przeciwdziałania Narkomanii, str. 199 – 206.

Raczkowski, K. editor (2009), *Narkotyki organizacja przestępczości i system przeciwdziałania*. Wydawnictwa Akademickie i Profesjonalne. Warszawa 2009.

Sierosławski J. (2011a). 4. Problem Drug Use. In: Malczewski A. *2011 NATIONAL REPORT (2010 data) TO THE EMCDDA by the Polish Reitox Focal Point*. Warsaw: National Bureau for Drug Prevention. 70-71.

Sierosławski, J. (2011b) *Używanie alkoholu i narkotyków przez młodzież szkolną.* Raport z ogólnopolskich badań ankietowych zrealizowanych w 2011 r. Europejski program badań ankietowych w szkołach ESPAD, Instytut Psychiatrii i Neurologii.

Sikora, A., Safjański, M., Gołębiewski, J. (2011) *Produkcja narkotyków z surowców naturalnych*. Kwartalnik Policyjny nr 2 (2011)

Standardy dobrej praktyki w opiece i leczeniu pacjentów uzależnionych od narkotyków w placówkach stacjonarnych - modyfikacja standardów opracowanych przez zespół ekspertów powołanych przez Ministra Zdrowia w 2004 r., w skład którego wchodził przedstawiciel środowiska specjalistów psychoterapii uzależnień, Krajowego Biura do Spraw Przeciwdziałania Narkomanii, Państwowej Agencji Rozwiązywania Problemów Alkoholowych oraz Centrum Monitorowania Jakości w Ochronie Zdrowia.

Struzik, M. (2012) *Problemy związane z używaniem substancji psychoaktywnych a występowanie zaburzeń psychicznych – charakterystyka zjawiska podwójnej diagnozy w Polsce i w Europie*. Serwis Informacyjny NARKOMANIA 3 (59) 2012

Vademecum 2012 - informator o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych.

Urząd m. st. Warszawy (2012) *Program Zapobiegania Przestępczości oraz Ochrony Bezpieczeństwa Obywateli i Porządku Publicznego dla m. st. Warszawy na lata 2012-2014* pn. „Bezpieczna Warszawa”, Warszawa.

Urząd m. st. Warszawy (2011) *Program Przeciwdziałania Narkomanii na lata 2012-2015*, Warszawa.

Urząd m. st. Warszawy (2008) Społeczna Strategia Warszawy. Strategia Rozwiązywania Problemów Społecznych na lata 2009-2020, warszawa.

Urzędy Gminne (2012) Sprawozdania z realizacji Gminnych Programów Przeciwdziałania Narkomanii w roku 2011 (maszynopis dostępny w Focal Point).

UNODC, World Drug Report (2010) (United Nations Publication, Sale No. E.10.XI.13)

Alphabetic list of relevant data bases

- 1) Database of admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances (Treatment Demand Indicator) pilot project of the Reitox National Focal Point of National Bureau for Drug Prevention.
- 2) Dane dotyczące pacjentów przyjętych do stacjonarnego leczenia psychiatrycznego w związku z używaniem narkotyków. Instytut Psychiatrii i Neurologii w Warszawie.
- 3) Dane dotyczące zgłoszonych chorób zakaźnych. Zakład Epidemiologii Narodowego Instytutu Zdrowia Publicznego – Państwowy Zakład Higieny w Warszawie.

Alphabetic list of relevant Internet addresses

- 1) Alternative Dance [online] <http://alternativedance.org/> [available at: 16.12.2012 r.]
- 2) Biuro Bezpieczeństwa i Zarządzania Kryzysowego Urzędu m. st. Warszawy [online] <http://bezpieczna.um.warszawa.pl/> [available at: 16.12.2012]
- 3) Biuro Pomocy i Projektów Społecznych m. st. Warszawy [online] <http://politykaspoleczna.um.warszawa.pl/> [available at: 16.12.2012 r.]
- 4) Stowarzyszenie MONAR [online] <http://www.monar.pl> [available at: 16.12.2012 r.]
- 5) National Bureau for Drug Prevention: www.kbpn.gov.pl [available at: 10.12.2012 r.]
- 6) REITOX Polish Focal Point: www.cinn.gov.pl [available at: 10.12.2012 r.]

14. Annexes

List of Figures and Tables used in the text

Figure 1.3.1. Proportions of communes which implemented NPCDA activities related to prevention and treatment.

Figure 1.4.1. Percentage breakdown of funds earmarked by communal governments to respective components of the NPCDA in 2011.

Figure 1.4.2. Communal NPCDA expenditure in 2011

Figure 1.4.3. Communal NPCDA expenditure per capita in 2011

Figure 2.2.1. Cannabis use prevalence rates among 15-16-year-olds

Figure 2.2.2. Amphetamine use prevalence rates among 15-16-year-olds.

Figure 3.3.1. Percentage of communes in provinces which financed universal drug prevention programmes (based on the number of communes which sent reports)

Figure 3.4.1. Percentage of communes in provinces which financed selective and indicated drug prevention programmes (based on the number of communes which sent reports).

Figure 3.4.2. Rates per 100 000 population for children and adolescents in universal drug prevention programmes in 2011

Figure 3.4.3. Rates per 100 000 population for children and adolescents in selective and indicated drug prevention programmes in 2011

Figure 5.3.1. Drug treatment sponsored by the National Health Fund in 2011. Respective types of treatment, detoxification and post-rehabilitation.

Figure 5.4.1.1. Admissions to residential drug treatment in 1997-2010 due to mental and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19) (numbers of patients).

Figure 5.4.1.2. Admissions to residential drug treatment in 1997-2010 due to mental disorders and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19) (numbers of patients per 100 000 population).

Figure 5.4.1.3. Admissions to residential drug treatment in 1997-2010 due to mental disorders and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19), numbers of patients by age.

Figure 5.4.1.4. Proportions of patients admitted to residential drug treatment in 2010 due to mental and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19), by substance.

Figure 5.4.1.5. Proportions of patients admitted to residential drug treatment in 1997-2010 due to mental and behavioural disorders caused by psychoactive substance use (ICD-10: F11-F16, F18, F19), by substance.

Figure 5.4.1.6. Rates per 100 000 population for residential drug treatment demand in 2010

Figure 5.4.1.7. Rates per 100 000 population for drug treatment units in 2011

Figure 5.4.2.1. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2011 – proportions of patients, by age.

Figure 5.4.2.2. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2011 – proportions of patients, by employment status.

Figure 5.4.2.3. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2010 – proportions of patients, by injecting drug use.

Figure 5.4.2.4. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2011 – proportions of patients, by primary drug.

Figure 5.4.2.5. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2011 – proportions of first-time patients, by primary drug.

Figure 6.2.1. Number of new HIV infections, including injecting drug use (recorded number and corrected value considering no data on route of transmission) detected in 1999-2011

Figure 6.2.2. Number of new AIDS cases, including injecting drug users in 1999-2011

Figure 6.2.3. HIV/AIDS cases in IDUs registered in 2011, by sex (numbers of people)*

Figure 6.2.4. HIV/AIDS cases in IDUs registered in 2011 by age group (numbers of people)*

Figure 6.2.5. AIDS-related deaths recorded in Poland by 31 July 2012, including IDUs, by date of death

Figure 6.2.6. New chronic HBV cases in 2005-2011

Figure 6.2.7. New acute HBV cases in IDUs in 2005-2011

Figure 6.2.8. Proportions of PKD clients in 2008-2011, by route of HIV transmission

Figure 6.2.9. Proportions of PKD clients who reported injecting drugs.

Figure 6.2.10. IDU population in 2010, proportions by age

Figure 6.2.11. Proportion of positive test results in IDU population in 2010 (N=333)

Figure 6.2.12. Proportion of positive test results in PKD population in 2010 (N=1001)

Figure 6.2.13. Drugs used intravenously in IDU population (proportions of answers in 2010).

Figure 6.2.14. Drugs used in way other than intravenously in IDU population (proportions of answers in 2010).

Figure 6.3.1. Patients with dual diagnosis in all admissions to residential psychiatric treatment in 1997-2010 (*percentages of patients*).

Figure 6.3.2. Total number of patients with dual diagnosis admitted to inpatient psychiatric treatment in 1997-2010.

Figure 6.3.3. Percentages of drug problem patients admitted to residential psychiatric treatment in 1997-2010, by ICD-10 diagnosis.

Figure 6.4.1. Drug-related death rates in 2009 and 2010, by province. Poland's average – 0.68.

Figure 6.4.2. Numbers of drug-related deaths in 2009 and 2010, by province.

Figure 6.4.3. Drug-related deaths in 1998 – 2010, by age (GUS data).

Figure 6.4.4. Medical interventions related to new psychoactive substances.

Figure 7.2.1. Number of SNEPs and host cities

Figure 7.2.2. Numbers of SNEP clients

Figure 7.2.3. Numbers of needles in distribution in 2002 – 2011

Figure 9.2.1. Crimes against Acts of 1997 and 2005 on counteracting drug addiction in 1999 – 2011

Figure 9.2.2. Suspects under Acts of 1997 and 2005 on counteracting drug addiction in 1999 – 2011

Figure 9.2.3. Drug-related crime rates in 2010 and 2011 under the Act of 2005 on counteracting drug addiction, by province (per 100 000 population).

Figure 9.2.4. Drug-related crime suspects in 2010 and 2011 under the Act of 2005 on counteracting drug addiction, by province (per 100 000 population).

Figure 9.2.5. Final conditional and unconditional prison sentences under Acts of 1997 and 2005 on counteracting drug addiction in 1989-2010, by place of committing crime.

Figure 9.2.6. Final prison sentences in 2009 and 2010 under the Act on counteracting drug, by province (Poland average of 53 in 2010).

Figure 10.2.1. Perceived availability of psychoactive substances ('easy' or 'very easy' responses to question about access to listed substances) – proportions of respondents in 2006 and 2006, by age (15-64) (%).

Figure 10.2.2. Perceived availability of respective psychoactive substances ('easy' or 'very easy' responses to question about access to listed substances) – proportions of respondents aged 15-16 (%).

Figure 10.2.3. Perceived availability of respective psychoactive substances ('easy' or 'very easy' responses to question about access to listed substances) – proportions of respondents aged 17-18 (%).

Figure 10.3.1. Number of clandestine laboratories dismantled in 2000–2011 (Police Headquarters data).

Figure 10.4.2. Purity of amphetamines and THC concentration in marijuana in 2004-2011 (%).

Figure 11.2.1. Structure of treatment facilities for drug users

Figure 12.1.1. Cost of drugs strategy per capita (PLN).

Figure 12.1.2. Universal, selective and indicated prevention – co-financed programme rate

Figure 12.1.3. Universal, selective and indicated prevention programme participant rate*

Table 1.4.1. NPCDA expenditure in 2011

Table 1.4.2. Communal expenditure in PLN

Table 2.1.1. Importance of social problems at national level (percentages of respondents)

Table 2.1.2. The most important social problem in Poland according to the respondents (percentage of respondents)

Table 2.1.3. Prevalence of drug use in a lifetime, last 12 months and last 30 days

Table 2.2.1. Lifetime prevalence rates for cannabis use.

Table 2.2.2. Last 12 months prevalence rates for cannabis use.

Table 2.2.3. Last 30 days prevalence rates for cannabis use.

Table 2.2.4. Lifetime prevalence rates, by year of study

Table 2.2.5. Lifetime prevalence rates, by sex.

Table 2.2.6. Last 12 months prevalence rates, by year of study

Table 2.2.7. Last 12 months prevalence rates, by sex

Table 2.2.8. Last 30 days prevalence rates, by year of study

Table 2.2.9. Last 30 days prevalence rates, by sex

Table 3.3.1. Universal drug prevention programmes conducted by communes in 2011.

Table 5.3.1. Drug treatment sponsored by the National Health Fund in 2004-2011

Table 5.4.2.1. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2009-2011.

Table 6.2.1. HIV incidence rates in IDUs in 2006-2011 (per 100 000 population) (infections registered by place of residence)

Table 6.2.2. AIDS incidence rates in IDUs in 2006-2011 (per 100 000 population) (infections registered by place of residence)

Table 6.2.3. HIV frequency in diagnostic testing in IDUs in 2006 – 2011

Table 6.3.1. Percentages of patients with dual diagnosis admitted to residential psychiatric treatment in 1997-2010, by ICD-10 diagnosis.

Table 6.3.2. Percentages of patients with dual diagnosis admitted to residential psychiatric treatment in 2010.

Table 6.4.1. Number of drug-related deaths in 2001 – 2010.

Table 7.4.1. Client profile of KBPN-financed health and social harm reduction programmes for drug dependent users in 2011

Table 7.4.2. Equipment distributed and collected under KBPN-financed health and social harm reduction programmes for drug-dependent individuals in 2011

Table 7.4.3. Substances used by clients of KBPN-financed health and social harm reduction programmes for drug-dependent individuals in 2011

Table 8.3.1. Client structure of KBPN-financed abstinence-based post-rehabilitation programmes in 2011

Table 9.2.1. Recorded crimes against Acts of 1997 and 2005 on counteracting drug addiction in 1998-2011

Table 9.2.2. Convicts finally sentenced to prison in total and under Acts of 1997 and 2005 on counteracting drug addiction and Act of 1985 on drug prevention, between 1997 and 2010, by conditional and unconditional sentence.

Table 9.4.1. Profile of patients in prison drug-free therapeutic wards in 2011.

Table 9.4.2. Profile of patients in prison drug-free therapeutic wards in 2011, according to ICD-10

Table 10.2.1. Perceived availability of psychoactive substances ('easy' or 'very easy' responses to question about access to listed substances) – proportions of respondents in 2006 and 2006, by last 12 months prevalence of substance use (%).

Table 10.3.1. Drug seizures in Poland in 2002–2011.

Table 10.3.2. Police seizures of illegal marijuana plantations in 2006-2010 as revealed by the Police Headquarters

Table 10.4.1. Minimum, maximum and modal prices of drugs in 2009 and 2011 (PLN)

Table 12.1.1. NPCDA areas included in municipal strategies.

Table 12.1.2. Municipal drugs strategies.

Table 12.1.3. Universal, selective and indicated prevention – numbers of programmes and participants.

Table 12.1.4. Drug Strategies of the big cities in Poland

List of abbreviations used in the text

1. ABW – Agencja Bezpieczeństwa Wewnętrznego (Internal Security Agency)
2. AIDS – Acquired Immune Deficiency Syndrome
3. ARV – Antiretroviral
4. CBS – Centralne Biuro Śledcze Komendy Głównej Policji (Central Bureau of Investigation of the Polish Police Headquarters)
5. DRUID – "Driving under Influence of Drugs, Alcohol and Medicines"
6. ESPAD – European School Survey Project on Alcohol and other Drugs
7. EMCDDA – European Monitoring Centre for Drugs and Drug Addiction in Lisbon
8. EU – European Union
9. GHB – Gamma – Hydroxybutyric acid

10. GPS – General Population Survey
11. GUS – Główny Urząd Statystyczny (Central Statistic Office)
12. HDG - Horizontal Working Party on Drugs
13. HIV - Human immunodeficiency virus
14. ICD – International Classification of Disease
15. KBPN / NBDP – Krajowe Biuro ds. Przeciwdziałania Narkomanii (National Bureau for Drug Prevention)
16. NFP – Polish Reitox Focal Point
17. NGO - Non governmental organizations
18. Narodowy Fundusz Zdrowia - (National Health Fund)
19. NPCDA – National Programme for Counteraction Drug Addiction (*pl; Krajowy Program Przeciwdziałania Narkomanii*)
20. OTC – Over the country drugs
21. PLN – name of the Polish currency
22. PMMA – p-methoxy-methamphetamine
23. TROIKA – Entity that includes previous, current and subsequent EU Presidency,
24. UNODC – United Nations Office on Drugs and Crime.

List of full references of laws in original language

1. Ustawa z dnia 29 lipca 2005 r. o przeciwdziałaniu narkomanii (Dz. U. Nr 179, poz.1485)
2. Rozporządzenie Rady Ministrów z dnia 22 marca 2011 r. w sprawie Programu Przeciwdziałania Narkomanii na lata 2011 – 2016 (Dz. U. z 2011 r. Nr 78, poz. 428)
3. Ustawa z dnia 1 kwietnia 2011 r. o zmianie ustawy o przeciwdziałaniu narkomanii oraz niektórych innych ustaw (Dz. U. z 2011 r. Nr 117, poz. 678).
4. *Council Decision 2005/387/JHA* of 10 May 2005 on the information exchange, risk-assessment and control of new psychoactive substances.
5. Ustawa z dnia 9 listopada 1995 r. o ochronie zdrowia przed następstwami używania tytoniu i wyrobów tytoniowych.
6. Ustawa z dnia 6 grudnia 2008 r. o podatku akcyzowym (Dz. U. z 2009 r., Nr 3, poz. 11)
7. Ustawa z dnia 11 marca 2004 r. o podatku od towarów i usług (Dz. U. z 2004 r., Nr 54, poz. 535)

Part D:

List of standard tables and structured questionnaires for 2012

1. Standard Table 01 Basic results and methodology of population surveys on drug use
2. Standard Table 05 Acute/direct related deaths
3. Standard Table 06 Evolution of acute/direct related deaths
4. Standard Table 09-1 Prevalence of hepatitis B/C and HIV infection among
5. injecting drug users: methods
6. Standard Table 09-2 Prevalence of hepatitis B/C and HIV infection among
7. injecting drug users
8. Standard Table 09-4 Notified cases of hepatitis C and B in injecting drug users
9. Standard Table 11 Arrests/Reports for drug law offences
10. Standard Table 13 Number and quantity of seizures of illicit drugs
11. Standard Table 14 Purity at street level of illicit drugs
12. Standard Table 15 Composition of tablets sold as illicit drugs
13. Standard Table 16 Price in Euros at street level of illicit drugs
14. TDI data
- 8.