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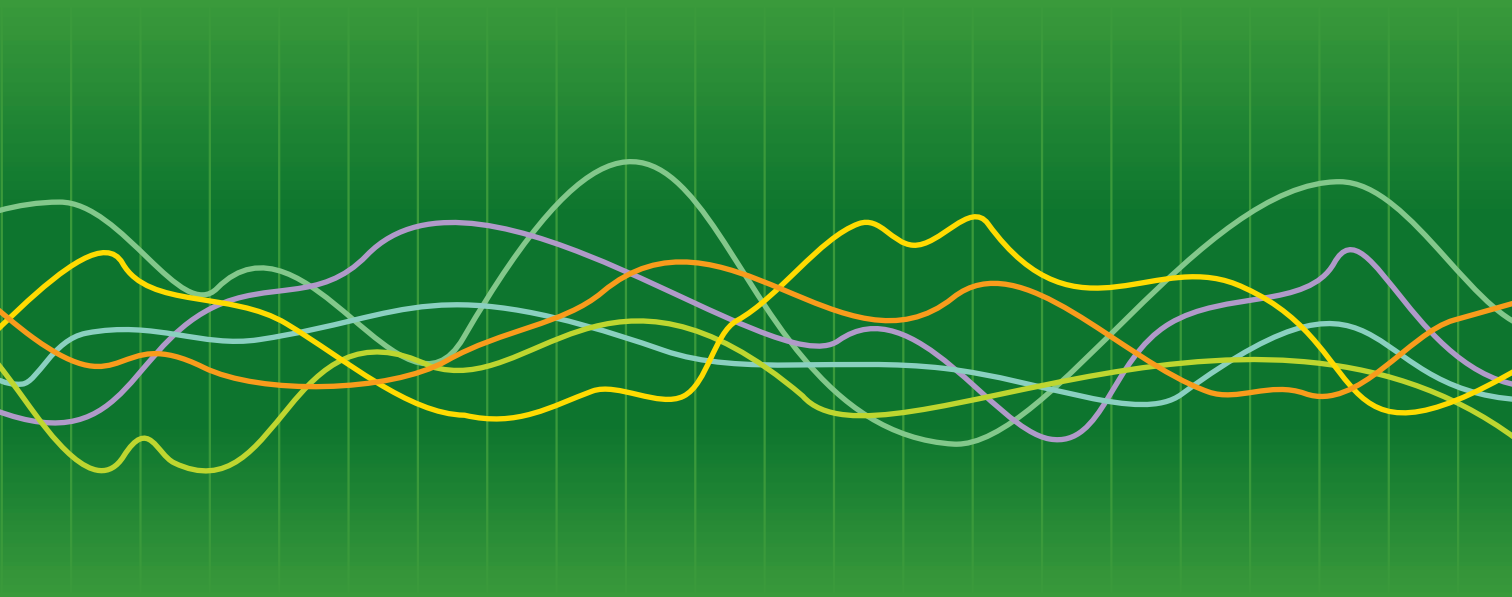

Raport dotyczy sytuacji narkotykowej w Polsce i zawiera streszczenie najnowszych danych w języku polskim

Krajowe Biuro ds. Przeciwdziałania Narkomanii
National Bureau for Drug Prevention

European Monitoring Centre
for Drugs and Drug Addiction

Krajowe Biuro
ds. Przeciwdziałania Narkomanii

CENTRUM INFORMACJI
O NARKOTYKACH I NARKOMANII

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

Polityka antynarkotykowa

W Polsce podstawowym aktem prawnym z zakresu prawa narkotykowego jest ustawa z dnia 29 lipca 2005 r. o przeciwdziałaniu narkomanii. Ustawa reguluje następujące kwestie: 1) kompetencje poszczególnych służb, instytucji centralnych oraz samorządów lokalnych w obszarze przeciwdziałania narkomanii, 2) działania edukacyjne i upowszechnianie informacji, 3) postępowanie wobec osób uzależnionych od substancji psychoaktywnych, 4) zasady i tryb postępowania w obrocie prekursorami, środkami odurzającymi i substancjami psychotropowymi, 5) zasady i tryb postępowania w obrocie słomą makową i konopiami włóknistymi, 6) przepisy karne oraz 7) substancje kontrolowane.

Kluczowym ciałem koordynująco-doradczym w zakresie polityki antynarkotykowej jest powołana w 2001 r. Rada ds. Przeciwdziałania Narkomanii. Zadania Rady obejmują: 1) monitorowanie i koordynowanie działań w zakresie realizacji polityki państwa w obszarze środków odurzających, substancji psychotropowych i prekursorów, 2) występowanie do ministra właściwego do spraw zdrowia w sprawach dotyczących tworzenia, zmian i uzupełnień do krajowych strategii i planów przeciwdziałania problemom wywoływanym przez obrót i używanie środków odurzających, substancji psychotropowych i prekursorów, 3) monitorowanie informacji o realizacji krajowej strategii i planów działania, 4) monitorowanie realizacji Krajowego Programu Preciwdziałania Narkomanii (KPPN), 5) zalecanie rozwiązań organizacyjnych w zakresie dotyczącym przeciwdziałania narkomanii, 6) współdziałanie z podmiotami realizującymi zadania z obszaru przeciwdziałania narkomanii w zakresie problematyki dotyczącej działalności Rady.

Aktem wykonawczym, który stanowi zarówno Plan Działania, jak i Krajową Strategię Antynarkotykową jest Krajowy Program Przeciwdziałania Narkomanii (KPPN), obecnie uchwalony na lata 2011-2016. Warto nadmienić, że Krajowy Program Przeciwdziałania Narkomanii od 2006 r. ma status rozporządzenia. Program promuje zrównoważone podejście do problemu narkotyków i narkomanii poprzez zbilansowane rozłożenie nacisku na działania z zakresu redukcji popytu i podaży. Ogólnym celem Programu jest ograniczenie używania narkotyków oraz związanych z tym problemów społecznych i zdrowotnych. Corocznie Krajowe Biuro ds. Przeciwdziałania Narkomanii opracowuje projekt Informacji o realizacji zadań wynikających z KPPN. Dane zebrane za rok 2012 wskazują, że ministerstwa i podmioty zobligowane do wdrażania Krajowego Programu Przeciwdziałania Narkomanii wykonywały działania w jego wszystkich obszarach. Wyniki monitorowania realizacji Krajowego Programu Przeciwdziałania Narkomanii w 2012 r. posłużyły do sformułowania następujących wniosków:

1. Jednym ze zidentyfikowanych deficytów w ofercie działań profilaktycznych, które prowadzone są w szkołach, jest niewystarczająca dostępność programów profilaktyki uniwersalnej o udokumentowanej skuteczności. W związku z tym resort edukacji powinien zintensyfikować działania ukierunkowane na upowszechnianie programów promocji zdrowia i profilaktyki uniwersalnej na różnych poziomach edukacji. Należy przez to rozumieć działania polegające na zwiększeniu liczby osób przygotowanych do realizacji ww. programów (szkolenie trenerów i realizatorów), działania wspierające wdrażanie programów w szkołach i placówkach systemu oświaty oraz monitorowanie procesu ich wdrażania poprzez zbieranie danych dotyczących co najmniej liczby szkół, które programy te realizują. Rekomenduje się upowszechnianie programów opartych na naukowych podstawach, o potwierdzonej w badaniach naukowych skuteczności, adresowanych zarówno do dzieci i młodzieży, jak też do ich rodziców i opiekunów, tj. np. program Unplugged.
2. Równolegle z działaniami z zakresu profilaktyki uniwersalnej należy zintensyfikować działania adresowane do dzieci i młodzieży zagrożonych uzależnieniem, demoralizacją i ze specjalnymi

potrzebami edukacyjnymi. Powinno się to odbywać poprzez implementację działań i programów profilaktycznych w placówkach opiekuńczo-wychowawczych nadzorowanych przez ministra właściwego ds. rodziny, placówkach resocjalizacyjnych podległych Ministrowi Sprawiedliwości oraz placówkach takich jak młodzieżowe ośrodki wychowawcze i młodzieżowe ośrodki socjoterapii podległych ministrowi właściwemu ds. edukacji. Resorty odpowiedzialne za nadzór nad ww. placówkami powinny dołożyć wszelkich starań, aby mieć możliwość monitorowania działań profilaktycznych prowadzonych w placówkach podległych.

3. Resort edukacji powinien podjąć niezbędne działania, aby gromadzić w swoich systemach statystycznych dane zgodnie z treścią KPPN na lata 2011-2016. Brak podania wartości wskaźników dotyczących liczby szkół objętych programami profilaktyki uniwersalnej o potwierdzonej skuteczności uniemożliwia ocenę stopnia realizacji działania, które ma istotne znaczenie z punktu widzenia upowszechniania programów profilaktycznych o udokumentowanej skuteczności.
4. Część Urzędów Marszałkowskich podjęła działania ukierunkowane na upowszechnianie programów z zakresu profilaktyki opartych na naukowych podstawach. Rekomenduje się szersze zaangażowanie samorządów wojewódzkich w realizację ww. działania. Samorządy mogą korzystać z bazy programów zamieszczonej na stronie KBPN oraz z m.in. skutecznych, opartych na naukowych podstawach programów takich, jak Unplugged, FreD i Candis, koordynowanych przez KBPN.
5. W związku z niewielkim wsparciem w 2012 r. przez Urzędy Marszałkowskie działań mających na celu podnoszenie kwalifikacji zawodowych osób zaangażowanych w działalność profilaktyczną, rekomenduje się większy nacisk na wyżej wymieniony obszar w kolejnych latach. Działania w tym zakresie mogą w istotny sposób przyczynić się do podniesienia skuteczności profilaktyki uzależnień.
6. Z uwagi na zwiększającą się liczbę osób zgłaszających się do lecznictwa z powodu problemowego używania przetworów konopi, rozwijanie i upowszechnianie oferty leczniczej adekwatnej do potrzeb tej grupy użytkowników (np. program Candis) powinno być kontynuowane. Ważna jest dalsza promocja programu zarówno wśród problemowych użytkowników konopi jak i wśród terapeutów, przedstawicieli wymiaru sprawiedliwości, pomocy społecznej, placówek służby zdrowia i edukacji.
7. Z roku na rok obserwujemy coraz lepszą dostępność programów leczenia substytucyjnego, choć nadal programy te nie są w stanie zaspokoić potrzeb wszystkich osób uzależnionych od opiatów. Mimo, że w 2012 r. wydano zgody na uruchomienie kolejnych 3 programów, szacuje się, że jedynie ok. 15 % osób uzależnionych objętych jest tą formą leczenia. W województwie podlaskim i podkarpackim nadal nie funkcjonują programy leczenia substytucyjnego, a wyraźnie ograniczony dostęp do tej formy leczenia występuje w województwach: warmińsko-mazurskim, pomorskim, zachodniopomorskim oraz wielkopolskim. Należy jednocześnie podkreślić, że leczenie substytucyjne znajduje się w katalogu świadczeń gwarantowanych, w związku z czym Narodowy Fundusz Zdrowia powinien każdego roku zabezpieczać środki finansowe na ten cel oraz ogłaszać konkurs na leczenie substytucyjne.
8. Niepokojące jest, iż w 2012 r. Urzędy Marszałkowskie w bardzo niewielkim stopniu zaangażowane były w rozwijanie dostępności do programów ograniczania szkód zdrowotnych i działań postrehabilitacyjnych. Jedynie Małopolski Urząd Marszałkowski sprawozdał, że w roku sprawozdawczym wspierał programy wymiany igieł i strzykawek oraz program noclegowni i hostelu dla osób uzależnionych w Krakowie. Dlatego rekomenduje się samorządom, tam gdzie jest to uzasadnione, uwzględnienie działań z obszaru ograniczania szkód zdrowotnych i postrehabilitacji (w szczególności wspieranie noclegowni, stacjonarnych oraz ulicznych programów wymiany igieł i strzykawek) w większym niż dotychczas zakresie. Także w większym stopniu niż obecnie Urzędy Marszałkowskie powinny angażować się w zwiększenie dostępności do programów leczenia substytucyjnego.

9. Od lat obserwuje się zjawisko przestępczości w cyberprzestrzeni. Internet jest jednym z narzędzi wykorzystywanych do prowadzenia nielegalnego zakupu prekursorów, narkotyków, a w szczególności środków zastępczych tzw. dopalaczy. Dlatego ważne jest rozwijanie przez organy ścigania wszelkich inicjatyw i działań, które służyłyby bardziej skutecznemu ściganiu tego typu przestępstw.
10. Wzrastająca liczba krajowych upraw konopi indyjskich wymaga skoordynowanych i zintegrowanych działań różnych służb zajmujących się zwalczaniem przestępczości narkotykowej. Działania Policji powinny być skierowane przede wszystkim przeciwko dużym uprawom zakładanym przez zorganizowane grupy przestępcze.
11. Scena narkotyków syntetycznych, na której nadal dominuje amfetamina, ulega zmianie. Pojawiają się sygnały używania i produkcji metamfetaminy oraz mefedronu. Spadek dostępności BMK, wykorzystywanego do produkcji amfetaminy, spowodował import do Polski legalnej substancji jaką jest APAAN. Zmiany metod produkcji amfetaminy wymagają wypracowania nowych rozwiązań i działań ze strony służb zajmujących się redukcją podaży.
12. Nowa Strategia Antynarkotykowa Unii Europejskiej na lata 2013-2020, a także towarzyszący jej Antynarkotykowy Plan Działania Unii Europejskiej wskazują obszary, w których niezbędne będzie zintensyfikowanie działań nie tylko na poziomie krajowym, ale także na forum UE. Do najpoważniejszych z nich zaliczają się: szybki wzrost liczby nowych substancji psychoaktywnych dostępnych na rynku (w tym tzw. dopalaczy), dywersyfikacja szlaku przemytu nielegalnych substancji oraz nowe metody dystrybucji narkotyków. W celu przeciwdziałania temu zjawisku niezbędne jest wzmocnienie międzynarodowej współpracy służb egzekwujących prawo (także współpracy wywiadowczej) oraz wypracowanie nowych metod takiej współpracy. Nowa Strategia Antynarkotykowa Unii Europejskiej podkreśla też konieczność szerszej współpracy z przedstawicielami społeczeństwa obywatelskiego oraz włączania ich w proces przygotowywania polityk i działań mających na celu ograniczanie problemu narkotyków i narkomanii. Ponadto Strategia kładzie nacisk na konieczność podejmowania decyzji i przygotowywania adekwatnych działań w oparciu o dowody naukowe (tzw. evidence based decision making). Działania wskazane powyżej realizowane są już przez podmioty krajowe, jednak dalsza intensyfikacja tych działań, szczególnie zaś rozwijanie współpracy z partnerami unijnymi, wydaje się uzasadniona.
13. Równolegle z działaniami realizowanymi na forum Unii Europejskiej i instytucji międzynarodowych zajmujących się problemem narkotyków i narkomanii należy rozwijać współpracę bilateralną z państwami trzecimi, nie należącymi do Unii Europejskiej, a zwłaszcza z państwami objętymi Partnerstwem Wschodnim.
14. W ostatnich latach prawdziwym wyzwaniem dla badań oraz systemów monitorujących stał się problem nowych narkotyków, inaczej narkotyków projektowanych (ang. designer drugs), w Polsce najczęściej utożsamiany z tzw. dopalaczami. Obecnie problem nowych narkotyków staje się coraz częściej obiektem zainteresowania badaczy i analityków. Wiedza na temat tego dynamicznie rozwijającego się zjawiska systematycznie rośnie, co pomaga zrozumieć jego charakter. Jednak w dalszym ciągu konieczne jest wypracowanie bardziej skutecznych metod oraz mechanizmów monitorowania pojawiania się nowych substancji. W tym kontekście ważne jest rozwijanie mechanizmów monitorowania występowania środków zastępczych na rynku polskim oraz rozwijanie współpracy pomiędzy odpowiednimi służbami, w szczególności z Głównym Inspektorem Sanitarnym i powiatowymi stacjami sanitarno-epidemiologicznymi.
15. Jednym z priorytetów KPPN pozostaje prowadzenie badań i rozwój monitoringu na poziomie centralnym oraz przez jednostki samorządu terytorialnego. Umożliwia on bowiem identyfikację wielu zagrożeń i zjawisk we wczesnym etapie rozwoju oraz daje szansę na przygotowanie odpowiedzi społecznej np. w formie interwencji profilaktycznych czy leczniczych dostosowanych do potrzeb. Rekomenduje się zatem systematyczne prowadzenie działań z zakresu monitorowania

problemów narkotyków i narkomanii przez jednostki samorządu terytorialnego, które mogą wykorzystać dane z monitorowania do przygotowania lokalnych strategii.

16. W dalszym ciągu należy promować nowe rozwiązania prawne dotyczące umorzeń postępowań przez prokuratorów i sądy przewidziane nowymi przepisami znowelizowanej w 2011 r. ustawy o przeciwdziałaniu narkomanii.

Ministerstwo Sprawiedliwości rozpoczęło w 2012 r. wstępną ewaluację wyników nowelizacji art. 62a ustawy o przeciwdziałaniu narkomanii z 2011 r., która dotyczyła bardziej liberalnego podejścia do spraw o posiadanie narkotyków. Z najnowszych danych wynika, że nieco ponad rok od wejścia w życie wskazanej wyżej nowelizacji, prokuratorzy umorzyli 2 145 postępowań. W 2012 r. nie wprowadzono istotnych zmian legislacyjnych w obszarze narkotyków i narkomanii, kontynuowano natomiast prace nad kilkoma aktami prawnymi w przedmiotowym zakresie. Jednym z nich jest projekt Rozporządzenia Ministra Zdrowia w sprawie zakresu i trybu współpracy podmiotów leczniczych prowadzących leczenie lub rehabilitację osób używających środków odurzających lub substancji psychotropowych z Krajowym Biurem do Spraw Przeciwdziałania Narkomanii. Prace nad tym projektem prowadzone były w 2012 r. i na początku 2013 r. Powyższy akt prawny ma szczególnie istotne znaczenie dla monitorowania problemu narkotyków i narkomanii w obszarze zgłaszalności do leczenia (ang. Treatment Demand Indicator).

W 2011 r. decyzją Dyrektora Krajowego Biura ds. Przeciwdziałania Narkomanii powołano Radę do spraw Badań Naukowych, która stanowi ciało doradcze i opiniotwórcze. W skład Rady wchodzi 7 członków powoływanych w oparciu o wiedzę i doświadczenie z zakresu badań nad uzależnieniami. Do zadań Rady należy inicjowanie badań naukowych, określanie potrzeb i ustalanie priorytetów badawczych w obszarze uzależnień.

W celu wspierania badań nad problematyką narkotyków i narkomanii, Krajowe Biuro ds. Przeciwdziałania Narkomanii od 2008 r. ogłasza konkursy na projekty badawcze w przedmiotowym zakresie. W ciągu ostatnich kilku lat, w ramach konkursów badawczych, sfinansowanych zostało kilkanaście badań dotyczących problematyki uzależnień od narkotyków, dzięki czemu możliwe było przeprowadzenie różnych projektów badawczych, począwszy od badań ewaluacyjnych, poprzez badania epidemiologiczne po badania ścieków na obecność metabolitów narkotyków. Część z tych projektów jest kontynuowana i finansowana z innych środków, np. Uniwersytet Medyczny w Poznaniu prowadzi w dalszym ciągu badanie w wybranych miastach Wielkopolski na obecność metabolitów narkotyków w ściekach. Badanie jest finansowane ze środków Urzędu Marszałkowskiego Województwa Wielkopolskiego. Konkursy badawcze Krajowego Biura miały na początku otwartą formułę, tzn. środki otrzymywały wszelkie ciekawe projekty badawcze, które przeszły procedurę konkursową. Ostatnie dwa konkursy koncentrują się na priorytetach, które zostały określone m.in dzięki wsparciu Rady ds. Badań Naukowych. W 2012 r. w ramach konkursu sfinansowano trzy nowe badania (Malczewski, Misiurek 2013b).

Kolejnym obszarem wspieranym przez KBPN jest wdrażanie lokalnego i wojewódzkiego monitoringu problemu narkotykowego. W ramach powyższych działań Centrum Informacji o Narkotykach i Narkomanii KBPN zorganizowało w 2012 r. i 2013 r. kilka konferencji mających na celu uwpowszechanianie informacji o metodologii monitorowania oraz o dobrych praktykach w tym zakresie[1].

W celu analizy systemu przeciwdziałania narkomanii w Polsce, pod koniec 2012 r. zrealizowane zostało przez ARS-C Robert Sobiech badanie pn. „Instytucjonalny system przeciwdziałania narkomanii w 2012 roku" (Sobiech, 2012[2]). W badaniu uczestniczyły organizacje o zasięgu ogólnopolskim prowadzące działania z zakresu redukcji popytu na narkotyki (29 podmiotów). W porównaniu z badaniami prowadzonymi w przeszłości nie odnotowano istotnych zmian dotyczących liczby aktywnych

1 Informacje o konferencjach dotyczących monitorowania znajdują się na stronie CINN KBPN: http://www.cinn.gov.pl/portal?id=1

2. Raport ARS-C Sobiech dostępny jest na stronie CINN KBPN: http://www.cinn.gov.pl/portal?id=165957

organizacji (32 organizacje w 2003 r. i 38 – w 1999 r.). Celem badania była m.in. charakterystyka zasobów ludzkich organizacji; sytuacja finansowa i źródła finansowania organizacji; obecne cele i przyszłe priorytety; działania prowadzone w sferze redukcji popytu; ocena krajowej strategii przeciwdziałania narkomanii; analiza sieci (kluczowych relacji) organizacji działających w sferze redukcji popytu. Badanie zostało zrealizowane metodą wspomaganego komputerowo wywiadu telefonicznego CATI (Computer Assisted Telephone Interwiev). Wywiady przeprowadzono z liderami badanych organizacji lub ze wskazanymi przez nich pracownikami odpowiedzialnymi za prowadzenie działań w sferze redukcji popytu. W pojedynczych przypadkach kwestionariusz wywiadu wypełniany był przez respondentów i przekazywany autorom badania pocztą elektroniczną. Wyniki badania pokazały, że polski system przeciwdziałania narkomanii charakteryzuje się zarówno stabilnością, jak i otwartością na obecność nowych podmiotów oraz w znaczącym stopniu wiąże się z działalnością organizacji pozarządowych. Widać wyraźny wzrost środków finansowych organizacji przeznaczanych na redukcję popytu na narkotyki w porównaniu z sytuacją z 2003 r. W 2012 r. średni budżet organizacji przeznaczany na działania związane z redukcją popytu zwiększył się z 319 tys. do 813 tys. euro. W porównaniu z 2003 r. odnotowano znaczące zwiększenie finansowania organizacji pozarządowych ze środków otrzymywanych od administracji publicznej. Dane dotyczące liczby pracowników zatrudnionych przy realizacji działań na rzecz redukcji popytu wskazują na podobny poziom zatrudnienia w okresie od 1999 r. do 2012 r. W 1999 r. badane organizacje zatrudniały przeciętnie 50 osób, w 2003 r. – 58 osób, zaś w 2012 r. – 48 osób. Odnotowano jednocześnie znaczący spadek liczby woluntariuszy pracujących przy działaniach w zakresie redukcji popytu prowadzonych przez organizacje pozarządowe. Wyniki badania wskazały, że polski system przeciwdziałania narkomanii charakteryzuje się znaczącym zróżnicowaniem prowadzonych oddziaływań. Obecność zróżnicowanych form działalności w niewielkim stopniu związana jest z wysokim stopniem specjalizacji badanych organizacji. Większość z nich prowadzi działania niemal we wszystkich dziedzinach redukcji popytu. Jednakże porównanie działań prowadzonych w 2012 r. z sytuacją sprzed 9 lat wskazuje na stopniowy proces koncentracji badanych organizacji na wybranych dziedzinach działalności. W 2012 r. zdecydowana większość badanych organizacji prowadziła działania profilaktyczne oraz organizowała szkolenia dla profesjonalistów zajmujących się problemem narkomanii. Jeśli chodzi o priorytety działalności badanych organizacji okazało się, że za najbardziej istotną formę działalności została uznana szeroko pojęta działalność profilaktyczna, obejmująca m.in. edukację oraz informację – 33% wskazań (w 2003 r. 42% wskazań). Kolejne miejsca wśród priorytetowych aktywności zajęły leczenie i opieka – 26% wskazań (tak, jak w 2003 r.), a następnie badania i analizy oraz szkolenie profesjonalistów – po 11% wskazań (3% wskazań w 2003 r.). Do najważniejszych pozytywnych zmian w aktywności organizacji należy z pewnością zaliczyć zwiększenie kwalifikacji ich personelu (m.in. rozwój kadry oraz jej kompetencji czy przeszkolenie kadry terapeutycznej i medycznej). Z kolei za najważniejsze negatywne zmiany funkcjonowania organizacji, jakie zaobserwowano na przestrzeni ostatnich 3 lat, należy uznać problemy i ograniczenia finansowe – na problemy w tej sferze wskazało 63% badanych organizacji. Przedmiotem badania było także odtworzenie istniejących relacji pomiędzy organizacjami w 3 kluczowych obszarach funkcjonowania systemu: prowadzenia wspólnych działań, nieformalnej komunikacji oraz współpracy strategicznej. W 2012 r. prowadzenie wspólnych działań przez organizacje biorące udział w badaniu charakteryzowało się podobnym natężeniem co w 2003 r. Podobnie było w przypadku badanej kwestii dotyczącej współpracy strategicznej. Jedynie w sferze nieformalnej komunikacji między organizacjami odnotowano wyraźne osłabienie wzajemnych kontaktów. Analiza wspólnych działań podejmowanych przez badane organizacje ujawniła wiodącą rolę Krajowego Biura ds. Przeciwdziałania Narkomanii, które w 2012 r. prowadziło wspólne działania z niemal wszystkimi organizacjami, tj. z 25 spośród 29 organizacji objętych badaniem (89%), podczas gdy w 2003 r. – z 58%. W 2003 r. największą aktywnością w omawianym obszarze wykazało się Stowarzyszenie „Monar". Kluczowa pozycja Krajowego Biura, będącego najważniejszym aktorem wspólnych działań podejmowanych w sferze redukcji popy-

tu, wydaje się być nie tylko konsekwencją formalno-prawnej pozycji Biura, ale przede wszystkim znaczącego zwiększenia zakresu współpracy w ciągu ostatnich 9 lat. Niepokoi natomiast zjawisko istotnego zmniejszenia się zakresu wspólnych działań podejmowanych z innymi uczestnikami systemu przez organizacje, które 9 lat wcześniej były kluczowymi centrami współpracy. W przypadku sfery dotyczącej współpracy strategicznej, za której wskaźnik uznaje się konsultowanie się z innymi organizacjami przed podjęciem ważnych decyzji dotyczących własnych działań, w 2012 r. najważniejszą organizacją, z którą konsultowano kluczowe decyzje okazało się Krajowe Biuro. Inne organizacje odgrywające w tym zakresie ważne role to Fundacja Pomocy Humanitarnej „Res Humane" oraz Zespół Profilaktyki Leczenia Uzależnień Instytutu Psychiatrii i Neurologii. Nieformalna komunikacja była jedyną sferą badanych relacji, w której miało miejsce znaczące zmniejszenie częstości interakcji (gęstości sieci) w porównaniu z sytuacją z 2003 r., co może być spowodowane zwiększoną formalizacją systemu oraz redukowaniem wielu wcześniej funkcjonujących powiązań między organizacjami.

Badania dotyczące problemu narkotyków i narkomanii

W 2012 r. w ramach badania zrealizowanego z Funduszu Rozwiązywania Problemów Hazardowych, które dotyczyło problematyki uzależnień behawioralnych, uwzględniono także pytania dotyczące używania substancji psychoaktywnych. Badanie zostało przeprowadzone w kwietniu 2012 r. przez Centrum Badania Opinii Społecznej na reprezentatywnej, ogólnopolskiej próbie osób w wieku 15+. Celem projektu było zbadanie skali zjawiska używania nielegalnych substancji psychoaktywnych, jak również próba określenia trendu rozmiarów konsumpcji nielegalnych substancji psychoaktywnych. Wyniki badania wskazały, że jakąkolwiek nielegalną substancję psychoaktywną używało kiedykolwiek w życiu 13,7% badanych. Wskaźniki dla używania aktualnego (ostatnie 12 miesięcy) oraz bieżącego (ostatnie 30 dni) wyniosły odpowiednio: 4,8% oraz 2,5%. Najbardziej popularną substancją wśród badanych są przetwory konopi indyjskich (12,2% respondentów używało konopi kiedykolwiek w życiu). Ponad czterokrotnie niższe wskaźniki odnotowano w przypadku osób deklarujących kontakt z amfetaminą (2,9%). Niewiele ponad 1% respondentów przyznało, że próbowało ecstasy. Podobne odsetki obserwuje się w przypadku środków halucynogennych (zarówno grzybów halucynogennych – 1,0%, jak i LSD – 0,8%). W obszarze używania substancji psychoaktywnych w ciągu ostatnich 12 miesięcy, 4% respondentów używało przetworów konopi, a 0,6% badanych przyznało się do używania amfetaminy. W przypadku pozostałych substancji wskaźniki używania były niższe niż 0,5%. Odsetki osób deklarujących używanie marihuany i haszyszu oraz amfetaminy w przypadku ostatnich 30 dni przed badaniem wynoszą odpowiednio: 1,8% oraz 0,3% (Malczewski, Misiurek, 2013). Mężczyźni częściej niż kobiety sięgają po substancje psychoaktywne i tendencję tę obserwuje się zarówno w przypadku eksperymentowania, jak i używania w ciągu ostatnich 12 miesięcy. Wśród badanych, 17,9% mężczyzn używało kiedykolwiek marihuany lub haszyszu, podczas gdy wśród kobiet odsetek ten wynosił 7,8%. Podobne różnice odnotowuje się w przypadku amfetaminy – mężczyźni (4,5%) sięgają po nią trzykrotnie częściej niż kobiety (1,4%). Wyższe wskaźniki używania wśród mężczyzn zaobserwowano także w przypadku środków halucynogennych, kokainy oraz sterydów anabolicznych. Biorąc pod uwagę wiek badanych, największe odsetki odnotowano wśród eksperymentujących z grupy 25-34 lata. W przypadku aktualnych i bieżących użytkowników narkotyków odsetek ten jest największy w najmłodszej kohorcie wiekowej (tj. 15-24 lata) i wynosi odpowiednio: 13,0% i 6,6%[3].

Jednym ze sposobów monitorowania problemu narkomanii jest analiza chemiczna zanieczyszczenia wód. Metoda ta polega na oszacowaniu konsumpcji substancji psychoaktywnych za pomo-

3 Wyniki badania zostały przedstawione w artykule: Malczewski, A., Misiurek, A. (2013), Używanie nielegalnych substancji psychoaktywnych – wyniki badań. Serwis Informacyjny NARKOMANIA nr 1 (61) str. 10-14: http://www.kbpn.gov.pl/portal?id=15&res_id=2826521.

cą nowoczesnych technik analitycznych w postaci chromatografu cieczowego ze spektrometrem mas. Projekt wykorzystujący powyższą metodę został w 2012 r. sfinansowany przez Urząd Marszałkowski w Poznaniu. Badanie pt. „Oznaczanie substancji odurzających w ściekach wybranych miast Wielkopolski. Szacowanie konsumpcji środków odurzających przez mieszkańców Konina, Kalisza i Wągrowca" zostało zrealizowane przez Uniwersytet Medyczny im. Karola Marcinkowskiego w Poznaniu (autorzy badania: Jolanta Kłos, Piotr Nowicki,). Celem badania było wdrożenie nowoczesnych metod szacowania rozpowszechnienia używania narkotyków na podstawie analizy wód ściekowych oraz oszacowanie na tej podstawie rozpowszechniania konsumpcji poszczególnych substancji w wybranych miastach województwa wielkopolskiego. Analiza zebranych danych wykazała, że we wszystkich próbkach wód ściekowych odkryto i skwantyfikowano obecność wydalanych związków amfetaminy oraz metamfetaminy (ang. Drug Target Residues). Należy zaznaczyć, że najwyższe stężenia wyżej wymienionych substancji (ng/L) odkryto w oczyszczalni ścieków w Wągrowcu, natomiast najniższe w oczyszczalni w Kaliszu. W większości próbek odkryto obecność MDMA (ecstasy), ale w niektórych próbkach stężenie tej substancji było poniżej poziomu kwantyfikacji. W niektórych analizowanych próbkach wykryto substancje takie jak MDA czy MDEA wraz z kokainą i jej metabolitami.

Kolejnym badaniem przeprowadzonym w 2012 r. był projekt pt. „Konstruowanie poczucia kontroli użytkowników nad marihuaną i kontekst nielegalności". Badanie to otrzymało dofinansowanie ze środków Krajowego Biura ds. Przeciwdziałania Narkomanii w ramach konkursu badawczego. Przedmiotem badania była analiza procesu utraty kontroli nad używaniem marihuany[4]. Podjęto próbę określenia i zdefiniowania wystąpienia u badanych problemowego używania substancji, a także okoliczności które zachęcałyby do zaprzestania używania. Chcąc prześledzić historię używania marihuany przez badanych, wykorzystano metodę biograficzną z użyciem techniki indywidualnego wywiadu biograficznego. Łącznie zrealizowano 96 wywiadów, w tym 48 wywiadów z aktualnymi i byłymi użytkownikami marihuany oraz 40 indywidualnych wywiadów z przedstawicielami otoczenia użytkowników i dilerami. Dodatkowo przeprowadzono 8 zogniskowanych wywiadów grupowych z terapeutami placówek leczenia uzależnień (zarówno stacjonarnych, jak i ambulatoryjnych), podczas których terapeuci podzielili się własnym doświadczeniem kontaktu i pracy z użytkownikami marihuany. Zdaniem badanych użytkowników określenie palacz przywołuje na myśl negatywne konotacje i stygmatyzuje, więc nie definiują siebie w ten sposób, w przypadku, gdy używanie marihuany ma jedynie charakter okazjonalny i nie powoduje społecznych oraz prawnych konsekwencji. W poszukiwaniu odpowiedzi na pytanie: kim jestem? użytkownicy porównują siebie z innymi użytkownikami-palaczami, osobami nieużywającymi, osobami sięgającymi po inne, tzw. twarde narkotyki. Kwestia nielegalności marihuany jest przez jej użytkowników bagatelizowana. Dużo większego znaczenia dla respondentów nabiera natomiast kwestia kontroli jakości oraz ilości używanego narkotyku, co przyczynia się do powstawania poczucia, że sprawują kontrolę nad swoim życiem i używaniem. Respondenci konstruują poczucie kontroli w wielu różnorodnych aspektach codziennego funkcjonowania, a jego wymiary uwzględniają m.in.: kontrolowanie oczekiwań i doświadczeń objawów używania marihuany, poznawcze kontrolowanie procesu używania, kontrolowanie poprzez dobór towarzystwa do palenia etc.

Profilaktyka

W 2012 r. Ministerstwo Edukacji Narodowej oraz Ośrodek Rozwoju Edukacji wdrażały działania ukierunkowane na wzmacnianie systemu wartości młodzieży i rodzin, w szczególności wartości zdro-

4 Raport z badania dostępny jest na stronie CINN KBPN: http://www.cinn.gov.pl/portal?id=15&res_id=574511

wia, a także kształtowanie przekonań normatywnych i umiejętności psychospołecznych chroniących przed używaniem narkotyków. Rok szkolny 2012/2013 został ogłoszony przez Minister Edukacji Narodowej Rokiem Bezpiecznej Szkoły. Projekt ten polegał na utworzeniu Koalicji na Rzecz Bezpiecznej Szkoły, w skład której weszły agendy i instytucje rządowe oraz organizacje pozarządowe działające na rzecz szeroko rozumianego bezpieczeństwa dzieci i młodzieży.

W celu promowania szkolnych programów profilaktycznych opartych na dowodach naukowych, Krajowe Biuro ds. Przeciwdziałania Narkomanii kontynuowało w 2012 r. realizację programu profilaktyki uniwersalnej pn. Unplugged. Natomiast mając na względzie redukcję rozpowszechniania używania środków odurzających, substancji psychotropowych oraz środków zastępczych wśród dzieci i młodzieży, Krajowe Biuro ds. Przeciwdziałania Narkomanii współfinansowało realizację i ewaluację programów szkoleniowych dla realizatorów Programu Wzmacniania Rodzin.

Na stronie www.narkomania.gov.pl funkcjonowała w 2012 r. internetowa poradnia narkotykowa, w ramach której udzielano pomocy oraz rzetelnych informacji na temat uzależnienia od narkotyków, rodzajów narkotyków i form pomocy dla problemowych użytkowników tych substancji oraz osób współuzależnionych. Podobnie do lat poprzednich, wspierano realizację programów profilaktyki selektywnej dla grup zagrożonych uzależnieniem oraz programów profilaktyki ryzyka kierowanych do okazjonalnych użytkowników narkotyków, np. bywalców dyskotek. W ramach internetowej gry edukacyjnej szerzono wiedzę na temat nowych rozwiązań legislacyjnych wprowadzonych do ustawy o przeciwdziałaniu narkomanii.

Podobnie jak w poprzednim roku, Krajowe Biuro ds. Przeciwdziałania Narkomanii wspierało realizację FreD goes Net – programu wczesnej interwencji, opartego na dowodach naukowych. W celu zapewnienia odpowiedniej realizacji programu FreD, zorganizowano seminarium szkoleniowe dla certyfikowanych realizatorów programu. KBPN wspierało również realizację programów dla rodzin problemowych użytkowników narkotyków oraz ich bliskich. Dofinansowanie otrzymały również programy profilaktyki wskazującej.

W 2012 r. kontynuowano kampanię pt: „Narkotyki? Na co mi to". Celem głównym kampanii było promowanie wśród młodych ludzi postaw prozdrowotnych oraz upowszechnianie informacji na temat rzeczywistego rozpowszechniania zjawiska używania narkotyków wśród młodzieży. Kampania realizowana była przede wszystkim za pośrednictwem Internetu.

Krajowe Biuro ds. Przeciwdziałania Narkomanii było również partnerem w projekcie pn. Safe Games Polska realizowanym podczas Europejskich Mistrzostw w Piłce Nożnej EURO 2012. Była to kampania edukacyjna mająca na celu uświadomienie kibicom piłkarskim konsekwencji wynikających z podejmowania ryzykowanych zachowań.

W lipcu 2012 r. wspólnie z Ministerstwem Zdrowia uruchomiono pięcioletni projekt finansowany w ramach Szwajcarsko-Polskiego Programu Współpracy. Projekt ma na celu zmniejszenie używania substancji psychoaktywnych (alkoholu, tytoniu i narkotyków) wśród kobiet w wieku produkcyjnym. Projekt będzie obejmował kampanię informacyjno-edukacyjną, badanie ankietowe wśród kobiet w ciąży, szkolenia dla personelu medycznego, program profilaktyki uniwersalnej w szkołach ponadgimnazjalnych, program profilaktyczny przewidziany do realizacji w zakładach pracy oraz dedykowaną stronę internetową. Projekt jest obecnie wdrażany przez Główny Inspektorat Sanitarny we współpracy z czterema publicznymi instytucjami z obszaru ochrony zdrowia.

Problemowe używanie narkotyków

Ogólnopolskie badania ankietowe zrealizowane w 2012 r. stanowiły podstawę do szacowania liczby problemowych użytkowników opioidów. Instytut Psychiatrii i Neurologii oszacował, że ogólna liczba użytkowników opioidów wyniosła od 10 444 do 19 794 (dane dla 2009 r.). Przedmiotowa kalkulacja

wskazuje również, że najwyższa liczba użytkowników opioidów dotyczy województwa mazowieckiego (4 760), a następnie województw dolnośląskiego (1 888) i śląskiego (1 181). Najniższe dane odnotowano w województwie opolskim (168), świętokrzyskim (185) i podkarpackim (254) (Sierosławski, 2012).

Od roku 2008, co dwa lata, przeprowadzane jest ogólnopolskie badanie ankietowe wśród klientów programów niskoprogowych. Pracownicy wszystkich programów niskoprogowych w Polsce (wymiany igieł i strzykawek oraz dziennych świetlic dla czynnych użytkowników narkotyków) podczas dwóch tygodni na przełomie listopada i grudnia przeprowadzali wywiady kwestionariuszowe z klientami korzystającymi z programu. Kontakty były nawiązywane przez użytkowników narkotyków w celu wymiany sprzętu do iniekcji, porady czy wsparcia. Klienci programów niskoprogowych byli pytani o używanie poszczególnych substancji psychoaktywnych w ciągu ostatnich 30 dni przed badaniem, a także o wzór używania. W trakcie wywiadów kwestionariuszowych użytkownicy narkotyków pytani byli także o używanie różnego rodzaju opioidów. Najbardziej popularną substancją z tej grupy w 2012 r. był metadon, którego poziom używania wzrósł z 30% w 2008 r. do 45% w 2012. W 2012 r. odnotowano natomiast spadek używania polskiej heroiny tzw. „kompotu" z 50% (w 2008 r.) do 20% oraz heroiny z 44% (w 2008 r.) do 30%. Do używania nowej substancji psychoaktywnej, tj. mefedronu przyznało się 10% (2010 r.) oraz 12% (2012) badanych. Ponadto w 2012 r., w kategorii „inne", 14% ankietowanych zadeklarowało używanie tzw. dopalaczy, a 8% wspomniało również o używaniu efedryny, czyli metaktynonu. Wyniki przeprowadzonych pomiarów wskazują na spadek używania heroiny wśród iniekcyjnych użytkowników narkotyków. Zmniejszyła się również nieznacznie grupa osób, która używała amfetaminę, z 61% (2008) do 52% (2012 r.) oraz barbiturany z 23% (2008 r.) do 5% (2012 r.). Największy odsetek badanych zadeklarował w 2012 r. używanie alkoholu (75%). Trzy czwarte badanych piło alkohol w ciągu ostatnich 30 dni. Warto zauważyć, że odsetek badanych zwiększył się w porównaniu do 2008 r. o 15 punktów procentowanych. Duży wzrost odnotować należy w przypadku używania benzodiazepin (60% respondentów używało tych substancji w 2012 r.). Substancją wskazywaną przez uczestników badania w 2012 r. jako najbardziej problemową były opioidy (40%), następnie amfetamina (18%) oraz „dopalacze" (15%). Alkohol jako substancję najbardziej problemową wskazało 14% respondentów. Wskazanie na benzodiazepiny, pomimo deklaracji używania u ponad połowy badanych, odnotowano u 2% respondentów, co oznacza, że środki te traktowane są raczej jako substancje dodatkowe. 5% badanych nie było w stanie określić jaka substancja powoduje u nich największe problemy (Malczewski, 2013m)[5].

Na podstawie danych uzyskanych dzięki opisanym powyżej wywiadom kwestionariuszowym przeprowadzono oszacowanie liczby iniekcyjnych użytkowników narkotyków. Oszacowanie dokonane na podstawie badania klientów programów wymiany oraz danych z lecznictwa metodą multiplier wskazuje, że liczba iniekcyjnych użytkowników waha się od 4 307 do 10 304 przy średniej ok. 7 170 (Malczewski, 2013k). Szacowania te mają charakter wstępny, ponieważ opierają się na danych z lecznictwa narkotykowego za 2011 r., natomiast powinny obejmować dane za 2012 r., które nie są jeszcze dostępne.

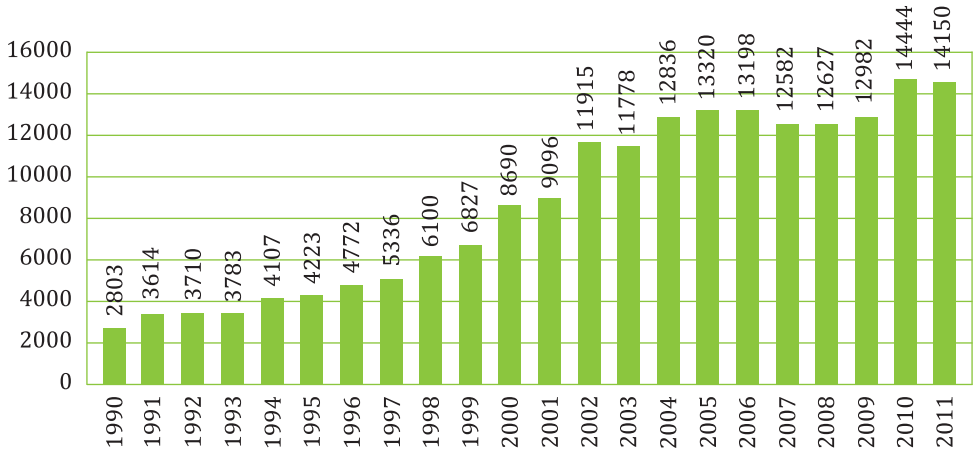
Leczenie stacjonarne z powodu narkotyków

Dane statystyczne stacjonarnego lecznictwa psychiatrycznego są używane do analizy trendów w zakresie zaburzeń psychicznych i zaburzeń zachowania spowodowanych używaniem substancji psychoaktywnych. Zgłaszalność do leczenia z powodu problemu narkotyków dotyczy statystyk stacjonarne-

5 Wyniki badania zostały przedstawione w artykule: Malczewski, A. (2013m) Odbiorcy programów wymiany igieł i strzykawek w 2012 roku – wyniki badań. Serwis Informacyjny NARKOMANIA nr 2 (63) str. 12-18 http://www.kbpn.gov.pl/portal?id=15&res_id=2835135

go lecznictwa psychiatrycznego oraz obejmuje także specjalistyczne lecznictwo uzależnień lekowych, które funkcjonuje w ramach psychiatrycznej służby zdrowia. Dane lecznictwa stacjonarnego obejmują wszystkich przyjętych do szpitali psychiatrycznych, w tym oddziałów detoksykacyjnych dla osób uzależnionych od substancji psychoaktywnych innych niż alkohol oraz ośrodków rehabilitacyjnych, w tym prowadzonych przez organizacje pozarządowe, o ile mają one status podmiotów leczniczych (wcześniej: publicznych zakładów opieki zdrowotnej). Według najnowszych dostępnych danych, tj. w 2011 r. do placówek stacjonarnych przyjęto 14 150 osób z powodu problemów związanych z używaniem narkotyków. Świadczy to o nieznacznym spadku w stosunku do 2010 r. (14 444 osoby).

Wykres 1. Liczba pacjentów przyjętych do lecznictwa stacjonarnego w latach 1990-2011 z powodu zaburzeń psychicznych i zaburzeń zachowania związanych z używaniem substancji psychoaktywnych



Źródło: Instytut Psychiatrii i Neurologii (2012)

W 2011 r., podobnie jak w latach poprzednich, zdecydowaną większość pacjentów lecznictwa stacjonarnego stanowili mężczyźni (73,8%). Osoby z problemem opiatów stanowiły 7,8% przyjętych. 13% pacjentów zgłosiło się do leczenia z powodu problemów wynikających z używania środków uspokajających i nasennych. U 3,5% pacjentów zdiagnozowano problemy związane z używaniem stymulantów, a w przypadku 3% osób powodem zgłoszenia się do leczenia były problemy związane z używaniem przetworów konopi. Odsetki osób uzależnionych od kokainy (0,3%), środków halucynogennych (0,3%) oraz substancji wziewnych (0,4%) utrzymywały się na bardzo niskim poziomie. System sprawozdawczy prowadzony przez Instytut Psychiatrii i Neurologii nie odzwierciedla pełnego i dokładnego obrazu wzorów używania narkotyków wśród pacjentów lecznictwa stacjonarnego, ponieważ w 2011 r. u 71,7% pacjentów rozpoznano zaburzenia psychiczne i zaburzenia zachowania spowodowane używaniem kilku substancji lub używaniem innych substancji psychoaktywnych (F.19 w ICD-10). Oznacza to, iż w przypadku blisko ¾ leczonych nie można nic powiedzieć o typach substancji, których używanie legło u podstaw zgłoszenia się do leczenia.

Do 2005 r. odsetek pacjentów z podwójną diagnozą wśród wszystkich pacjentów przyjętych do lecznictwa stacjonarnego wskutek nadużywania substancji psychoaktywnych utrzymywał tendencję wzrostową i w 2005 r. wynosił 7,6%. Po 2006 r. trend wzrostowy został zahamowany, a odsetek tego typu pacjentów na tle wszystkich osób przyjętych do lecznictwa stacjonarnego utrzymuje się na poziomie 7,4-7,9% (w 2011 r. odsetek ten wyniósł 7,9%). W stacjonarnych ośrodkach psychia-

trycznych w Polsce w 2011 r. największą grupę stanowili pacjenci z rozpoznaniem mieszczącym się w kategorii „inne zaburzenia psychiczne" (60%), która obejmuje m.in. zaburzenia psychotyczne, w tym halucynacje i urojenia, schizofrenię oraz zaburzenia zachowania. Znaczna liczba pacjentów ujawniała symptomy zaburzeń osobowości (25%). Ponadto pacjenci wykazywali zaburzenia lękowe (9%), objawy depresji (5%) oraz innych zaburzeń afektywnych (1%). Analizując dane dotyczące tego, jakiego rodzaju zaburzenia psychiczne prezentują pacjenci przyjęci do lecznictwa stacjonarnego można zauważyć, że w latach 2004-2008 nastąpił wzrost udziału grupy pacjentów diagnozowanych w kierunku innych zaburzeń psychicznych. W 2009 r. odnotowano spadek tego trendu i od tego też roku pozostaje on względnie stabilny. Po spadku do roku 2008 liczby pacjentów z zaburzeniami osobowości, od kilku lat odsetek ten pozostaje także na dość stabilnym poziomie. Widoczny jest także stabilny trend przyjęć pacjentów z zaburzeniami lękowymi, objawami depresji oraz innych zaburzeń afektywnych. Analiza danych za rok 2011 wskazuje, że podwójne rozpoznanie najczęściej diagnozowano u osób uzależnionych od leków uspokajających i nasennych (brak podwójnej diagnozy dotyczył 89,6% przypadków) oraz substancji wziewnych (brak podwójnej diagnozy dotyczył 90,7% przypadków). Najmniej przypadków współzachorowalności odnotowano u pacjentów uzależnionych od opiatów (98,7% pacjentów bez podwójnej diagnozy). Inne zaburzenia psychiczne, czyli kategoria diagnostyczna, która najczęściej dotyczy osób z problemem narkotykowym, rozpoznawana była w 2011 r. najczęściej u pacjentów uzależnionych od wielu różnych substancji psychoaktywnych (5,6%), substancji wziewnych (5,5%) oraz leków uspokajających i nasennych (4,2%). Zaburzenia osobowości w największym stopniu obserwowano w 2011 r. wśród osób uzależnionych od kokainy (5,6%) oraz halucynogenów (5,3%). Zaburzenia lękowe w największym stopniu diagnozowano u pacjentów uzależnionych od leków uspokajających i nasennych (3,3%).

Lecznictwo uzależnień od narkotyków w Polsce

Leczenie uzależnienia od narkotyków, rehabilitacja i readaptacja są świadczone nieodpłatnie bez względu na miejsce zamieszkania pacjenta. Leczenie mogą prowadzić publiczne lub niepubliczne podmioty lecznicze (wcześniej: zakłady opieki zdrowotnej) oraz lekarze wykonujący praktykę lekarską, w tym w ramach grupowej praktyki lekarskiej. Udzielanie świadczeń zdrowotnych osobom uzależnionym od narkotyków prowadzone jest w oparciu o rozbudowany system placówek ambulatoryjnych i stacjonarnych, tj. poradnie leczenia uzależnień, oddziały detoksykacyjne, oddziały dzienne, oddziały leczenia uzależnień w strukturach szpitala, ośrodki rehabilitacji średnio- i długoterminowej oraz oddziały dla osób uzależnionych w zakładach karnych, a także programy postrehabilitacyjne. W przypadku braku ww. placówki na danym terenie istnieje możliwość skorzystania ze świadczeń w poradni zdrowia psychicznego lub poradni/oddziale leczenia uzależnienia od alkoholu w związku z ich znacznie większą dostępnością w porównaniu z placówkami leczenia uzależnienia od narkotyków.

Lecznictwo stacjonarne jest w Polsce najstarszą i najbardziej rozpowszechnioną formą leczenia uzależnień od substancji psychoaktywnych. Ośrodki stacjonarne będące podmiotami leczniczymi prowadzą leczenie, rehabilitację i reintegrację społeczną osób uzależnionych od narkotyków, a za świadczenia te w rozumieniu ustawy o przeciwdziałaniu narkomanii nie pobiera się od osób uzależnionych opłat. Szeroko pojmowana terapia oraz inne świadczenia finansowane są przez Narodowy Fundusz Zdrowia. NFZ reguluje również swoimi przepisami minimalne ilości świadczeń gwarantowanych w placówkach.

Oferowane programy podzielone są na krótko-, średnio- i długoterminowe. Spośród 79 ośrodków prowadzących leczenie stacjonarne, ponad połowa oferowała leczenie długoterminowe trwające od 12 do 24 miesięcy.

Rehabilitacja stacjonarna prowadzona przez ośrodki pozostające w gestii publicznej służby zdrowia oraz organizacji pozarządowych jest w Polsce oparta głównie na modelu społeczności terapeutycznej jako wiodącym narzędziu oddziaływań terapeutycznych. Według informatora "Narkomania – gdzie szukać pomocy", metodę tę stosowało 70 ośrodków, a 59 z nich wskazało ją jako jedyną.

Założenia polskiego modelu społeczności terapeutycznej oraz szkolenia oferowane dla specjalistów nie odbiegają od ogólnie przyjętych, światowych standardów. Przeciwstawiają się one tradycyjnej hospitalizacji, w której pacjent najczęściej czuł się osamotniony i pozbawiony możliwości aktywnego uczestniczenia w procesie zdrowienia.

Kierowanie do ośrodków stacjonarnych lub oddziałów detoksykacyjnych odbywa się za pośrednictwem ambulatoryjnego systemu placówek dla osób używających substancji psychoaktywnych.

Placówki ambulatoryjnego leczenia uzależnień od środków psychoaktywnych prowadzą także programy postrehabilitacyjne skierowane do osób, które ukończyły leczenie stacjonarne.

W Polsce dostępne są specjalistyczne programy lecznicze skierowane do osób uzależnionych od wybranych grup substancji psychoaktywnych. I tak np. osoby uzależnione od opiatów mogą leczyć się w ramach programów leczenia substytucyjnego. Leczenie substytucyjne w Polsce polega na wydawaniu pacjentowi substytucyjnych dawek leku, kontroli abstynencji, badaniu stanu somatycznego i psychicznego pacjenta (okresowo), a także oferowaniu możliwości uczestniczenia w psychoterapii indywidualnej lub grupowej (ok. 2 godz. tygodniowo), konsultacjach pracownika socjalnego oraz poradnictwie dla rodzin. Głównym środkiem substytucyjnym stosowanym w Polsce jest metadon, przy czym coraz częściej wykorzystywana jest również buprenorfina, a ostatnio także Suboxone. W 2012 r. funkcjonowało w Polsce 25 pozawięziennych programów leczenia substytucyjnego, które świadczyły usługi dla 2 057 pacjentów.

W 2012 r. Krajowe Biuro ds. Przeciwdziałania Narkomanii rozpoczęło realizację nowego programu terapeutycznego o nazwie CANDIS. Program został opracowany w Niemczech i zaadaptowany na grunt polski. Jest to krótkoterminowy modułowy program terapeutyczny kierowany do problemowych użytkowników konopi indyjskich.

W celu podniesienia jakości i skuteczności usług terapeutycznych w latach 2004-2009 opracowano w Polsce zbiór standardów leczenia i rehabilitacji osób uzależnionych od narkotyków. W 2007 r. przyjęto ponadto Kodeks Etyki Terapeuty Uzależnień, który stanowi zbiór zasad określający standardy postępowania terapeuty. W ramach podnoszenia jakości świadczeń leczniczych, działa w Polsce system certyfikacji instruktorów i specjalistów terapii uzależnień od narkotyków. Na podstawie ustawy z dnia 29 lipca 2005 r. o przeciwdziałaniu narkomanii mogą oni po ukończeniu szkolenia otrzymać prawo do udzielania świadczeń osobom uzależnionym od narkotyków, szkodliwie używającym oraz ich rodzinom. Dodatkowo w 2012 r. organizowane były szkolenia dla specjalistów z innych grup zawodowych.

Dane zbierane w ramach ogólnoeuropejskiego monitorowania zgłaszalności do leczenia z powodu narkotyków (ang. Treatment Demand Indicator TDI) są w Polsce gromadzone od 2008 r. w ramach projektu pilotażowego, ponieważ nie obejmuje on swoim zasięgiem większości placówek leczniczych w kraju. W związku z rozpoczęciem działania w 2012 r. Sieci Koordynatorów Wojewódzkich TDI KBPN, ponad dwukrotnie zwiększyła się liczba placówek uczestniczących w pilotażu. Koordynatorzy TDI mieli za zadanie nawiązywanie kontaktu z nowymi placówkami, szkolenie osób zajmujących się zbieraniem i raportowaniem danych do Centrum Informacji o Narkotykach i Narkomanii Krajowego Biura, jak również wsparcie merytoryczne dotyczące TDI. W 2012 r. do CINN KBPN informacje o pacjentach przesłało 59 ośrodków leczenia uzależnień od narkotyków. Wyniki monitorowania zgłaszalności do leczenia z powodu narkotyków wskazują, że łącznie w 2012 r. do placówek objętych pilotażem zgłosiły się 2 833 osoby, z czego 1 171 stanowili pacjenci, którzy podjęli leczenie po raz pierwszy w życiu. Ogółem chęć rozpoczęcia leczenia wyraziło 2 256 mężczyzn oraz 577 kobiet. Wśród pacjentów zgłaszających się do leczenia po raz pierwszy wartości te wynosiły odpowiednio 915 i 256. Z powodu

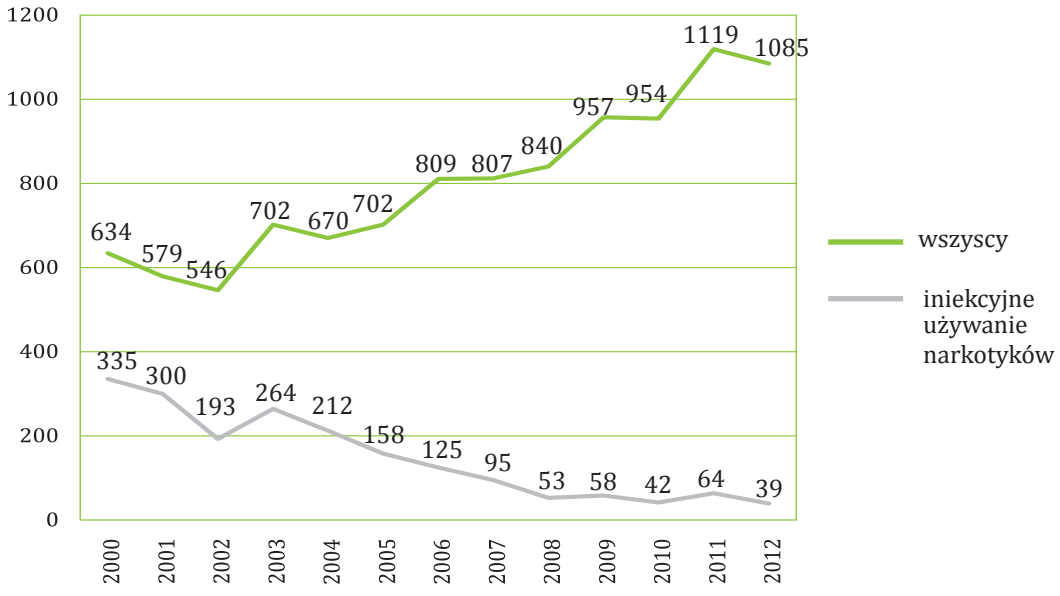
problemowego używania narkotyków w 2012 r. najczęściej zgłaszały się osoby w wieku od 15 do 19 lat. Dane wskazują także na trend spadkowy dotyczący iniekcyjnego używania narkotyków. W 2010 r. połowa pacjentów placówek lecznictwa uzależnienia od narkotyków nigdy nie używała narkotyków dożylnie. W 2012 r. udział ten wzrósł do dwóch trzecich. Dane dotyczące pacjentów pierwszorazowych pokazują, że niemal połowa wszystkich przyjętych w 2012 r. to osoby zgłaszające się do leczenia z powodu problemów z używaniem konopi indyjskich. Co trzeci pacjent w 2012 r. nadużywał amfetaminy, a co dziesiąty opioidów. W systemie TDI obserwuje się wyraźny spadek odsetka pacjentów pierwszorazowych zgłaszających się do leczenia w związku z używaniem opioidów.

Choroby zakaźne związane z narkotykami

Informacje ogólnopolskie dotyczące zakażeń HIV oraz zachorowań na AIDS powiązanych z iniekcyjnym używaniem narkotyków otrzymywane są w ramach systemu zbiorczego zgłaszania zachorowań na choroby zakaźne. W systemie klinicyści i laboratoria zgłaszają nowe przypadki zakażeń do Wojewódzkich Stacji Sanitarno-Epidemiologicznych (SANEPID). Raporty są następnie przesyłane do Narodowego Instytutu Zdrowia Publicznego – Państwowego Zakładu Higieny. Od 1985 r., czyli momentu wprowadzenia rutynowego systemu nadzoru epidemiologicznego nad HIV/AIDS w Polsce, do końca 2012 r. (dane zaraportowane do 30 czerwca 2013 r.) zarejestrowano 16 562 przypadki zakażeń HIV. Wśród nich 5 970 (36%) stanowiły osoby używające narkotyków w iniekcjach, w tym 4 472 (75%) mężczyzn oraz 1 442 (24%) kobiety (w przypadku 56 zgłoszeń brakuje informacji o płci). Analizując powyższy okres monitorowania pod względem zachorowań na AIDS, zarejestrowano 2 907 przypadków. Wśród nich 1 412 (49%) dotyczy osób używających narkotyków drogą dożylną, w tym 1 109 (79%) mężczyzn oraz 303 (21%) kobiety.

Analiza zakażeń HIV wśród iniekcyjnych użytkowników narkotyków w latach 2000-2012 wskazuje na ogólny trend spadkowy i jego stabilizację w ostatnich latach.

Wykres 2. Liczba nowych zakażeń HIV, w tym wśród iniekcyjnych użytkowników narkotyków w latach 2000-2012 (wg daty rozpoznania)



Źródło: Narodowy Instytut Zdrowia Publicznego - Państwowy Zakład Higieny (Zakład Epidemiologii)

Dane na temat zakażeń HIV wśród iniekcyjnych użytkowników narkotyków są również dostępne bezpośrednio z sieci punktów konsultacyjno-diagnostycznych (PKD), które wykonują anonimowo i bezpłatnie testy w kierunku HIV, a także oferują poradnictwo okołotestowe. PKD są koordynowane i współfinansowane przez Krajowe Centrum ds. AIDS, a prowadzone przez organizacje pozarządowe ściśle współpracujące z podmiotami leczniczymi. Dominującą drogą zakażenia wśród klientów PKD są kontakty seksualne. Przyjmowanie narkotyków w iniekcji jako droga zakażenia z roku na rok ulega zmniejszeniu i w 2012 r. w ten sposób zakaziło się jedynie 1% badanych. Jednak biorąc pod uwagę zarówno przyjmowanie narkotyków drogą iniekcji, jak i ryzykowne kontakty seksualne, to współczynnik ten w 2012 r. wynosił 10,9%.

Zgony związane z używaniem narkotyków

Do najbardziej dramatycznych konsekwencji używania narkotyków należą zgony z powodu przedawkowania. Głównym źródłem informacji na ten temat w Polsce jest rejestr prowadzony przez Główny Urząd Statystyczny. Przypadki zgonów zostały wyselekcjonowane według krajowej definicji, która obejmuje następujące kody klasyfikacji ICD-10: F11-12, F14-16, F19, X42, X44, X62, X64, Y12 i Y14.

Analiza najnowszych danych za rok 2011 wskazuje na nieznaczny wzrost zgonów do 285 przypadków (z 261 w 2010). W 2011 r. średni wiek osoby zmarłej wskutek przedawkowania narkotyków wynosił 37 lat (Malczewski, 2013j). Spośród 285 przypadków śmiertelnych, większość (70%) stanowili mężczyźni. Większość przedawkowań na przestrzeni wszystkich lat odnotowuje się u mężczyzn. Sytuacja dotycząca zgonów różni się pomiędzy województwami. W liczbach bezwzględnych najwięcej zgonów wystąpiło w 2011 r. w województwie mazowieckim (110), śląskim (29) i lubelskim (16). Śmiertelne przypadki w województwie mazowieckim stanowią 39% wszystkich przypadków w Polsce z dominacją Warszawy. W celu porównania sytuacji pomiędzy województwami dane z województw zostały przeliczone na 100 tysięcy mieszkańców. W 2011 r. najwyższą wartość wskaźnika zgonów odnotowano w województwie mazowieckim 2,08 osoby na 100 tysięcy mieszkańców (1,96 w 2010 r.), a najniższy w województwie opolskim 0,20 (0 w 2010 r.) i lubuskim 0,20 (0,59 w 2010 r.). W czołówce województw z wysokimi wskaźnikami było w 2011 r. województwo podlaskie 0,89 (0,67 w 2010 r.). W województwach mazowieckim, świętokrzyskim oraz lubelskim corocznie od 2009 r. wzrastał wskaźnik zgonów z powodu narkotyków.

Działania zaradcze wobec konsekwencji zdrowotnych

Potrzeba zwiększenia dostępności do programów redukcji ryzyka kierowanych do okazjonalnych użytkowników narkotyków, programów redukcji szkód zdrowotnych kierowanych do osób uzależnionych i niezmotywowanych do zmiany zachowania, jak też programów leczenia chorób zakaźnych została wskazana między innymi w Krajowym Programie Przeciwdziałania Narkomanii na lata 2011-2016.

W Polsce programy redukcji szkód od samego początku realizowane były przede wszystkim przez organizacje pozarządowe na terenie dużych miast, na ulicach, w noclegowniach dla bezdomnych, w miejscach spotkań osób uzależnionych (meliny, dworce kolejowe, ulica, parki) oraz w miejscach sprzedaży usług seksualnych. W 2012 r., podobnie jak w 2011 r., Krajowe Biuro dofinansowało na terenie całego kraju łącznie 12 programów redukcji szkód zdrowotnych i społecznych dla osób uzależnionych od substancji psychoaktywnych, niezmotywowanych do leczenia, w tym również w zakładach karnych i aresztach śledczych (jednak bez wymiany sprzętu do iniekcji, gdyż jest to zabronione), a także w szpitalu zakaźnym – w oddziale przeznaczonym dla osób uzależnionych od narkotyków i żyjących z HIV/AIDS.

Analizując działania z zakresu redukcji szkód i poziom ich wspierania przez jednostki samorządu terytorialnego, należy odnotować zmniejszenie się zjawiska używania narkotyków w iniekcjach,

w tym używania opiatów, jak również zanik otwartych scen narkotykowych, które są obszarem działania dla programów ulicznej wymiany igieł i strzykawek. Dlatego też odnotowana niewielka liczba gmin jak i województw wspierających programy redukcji szkód może wynikać między innymi ze zmniejszania się liczby grup odbiorców dla tego typu programów.

Inną formą działań mających na celu zapobieganie konsekwencjom zdrowotnym związanym z używaniem substancji psychoaktywnych są programy ograniczania ryzyka szkód zdrowotnych realizowane zazwyczaj w formie tzw. „party workingu". Potrzeba tworzenia kolejnych tego typu projektów wynika przede wszystkim z obserwowanych zmian na rynku narkotykowym – popularności nowych substancji psychoaktywnych, często tzw. „imprezowych", przyjmowanych nieiniekcyjnie. Jednym z celów tychże projektów, realizowanych w pubach, klubach, na dyskotekach czy imprezach masowych jest zapobieganie przedawkowaniom spowodowanym narkotykami, ryzykownym zachowaniom (kontakty seksualne bez zabezpieczenia, niebezpieczne łączenie poszczególnych substancji, prowadzenie pojazdów mechanicznych pod wpływem środków zmieniających świadomość), a także przechodzeniu z używania okazjonalnego na nadużywanie czy uzależnienie.

W Polsce wszyscy obywatele, także osoby uzależnione od narkotyków i jednocześnie nieubezpieczone mają możliwość wykonania bezpłatnego testu w kierunku zakażenia HIV. Placówki testujące mają w Polsce obowiązek udzielania poradnictwa przed i po wykonaniu powyższych testów.

W 2012 r. NFZ finansował działania mające na celu zwiększenie dostępności do programów zapobiegania chorobom zakaźnym wśród osób używających narkotyków. Obejmowały one kontraktowanie świadczeń w specjalistycznych placówkach testowania w kierunku HIV i HCV oraz szczepienia przeciw HBV. W finansowanie programów testowania w kierunku HIV włączają się także Urzędy Marszałkowskie.

W 2012 r. program leczenia ARV realizowany był w 21 szpitalach, na bazie których działają ośrodki referencyjne leczące zakażonych HIV i chorych na AIDS w Polsce. Programem objęte były również kobiety ciężarne zakażone HIV oraz noworodki urodzone przez matki zakażone HIV, zgodnie z obowiązującymi w tym zakresie standardami. Leczenie antyretrowirusowe było również prowadzone w zakładach penitencjarnych jako kontynuacja leczenia pacjentów przed umieszczeniem ich w zakładzie penitencjarnym lub pacjentów wymagających włączenia do terapii w trakcie odbywania kary pozbawienia wolności.

W ramach 12 programów wymiany igieł i strzykawek funkcjonujących w 2012 r., około 1500 klientów otrzymało 145 466 igieł i 99 289 strzykawek. Zebrano łącznie 87 435 igieł i 63 363 strzykawki.

Korelaty społeczne i readaptacja

W Polsce nie istnieje ujednolicony system zbierania danych na temat używania narkotyków przez osoby bezdomne, bezrobotne czy też przez mniejszości narodowe. Wiadomym natomiast jest, że używanie substancji psychoaktywnych, zwłaszcza opioidów, w znacznym stopniu wpływa na marginalizację społeczną ich użytkowników. Osoby te doświadczają, oprócz szkód zdrowotnych, problemów natury socjalnej i społecznej, np. bezrobocia, bezdomności, braku środków do życia oraz konfliktów z prawem, co znajduje potwierdzenie w wielu statystykach i badaniach. Wyniki badania Instytutu Psychiatrii i Neurologii z 2012 r. pt.: „Koszty ponoszone przez konsumentów narkotyków. Badanie w sześciu miastach europejskich" jednoznacznie wskazują, że opioidy są narkotykiem najbardziej sprzyjającym marginalizacji. Niewystarczająca wiedza na temat możliwości i sposobów skorzystania z pomocy socjalnej oraz obowiązujących przepisów prawa w tym zakresie, powoduje, że osoby uzależnione niechętnie zgłaszają się z prośbą o pomoc do placówek świadczących tego typu usługi. Powyższa sytuacja przyczynia się w jeszcze większym stopniu do pogłębiania szeroko rozumianego wykluczenia społecznego tych osób. W 2012 r. na terenie całego kraju ośrodki pomocy społecznej

udzieliły pomocy z powodu narkomanii 3 373 rodzinom; w tym 404 żyjącym na wsi. Pomocy udzielono łącznie 5 208 osobom, w tym współuzależnionym.

W 2012 r. Krajowe Biuro ds. Przeciwdziałania Narkomanii dofinansowało 4 programy redukcji ryzyka/szkód zdrowotnych wśród osób używających narkotyków i jednocześnie świadczących usługi seksualne, 2 programy noclegowni dla osób uzależnionych od narkotyków, programy postrehabilitacyjne w 9 hostelach i mieszkaniach readaptacyjnych oraz programy profilaktyki nawrotów w placówkach stacjonarnych i ambulatoryjnych prowadzonych przez 20 organizacji pozarządowych.

W celu aktywizacji zawodowej, osoby po ukończonym procesie terapii często uczestniczą również w kursach zawodowych. W roku sprawozdawczym ze środków Krajowego Biura ds. Przeciwdziałania Narkomanii podjęto działania zmierzające do podniesienia szans na rynku pracy dla 81 odbiorców programów post-rehabilitacji i reintegracji społecznej. Jednakże, podobnie jak w latach poprzednich, w 2012 r. zaangażowanie samorządów lokalnych w finansowanie hosteli i mieszkań readaptacyjnych było niewystarczające.

Przestępczość narkotykowa, zapobieganie przestępczości narkotykowej i więziennictwo

Uwzględniając znaczne potrzeby w zakresie profilaktyki i terapii uzależnień wśród osób przebywających w izolacji więziennej, Biuro Penitencjarne Centralnego Zarządu Służby Więziennej przygotowało i wdrożyło do systemu polskiego więziennictwa program krótkiej interwencji wobec skazanych nadużywających substancji psychoaktywnych. Krótkie interwencje to praktyki, które mają na celu zbadanie potencjalnego problemu oraz zmotywowanie osoby do zmiany dotychczasowego destrukcyjnego wzorca zachowań, związanego z nadużywaniem substancji. W 2012 r. programem krótkich interwencji objęto ogółem 4 556 osadzonych, w tym 455 osób z problemem narkotykowym. Należy odnotować, że program ten w niedługim czasie od jego wprowadzenia zyskał bardzo szeroki zasięg (w roku 2012 krótkie interwencje były już prowadzone w 132 spośród 156 polskich jednostek penitencjarnych).

Ponadto w ramach systemu penitencjarnego realizowano programy psychokorekcyjne dla skazanych z art. 178A kodeksu karnego, tj. za prowadzenie pojazdów mechanicznych pod wpływem substancji psychoaktywnych. W 2012 r. zrealizowano łącznie 571 grup dla 6972 osadzonych. Zapewniono także możliwość działalności na terenie jednostek penitencjarnych grup samopomocowych osób uzależnionych, w tym w zakresie narkomanii (Anonimowi Narkomani). W 2012 r. na terenie jednostek działało 25 tego typu grup, z których skorzystało łącznie ok. 500 osadzonych.

Terapię nastawioną na abstynencję od substancji psychoaktywnych realizowano w 15 oddziałach terapeutycznych (programy 6-miesięczne). W ten sposób leczono łącznie 1493 osoby. Ponadto w 2012 r. podobnie jak w 2011, w 22 oddziałach terapeutycznych dla skazanych z niepsychotycznymi zaburzeniami psychicznymi lub upośledzonych umysłowo leczyło się 279 pacjentów z podwójnym rozpoznaniem (zaburzenia psychiczne i uzależnienie od substancji psychoaktywnych innych niż alkohol).

W 2012 r. realizowano 7 programów substytucji przy użyciu metadonu w 23 jednostkach organizacyjnych Służby Więziennej. W powyższych 23 jednostkach penitencjarnych leczyło się łącznie 143 pacjentów.

W porównaniu do lat ubiegłych, nastąpił dalszy spadek liczby skazanych skierowanych na terapię przez sąd (o 4,4%). Trudno jednoznacznie ustalić przyczyny, z powodu których sądy coraz rzadziej orzekają system terapeutyczny w odniesieniu do skazanych uzależnionych od narkotyków – w ciągu ostatnich dwóch lat łączny spadek liczby takich orzeczeń wyniósł ok. 20%. Jedną z przyczyn może być brak wiedzy sądu o uzależnieniu skazanego, potwierdzonej opinią kompetentnego specjalisty. Niezależnie jednak od tego skazany, który wymaga terapii w związku z uzależnieniem, trafi do odpowiedniego oddziału skierowany tam decyzją komisji penitencjarnej na wniosek więziennego psychologa.

W polskich zakładach karnych nie prowadzi się typowych programów redukcji szkód zdrowotnych z wymianą igieł i strzykawek. Oficjalnie w polskich zakładach karnych nie ma dostępu do narkotyków i w związku z tym nie ma dostępu do sprzętu iniekcyjnego. Z drugiej jednak strony działają organizacje pozarządowe, które za zgodą zarządów jednostek penitencjarnych mają wstęp do zakładów karnych i prowadzą tam programy redukcji szkód zdrowotnych o charakterze edukacyjnym dla osób używających substancji psychoaktywnych. W 2012 r. Krajowe Biuro ds. Przeciwdziałania Narkomanii dofinansowało 2 takie programy.

W polskich zakładach karnych wszyscy osadzeni wymagający leczenia chorób zakaźnych objęci są terapią antyretrowirusową, bez względu na to czy używali narkotyków, czy nie. W jednostkach penitencjarnych w roku 2012 leczeniem antyretrowirusowym objęto 236 osób.

Osoby uzależnione od substancji psychoaktywnych uczestniczą również we wspólnych programach aktywizacji zawodowej wraz z innymi więźniami. Wiadomo jednak, że większość więźniów, która kończy terapię obejmowana jest programami readaptacji społecznej i, że wśród odbiorców programów readaptacji jest sporo osób po ukończonym procesie terapeutycznym. W readaptacji społecznej osób pozbawionych wolności niezastąpioną rolę odgrywa pomoc postpenitencjarna. Ok. 60% ogólnych kosztów tej pomocy przeznacza się każdego roku na formy aktywne, tj. realizację zadań podnoszących efektywność readaptacji społecznej osób opuszczających zakłady karne. Z powyższych środków sfinansowano specjalistyczne programy resocjalizujące mające na celu podnoszenie kultury prawnej wśród skazanych, promocję zatrudnienia, aktywizację zawodową, profilaktykę różnych problemów społecznych (np. agresja, przemoc, przemoc domowa) oraz rozmaite programy interwencji psychologicznej (np. uczące umiejętności społecznych albo poznawczych).

Ponadto więziennictwo wykorzystuje środki z funduszy strukturalnych Unii Europejskiej, realizując programy mające ułatwić osobom pozbawionym wolności płynny powrót do społeczeństwa. Ukształtowana sieć szkół przywięziennych, jaką dysponuje więziennictwo, zapewnia możliwość kształcenia zarówno skazanym nieletnim, którzy objęci są nauczaniem obowiązkowym, jak i tym, którzy z własnej inicjatywy ubiegają się o podjęcie nauki. W roku szkolnym 2012/13, podobnie jak w latach wcześniejszych, osadzeni pobierali naukę w formach szkolnych i pozaszkolnych zarówno w szkołach funkcjonujących w zakładach karnych, jak również w szkołach różnego typu poza ich obrębem. Nauczaniem objętych było łącznie ponad 14 tysięcy osadzonych, co oznacza, że co szósty osadzony uczył się. W szkołach funkcjonujących na terenie jednostek penitencjarnych w omawianym roku szkolnym objętych było nauczaniem 3 976 słuchaczy. Uzupełnieniem oferty edukacyjnej dla osób pozbawionych wolności są dostosowane do potrzeb lokalnego rynku pracy szkolenia i kursy organizowane przez jednostki penitencjarne. Organizuje się je przede wszystkim dla skazanych kończących odbywanie kary, aby zwiększyć ich szanse na podjęcie pracy zarobkowej po opuszczeniu zakładu karnego i wpłynąć tym samym na ograniczenie powrotu do przestępstwa. W 910 szkoleniach, jakie zorganizowano w 2012 r., wzięło udział 10 675 osadzonych – szkolenia ukończyło 10 481 osadzonych.

Ponadto każdego roku więziennictwo realizuje szereg programów resocjalizacyjnych, które mają na celu zmniejszenie zjawiska recydywy przestępczości.

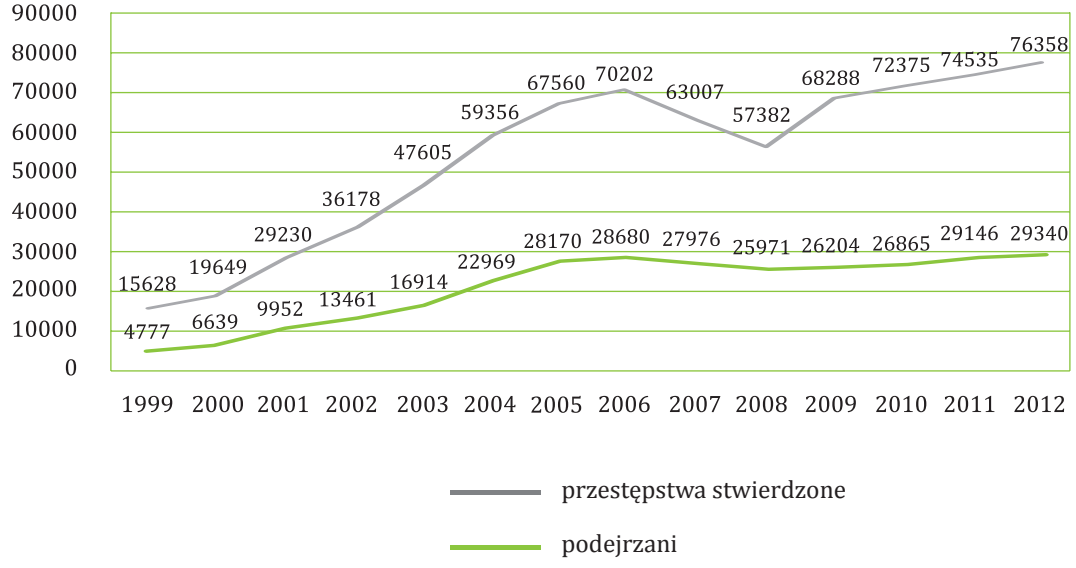
W Polsce przestępstwa związane z narkotykami dzielimy na dwie zasadnicze grupy:

- pospolite przestępstwa kryminalne opisane w kodeksie karnym i innych ustawach karnych (np. rozboje, kradzieże, w tym także z włamaniem, fałszerstwa),
- przestępstwa określone w ustawie o przeciwdziałaniu narkomanii z 1997 r. oraz 2005 r. polegające np. na nielegalnej produkcji, przemycie, udzielaniu, wprowadzaniu do obrotu, posiadaniu środków odurzających i psychotropowych, a także prowadzeniu niedozwolonych upraw roślin, służących do produkcji narkotyków.

Policyjne dane dotyczące przestępstw narkotykowych rejestrowane są w bazie policyjno-prokuratorskiej TEMIDA, która odnotowuje przypadki łamania ustawy o przeciwdziałaniu narkomanii z 2005 r. Podstawowymi jednostkami statystycznymi, jakimi posługuje się Policja są podejrzani,

postępowania wszczęte i zakończone oraz przestępstwa stwierdzone. Dane zawarte na wykresie 3 przedstawiają przestępstwa stwierdzone z ustawy o przeciwdziałaniu narkomanii z ponad 10 lat. W 2012 r. odnotowano rekordową ich liczbę – 76 358. Najwięcej czynów karalnych zarejestrowano z artykułu 62 dotyczącego posiadania narkotyków: 37 540 (49% wszystkich przestępstw). W porównaniu do roku poprzedniego nastąpił wzrost o 2%. Drugim w kolejności artykułem, którego łamanie stwierdzono, jest udzielanie narkotyków w celu korzyści (art. 59) – są to czyny karalne dotyczące handlu narkotykami. W 2012 r. Policja stwierdziła 18 706 takich przestępstw, co oznacza, że co czwarte przestępstwo odnotowano z artykułu 59. W ciągu ostatnich dwóch lat liczba tego typu przestępstw wzrastała o ok. 2%. Biorąc pod uwagę substancję, która była powodem przestępczości, najwięcej przestępstw dotyczyło przetworów konopi, czyli przeważnie marihuany, ale również haszyszu. Stanowiły one 70% wszystkich przestępstw w 2011 r., a w 2012 r. już 78%. Prawie co piąte przestępstwo zostało popełnione w 2011 r. z powodu amfetaminy (19%), a rok później co szóste (17%). Przestępstwa z powodu opiatów stanowią niewielki procent wszystkich spraw, w 2011 r. niecałe 2%, a w 2012 r. 1,5%. Na zwiększenie liczby przestępstw z powodu marihuany ma wpływ rozwój krajowych upraw konopi indyjskich. W 2012 r. zabezpieczono w Polsce 61 585 roślin konopi indyjskich. Policja zlikwidowała 1314 upraw, z tego 48% to były uprawy zewnętrzne („outdoor"). Warto jednak zaznaczyć, że coraz bardziej popularne stają się uprawy wewnętrzne nazywane „indoor". W 2012 r. Policja zatrzymała największą do tej pory liczbę osób podejrzanych (29 340) z ustawy o przeciwdziałaniu narkomanii, co przekłada się na 2,6 przestępstwa stwierdzonego na osobę. Liczba podejrzanych wzrosła o 0,6% w porównaniu do 2011 r.. Najwięcej podejrzanych odnotowano z artykułu 62 (posiadanie narkotyku): 71% wszystkich osób (72% w 2011 r.), z artykułu 58 (udzielanie narkotyku): 7,5% podejrzanych (7% w 2011 r.), a z artykułu 59 (udzielanie w celu korzyści): 10% (11% w 2011 r.). W sumie 88% wszystkich podejrzanych w 2012 r. stanowiły osoby podejrzane z tytułu tych trzech ww. artykułów (Malczewski, 2013h).

Wykres 3. Przestępstwa stwierdzone oraz podejrzani w związku z łamaniem ustawy o przeciwdziałaniu narkomanii z 1997 r. i 2005 r. w latach 1999-2012



Źródło: Komenda Główna Policji

Analizując skalę przestępczości narkotykowej należy uwzględnić także dane dotyczące osób skazanych z ustawy o przeciwdziałaniu narkomanii. Zgodnie z ostatnimi dostępnymi informacjami z Ministerstwa Sprawiedliwości odnotować można, że w 2011 r. nastąpił wzrost liczby osób skazanych z ustawy do 21 049 osób. Jest to największa liczba skazanych odnotowana do tej pory. W strukturze wszystkich skazanych, odsetek skazanych z ustawy o przeciwdziałaniu narkomanii wynosi prawie 5%. Spośród wszystkich skazanych z ustawy o przeciwdziałaniu narkomanii, na karę pozbawienia wolności w zawieszeniu lub bez zawieszenia skazano w 2011 r. 68% z nich (14 437 osób). Oznacza to tendencję spadkową, ponieważ w 2009 r. odsetek ten wyniósł 74%, a w 2010 r. – 72%. Wśród tych osób nie wszyscy otrzymali karę bezwzględnego pozbawienia wolności (bez zawieszenia). Takich osób było w 2011 r. 2 163, co jest najmniejszą wartością w ciągu ostatnich czterech lat. W 2011 r. na karę pozbawienia wolności najwięcej osób skazanych było z artykułu 62 (posiadanie) to jest 7 825 osób (54% wszystkich skazanych).

Nieleglany rynek narkotyków

W Polsce ujawnieniami narkotyków zajmuje się Policja, Służba Celna (usytuowana w Ministerstwie Finansów), Straż Graniczna, Żandarmeria Wojskowa, Agencja Bezpieczeństwa Wewnętrznego oraz Służba Więzienna na terenie jednostek penitencjarnych. Wszystkie powyższe instytucje nie wypracowały jeszcze wspólnego systemu zbierania danych, co utrudnia oszacowanie ilości narkotyków skonfiskowanych na poziomie całego kraju.

W 2012 r. odnotowano wzrost konfiskat marihuany (z 1265 kg do 1489 kg), kokainy (z 78 kg do 213 kg), amfetaminy (z 395 kg do 614 kg), metamfetaminy (z 0,5 kg do 4 kg) i LSD (29173 listki). Nastąpił za to spadek konfiskat haszyszu (z 59 kg do 39 kg) oraz ecstasy (z 75 082 tabletek do 31 092). Dane na temat konfiskat wskazują na wzrost dostępności metamfetaminy na polskim rynku narkotyków. W 2012 r. konfiskaty metamfetaminy były najwyższe od trzech lat. Duża ilość ujawnionej marihuany, a niewielka haszyszu wskazuje na coraz większą rolę krajowych upraw jako źródła zaopatrzenia krajowego rynku.

Od 2008 r. problemowi użytkownicy narkotyków pytani są o cenę ostatniego zakupu narkotyków. Metodologia badania została opisana na stronie 13 raportu. Średnia cena grama marihuany wyniosła w 2012 r. około 31 zł i była ona bardzo zbliżona do najczęściej występującej (30 zł). Średnia cena z ostatniego roku jest zbliżona do wartości z 2008 r., ale w tym samym czasie wzrosła moc (zawartość THC) marihuany na rynku. Amfetamina, podobnie jak marihuana, sprzedawana jest w podobnej cenie do tej z 2008 r. (32 zł w 2008 r. i 34 zł w 2012 r.), jednakże średnia czystość amfetaminy zmniejszyła się w tym czasie. W przypadku obydwu substancji ceny najczęściej występujące (modalne) spadły. Narkotykiem o wiele tańszym jest ecstasy, sprzedawana w postaci tabletek. Obserwujemy wyraźny spadek cen ecstasy w analizowanym okresie z 28 zł do 7 zł. Najdroższym narkotykiem jest kokaina, której gram sprzedawany był najczęściej za 200 zł. Wysoka cena skutecznie ogranicza popyt na tę substancję.

Po wzroście cen z 2010 r., w odniesieniu do większości narkotyków nastąpił powrót do wartości z 2008 r. Koniec 2010 r. i początek 2011 r. charakteryzował spadek dostępności heroiny na rynku i w konsekwencji wzrost jej ceny.

Tabela 1. Zabezpieczenia narkotyków w latach 2003-2012

Narkotyki	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Haszysz (kg)	46,568	41,495	19,292	35,401	33,128	114,681	17,142	85,445	59,139	38,946
Marihuana (kg)	233,164	232,646	227,124	401,659	352,934	492,725	883,053	1501,801	1265,403	1489,240
Heroina (kg)	6,913	255,214	41,151	155,401	123,623	78,915	85,873	24,871	51,359	35,620
Kokaina (kg)	800,558	28,029	16,871	21,932	160,981	28,710	117,491	111,084	78,121	213,391
Amfetamina (kg)	203,299	242,034	344,578	333,038	423,65	356,196	421,65	534,299	394,77	613,733
Metamfetamina (kg)				0,163	5,712	0,124	10,069	1,234	0,517	4,254
Ecstasy (tabletki)	102520	272198	492531	145344	610383	651 985	218616	269842	75082	31092
LSD (listki)	20602	34288	2226	1453	327	353	642	1353	0	29173

Źródło: Centrum Informacji o Narkotykach i Narkomanii na podstawie danych Straży Granicznej oraz KGP.

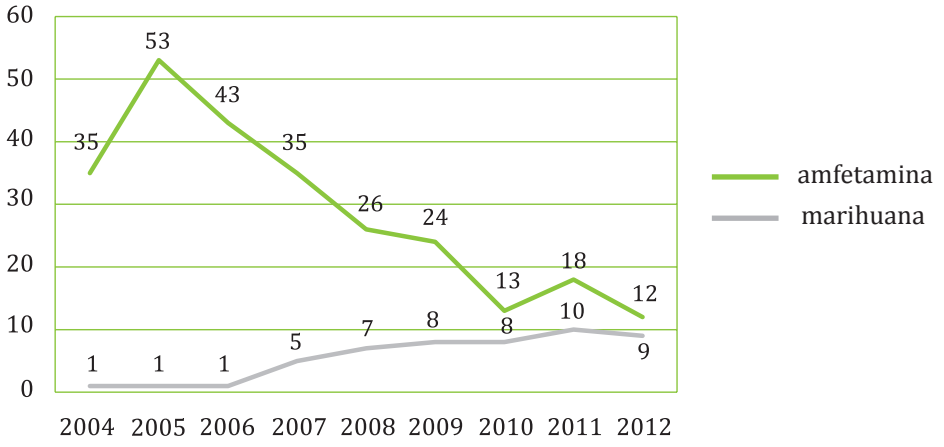
Tabela 2. Ceny narkotyków w zł według informacji od użytkowników narkotyków

	Marihuana (gram)			heroina (gram)			Kokaina (gram)			Amfetamina (gram)			ecstasy (tabletka)		
	2008	2010	2012	2008	2010	2012	2008	2010	2012	2008	2010	2012	2008	2010	2012
Liczba cen	455	171	167	223	64	81	174	42	49	455	250	191	85	46	58
minimalna	15	15	10	95	100	120	100	100	130	15	20	20	5	4	3
maksymalna	55	40	50	350	400	270	300	260	250	55	100	100	30	20	25
modalna	40	30	30	120	160	130	150	200	200	40	40	35	20	5	5
średnia	32	26	31	159	173	152	161	180	182	32	39	34	28	8	7
mediana	-	30	30	-	160	150	-	200	180	-	40	35	-	6	5

Źródło: Centrum Informacji o Narkotykach i Narkomanii KBPN na podstawie wywiadów z użytkownikami narkotyków

W oparciu o dane Policji oraz badania jakościowe przeprowadzone wśród użytkowników narkotyków, wiemy, że czystość narkotyków sprzedawanych na nielegalnym rynku jest znacznie zróżnicowana. Dane otrzymane z Centralnego Laboratorium Kryminalistycznego Policji wskazują na wzrost stężenia THC w marihuanie. Im więcej THC tym „mocniejsza" jest marihuana. W 2007 r. marihuana zawierała 5% THC, gdy w 2012 r. – 9%. Dane na wykresie 4 pokazują na wzrost stężenia THC w marihuanie. W przypadku amfetaminy odnotowujemy odwrotny trend. W 2007 r. średnia czystość amfetaminy oferowanej na nielegalnym rynku wyniosła 35%, podczas gdy w roku 2012 – 12%. Tabletki sprzedawane na rynku jako ecstasy rzadko zawierały typową ecstasy, tylko co czwarta miała w swoim składzie MDMA.

Wykres 4. Czystość amfetaminy oraz zawartość THC w marihuanie w latach 2004-2012 (%)



Źródło: Centralne Laboratorium Kryminalistyczne

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 the lays down the priorities serving both as the National Antidrug Strategy as well as the Action Plan is the National Programme for Counteracting Drug Addiction (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 2012, no significant legal changes were introduced in the field of drugs and drug addiction. However, works were continued on several important legal acts in this matter. Ministries and entities obliged to implement the National Drugs Strategy performed activities in all prevention-related areas planned for 2012. In the first year of the provision in force, prosecutors discontinued a total of 2 145 proceedings. Ministry of Justice embarked on an initial evaluation of the enforcement of the 2011 modification of Article 62a of the Act on counteracting drug addiction concerning the more liberal approach to drug possession.

The first was the draft Regulation of the Minister of Health on the scope and framework of cooperation between drug treatment and rehabilitation services and the National Bureau for Drug Prevention. The work on this was held in 2012 and at the beginning of 2013. This act is particularly important in the field of monitoring. It will lay down principles of cooperation in TDI data collection.

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 strategies and action plans; 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. In framework of implementation of local and regional monitoring Focal Point was organized few conferences in Kielce, Wrocław, Warszawa (two) in 2012 and 2013. In framework of implementation of local and regional monitoring Focal Point was organized few conferences in Kielce, Wrocław, Warszawa (two) in 2012 and 2013.

The Council for Scientific Research was established by the order of the Director of the National Bureau for Drug Prevention in 2011. It is an advisory and opinion-making body. The Council is comprised of 7 members, appointed due to their knowledge and experience in addiction-related research. The Council is responsible for initiating research, defining needs and priorities in the field of addictions.

In order to support drug-related research, the National Bureau since 2008 has been holding competitions in the field of drugs. The projects are selected by the Director-appointed commission based on additional reviews. In 2012, the three new projects were financed by way of competition.

General population studies

In 2012, a survey conducted in the course of Gambling Problem Fund research studies into behavioural addictions included questions about the use of psychoactive substances. The survey was carried out by the Public Opinion Research Centre (CBOS) in April 2012 on a nationally representative sample of Polish population aged +15. The aim of the survey was to determine the scale of illegal substance use and to identify trends of illegal drug.

13.7% of the respondents had used drugs in a lifetime. The recent and current use prevalence rates stood at 4.8% and 2.5% respectively. The most popular drug among the respondents was cannabis (lifetime prevalence rate of 12.2%). Over fourfold lower rate was recorded for amphetamine use (2.9%). Slightly more than 1% of the respondents had ever used ecstasy. Similar values were observed for hallucinogens (both hallucinogenic mushrooms - 1% and LSD – 0.8%). In the last 12 months prevalence, 4% of the respondents reported using cannabis and 0.6% had used amphetamine. In the case of the remaining substances, the rates were lower than 0.5%. The last 30 days prevalence rates for cannabis and amphetamine use stand at 1.8% and 0.3% respectively. Men use psychoactive substances more frequently than women and this trend is observed both in experimental and the last 12 months use. Among the respondents, 17.9% of men had ever used cannabis whole the rate in women stood at 7.8%. Similar differences are observed in the case of amphetamine – men (4.5%) use it three times as frequently as women (1.4%). Higher drug use prevalence rates among men were recorded in the case of hallucinogenic substance, cocaine and anabolic steroids. The highest rates were recorded among experimental users aged 25-34. As for recent and current users the rates are the highest in the youngest age cohort: 13.0% and 6.6% respectively.

One of the ways of monitoring drug addiction is the analysis of sewage water. This method serves to estimate the consumption of psychoactive substances through the application of the modern analytical technique of liquid chromatography coupled with mass spectrometry. The aim of the study was to implement the modern method of determination of illicit drugs in wastewater and to estimate on that basis the level of consumption of respective substances by residents of selected cities of Wielkopolska Province. The project was financed by the Marshal Office in Poznan, which was responsible for taking and supplying samples.

The analyses showed that in all of the urban wastewater samples, amphetamine and methamphetamine residues (DTRs) were identified and quantified. It must be noted that the highest concentrations of the abovementioned substances (ng/L) were found in the Wagrowiec sewage treatment plant and the lowest ones in the Kalisz sewage treatment plant. Moreover, in most samples MDMA (ecstasy) was determined, while in case of some samples - the concentration of this compound was below the level of quantification. Some amphetamine-type compounds such as MDA and MDEA and cocaine along with its metabolite were not detected in the analysed samples.

The subject of the research project entitled “Developing self-control over cannabis use and the context of illegality” was financed with the funds of the Information Polish REITOX Focal Point (CINN) of the National Bureau for Drug Prevention under the annual research competition. The researchers analyzed the process of the loss of control over cannabis use and tried to identify and define the emergence of problem drug use. They also identified and defined situations for problem cannabis users which would prompt them to stop using.

To follow histories of cannabis use, the study was based on the biographical method of individual interview. A total of 96 interviews were conducted, including 48 interviews with current and former cannabis users, 40 individual interviews with drug user-related individuals and dealers, 8 focus group interviews with substance abuse therapists at inpatient and outpatient clinics during which the therapists shared their experiences with cannabis users.

The survey participants believe that the term *smoker* brings negative connotations and stigmatizes and its use towards cannabis users is acceptable when cannabis use generates life problems. In

seeking an answer to the question of *who I am?* users compare themselves to other user-smokers, non-users and individuals taking hard drugs. The cannabis illegality issue is trivialized by the users. A lot more importance is attached to the control of quality and amount of the drug consumed, which contributes to the development of a sense that they exercise control over their lives and use. The respondents develop a sense of self-control in various aspects of everyday functioning and its dimensions involve controlling expectations and experiences of cannabis use symptoms, cognitive control of using, controlling through selecting the smoking company, etc.

Prevention

In 2012, the Ministry of National Education and the Centre for Education Development implemented school-based prevention activities aimed at shaping normative beliefs and psychosocial skills which protect children and adolescents against using psychoactive substances. The school year 2012/2013 was announced the Year of Safe School. This project featured the Coalition of governmental agencies and institutions as well as non-governmental organizations acting for the benefit of broadly understood safety of children and adolescents. In order to promote evidence-based drug prevention programmes in schools, the National Bureau for Drug Prevention continued the implementation of the universal drug prevention programme called Unplugged. In order to reduce the use of drugs, alcohol and adolescence-related problems, the National Bureau co-financed the implementation and evaluation of training seminars for the providers of the Family Strengthening Programme. At www.narkomania.gov.pl there was online drug counselling centre which provided assistance and reliable knowledge on drug addiction, drugs and assistance options for problem drug users and co-dependent individuals. Similarly to previous years, the implementation of selective prevention programmes for at-risk groups and risk prevention programmes among occasional drug users such as clubbers was supported. Legal education on the new provisions of the Act on counteracting drug addiction was provided through an online educational game. As in the previous year, the National Bureau for Drug Prevention (KBPN) ordered the implementation of the evidence-based FreD goes net early intervention programme. In order to keep up proper quality of the FreD programme, a seminar for certified providers was held. The KBPN supported the implementation of programmes for families and close relatives of problem drug users as well as indicated drug prevention programmes.

In 2012, the campaign entitled "Drugs? What do I need them for?" was continued. The aim of the campaign was to promote pro-health attitudes and beliefs on the real prevalence of drug use in adolescents. The campaign was conducted mainly online. The National Bureau for Drug Prevention also became a partner in the Safe Games Polska project launched during the European Football Championship 2012. It was an awareness campaign aimed to sensitize football fans to the consequences resulting from engaging in risky behaviour.

In July 2012, the 5-year Swiss-financed project was launched under the Swiss-Polish Cooperation Programme and the Minister of Health. The Programme is intended to reduce psychoactive substance use (alcohol, tobacco and drugs) among women at the procreative age. The Programme will feature an awareness campaign, questionnaire survey among pregnant women, training seminars for medical staff, implementation of a universal prevention programme in secondary schools, an in-house programme and a web portal. The project is being implemented by the Chief Sanitary Inspectorate in partnership with four public health care institutions.

Problem drug use

The nationwide surveys conducted in Poland in 2012 provided data to estimate the number of problem drug users. It was estimated that the overall number of opioid users ranges from 10 444 to

19 794. This calculation shows that the highest number of problem opioid users is recorded in the provinces of mazowieckie (4760), followed by dolnoslaskie (1888) and slaskie (1181). The lowest figures occur in the provinces of opolskie (168), swietokrzyskie (185) and podkarpackie (254). In 2008, the national survey of needle and syringe programme clients was launched. The measurements are taken biennially towards the end of year. Staff at low threshold programmes in Poland (needle and syringe exchange, drop-in centres for active drug users) for two weeks at the turn of November and December held questionnaire interviews with the programme clients. Contacts were made through drug users in order to exchange injecting equipment, give advice, provide support or just talk. Clients of low-threshold programmes were asked about using respective psychoactive substances in the last 30 days prior to survey along with the use pattern.

During the questionnaire interviews the respondents were asked about the use of opioids. In this group the most prevalent substance in 2012 was methadone whose prevalence rate rose from 30% in 2008 to 45% in 2012. The rise in the prevalence of methadone use is the effect of the evolution of NSPs and substitution treatment programmes. During the reported period a fall was recorded in the prevalence of Polish homemade heroin (kompot) from 50% to 20% and heroin from 44% to 30%. In the following measurements 10% (2010) and 12% (2012) of users reported using mephedrone. Moreover, under the category "other substances" 14% of the interviewees reported using NPS drugs and 8% mentioned ephedrine. On the other hand, the results of the survey indicate a fall in the prevalence of heroin use. There was also a drop in the percentage of amphetamine users from 61% to 52% and barbiturates from 23% to 5%. The highest number of the survey participants reported using alcohol. Two thirds had been drinking in the last 30 days prior to survey and this percentage increased by 15 percentage points compared to 2008. A sharp increase of 50% must also be noted in the case of benzodiazepines (60% used benzodiazepines in 2012). Minor percentages of the respondents reported using hallucinogens. The most problematic substance according to the respondents was opioids (40%) followed by amphetamine (18%) and then NPS (15%). Alcohol was reported by 14% of the survey participants. Benzodiazepines, whose use was reported by over a half of the respondents, was considered most problematic by 2%. 5% of the respondents were unable to determine the most problematic substance. Based on data from the survey number of injecting drug users was conducted.

The estimate, based on data from this survey and TDI, shows that the number of injecting drug users ranges from 4 307 to 10 034 with the mean of approx. 7 170. The above estimate is of preliminary nature as it is based on the 2011 drug treatment data and it should included the 2012 data, which are not available yet.

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 2011 (the latest data available) 14 150 patients were admitted to residential treatment due to problems related with use of psychoactive substances, which is a slight fall compared to 2010. In 2011, similarly to previous years, male patients constituted the vast majority in residential drug treatment units (73.8%). Opioid users were accounted for 7.8% of all admissions to drug treatment. 13% of the patients reported to residential treatment due to problems related to the use of 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 71.7% of patients fall within the category 'mixed and other' (Code F19).

Up to 2005, the percentage of patients with dual diagnosis in the total number of patients admitted to residential drug treatment due to drug abuse was on the rise and reached the rate of 7.6% in 2005. After 2006 the upward trend was 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 7.4-7.9% ever since.

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, 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 information booklet: "Drug addiction – where to seek help?", 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. Drug treatment, rehabilitation and reintegration services are free of charge, regardless of the patient's place of residence.

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 abuse 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. In 2012, the National Bureau started the implementation of a new therapeutic programme called CANDIS. The programme was developed in Germany and adapted to the Polish conditions. It is a short-term modular therapy programme for problem cannabis users. Moreover, opioid-dependent individuals may receive treatment under opioid replacement therapy. 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 by a social worker, family counselling. The main substitute drug administered in Poland is methadone; however, buprenorphine and Suboxone are becoming widely used. In 2012, there were 25 non-prison substitution treatment programmes across Poland which provided services for 2 057 patients.

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. Moreover, also other trainings for specialist from different groups (not only for drug therapy instructors/specialists) were provided in 2012.

Data on drug treatment in Poland have been collected under the European Drug Treatment Demand monitoring system since 2008. Similarly to previous years, in 2013 the system of collecting data on patients reporting to drug treatment facilities was operating in Poland as a pilot project as it did not cover the majority of the facilities in the country. In 2012 the Polish Focal Point (CINN KBPN) received information from 59 drug treatment centre.

Following the establishment of the TDI KBPN Provincial Coordinators Network the number of participant facilities increased over twofold. 2 833 individuals reported to treatment, including 1 171 first-timers. In total, 2 256 men and 577 women expressed willingness to enter drug treatment. In first-time patients these numbers were 915 and 256 respectively. The TDI coordinators were responsible for contacting new facilities, training data collection and CINN reporting staff as well as providing technical TDI-related support. In 2012 individuals aged 15-19 most frequently reported to treatment due to problem drug use.

Data show a downward trend concerning the percentage of injecting drug users. In 2010, half of drug treatment patients had never injected drugs. In 2012, this number rose to two thirds.

Data regarding first-time patients show that the highest number reported due to cannabis use (nearly half of all admissions). Every third patient abused amphetamines and every tenth opioids. There is a clear fall in the percentage of opioid-related TDI first-time patients.

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 2006-2012 indicates a downward trend, which levelled off in more recent years.

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. HIV infections recorded with reference to injecting drug use is falling every year and in 2012 only 1% of the clients got infected in this manner. However, combining both injecting drug use and risky sexual behaviour the rate reached 10.9% in 2012.

Drug-relatd 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 2011, we notice a slight increase to 285 cases. In 2011, the average age of drug-related death was 37. Out of 285 deaths, most cases (70%) were male. Throughout all the years, most fatal drug overdoses were recorded in men.

Responses to health correlates and consequences

The need to increase the availability of harm reduction programmes for occasional drug users, drug-dependent individuals, unmotivated for change as well as programmes infectious disease treatment programmes was specifically defined for example in the National Drug Strategy 2011-2016.

In Poland, harm reduction programmes since the beginning have been implemented mainly by non-governmental organizations in large cities, street, night shelters for the homeless, meeting spots of drug abusers (dealer's dens, train stations, parks) and sex service settings. Similarly to 2011, in 2012 the National Bureau co-financed 12 harm reduction programmes across Poland for drug-dependent individuals unmotivated for treatment, including inmates in correctional facilities and remand centres (however without needle and syringe exchange as it is prohibited) and in an infectious diseases hospital, in a ward for drug abusers and HIV/AIDS patients. The abovementioned programmes included 2 778 participants. 136 000 needles and 98 203 syringes were distributed.

The analysis of harm reduction activities and the level at which they are supported, one must notice a downward trend in injecting drug use, including opioids as well as open drug scenes, where street syringe and needle exchange programmes are provided. That is why, the low number of communes and provinces which support harm reduction programme might be related to the fact that the number of participants of such programmes has gone down.

Another form of drug prevention are outreach-based harm reduction programmes. The need to create such projects is mostly necessitated by the changes observed on the illegal market for some time namely the prevalence of new psychoactive substances, often referred to as party drugs. They are used in the non-injecting manner. 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, and driving mechanical vehicles under the influence of psychoactive substances) as well as moving from occasional use to abuse or dependence.

All Polish citizens, including uninsured drug addicts, have the option of undergoing a free HIV test. Testing sites in Poland are obliged to offer counselling before and after the test.

In 2012, the National Health Fund activities aimed to improve the availability of drug-related infectious disease prevention programmes included financing HBV vaccinations and HCV and HIV tests done at specialist sites. Marshal Offices also participate in the financing.

In 2012, ARV treatment for HIV/AIDS patients was provided at 21 hospital-based referral centres. The ARV programmes also covered HIV-positive pregnant women and newborn children, according to the existing standards. The ARV treatment was also provided at correctional facilities. Inmates continued treatment which they had started before they had been sent to prison or they started treatment while in prison.

Under 12 needles and syringes programmes in 2012, 145 466 needles and 99 289 syringes were distributed among around 1600 clients. 87 435 needles and 63 363 syringes were collected.

Social correlates and social reintegration

In Poland, there is no single data collection system on drug users who are homeless, unemployed or come from ethnic minorities. But it is known that 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 which 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 2012, social welfare centres across Poland provided drug-related assistance for 3 373 families; including 404 in rural areas. The assistance was provided for 5 208 clients, including co-dependent individuals.

In 2012, the National Bureau for Drug Prevention i.a. co-financed 4 harm/risk reduction programmes for prostitute drug users, 2 night shelter programmes, reintegration programmes in 9 hostels and re-entry flats, relapse prevention programmes in inpatient and outpatient facilities conducted by 20 non governmental organizations.

Therapy graduates often take part in vocational courses in order to increase their job opportunities. In the reporting year, the National Bureau for Drug Prevention made efforts to increase job opportunities of 81 participants of post-rehabilitation and social reintegration programmes.

However, in the case of reintegration hostels and flats the involvement of local government funding in 2012, similarly to previous years, was still insufficient.

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

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 assess a problem and motivate an inmate to change the existing destructive behavioural pattern related to substance abuse. In 2012, 4 556 inmates participated in short-term interventions, including 455 problem drug users. It must be noted that this programme became widespread in no time. In 2012, short-term interventions were conducted in 132 out of 156 Polish correctional institutions.

In addition, psycho-correctional programmes were implemented for inmates sentenced under Article 178A - of the Penal Code i.e. driving mechanical vehicles under the influence of psychoactive substances. In 2012, 571 group sessions were conducted for the total number of 6 972 inmates

Self-help groups for dependent individuals, including drug addicts (Narcotics Anonymous) were provided with an opportunity to operate in correctional facilities. In 2012, 25 such groups were active. Approx. 500 inmates benefited from this sort of assistance.

Abstinence-based programmes included 1 493 inmates in 15 therapeutic wards (6-month programmes).

Moreover, in 2012, similarly to 2011, in 22 therapeutic wards for inmates with non-psychotic mental disorders or mentally disabled ones, there were 279 patients with dual diagnosis (mental disorders and addiction to psychoactive substances other than alcohol).

In 2012, 7 methadone-based substitution treatment programmes were also implemented in 23 organizational units of Prison Service. 143 patients were treated in the 23 correctional facilities.

Compared to previous years, there was a further fall in the number of inmates referred to therapy by the court order (by 4.4%). It is hard to clearly state why courts are ceasing to refer convicts to drug therapy. In the last two years, the total decrease of such orders stood at approx. 20%. One of the reasons might be the court's lack of awareness that a convict is addicted as confirmed by a competent specialist. Regardless of this fact it also seems likely that judges are aware that even if they fail to decide that an addicted convict should be sent to a prison therapeutic ward, then he or she will be sent there by the penitentiary commission upon request of a prison counsellor.

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 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 2012, the National Bureau co-financed 2 such programmes.

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 2012, the ARV treatment was provided for 236 inmates.

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. However, 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. Approx. 60% of the overall costs of the assistance are earmarked each year for the implementation of active forms i.e. improving the effectiveness of social reintegration of inmates upon release from prison. The abovementioned resources were used to conduct specialist social rehabilitation programmes intended to improve legal competence of inmates, promote employment, vocational activity, drug prevention and treatment. There were programmes concerned with prevention of various social problems (e.g. aggression, (domestic, violence) and psychological interventions (e.g. teaching social or cognitive skills).

Moreover, prisons obtain EU structural funds and implement programmes which are expected to help inmates re-enter society smoothly. The established network of prison schools provides inmates, including minors under statutory obligation to learn, with an opportunity to pursue education. In school year 2012/13, similarly to previous years, inmates were provided with education opportunities in school operating within and outside prisons. 14 thousand students received schooling, which means that every sixth inmate was in some sort of training. In this period, prison schools were attended by 3 976 students. Education for prison inmates was also complemented by local market needs-adapted training courses conducted at correctional facilities. Such courses are mainly organized for inmates finishing their sentences in order to increase their chances to find employment upon release from prison and to reduce crime relapse. In 2012, 10 675 inmates took part in 910 training courses. The courses resulted 10 481 graduations.

Each year prison authorities conduct a number of social rehabilitation programmes aimed at reducing recidivism rates.

In 2012, the Police detained the highest number of suspects ever (29 340), which translates into an average of 2.5 recorded crimes per individual. The number of suspects rose by 0.6%. Let us take a look at which articles of the Act on counteracting drug addiction constituted grounds for police arrests in 2012. The highest number of suspects was related to Article 62 (drug possession): 71% (72% in 2011), then came Article 58 (supplying drugs): 7.5% (7% in 2011) and Article 59 (supplying drugs to gain material benefit): 10% (11% in 2011). In total, these three articles accounted for 88% of all suspects in 2012. 15% of the suspects (4 595) were minors, similarly to 2011. The biggest share of minors, similarly to the general population, concerned violations of Articles 62-67. The analysis of the scale of drug-related crime should include data on convictions under the Act of counteracting drug addiction. Analyzing the latest data available it must be noted that in 2011 there was a slight rise to 21 049 in the number of convictions under the Act. It is the highest number of convictions ever noted. Out of all convicts, the percentage of those convicted under the Act stood at nearly 5%. Out of all convictions under the Act on counteracting drug addiction in 2011, 68% were prison sentences (14 437). We deal with a downward trend here as in 2009 this percentage stood at 74% and in 2010 at 72%. Not all convicts were given prison sentences. In 2011, there were 2 163 such individuals, which is the lowest figure in the last four years. Let us take a look at the reasons for prison sentences in 2011 under the Act of 2005. The most sentences were passed under Article 62 (drug 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).

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. In 2012 we record an increase in the seizures of marijuana (from 1265 kg to 1489 kg), cocaine (78 kg to 213 kg), amphetamine (394 kg to 613 kg), methamphetamine (0,5 kg to 4 kg) and LSD (29173 blotters). There was a fall in the seizures of hashish (from 59 kg to 60 kg) and ecstasy tablets (from 75082 tablets to 31092) Seizure data reveal a rise in methamphetamine on the Polish illegal drug market. In 2012, methamphetamine seizures had been the highest for the last three years. High seizures of marijuana with low amounts of hashish prove that the role of domestic cultivation as the source of internal market supply is rising.

Since 2008, problem drug users have been asked about the value of the latest drug purchase. An average price of a gram of marijuana in 2012 stood at PLN 31 and approximated to the modal value of PLN 30. An average last year price approximates to the value of 2008. However, during that time the potency of marijuana (THC concentration) rose. Amphetamine, similarly to marijuana, is sold at a similar price (PLN 32 in 2008 and PLN 34 in 2012) to that of 2008; however, an average purity level of amphetamine in that period decreased. In the case of both of these substances, most frequent (=modal) prices fell. A drug, which is much cheaper, is ecstasy. It is sold in the form of tablets. We notice a clear fall in ecstasy prices in the period in question, from PLN 28 to PLN 7. The most expensive drug remains cocaine. It is usually sold at PLN 200 per gram. A high price of this drug effectively limits its availability. Data from the survey shows that after the 2010 rise, prices of most drugs returned to the level of 2008. The end of 2010 and beginning of 2011 saw a drop in the availability of heroin and the consequent rise in its price.

Part A: New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

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1. Introduction

The basic anti-drug legal act remains the Act of 29 July 2005 on Counteracting Drug Addiction[1]. 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 Polish REITOX Focal Point operating within the National Bureau.

The executives act the lays down the priorities serving both as the National Antidrug Strategy as well as the Action Plan is the National Drug Strategy 2010-2016[2,3]. 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". The existing programme has replaced the National Drug Strategy 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 National Drug Strategy 110 actions were formulated to be implemented by 7 ministries and 22 central level institutions, Provincial Pharmaceutical Inspectorates, provincial and communal governments. The programme implementation by respective ministers or central agencies often meant the involvement of a number of subordinate institutions, which means that the Programme had a massive coverage. The programme was designed to integrate the vast majority if antidrug actions in Poland. The coordinating role in implementing the National Programme is fulfilled by the Council for Counteracting Drug Addiction.

2. Legal framework

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

In 2012, no significant legal changes were introduced in the field of drugs and drug addiction. However, works were continued on several important legal acts in this matter.

1 Act of 29 July 2005 of counteracting drug addiction (Journal of Laws "Dz.U." No. 179, item1485).

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

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

The first was the draft Regulation of the Minister of Health on the scope and framework of cooperation between drug treatment and rehabilitation services and the National Bureau for Drug Prevention. The work on this was held in 2012 and at the beginning of 2013. This act is particularly important in the field of monitoring. It will lay down principles of cooperation in TDI data collection.

The Regulation will specify manner of collecting, storing and processing information on patients reporting to treatment due to substance abuse; manner of storing and securing the information as well as a sample questionnaire to be filled by an individual reporting to drug treatment.

In the reporting period, works were in progress on two amendments of drug laws related to new psychoactive substances. One concerns introducing over 60 new substances under legal control. Interdepartmental consultations have been completed. However, due to a great number of proposed changes compared to the original proposal, it is likely that the consultations will have to be repeated.

The other amendment of drug law, which is currently being prepared is to improve the functioning of the 2010 regulations regarding new psychoactive substances. It was developed at the beginning of 2013 by a team of experts. The amendment introduces a risk assessment mechanism and elements of generic law. In order to facilitate the practical implementation of the law by institutions who are responsible for controlling new psychoactive substances, and making the law more transparent, the amendment introduces a generic and individual list of new psychoactive substances announced by way of regulation of the Minister of Health. The definition of substitute drug is changed by adding new psychoactive substances and making reference to the abovementioned regulation. As in currently existing regulation, listed substances are subject to administrative sanctions according to the existing and binding provisions of Article 44a of the Act on counteracting drug addiction. And Article 27c of the Act of 14 march 1985 on State Sanitary Inspection (Journal of Laws 'Dz. U.' of 2011 No. 212, item 1263) for substitute drugs i.e. a fine ranging from PLN 20 000 to PLN 1 000 000. The supervision over the enforcement of these laws is vested in the Sanitary Inspection. Possession of new psychoactive substances will not be penalized. Moreover, the draft amendment provides for a substance risk assessment team to be composed of experts and scientists. The mission of the team is to assess threats to public health posed by selected new psychoactive substances. The draft law specifies that in the event of such a threat, selected NPSs become more strictly controlled by adding them to schedules of the Act on counteracting drug addiction. Works on the draft amendment are at an early stage. The draft is being consulted in terms of technical and legal details in the Ministry of Health. Provisions concerning the generic ways of defining substances are particularly controversial among lawyers. Some professionals hold that such provisions are unconstitutional.

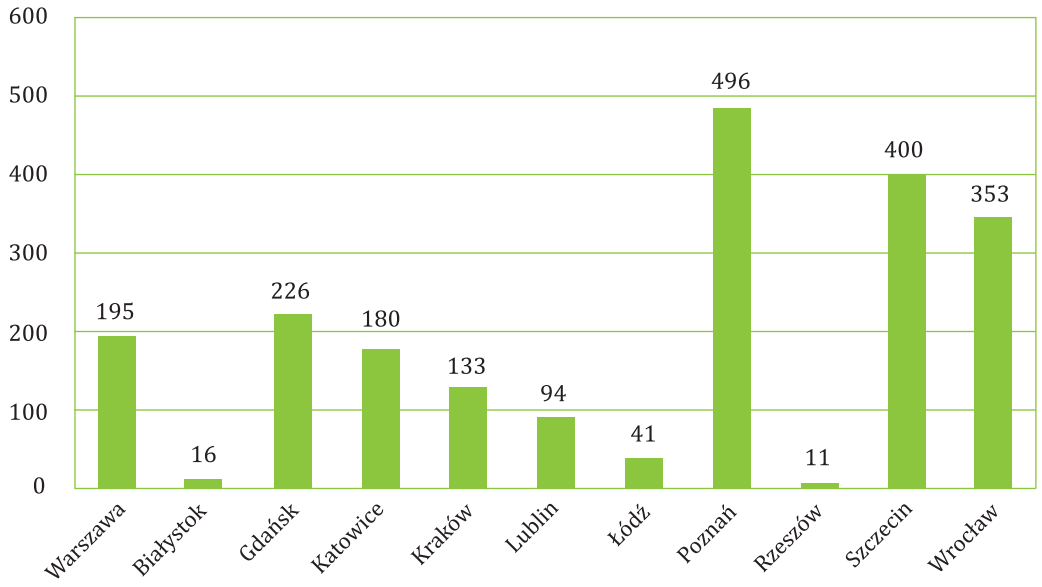
This report presents only the basic concepts of the draft amendment. The final version is likely to change compared to the original proposal. It has not been submitted for interdepartmental and public consultations. Therefore, it is too early to go into details about it and describe the accompanying discussions for that matter.

Moreover, works were being continued on the changes to the National Drugs Strategy based on conclusions and recommendations following the audit of the Supreme Audit Office (more broadly discussed in Chapter 1.2 National action plan, strategy, evaluation and coordination). The changes concerned mainly improvements to the indicators and tasks of respective institutions going beyond their statutory competences. The draft strategy has been submitted for approval by the Council of Ministers.

Apart from works on the new legal acts in 2012, the Ministry of Justice (Wilamowska, 2012) embarked on an initial evaluation of the enforcement of the 2011 modification of Article 62a of the Act on counteracting drug addiction concerning the more liberal approach to drug possession. As a reminder, Article 62a of the Act gives the prosecutor and judge the power to discontinue penal proceedings towards individuals who have been caught possessing small amounts of narcotic drugs or psychotropic substances for personal use, if a penalty is inadvisable.

According to the newest data of Ministry of Justice presented on the meeting of Council for Counteracting Drug Addiction held on 26 of March 2013, after slightly than a year of the enforcement of Article 62a, the scope of application to this provision by prosecutors is broad (Wilamowska, 2012). In the first year of the provision in force, prosecutors discontinued a total of 2 145 proceedings. The number of discontinued proceedings varies geographically between cities as Figure 1.2.1. below shows.

Figure 1.2.1. Number of discontinued proceedings by prosecution pursuant to Article of 62a of the Act on counteracting drug addiction in 2012



Source: Ministry of Justice

The data above are in line with the data on residential drug treatment demand in 2010 according to the records of the Institute of Psychiatry and Neurology. The analyses of drug treatment records show the highest rates per 100 000 population ranging from 42.0 to 54.0 in the provinces of zachodniopomorskie, lubuskie, wielkopolskie, dolnoslaskie, lodzkie and mazowieckie, i.e. regions of western and central Poland.

However, it would be unfounded to conclude that these are the only determining factors for such statistics as other circumstances are also likely to come into play. However, it is not feasible to examine them due to the lack of detailed criminal file data in such cases.

Active enforcement of Article 62a is confirmed by court statistics. In 2012, out of 177 cases tried under Article 62a of the Act on counteracting drug addiction, 160 were dropped (90%).

Furthermore, the number of convicts under the Act on counteracting drug addiction in district courts (lower instance) fell from 22 076 in 2011 to 20 890 in 2012. A fall was also recorded in drug possession-related convictions from 12 451 in 2011 to 10 934 in 2012.

Court statistics also show an increase in the number of dropped cases and conditional suspensions in drug possession-related cases from 212 in 2012 to 607 in 2012. Changes have also taken place in the structure of drug possession - related sentences. Imprisonment sentences were imposed on 6 300 convicts, which 10% less compared to 2011. It means that courts impose other sanctions than imprisonment such as fines or limitation of liberty.

The presented data refer to a very short period after the introduction of the new provisions. The analyses carried out in longer time intervals will provide more precise and realistic conclusions con-

cerning the evaluation of this provision in the Polish legal system. They will also provide more complete data for the analysis of the long-term effectiveness of the new laws.

3. National action plan, strategy, evaluation and coordination

• National action plan and/or strategy

The National Drug Strategy 2011-2016 (KPPN)[4], 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 addiction[5]) 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.

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.

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 National Programme 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 intensi

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

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

fied. The measures included operations against the use of precursors in the manufacture of drugs. A new element of the KPPN 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 KPPN 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 KPPN 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 KPPN 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 National Drug Strategy (KPPN).

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

Ministries and entities obliged to implement the National Drugs Strategy performed activities in all prevention-related areas planned for 2012. In 2012, central institutions aimed at strengthening social attitudes favouring the reduction of drug use in the general population by conducting information and educational activities with the application of various communication methods. The National Bureau for Drug Prevention ran educational websites addressed to various target groups. The Facebook fanpage for young people created under the national antidrug campaign entitled "Narkotyki? Na co mi to?" (Drugs? What do I need them for?) was continued. In the reporting year, the National Bureau for Drug Prevention was involved in the implementation of the Safe Games Polska. The project aimed at running an educational campaign during the European Football Championship. The action was intended to sensitize football fans to the consequences resulting from engaging in risky behaviour. The campaign website was launched at www.safegamespolska.com along with a Facebook fanpage.

In 2012, units of State Sanitary Inspection headed by Chief Sanitary Inspectorate continued the implementation of awareness actions aimed at providing education on substitute drug-related threats. Moreover, in 2012, the Chief Sanitary Inspectorate in collaboration with the National Bureau for Drug Prevention, Institute of Rural Health in Lublin, J. Nofer Occupational Medicine Institute in Lodz, State Agency for Prevention of Alcohol-Related Problems has been implementing Project KIK/86 entitled "Alcohol, tobacco and other substance abuse prevention programme" co-financed under the Swiss-Polish Cooperation Programme. The general aim of the prevention programme is reducing substance use in women at the procreative age. In 2012, a survey entitled "Pro-health behaviours among pre-

gnant women" was conducted and works on the online System of Electronic Monitoring and Health Promotion (SEMPZ) were launched at www.zdrowiewciazy.pl.

In the reporting year, works were conducted on the development of framework and methods of in-house universal drug prevention programmes. The National Bureau for Drug Prevention reviewed the existing regulations and the international recommendations and standards of in-house drug prevention. The Ministry of National Defence conducted educational actions related to in-house drug prevention under the "Strategy for strengthening discipline, addiction prevention and social pathology prevention in the Armed Forces of the Republic of Poland 2012-2013".

Core units of occupational medicine service of the Prison Service continued in the reporting year the activities aimed at identifying threats related to psychoactive substance abuse among Prison Service officers and staff members.

In order to reduce the prevalence of initiating the use of narcotic drugs, psychotropic substances and substitute drugs among young Poles, attempts were made to support the implementation and promotion in primary schools of evidence-based universal drug prevention programmes recommended under the recommendation system.

In the reporting year, the Centre of Education Development held a conference summarising the 20th anniversary of the Health Promoting Schools network in Poland. The event was intended to promote and disseminate innovative solutions in the field of health promotion. The number of schools involved in the Health promoting Schools network in 2012 stood 2 084[6] (2 200 in 2011). Similarly to the previous year, the Centre for Education Development of the Ministry of Education disseminated information on evidence-based universal drug prevention programmes via the Bank of Prevention Programmes and through telephone consultations with decision-makers, headmasters or school counsellors. However, the survey submitted by the Centre for Education Development shows that the Centre did not collect data on the number of schools implementing prevention programmes listed in the Bank of Recommended Programmes.

The National Bureau for Drug Prevention similarly to the previous year, supported the dissemination of the Unplugged evidence-based universal drug prevention programme. The programme targets adolescents in school. The implementation of the programme might contribute to filling the gap in the availability of universal drug prevention programmes in middle schools.

In order to reduce the prevalence of use of narcotic drugs, psychotropic substance and substitute drugs among children and adolescents, in 2012 the National Bureau for Drug Prevention ordered the implementation of drug prevention programmes by way of open-ended competition. A total of 130 (136 in 2011) selective, indicated and universal drug prevention programmes in high drug risk settings were accepted for implementation. An early intervention programme called FreD goes net was also approved. More than 300 000 participants were involved in the programmes (over 380 000 in 2011).

The National Bureau also continued the implementation of the FreD goes net early intervention programme by training more programme providers. Efforts were made to ensure sufficient quality of the programme implementation. An online drug counselling centre and the drugs helpline continued their operation.

The Ministry of Justice ran and supported selective drug prevention programmes in social rehabilitation facilities in various forms.

According to the report of the Ministry of Labour and Social Policy, in care and educational units, selective and indicated prevention programmes are not conducted independently and they are integrated in the larger framework of educational work. A total of 179 programmes for 3 457 charges were conducted in care and educational units.

6 Estimated data from 14 provinces.

According to the report of the Ministry of National Education the operation of youth educational and sociotherapeutic facilities is governed by the provisions of the Regulation of Minister of National Education of 27 December 2011 on specific terms and conditions of managing, admitting, transferring, discharging and housing minors in youth facilities. However, no information was provided on specific prevention activities performed towards charges of these facilities.

The Institute of Psychiatry and Neurology continued the implementation of the ReDNet programme, which started in 2011. The programme is concerned with the problem of new psychoactive substances.

The school year 2012/2013 was announced the Year of Safe School by the Minister of National Education. A number of institutional and public partners (NGOs) got involved in prevention activities aimed at raising school student safety and promoting safe behaviours. Educational materials and offers were presented at www.bezpiecznaszkola.men.gov.pl.

In the reporting year, the system of recommended drug prevention and mental health promotion programmes continued to be developed. The project involved such institutions as the National Bureau for Drug Prevention, Centre for Education Development, Institute of Psychiatry and Neurology and State Agency for Preventing Alcohol-related Problems. Four universal drug prevention programmes were awarded recommendations.

In order to raise quality of drug prevention, the National Bureau held an evaluation seminar for the providers of the Candis therapeutic programme intended for problem cannabis users.

At provincial level, all activities recommended for local and regional governments in the field of drug prevention were performed. Provincial governments were mostly involved in supporting universal prevention programmes while raising professional qualifications of drug services staff was given the least attention. In provinces, evidence-based programmes were implemented such as the early intervention programme FreD goes net, universal prevention programme Unplugged, parenting skills improving programme School for Parents and Educators, Family Strengthening Programme and Archipelago of Treasures.

In 2012, Marshal Offices continued developing both selective and indicated prevention programmes aimed for individuals with substance abuse problems and their families. In 2012, PLN 1 471 277 was allocated to this goal and the activities targeted 32 130 individuals (PLN 1 159 558 and 34 591 participants in 2011). Only two Marshal Offices reported supporting evidence-based prevention programme development trainings and only one Marshal Office supported supervision for drug prevention providers.

Out of 2 255 communes which submitted National Drugs Strategy implementation reports in 2012, nearly 80% conducted drug prevention activities. However, the level of involvement of local governments in implementing respective tasks depended on the type of prevention it referred to. The analysis of reports points to the fact that much more communes support universal prevention programmes (general population as target audience, especially children and adolescents) rather than selective or indicated prevention programmes (addressed to children, adolescents and families who already experience problems which might be related to psychoactive substance use). In 2012, universal drug prevention programmes were implemented by 66% of all reporting communes while selective and indicated programme were implemented by merely 18% of all reporting communes. Drug prevention activities were performed, similarly to the previous year, most of all by urban communes (over 90% in the case of universal prevention programmes and almost 50% in the case of selective and indicated prevention programmes). A considerable difference in the involvement in implementing universal, selective and indicated drug prevention programmes also occurred in rural communes (58% and 9% respectively). The difference can be explained by the fact that in rural communes there are fewer individuals experimenting with psychoactive substances or risk groups and consequently the threat of drug addiction is not as high as in cities. Moreover, urban communes enjoy greater financial resources related to solving social problems than rural communes.

Within the scope of drug treatment, rehabilitation, harm reduction and social reintegration, the National Bureau organized training courses and conferences during which various evidence-based approaches to client work were presented. For example, the implementation of the German modular therapeutic programme for problem cannabis users aged 16 and older called Candis was launched. In order to raise competences of family doctors in terms of broadly understood drug prevention work, the National Bureau, in the reporting year, ordered the creation of the e-learning platform framework for the abovementioned group. In 2012, the first stage i.e. the e-learning platform framework was created. The training courses will be run by the second half of 2013. In order to improve access to a specialist ambulatory health care for problem drug users, the National Health Fund (NFZ) increased in 2012 the spending on ambulatory health care services by approx. 3.5%.

Despite a clear improvement in access to substitution treatment programmes over the last years, the number of opioid-dependent clients of these programmes is lower than planned in the National Drugs Strategy.

In 2012, 3 approvals to launch 3 more programmes (in Glogow, Kostrzyn and Warsaw) were given. It is estimated that between 10% and 20% of drug-dependent population are suing this form of treatment (assuming that the number of opioid-dependent users ranges from 10 400 to 19 800).

In order to provide access to substitution treatment for at least 25% of opioid-dependent individuals in each province, it is necessary to launch programmes in the provinces of podlaskie and podkarpackie, where no such programmes were available in 2012. It is also necessary to widen substitution treatment services in the provinces of warminsko-mazurskie, wielkopolskie, pomorskie and zachodniopomorskie. In the reporting year, only three facilities (provinces of lubuskie, kujawsko-pomorskie and mazowieckie) managed or nearly managed to ensure access to substitution treatment at the level of 25%. It is also worth stressing that substitution treatment is listed in the catalogue of warranted health care services. Consequently, the NFZ should allocate financial resources to this goal and announce substitution treatment provision competitions.

Substitution treatment is also provided in correctional facilities. In 2012, 7 such programmes were operational. They existed in 23 correctional units. 283 inmates benefited from the programmes. In order to ensure continuation of treatment started before going to prison, it is recommended that all correctional facilities offer substitution treatment.

The National AIDS Centre reported that in 2012 the ARV treatment was provided for all HIV and AIDS patients who met medical criteria and who may be covered with a health policy strategy and it is not against the biding regulations. As at 31 December 2012, the ARV treatment was provided for 6 297 HIV and AIDS patients. 1 827 of them (29%) were likely to have become infected with HIV through injecting drugs or engaging in unsafe sex. The ARV programme was run in 21 hospitals which operates as referral centres for HIV and AIDS patients in Poland.

Moreover, in 2012 there were 31 sites providing free and anonymous HIV testing. In 2011, 5 130 test-takers were also drug users, which constituted 20.2% of all test-takers in diagnostic and consultation centres.

In 2012, in Prison Service units, apart from the abovementioned substitution treatment, abstinence-oriented programmes, anti-retroviral programmes and drug prevention programmes were also conducted. Since 2010, there has also been a short-term intervention programme for substance abusers. Moreover, training was provided for substitution treatment staff and HBV vaccinations were given to inmates.

In the reporting year, the National Bureau ordered post-rehabilitation programmes to be implemented in 20 hostels and 15 re-entry flats across Poland. 1 705 individuals were provided with these services.

The National Health Fund (NFZ) reported an 8.5% increase in post-rehabilitation hostel-based spending. 7 NFZ branches reported that they financed post-rehabilitation programmes for harmful drug users and drug-dependent individuals in hostels.

Similarly to the previous year, in the reporting year, 12 Marshal Offices financed activities to increase the availability of therapeutic and rehabilitation services. A total of PLN 2 396 563 was spent to this goal.

However, it is alarming that in the reporting year Marshal Offices were to a small extent involved in widening harm reduction services. Only the Marshal Office of malopolskie province reported that in the reporting year it supported needle and syringe exchange programmes, night shelter and hostel of drug abusers in the city of Krakow. Consequently, it is recommended that Marshal Offices become more involved in supporting night shelters for drug users.

In 2012, 2 255 communes submitted National Drugs Strategy reports, which accounted for 91% of all communes. Drug treatment, rehabilitation, harm reduction and social reintegration were financed by 722 communes (32%) at the total amount of PLN 15 105 423, with an average spending of PLN 20 922 per commune. Local governments performed respective activities to different degrees depending on the geographical location and the type of commune. The most popular activities included improving the availability of drug therapy and rehabilitation for harmful users and drug-dependent individuals, such as drug therapy and rehabilitation programmes in addiction treatment facilities or specific target group-oriented programmes i.e. women, mothers with children (349 communes) and disseminating information on drug services (482 communes). Another form of communal activity was financing programmes aimed at reducing social exclusion of drug users (110 communes). The spending on the abovementioned activities amounted to PLN 8 510 192 and PLN 4 869 190 respectively.

117 local governments supported professional development of drug treatment and rehabilitation staff as well as other professional groups working with drug users. Such activity remains in the domain of urban communes mainly. Urban communes enjoy higher budgets for tackling social problems, proper infrastructure and human resources. Moreover, the potential of urban communes makes it possible to provide quite a high number and range of drug treatment services for residents of urban-rural and rural communes, which causes that the latter do not have to develop and finance activities in their areas.

In 2012, the cooperation among supply reduction agencies was continued. Activities were still performed to reduce amphetamine production. Consequently, 15 clan labs producing amphetamine were dismantled. 33 criminal groups handling the production of drugs, including 17 concerned with the production of amphetamine and its derivatives, were dismantled. Officers of the Central Bureau of Investigation (CBS) dismantled 15 criminal groups concerned with the production of amphetamine and its derivatives while officers of the Internal Security Agency (ABW) dismantled 2 such groups. Moreover, under the action of intensifying operational and reconnaissance activities, Police officers conducted 21 special operations and officers of Military Police 2 such operations. Specialist training courses devoted to dismantling clan labs and reduction of domestic amphetamine production for law enforcement staff were also conducted. The 6 training courses organized by the Police were attended by 350 participants. Military Police held 15 short-term courses on operational-reconnaissance and investigative work, during which 105 personnel were trained. The Central Bureau of Investigation implemented principles of cooperation of law enforcement staff with representatives of the chemical and pharmaceutical industry aimed at exchanging information pursuant to Article 16 of Regulation (EC) No 273/2004 of the European Parliament and of the Council of 11 February 2004 and Article 32 of Regulation (EC) No 111/2005 of the Council. Under the regulation and guidelines laying down the principles of cooperation with the chemical and pharmaceutical industry adopted by the European Commission, in 2012, by way of decision of the Chairman of the Council for Counteracting Drug Addiction – coordinative and advisory body by the Prime Minister of the Republic of Poland – Drug Precursors Team was appointed. The Team comprises the following institutions: Head Office of the Border Guard, Central Bureau of Investigation of the Police Headquarters, Headquarters of Military Police, Chief Pharmaceutical Inspectorate, Main Sanitary Inspectorate, Customs Service, Bureau of Chemical Substances, Office of Registration of Medicinal Products, Medical Products and Biocides, Ministry of Economy.

Under the system of collecting data of the equipment and chemicals used in clan labs, the Central bureau of Investigation runs a database named "KOKON". The database lists data on Police-revealed clan labs producing synthetic drugs as well as equipment and chemicals used therein. In 2012, since the beginning, the base listed 28 000 records. Over the last several years, a rise in the number of cannabis plantations has been observed, which is reflected in police statistics. The rise is related to the increasing popularity of home-based plantations. In 2012, the Border Guard, in the course of running the Register of Operational Activities, performed reconnaissance of criminal groups concerned with drug trafficking and manufacture. Military Police performed operational and reconnaissance activities aimed at tracking down the origin of drugs and all individuals involved in the drug business.

Police performed actions related to reconnaissance and liquidation of criminal groups. The Internal Security Agency conducted reconnaissance of criminal groups in the course of preparatory proceedings.

Under the regular trainings conducted by the Border Guard for the operations and investigations department, the course participants were familiarized with methods of reconnaissance and modi operandi of criminal groups as well as methods of combating drug-related crime.

The Police held specialist trainings for staff of drug enforcements agencies and prosecutor's offices in the field of combating drug-related crime, detecting drugs by sniffer dogs, performing selected operational-reconnaissance and investigative activities by criminal police officers, combating organized crime under professional trainings for college graduates, identification, research and storage of narcotic drugs and psychotropic substances, combating and counteracting drug addiction and combating drug-related crime. The National School of Judiciary and Public Prosecution organized a systemic training course entitled "Medical, judiciary and criminalistic aspects of obtaining and evidential application of biological traces".

The information of drug seizures were collected by units of the Police at national level and the Police Headquarters of the city of Warsaw and then passed on to the Criminal Department of the Police Headquarters. The data obtained formed grounds for planning and task setting with regard to this type of crime. The Border Guard, in the course of operational-reconnaissance activities, monitored major drug trafficking routes and methods. The Internal Security Agency was discovering methods and routes of drug trafficking by air, train and car. The Customs Service familiarized itself with the Strategic Risk Description Worksheets based on which audit activities will be performed. The Border Guard conducted international operations aimed at combating drug trafficking by sea and land.

The Border Guard activities in terms of the intensification of special operation included training courses for officers of operational and investigation department, assessment of material collected in the course of special operation and improvement of awareness of officers performing operational and investigative duties in exercising their mandate. The Border Guard synchronized the information exchange with the department responsible for the technical supervision from the Operations and Investigations Management Division of the Border Guard Headquarters. The Customs Service as the National Contact Centre supervised audit measures under the Joint Customs Operations.

In order to dismantle a criminal group concerned with drug trafficking of pharmaceuticals which were imported to Poland form the United States, Canada and United Kingdom, the Border guard along with the Police Headquarters appointed the Coordination Team in 2012. The Customs Service appointed the Working team on New Psychoactive Substances and the Working Team on Drug Precursors. The Teams were responsible for exchanging information on new psychoactive substances, drug precursors and actions taken as well as coordinating actions of involved institutions and ministries.

Under international antidrug operations, the Police along with Europol and Dutch police, conducted an action related to amphetamine trafficking to Scandinavia, preparation of the Polish-Franco crackdown operation on trafficking in synthetic drugs, precursors and cocaine as well as an operation to combat trafficking in cocaine by sea from South America to Europe. The Border guard participated in three international operations.

The Police developed investigative techniques in the course of identifying origins of chemicals and precursors under the task of controlled deliveries. The Border Guard conducted trainings on drug supply and demand reduction at the Border Guard Training Centre in Ketrzyn. The trainings were concerned with methods of identifying narcotic drugs, psychotropic substances and drug precursors.

The Police in collaboration with Europol conducted joint trainings on dismantling clandestine labs including precursor labs. The Police also collaborated under the EMPACT Synthetic drugs project. The Police developed plans for 2013 under the Policy Cycle EU on synthetic drugs and made contribution to the analytic file of SOC FP Synergy, Cannabis and Cola. 3 cases were processed with the use of Europol analyses and 65 contributions were made under the AWF files. The Border Guard cooperated with Europol many times in the field of information exchange on organized crime groups and their members involved in drug trafficking. The Customs Service participated in the Joint Customs-Police Operation aimed at combating container cocaine trafficking from South America.

Military Police, under the trainings for officers on combating drug-related crime with the use of the Internet, trained officers on obtaining information via the Internet for policemen. The National School of Judiciary and Public Prosecution organized a systemic training course entitled "Medical, judiciary and criminalistic aspects of obtaining and evidential application of biological traces". The subject of one of the blocks was "Judiciary toxicology". It featured discussions on the availability of drugs, application of drug tests and issue of pharmaceuticals used to commit a crime.

While implementing good practice in the field of confiscating property the Department of Property Repossession of the Criminal Department participated actively in the actions aimed at improving knowledge of policemen on detecting and identifying property from criminal activity and various methods of combating crime. The Border Guard, considering the effective combating and preventing money laundering and identifying components of property, implemented of the framework Concept entitled "Identifying components of property from illegal and unrevealed sources by Border Guard officers". Cooperation was also maintained with the Finance Supervision Commission, General Inspectorate of Revenue Audit and National Bureau of Property Repossession of the Criminal Department of the Police Headquarters in order to implements agreements signed by the Commanders-in-Chief of the Police and Border Guard.

Moreover, Military Police, Police and Border Guard implemented ministerial programme of drug supply and demand reduction. Military Police implemented "Military Police Drugs Strategy 2011-2016", which covered issues related to drug prevention, supply reduction, research and monitoring. The Police and Border Guard implemented "Drugs and Drug-related Crime Strategy of the Ministry of Internal Affairs" developed in 2011.

The tasks related to international cooperation can be divided into three groups:

- increasing Poland's involvement in planning, creating and coordinating EU drugs policy;
- increasing Poland's involvement in the works of international institutions and organizations other than the EU;
- developing international cooperation with third countries (non-EU members) both in the context of combating illegal trade in drugs and health care programme.

In 2012, the Police Headquarters and the National Bureau for Drug Prevention took part in the proceedings of the Horizontal Drugs Group. Polish representatives participated in the works devoted to the following documents related to drugs and drug addiction:

- UE Drugs Strategy 2013-2020;
- EU Action Plan on Drugs 2013-2017;
- Amendment of the Council Decision No 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substance;
- European quality standards and indicators in drug prevention, treatment and harm reduction.

It must be stressed that upon request of the Danish Presidency, for the six months of the presidency, experts of the Police Headquarters chaired the proceedings on the so-called Political Dialogue with third countries in the field of drugs.

Apart from initiatives at EU level, measures were taken at international institutions and organizations combating drugs and drug addiction.

In 2012, most responsible institutions (Police Headquarters, National Bureau for Drug Prevention, Main Pharmaceutical Inspectorate, Chief Sanitary Inspectorate) participated in works of international organizations preventing drugs and drug prevention or participated in international projects devoted to these matters. The abovementioned organizations include Commission on Narcotic Drugs, United Nations Office on Drugs and Crime, Pompidou Group of the Council of Europe, European Network of Forensic Science Institutes and COPOLAD Project.

In terms of cooperation with third non-EU member states, in 2012, the Police Headquarters (KGP) participated in the EUBAM project (with Moldova and Ukraine) devoted to the reduction of demand for new psychoactive substances. KGP representatives also took part in the COPOLAD project. Moreover, the KGP's Central Bureau of Investigation coordinates, on the Polish part, the project of the Polish-Russian Commission on Interregional Cooperation. One of the areas of cooperation is combating crime, especially drug-related crime.

Chief Sanitary Inspectorate cooperated with third countries in the field of Category I and II precursors. The cooperation was pursued under Article 11.1 and 2 or Regulation No 111/2005 laying down rules for the monitoring of trade between the Community and third countries in drug precursors.

Research and monitoring tasks provide support for the implementation of the National Drugs Strategy (KPPN). Respective institutions specified in the KPPN monitored the epidemiological situation by collecting data in drugs and drug addiction according to their competencies. Information collected by central institutions were compiled and processed by the Polish Focal Point in the form of the Annual Report on the situation of drugs and drug addiction in Poland. The publication was submitted to the EMCDDA under yearly reporting obligation. The results of the drug monitoring and the institutional response to diagnosed problems were presented in the Information on the implementation of National Drugs Strategy tasks. Apart from the abovementioned publications, institutions monitoring selected problems prepared analyses and published reports.

In 2012, the National Bureau continued the initiative aimed at supporting scientific research into drugs and drug addiction by announcing a research competition for projects exploring drugs and drug addiction in terms of illegal trade in drugs, drug-related crime and drug demand reduction. At the same time, in 2012, research projects previously chosen under the 2011 competition were continued.

In order to improve the quality of monitored indicators, attempts were made to develop a drug information system. The Polish Focal Point continued the pilot project of the Polish drug treatment demand system. The results of the pilot project were processed and reported to the EMCDDA. The deficit area still remains the system of collecting data on drug-related deaths. The records on drug-related deaths have been collected according to the EMCDDA standard protocol for a number of years. The consequence is the lack of credible information on the real number of drug-related deaths and the collected data are underestimated.

In the course of consolidating national systems, emphasis was also placed on the quality improvement of local and provincial drug monitoring. In order to improve the quality of monitoring activities a series of national and international conferences and training courses were held.

The data shown in communal questionnaires show that 12% of communes implemented research and monitoring activities. Similarly to the previous year, monitoring drugs and drug addiction is more frequent in urban communes (20%) than rural communes (4%). Communes of the provinces of kujawsko-pomorskie and pomorskie were the most active in this respect. Drug treatment demand and drug-related Police records were monitored most often.

In 2012, public attitudes to drugs and drug addiction were monitored in 5.5% of communes while the activities related to the development and consolidation of the drug information system was reported by 4% of communes.

Summing up, both at the level of Marshal Offices and local governments clear discrepancies are observed in relation to the level and quality of research and monitoring in progress. It is therefore necessary to keep stimulating local and regional governments in this matter, especially the rural communes.

Conclusions

1) One of the deficits identified in drug prevention services is the insufficient number of evidence-based drug prevention programmes in schools. Consequently, the Ministry of Education should intensify activities aimed at disseminating health promotion and universal drug prevention programmes at different levels of education. One should understand these actions as increasing the number of providers of the abovementioned programmes (trainer and provider trainings), supporting the implementation of programmes in schools and education system facilities as well as monitoring the process of implementing the programmes by collecting data on, at least, the number of schools running such programmes. It is recommended that evidence-based prevention programmes for children and adolescents, their parents and guardians are disseminated e.g. the Unplugged programme.
2) Along with the universal prevention programmes, projects for children and adolescents at risk of drug addiction, corruption and with special educational needs should be intensified by the implementation of actions and programmes in education and care facilities supervised by the minister competent for the matters of family, social rehabilitation centres controlled by the Ministry of Justice and youth education and sociotherapeutic centres reporting to the minister competent for the matters of education. Ministries responsible for the supervision over the abovementioned facilities should make every effort to be able to monitor prevention activities performed therein.
3) The Ministry of Education should take necessary action to collect data mandated by the National Drugs Strategy 2011-2016 in its statistical systems. The failure to provide numerical data on the number of schools covered by evidence-based universal drug prevention programmes makes it impossible to evaluate the progress of the task, which is crucial for the dissemination of evidence-based prevention programmes.
4) Some Marshal Offices made efforts to disseminate evidence-based prevention programmes. It is recommended that provincial governments be involved more widely in the implementation of the abovementioned task. Local governments may use the database of programmes at the website of the National Bureau for Drug Prevention (KBPN). They can also implement such evidence-based programmes as Unplugged, FreD and Candis, coordinated by the KBPN.
5) Due to poor support of the Marshal Offices in 2012 for the activities aimed at raising professional qualifications of prevention staff, it is recommended that such activities enjoy greater support in the coming years. These measures might considerably improve the effectiveness of drug prevention.
6) Due to the increasing number of problem cannabis users reporting to treatment and developing and disseminating treatment services adequate to the needs of this target group (e.g. Candis programme) should be continued. It is important to further promote the programme both among problem cannabis users and therapists, representatives of the justice system, social welfare, health care and education.
7) Every year, we are observing wider availability of substitution treatment programmes although they are not capable of meeting the needs of all the opioid-dependent population. Although in 2012 approvals were given to launch another 3 programme, it is estimated that only 15% of drug-dependent individuals are covered with this form of treatment. In the provinces of podlaskie and podkarpackie there are still no substitution treatment programmes. Clear limitations in access to

substitution treatment are observed in the provinces of warminsko-mazurskie, pomorskie, zachodniopomorskie and wielkopolskie. Moreover, it must be stressed that substitution treatment is a warranted heath care service and as a result the National Health Fund should earmark financial resources for this goal and announce competitions for providing substitution treatment.

8) It is alarming that in the reporting year Marshal Offices were scarcely involved in widening the availability of harm reduction and post-rehabilitation services. Only the Marshal Office of malopolskie province reported that in the reporting year it supported syringe and needle exchange programmes and the programme of night shelter and hostel for drug abusers in the city of Krakow. That is why local governments are recommended, wherever is it is possible, that harm reduction and post-rehabilitation activities (especially supporting night shelters, stationary and street syringe/needle exchange programmes) be implemented on a larger scale. Marshal Office should also be more involved in increasing the availability of substitution treatment programmes.
9) Cybercrime has been developing for years. The Internet is one of the tools used in illegal trade in precursors, drugs and substitute substances the so-called legal highs, in particular. That is why it is important for law enforcement agencies to develop initiatives and activities which would help to prosecute such crime more effectively.
10) A rising number of domestic cannabis plantation calls for coordinated and integrated action of various drug enforcement agencies. Police actions should focus mainly on large plantations established by organized crime syndicates.
11) The synthetic drugs scene, where amphetamine still remains a dominant drug, is changing. Signals of using and producing methamphetamine as well as mephedrone are emerging. A fall in the availability of BMK used for amphetamine production caused that a legal substance named APAAN started to be imported to Poland. Changes in amphetamine production methods require developing new solutions and actions on the part of supply reduction agencies.
12) The new EU Drugs Strategy 2013-2020 and the accompanying EU Action Plan on Drugs point to developments demanding intensive actions at both EU and national levels. The most serious developments include a rapid increase in the number of new psychoactive substances on the market (so-called legal highs), diversification of drug trafficking routes, new drug distribution channels. In order to counteract the phenomena it is necessary to strengthen the international cooperation among law enforcement agencies (including intelligence cooperation) and furthermore to work out new methods of such cooperation. The new EU Drugs Strategy emphasises the necessity to cooperate more broadly with representatives of civic society and integrating them in the process of developing policies and actions aimed at combating drugs and drug addiction. Moreover, the Strategy places emphasis on the necessity to make evidence-based decisions and activities. The abovementioned activities are already implemented by national entities, however, it seems justified to intensify them and develop cooperation with EU partners.
13) Along with the activities implemented at the EU level and international institutions tackling the problem of drugs and drug addiction, bilateral cooperation with third non-EU Member States should be developed, especially the countries of the Eastern Partnership.
14) In recent years, the problem of new psychoactive substances, the so-called designer drugs, have become the real challenge for research and monitoring systems. In Poland, it is most often associated with the so-called legal highs. At present, the problem of new drugs is increasingly becoming the focus of the attention of researchers and analysts. Knowledge on this rapidly developing phenomenon is systematically being improved, which helps to understand its nature. However, we still need to work out more effective methods and mechanisms of monitoring the arrival of new psychoactive substances. In this context, it is important to develop mechanisms of monitoring substitute drugs emerging on the Polish drug scene as well as cooperation among responsible service, particularly the Chief Sanitary Inspectorate and county sanitary and epidemiological stations.

15) Research and monitoring development at central and local level remains a priority of the National Drugs Strategy. It actually allows for identifying a number of threats and phenomena at an early stage and provides a chance to prepare social response in the form of intervention e.g. need-adjusted prevention or treatment. Therefore, it is recommended that drugs and drugs addiction be monitored systematically by local and regional governments so that they can later use them in the process of developing local drugs strategies.
16) The new legislative solutions provided for in the amended Act of 2011 concerning the discontinuation of prosecution and judiciary proceedings must still be promoted.

Research Competitions

In order to support drug-related research, the National Bureau since 2008 has been holding competitions in the field of drugs. The projects are selected by the Director-appointed commission based on additional reviews. In 2012, the following new projects were financed by way of competition:

1) "Evaluation of the effectiveness of proprietary programme of psychosocial support for middle-school youth" – Kazimierz Wielki University in Bydgoszcz.
2) "Evaluation of effectiveness of proprietary programme of psychosocial support for school children in following the school curriculum" - Kazimierz Wielki University in Bydgoszcz.
3) "Teaching users to control cannabis use and the illegality context" – Pracownia Rozwoju Osobistego in Opole.

In the last several year, more than a dozen projects were conducted under the drug-related research competitions. Consequently, it was possible to implement many projects ranging from evaluations, epidemiological studies to wastewater projects. Some of the projects are continued and financed from other sources. The Medical University of Poznan is still conducting research on waster water analysis in selected cities of wielkopolskie province. The National Bureau research competitions were initially open-ended i.e. funding was awarded to interesting research projects which met the competition criteria. Both the latest and the new competition is concentrated on priorities defined by bodies such as the Council for Scientific Research (Malczewski, Misiurek, 2013a).

Selection of priorities

In April this year, the National Bureau while applying the method of the EMCDDA's Scientific Committee, conducted an exercise of defining and assessing research priorities in the field of drugs and drug addiction. The aim of the method is to formulate research and information needs and to explore areas which failed to be explored by the previous projects. The exercise focuses on three areas (prevention, treatment and supply reduction) defined in the National Drug Strategy 2011-2016. Apart from members of the Council for Scientific Research, representatives of civic society were also invited to assess the priorities. The expert panel comprised personnel of universities, higher schools of education and central institutions (Institute of Psychiatry and Neurology, Police Headquarters) and NGOs or the media. Questionnaires were sent to eleven individuals. There were ten replies. The findings were presented at the meeting of heads of Focal Points devoted to research in Lisbon in May this year. Experts, who were mainly members of the Council, were presented with a list of 14 priorities in the three areas defined in the National Drugs Strategy. The exercise participants were asked to choose three priorities out of prevention, treatment and supply reduction and rate them from 1 (most important) to 3 (least important). The ratings were then totalled. Experts were also asked to provide each priority they selected with a research procedure which would allow for exploring it.

In the field of prevention the top-rated priority was "Improvement of prevention quality". It scored 18 points and compared to the other priorities, it was usually given the rating of 1. Experts also pointed to the need of analyzing the system of prevention interventions, which on the one hand would mean verification of programme frameworks (analysis of scope and form of actions in place and demand for them) as well as outcomes and outputs (surveys of programme participants and providers). Moreover, an important element of such research would be to analyze the demand for trainings and workshops on developing and implementing such programmes and explore the extent of implementation of prevention interventions at national and local level. The research projects proposed included evaluation studies, qualitative research (focus groups, case studies) and quantitative measurements (self-reported questionnaires).

In the field of drug treatment and rehabilitation, two priorities were indicated "Improvement of health of harmful users and drug-dependent individuals" and "Reduction of social exclusion of harmful users and drug-dependent individuals". In the case of the first priority, experts suggested surveying participants of harm reduction programmes both in terms of their experience in substitution treatment and health consequences related to the use of respective substances. Moreover, the experts recommended surveys among medical staff and analysis of state, quality and access to primary and specialist health care services. In the area of reduction of social exclusion of harmful users and drug-dependent individuals, there were propositions such as exploring methods of equal chances, expert panels on ways of reducing social exclusion or analyses or post-rehabilitation and reintegration programmes at national and local level.

In the field of supply reduction, the top priority was "Reduction of benefits from drug-related crime". The following research ideas were proposed: analyzing drug trade structures, with particular emphasis placed on retail trade, profiles of drug dealers, descriptions of circumstances and motivations. Forms of interventions leading to change or exploring mechanisms of legalizing profits from criminal activity, especially drug-related crime (analyses of at the border of economics and criminology) were also suggested. In the field of studying the illegal market, the following suggestions emerged: criminal records projects, statistical data analyses, in-depth interviews with police officers, prosecutors and judges (Malczewski, Misiurek 2013a).

Council for Scientific Research

The Council for Scientific Research was established by the order of the Director of the National Bureau for Drug Prevention in 2011. It is an advisory and opinion-making body. The Council is comprised of 7 members[7], appointed due to their knowledge and experience in addiction-related research. The Council is responsible for initiating research, defining needs and priorities in the field of addictions. The Council is also concerned with research competition procedures (reviewing application, assessing project, evaluating project implementation and results). Moreover, the Council's mandate was defined in the National Drug Strategy 2011-2016. Under the tasks defined in the National Drugs Strategy, the Council on the hand initiates and supports scientific research into drug demand reduction and on the other hand evaluates the drug information system.

• Courses of action for local and regional governments

The KPPN places special emphasis on the role of local governments. Important tasks of theentities involved in the implementation of the National Drug Strategy (KPPN) include developing their own

7 The Council comprises: Prof. Czesław Czabała Ph. D., Prof. Krzysztof Krajewski Ph. D., Waldemar Krawczyk Ph. D., Prof. Zofia Mielecka – Kubień Ph. D., Janusz Sierosławski MA, Prof.. Marcin Wojnar Ph. D., Joanna Zamecka Ph. D.

programmes, i.e. strategies which are based on the KPPN and the Act of 2005 on counteracting drug addiction[8]. In the course of the KPPN implementation, provincial and local governments develop their own ministerial, provincial or communal programmes.

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

1) Supporting universal prevention programmes.
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 KPPN, 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.

"Drug prevention at schools" report by Supreme Audit Office

The Supreme Audit Office (NIK) is the top and independent state audit body whose mission is to safeguard public spending. In 2012, the NIK conducted an audit and evaluation of school prevention activities. The results were published in the report entitled "Drug prevention at schools" [NIK, 2013]. One of the audited and evaluated aspects was the process of developing, coordinating, implementing and monitoring the National Drugs Strategy (KPPN) 2006-2010 and 2011-2016.

The coordination and implementation of the National Drugs Strategy was well rated. However, a few deficits were identified with regard to the framework of the Strategy. KPPN activities and tasks were formulated in too general a manner. Moreover, it was concluded that tasks assigned to some institutions went beyond their capacity. A problem arose with regard to monitoring indicators. The Strategy indicators fail to determine the ultimate value, which according to the NIK auditors impedes complete evaluation of the Strategy implementation. The NIK also criticised the indicators system as too elaborate, which burdens the implementing bodies with unnecessary reporting obligations. Moreover, the NIK contested the way of collecting data on financing the Strategy activities. The Office concluded that due to incoherent data collection methodology it is not possible to provide reliable information on the Strategy-related spending.

• 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

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

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 strategies and action plans; 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 and created in 2011 new psychoactive substances team. The teams play an advisory role and provide technical support for the Council.

In 2012, three sessions of the Council and several sessions of Council working teams were held. Major subjects discussed by the Council and the teams included the following:

1) Monitoring the implementation of new provisions of the Act on counteracting drug addiction under the amendment of 1 April 2011.
2) Cooperation with the pharmaceuticals industry in order to prevent escape of drug precursors.
3) New psychoactive substance prevention.
4) Implementation of the National Drugs Strategy.

In the course of monitoring the implementation of the new provisions of the Act on counteracting drug addiction as amended on 1 April 2011, representatives of the Ministry of Justice prepared and presented a data analysis concerning the enforcement of the new Article 62a which gives a prosecutor and judge the power to drop criminal proceedings towards individuals found in possession of small amounts of narcotic drugs and psychotropic substances for personal use if a penalty was not advisable (for more on this analysis see Section 1.1 Legal Framework). The data demonstrate positive changes in enforcing this provision, however, due to a short period they were available for, it is too early to draw clear conclusions.

In order to intensify the cooperation with the pharmaceuticals industry, in 2012 a kick-off meeting was held between representatives of the Council for Drug Precursors and associations of producers of pharmaceuticals and pharmacists. The meeting was attended by the National Retail Pharmacy Consultant. The meeting featured a presentation of the current situation regarding drug precursors, especially GBL, BDO and APAAN, a proposal of the European Commission to modify the definition of drug precursor. Moreover, activities and work aspects of the Council for Drug Precursors were presented. Possible forms and fields of tightening cooperation with the pharmaceuticals industry were also discussed. A decision was taken to organize trainings for staff members of the pharmaceuticals industry in the field of preventing and combating escape of drug precursors.

In order to prevent new psychoactive substances members of the working team on new psychoactive substances and the Council decided to undertake work on amending the Act on counteracting drug addiction and develop a new complex approach to NPS prevention. A decision was also taken to reconsider the generic approach to defining the controlled substances and necessity to formulate a legal opinion on the possibility of implementing this solution on the Polish legal system. The works began at the beginning of 2013 (more broadly discussed in 1.1 Legal Framework).

In the course of monitoring the National Drugs Strategy the main problem identified was the lack of the strategy implementation indicators. Some institutions indicated that they did not have or run the right statistical systems to provide values of the strategy indicators. Consequently, a decision was taken to introduce changes in the Regulation of the Chairman of the Council of Ministers on the Na-

tional Drug Strategy 2011-2016. In the reporting period a draft regulation was developed (broadly discussed in 1.1 Legal Framework).

Development and consolidation of provincial monitoring systems

In 2012 a lot of work was performed towards the development and consolidation of provincial and local monitoring systems (Malczewski, 2012m).

On 25-27 April 2012 in Kielce 22nd Conference of Provincial Drug Information Experts was held by Polish Focal Point (CINN KBPN) in cooperation with the Marshal Office of Swietokrzyskie Province. During the conference the state of drugs and drug addiction in respective provinces of Poland and planned action in the field of monitoring drug problem were discussed. There were also debates regarding directions of development of provincial antidrug strategies and priority actions at provincial level. The conference featured presentations of Poland's antidrug involvement in the European Union, including the crackdown on legal highs and the evaluation of the European drugs strategy. The meeting provided detailed insight into the epidemiology and activities in Swietokrzyskie Province in response to drugs and drug addiction.

4th National conference for representatives of partner communes in the local drug monitoring project, Wroclaw, 22-23 March. The conference organized in cooperation with Wroclaw City Hall was attended by 48 representatives of communes, public institutions and NGOs responsible for developing and implementing antidrug activities at local level.

The conference organized in cooperation with Wroclaw City Hall was attended by 48 representatives of communes, public institutions and NGOs responsible for developing and implementing antidrug activities at local level. The meeting provided platform for sharing experience in monitoring drugs and drug addiction at local level, identifying problem areas and challenges ahead of stakeholders. Efforts were made to improve the progress report questionnaire on the National Antidrug Strategy. It is worth noting that the day before the conference the National Bureau for Drug Prevention in cooperation with the Marshal Office of Dolnoslaskie Province organized a training seminar for new communes from Dolny Slask (Lower Silesia) on monitoring drugs and drug addiction at local level. During the conference a representative of Wroclaw City Hall provided information on the activities of Wroclaw authorities in the field of addictions while representatives of the National Bureau presented the latest changes to the Act of 29 July 2005 on counteracting drug addiction as well as the results of new research into drugs and drug addiction in Poland. There were also presentations of research into gambling. Moreover, information on the Gambling Problem Fund was presented. A highlight of the conference was debate on establishing communal drugs monitoring structures. Representatives of cities of Gdansk, Kedzierzyn-Kozle, Lodz, Opole, Pabianice, Radom and Sopot shared their experience. The meeting also featured Poland's top priorities during the UE Presidency with particular emphasis placed on anti-legal highs actions. The overview of the European Drugs Strategy including its evaluation was given. There was also a presentation devoted to the European Quality Standards in Drug Prevention. The standards might provide support for drug prevention at national level. The conference ended with the summary of the priority issues regarding the National Mental Health Strategy. The results of monitoring drugs and drug addiction in Dolnoslaskie Province were also presented.

On 4-5 December 2012 in Warsaw the 5th National conference for representatives of partner communes in the local drug monitoring and 23rd Conference of Provincial Drug Information Experts was held by the Polish Focal Point in cooperation with the Mazovian Centre for Social Policy (MCPS).

The 2-day conference entitled "Drug monitoring at national, regional and local level – challenges and achievements" was attended by nearly 60 drug professionals dealing with drugs and drug addiction at local government level.

During the conference, results of the latest research (general population surveys and wastewater analysis). Moreover, harm reduction programmes for injecting drug users and clubbers were pre-

sented. The presentations were intended to encourage local governments to support such activities. The results of the pomorskie province analysis were also demonstrated.

A representative of the National Medicines Institute presented results of the latest analyses of NPS. The conference was aimed to improve knowledge of staff of communal authorities and marshal Office in the field of drug monitoring.

At the end of September, Provincial Drug Information Experts took part in a study visit to the European Monitoring centre for Drugs and Drug Addiction (EMCDDA) in Lisbon**.** The two-day trip featured presentation of drug prevention activities in the provinces zachodniopomorskie, wielkopolskie, malopolskie and opolskie. The actions of the Polish Focal Point were also presented. Moreover, experiences in monitoring drugs and drug addiction at provincial and local level were demonstrated. The visit was concluded with an invitation of the representative of the city of Opole to a local monitoring expert meeting in Lisbon.

Moreover between 19 and 20 March 2013 in Warsaw, an international conference entitled "National, regional and local monitoring of drugs and drug addiction – challenges and achievements across Europe" was organized by Reitox Focal Point along with the Masovian Centre for Social Policy and the Italian Focal Point and the European Monitoring Centre for Drugs and Drug Addiction. The conference was attended by 100 participants representing the Network of Provincial Drug Information Experts, network of communes monitoring drugs and drug addiction at local level, NGOs and Polish drug services. There were also experts from 11 countries: Austria, Georgia, Lithuania, Latvia, Germany, Portugal, Slovakia, Turkey, Romania, United Kingdom and Italy and an official from the European Monitoring Centre for Drugs and Drug Addiction. The purpose of the conference was to share the experience of monitoring drugs and drug addiction in Poland and Europe and discuss possible developments of drugs strategies. Respective conference sessions were devoted to the principles and ways of monitoring drugs and drug addiction at local and regional level with particular emphasis placed on the Italian model. There were also discussions regarding the evaluation and monitoring of the implementation of drugs strategies including the Polish approach. The meeting ended with the analysis of examples of national drug monitoring models and responses to identified problems. During the conference was presented to the participants a Polish version of the EMCDDA handbook entitled "Building a national drugs observatory". The wide range of drug monitoring models presented during the conference confirmed a multidimensional nature of the drugs problem along with a diversity of institutional responses to the drug-related consequences. Collecting and analyzing drug-related data are therefore of key importance in the process of implementing effective and adequate remedial action. It is possible thanks to ongoing updates on drugs and drug addiction both at national as well as regional and local levels (Malczewski, 2013m).

As every year, Provincial Drug Information Experts, in collaboration with the Polish REITOX Focal Point (CINN) and according to the CINN manual, drew up reports on drug addiction risks in respective provinces. The reports presented the epidemiological situation and overview of drugs and drug addiction at regional level. Provincial resources with reference to drug prevention the extent of needs satisfaction in the field of drug prevention and treatment were also assessed. The reports also contained suggestions and recommendations as to the further development of provincial drugs strategies. The CINN collected and submitted to Provincial Drug Information Experts available statistical data on drugs and drug addiction as well as institutional response in this field. The data were later used by the Provincial Experts in regional analyses.

Moreover, the CINN performed actions aimed at promoting and developing the monitoring of drugs and drug addiction at local level by supporting and participating in seminars and training courses in monitoring drugs and drug addiction organized by the governments of wielkopolskie, malopolskie and mazowieckie provinces (Malczewski, 2013l).

Institutional response to drug addiction in 2012 – ARS-C Robert Sobiech, survey ordered by the National Bureau for Drug Prevention

Introduction

A considerable number of analysis of drugs and drug addiction are conducted on the basis of the diagnosis of the scale of the problem, harm caused by the drug problem, risk groups, causes of drug use problems and evaluations of actions implemented. It happens relatively rarely that analyses of drug prevention systems or resources of national drugs strategy entities are conducted. The lack of such knowledge poses a major obstacle to the assessment of effectiveness of strategies adopted and prevents corrective measures.

This survey was carried out between 20 November and 10 December 2012 and included all NGOs dealing with drug demand reduction at national level. The study involved organizations operating exclusively in the field of drug demand reduction but also entities which deal with demand reduction as part of their mandate. The list of the surveyed organizations was agreed with the National Bureau for Drug Prevention. The first project devoted to the institutional response to the drug problem, similar to this one, was conducted in Poland and three other Central European Countries towards the end of the 1990s. In 2003, ARS-C implemented another survey of such type in Poland.

In 2012, 31 organizations reduced drug demand at national level, out of which 29 were involved in this survey. Compared to the surveys conducted previously, no changes were noticed in terms of the number of active organizations (32 organizations in 2003 and 38 in 1999).

Objectives

Objectives of this survey were the following:

- finding out about human resources of NGOs (staff qualifications, number of employees and volunteers);
- finding out about organizations' financial situation and sources of funding (analysis of budgets, including resources earmarked for drug prevention, description of current sources of funding);
- finding out about current goals and future priorities (mission and aims of NGOs, courses of development);
- finding out about activities in the field of drug demand reduction (comprehensive review of programmes in the field of drug prevention, information, treatment, care, rehabilitation, research, documentation, financing, coordination, interest representation, involvement in the process of development of public programmes, legislation and staff training);
- evaluating the National Drugs Strategy (opinions of leaders of NGOs concerning strengths and weaknesses of the Polish policy and opinions of preferred courses of development);
- analyzing networks (key relations) of organizations concerned with drug demand reduction.

Methodology

The survey was conducted through the CATI method (Computer Assisted Telephone Interview). Leaders of the surveyed NGOs or designated staff members responsible for drug demand reduction were interviewed. In individual cases the survey questionnaire was completed by respondents and then emailed to the authors. The interviewers were qualified surveyors with experience in similar projects implemented for central and local public administration.

Survey results – conclusions

- **Summary of institutional response to drug addiction:** Polish drug prevention system is both stable and open to the presence of new entities. It relies strongly on NGOs.
- **Financial resources:** The survey results showed a clear rise in financial resources of NGOs allocated for drug demand reduction compared to the situation of 2003. In 2012, an average budget earmarked for drug demand reduction increased from EUR 319 thousand to EUR 813 thousand. Compared to 2003, there were considerable improvements in NGOs financial situation regarding the public administration support.
- **Human resources:** Data on the numbers of employees responsible for drug demand reduction between 1999 and 2012 are similar. In 1999, the surveyed organizations employed 50 staff on average, in 2003 – 58 and in 2012 – 48. There was also a sharp decrease in the numbers of NGO volunteers responsible for combating demand for drugs.
- **NGO activities:** The Polish system of drug prevention varies in terms of actions implemented. The existence of various forms of activities is barely linked to the high level of specialist profile of NGOs surveyed. Most NGOs operate in almost all areas of demand reduction. However, the comparison of 2012 actions with those implemented 9 years before indicates a steady process of concentration on selected areas of operation. In 2012, a vast majority of NGOs preformed drug prevention and held training seminars for drug professionals. As for the priorities, it appeared that the most important area of operation was broadly understood prevention, including education and information – 33% of answers (42% in 2003). Other priorities included treatment and care – 26% of answers (same in 2003) and research/analyses and drug professional training – 11% respectively (3% in 2003). Major positive changes in NGO profiles is the improvement in staff competence (e.g. staff development or therapeutic and medical trainings). Negative changes in the last 3 years included financial problems and limitations – 63% of answers.
- **Opinions on the scale of drug problem:** The survey results show that even among professionals dealing with drug prevention on a daily basis there are different opinions as to the scale of the problem. Estimates of illegal substance users ranged from 25 thousand to 12 million. It must be stressed that the 2012 estimates were far higher compared to those of 1999 and 2003.
- **Attitudes to drug addiction:** The results of this survey revealed major liberalization of attitudes to drugs and drug addiction. In 1999, permissive attitudes were recorded in 16% of NGOs, in 2003 the figure stood at 4% and in 2012 at 23%.
- **Opinions of drug policy:** Over a half of the surveyed organizations believe that the current policy towards drugs and drug addiction concentrates on demand reduction, harm reduction and legal control.
- **Relations among NGOs:** The survey also aimed at finding out about the relations among NGOs in 3 key areas of the drug prevention system: joint actions, informal communication and strategic cooperation. In 2012, the level of joint actions was as intensive as in 2003. A similar situation was noticed in terms of strategic cooperation. Only in the case of informal communication was a clear fall in mutual relations recorded. The analysis of joint actions revealed a leading role of the national Bureau for Drug Prevention. In 2012, the National Bureau was co-implementing actions with nearly all organizations i.e. 25 out of 29 surveyed (89%) while in 2003 it was 58%. In 2003, the MONAR Society played a key role in this area. The leading role of the National Bureau in joint drug demand reduction-related actions seems not only the consequence of the formal and legal position of the Bureau but also substantial intensification of joint action in the last 9 years. However, a source of concern is the narrowing scope of joint actions implemented by NGOs. 9 years before they were major centres of cooperation with other entities within the system. In terms of strategic cooperation, whose indicator is consultations with other organizations prior to major

decisions within a given organization, in 2012 it was the National bureau that was consulted in the area of key decisions. Other organizations that played an important role included Res Humane Humanitarian Aid Foundation and Drug Treatment and Prevention Team of the Institute of Psychiatry and Neurology. Informal communication was the only sphere of relations where a shrimp decrease in interactions was noticed (intensity of network) compared to the situation of 2003, which might have been caused by a higher formality of the system and reductions of many previous relations between organizations.

New psychoactive substances

For a number of years Poland has been actively supporting international efforts related to new psychoactive substances (legal highs) by participating in expert conferences and meetings. Polish experience in the field of NPS prevention has been presented in many EU Member States e.g. in Amsterdam, Lisbon, London, Brussels, Frankfurt, Rome, Budapest and beyond the EU in Palm Springs, Skopje and Tbilisi. This year a representative of the Polish Focal Point has taken part in two expert meetings under the G8 Roma-Lyon Group (RLG) in London during the British Presidency of the G8 Group and presented the Polish experience in NPS prevention. In the course of international cooperation, the Polish REITOX Focal Point by the National Bureau for Drug Prevention along with the Hungarian Focal Point and the European Monitoring Centre for Drugs and Drug Addiction organized an international conference devoted to new psychoactive substances entitled Reitox Academy on New Psychoactive Substances. The meeting was held in Warsaw at the beginning of September and was the follow-up of the first Budapest expert conference of 2012. The Warsaw conference was attended by experts from over twenty countries, especially the EU but also from Norway, Macedonia, Serbia and Georgia. They were principally Focal Point workers but there were also representatives of universities (Prague, Frankfurt, Warsaw), ministries (Latvia, Romania) and drug treatment services (Tbilisi, Warsaw). Moreover, the conference was inaugurated by a representative of the European Commission who presented the state of works on the European approach to new psychoactive substances. During the five sessions the following issues were discussed: NPS monitoring, legal solutions, NPS use patterns and qualitative research methodology (Malczewski, 2013g). Summing up, during the two days 25 presentations were delivered by representatives on over ten countries on different aspects of new psychoactive substance and the ways of preventing the phenomenon (Malczewski, 2013). At present, Poland (represented by University of Social Sciences and Humanities) is participating in the I-Trend international project, which seeks to develop an NPS user profile as well as research tools. During the conference, lab analyses of seized NPS were presented. They show that that the most popular new drugs on the market now are synthetic cannabinoids. The conference was an opportunity to exchange information and continue works on drug prevention and enjoyed great interest of the participants. The only measurement which shows NPS prevalence use across the whole European Union is Eurobarometer 2011 commissioned by the European Commission. The highest prevalence rates for NPS use were recorded in Ireland (16%), Poland (9%), Latvia (9%) and the United Kingdom (8%). The European average rate stood at 5% (European Commission, 2012). During the Warsaw conference, more recent studies conducted in respective countries were presented. The prevalence of NPS use in Portugal according to the latest research is relatively low and stands at 0.4% (participants aged 15-64, 2012). However, the latest survey conducted among Lisbon students (SICAD) indicate that new psychoactive substances are used by every third respondent (Duarte, 2013). In Norway, in the age group 16-30.3% of the respondents reported using NPS in 2013 (Odd, 2013). The epidemiological situation in Latvia is similar to Poland. According to Eurobarometer 2011, the percentage of experimenting users was the same as in the ESPAD survey. 11% of 15-15-year-olds in Latvia (Zile-Vesiberga, 2013) and 10% in Poland (Sierosławski, 2011) reported using NPS in a lifetime. According to the Czech su-

rvey of 2012 conducted in the population aged 15-64 the lifetime prevalence of NPS use stood at 1.1% (Grohamnova, 2013). The survey conducted the same year in Poland (Malczewski, Misiurek, 2013) demonstrated prevalence rates of similar level (1.4%) as in the Czech survey. In 2011, there were approx. fifty stationary NPS shops and seventeen online. After the closure of Polish shops, there was a rise of Czech NPS outlets located close to the Polish border (Vendula, 2013). Some of these shops were run by Poles. Some countries conducted surveys among problem drug users, predominantly injecting users. The results of such research of Poland, Czech Republic, Hungary and Romania were presented during the conference. In Poland, the Polish Focal Point carries out national survey of low-threshold programme clients (needle and syringe exchange, drop-in centres). In 2010, the survey questionnaire for the first time included a question about mephedrone use in the last 30 days. The survey showed that 10% of the respondents had used mephedrone. In 2012 the rate remained at a similar level (12%), however, the mephedrone use pattern changed (Malczewski, 2013c). In 2012, a considerably larger group of respondents injected the drug (90%) while in 2010 it was 40%. Moreover, in 2012, approx. 14% of the respondents reported using various NPS under the category 'other substances' (Malczewski, 2013g). Analyzing the profile of mephedrone users, based on the 2012 survey, it can be stated that the users were predominantly male aged 34 on average. They were mostly aged 20-54. The mephedrone respondents had also used other substances: methadone (51% of mephedrone users), heroin (49%) Polish homemade heroin (20%) and amphetamine (48%). Last year, the Polish Focal Point conducted a focus group under the cooperation with the EMCDDA and other drug treatment services. Drug treatment professionals provided information on new clients dependent on mephedrone. The NPS market is changing dynamically. In the last 8 years the European Early Warning System on Synthetic Drugs included 273 new psychoactive substances. Poland reported twelve substances. The situation is changing rapidly. New substances are quickly being replaced. According to the National Institute of Medicines (NIL) the most prevalent substance in 2008 was BZP, which appeared in half of the samples examined by the NIL. BZP, which was delegalized in 2009, was replaced by mephedrone, which was found in every third NPS. The following year, mephedrone was delegalized and in 2010 another substance (MDPV) was found in every fifth product. The year 2012 was dominated by the synthetic cannabinoid UR-144, which was detected in every third new psychoactive substance – 29% of the products contained this agent (Błażewicz, 2013). In 2013, another rise in NPS stores was observed in Poland. This trend triggered intensive activity of the sanitary inspection service, which has conducted 427 inspections since the beginning of the year and seized 15 000 products. 540 of them underwent analysis and PLN 7 million worth of penalties were imposed (Hołownia, 2013). During the September conference on NPS, an international project was presented. The project called 'I-Trend' includes France (project leader), Netherlands, United Kingdome, Czech Republic and Poland. It is funded by the European Commission and aims at finding tools for online research into new psychoactive substances based on qualitative and quantitative methods. Poland is represented in the project by the University of Social Sciences and Humanities, which is responsible for the quantitative component of the online survey. The project also aims at identifying the most prevalent new psychoactive substances (so-called TOP 10). In 2013, the TOP 10 generated on the basis of lab analyses results included the following substances: 3,4-DMMC; 3-MMC; AM-2201; Brephedrone; Ethcathinone; MDPBP; Mephedrone; Pentedrone; PVP; UR-144; MPPP.

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

prepared by Artur Malczewski, Anna Strzelecka, Anna Misiurek

1. Drug use in the general population

• Prevalence of illicit substance use – results of 2012 survey[9]

In 2012, a survey conducted in the course of Gambling Problem Fund research studies into behavioural addictions included questions about the use of psychoactive substances. The survey was carried out by the Public Opinion Research Centre (CBOS) in April 2012 on a nationally representative sample of Polish population aged +15. The measurement was based on the computer-assisted personal interviewing method (CAPI). The sample was randomly drawn from the frame of the Universal Electronic System of Population Registration (PESEL) 4 038 interviews were held. The degrees of bias in the respective sociodemographic groups were minimised by the weighting procedure. Therefore, the sets were weighted according to the following variables: sex, age (in groups according to sex), place of residence category and education (Badora, 2012). The weighted sample size aged 15-64 was 3 428 participants.

The calculations presented herein were conducted by means of the SPSS statistical package. Results of the two previous drug use prevalence measurements of 2006 (Sieroslawski, 2006) and 2010 (Malczewski, Struzik, 2012) were used for comparison. The 2012 report results on behavioural addiction are available at the website of the National Bureau for Drug Prevention http://www.kbpn.gov.pl/portal?id=15&res_id=2264442.

The aim of the survey was to determine the scale of illegal substance use and to identify trends of illegal drug use by comparing this measurement to those of 2006 and 2010. Consequently, the results will have a practical dimension as they could be applied to evaluate the actions taken in the field of drug demand reduction.

Prevalence

The survey participants were asked about their drug use experiences. They answered questions about using psychoactive substances in the last 30 days (current use), last 12 months (recent use) and ever in a lifetime (lifetime prevalence). The respondents who reported using drugs in the last 12 months are called recent users and those who used drugs in a lifetime are referred to as experimental users. In the measurement, questions about using respective drugs were asked separately. There was an additional question about a non-existent drug called 'astrolit'. If the substance was used by very few individuals and the prevalence rates stood below 0.05% then the '0' answer was entered in the table. If no one reported using a substance, then the sign '-' was entered.

13.7% of the respondents had used drugs in a lifetime. The recent and current use prevalence rates stood at 4.8% and 2.5% respectively. The most popular drug among the respondents was cannabis (lifetime prevalence rate of 12.2%). Over fourfold lower rate was recorded for amphetamine use (2.9%). Slightly more than 1% of the respondents had ever used ecstasy. Similar values were observed for hal

9 Published in Serwis Informacyjny NARKOMANIA No 1 (61) of 2013: Malczewski, A., Misiurek, A. (2013a), Badanie w obszarze uzależnień od narkotyków. Serwis Informacyjny NARKOMANIA nr 1 (61) str. 41-43

lucinogens (both hallucinogenic mushrooms - 1% and LSD – 0.8%). In the last 12 months prevalence, 4% of the respondents reported using cannabis and 0.6% had used amphetamine. In the case of the remaining substances, the rates were lower than 0.5%. The last 30 days prevalence rates for cannabis and amphetamine use stand at 1.8% and 0.3% respectively (see Table 2.2.1.).

Table 2.2.1. Lifetime, last 12 months and last 30 days drug use prevalence rates (%)

Drug use prevalence rates (%)			
	Lifetime	**Last 12 months**	**Last 30 days**
Any drug	13.7	4.8	2.5
Cannabis	12.2	3.8	1.8
LSD	0.8	0.1	-
Amphetamine	2.9	0.6	0.3
Hallucinogenic mushrooms	1.0	0.1	-
Ecstasy	1.1	0.1	0.0
Crack	0.2	-	-
Cocaine	0.8	0.2	-
Astrolit	-	-	-
Heroin	0.1	0.0	0.0
Methadone	0.0	0.0	-
Kompot – Polish homemade heroin	0.2	0.1	0.1
GHB	0.0	0.0	-
Anabolic steroids	0.5	-	-
Inhalants	0.4	-	-
Legal highs	1.4	0.2	0.0

Source: Polish Focal Point, 2013

Let us see whether the sex variable differentiates the prevalence rates. The analysis of Table 2.2.2. shows that men use psychoactive substances more frequently than women and this trend is observed both in experimental and the last 12 months use. Among the respondents, 17.9% of men had ever used cannabis whole the rate in women stood at 7.8%. Similar differences are observed in the case of amphetamine – men (4.5%) use it three times as frequently as women (1.4%). Higher drug use prevalence rates among men were recorded in the case of hallucinogenic substance, cocaine and anabolic steroids.

Table 2.2.2. Lifetime and last 12 months drug use prevalence rates, by sex (%)

Drug use prevalence rates by sex (%)				
	Lifetime		Last 12 months	
	Women	Men	Women	Men
Any drug	7.8	19.9	2.3	7.5
Cannabis	6.6	17.9	1.7	6.0
LSD	0.3	1.2	-	0.1
Amphetamine	1.4	4.5	0.3	0.8
Hallucinogenic mushrooms	0.3	1.8	-	0.1
Ecstasy	0.7	1.6	-	0.3
Crack	0.1	0.3	-	-
Cocaine	0.2	1.4	-	0.3
Astrolit	-	-	-	-
Heroin	0.1	0.1	0.1	-
Methadone	-	0.1	-	0.1
Kompot – Polish homemade heroin	0.1	0.3	0.0	0.1
GHB	0.1	-	0.1	-
Anabolic steroids	-	0.9	-	-
Inhalants	0.3	0.6	-	-
Legal highs	0.4	2.4	-	0.5
Sedatives and hypnotics	5.6	2.6	3.0	1.4

Source: Polish Focal Point, 2013

Apart from age, a differentiating factor for drug use is age. Table 2.2.3. shows results of illicit drug use prevalence rates in five age groups. The highest rates were recorded among experimental users aged 25-34. As for recent and current users the rates are the highest in the youngest age cohort: 13.0% and 6.6% respectively.

Table 2.2.3. Lifetime, last 12 months and last 30 days drug use prevalence rates in 2012, by age (%)

Drug use prevalence rates by age (%)					
	15-24	**25-34**	**35-44**	**45-54**	**55-64**
Lifetime	22.6	23.5	11.6	5.5	3.8
Last 12 months	13.0	7.2	2.0	0.8	1.0
Last 30 days	6.6	3.8	0.6	0.5	0.5

Source: Polish Focal Point, 2013

In the division into age groups and the respective psychoactive substance, the highest prevalence rates were observed in cannabis users aged 15-24 (21%). As for amphetamine and ecstasy, the highest rates were recorded in an older age group of 25-34 (7.4% and 3.2% respectively). It must be stressed that with age the rates for respective substances decrease and except for cannabis they do not exceed 3%. It is worth noting that cannabis use was reported by every fifth respondent aged 25-34 and every tenth respondents in the age group 35-44 (10.4%).

Table 2.2.4. Lifetime drug use prevalence rates in 2012, by age (%)

Lifetime drug use prevalence rates by age (%)					
	15-24	25-34	35-44	45-54	55-64
Cannabis	21.0	20.3	10.5	4.8	3.0
LSD	0.8	1.3	1.5	0.2	0.0
Amphetamine	3.1	7.4	2.9	0.2	0.1
Hallucinogenic mushrooms	0.6	2.6	1.2	0.3	0.0
Ecstasy	1.4	3.2	0.5	0.2	0.0
Crack	0.0	0.1	0.5	0.3	0.0
Cocaine	1.1	1.1	1.2	0.2	0.3
Heroin	0.2	0.0	0.0	0.2	0.1
Kompot – Polish homemade heroin	0.3	0.3	0.0	0.3	0.3
Anabolic steroids	0.9	0.8	0.5	0.2	0.0
Methadone	0.2	0.0	0.0	0.0	0.0
Inhalants (e.g. glues, paints)	0.3	0.6	0.2	0.8	0.3
Other	1.1	1.0	0.2	0.5	0.5

Source: Polish Focal Point, 2013

Let us compare drug use prevalence rates in different age group according to sex. Table 2.2.5. shows rates of the respondents across three age groups, separately for both sexes. Almost every third man and every tenth woman up to the age of 35 had used cannabis. While the rates for cannabis users in both age groups of 15-24 and 25-34 are the same, in the case of amphetamine the older age cohort participants (25-34) admitted using amphetamine two times as frequently.

Table 2.2.5. Lifetime drug use prevalence rates in 2012, by sex and age (%)

Lifetime drug use prevalence rates by age (%)						
	Men			Women		
	15-24	25-34	35+	15-24	25-34	35+
Cannabis	29.3	29.6	9.0	12.5	10.7	3.3
LSD	1.2	2.2	0.8	0.3	0.3	0.3
Amphetamine	4.5	11.7	1.4	1.6	2.8	0.8
Hallucinogenic mushrooms	1.2	4.2	1.1	0.0	1.3	0.0
Ecstasy	1.8	4.5	0.2	0.9	1.8	0.2
Crack	0.0	0.0	0.5	0.0	0.3	0.0
Cocaine	1.8	2.2	0.9	0.3	0.0	0.2
Heroin	0.0	0.0	0.1	0.3	0.0	0.1
Kompot – Polish homemade heroin	0.3	0.5	0.2	0.3	0.0	0.2
Anabolic steroids	1.8	1.5	0.4	-	-	-
Methadone	0.3	0.0	0.0	-	-	-
Inhalants (e.g. glues, paints)	0.0	0.7	0.6	0.6	0.5	0.2
Other	0.9	1.7	0.4	1.2	0.3	0.3

Source: Polish Focal Point, 2013

Last 12 months prevalence

In the case of describing trends on the drug scene, it is more useful to consider the recent use rate. Experimenting might be related to one-off incidents of using a given substance and/or one-off behaviours which had occurred many years prior to measurement.

The analysis of Table 2.2.6. shows that the highest 12 months prevalence rates are observed for cannabis and amphetamine. The rates for the other substances are low and do not exceed 1%. 2% of the respondents aged 15-24 and 1% aged 25-34 had used amphetamine in the last 12 months. Cannabis had been used by every tenth respondent aged 15-24 (11%), while in the older age group the rate was lower by half (5.7%).

Table 2.2.6. Last 12 months drug use prevalence rates, by age (%)

Last 12 months drug use prevalence rates by age (%)					
	15-24	**25-34**	**35-44**	**45-54**	**55-64**
Cannabis	11.0	5.7	1.4	0.3	0.4
LSD	0.3	0.0	0.0	0.0	0.0
Amphetamine	2.0	0.9	0.0	0.0	0.0
Hallucinogenic mushrooms	0.3	0.0	0.0	0.0	0.0
Ecstasy	0.5	0.1	0.0	0.0	0.0
Crack	0.0	0.1	0.5	0.3	0.0
Cocaine	0.6	0.0	0.2	0.0	0.0
Heroin	0.2	0.0	0.0	0.0	0.0
Kompot – Polish homemade heroin	0.3	0.0	0.0	0.0	0.0
Anabolic steroids	-	-	-	-	-
Methadone	0.2	0.0	0.0	0.0	0.0
Inhalants (e.g. glues, paints)	-	-	-	-	-
Other	0.3	0.4	0.0	0.0	0.3

Source: Polish Focal Point, 2013

Last 12 months drug use prevalence rates among men are higher than men in all age groups (Table 2.2.7.). The percentage of men (15.8%) aged 15-24 using cannabis is almost three times as high as that of women (5.9%). In the case of amphetamine it is over two times as high (2.7% and 1.2% respectively). Apart from these two substances women practically had not used other substances in the last year. Both in men and women the prevalence rates decrease with age.

Table 2.2.7. Last 12 months drug use prevalence rates in 2012, by sex and age (%)

Last 12 months drug use prevalence rates by age (%)						
	Men			Women		
	15-24	25-34	35+	15-24	25-34	35+
Cannabis	15.8	9.5	1.2	5.9	1.8	0.3
LSD	0.6	0.0	0.0	-	-	-
Amphetamine	2.	1.2	0.0	1.2	0.5	0.0
Hallucinogenic mushrooms	0.6	0.0	0.0	-	-	-
Ecstasy	0.9	0.2	0.0	-	-	-
Crack	-	-	-	-	-	-
Cocaine	1.2	0.0	0.1	-	-	-
Heroin	-	-	-	0.3	0.0	0.0
Kompot – Polish homemade heroin	0.3	0.0	0.0	0.3	0.0	0.0
Anabolic steroids	-	-	-	-	-	-
Methadone	0.3	0.0	0.0	-	-	-
Inhalants (e.g. glues, paints)	-	-	-	-	-	-
Other	0.0	0.7	0.1	0.6	0.0	0.1

Source: Polish Focal Point, 2013

Drug use and age

Table 2.2.8. show lifetime and last 12 months drug use prevalence rates. The data have been presented according to sociodemographic data, which are significant for drug consumption analyses. It must be stressed that the last year results demonstrate the recent situation on the drug scene.

The highest illicit drug use prevalence rates among experimental users were recorded in age group 25-34 (23.5%) and the lowest in the oldest cohort (55-64: 3.8%). A high percentage of lifetime drug users is observed among 15-24-year-olds: 22.6%.

In the case of recent drug use the highest rates appear in the youngest cohort (15-24: 13%) and the lowest, similarly to experimental users, among the oldest respondents (55-64: 1%).

Drug use poses a problem especially in big cities, both in terms of experimenting and recent use. Every fourth respondent (26.9%), who lived in a city of over half a million population, reported expe-

rimenting with drugs. In towns of up to 20 000 population this rate stood at 17.5%. Drugs were least prevalent in rural areas (8.1%). It must be stressed that the percentage of city dwellers (17.2%) who had experimented with drugs is two times as high as the percentage of residents of rural areas (8.1%).

Over 10% of the respondents living in large cities reported using psychoactive substances in the last 12 months. In cities of population ranging between 20 000 and 50 000 the recent use prevalence rates stood at 5%. The lowest rates were recorded among residents of rural areas.

The results of the survey show that substance use is linked to education. The highest lifetime prevalence rates were recorded in respondents with higher education (19.9%) and among middle school students (19.6%). Among respondents with secondary education this rate stood at 17%. The lowest prevalence was observed among respondents with primary education (5.6%).

In the case of recent use, the highest rates are observed among middle school students (11.7%) and individuals with incomplete secondary education (8.8%). Among college graduates this rate stood at nearly 6%. The lowest rates were recorded in vocational school graduates (1.7%) and individuals who completed post-secondary education (2.7%).

Occupational status is also a differentiating factor. The data analysis shows that drugs are most frequently used by school and college students (21.3%) and to a lesser degree by employed (15.3%) and unemployed individuals (13.6%). The lowest rate was recorded among pensioners and long-term disability beneficiaries (3.9%).

Similar results are observed in recent drug use. The table below shows that the highest rates are observed among school and college students (13.3%), unemployed (5.7%) and employed individuals (4%) while the lowest in pensioners and long-term disability beneficiaries (1%).

The table below also contains data on the marital status of the respondents. Drugs are most often used by single individuals (23.4%). 13.2% of divorced or separated respondents reported experimenting with drugs. The lowest lifetime prevalence rates are observed among widows or widowers (0.8%).

11.5% of single respondents reported using drugs in the last 12 months. This is the group with the highest rate in this category. Among widows/widowers this rate was nearly 1%.

A differentiating factor was the economic status. Respondents who considered their situation good or fairly good had used psychoactive substances more frequently (17.0%-18.4%). These rates were by a third higher than those observed among respondents who regarded their economic status as bad (10.2%-11.5%). Similar values were recorded with reference to the last 12 months prevalence. The highest rates were recorded among individuals who viewed their economic situation as good or very good (7.4%-8.9%). Among individuals viewing their economic situation as bad or very bad the rates were below 4%.

The survey also featured a question about the involvement in religious practices. The highest rates were recorded among non-church goers. In this group, every third respondent reported using drugs in a lifetime (29.9%). Among respondents who practised religion several time a week, the rates are ten times as low and stand at 2.9%. Similar lifetime prevalence rates are observed if we compare deep believers (7.1%) and non-believers (40%). Every fourth respondent considering themselves a non-believer reported using psychoactive substances in the last year. Among deep and moderate believers these rates stood at 2.4% and 3.5% respectively. Similarly to experimenting, respondents practising religion one or several times a week presented lower prevalence rates (2%). The rates among non-practitioners are sixfold higher and stand at 12.8%.

Table 2.2.8. Lifetime and last 12 months prevalence rates according to sociodemographic data (2012) (%)

Lifetime and last 12 months prevalence rates		
	Lifetime	**Last 12 months**
Total	13.7%	4.8%
Women	7.8%	2.3%
Men	19.9%	7.5%
Age		
15-24	22.6%	13.0%
25-34	23.5%	7.2%
35-44	11.6%	2.0%
45-54	5.5%	0.8%
55-64	3.8%	1.0%
Size of place of residence		
Rural areas	8.1%	3.1%
Up to 19 999 population	17.5%	5.3%
20 000 to 49 000 population	15.5%	5.4%
50 000 to 99 999 population	11.4%	4.3%
100 000 to 4999 999 population	13.9%	4.0%
over 500 000 population	26.9%	10.7%
Education		
Incomplete or no primary education	0.0%	0.0%
Primary	5.6%	2.9%
Middle school	19.6%	11.7%
Vocational	7.5%	1.7%
Incomplete secondary	16.9%	8.8%
Secondary	16.7%	5.2%
Post-secondary	9.0%	2.7%
Higher	19.9%	5.6%
Occupational status (significance level < 0,000)		
In employment	15.3%	4.0%
Long-term disability beneficiary, pensioners	3.9%	1.0%
School/college student	21.3%	13.3%
Housewife	4.3%	0.0%
Unemployed	13.6%	5.7%
Not in employment for other reasons	6.3%	2.1%

Marital status (significance level < 0,000)		
Single	23.4%	11.5%
Married (also in a steady family-like relationship, however, not married)	9.1%	1.5%
Divorced (in separation)	13.2%	3.3%
Widowed	0.8%	0.8%
Hometown		
Urban area	17.2%	5.9%
Rural area	8.1%	3.1%
Economic status perception (significance level < 0,000)		
Very good	17.0%	8.9%
Fairly good	18.4%	7.4%
Average	11.8%	3.4%
Rather bad	10.2%	3.9%
Very bad	11.5%	3.8%
Hard to say	6.7%	0.0%
Involvement in religious practices (significance level < 0,000)		
Yes, usually several times a week	2.9%	1.9%
Yes, once a week	6.8%	1.9%
Yes, on average, once or twice a week	13.5%	4.6%
Yes, several times a year	19.8%	6.5%
I do not practice religion	29.9%	12.8%
Refusal to answer	7.7%	7.7%
Involvement in religious practices (significance level < 0,000)		
Deep believer	7.1%	2.4%
Moderate believer	11.9%	3.5%
Moderate non-believer	42.9%	18.4%
Total non-believer	43.9%	25.2%
Refusal to answer	16.7%	16.7%

Source: Polish Focal Point, 2013

2012 Survey and previous measurements

Let us compare the results of the 2012 survey to the previous measurement. It must be acknowledged that the latest study covered not only substance use but also behavioural addictions. The 'drug' questions constituted only part of the whole interview. Previous measurements of 2006 and 2010 focused exclusively on psychoactive substances. Table 2.2.9. shows results of the three surveys. In 2010, the highest prevalence rates were recorded for all substances. In the case of lifetime prevalence, the results of the latest measurement indicate a return to the values of 2006. The only exception is the prevalence cannabis use, which increased in 2010 compared to 2006. The 2012 last 12 months prevalence rates are slightly higher compared to 2006 (Malczewski, 2013d).

Based on the results of the survey we may tentatively conclude that the sharp rise in drug use prevalence of 2012 became halted or might have even decreased in 2012. Due to varying contexts of 'drug; questions in the 2012 survey, compared to the previous measurements, firm conclusions must be drawn with caution.

Table 2.2.9. Lifetime, last 12 months and last 30 days drug use prevalence rates in 2006, 2010, 2012 (%)

Drug use prevalence rates in 2006, 2010, 2012 (%)									
	Lifetime			Last 12 months			Last 30 days		
	2006	2010	2012	2006	2010	2012	2006	2010	2012
Any drug	n/a	19.3	13.7	3.1	10.3	4.8	n/a	5.8	2.5
Cannabis	9.0	17.5	12.2	2.7	9.6	3.8	0.,9	5.4	1.8
LSD	0.9	2.0	0.8	0.1	0.7	0.1	0.0	0.4	-
Amphetamine	2.7	4.2	2.9	0.7	1.9	0.6	0.2	0.9	0.3
Hallucinogenic mushrooms	1.0	2.0	1.0	0.1	0.5	0.1	-	0.4	-
Ecstasy	1.2	3.4	1.1	0.3	1.5	0.1	0.1	0.6	0.0
Crack	0.2	0.2	0.2	0.0	0.1	-	-	0.0	-
Cocaine	0.8	1.2	0.8	0.2	0.7	0.2	0.1	0.5	-
Astrolit	n/a	0.1	-	n/a	0.0	-	n/a	-	-
Heroin	0.1	0.2	0.1	0.1	0.1	0.0	0.0	0.05	0.0
Methadone	n/a	0.1	0.0	n/a	0.0	0.0	n/a	0.0	-
Kompot – Polish homemade heroin	0.2	0.5	0.2	-	0.1	0.1	-	0.07	0.1
Anabolic steroids	0.4	1.7	0.5	0.1	0.7	-	0.0	0.5	-
Inhalants	n/a	1.8	0.4	n/a	0.4	-	n/a	0.3	-
Legal highs	n/a	n/a	1.4	n/a	n/a	0.2	n/a	n/a	0.0
Other	n/a	0.2	n/a	n/a	0.2	0.2	n/a	0.0	0.2

Source: Polish Focal Point, 2013

International analyses (Skarupova, 2010) indicate that including drug-related issues in surveys covering other areas such as health might affect the results. In such cases, drug use prevalence rates are lower. A survey on a youth sample, to be jointly implemented with the Public Opinion Poll Centre this year, will help us answer the question about changes in drug use prevalence trends. The measurement could then be compared to the 2010 CBOS youth survey and other surveys conducted in the past. This will enable us to find out in which group drugs are most prevalent.

2. Drug use among targeted groups/settings at national and local level

- **"Analysis of psychoactive substances in wastewater in selected cities of Wielkopolska Province. Estimating prevalence of drug use among the residents of the cities of Konin, Kalisz and Wagrowiec"**

  by Paweł Dereziński, Agnieszka Klupczyńska, Jolanta Kłos, Zenon J. Kokot, Poznan University of Medical Sciences

One of the ways of monitoring drug addiction is the analysis of sewage water. This method serves to estimate the consumption of psychoactive substances through the application of the modern analytical technique of liquid chromatography coupled with mass spectrometry. This approach is particularly useful for estimating consumption in real time and to detect trends in psychoactive substances abuse of the local population, which in turn enables the implementation of appropriate countermeasures and evaluation of their effectiveness. It can therefore complement the traditional methods of estimation of illicit drugs use in society.

Aim and method

The aim of the study was to implement the modern method of determination of illicit drugs in wastewater and to estimate on that basis the level of consumption of respective substances by residents of selected cities of Wielkopolska Province. The project was financed by the Marshal Office in Poznan, which was responsible for taking and supplying samples.

In the course of the study measurements were conducted in three cities of Wielkopolska Province (Konin, Kalisz and Wagrowiec) in November and December 2012. Based on the knowledge of the metabolism of the respective substances in human organism and their presence in urine, drug target residues (DTR) were defined. In case of cocaine it was its main metabolite benzoylecgonine whereas in case of the amphetamine-type drugs they were primary compounds. These drug target residues were determined in wastewater samples. The substances were quantified using a liquid chromatograph 1260 Infinity (Agilent Technologies) coupled with ESI - triple quadrupole mass spectrometer 4000 QTRAP (AB Sciex). The analysis included cocaine along with its metabolite benzoylecgonine and amphetamine-type drugs (amphetamine, methamphetamine, MDMA, MDEA, MDA). Based on the concentration of DTRs in urban wastewater samples, consumption of the respective substances per 1 000 inhabitants in 3 cities of Wielkopolska Province was determined.

The samples were provided by the Department of Health Protection and Addiction Prevention of the Marshal Office in Poznan. On a selected day, staff member of the sewage treatment plants in Konin, Kalisz and Wagrowiec took 5-litre samples which were then delivered to the Department of Inorganic and Analytical Chemistry, Poznan University of Medical Sciences in Poznan, Poland, where they were further analyzed.

Results:

The analyses showed that in all of the urban wastewater samples, amphetamine and methamphetamine residues (DTRs) were identified and quantified. It must be noted that the highest concentrations of the abovementioned substances (ng/L) were found in the Wagrowiec sewage treatment plant and the lowest ones in the Kalisz sewage treatment plant. The concentration of amphetamine in wastewater from Wagrowiec was from 2.5 to 8 times higher than in wastewater from Kalisz and from 1.6 to 7.2 times higher than in wastewater from Konin. In case of methamphetamine, the concentration of this substance in wastewater from Wagrowiec was from 7.8 to 11 times higher than in wastewater from Kalisz and from 1.9 to 10.8 times higher than in wastewater from Konin.

In the study a number of doses per 1 000 people per day was estimated based on the typical dose of analysed drugs. For amphetamine it ranged from 5.6 to 10.4 in Wagrowiec, 3.7-8.6 in Konin and 2.3-4.1 in Kalisz. Lower values were observed in case of methamphetamine. The highest values was recorded in Wagrowiec (0,076 – 0,097) and the lowest in Kalisz (0,017 – 0,018).

Moreover, in most samples MDMA (ecstasy) was determined, while in case of some samples - the concentration of this compound was below the level of quantification. Some amphetamine-type compounds such as MDA and MDEA and cocaine along with its metabolite were not detected in the analysed samples.

As the authors underline, the results and the above estimation are based on the analyses of few urban wastewater samples (the samples were taken twice – 24 September 2012 and 01 October 2012 or 26 November and 1 December 2012), so these results apply only to situations in those specific sampling days. In the final conclusion other factors should be also taken into account. These factors are: weather conditions, variable number of people staying in a given area, condition and size of sanitation as well as potential changes of the analysed substances in sewage.

- **Developing self-control over cannabis use and the context of illegality – study commissioned by the National Bureau for Drug Prevention**

  Authors: Dariusz Parzych, Magdalena Piejko, Michał Wanke – Pracownia Rozwoju Osobistego in Opole

Introduction and project aim

The study "Developing self-control over cannabis use and the context of illegality" was financed with the funds of the Information Polish REITOX Focal Point (CINN) of the National Bureau for Drug Prevention under the annual research competition. The researchers analyzed the process of the loss of control over cannabis use and tried to identify and define the emergence of problem drug use. They also identified and defined situations for problem cannabis users which would prompt them to stop using. However, the authors note that cannabis use and being a user have their own dynamics i.e. time variables which should be included in the analysis of the phenomenon.

Method

To follow histories of cannabis use, the study was based on the biographical method of individual interview. A total of 96 interviews were conducted, including 48 interviews with current and former cannabis users, 40 individual interviews with drug user-related individuals and dealers, 8 focus group interviews with substance abuse therapists at inpatient and outpatient clinics during which the therapists shared their experiences with cannabis users.

In the case of interviews conducted with cannabis user-related individuals, interviews were first held with family relation, partners, close friends and colleagues. The aim of these interviews was to capture the object of the study from a different perspective – seen from outside. Interviews with drug dealers provided information on the functioning of the illegal cannabis market and the user-dealer relationship.

The survey was conducted in two phases: first involved concept works and the field study, second focused on the analysis of the data collected. In the first stage interview scenarios were developed for each of the survey subgroups and then a pilot survey was carried out.

The survey participants were recruited through a network of contacts, which on the one hand made respondents comfortable during interview and on the other hand reduced the problem of selecting participants through substance abuse clinics, which usually results in the fact that a study focuses on a single type of users.

The categorized survey data were subject to comparative analysis including the perspective of current drug users, former users, individuals around users and dealers as well as therapists.

Owing to the delicate subject matter of the survey and the so-called sensitive data obtained in the course of interviews with the respondents, the survey providers were particularly careful about following strict ethical standards. To this end, detailed confidentiality rules were developed for each stage of the study, starting with approaching respondents through conducting interviews and processing the material gathered. During the interviews the researchers did not interfere with the content of the interviewers' answers, did not suggest answers and were neutral towards the participants in discussions on cannabis use and the role of cannabis in social life.

Outcome

- **Who is a cannabis user? Social definitions of cannabis and its users.**

The results of the survey demonstrate that cannabis use is related to participation in a number of social situations and relationships whose nature is determined by actions taken by cannabis users regarding purchase, transport, storing, sharing and the very using of the substance. This in turn causes that the respondents while answering the question of "*who am I?"* draw on personal experience related to the above practices. It appears then that for cannabis users using is a vital point of reference in self-perception and definition.

According to the respondents one must spate *a cannabis user* from *a cannabis smoker*. A smoker is an individual for whom using cannabis has become a problem. According to the respondents, the *smoker* term has negative connotations and is stigmatizing, consequently they do not define themselves this way if cannabis is used occasionally and does not bring social and legal consequences.

In responding to the question of "*Who am I?* users compare themselves to other user smokers, non-users or individuals using hard drugs. The awareness of the existence of other smokers (real or imaginary) provides a sort of positive reinforcement for cannabis users and somewhat justifies their cannabis use.

Considering non-users as the point of reference for cannabis smokers, the survey participants, even in response to negative opinions, rationalize such statements as they regard them as unfounded since they are formed based on rumors and simplified opinion and not personal experience.

Besides, the respondents believe that behaviour, lifestyle, goals and ideals of non-cannabis users do not differ significantly from those shared by users. The respondents clearly state that a smoker is a regular human being and in this context cannabis use cannot be considered abnormal behaviour. At the same time however, they describe changes related to different perception of the world and mood under the influence of the drug. The respondents report that using cannabis has quietening and rela-

xing qualities and makes one think creatively as well as helps to overcome shyness and integrates the group of users.

In turn, comparisons with users of hard drugs and the related consequences reinforce in the respondents the belief that cannabis use is safe and fully controllable. Due to the lack of negative consequences (health, mental, social or legal), cannabis users do not identify themselves as drug addicts.

In experiences related in interviews one could notice a recurrent sense of social misunderstanding, which to a large extent provided grounds for the distinction between smokers and non-users.

Defining users and cannabis in social terms is context dependent and relates to situations in which the defining subjects function, their individual biographies and the knowledge necessary to start or quit suing cannabis. A number and variety of such situations and experiences as well as the varied knowledge in this respect cause that who a cannabis user is and what cannabis is can be viewed from different perspectives. What is important and what the authors pay attention to in the report is the inability to translate these perspectives and the lack of intersubjectivity between the world of users and therapists, which might result is inadequacy and ineffectiveness of prevention and therapeutic programmes in place.

- **Importance of illegality of cannabis for users**

As in Poland production, distribution and possession of drugs is penalized, the survey providers focused on the users' perception of cannabis illegality and the way this illegality affects the development of self-control over being a smoker.

The survey results show that the participant did not attach too much importance to the issue of cannabis illegality. They attached much more importance to controlling the quality of the drug, their mental state or motivation, which does not mean that they fail to consider in actions related to cannabis use. What is more, the very context of the substance illegality provides for users a sort of emotional thrill, experiencing an adventure while getting hold of, storing and using the drug. It appears that the respondents build a sort of buffer between the uncomfortable situation of breaking the law and being simply a cannabis user. The safety limit is already visible at the stage of obtaining the drug. They follow certain safety rules while getting cannabis, which takes place inside their social network.

However, according to the researchers, the most important issue in developing the secure manner of obtaining the drug is the right source i.e. a supplier. Most respondents have never even contacted a dealer since cannabis is provided for them by friends, friends' fiends, etc. The respondents' reports show that cannabis users regard the illegality issue as an obstacle to overcome and an objective state that one must find a way to deal with. Cannabis illegality fulfils somewhat preventive role in the sense that the respondents approach it from the technical perspective and shy away from situation that could expose them to the risk of breaking the law.

- **Developing self-control**

The core of the survey was to find out ways the respondent develop or lose self-control over cannabis use.

The results show that the respondents develop self-control in a number of aspects while the very control of cannabis use is situation and process dependent. Based on the analysis of the data collected, various dimensions of self-control over cannabis use were reconstructed. However, it must be mentioned that the following generalizations are purely theoretical as they refer exclusively to the particular group of the survey participants and not the general population of cannabis users. The self-control dimensions presented by the respondents include controlling expectations and experiences of cannabis use symptoms, cognitive control of the use process, controlling through selecting smoking

company, not substituting other drugs for cannabis, controlling quality and amount of the substance used or controlling in the form of being expected to fulfil certain social roles.

Summary and conclusions

The survey participants believe that the term *smoker* brings negative connotations and stigmatizes and its use towards cannabis users is acceptable when cannabis use generates life problems.

In seeking an answer to the question of *who I am?* users compare themselves to other user-smokers, non-users and individuals taking hard drugs.

The cannabis illegality issue is trivialized by the users. It does not matter much to them and sometimes it is an extra benefit of using (conspiracy, getting hold of the substance, being in hiding). A lot more importance is attached to the control of quality and amount of the drug consumed, which contributes to the development of a sense that they exercise control over their lives and use.

The respondents develop a sense of self-control in various aspects of everyday functioning and its dimensions involve controlling expectations and experiences of cannabis use symptoms, cognitive control of using, controlling through selecting the smoking company, etc.

The survey indicates that in developing actions focused on cannabis use both in the field of research and therapy, prevention or education one must consider the following aspects:

- working towards agreement with users – dialogue should take place at the same level of communication, any deviations in terms of definitions and (social, legal) norms make it difficult to reach expected results and users develop a sense of control also through the language;
- shifting stress from cannabis illegality to its role in situations, emotions and relationships – the very illegality does not constitute enough motivation in the recovery process so the former aspects should be considered in cannabis-related therapeutic activities and work methods;
- redefining therapy goals for cannabis users – it is worth paying particular attention whether quitting is to be the main goal or working towards situation when the user will use cannabis with greater awareness (it is of fundamental importance in the context of possible legal changes legalizing cannabis).

3. Prevention

prepared by Anna Radomska, Elżbieta Stawecka, Anna Poleganow, 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).

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 purpose 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 supplemented by establishing and developing social organizations which promote sobriety and abstinence and target alcohol abusers and provide assistance for their families.

At provincial and communal level, alcohol prevention is defined by Provincial and Communal Strategies for Prevention of Alcohol-Related Problems. These tasks are performed by provincial and communal authorities and financed through the 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.

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 outlets with sales space exceeding 200 m^2 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, students' dormitories, on site 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 is permitted. It is also prohibited to bring alcoholic beverages into stadiums and other places where mass sport and entertainment events take place. Individuals 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. Furthermore, the 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 during 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 from the customer an identity card. According to the Penal Code, driving vehicles in the state of alcohol intoxication is punishable. An individual is in the state of intoxication, within the meaning of the Penal Code, when the blood alcohol content exceeds 0.05% or leads to the concentration which will exceed 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 against 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 implementing 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 by labelling the packages of tobacco products and by advertising.
5) Decreasing the maximum legal limit of harmful substances in tobacco products.
6) Treatment and rehabilitation of tobacco-dependent patients.

According to the law, it is forbidden to smoke tobacco products outside designated and adapted areas. Smoking tobacco products 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 legal limit 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 the related facilities performing their duties as well as supporting 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 2012, 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.

In 2012, the Centre for Education Development continued supporting the network of Health-Promoting Schools which 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 effects of the Health-Promoting Schools were presented during the national conference on the 20th anniversary of Health-Promoting Schools in Poland. Today the number of schools in the network stands at 1994.

In the Polish education system health education is pursued at every level pursuant to the core curriculum defined in the Regulation of 27 August 2012 of the Minister of National Education on core curriculum in nursery school education and general education respective types of schools (Journal of Laws "Dz. U." item 977).

The core curriculum specifies mandatory teaching goals and content, including skills described in the form of general and specific standards on knowledge and skills which a student must meet upon completing respective stages of education as well as educational tasks for schools which are included in nursery school education plans and curricula.

The document also contains teaching content related to counteracting drug addiction. The preamble of the core curriculum states that health education is a vital task of the school. It teaches children to care for personal and other people's health and how to create a health-friendly environment.

Moreover, the Centre for Education Development disseminated information on evidence-based universal prevention programmes through the Bank of Prevention Programmes and telephone consultations with decision-makers, school headmasters or counsellors. The Bank is available at www.ore.edu.pl.

The Bank programmes are refer to the broadly understood health promotion and focus on risky behaviours among children and adolescents such as substance use, aggression, violence or premature sex.

In the field of legal changes, the Ministry of National Education continued works on the regulation on specific forms of educational and preventive activity among children and adolescents at risk of drug addiction. The draft regulation is the statutory obligation stipulated by Article 22.3 of the Act of 29 July 2005 on counteracting drug addiction. The Article states that the minister responsible for the matters of education in collaboration with the minister responsible for the matters of health shall define by way of regulation forms of educational, awareness and preventive activity among children and adolescents at risk of drug addiction while considering the well-being of children.

The Minister of National Education in the objectives of the state educational policy gave strengthening safety at schools and educational units top priority. Teacher training centres, counselling centres and pedagogical libraries were obliged to prepare training courses, conferences and seminars to support teachers in their actions to improve safety. In school year 2012/13 – declared the Year of Safe School by the Minister of National Education. The Coalition for Safe School was created. It comprised 16 NGOs working for the benefit of the broadly understood safety of children and adolescents. Actions to improve safety at school were also supported by the Ministry of National Education (National Bureau for Drug Prevention), Ministry of Justice, Ministry of Labour and Social Policy, Ministry of Agriculture and Rural Development, Ministry of Sport and Tourism, National Labour Inspectorate and Chief Sanitary Inspectorate. Educational and training materials were posted at www.bezpiecznaszkola.men.gov.pl.

Units of the State Sanitary Inspectorate headed by the Chief Sanitary Inspectorate continued works aimed to educate the public on risks related to using substitute drugs. At regional and local level trainings, lectures, pro-health events, competitions and educational exhibitions were organized. Moreover, educational materials were distributed by the Chief Sanitary Inspectorate, provincial and county sanitary and epidemiological stations as well as institutions responsible for drug prevention and treatment, including the National Bureau for Drug Prevention. The project targeted middle and secondary school students, education environment nurses, teachers, parents and guardians, summer and winter holiday managers and vacationers, social welfare staff, (municipal) police officers and local communities. In 2012, the target population of the substance prevention campaign including substitute drugs conducted by the State Sanitary Inspection totalled 892 172.

The National Bureau for Drug Prevention, under the task of disseminating evidence-based prevention programmes in middle schools, continued the implementation of the Unplugged universal substance abuse prevention programme. The programme targets school population aged 12-14. It is based on the comprehensive social influence approach. The aim of the programme is the reduction of drug initiation including such psychoactive substances as alcohol, tobacco, drugs and delaying the transition from experimental use to problem use. The programme consists of 12 lessons which concentrate on life skills, normative beliefs and knowledge of psychoactive substances. It also features

three workshops for parents of participant students. The programme is conducted by teachers/pedagogues previously trained by qualified trainers. By the end of 2012, the National Bureau-trained trainers prepared 554 teachers/pedagogues.

- **Family**

In 2012, the National Bureau co-financed a second edition of the provider training of the "*Family Strengthening Programme 10-14"*. The aim of the programme is to reduce drug and alcohol consumption as well as risky behaviours in children and adolescents aged 10-14. This aim is achieved through developing parenting skills and exercising control over children as well as improving interpersonal and individual skills among young people. The Family Strengthening Programme is largely based on video materials showing pro-social behaviour. In 2012, 60 programme providers were trained thanks to the financial support of the National Bureau.

Moreover, in 2012 the evaluation of the Family Strengthening Programme was completed. The study was financed by the National Bureau. The aim of it was to evaluate the impact of the programme on the risky behaviour of youth, mainly alcohol and other substance use as well as important mediators such as parent-child relationships (e.g. spending time together) and parenting practices (skill of showing love, setting and executing limits). The results of the evaluation confirmed positive impact of the programme on substance use reduction among growing children. This was caused by positive changes in parent-child relationships and development of parenting skills of parents participating in the programme.

In 2012, the Centre for Education Development supported the organization of trainings for the School for Parents and Educators programme. The programme builds solid ties between parents or educators and children – the crucial protective factor for problem behaviours. It teaches how to introduce healthy discipline and respond adequately to child misbehaviour. The School for Parents and Educators is implemented in a cascade-like manner through the network of trainers who prepare programme providers. The programme providers conduct workshops for parents and teachers. Under the programme, 40-hour training courses for parents and teachers were provided: 434 groups for 5 019 participants. The idea and concept of the School for Parents and Educators was presented during 9 provincial and one international conference.

The Centre for Education Development also co-financed the Golden Five programme which targets middle school teachers and students. The programme prepares teachers to support the adaptation of students to the middle school environment, especially first graders. 21 candidates for programme instructors were trained i.e. psychologists and pedagogues from psychological and pedagogical counselling centres in the city of Gdansk.

In 2012, the National Bureau for Drug Prevention kept financing the national online drug counselling centre at www.narkomania.org.pl. The aim of the programme was to provide assistance and reliable knowledge both to problem drug users and co-dependent individuals on the available drug services. The website features articles and publications on drug addiction, symptoms and consequences of substance use, legal regulations as well as prevention materials such as activity scenarios and educational movies which can be used in schools. The database of drug services lists contact details for centres which provide detoxification, substitution treatment and reintegration across Poland. Assistance could be obtained from a physician, psychologist or lawyer. In 2012, the online counselling centre provided 769 consultations, 88 individuals asked a question to the specialist more than once (in 2011, 782 consultations were provided).

Traditionally, the National Bureau runs the National Drugs Helpline which targets substance abusers, addicted individuals and their relatives. In 2012, 1 205 consultations were provided. The hotline mainly attracted families of drug users or individuals with other problems (66%), 21% reported their

own problems with using psychoactive substances and 13% were interested in drug-related matters for various reasons. In 84% of cases the age information was obtained from callers: 62% were over 18 years old, 25% were aged 16-18 and 13% were under 16.

- **Local community**

In 2012, 2 255 communes (gminy) submitted reports on the implementation of the National Drugs Strategy (KBPN), which accounts for 91% of all Polish local governments (2 479) (Minister Zdrowia, 2013). The highest report submission rate was recorded in the provinces of wielkopolskie (100%), dolnoslaskie, podlaskie and swietokrzyskie (99%). The lowest rate was recorded in podkarpackie province (76%).

In 2012, 1 201 communal governments decided to develop their own drugs strategies. 117 failed to develop the strategy and 936 communes developed strategies covering jointly several addiction areas. The 2012 drug prevention expenditure amounted to PLN 59 491 140, which is PLN 257 920 more compared to the previous year (PLN 59 749 060). The drug prevention expenditure comprised the following areas:

- Universal drug prevention programmes – PLN 32 174 347, which is PLN 1 225 712 more compared to the previous year (PLN 30 948 635). The amounts allocated to this task ranged from PLN 75 PLN to PLN 7 349 062, depending on the population and the severity of the drug problem;
- Selective and indicated drug prevention programme – PLN 24 369 498, which is PLN 894 832 less compared to 2011 (PLN 25 264 330). The amounts earmarked for this goal at communal level ranged from PLN 100 to PLN 1 883 971;
- Improving public knowledge of problems related to psychoactive substance use and the ways of preventing the phenomenon – PLN 1 774 886. The allocated amounts ranged from PLN 30 to PLN 101 314;
- Organizing and co-financing training courses aimed at raising professional qualifications of drug prevention staff – PLN 1 172 409. The amounts ranged from PLN 50 to PLN 117 218 per commune.

In 2012, 1 479 communal governments (66%) were implementing 6 050 universal drug prevention programmes, which is 1 990 programmes fewer compared to the previous year. The programme were being conducted at 14 740 facilities (15 574 in 2011) and included a total of 1 153 278 participants (1 345 131 in 2011). Universal drug prevention programmes targeted various groups. The programmes were conducted at all educational levels (nursery schools, primary schools, middle schools and secondary schools). There were extramural programmes, which also targeted parents. In 2012, in 7994 facilities a total of 6 118 drug prevention programmes were conducted at all levels of education (nursery schools, primary schools, middle schools, secondary schools and other educational units). The programmes included 1 157 199 children and adolescents. In 2012, the following programmes recommended by the National Bureau were conducted:

- Archipelago of Treasures (46 communes);
- Fantastic Opportunities (17 communes);
- Home Detectives (45 communes);
- Family Strengthening Programme (32 communes);
- Unplugged Programme (34 communes);
- School for Parents and Educators (84 communes).

The total number of participants targeted by the recommended programmes stood at 40 345. The most participants were involved in the programme entitled Archipelago of Treasures while the lowest attendance was recorded for the Fantastic Opportunities programme. The highest share of communes

which co-financed drug prevention programmes was recorded in the province of dolnoslaskie (82%) and slaskie (78%). Similar figures were noted in the provinces of pomorskie (76%) and zachodniopomorskie (75%). The lowest shares of communes which provided funding for universal drug prevention programmes in 2012 were recorded in the provinces of lubelskie (56%) and podlaskie (57%). Out of all communes which submitted National Drugs Strategy implementation reports (2 255), 264 urban communes, 400 urban-rural communes and 832 rural communes reported financing universal drug prevention programmes, which accounts for 91%, 74% and 58% respectively of all KBPN reporting communes in 2012.

The above data show that the widest coverage of universal drug prevention, measured by the percentage of communes involved in financing prevention in a given province, occurred in the communes of western Poland, which is consistent with the values of drug prevalence and treatment demand indicators.

3.4. Selective prevention in at-risk groups and settings

- **At-risk groups**

In 2012, 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 presenting (individual, family and environmental) factors for risky behaviour, i.e. "children of the street", minors endangered by 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. The programmes included over 300 000 participants across Poland and were conducted by NGOs.

The National Bureau also supported drug prevention programmes which included over 11 000 occasional drug users. The programmes 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). One of the programmes was about creating a game called "Take a hit of your rights", which was to familiarize young people with legal and physical consequences of possessing and using illicit drugs. The game presents new provisions of the Act on counteracting drug addiction which came into force in 2011 in a user-friendly fashion. It makes one reflect on drug use and participate in drug prevention or treatment programmes. The main channel of reaching drug users with the prevention message was YouTube and an advertising banner posted at the website of the National Bureau (www.kbpn.gov.pl). The website had scored over 30 000 hits by the end of 2012.

The National Bureau ordered the implementation of the Fred goes net early intervention programme. The programme was implemented by 15 NGOs in 27 cities. It targeted young occasional or problem drug users aged 14-21, excluding drug-dependent individuals. Sessions are held in small groups. The programme uses the motivational interviewing method. The aim is to make participants become more reflective, improve their knowledge of drug use, motivate them to assess risk and act responsibly, change attitude and behaviour related to drug use and get insight into the local drug services. The programme's effectiveness was verified in evaluation studies. Fred goes net was conducted by qualified trainers according to the pre-defined standards. The KBPN-sponsored programmed attracted 2 124 participants (including 308 parents and representatives of partner institutions – police, courts, prosecutor's offices, schools).

In 2012, the National Bureau conducted a training course for 32 FreD goes net providers. The course featured lectures and workshops carried out by certified specialists in motivational interviewing and Fred goes net early intervention. Towards the end of 2012 there were 100 trained providers of 61 prevention and treatment facilities as well as psychological and pedagogical counselling centres. In order to keep up the quality of the programme, in 2012 the National Bureau organized a seminar for the programme providers which focused on improving practical skills of motivational interviewing applicable in the programme.

Additionally, the National Bureau evaluated the programme based on the 2011 data in Poland. The evaluation results show that for 87% of the participants, Fred goes net was the first drug prevention programme. The referring institutions included schools (30% of participants), families (25%), other institutions - mainly toxicological wards (21%), courts and prosecutor's offices (10%), police (6%). Most participants stated that thanks to the participation in the programme they improved their knowledge on the risks related to substance use. 44% of the participants stated that thanks to the programme they changed their views on drug use, 43% were going to cut down on psychoactive substances and 38% wanted to quit drugs altogether. Most participants (87%) were satisfied or greatly satisfied with the programme and as many as 97% would recommend the programme to others. Is worth noting that Poland and Germany are two countries where the programme participation rates were the highest.

- **Families at risk of drug addiction**

In 2012, the National Bureau co-financed programmes addressed to families and relatives of individuals with a drug problem. The programmes featured education and awareness courses on mechanisms of drug dependence and co-dependence, 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. The NGO-run programmes included 4 000 participants across Poland.

- **Indicated prevention**

In 2012, 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 where such offer 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 offences. 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 is completed provided that the offence in question is subject to the penalty of up to 5 years in prison. Over 6 thousand participants took part in the indicated drug prevention activities performed by NGOs all over Poland.

- **Campaigns**

In 2012, the National Bureau for Drug Prevention continued the campaign called "Narkotyki? Na co mi to" ("Drugs? What do I need them for?"). The main slogan was reinforced with "Odleć z nami, nie z narkotykami" ("Get high with us not drugs") and it referred to the campaign's message. The aim of

the campaign was to encourage young people to pursue their passions and interests without resorting to drugs. Information on the actual prevalence of drug use among young people was also disseminated. The campaign was conducted mainly online via www.nacomito.com.pl and the Facebook fanpage. Thematic series were launched. "Mój wybór" ("My choice") encouraged fans to express their opinions, based on 4 presented stories, how to refuse drugs in different situations and provoke discussions on likely results of various choices. The "My story" series presented example stories of young people getting addicted. The "My passion" series took up subjects of various activities. The fanpage users were able to get in touch with a drug professional. The campaign was supplemented by a number of events. During the "High Stop" event, which was the final of the national competition called "Get high with use not drugs", the prize was a glider flight with Sebastian Kawa, multiple world gliding champion. Similarly to previous years, close cooperation was maintained at local and regional level with provincial governments (Marshal Offices), municipal and communal governments (City Councils, Communal Councils). Provincial Drug Information Experts also got engaged in the cooperation and disseminated information on relevant websites and distributed promotional posters.

In 2012, the National Bureau for Drug Prevention became a partner in the Safe Games Polska project launched under 2012 European Football Championship by the Safe Games Inc. The campaign in Poland was coordinated by an NGO called the Social AIDS Committee. The awareness campaign targeted the Euro fans and was intended to sensitize them to the consequences resulting from risky behaviours. The project involved 20 NGOs as well as governmental agencies (Chief Sanitary Inspectorate or National AIDS Centre). The campaign website was launched at www.safegamespolska.com along with a Facebook fanpage.

Since July 2012, the Chief Sanitary Inspectorate in collaboration with the National Bureau for Drug Prevention, Institute of Rural Health in Lublin, J. Nofer Labour Medicine Institute in Lodz, State Agency for Prevention of Alcohol-Related Problems has been implementing Project KIK/86 entitled "Alcohol, tobacco and other substance abuse prevention programme" co-financed under the Swiss-Polish Cooperation Programme.

The general aim of the prevention programme is reducing substance use in women at the procreative age. In 2012, a survey entitled "Pro-health behaviours among pregnant women" was conducted and works started on the website www.zdrowiewciazy.pl.

Moreover, works were launched on designing an educational programme for secondary school students as well as a programme intended for implementation in the workplace. A number of awareness and promotional materials were developed. The framework of the awareness campaign was established along with schedules of nationwide training courses for medical and teaching staff (coordinators of the educational programme at secondary schools).

The media substance abuse awareness campaign will be launched in 2013. The campaign will feature a series of TV spots and educational movies in the media and public transport across the country. Educational contents will also appear on billboards. Leaflets, brochures and posters will be distributed. Educational events will be organized in local communities.

- **Promoting European Drug Prevention Quality Standards**

The National Bureau for Drug Prevention was involved in developing the European Drug Prevention Quality Standards. In the course of implementing and promoting the publication, at the end of 2012 a second edition of the manual in Polish language was published. It is also available in PDF format at the National Bureau's website www.kbpn.gov.pl/wydawnictwa_on_line.htm?id=110707 and www.kbpn.gov.pl/portal?id=15&res_id=2819232. Moreover, in 2012 and 2013 during conferences and trainings, a staff member of the Polish Focal Point delivered Power Point presentations of the European Quality Standards during the following events:

- Pomeranian forum of solving addiction-related problems in Gdansk (25 January, 2012, 20 participants);
- 4th National conference of drug monitoring communes (Wroclaw, 22-23 March 2012, 60 participants);
- Drug prevention conference (Ankara, 3 June 2012, 70 participants);
- Monitoring drug problem at local level – training seminar (Ustron, 25-26 June 2012, 25 participants);
- Monitoring drug problem at local level – training seminar (Poznan, 7 may 2013, 25 participants);
- Monitoring drug problem at local level – training seminar (Poznan, 19 September 2013, 25 participants);
- Training seminar on drugs and drug addiction for communes (Jurata, 25 September 2013, 45 participants).

Furthermore, the European Quality Standards were presented in the Monitoring manual released by the Mazovian Centre for Social Policy in 2013 (one of chapter in the book) and articles (Swiat Problemow No 6 in 2010 and No 8 in 2013) addressed mainly to communal governments (Malczewski, Wrońska, 2013).

4. Problem drug use

prepared by Michał Kidawa, Artur Malczewski

4.1. Problem Drug Use – estimate of opioid users in Poland in 2009[10]

Method

In 2012, results of the new estimate of problem opioid users were published (Sieroslawski, 2012). In this estimation a problem opioid users is defined as 'a person who regularly uses substances from the opioid group (mainly heroin), experiencing serious problems as a result. One might say that this definition basically goes along with that of "a person dependent on opioids" if strictly medical criteria are not applied in the process of definition." (Sierosławski, 2012). The estimate was conducted based on the benchmark method (Taylor, 1997), which relates to gaining a proportion of individuals with a certain statistical characteristic (like being treated for drug use in certain year) to the rest of population defined population (like problem drug users) This way the estimate indicator is calculated. After multiplying this retio by the statistical number which was obtained an estimate of the whole population is being produces. This procedure is basically identical to the multiplier methods but the nominations are used, in order to get the proportion.. This estimate was based on the results of general population questionnaire-based surveys conducted in 2010 on a randomly selected sample of Polish citizens aged 16-64. The nomination technic was used in order to collect all necessary information, so the information were collected not about the respondents themselves, but problem drug users known to them. In the course of surveys on special nomination sheets, data were collected i.a on all problem opioid users known to the respondents, including information of sex and age of these individuals and the history of residential and ambulatory drug treatment. The estimate was also based on the residential and ambulatory drug treatment data from statistical system of Institute of Psychiatry and Neurology. Due to the fact that the data collection system of the Institute of Psychiatry and Neurology is based on the International Classification of Diseases (ICD-10), there are gaps in data on opioid user because large part of these individuals are diagnosed under category F19 (other and mixed). In the case of this group there is no information on actual most problematic drug. Consequently, in this study data from the pilot treatment demand indicator project implemented by the National Bureau for Drug Prevention were used. This system is build according to the standards of the EMCDDA TDI protocol. Under this pilot project data are collected on both the ICD-11 diagnosis and the primary drug that causes most problems. As a result of the pilot data analysis, a proportion of F19-diagnosed problem opioid users to all individuals with F-19 was determined. Then these data were extrapolated to the data of the residential and ambulatory drug treatment in order to estimate how many opioid users are treated in such facilities. The pilot data could not be used as a primary source of data due to relatively low coverage. The institutional system fails to have a double counting control mechanism in the case of ambulatory clinics. Double counting is eliminated in the case of residential treatment. The estimate is based on the 2009 data which were used in the general population survey of 2010.

Results

The pilot TDI project provided information on 382 individuals from 13 ambulatory facilities and 454 individuals from residential facilities, who were given F19 diagnosis. The data analysis revealed that

10 Prepared basing on Sierosławski J. 2012 „Oszacowanie liczby problemowych użytkowników opioidów w Polsce" published in the quarterly Alkoholizm i Narkomania, 2012, 25, 4, 347–356.

21.6% of individuals in residential drug treatment and 32.3% individuals in ambulatory drug treatment were given F19 diagnosis. Based on the statistics of the residential and ambulatory treatment the Institute of Psychiatry and Neurology determined the number of F11 (opioids) individuals and F19 (other and mixed) individuals. As a result of combining these data, an estimate of opioid users in both types of drug treatment was provided. The results are presented in Table 4.1.1.

Table 4.1.1. Estimate of problem opioid users in drug treatment in 2009

Problem opioid users in drug treatment					
	All patients	**F11 patients**	**F19 patients**	**Percentage of opioid user among F19 patients**	**Number of all opioid users**
Residential treatment	15412	2353	9985	21,6%	4510
Ambulatory treatment	29889	4380	13294	32,3%	8674

Source: Sierosławski, 2012

Based on the data, it was estimated that residential drug treatment centres admitted 4 510 opioid users in 2009 while 8 674 opioid users were admitted to ambulatory treatment. These data were used to estimate the overall in-treatment population of opioid users.
In the course of the general population survey, 215 respondents stated that they knew at least one problem opioid user. Consequently, 299 nominations were collected. Based on the nomination questionnaires the proportion of opioid users in residential treatment in 2009 was calculated at 27.2% while the proportion of ambulatory opioid patients stood at 43.8% (Table 4.1.2.).

Table 4.1.2. Estimate of problem opioid users in Poland in 2009

Estimate of problem drug users				
	IPiN statistical data	**Proportion of users in drug treatment found out in field studies**	**Estimate multiplier**	**Estimate**
Residential treatment	4510	43,2	2,32	10444
Ambulatory treatment	8674	43,8	2,28	19794

Source: Sierosławski, 2012

Based on the presented data estimate multipliers were calculated which shows that the estimated number of opioid users is 2.32 times higher than the number of opioid users admitting to residential treatment and 2.28 times higher than the number treated in the ambulatory mode.

Based on this multipliers it was estimated that the overall number of opioid users ranges from 10 444 to 19 794.

The middle value of 15 119 can be assumed as the most likely number of problem opioid users in Poland. Additionally, the distribution of estimated problem opioid users with breakdown into respective Polish provinces was obtained based drug treatment data and multiplier data. The findings are shown in Table 4.1.3.

Table 4.1.3. Geographical distribution of problem opioid users in 2009

Geographical distribution of problem opioid users				
Province	**Estimate based on residential treatment data**	**Estimate based on ambulatory treatment data**	**Most likely estimate**	
			Total	Rate per 100 thousand population
Dolnoslaskie	1054	2721	1888	65,6
Kujawsko-pomorskie	281	989	635	30,7
Lubelskie	254	818	536	24,8
Lubuskie	672	596	634	62,8
Lodzkie	736	872	804	31,6
Malopolskie	256	1080	668	20,3
Mazowieckie	3344	6175	4760	91,1
Opolskie	132	204	168	16,3
Podkarpackie	118	389	254	12,1
Podlaskie	363	330	347	29,2
Pomorskie	441	1252	847	38,0
Slaskie	615	1746	1181	25,4
Swietokrzyskie	115	254	185	14,6
Warminsko-mazurskie	380	491	436	30,6
Wielkopolskie	693	785	739	21,7
Zachodniopomorskie	427	1092	760	44,9
Not available	282	-	-	-

Source: Sierosławski, 2012

This calculation shows that the highest number of problem opioid users is recorded in the provinces of mazowieckie (4760), followed by dolnoslaskie (1888) and slaskie (1181). The lowest figures occur in the provinces of opolskie (168), swietokrzyskie (185) and podkarpackie (254).

Based on the rate per 100 thousand population, which controls for various levels of population in the respective regions, the highest values were obtained in the provinces of mazowieckie (91.1), dolnoslaskie (65.6) and lubuskie (62.8).

- **Comment**

The results of this estimation has to be approached with care. The vital for this estimation proportion of F19 diagnosed problem opioid users is gained from pilot treatment demand indicator project implemented by the National Bureau for Drug Prevention. The above mentioned system is still in pilot phase, due to a limited coverage the data might not be representative for all population of drug users in treatment. It must be also noted that the above estimate at regional level does not differentiate between the availability of drug services across the regions but is solely based on the proportion between the individuals outside and inside drug treatment obtained in the course of questionnaire surveys conducted on a representative sample of the general population of Poland. The results of this estimate must therefore be approached with care. For example, Warsaw is the biggest city in mazowieckie province. It offers the most advanced network of drug services. Consequently, the number of individuals reporting to treatment is the highest. It might be inferred that in this methodology the multiplier for Warsaw and the whole mazowieckie province is in fact much lower than in the whole country. If we used a multiplier representative for the whole country and the treatment data we would obtain overestimated data. And the other way round, in provinces with poor access to drug services the number of opioid users would is underestimated. This result is to some extent eliminated by the fact that statistical data of the institute do not include place of treatment but the place of residence of the patient, which is dictated by the lack of the regional catchment area system in Poland. It does not change the fact that the proportions of individuals in and out of drug treatment are likely to vary geographically and in order to make the estimate methodologically sound one would have to calculate individual multipliers for each province.

4.2. Data on PDUs from non-treatment sources

- **Clients of needle and syringe programmes in 2012 – research results**

In 2008, the national survey of needle and syringe programme clients was launched. The measurements are taken biennially towards the end of year. The questionnaire survey is conducted along with the French Reitox Focal Point (OFDT). The questionnaire was adapted to Polish conditions and has been used with minor changes since 2008. Some questions were modified and a unique ID code was introduced in order to avoid double counting. Staff at low threshold programmes in Poland (needle and syringe exchange, drop-in centres for active drug users) for two weeks at the turn of November and December held questionnaire interviews with the programme clients. Contacts were made through drug users in order to exchange injecting equipment, give advice, provide support or just talk. Actually, the measurement was an act of registering all clients of needle and syringe programmes in Poland who contacted those programmes at the end of year. Since 2008 the survey has been conducted every two years at the same time, which makes it possible to estimate fluctuations in client numbers (Malczewski, 2013m). In 2008 a downward trend can be observed. The survey included over 700 clients, in 2010 it was 400 and in 2012 approx. 350. A full sample was adopted, which means that a question-

naire interview was conducted with every individual that visited the programme. In 2010, the survey included 9 needle and syringe programmes of 8 cities while in 2012 there were 8 programmes of 9 cities. The survey results were analyzed by means of the SPSS IBM statistical software. The majority of the 2012 survey results will be compared to the 2010 results. Those interested in the 2008 edition can find the results at the CINN website (http://www.cinn.gov.pl/portal?id=15&res_id=216462). Chapter 2 of the National Report contains selected results, mainly concerning drug use. Risky behaviours and HIV/HCV infections are discussed in Chapter 6 and more information on the profile of the target population can be found in Chapter 8.

Target population

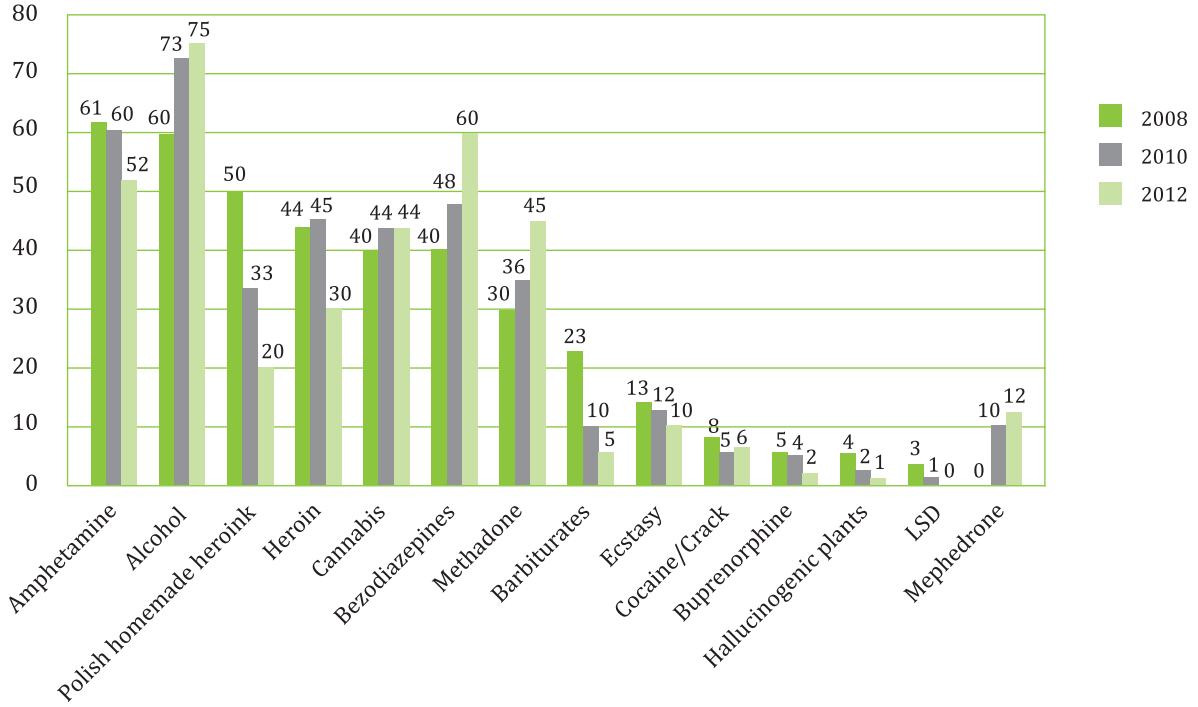
As it has been mentioned, in 2010 398 individuals were interviewed while in 2012 the number reached 349. At that time harm reduction programmes operated in Pulawy, Wroclaw, Czestochowa, Katowice, Warszawa, Gdansk, Krakow, Olsztyn and Zgorzelec. In 2012, the Gdansk programme operating at the MONAR drug counselling centre had only one client during the two weeks of the survey. Most probably it was the result of the establishment of substitution treatment programmes in Gdansk after 2010. The new substitution treatment programmes took over clients of the needle and syringe programme at the MONAR counselling centre. The most interviews were conducted in Warsaw (19.2%) and the fewest in Olsztyn (3.4%) (28 clients in 2010). The 2008 survey clients were mainly from the cities of Warszawa, Krakow and Wroclaw. In those locations the service range is the broadest: residential and street exchange, drop-in centres, night shelters. Consequently, the survey included more or less every sixth client of a needle and syringe programme (NSP). It must be noted that for several years the number of NSP clients has been falling. In 2005, over 5 000 individuals visited needle and syringe programmes. After five years the number dropped to 2 000. The sizes of target groups in residential and street-based needle and syringe programmes were more or less the same. Most interviewees were male 74.% (261 individuals in 2010). In the 2010 survey the percentage was slightly lower: 69% (283 individuals). An average age was 35 (median 35). Two years before an average age was similar: 33 (median 32). NSP clients were aged 19-58. An average male age (36) (34 in 2010) was higher than female (33) (30 in 2010). The highest number of male interviewees were aged 30-34 (every fourth respondent) while among women the group was slightly younger 25-29 (31.6% of all women). The survey results indicate a high average age of low-threshold programme clients. Staff members working with injecting drug users report that new clients are rare and the majority of clients are the same individuals. If we compare the results of the latest measurement with the first one of 2008 we can observe a rising average age of the clients. The data concerning age and the information of no new clients might imply a fall in the prevalence of injecting drug use.

Drug use

Clients of low-threshold programmes were asked about using respective psychoactive substances in the last 30 days prior to survey along with the use pattern. Figure 4.2.1. shows percentages of the survey respondents who had used the respective psychoactive substances in the last 30 days in the three measurements of 2008, 2010 and 2012 conducted so far. During the questionnaire interviews the respondents were asked about the use of opioids. In this group the most prevalent substance in 2012 was methadone whose prevalence rate rose from 30% in 2008 to 45% in 2012. The rise in the prevalence of methadone use is the effect of the evolution of NSPs and substitution treatment programmes. In Poland there 25 substitution treatment programmes providing services for 2 200 clients. During the reported period a fall was recorded in the prevalence of Polish homemade heroin (kom-

pot) from 50% to 20% and heroin from 44% to 30%. Analyzing data concerning opioids it must be remembered that in 2010 the European markets witnessed a fall in the availability of heroin. In Hungary, heroin users started using one of the cathinones i.e. mephedrone. This substance was virtually non-existent on the drug market in 2008, which is why it was not included in the first measurement. In the following measurements 10% (2010) and 12% (2012) of users reported using it. Mephedrone is a designer drug and was delegalized in 2009 following the amendment of the Act on counteracting drug addiction. In 2012, the Polish Focal Point participated in an EMCDDA project whose purpose was to determine information needs of drug treatment services. A focus group was established where representative of drug treatment facilities reported patients addicted to mephedrone. The study data show that the substance which arrived in 2009 had already been used by 10% of problem drug users in 2010. Moreover, under the category other substances' 14% of the interviewees reported using designer drugs and 8% mentioned ephedrine. On the other hand, the results of the survey indicate a fall in the prevalence of heroin use There was also a drop in the percentage of amphetamine users from 61% to 52% and barbiturates from 23% to 5%. The highest number of the survey participants reported using alcohol. Two thirds had been drinking in the last 30 days prior to survey and this percentage increased by 15 percentage points compared to 2008. A sharp increase of 50% must also be noted in the case of benzodiazepines. Minor percentages of the respondents reported using hallucinogens.

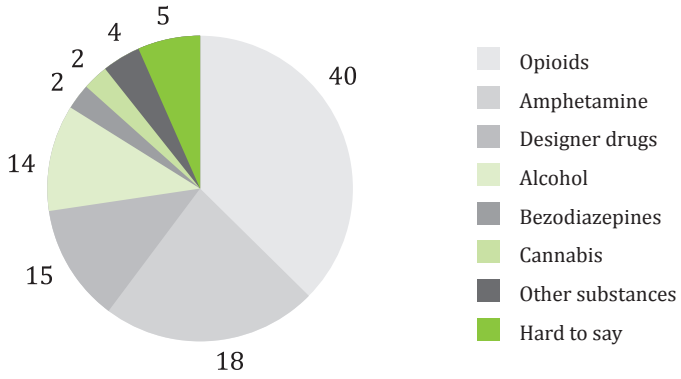
Figure 4.2.1. Prevalence of drug use in the last 30 days – percentages of respondents



Source: Polish Focal Point, Malczewski, 2013b, p.31

Let us take a look at the 2012 survey results which show the most problematic substance according to the respondents. Most respondents pointed to opioids (40%) followed by amphetamine (18%) and then NPS (so called designer drugs) (15%). Alcohol was reported by 14% of the survey participants. Benzodiazepines, whose use was reported by over a half of the respondents, was considered most problematic by 2%. 5% of the respondents were unable to determine the most problematic substance.

Figure 4.2.2. Most problematic substance according to the respondents in 2012



Source: Polish Focal Point, Malczewski, 2013b, p. 31

Intravenous use

The survey also focused on drugs used in injections. The interviewees were asked about injecting drugs in the last 30 days. Moreover, information on the initiation age was collected. According to the 2010 data, an average age of the first intravenous drug administration was 19 (median 18). The youngest age of the first injecting drug use was 12 and the oldest 38. 40% of the respondents injected drugs for the first time while being 17-19. In the latest measurement of 2012 an average initiation age was also 19 (median 18). Drugs were injected for the first time as early as 12 years of age whereas the latest initiation took place at the age of 53. In the 2012 cohort, half of the participants were aged 17-20. A vast majority of the latest measurement participants were injecting drug users. In the whole population 80% used drugs intravenously in the last 30 days whereas 19% more rarely. 1% of the respondents did not inject drugs. 88% of those who used opioids in the last 30 days (199 individuals) did it intravenously. In the case of amphetamine users this percentage was similar and stood at 89%. Let us take a look at the group of 2010. Similarly to the previous measurement, 80% had used drugs in the last 30 days. 16% had used drugs in a lifetime and in the case of 4% no information was available.

Intravenous use and substitution treatment

Among the survey participants 33% were being clients of substitution treatment. They were mostly treated with methadone (30%). In the survey of 2008 this percentage stood at 16% and in 2010 it reached 27%. Consequently, the population of substitution treatment clients is on the rise. They are also clients of needle and syringe programmes. All the substitution treatment clients who took part in the survey used drugs intravenously and most of them had done it in the last 30 days (69% out of 113 individuals in 2012). However, it must be stressed that individuals who had used injected drugs in the last 30 days and at the same time were in substitution treatment do not have to break the abstinence rules of methadone programmes. The results of the survey demonstrate that there is a group of substitution treatment clients who inject drugs. Open drug scenes (so-called bajzle) which, due to wider availability of substitution treatment, disappeared in some cities emerged to a much lesser extent in the vicinity of substitution treatment facilities. “Bajzle” are places which street workers regularly visit.

Injecting drug use in Poland

The estimate of injecting drug use prevalence was conducted by means of the multiplier method based on data of residential and ambulatory drug treatment, Institute of Psychiatry and Neurology, pilot

Treatment Demand Indicator project and field studies collected through questionnaire interviews with participants of syringe and needle exchange programmes. In Polish drug treatment system the patient is diagnosed on an ICD-10 code, which does not list information on the drug use pattern. Consequently, we do not have data on the numbers and percentages of injecting drug users who reported to treatment. In order to estimate this population we used a pilot TDI project conducted by the Polish REITOX Focal Point. The project complies with the standards of the European Monitoring Centre for Drugs and Drug Addiction. Data collected from residential and ambulatory drug treatment units contain information in injecting drug use. Currently, 50 units are reporting data to the system. This number does not cover all the units. That is why the benchmark was based on the national statistical system of the Institute of Psychiatry and Neurology (IPiN), which covers all drug treatment services in Poland. The IPiN system presents certain limitations. Ambulatory drug treatment data may be burdened with double counting of the same patients.

According to the field studies conducted in the last week of November and the first week of December 2012 among 349 injecting drug users the percentages of users in residential and ambulatory treatment stood at 11% and 52% respectively (Table 4.2.1. column 4). Based on the data the estimate multipliers for residential and ambulatory drug treatment were determined at 9.09 and 1.92 respectively (Table 4.2.1. column 5). This way, the number of injecting drug users is estimated to be twice as high as the number of individuals reporting to ambulatory drug treatment. By analogy, the multiplier for residential drug treatment indicates that the number of injecting drug users should be ninefold higher than the actual number of patients. The interviewees were asked whether they were treated in an ambulatory or/and residential clinic. According to the data of the pilot TDI project implemented by the Polish REITOX Focal Point, almost 8% of injecting drug users reported to treatment (Table 4.2.1. column 2). It means that based on the IPiN data we found 2 240 individuals who had reported to ambulatory treatment and injected drugs and by analogy the number of 1 104 for residential treatment. These data were used to calculate the population of injecting drug users by means of the estimate multiplier (Table 4.2.1. column 5).

Table 4.2.1. Estimate of injecting drug users in Poland in 2012

Problem opioid users in drug treatment						
	Number of drug users in treatment (IPiN data)	**Percentage of injecting drug users in treatment (TDI data)**	**Number of injecting drug users in treatment (IPiN data)**	**Percentage of injecting drug users in treatment (Polish Reitox Focal Point field study)**	**Estimate multiplier**	**Multiplier-based estimate**
	1	2	3	4	5	6
Ambulatory drug treatment	29862	7.5%	2240	52%	1.92	4307
Residential drug treatment	14150	7.8%	1104	11%	9.09	10034

Source: Malczewski, 2013k

The estimate shows that the number of injecting drug users ranges from 4 307 to 10 034 (Table 4.2.1. column 6) with the mean of approx. 7 170 (Malczewski, 2013k). The above estimate is of preliminary nature as it is based on the 2011 drug treatment data and it should included the 2012 data, which are not available yet. However, the estimated number should not change much because the residential drug treatment data are fairly stable. In 2010, 14 444 drug users reported to treatment while in 2011 the number stood at 14 150. Based on the field study we can determine which substances were used by injecting drug users. Over a half of the respondents reported using amphetamine (52%) and almost two thirds stated opioids (64%). The biennial survey shows the falling number of kompot (Polish homemade heroin) users. In 2008, every second user reported using this substance while in 2012 it was every fifth user. This is a signal of the decreasing prevalence of injecting drug use. The results of the injecting drug use prevalence estimate will be discussed at the annual conference of the Polish REITOX Focal Point (CINN KBPN) for harm reduction programmes.

5. Drug treatment: treatment demand and treatment availability

prepared by: Dawid Chojecki, Marta Struzik, Katarzyna Sollich

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, drop-in centres, psychiatric wards, addiction treatment units as well as detoxification wards. The Institute data below refer to 2011. The Institute does not provide data for 2012.

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 exiting 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. General profile, availability, quality assurances

2.1. Strategy/policy

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

- Act of 29 July 2005 on counteracting drug addiction (Journal of Laws "Dz. U." of 2012 item 124 as further amended);
- Act of 6 November 2008 on patient rights and Patient Ombudsman;
- Regulation of Minister of Health of 1 March 2013 on substitution treatment;
- 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-dependent individuals placed in Prison Service units (Journal of Laws "Dz. U." of 2007 No. 5, item 40);
- 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 (Journal of Laws "Dz. U." No. 239, item 1738);
- 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 (Journal of Laws No. 93, item 627);
- Regulation of Minister of Health of 13 July 2006 on addiction-related trainings (Journal of Laws "Dz. U." No. 132, item 931).

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 individual or harmful user 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 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 Drugs Strategy serving as 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 National Drugs Strategy 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 National Drugs Strategy 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".

2.2. 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 abuse 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 opioid replacement therapy.

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 consultations; 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.

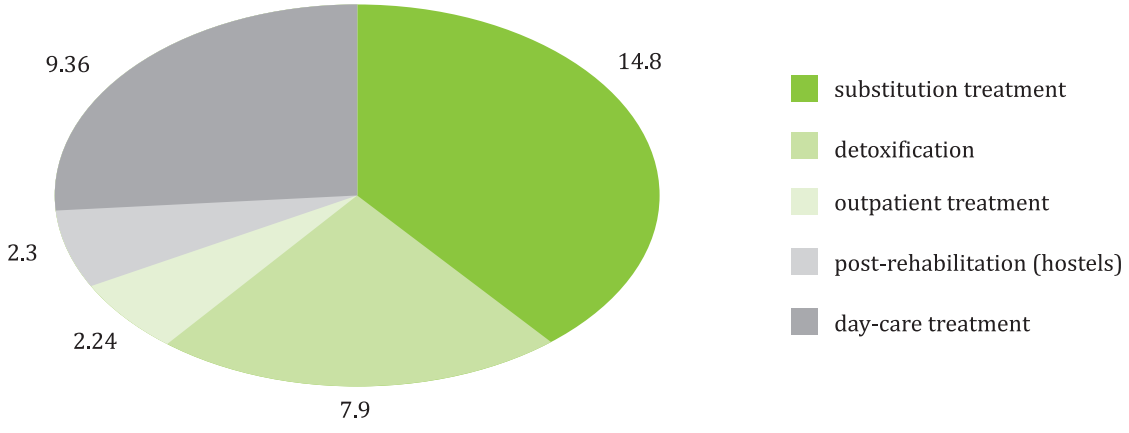
Pursuant to Article 26.5 of the Act of 29 July 2005 on counteracting drug addiction, drug treatment, rehabilitation and reintegration services are free of charge, regardless of the patient's place of residence. Moreover, there is an option to participate in drug therapy provided in private clinics or 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 5.2.2.1. Drug treatment sponsored by the National Health Fund in 2004-2012

Drug treatment sponsored by the National Health Fund	
Year	**Drug addiction treatment expenditure**
2004	PLN 54 017 159
2005	PLN 60 089 521
2006	PLN 62 199 614
2007	PLN 64 047 046
2008	PLN 79 121 702
2009	PLN 111 125 110
2010	PLN 111 281 201
2011	PLN 114 209 870
2012	PLN 123 849 353

Source: National Health Fund, as at May 2013

Figure 5.2.2.1. National Health Fund-sponsored drug treatment in 2012 by types of treatment



Source: National Health Fund, as at May 2013

The above figure does not contain information about the expenditure on antiretroviral treatment of drug-dependent individuals because the National Health Fund does not hold specific data. Only general antiretroviral treatment-related data are collected without breakdown by target groups.

Moreover, in 2012, 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, institution subordinate to the Ministry of Justice. For more information, see Chapter 9.8 Responses to drug-related health issues in prisons.

• 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 are making it necessary to shorten programmes. In 2011 (latest data), there were 79 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 drug-dependent and problem users are also treated; however, usually due to co-existing psychotic symptoms, not drug addiction.

Outpatient treatment

In Poland, the outpatient assistance for users of illicit psychoactive substances is provided at outpatient mental health 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.

Between 2006 and 2010 there was a rise in the number of outpatient drug clinics. However in 2011 (latest data), the number decreased from 104 to 96 (Institute of Psychiatry and Neurology 2013).

According to the electronic 2012 edition of "Drug Addiction – where to seek help?", the number of outpatient clinics across Poland stands at 213 (including consultation settings which by default do not provide drug treatment but counselling, consultation and emergency support).

Assistance services such as day-care wards/centres are still insufficient. In 2011 (latest data), similarly to previous years, there were 15 day-care centres for drug-dependent individuals (excluding alcohol) in Poland. They offered 315 places (Institute of Psychiatry and Neurology, 2013).

In 2011 (latest data), outpatient drug clinics provided treatment for 31 277 patients, including 1 415 at day-care wards/centres. The year before, the number of patients stood at 33 159, including 1 275 at day-care wards/centres (Institute of Psychiatry and Neurology, 2013).

In order to improve the availability of outpatient drug treatment the National Health Fund increased spending in this regard from PLN 13 873 553 to PLN 14 367 786.

In 2012, the National Bureau started the implementation of a new therapeutic programme called CANDIS. The programme was developed in Germany and adapted to the Polish conditions. It is a short-term modular therapy programme for problem cannabis users. At the first stage of implementation 22 CANDIS therapists were trained how to use the Motivational Interviewing method. Next stage involved trainings provided by German trainers, which included 35 prospective programme

providers from all over Poland. After 8 months of the programme implementation the first CANDIS evaluation session was held in Warsaw. The session was led by Dr Eva Hoch of the University of Munich. Dr Hoch was a leading expert in Germany responsible for the development, implementation and evaluation of the CANDIS programme. The evaluation session was attended by 14 participants. The CANDIS programme is currently being conducted in 43 Polish cities, at approx. 50 facilities by 60 trained professionals.

• Medical treatment

Withdrawal treatment

According to the Statistical Yearbook of the Institute of Psychiatry and Neurology, 19 detoxification wards operating in 2011 (latest data) and providing services for individuals dependent on psychoactive substances other than alcohol offered 198 beds (21 wards with 224 beds in the previous year) (Institute of Psychiatry and Neurology, 2013). The wards targeted mainly opioid withdrawals.

The main form of withdrawal treatment at detoxification wards is the administration of decreasing doses of opioids. The substance used in Poland is basically 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 and specific conditions which a health care centre providing substitution treatment must meet*, a 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 by a social worker, family counselling.

In 2012, there were 25 non-prison substitution treatment programmes across Poland and 7 conducted by Prison Service. They provided services for 1583 patients (data from the National Bureau's Registry of Substitution Treatment Patients). Despite the fact that in 2012 the National Health Fund increased spending on substitution treatment by 5.3% compared to 2011, in 4 provinces the availability of this service was below 10%.

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. Men account for 74% of patients.

Other forms of medical treatment of coexisting diseases

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

Treatment of patients with dual diagnosis was outlined more widely in Chapter 7.4 "Response to health correlates and consequences", section "Activities related to coexistence of mental diseases".

Treatment of coexisting drug-related infectious diseases was outlined in Chapter 7.4 "Response to health correlates and consequences" – prevention and treatment of drug-related infectious diseases, section "Treatment of infectious diseases".

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

• Quality assurance

Standards and accreditation

In 2004, a special team of experts appointed by the Minister of Health started 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 submitted for consideration by the Accreditation Council. In 2011, the Accreditation Council recommended the Accreditation Standards for Drug Treatment Units to the Minister of Health. In 2012, the Accreditation Council in collaboration with the Department of Health Care Management and Legal Department of the Ministry of Health conducted modification works on adapting selected standards to the existing organizational and legal regulations.

Moreover, in the reporting year, 4 entities (out of 5) conducting trainings in addictions acted on the recommendation of the Director of the KBPN and included issues of good practice-related standards in drug treatment and rehabilitation in their work. A total of 5 trainings were conducted for 146 participants.

• Evaluation

No changes compared to the previous report.

• Trainings and conferences

In 2012, 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. The following events were organized:

1) Training for substitution treatment staff
   The course took place in Gdansk between 28 and 29 January 2012. It was attended by the staff of new substitution treatment programmes from Olsztyn, Gdansk and Bydgoszcz. Physicians, nurses, addiction therapists and auxiliary personnel were trained.

2) CANDIS Programme
   In 2012, the National Bureau started implementing a new therapeutic programme called CANDIS. It is a German short-term modular programme adapted to the Polish conditions and targeting problem cannabis users. The first stage involved training CANDIS providers in terms of Motivational Interviewing. The course was held by the Centre for Motivational Interviewing and Psychotherapy and comprised two modules (Module I, 1-2 February 2012 and Module II, 29 Fe-

bruary – 1 March 2012). The course was attended by 22 drug professionals from drug treatment centres all over Poland. Next stage was the training held by the German CANDIS specialists on 23-25 April 2012 in Warsaw. 35 future programme providers from all over Poland were trained. The trained pool will later serve as the source of Polish trainers certified to train more Polish CANDIS providers. After 8 months of the programme implementation, on 4-5 December 2012 in Warsaw the first CANDIS evaluation meeting was organized. The meeting was led by Dr Eva Hoch of the University of Munich. The presence of Dr Hoch was valuable due to her long-term involvement in the project. She took part in the development, implementation and evaluation of the programme in Germany as well as other countries in Western Europe. Dr Hoch is also the co-author of the CANDIS manual. CANDIS providers invited to the evaluation meeting had an opportunity to share their CANDIS experiences, successes and challenges. The participants also discussed challenging cases and worked out possible solutions. The supervision was a valuable experience for the CANDIS professionals. The ways of adapting the manual to the Polish conditions were also discussed. All the participants emphasised the advantages of CANDIS as a programme which is novel, structured, effective, evaluated and flexible in terms of choosing the therapy objective. The meeting was attended by 14 participants.

3) "Work with families of drug-dependent users"
On 8-10 October 2012 in Jachranka, a conference entitled "Work with families of drug-dependent users was organized in collaboration with the National Bureau for Drug Prevention and the State Agency for Prevention of Alcohol-Related Problems. The conference enjoyed great interest. The importance and relevance of the subject is attested by the fact that the number of registrations was two times as high as the number of invitations (100).
The conference was focused on the following four major aspects of drug-related family work:
   – sexual problems of dependent drug users;
   – couples work in drug addiction therapy;
   – work with drug-dependent adults;
   – work with the family of a drug-dependent teenager and young adult.

   Drug therapy/psychotherapy specialists invited to the conference particularly praised the event's lectures and workshops. They provided them with an opportunity to improve their knowledge and share experiences with other drug professionals. The evaluation questionnaire showed a high level of satisfaction of the participants concerning their expectations and opportunities to adopt the new content in professional life. The conference was attended by 100 participants.

4) Under the system of training courses for drug therapy specialists and instructors, the National Bureau for Drug Prevention conducted in 2012 5 certification trainings for future certified drug therapy instructors and specialists. Consequently, 10 drug therapy instructor certificates and 107 drug therapy specialist certificates were awarded. Moreover, clinical internships and supervisions for the training participants were financed. 5 training providers conducted the courses in the reporting year.

Moreover, 6 provincial governments sponsored professional development trainings for various groups dealing with the drug problem e.g. drug treatment professionals and other staff responsible for providing support and assistance for drug-dependent individuals.

The trainings were conducted for pharmacists, probation officers, police officers, members of communal substance abuse boards, representatives of social welfare centres, special educational care facilities, NGOs as well as teachers, counsellors and drug services staff. The 44 courses included 1 248 participants.

The provincial governments' expenditure on the training courses and supervisions stood at PLN 105 290.24.

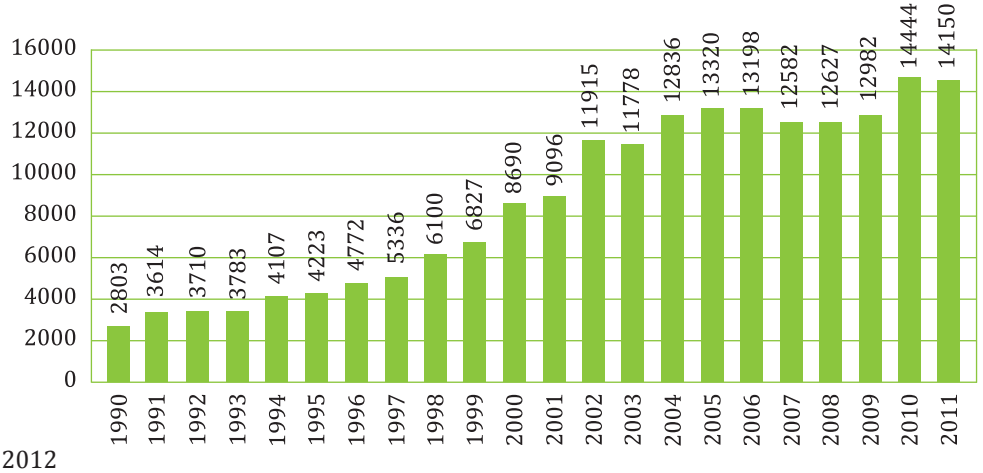
5.3. Characteristic of treated clients (TDI data included) and trends of treated population and treatment provision (incl. numbers)

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

Drug treatment demand

Statistical data from residential psychiatric drug treatment are used to analyze trends in drug-related mental and behavioural disorders. The latest data of the Institute of Psychiatry and Neurology (IPiN) refer to 2011, when the residential treatment facilities admitted 14 150 patients due to drug-related problems. Compared to 2010, there was a slight fall. After a rapid increase in the number of drug patients in 1995-2005, a downward trend was observed up to 2007 followed by an increase for three consecutive years. However, it can be noted that from a global perspective since 2004, despite fluctuations in respective years, the overall number of patients has been holding steady.

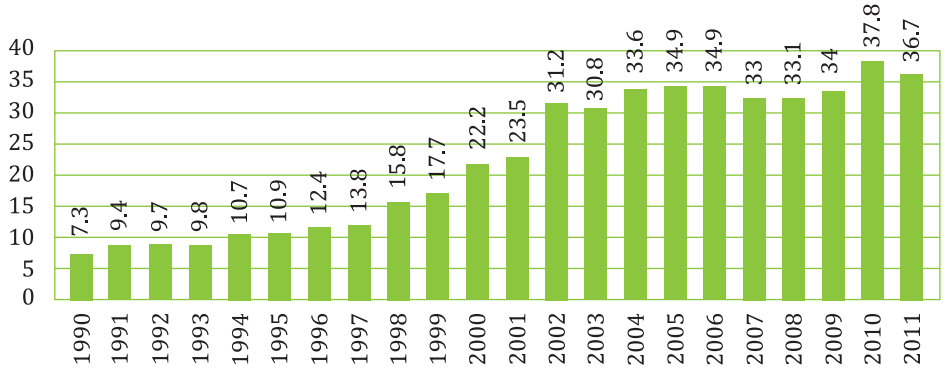
Figure 5.3.1.1. Admissions to residential drug treatment in 1990-2011 (numbers of patients)



Source: IPiN, 2012

Figure 5.3.1.2. shows patients admitted to residential treatment per 100 000 population in 1990-2011. These data demonstrated the same trends as shown in the previous figure. The rate per 100 000 population in 2011 stands at 36.7.

Figure 5.3.1.2. Admissions to residential drug treatment in 1990-2011 (per 100 000 population)



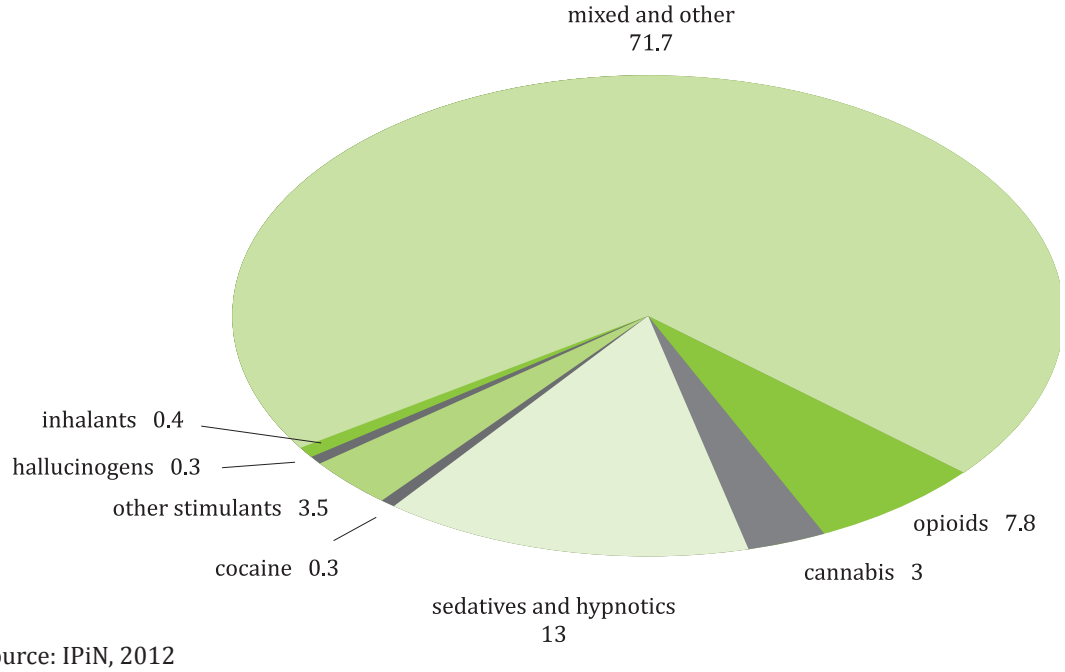
Source: IPiN, 2012

In 2011, similarly to previous years, male patients constituted the vast majority in residential drug treatment facilities (73.8%).

Most patients admitted to residential treatment units in 2011 were diagnosed with mental and behavioural disorders related to the use of several substances or other psychoactive substances (F.19 in ICD 10). It means that in almost three quarters of the patients nothing can be said about the types of substances which caused the patients to start treatment.

Opioid users accounted for 7.8% of all admissions and compared to 2010 (14.7%) this figure is lower. 13% of the patients reported to residential treatment due to problems related to the use of sedatives and hypnotics and in 3.5% of the patients problems related to using other stimulants were diagnosed. In 2011, similarly to previous years, small numbers of patients were addicted to cannabis (3.0%), inhalants (0.4%), hallucinogens (0.3%) and cocaine (below 0.3%).

Figure 5.3.1.3. Admissions to residential drug treatment in 2011 due to mental and behavioural disorders by type of substance



Source: IPiN, 2012

3.2 Treatment Demand Indicator Database of individuals reporting to substance abuse treatment – results of the TDI pilot project in 2010 – 2012

Data on drug treatment in Poland have been collected under the European Drug Treatment Demand monitoring system since 2008. Similarly to previous years, in 2013 the system of collecting data on patients reporting to drug treatment facilities was operating in Poland as a pilot project as it did not cover the majority of the facilities in the country. In 2012 the Polish Focal Point (CINN KBPN) received information from 33 outpatient clinics (including 1 day care centre and 3 substitution treatment facilities), 23 inpatient clinics and 3 detoxification centres. Caution is advised in comparing data of respective years because numbers of facilities and their profiles varied (inpatient, outpatient clinics).

Table 5.3.2.1. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2012

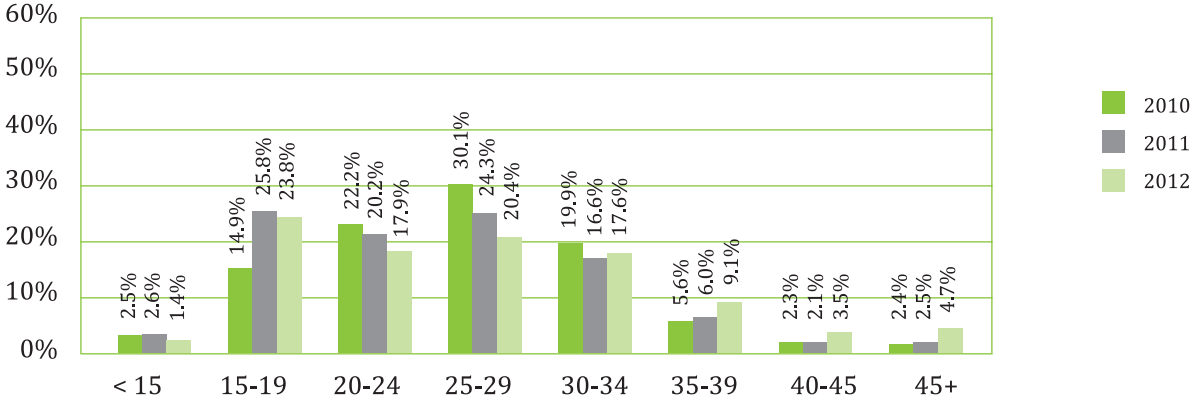
Admissions to drug treatment or rehabilitation due			
Patients in respective years	**2010**	**2011**	**2012**
All patients	1 342	2 217	2 833
First-time patients	364	813	1 171
Number of reporting facilities	21	28	59

Source: TDI CINN KBPN

Following the establishment of the TDI KBPN Provincial Coordinators Network the number of participant facilities increased over twofold. 2 833 individuals reported to treatment, including 1 171 first-timers. In total, 2 256 men and 577 women expressed willingness to enter drug treatment. In first-time patients these numbers were 915 and 256 respectively. The TDI coordinators were responsible for contacting new facilities, training data collection and CINN reporting staff as well as providing technical TDI-related support.

In 2012 individuals aged 15-19 most frequently reported to treatment due to problem drug use. Just as in previous years, the rates for treatment demand among individuals under 15 and over 40 was minimal. For the first time, a TDI rise was recorded among individuals aged 35-39. Among TDI men in 2012, 35% were aged 15-34. Among TDI women over 35% were aged 15-19 and 45% were 20-34 years old.

Figure 5.3.2.1. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2012 – proportions of patients by age

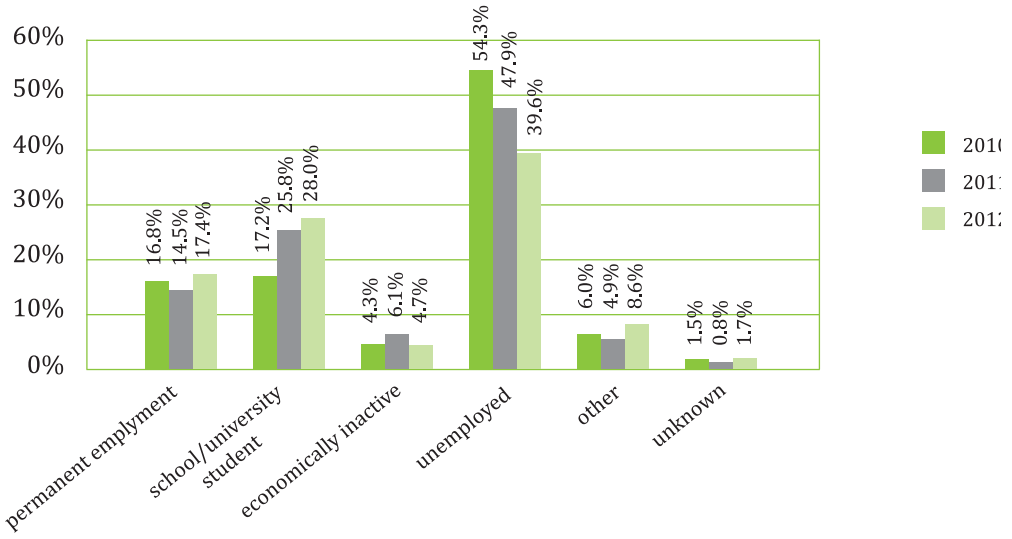


Source: TDI CINN KBPN data

Let us take a look at the employment status of TDI patients. Almost 40% of them in 2012 were unemployed. Despite a relatively high unemployment rate in this group, similarly to previous rate, a downward trend is observed.

A considerable number of drug treatment admissions in 2012 concerned school and university students (every third individual). It is caused by the large number of young people reporting to treatment (every fourth was 15-19). The percentages of jobless and employment status-unknown individuals, similarly to previous years, did not exceed 10%. However, a slight rise was recorded in the group defined as 'others'. This group comprises military servicemen and prison inmates.

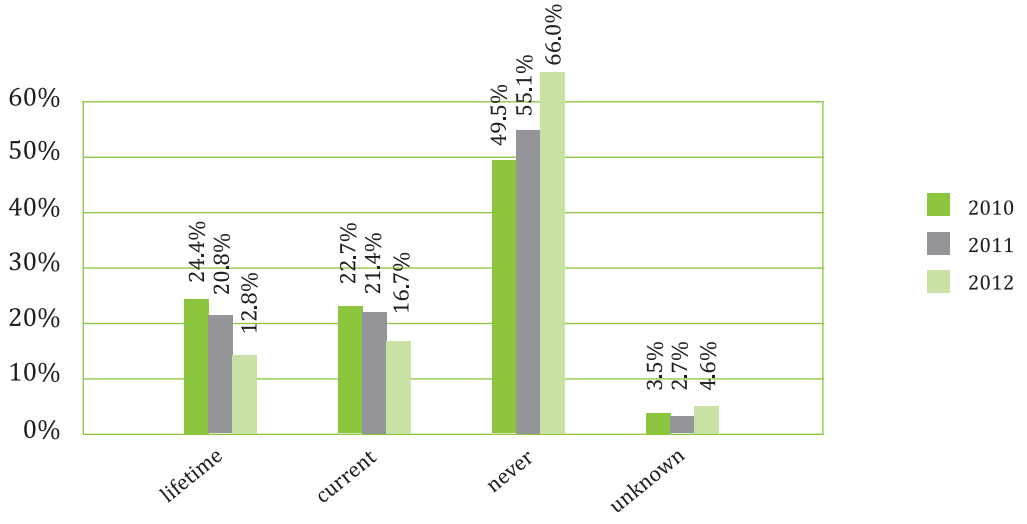
Figure 5.3.2.2. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2012 – proportions of patients, by employment status



Source: TDI CINN KBPN data

Data at 5.3.2.3. show a downward trend concerning the percentage of injecting drug users. In 2010, half of drug treatment patients had never injected drugs. In 2012, this number rose to two thirds. Drug treatment data are similar to needle and syringe programmes, which also record falling numbers of clients demanding injection equipment.

Figure 5.3.2.3. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2012 – proportions of patients, by injecting drug use

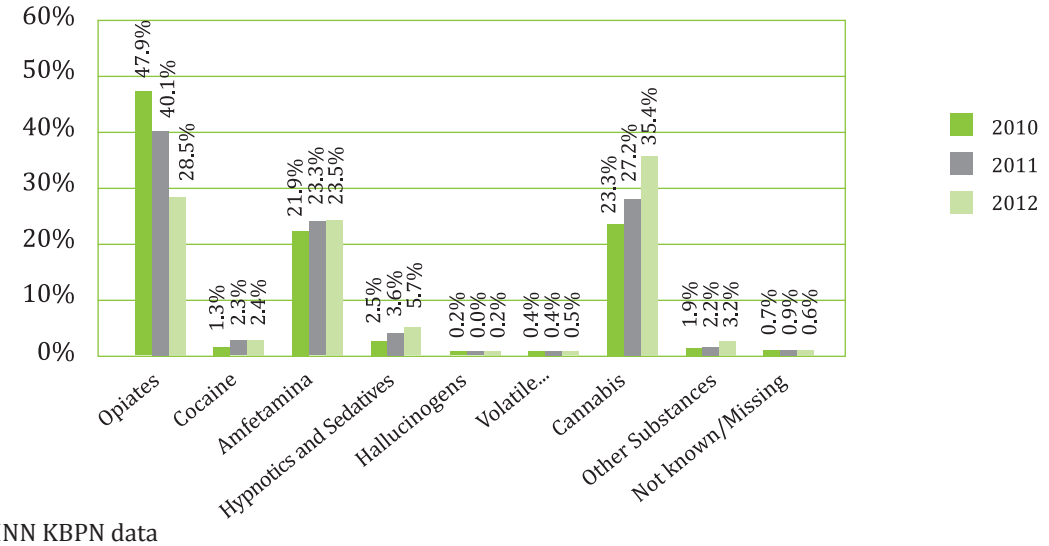


Source: TDI CINN KBPN data

Let us take a look at primary drugs used by TDI patients. The most prevalent drug among TDI patients was cannabis (every third admission). In the case of cannabis we record an upward trend. An upward trend (twofold since 2010) is also recorded in the case of sedatives and hypnotics. A percentage of opioid users is decreasing. In 2010, 50% and in 2012 fewer than every third. Similar trends

over the years are observed in the case of amphetamines. The results of surveys among low-threshold programme clients (needle and syringe exchange) described in Chapter 2 of this report also show falling prevalence of opioids in 2008-2012.

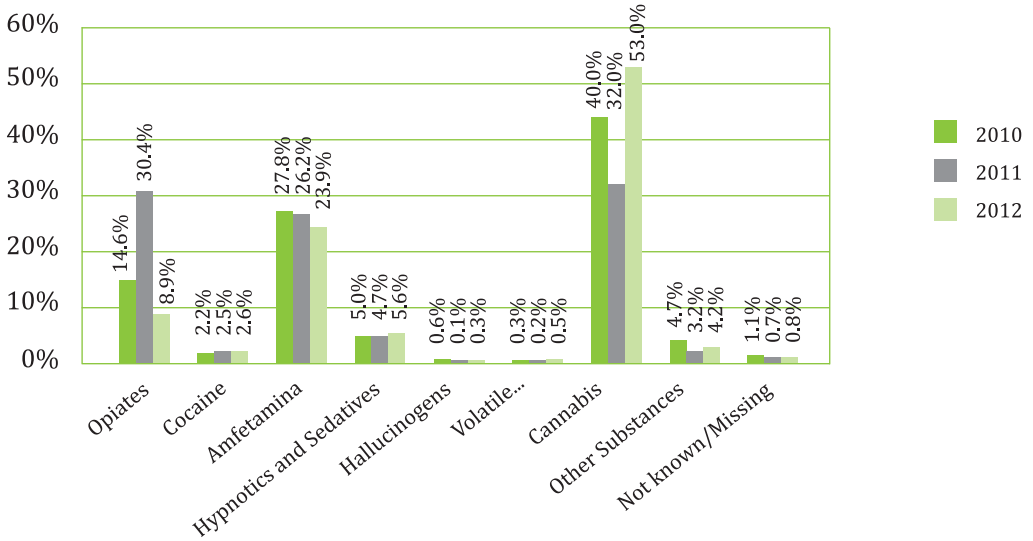
Figure 5.3.2.4. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2012 – proportions of patients, by primary drug



Source: TDI CINN KBPN data

Data regarding first-time patients show that the highest number reported due to cannabis use (nearly half of all admissions). Every third patient abused amphetamines and every tenth opioids. There is a clear fall in the percentage of opioid-related TDI first-time patients.

Figure 5.3.2.5. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2012 – proportions of first-time patients, by primary drug



Source: TDI CINN KBPN data

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 2012[11], 16 562 HIV infections were diagnosed. Out of these infections 5 970 (36%) were injecting drug users (IDUs), including 4 472 men (75%) and 1 442 women (24%) (in 56 cases the information on sex is missing). Analyzing the above monitoring period in terms of AIDS, 2 907 cases were diagnosed. Out of these 1 412 (49%) were IDUs, including 1 109 men (79%) and 303 (21%) women.

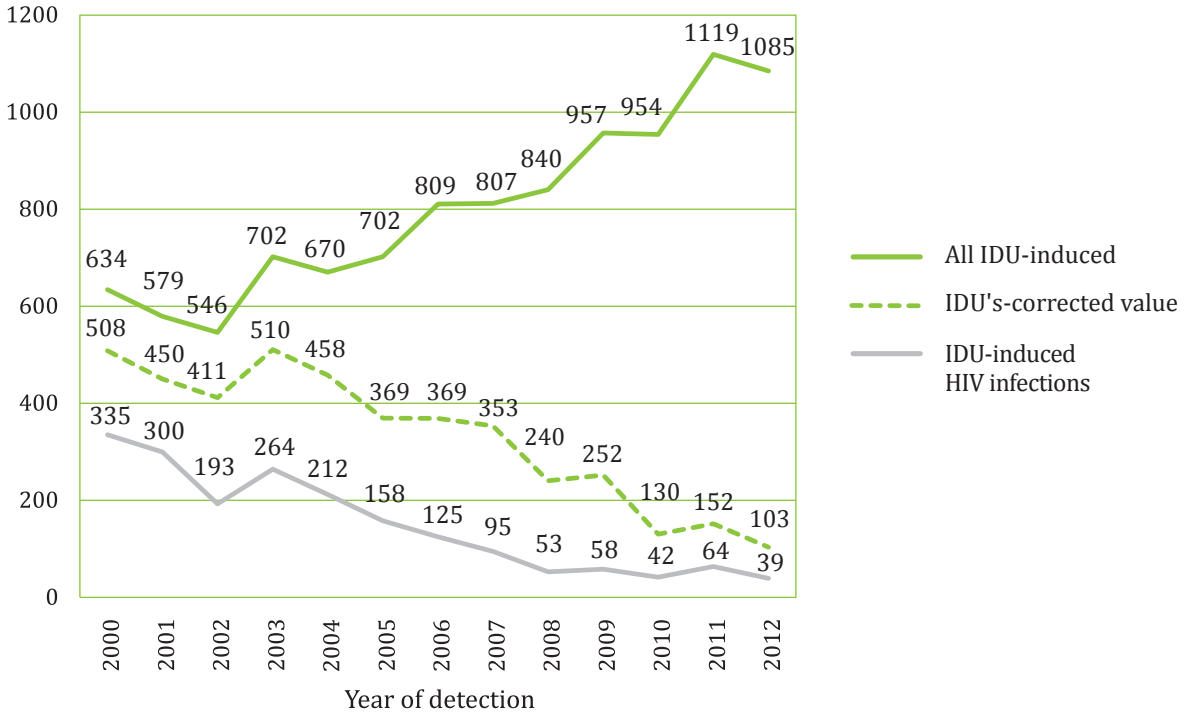
Analysis of HIV/AIDS data by year of detection

The analysis of IDU-related HIV infections for 2006-2012 indicates a downward trend, which levelled off in more recent years. 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 (58 new

11 Reported until 30 June 2013

cases). In 2010, 42 new IDU-related HIV infections were detected, in 2011 - 64 and in 2012 the number decreased to 39. The interpretation of these data should consider a notification delay and the fact that a considerable number of infections with no likely route of HIV transmission was reported (in 2012 it referred to 62% of infections). The information on the route of transmission can also be provided later if the report is submitted by the attending doctor. The figure below presents the number of new HIV infections reported by the end of June 2013 by year of detection with the a line representing data with imputed missing route of infection transmission. 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 2012 data are still underestimated. However, due to more complete reporting of the risk group in 2011-2012 the risk group adjusted data in fact show a more clear downward trend in the number of newly detected IDU-related HIV infections with the overall rise in the new infections, especially among 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 IDUs from other sexually transmitted HIV infections.

Figure 6.2.1. Number of new HIV infections, including injecting drug use (recorded number and corrected value imputing missing data on route of transmission) detected in 2000-2012



Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department) by date of detection, registered by 30 June 2013

AIDS incidence among IDUs held steady in 2003-2006 ranging from 91 cases in 2003 to 90 in 2006. In 2007, 141 AIDS cases were detected altogether, including 77 among IDUs. In 2008, 179 AIDS cases were recorded in total, including 73 among IDUs. The data for 2009 included the total of 129 cases,

including 55 among IDUs and 173 and 70 respectively in 2010. In 2011 the total number of AIDS cases were 181, including 60 among IDUs and in 2012 this number decreased to 147 AIDS cases and 53 AIDS cases among IDUs. AIDS incidence rates in recent years have been fluctuating while preserving comparable values. Simultaneously, the proportion of incident AIDS cases attributed to IDU fell from 42% to 36% between 2009 and 2012. 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 2012 incidence statistics will be higher.

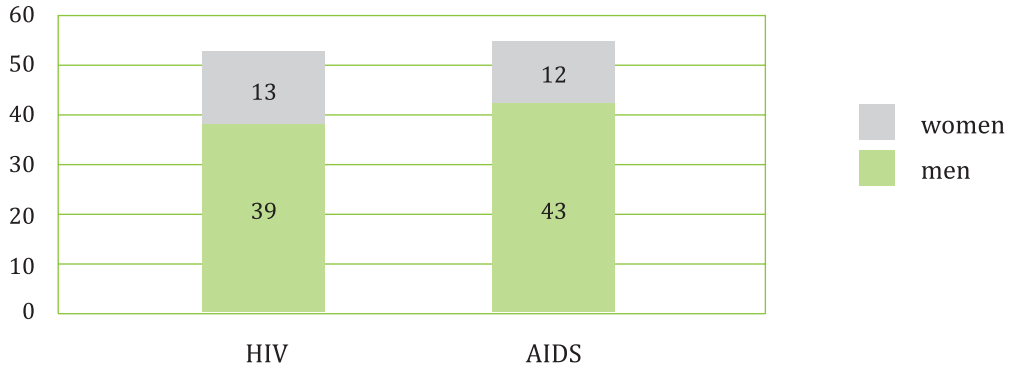
Figure 6.2.2. Number of new AIDS cases, including injecting drug users (recorded number and corrected value imputing missing data on route of transmission) in 1999-2012

Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department) by date of detection, registered by 30 June 2013

Analysis of HIV/AIDS data by year of registration

The below analysis of HIV/AIDS incidence includes cases registered in 2012 (52 newly registered HIV cases and 55 newly registered AIDS cases among IDUs). Among HIV IDU patients registered in 2012 there were 39 men (75%) and 13 women (25%). Newly registered AIDS cases among IDUs in 2012 referred to 43 men (78%) and 12 women (22%).

Figure 6.2.3. HIV/AIDS cases in IDUs registered in 2012, by sex (numbers of people)

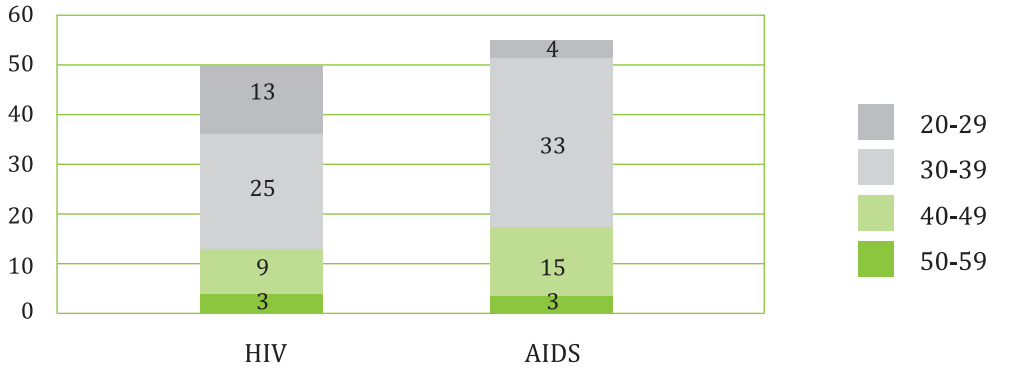


Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)

In 2012, among newly registered HIV infections related to IDU the largest group were users aged 30-39 (25 individuals, 48%), then 20-29 (13 individuals, 25%) and 40-49 (9 individuals, 17%).

In 2012, out of the reported new AIDS cases in IDUs the largest group were users aged 30-39 (33 individuals, 60%) and 40-49 (15 individuals, 27%), then 20-29 (4 individuals, 7%) and 50-59 (3 individuals, 6%).

Figure 6.2.4. HIV/AIDS cases in IDUs registered in 2012 by age group (numbers of people)*



Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department)
* For HIV infection in 2 cases there is no information on age.

In Poland in 2007-2008, there was a fall in HIV detection rates among IDUs per 100 thousand population. The data for 2009 and 2012 show that the trend had levelled off. However, the HIV detection varies across provinces. In 2007-2008, the highest HIV rates were recorded in dolnoslaskie, warminsko-mazurskie and lodzkie provinces. In 2006-2007, the fewest cases were recorded in podkarpackie, lubelskie and malopolskie provinces. In the next year the situation was similar in these provinces. The data for 2010-2011 show that the high rates are recorded in dolnoslaskie, podlaskie, slaskie, lubuskie and lodzkie province. In 2012, the most cases were recorded in lodzkie province. In the provinces of lubuskie, kujawsko-pomorskie and swietokrzyskie no new HIV case among IDUs was recorded in 2012. Between 2007-2012 no HIV infections among IDUs per year were registered in swietokrzyskie province (during 4 years), podkarpackie (3 years), opolskie province (2 years).

Table 6.2.1. HIV detection rates in IDUs in 2006-2012 (per 100 000 population) (infections registered by place of residence)

HIV detection rates in IDUs												
Province	**2007**		**2008**		**2009**		**2010**		**2011**		**2012**	
	number	rate	number	rate	number	rate	number	rate	number	rate	number	rate
dolnoslaskie	36	1.25	19	0.66	9	0.31	14	0.49	6	0.21	3	0.10
kujawsko--pomorskie	4	0.19	2	0.10	4	0.19	0	0.00	4	0.19	0	0.00
lubelskie	2	0.09	1	0.05	1	0.05	1	0.05	0	0.00	3	0.14
lubuskie	1	0.10	4	0.40	9	0.89	2	0.20	5	0.49	0	0.00
lodzkie	9	0.35	8	0.31	9	0.35	6	0.24	3	0.12	12	0.48
malopolskie	3	0.09	1	0.03	1	0.03	0	0.00	1	0.03	4	0.12
mazowieckie	7	0.14	3	0.06	3	0.06	11	0.21	10	0.19	8	0.15
opolskie	1	0.10	0	0.00	0	0.00	1	0.10	2	0.20	2	0.20
podkarpackie	0	0.00	0	0.00	3	0.14	0	0.00	2	0.09	2	0.09
podlaskie	1	0.08	1	0.08	1	0.08	6	0.50	6	0.50	1	0.08
pomorskie	4	0.18	1	0.05	0	0.00	1	0.04	5	0.22	1	0.04
slaskie	7	0.15	7	0.15	2	0.04	2	0.04	14	0.30	3	0.06
swietokrzyskie	0	0.00	1	0.08	1	0.08	0	0.00	0	0.00	0	0.00
warminsko--mazurskie	9	0.63	5	0.35	4	0.28	1	0.07	4	0.28	4	0.28
wielkopolskie	3	0.09	2	0.06	7	0.21	4	0.12	1	0.03	6	0.17
zachodnio pomorskie	3	0.18	1	0.06	3	0.18	1	0.06	1	0.06	3	0.17
POLSKA	98	0.26	57	0.15	61	0.16	55	0.14	64	0.17	52	0.13

Source: National Institute of Public Health - National Institute of Hygiene. For HIV infection in 18 cases there is no information on place of residence

AIDS incidence rates in IDUs in 2007-2012 fluctuated between 0.14 and 0.27 per 100 000 population. In 2007-2008, the highest AIDS incidence rates were recorded in dolnoslaskie, warminsko-mazurskie, podlaskie and lubuskie provinces. In 2009, the highest rates were recorded in the provinces of dolnoslaskie and warminsko-mazurskie. In 2010 the highest rates were in the dolnoslaskie and lubuskie province. Between 2007-2010 the highest rate was in dolnoslaskie but in 2011 the most new AIDS cases were registered in the province of lubuskie. In 2007-2009, the lowest AIDS incidence rates were registered in the provinces of malopolskie, swietokrzyskie and zachodniopomorskie. In

2010-2012, the lowest AIDS incidence rates referred to the following provinces: kujawsko-pomorskie, podlaskie and zachodniopomorskie. Between 2007-2012 no AIDS cases were registered in swietokrzyskie province (3 times), pomorskie, podlaskie and slaskie province (2 times). In 2012 no new AIDS case was recorded in the kujawsko-pomorskie, lubuskie, podlaskie, slaskie and swietokrzyskie province.

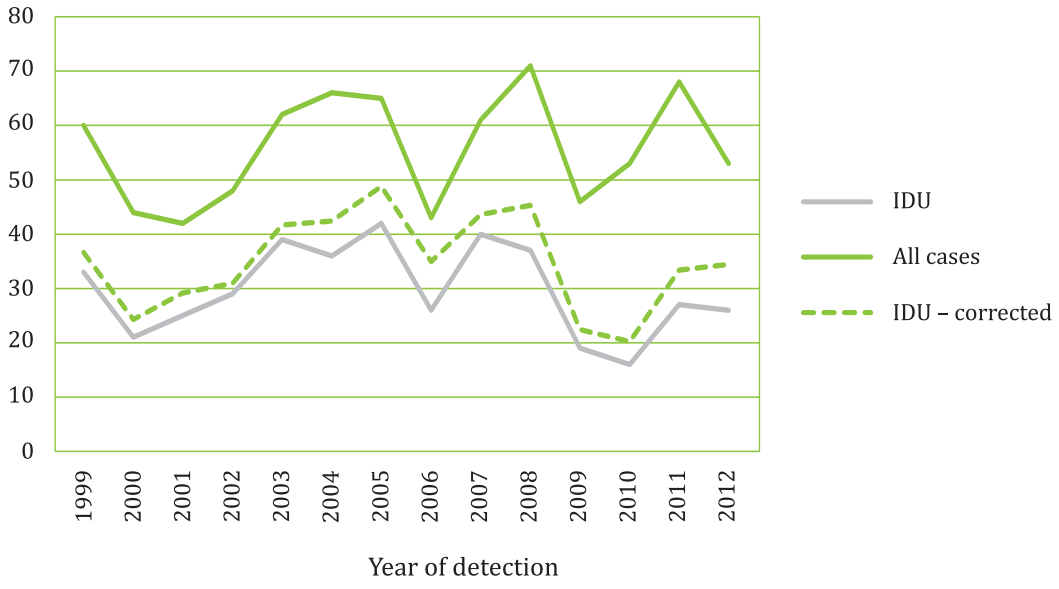
Table 6.2.2. AIDS incidence rates in IDUs in 2007-2012 (per 100 000 population) (infections registered by place of residence)

AIDS incidence rates in IDUs												
Province	**2007**		**2008**		**2009**		**2010**		**2011**		**2012**	
	number	rate	number	rate	number	rate	number	rate	number	rate	number	rate
dolnoslaskie	44	1.53	30	1.04	17	0.59	27	0.94	20	0.69	13	0.45
kujawsko--pomorskie	2	0.10	1	0.05	1	0.05	1	0.05	1	0.05	0	0.00
lubelskie	4	0.18	1	0.05	4	0.19	3	0.14	2	0.09	1	0.05
lubuskie	6	0.59	2	0.20	3	0.30	6	0.59	13	1.27	0	0.00
lodzkie	6	0.23	2	0.08	6	0.24	7	0.28	15	0.59	11	0.44
malopolskie	2	0.06	3	0.09	2	0.06	3	0.09	0	0.00	6	0.18
mazowieckie	4	0.08	5	0.10	3	0.06	1	0.02	6	0.11	4	0.08
opolskie	2	0.19	1	0.10	2	0.19	4	0.39	1	0.10	3	0.30
podkarpackie	0	0.00	1	0.05	3	0.14	2	0.10	1	0.05	2	0.09
podlaskie	4	0.33	4	0.34	0	0.00	1	0.08	4	0.33	0	0.00
pomorskie	6	0.27	2	0.09	0	0.00	0	0.00	12	0.53	4	0.17
slaskie	8	0.17	9	0.19	2	0.04	0	0.00	9	0.19	0	0.00
swietokrzyskie	1	0.08	1	0.08	0	0.00	0	0.00	2	0.16	0	0.00
warminsko--mazurskie	8	0.56	6	0.42	6	0.42	1	0.07	4	0.28	4	0.28
wielkopolskie	5	0.15	1	0.03	4	0.12	4	0.12	2	0.06	2	0.06
zachodnio-pomorskie	1	0.06	2	0.12	1	0.06	0	0.00	6	0.35	5	0.29
POLSKA	103	0.27	71	0.19	54	0.14	60	0.16	98	0.25	55	0.14

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

According to the statistics collected since 1986, 1 206 deaths of AIDS patients had been recorded by 30 June 2013, including 601 (around 50%) among IDUs.

Figure 6.2.5. Deaths of patients ever diagnosed with AIDS recorded in Poland by 30 June 2013, including IDUs, by date of death



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

In 2012, 53 AIDS-related deaths were recorded, including 26 deaths of IDUs (49%). The monitoring of AIDS-related mortality in IDUs reveals that deaths in 2012 related to 20 men (77%) and 6 women (23%). The highest mortality among IDUs diagnosed with AIDS in 2012 concerned the age group 30-39 (11 deaths), then 40-49 (9 deaths) and 50+ (4 deaths) but deaths were also noted in the age group 20-29 (2 cases).

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 for more recent years 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 downward trend in this indicator in the years 2007-2012 but also a huge decrease in the number of tests reported was noted between 2009-2012 (Table 6.2.3.). This may not necessarily reflect the trend testing patterns among the drug users, but could result from organizational changes at the laboratories participating in the survey, who are not mandated to store risk group data. The HIV frequency among those tested may be interpreted as a proxy for undiagnosed prevalence and this indicates that many infections remain undetected in this group, although the number of undetected HIV-positive IDUs is likely lower in recent years. The data do have a number of limitations. The representativeness of the IDU who comes for testing for the whole IDU population is unknown, the survey among the laboratories is voluntary and some of them do not systematically record the risk group information. This has changed over the years with many laboratories stopping collecting the risk information from the test seekers.

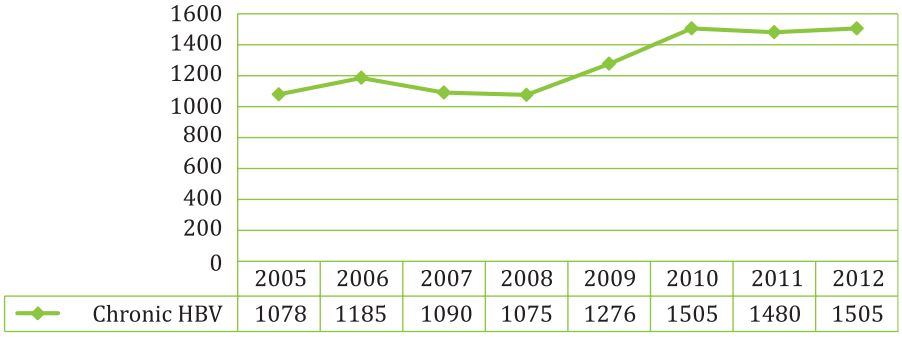
Table 6.2.3. HIV frequency in diagnostic testing in IDUs in 2007 – 2012

HIV frequency in diagnostic testing in IDUs						
	2007	2008	2009	2010	2011	2012
Number of HIV-positive IDUs	121	101	65	45	26	11
Number of all IDUs tested for HIV (valid tests)	1064	1084	1176	657	884	219
HIV frequency rate	0.1137	0.0932	0.0553	0.0685	0.0294	0.0502

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 2010-2012 data display stabilization at approximately 1500 chronic cases. The data on chronic HBV incidence among IDUs are available only for 2009. 6 individuals were diagnosed with the disease then (data might be underestimated because in approx. 40% of cases, the IDU status was not known).

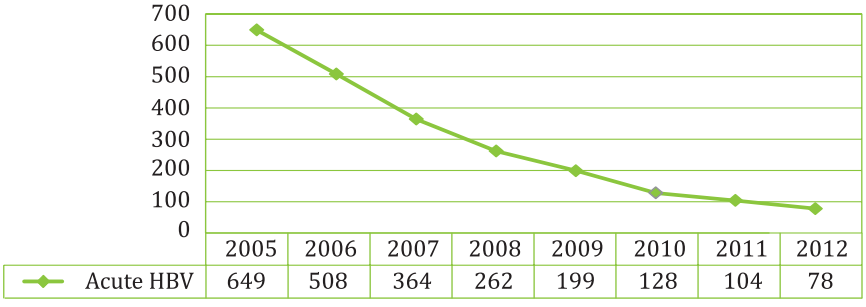
Figure 6.2.6. New chronic HBV cases in 2005-2012



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

In 2005-2012, 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, but decreased again to 5.7% in 2012. However, this trend may simply represent random variation due to small number of cases attributed to IDU (2009 - 3, 2010 - 5, 2011 - 8, 2012 - 4).

Figure 6.2.7. New acute HBV cases in IDUs in 2005-2012



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 in 2009-2012 show that the total number of infections varied from 41 in 2012 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 (14%) in 2011 with a drop in 2012 to 1 case (2%). The overall number of newly diagnosed chronic HCV cases was 2 027 in 2010, 2177 in 2011 and 2213 in 2012. As for HCV infection in IDUs, there were 138 registered cases in 2010 (10.1% of cases with known transmission route), 150 in 2011 (7.1%) and 158 in 2012 (7.3%).

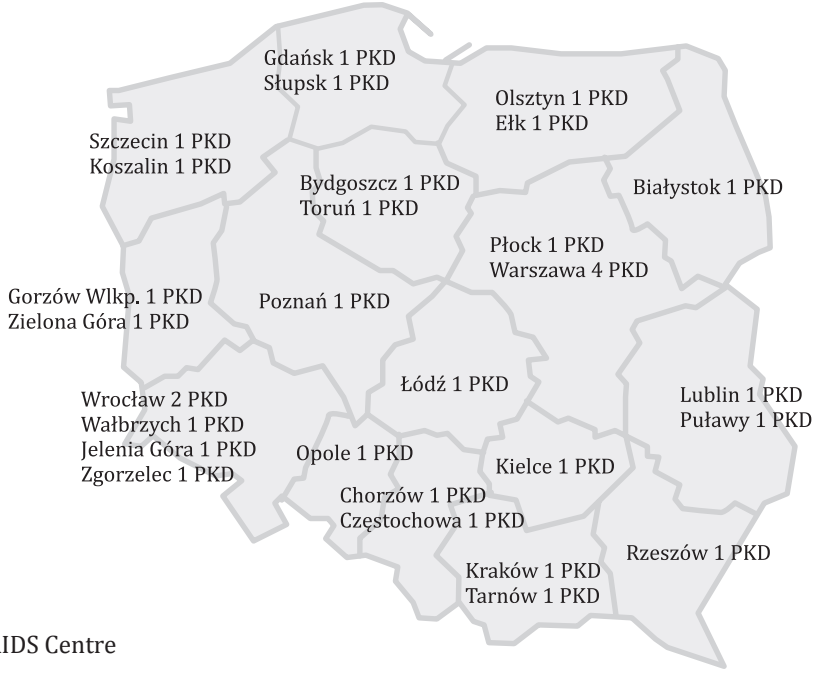
- **Data from the network of consultation and testing sites - PKD (based on the report "Analysis of survey questionnaires at consultation and testing sites in 2011" by TNS Polska by order of the National AIDS Centre.)**

Since 1996 a network of consultation and testing sites (PKDs) has been operating in Poland. The sites provide anonymous and free HIV testing combined with preliminary consultation. The PKD network 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 sited include:

- providing anonymous and free HIV testing for individuals engaging in risky behaviours who wish to keep it private without giving personal data. It allows early detection of HIV infections, which prevents further transmission. It also allows for 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 population,
- collecting epidemiological data on routes of HIV transmission in Poland based on the information provided by the survey participants.

At present, in Poland there are 32 consultation and testing sites in operation.

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



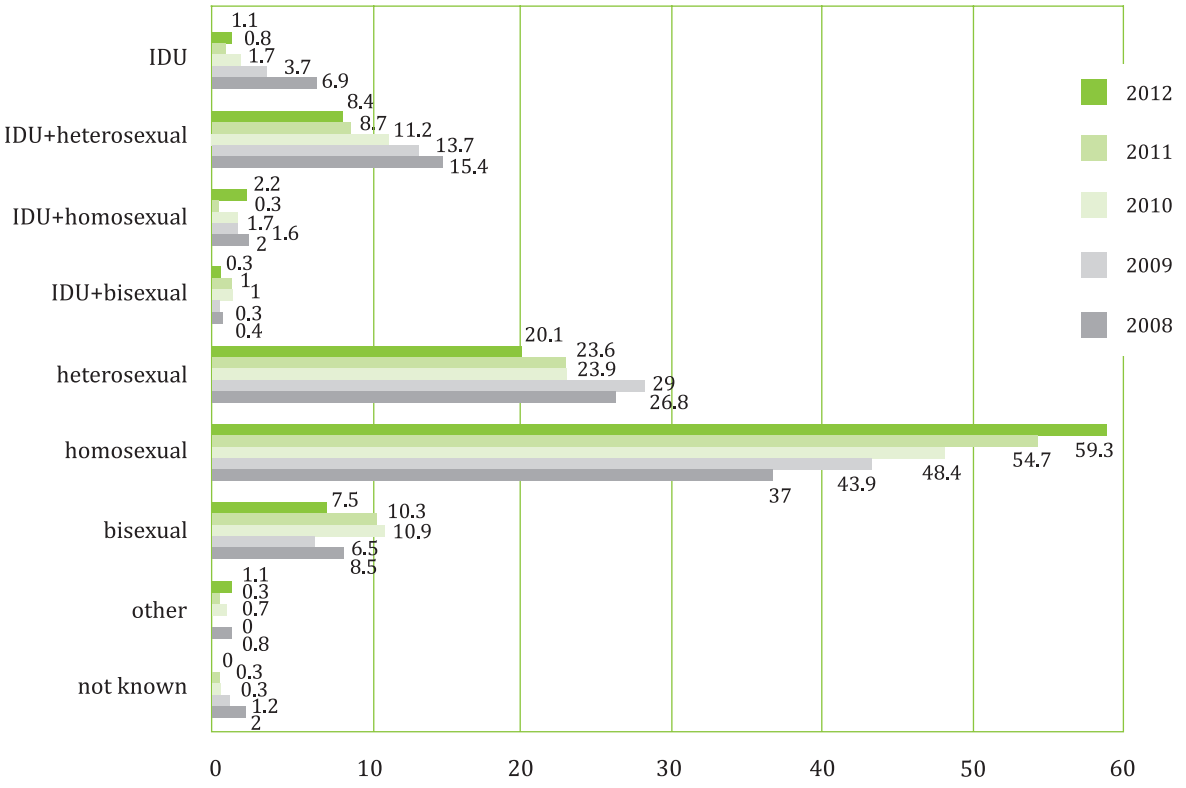
Source: National AIDS Centre

From the beginning of the PKD till 31 December 2012 a total of 209 081 people got tested for HIV and in 2 398 cases positives results were recorded.

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 individuals.

In 2011 the total number of PKD clients was 29 826 and 369 of them received a positive HIV test result.

Figure 6.2.8. HIV transmission routes among all PKD clients (percentages of clients)



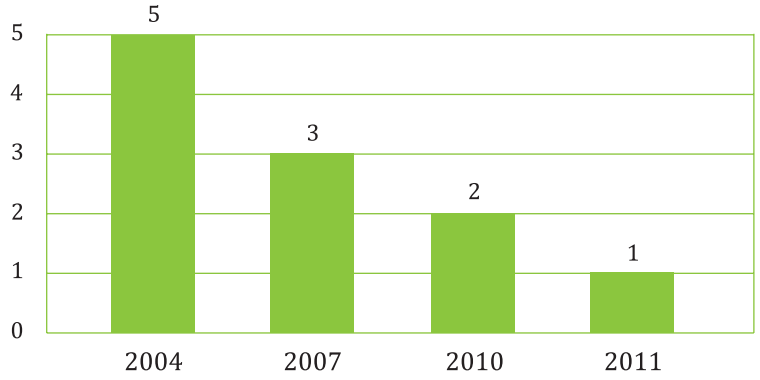
Source: based on the report "Analysis of survey questionnaires at consultation and testing sites in 2011" by TNS Polska by order of the National AIDS Centre.

The main route of HIV transmission among PKD clients is sexual intercourse. HIV infections recorded with reference to injecting drug use is falling every year and in 2012 only 1% of the clients got infected in this manner. However, combining both injecting drug use and risky sexual behaviour the rate reached 10.9% in 2012.

Injecting drug users as PKD clients

Comparing data from four 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 aprox. 5% and it fell by 1.7 percentage points in 2007 and by 1 percentage point between 2007 and 2010. In 2011, the number of injecting drug users (lifetime prevalence) stood at 224 out of all PKD clients (29 826).

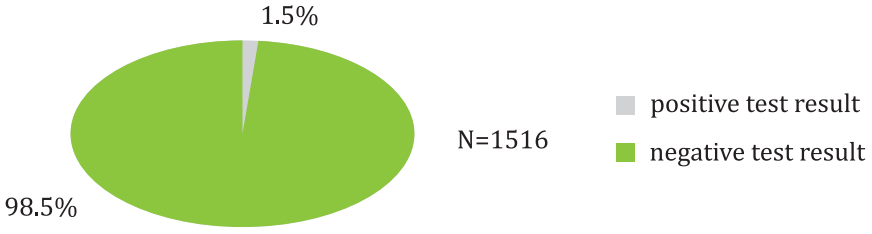
Figure 6.2.9. Percentages of all PKD clients who reported injecting drugs



Source: based on the report "Analysis of survey questionnaires at consultation and testing sites in 2011" by TNS Polska by order of the National AIDS Centre

Comparing the percentages of positive HIV test results in the IDU population and the general PKD population one can notice a significant difference (Figures 6.2.10., 6.2.11. and 6.2.12.). In 2011, the percentage of positive results in all the PKD population stood at 1.5% and had been holding steady for several years. However, if we analyse the IDU population only, we will see that the percentage of positive results stands at 14.7% and is the highest among all the populations under scrutiny (in 2010 it stood at 8.1%). For comparison, the percentage of positive results in the MSM population, where HIV detection rates are traditionally the highest at PKDs, stood in 2011 at 5.4%. The percentage of positive results among IDU population for 2012 stays at 9.1% what indicates that the increase observed in 2011 was just temporary.

Figure 6.2.10. Percentage of positive results in PKD population in 2011



Source: based on the report "Analysis of survey questionnaires at consultation and testing sites in 2011" by TNS Polska by order of the National AIDS Centre

Figure 6.2.11. Percentage of positive results in IDU population in 2011

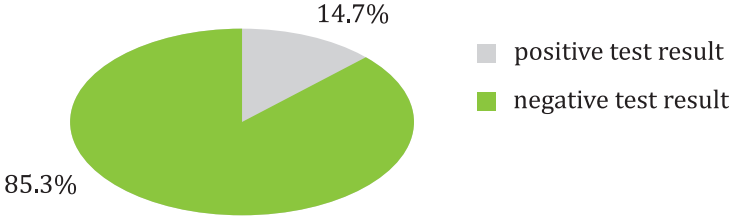
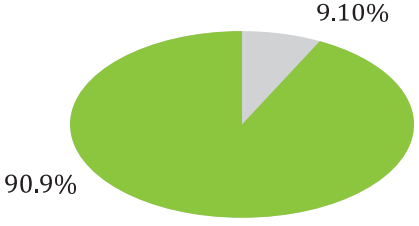


Figure 6.2.12. Percentage of positive results in IDU population in 2012



Source: based on the report "Analysis of survey questionnaires at consultation and testing sites in 2011" by TNS Polska by order of the National AIDS Centre

According to the 2011 data, 55% of injecting drug users ever shared needles and syringes.

The 2011 data clearly indicate that sex of the survey participants is a key differentiating factor for drug use. Drug users are predominantly men (68%) compared to 32% of women.

Analyzing data concerning the age of the IDU population, a certain pattern can be noticed. IDU PKD clients fall within age group 20-40. An average age is almost 31 and the most numerous group is made up by 26-year-olds. Only 25% of IDU PKD clients are in employment. The remaining clients are mostly unemployed and a relatively high number are in drug rehab at other facilities. 92% of IDUs are heterosexual. 2% consider themselves homosexual and 3% bisexual. IDU clients tend to use condoms more often in vaginal intercourse rather than oral or anal (45% vs. 5% and 9% respectively) as well as outside steady relationships (by analogy with the general PKD population). 40% of IDU clients admitted that during the intercourse condoms could not have been damaged while 15% recalled such situations.

Sexual intercourse under the influence of psychoactive substances may pose a greater risk of HIV infection. Over 50% of the IDU survey participants reported having sex under the influence of alcohol, drugs or other substances.

Injecting drug users rarely get tested for HIV at PKDs. There are more HIV test takers at PKDs which are located by drug counselling centres or methadone programmes. The others might either get tested elsewhere or fail to get tested at all.

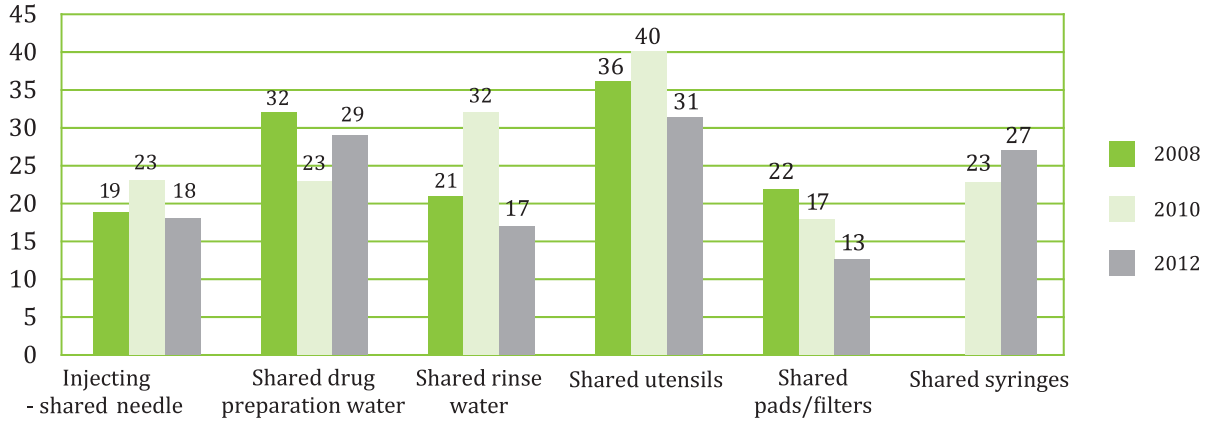
- **Data from national survey of clients of needle and syringe programmes**

In 2008, the Polish Focal Point (CINN) launched a national survey of clients of needle and syringe programmes. Measurements are repeated every two years towards the end of year (turn of November and December). In 2012, 349 interviews with drug users were held. The results of the survey have also been presented in Chapter 2 and 8.

Risky behaviours

One of the subjects of the survey were risky behaviours which drug users engaged in while injecting drugs in the last 30 days. The respondents were asked about sharing or borrowing injecting equipment. The presentation of the results was based on users who reported injecting drugs in the last 30 days. Most often the respondents used the same utensils e.g. a spoon (31%) or shared water for preparing the drug (29%). Not fewer respondents used the same syringe (27%). Fewer than every fifth respondent used the same water for rinsing the equipment (17%). The lowest percentage reported using the same cotton pads and filters (13%). The riskiest behaviour i.e. sharing a needle was reported by 18% of the respondents. The abovementioned results refer to 2012. In 2010, every fifth respondent shared a needle, syringe or rinse water (23%), more respondents used the same drug preparation water (32%), shared a spoon (40%) or cotton pads (17%). Comparing the results of the latest measurement of 2012 to the first one four years before, a fall in the prevalence of risky behaviours is observed. In 2012, there was a rise the number of users who share syringes compared to 2010. Figure 6.2.13. shows details. In 2008, the respondents were not asked about sharing syringes.

Figure 6.2.13. Risky behaviours of injecting drug users (%)



Source: Polish Focal Point, Malczewski, 2013n, p. 17

Prevalence of HIV and HCV

At first, the respondents were asked whether they had been tested. The results showed that most of the respondents tested for HIV (70%). More than a half (57%) were HIV positive. Comparing the results of the 2010 survey we notice a rise in the percentage of seropositive users. In 2010, fewer than a half of the tested survey participants were infected with HIV (43%). Analyzing the group of 137 HIV-positive individuals we observe that 73% of them had visited a doctor in the last 12 months prior to survey and 75% of them had started treatment (in the past or in the last year). In 2010, 127 individuals were positive and 76% of them had been to a doctor and 57% started treatment. In 2010, a lower percentage started HIV treatment compared to the latest measurement.

It must be added that two thirds of the respondents out of those who had tested for HIV had done so longer than a year before (76%) and only 14% in this group had tested in the last 6 months and 9% less than 6 months before, however, not longer than a year before. In 2010, the percentage of respondents who had tested longer than a year before was lower (62%), 15% had tested in the last 6 months and 22% longer than half a year before the survey, however, not longer than a year before. In the case of 2% of the survey participants no data were available. Moreover, the respondents were asked about the HCV status. Fewer respondents tested for HCV (68%) compared to HIV. The prevalence of HCV is far higher compared to HIV. Out of 250 users who tested for HCV, four fifths tested positive (78%). The prevalence of HCV is far higher, which is also confirmed by other studies. Out of those who were aware of being HCV positive, 28% had visited a doctor and only 18% had received or were receiving treatment.

Similarly to HIV infection, most respondents had undergone HCV tests over a year before (77%). Nearly 11% of them had tested in the last 6 months and 4% had done so in the period between 6 months a year prior to survey. In the case of 7% no HCV test-related information was obtained.

Let us take a look at the 2010 survey results in order to identify changes in the two years between the measurements. A higher percentage of the respondents (74%) had tested for HCV in the 2010 survey. Out of 292 individuals who tested for HCV nearly four fifths tested positive (70%). The 2012 result of 78% is higher. Out of those survey participants who were aware of being infected with HCV 43% had visited a doctor and only 24% had received or were receiving treatment in 2010.

In 2010, most respondents had for HCV over a year prior to survey (64%). Every tenth respondent (11%) had done the test in the last 6 months and 19% had done it in the period between half a year and a year prior to survey. In the case of 5% on information was obtained regarding the test. The prevalence of HCV was considerably higher than HIV.

6.3. Other drug-related health correlates and consequences (dual diagnosis)[12]

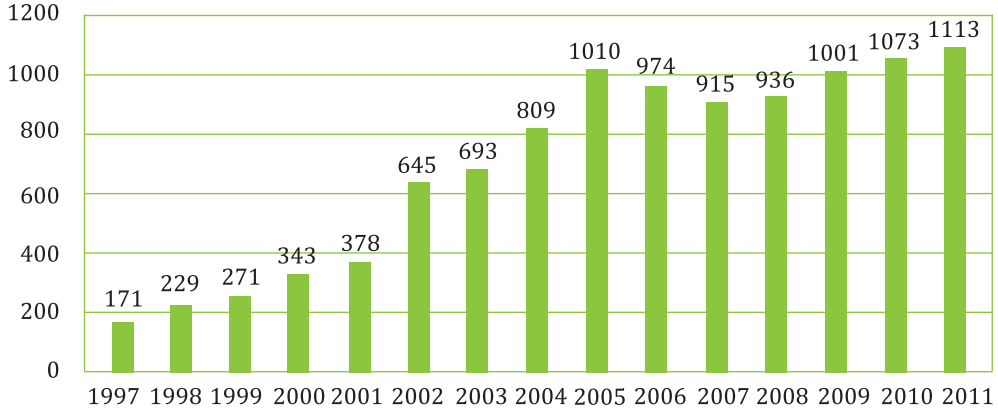
Up to 2005, the percentage of patients with dual diagnosis in the total number of patients admitted to residential drug treatment due to drug abuse was on the rise and reached the rate of 7.6% in 2005. After 2006 the upward trend was stemmed and the percentage of patients with dual diagnosis in the overall number of all patients admitted to residential treatment has been holding steady at 7.4-7.9% ever since.

Figure 6.3.1. Patients with dual diagnosis among all admissions to residential psychiatric treatment in 1997-2011 (percentages of patients)

Source: Institute of Psychiatry and Neurology in Warsaw, 2013

Between 1997 and 2005 the number of hospitalized patients with dual diagnosis rose from 171 in 1997 to 1 010 in 2005. After a fall between 2005 and 2007, since 2008 an upward trend was observed again, though less dynamic as previously. In 2011, the highest number of dual diagnosis admissions was recorded i.e. 1 113 patients.

Figure 6.3.2. Numbers of patients with dual diagnosis admitted to residential treatment in 1997-2011



Source: Institute of Psychiatry and Neurology in Warsaw, 2013

12 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

At residential psychiatric clinics in Poland in 2011, the most numerous group was made up by patients of the category "other mental disorders" (60%). This group comprises psychotic disorders, including hallucinations and delusions, schizophrenia and behavioural disorders. A considerable number of patients manifested personality disorder symptoms (25%). Moreover, the patients showed symptoms of anxiety disorders (9%), depression (5%) and other affective disorders (1%).

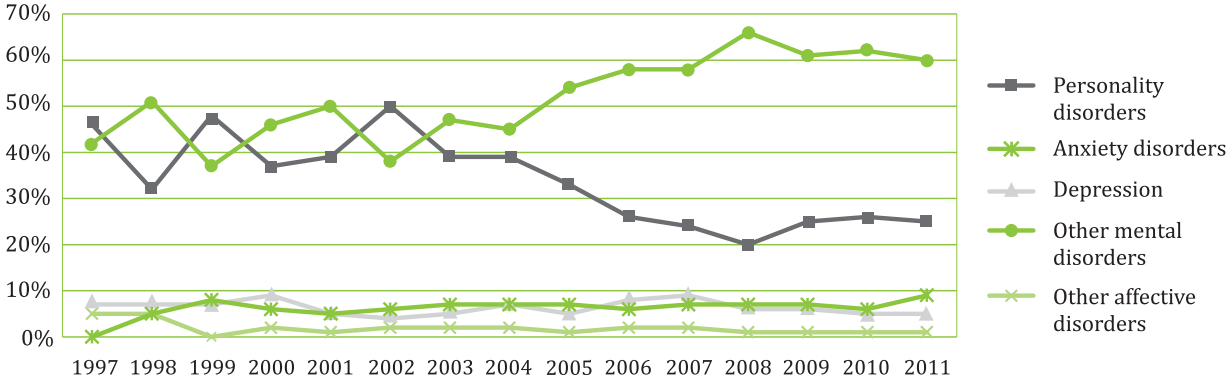
Table 6.3.1. Percentages of patients with drug problem admitted to residential psychiatric treatment in 2000-2011, by ICD-10 diagnosis

Percentage of patients with drug problem												
ICD-10 diagnosis	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Personality disorders	37%	39%	50%	39%	39%	33%	26%	24%	20%	25%	26%	25%
Depression	9%	5%	4%	5%	7%	5%	8%	9%	6%	6%	5%	5%
Other affective disorders	2%	1%	2%	2%	2%	1%	2%	2%	1%	1%	1%	1%
Anxiety disorders	6%	5%	6%	7%	7%	7%	6%	7%	7%	7%	6%	9%
Other mental disorders	46%	50%	38%	47%	45%	54%	58%	58%	66%	61%	62%	60%

Source: Institute of Psychiatry and Neurology in Warsaw, 2013

Analyzing data on what mental disorders are manifested by patients admitted to residential treatment there is a visible upward trend regarding patients diagnosed with "other mental disorders" in years 2004-2008. It seems that in 2009 the trend started to level off and became relatively stable. After a decrease of number of patients with personality disorders in 2008, for several years the percentage is relatively stable. A stable trend of admissions related 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 1997-2011, by ICD-10 diagnosis



Source: Institute of Psychiatry and Neurology in Warsaw, 2013

The analysis of the 2011 data indicates that dual diagnosis was most often diagnosed among individuals addicted to sedatives and hypnotics (lack of dual diagnosis occurred in 89.6% of cases) and inhalants (lack of dual diagnosis occurred in 90.7% of cases). The fewest cases of co-morbidity were recorded in opioid patients (98.7% of patients without dual diagnosis). The 'other mental disorders' category, i.e. the diagnostic category which most often refers to drug problem patients, is mainly identified in polydrug users (5.6%), inhalants (5.5%) and sedatives/hypnotics (4.2%). In 2011, personality disorders were most frequently observed among individuals dependent on cocaine (5.6%) and hallucinogens (5.3%). Anxiety disorders were most often diagnosed in patients addicted to sedatives and hypnotics (3.3%).

Table 6.3.2. Percentages of patients with dual diagnosis admitted to residential psychiatric treatment in 2011, by type of drug addiction

Percentage of patients with dual diagnosis						
Type of drug addiction	Lack of dual diagnosis	Personality disorders	Depression	Other affective disorders	Anxiety disorder	Other mental disorders
Opioids	98.7%	0.3%	0.4%	0.0%	0.0%	0.6%
Cannabis	96%	0.9%	0.2%	0.0%	0.2%	2.7%
Sedatives and hypnotics	89.6%	1.4%	1.1%	0.4%	3.3%	4.2%
Cocaine	94.4%	5.6%	0.0%	0.0%	0.0%	0.0%
Amphetamines	97.4%	0.6%	0.0%	0.0%	0.0%	2.0%
Hallucinogens	92.1%	5.3%	0.0%	0.0%	0.0%	2.6%
Inhalants	90.7%	1.9%	1.9%	0.0%	0.0%	5.5%
Polydrug use	91.5%	2.3%	0.3%	0.0%	0.3%	5.6%

Source: Institute of Psychiatry and Neurology in Warsaw, 2013

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.

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 2011, we notice a slight increase to 285 cases. In 2011, the average age of drug-related death was 37. Out of 285 deaths, most cases (70%) were male. Throughout all the years, most fatal drug overdoses were recorded in men (Malczewski, 2013j).

Table 6.3.3. Number of drug-related deaths in 2001 – 2011

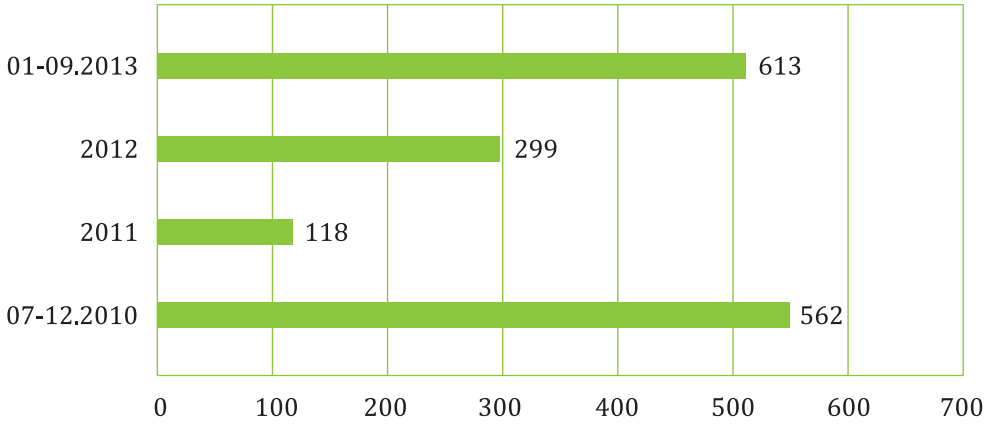
Number of drug-related deaths											
ICD-10 diagnosis	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Men	184	186	187	143	172	145	137	142	174	160	198
Women	110	138	90	88	118	96	77	102	73	101	87
Total	294	324	277	231	290	241	214	244	247	261	285

Source: GUS

Legal highs-related poisonings

In 2010, 562 legal highs-related poisonings were recorded. The number of poisonings after the closure of legal highs stores in November fell dramatically. Analyzing the latest available data for 2013 (January – September), we notice an increase of medical interventions related to new psychoactive substances to 613 cases.

Figure 6.3.4. Medical interventions connected with „legal highs" reported to National Consultant in Clinical Toxicology

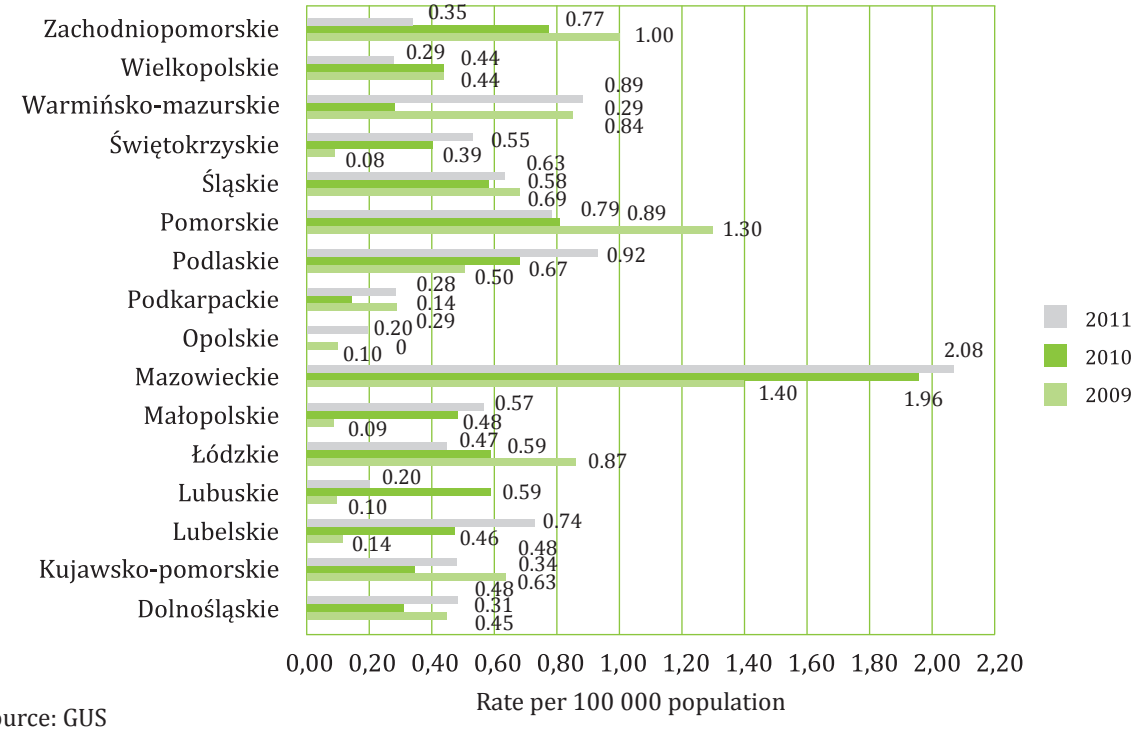


Source: National Consultant in Clinical Toxicology

Situation in provinces

The situation in terms of drug-related deaths varies depending on the province. In 2011, the highest drug-related mortality rate was recorded in mazowieckie province (2.08 per 100 thousand population; 1.08 in 2010) while the lowest one in opolskie province (0.2; 0 in 2010) and lubuskie province 0.2 (0.59 in 2010). The provinces with the highest drug-related mortality rates include podlaskie 0.89 (0.67 in 2010). In the provinces of mazowieckie, swietokrzyskie and lubelskie the rate has been rising annually since 2009.

Figure 6.3.5. Drug-related mortality in 2009-2011 by province; national rate at 0.74 (2011)



Source: GUS

In absolute terms the highest numbers were recorded in the provinces of mazowieckie (110), slaskie (29) and lubelskie (16). Deaths in mazowieckie province account for 39% of all fatal cases in Poland, with Warsaw topping the statistics.

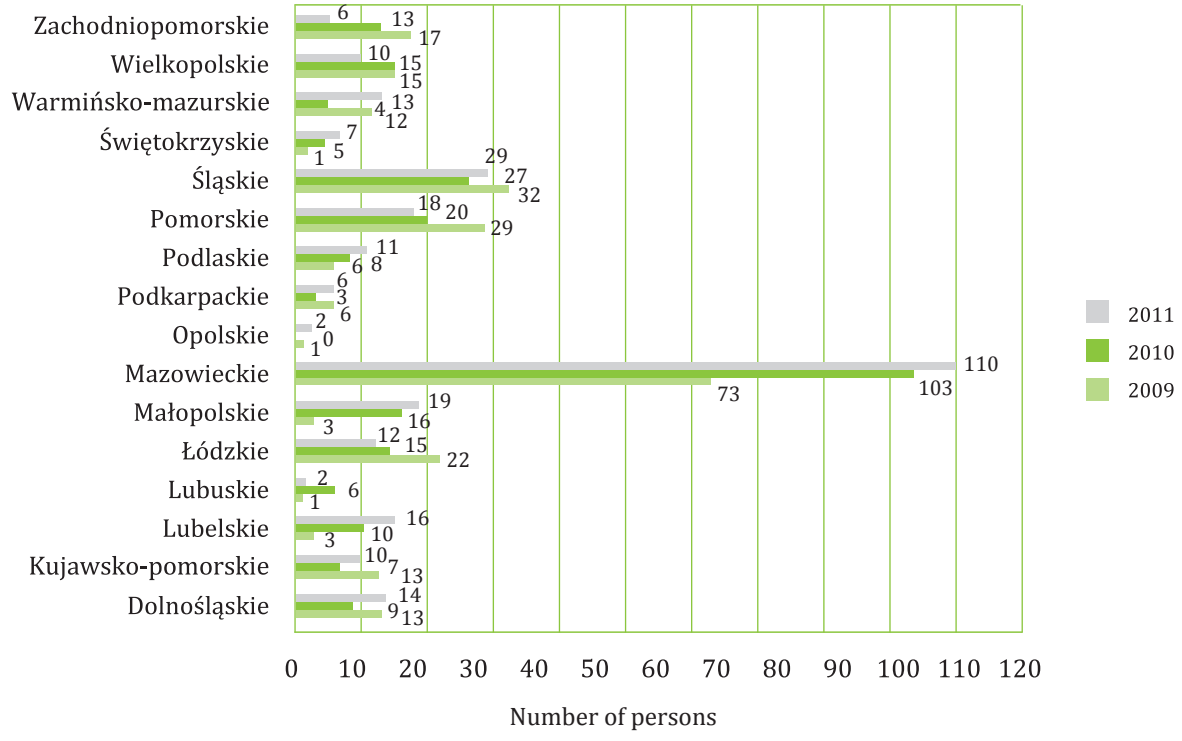
Acute encephalopathy induced by potassium permanganate used in methcathinone (ephedrone) production from pseudoephedrine-based pharmaceuticals[13].

Since 2005 a number of cases of acute encephalopathy among methcathinone (ephedrone) users have been detected in Russia and former Soviet Union republics (Georgia, Ukraine, Latvia, Estonia, Azerbaijan) as well as the neighbouring countries (Turkey). The cause of this phenomenon was pin pointed to manganese compounds used in methcathinone production from pseudoephedrine-based pharmaceuticals. In Poland, similar cases were observed in individuals who used preparations conta-

13 This is abstract of the article by Bogusława Habrat "Acute encephalopathy induced by potassium permanganate used in methcathinone (ephedrone) production from pseudoephedrine-based pharmaceuticals published in Serwis Informacyjny NARKOMANIA Nr 1 (63) of 2013.

ining methcathinone and other manganese compounds (Habrat, 2013). There is no research into the prevalence of manganese encephalopathy. In recent years, also in Poland, the production of ephedrone from pseudoephedrine-based pharmaceuticals has become widespread. Manganese compounds used to synthesize ephedrone from pseudoephedrine are highly neurotoxic and cause acute encephalopathy of high harm potential, including simple role functioning difficulties. The results of treatment are unsatisfactory and the treatment often fails to prevent the disease from developing. In this context, prevention seems to be essential. It should be based on promoting reliable knowledge and the actions should target both drug users and the wide spectrum of professionals. As at the end of 2012, 16 individuals remained in treatment for acute encephalopathy induced by potassium permanganate used in methcathinone production in the Institute of Psychiatry and Neurology.

Figure 6.3.6. Drug-related mortality in 2009-2011 by province



Source: GUS

7. Responses to health correlates and consequences

prepared by Dawid Chojecki, Artur Malczewski

7.1. Introduction

Harm reduction programme 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 are 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, and 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 drugs.

The following section discusses life-saving medications administered 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 Drugs Strategy 2011-2016 (KPPN).

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 developed 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 (Recreational settings incl. reduction of drug and alcohol related harm).

Under harm reduction programmes for psychoactive substance users (described broadly in Chapter 7.4), 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 medications are used:

- Naloxone, in acute opioid poisonings,
- Naltrexone, in maintaining abstinence or preventing relapse. In Poland, this drug is registered to support opioid treatment following detoxification. It 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).

7.3. Prevention and treatment of drug-related infectious diseases

• Prevention: vaccinations, testing and counselling

All Polish citizens, including uninsured drug addicts, have the option of undergoing a free HIV test. Testing sites in Poland are obliged to offer counselling before and after the test.

In 2012, the National Health Fund activities aimed to improve the availability of drug-related infectious disease prevention programmes included financing HBV vaccinations and HCV and HIV tests done at specialist sites. Moreover, in 2012 there were 31 testing sites, which provided anonymous and free HIV tests. In 2011 (latest data), 5 130 test takers were also drug users. They account for 20.2% of all test takers.

In the reporting year, 7 Marshal Offices co-financed HIV prevention programmes at the total amount of PLN 115 990. The Marshal Offices supported 10 HIV prevention programmes, including consultation and diagnostic centres for anonymous HIV testing. For example, in opolskie province a provincial conference entitled "HIV among us" was organized. The conference was also attended by drug patients. It featured an HIV/AIDS quiz for drug patients treated at MONAR Society facilities. Opole HIV Testing Days were held in collaboration with the Family Development Society. In swietokrzyskie province, in collaboration with NGOs, a programme called "Initiating and supporting HIV, HBV/HCV prevention programmes" was organized. It involved information and education sessions and the opportunity to have a free HIV/HBV/HCV test. A total of 300 tests were conducted. 6 HCV infections were detected.

• Infectious diseases treatment

The National AIDS Centre reported that 21 hospital-based referral centres provided complex antiretroviral treatment for HIV/AIDS patients in 2012. 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.

As at 31 December 2012, the ARV treatment was provided for 6 297 HIV/AIDS patients, including 1 827 cases (29%) where the likely route of HIV transmission was injecting drug use or unprotected sex.

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

7.4. Responses to other health correlates among drug users

• Harm reduction programmes for drug users

Similarly to 2011, in 2012 the National Bureau for Drug Prevention co-financed across Poland 12 health and social harm reduction programmes for drug-dependent individuals unmotivated to enter treatment, including prisons and remand centres (no injecting equipment exchange as it is prohibi-

ted) and at drug and HIV/AIDS treatment ward of an infectious disease hospital. The programmes were conducted in major Polish cities including Warsaw, Czestochowa, Gdansk, Chorzów, Katowice, Krakow, Olsztyn, Pulawy, Wroclaw, Zgorzelec, Zielona Gora. Mainly street work-based harm reduction programmes received co-financing. Needles and syringes were exchanged in 5 drop -in's and 2 night shelters for drug users. All harm reduction programmes provided services for the total of 2 778 clients who were not only injecting drug users. 136 000 needles and 98 203 syringes were distributed.

The tables below show profiles of clients of the 12 harm reduction programmes, the most prevalent psychoactive substances and figures of the equipment exchanged. The most prevalent main drug used by the clients of such programmes is heroin However it is not the most prevalent drug but among harm reduction project clients the most of them have the main problem with heroine (after poly drug use, because half of all clients 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 2012

Client profile – 2012 report	
Action – Health and social harm reduction in drug-dependent population	
Client group	**Total**
Clients with social problems	1153
Clients with legal problems	773
Clients with health problems	1079
Ethnic groups	53

Source: National Bureau for Drug Prevention, 2013

Table 7.4.2. Equipment distributed and collected under KBPN-financed health and social harm reduction programmes for drug-dependent individuals in 2012

Equipment distributed and collected – 2012 report	
Action – Health and social harm reduction in drug-dependent population	
Equipment	**Total**
Needles distributed	136012
Syringes distributed	98203
Condoms distributed	26601
Water for injecting distributed	4984
Cotton pads distributed	17906
Antiseptic liquids distributed	902

Other equipment distributed	50
Other distributed	1745
Needles collected	81763
Syringes collected	60107

Source: National Bureau for Drug Prevention, 2013

Table 7.4.3. Substances used by clients of KBPN-financed health and social harm reduction programmes for drug-dependent individuals in 2012

List of (primary) drugs used by clients of health and social harm reduction programmes in drug-dependent population – 2012 report	
Action – Health and social harm reduction in drug-dependent population	
Primary drug	**Client total**
Alcohol	307 (11.5%)
Amphetamines	681 (24.5%)
Crack	0
Ecstasy	6 (0.2%)
Hallucinogenic mushrooms	0
White heroin	15 (0.5%)
Brown heroin	588 (21%)
Polish homemade heroin	333 (12%)
Cocaine	100.4%
Tranquilizers/sedatives	38 (1.4%)
LSD	3 (0.1%)
Mixed	1385 (50%)
Cannabis	145 (5%)
Inhalants	11 (4%)
Other	198 (7%)

Source: National Bureau for Drug Prevention, 2013

In 2012, similarly to previous years, the National Bureau co-financed "Monar na bajzlu", magazine addressed to drug users and providers of drug treatment, especially harm reduction programmes[14].

Harm reduction programmes are also supported by local governments. However, in the reporting year out of 16 Marshal Offices, only 1 supported needle and syringe exchange programmes: stationary and street syringe and needle exchange as well as a night shelter for drug addicts Krakow.

Communal governments were also responsible to sponsoring drug-related harm reduction programmes. In 2012, they supported 38 harm reduction programmes, including syringe and needle programmes, street-based HIV, HBV and HCV programmes, drop-in centres for active drug users, night shelters for addicts, discotheque-based programmes as well as rehabilitation camps. The programmes included 27 150 participants. The 2012 expenditure stood at PLN 840 811 (PLN 1 275 383 in 2011).

The analysis of harm reduction activities and the related-expenditure incurred by local governments shows a fall in the prevalence of injecting drug use, including opioids. Open drug scenes, which provide grounds for street-based syringe and needle exchange, are also disappearing. That might be the reason why so few communal and provincial governments supported harm reduction programmes.

7.5. Syringe and needle exchange programmes in Poland

First pilot syringe and needle exchange programme were established towards the end of 1980s by MONAR Society. MONAR consultation centres across the country were distributing injecting equipment. According to the data of the Institute of Psychiatry and Neurology, in 1989, 66 000 needles and syringes were handed out and in 1993 the figure rose to 360 thousand (Kulka, Z., Moskalewicz, J., 1998). In 2004, the Polish Focal Point started monitoring harm reduction activities by collecting information from syringe and needle programmes. Annual conferences for harm reduction programmes were also started. In 2002, 21 NSPs were operational in 23 cities. In 2012, 12 such programmes were operational in the following cities: Wroclaw, Czestochowa, Warszawa, Zielona Gora, Zgorzelec, Olsztyn, Pulawy, Krakow, Katowice and Gdansk. Apart from the injecting equipment, the programmes provided counselling, education and welfare support. The highest number of programmes were run by Monar Society (7 programmes). The programmes offer stationary exchange and some of them reach injecting drug users in the street.

In previous years one of the programmes distributed syringes and needles through a minivan (Krakow) and other programmes used bicycles (Warsaw).

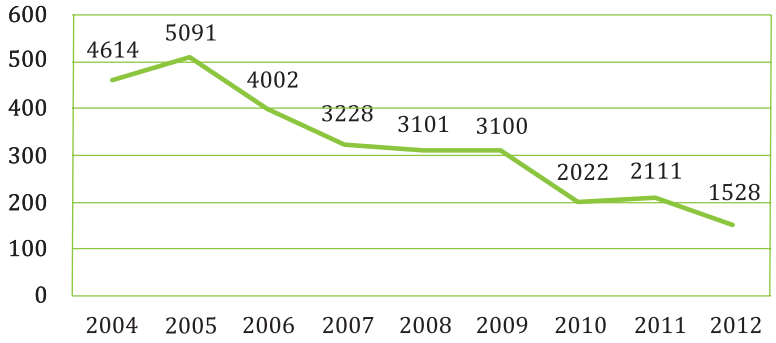
Figure 7.5.1. Number of syringe and needle programmes in Poland in 2002-2012

Source: Polish Focal Point

14 http://magazynmnb.pl/
http://issuu.com/magazynmnb/docs/mnb_2013_lato_big/1?e=4272161/4038322
http://issuu.com/magazynmnb/docs/mnb_2012-2013_zima_small/

In 2011, the programmes distributed almost 195 thousand needles for 2000 users. In 2012, the syringe and needle programmes reached over 1500 individuals. There are enormous differences in the programme clients. In one of them there were only 10 injecting drug users. The latest data indicate a fall in the number of NSPs clients (Figure 7.5.2.). The results of biennial surveys among injecting drug users show a steady decrease of the programme clients. In 2008, questionnaire interviews were held with 700 individuals, in 2000 the number was 400 and in 2012 there were 350 respondents. The survey results have been presented in Chapters 4, 6 and 8 of the National Report.

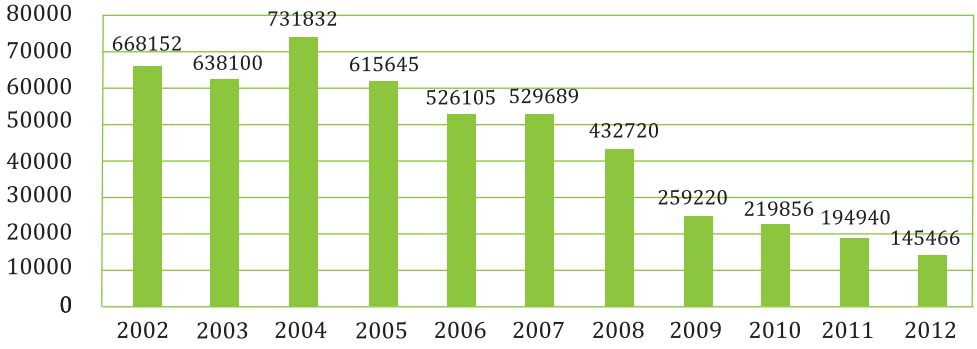
Figure 7.5.2. Numbers of NSPs clients 2004-2012



Source: Polish Focal Point

Under 12 NSP in 2012, 145 466 needles and 99 289 syringes were distributed. 87 435 needles and 63 363 syringes were collected (Figure 7.5.3.). The highest number of NSPs beneficiaries was recorded in 2005: over 5000 injecting drug users received more than 731 thousand needles. In some programmes, drop-in centres are operational. Such facilities were opened in the cities of Wroclaw, Krakow and Warsaw. In the last 10 years, the drug scene in Poland has undergone certain changes. For example, in some cities open drug scenes (the so-called *bajzle*) have disappeared. New substitution treatment programmes have been established where opioid dependent-individuals started treatment. Moreover, there has been a fall in the prevalence of injecting drug use. Analyzing harm reduction activities, one must take into account legal changes introduced since 2000, which aimed at tightening the drug law. Following these measures, open drug scenes started disappearing and they were primary settings for outreach workers who offered assistance and distributed injecting equipment. Analyzing the changes in the drug services, one must note a decrease in the coverage and number of syringe and needle exchange programmes. In the last 10 years, NSPs ceased to exist in the cities of Szczecin, Poznan, Jelenia Gora, Rzeszow and several cities in Silesia. Wide harm reduction services are still available in the cities of Wroclaw, Krakow and Warsaw. Drop-in centres operate in these cities as well as night shelters (Warsaw and Krakow).

Figure 7.5.3. Numbers of needles in distribution in 2002 - 2012

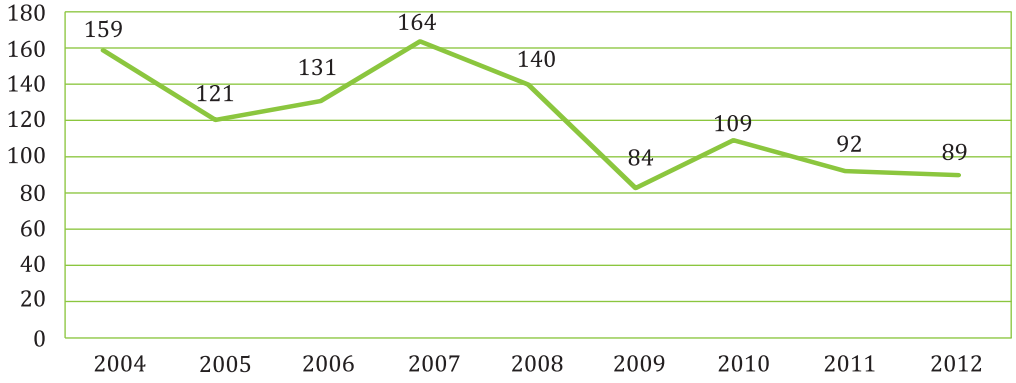


Source: Polish Focal Point

At present, discussion is under way in Poland on the new formula of harm reduction programmes, which are adapting to the needs of new clients who do not inject drugs so often and need sterile equipment but seek social assistance, legal counsel and support in contacts with various offices. One of the challenges is the adaptation to the new drug market, which is offering more and more new psychoactive substances online (Wodowski, 2013). The programmes also feature clients who receive substitution treatment at the same time. The Polish Focal Point annually holds a national conference for harm reduction programmes, which serves as a platform of information exchange. The latest conference was organized in September 2012 and it featured works on harm reduction standards. Next conference is due to be held in December this year.

Let's look at average number of needles provided by NSP in Poland. In 2012 one IDU received 89 needles what is similar to the previous year. The highest number was in 2007 (164). Number of injecting drug users ranges from 4 307 to 10 034 with the mean of approx. 7 170 in 2012 (preliminary data see chapter 4). Based on this estimation NSP covered in Poland approx. 23% IDU.

Figure 7.5.4. Numbers of needles per clients in NSP in 2004-2102



Source: Polish Focal Point

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

In 2011 (the latest data), there were 3 wards in psychiatric hospitals (46 beds) and 2 wards in drug rehabilitation clinics (35 beds). In addition, there was 1 ward in a general hospital (26 beds). The above wards admit patients with dual diagnosis.

Most drug treatment units are not ready to treat patients with dual diagnosis. Such patients are referred to mental health counselling centres and in 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

8. Social correlates and social reintegration

prepared by Dawid Chojecki, Artur Malczewski

8.1. Introduction

Using drugs, 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 among drug users

- **Social exclusion among drug users**

In 2012, social welfare centres across Poland provided drug-related assistance for 3 373 families (2011: 3 309); including 404 in rural areas (397 in previous year). The assistance was provided for 5 208 clients, including co-dependent individuals (2011: 5 286). Similarly to previous years, the highest proportion of beneficiaries came from mazowieckie province – 973 individuals (633 families) and the lowest from swietokrzyskie province (150, 68 families), podkarpackie province (105, 69 families) and podlaskie province (82, 62 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 2012, 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 140 sex workers (including 11 people 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", 2013). 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. The programme included 210 participants. The outreach was primarily provided in the work environment of the programme participants. 53 escort agencies were reached (DA-DU Charity, 2013).

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 – harm reduction programmes for men who have sex with men". The programme was conducted in Warsaw. The programme settings included MSM clubs and two saunas. GHB and ketamine tests, condoms and lubricants were distributed. The programme targeted 900 individuals (Lambda Society, 2012).

The programme of the Dolnoslaskie Psychoprevention Association "Return" entitled "Outreach in music clubs and selected music events in Wroclaw and across Poland" featured actions targeting gay population (Dolnoslaskie Psychoprevention "Return" Association, 2013).

Social exclusion and drug use

Since 2008, every two years at the turn of November and December, questionnaire interviews have been held across Poland with low-threshold programme clients. In fact, the interviews make up a database of all clients of such programmes. In 2012, 349 interviews were conducted (99% were IDUs). As the measurements are taken at the same time of year we can compare results and follow trends on the drug scene of injecting drug users. In this part of the National Report we present a profile of this population. Drug use patterns have been presented in Chapter 2 and HIV/HCV infection along with risky behaviours in Chapter 6.2.

The survey participants were asked whether they had children and if so how many. Slightly fewer than a half were parents (46%; 45% in 2010). Every fourth respondent had one child (26% in 2010 and 2012), 15% had two children (10.8% in 2010), 5% three and nearly 1% (3% in 2010) four or five children. Analysing education of the survey participants in 2012 we notice that almost every third respondent had primary (28.4%) or secondary education (29.5%). The most numerous group was made up by users with vocational training (33%). Far lower percentages of the survey participants had middle school (4.3%) and higher education (4%). In the case of 1% of the respondents no information regarding education was available.

The measurement also focused on the housing situation of injecting drug users. Most respondents i.e. almost three quarters had a permanent place of residence (71%) defined as an opportunity to spend at least 6 months at the same place in 2012. A similar percentage was recorded in 2010: 68%. Individuals who had a permanent place of residence most often lived with a family or friends: 40% (48% in 2010), independently: 23% (17% in 2010) or at an institution such as a night shelter, hostel or other: 8% (4% in 2010). Compared to 2010, it can be noticed that fewer users resided permanently with someone and more independently. It is worth noting that every fourth respondent did not have a permanent place of residence. Out of all respondents, 11% were staying temporarily with someone (15% in 2010) and 7% at an institution (4% in 2010). Homeless users, who actually lived in the street, accounted for 4% of the survey respondents (the same percentage as in 2010). 6% of the respondents lived in squats (2% in 2010). The total percentage of individuals who sought institutional assistance in terms of housing stood at 15% in 2012 compared to 12% in 2010. Drug users were also asked about people they lived with. During the interview they could choose more than one answer. Every fourth respondent lived with parents: 23% (41% in 2010) while every sixth with a spouse or partner: 15% (22.4% in 2010). Sharing a flat with a friend or friends was reported by not fewer respondents: 14% (19% in 2010). Only 4% lived with children (10% in 2010) despite the fact that 45% had children. 12% of the respondents lived independently (the same as in 2010) and almost 16% were unable to say whether they lived on their own or with someone else (10% in 2010). Compared to 2010, there was a fall in the percentage of individuals who reported living with parents. It is worth noting that a higher percentage in the previous measurement reported living with children. An important element of social profile is the source of income. The respondents were asked to state their main source

of income by selecting two most relevant answers from the list. In 2010, the respondents selected only one answer. Consequently, I do not present the results in that measurement. Living off paid work was reported by 11% of the respondents. A similar percentage concerned those living off disability benefit or pension (12%). The same proportion is maintained by others (12%). The unemployment rate among the respondents stood at 8%. Almost every fifth received welfare benefits, which were the main source of income (17%). 8% of the respondents answered that they had no source of income, including those who lived off begging. The biggest group of respondents were those who failed to fall under any of the abovementioned categories. Every fourth respondent selected the 'other income' answer, which meant that they also received income from illegal sources. Based on the results, we can conclude that more than every fourth respondent received unofficial income. A major source of income were welfare benefits while a small percentage of respondents performed paid work (Malczewski, 2013a).

- **Homelessness**

In Poland, data on the number of homeless drug users does not exist. However it is widely known that a lot of addicts, particularly opioid users, are homeless. Such conclusions might be drawn upon the data analysis of 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 consequences.

In 2012, the National Bureau sponsored 2 night shelter programmes implemented by the Krakow-based Society for Drug Related Help and the Monar Society in Warsaw. 294 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 2012, the National Bureau also co-financed reintegration programmes in hostels and re-entry flats run by 15 NGOs. 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 (usually residential) drug treatment.

In 2012, provincial governments also financed social exclusion prevention programmes for drug-dependent individuals. 9 hostels and re-entry flats were provided with funding. Communal authorities also financed hostels and re-entry flats. However, in 2012, only 25 communes (out of 2 255 who submitted reports) co-financed such facilities.

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. The aim is to reintegrate a drug user into society by providing education, employment as well as opportunities to assume 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.

In 2012, 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 2012, the National Bureau co-financed abstinence-supporting programmes conducted by 20 organizations. Post-rehabilitation programmes targeted a total number of 1 705 clients. 784 participants were in employment (approx. 46%) and 331 were in school (approx. 19%). The table below shows 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 2012 (age)

Target groups by age - 2012 report	
Action – Abstinence-based post-rehabilitation programmes	
Age groups	**Total**
Under 12	31
12–15	5
16-19	104
20-24	450
25–34	755
over 34	464
Total number of participants	1705
Including new participants	638

Source: National Bureau for Drug Prevention, 2013

Table 8.3.2. Client structure of KBPN-financed abstinence-based post-rehabilitation programmes in 2012 (characteristics)

Program receivers characteristics - 2012 report	
Action – Abstinence-based post-rehabilitation programmes	
Target groups	**Total**
Pupils	162
Students	169
Clients in emloment	784
Clients with social problems	765
Clients with legal problems	572
Clients with health problems	372
Parents, families	201

Source: National Bureau for Drug Prevention, 2013

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 drug treatment programmes are still insufficient. There are still too few re-entry flats and hostels. In 2012, 9 provincial governments co-financed social exclusion prevention programmes for drug addicts. The governments spent PLN 469 020 in that regard (the highest share by the government of lubelskie province government at PLN 390 840 and podlaskie province at PLN 50 000).

Provincial governments co-finance the so-called Social Integration Centres. The aim of the centres is to provide assistance in mastering skills helpful to assume social role, get or improve professional qualifications, train for a job, learn to plan life, manage personal finances and become self-reliant in terms of satisfying one's own needs. The Social Integration Centres admit drug addicts upon completed drug rehabilitation. Such centres were co-financed by 5 provincial governments.

In 2012, 110 communes (5%) co-funded the implementation of social reintegration programmes for harmful users and drug-dependent individuals. There were 33 communes more compared to 2011 (77). The abovementioned Social Integration Centres were co-financed by 40 communes (i.e. only by every 56th). Social exclusion reduction programmes are infrequently sponsored by communal authorities.

For more information on this issue see section "Employment".

- **Housing**

It is possible for a person struggling with difficult housing situation to apply for a social flat. Social flats are awarded by housing commissions (operating by city councils) based on approval of a social

welfare centre and health care unit. However, there is no information on the number of drug treatment graduates who moved to such flats.

- **Education, trainings**

In order to increase the likelihood of finding employment after completing drug treatment, the treatment graduates take vocational courses. In the reporting year, the National Bureau for Drug Prevention financed 380 hours of vocational training for 81 participants of post-rehabilitation and social reintegration programmes.

Communal authorities are also responsible for supporting vocational trainings. However, out of 2 255 communes which filed annual National Drugs Strategy reports, only 13 communes sponsored vocational trainings for harmful drug users and drug-dependent individuals. The total number of sponsored trainings and participants stood at 49 and 195 respectively.

Completing or starting education is also of great importance as most drug abusers suffer considerable deficits in this respect. Among participants of the National Bureau-sponsored post-rehabilitation and social reintegration programmes for drug treatment graduates, 331 were pupils or college students. They accounted for 19% of all participants of such programmes.

- **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

1. Introduction

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 1997 and 2005 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.

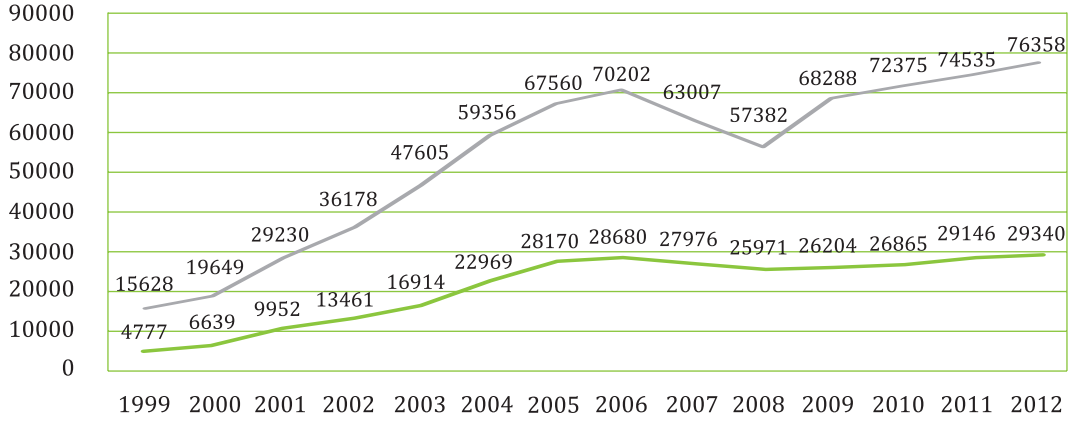
Police data on drug-related crime are registered in the TEMIDA police and prosecution database, which contains violations of the Act on counteracting drug addiction. Basic statistical units used by the Police include suspects, instigated and completed proceedings as well as recorded crimes

2. Drug related crime

• Recorded crimes

Figure 9.2.1. shows recorded crimes under the Act on counteracting drug addiction throughout the period of 15 years. In 2007, for the first time since 1999, we recorded a fall of as much as 10% in the number of drug-related crimes. This trend continued in 2008 (further fall of 9%). In the following years the number of recorded crimes rose with each year. In 2012, we the number of recorded crimes reached a record high of 76 358. The highest proportion of crimes was related to Article 62 (drug possession): 37 540 (49 of all crimes). Compared to the previous year, there was a rise of 2%. Next article in terms of drug-related crime prevalence was supplying drugs to gain material benefit (Article 59) i.e. drug dealing. In 2012, the police recorded 18 706 such crimes. Every fourth crime was recorded under Article 59. In the last two year the number of such crimes has risen by approx. 2%.

Figure 9.2.1. Recorded crimes (line above) and suspects (line below) against the Acts of 1997 and 2005 on counteracting drug addiction in years 1999–2012

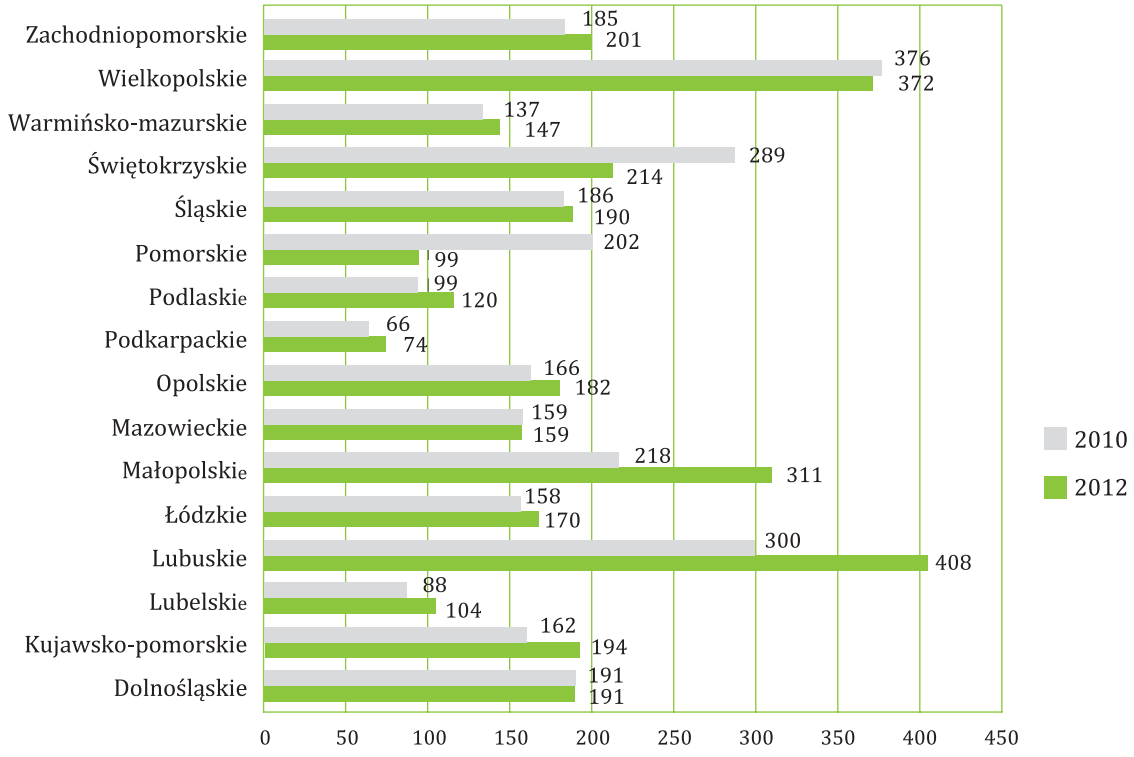


Source: Police Headquarters, Malczewski, 2013h

Drug-related crime at provincial level

For comparison, the drug-related crime numbers have been converted to rates per 100 000 population. Figure 9.2.2. shows data for 2010 and 2012. The national average stood at 198 drug-related registered offences per 100 000 in 2012. The list is topped by lubuskie province (408 offences per 100 000 population; 300 in 2010), which was two times as high as the national average. Second came wielkopolskie province (372 in 2012; 376 in 2010). As long as in wielkopolskie province the rate held steady, in lubuskie province there was a rise of 36%. The list leaders also include malopolskie province (311 in 2012; 218 in 2010). The lowest rates were recorded in the provinces of podkarpackie (74; 66) and pomorskie (99; 202). Last year the drug-related crime rate in pomorskie province halved. The analysis shows that the situation regarding drug-related crime varies significantly between provinces. Eastern provinces present the lowest rate compared to the rest of the country even though they are border provinces.

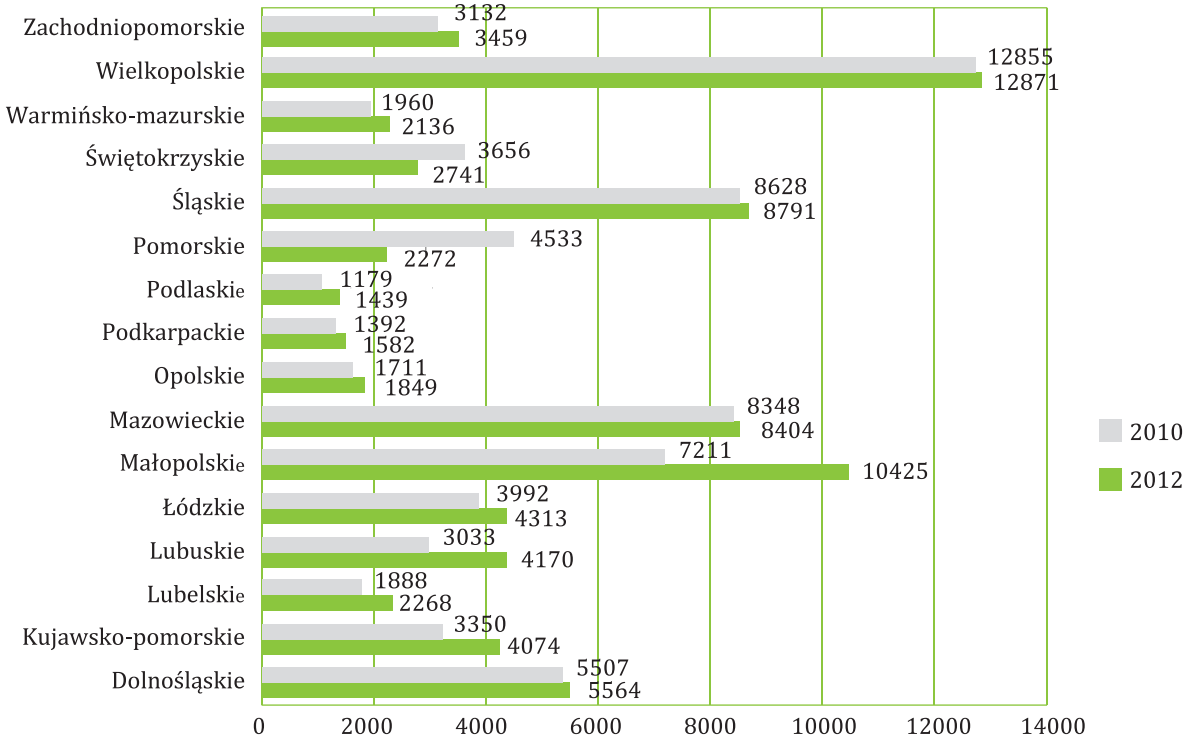
Figure 9.2.2. Drug-related crime rates in 2010 and 2012 against the Act of 2005 on counteracting drug addiction, by province (per 100 000 population)



Source: Police Headquarters

In terms of absolute numbers, the highest offences were recorded in wielkopolskie province. In 2012, the police registered 12 871 drug-related offence and a similar figure was observed in 2010 (12 855). Malopolskie province followed second (10 425 punishable acts) with high rise in drug-related crime compared to 2010 (7 211). Slaskie province came third (8 791) with a similar value recorded in 2010 (8 628). The lowest number in 2012 was recorded in podlaskie province (1 439) and podkarpackie province (1 582).

Figure 9.2.3. Numbers of crimes recorded in 2010 and 2012 against the Act of 2005 on counteracting drug addiction, by province



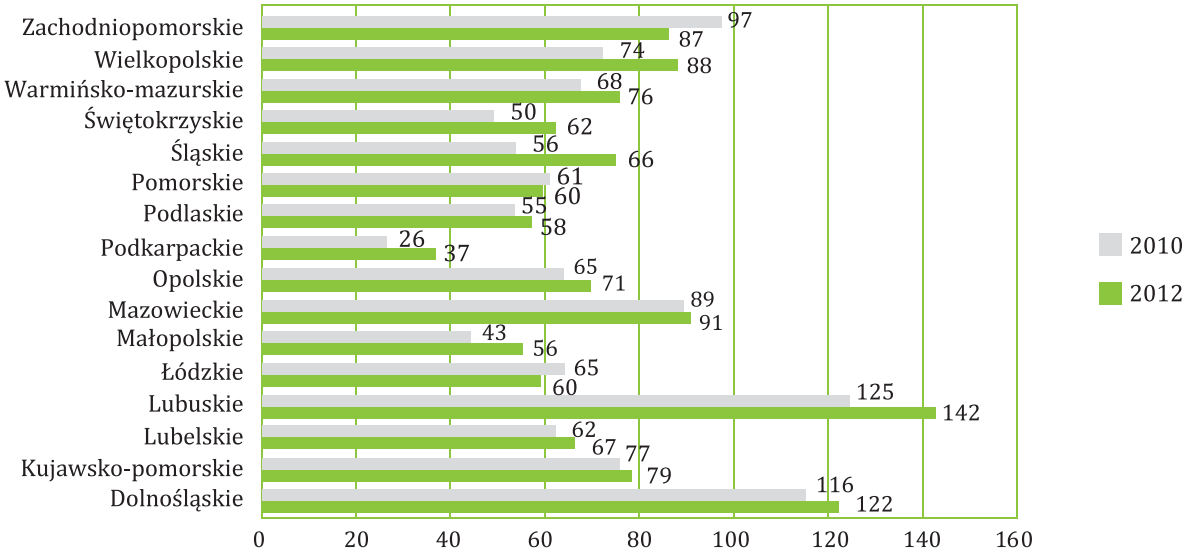
Source Police Headquarters

- **Suspects**

Apart from recorded crimes, police statistics also contain suspects. In the years 1999-2006 the number of suspects 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 be waived 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 2012, the Police detained the highest number of suspects ever (29 340), which translates into an average of 2.5 recorded crimes per individual. The number of suspects rose by 0.6%. Let us take a look at which articles of the Act on counteracting drug addiction constituted grounds for police arrests in 2012. The highest number of suspects was related to Article 62 (drug possession): 71% (72% in 2011), then came Article 58 (supplying drugs): 7.5% (7% in 2011) and Article 59 (supplying drugs to gain material benefit): 10% (11% in 2011). In total, these three articles accounted for 88% of all suspects in 2012. 15% of the suspects (4 595) were minors, similarly to 2011. The biggest share of minors, similarly to the general population, concerned violations of Articles 62-67.

Let us take a look at the drug-related crime suspect rate per 100 000 population. The highest rate was recorded in lubuskie province (142 in 2012; 125 in 2010), followed by dolnoslaskie province (122 in 2012; 116 in 2010) and mazowieckie province (91 in 2012; 89 in 2010). The lowest rates were recorded in the provinces of podkarpackie (37 in 2012; 26 w 2010) malopolskie (56 in 2012; 43 in 2010). The trends here are not as strong as in the case of the registered crime indicator.

Figure 9.2.4. Numbers of suspects against the Act of 2005 on counteracting drug addiction in 2010 and 2012, by province (per 100 000 population), national average: 70



Source Police Headquarters

• Illegal cannabis market

The highest number of crimes was linked to cannabis, usually marijuana but also hashish. These crimes accounted for 70% of all crimes in 2011 and as many as 78% in 2012. Nearly every fifth crime was committed in relation to amphetamine in 2011 (19%) and a year on every sixth (17%). Opioids-related crimes constitute a small share of all cases, in 2011 it was almost 2% and in 2012 1.5%. Cannabis-related crime rose due to an increase in domestic cannabis plantations. In 2012, 61 585 cannabis plants were seized in Poland. Drug enforcement services seized 1 489.25 kg of marijuana and 38.95 kg of hashish. The Police dismantled 1 314 plantations. 48% of them were outdoor plantations. Indoor plantations are becoming increasingly popular. Apart from organized crime groups, cannabis is grown by drug users. Cannabis plants are hidden in wardrobes, loudspeaker boxes, fridges or special tents. Young growers find out about how to cultivate cannabis and where to get supplies of seeds from the Internet or special magazines. In 2012, the Police recorded 1 722 crimes under Article 63.1 (illegal cultivation). A vast majority of such cases was related to cannabis plantation. Compared to the previous year, there was an increase of 50%. Apart from domestic plantations, cannabis is imported to Poland from the Netherlands, Germany and the Czech Republic.

• Drug-related crime convictions

The analysis of the scale of drug-related crime should include data on convictions under the Act of counteracting drug addiction. 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 9.2.1. The data were collated by the Ministry of Justice for the period of over 10 years. 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 2011 there was a slight rise to 21 049 in the number of convictions under the Act. It is the highest number of convictions ever noted. Out of all convicts, the percentage of those convicted under the Act stood at nearly 5%. Out of all convictions under the Act on counteracting drug addiction in 2011, 68% were prison sentences (14 437). We deal with a downward trend here as in 2009 this percentage stood at 74% and in 2010 at 72%. Not all convicts were given prison sentences. In 2011, there were 2 163 such individuals, which is the lowest figure in the last four years. Let us take a look at the reasons for prison sentences in 2011 under the Act of 2005.

The most sentences were passed under Article 62 (drug 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). In 2011, fewer people were convicted under Article 62 i.e. 7 825; however, the percentage remained the same (54%). 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. Moreover, there was a rise in the number and percentage of individuals who were given unconditional sentence (716, 9.2%).

In 2011, 3 101 individuals were convicted, which accounts for 21% of convictions under this article. Just as in 2010, every fifth convict was given an unconditional sentence. Data of the Ministry of Justice show that most convicts under the Act are given conditional sentences. In the case of the Article concerning drug possession, an unconditional sentence is given to every tenth convict and as for Article concerning drug distribution with intent to gain material benefit it is every fifth convict. In mid-2011, the Act was amended by introducing Article 62a which provides for discontinuance of proceeding prior to an investigation order. This Article can be applied in small amounts of drugs for personal use. Last year was the first full year of operation of the new provisions. First data are available for that matter. In 2012, prosecutors dropped 2 145 cases. Moreover, in that period courts tried a total of 177 cases under Article 62a and dropped 160 cases (90%). First data show that the new provision was applied by courts and prosecution.

Table 9.2.1. Convicts finally sentenced to prison in total and under Acts on counteracting drug addiction, by place of committing the crime, including conditional and unconditional sentences in years 1999-2011

Convicts finally sentenced to prison						
Year	All convicts with final sentences, including convictions under the Act on counteracting drug addiction and drug prevention			Convicts with prison sentences, including convictions under the Act on counteracting drug addiction and drug prevention		
	Total	Under Act on counteracting drug addiction	Percentage of convicts under the Acts	Convicts in total	Convicts with conditional prison sentences	Convicts with unconditional prison sentences
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
2011	423464	21049	4.97	14437	2163	12274

Source: Ministry of Justice

3. Interventions in the criminal justice system

• Interventions in the criminal justice system

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 assess 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 form of intervention);
- drug-dependent individuals enrolled 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 been enrolled 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).

In 2012, 4 556 inmates participated in short-term interventions, including 455 problem drug users (353 in the previous year). It must be noted that this programme became widespread in a very short time. In 2012, short-term interventions were conducted in 132 out of 156 Polish correctional institutions (Central Management Board of Prison Service 2013).

Among short-term intervention clients there is a considerable number of alcohol or drug-dependent individuals. They received short sentences, which prevented them from entering prison therapeutic wards. The short-term intervention, which was developed for risky or harmful alcohol or drug users, is applied in such cases as alternative to long-term therapy.

This new approach has been implemented in correctional settings for 3 years. It complements long-term options implemented in therapeutic wards. Thanks to the short-term intervention, it is possible to initiate behavioural change in response to substance abuse, even in the case of prisoners with very short sentences. Further development of the short-term intervention model should be a priority in the future.

Other actions:

Psycho-correctional programmes were implemented for inmates sentenced under Article 178A of the Penal Code i.e. driving mechanical vehicles under the influence of psychoactive substances. In 2012, 571 group sessions were conducted for the total number of 6 972 inmates.

Self-help group for, including drug addicts (Narcotics Anonymous) were provided with an opportunity to operate in correctional facilities. In 2012, 25 such groups were active. Approx. 500 inmates benefited from this sort of assistance.

4. Drug use and abuse in correctional settings

In 2012, in 131 cases therapy was imposed on the basis of judicial decisions. 66 inmates were referred to therapy pursuant to Article 62 of the Penal Code and 65 inmates were forced to enter therapy upon

request of heads of correctional units filed under Article 117.2 of the Executive Penal Code. In the remaining cases, drug therapy was ordered by penitentiary commissions pursuant to Article 76 of the Executive Penal Code. Compared to previous years, there was a further fall in the number of inmates referred to therapy by the court of law (by 4.4%). It is hard to clearly state why courts are ceasing to refer convicts to drug therapy. In the last two years, the total decrease of such orders stood at approx. 20%. One of the reasons might be the court's lack of awareness that a convict is addicted as confirmed by a competent specialist. Regardless of this fact it also seems likely that judges are aware that even if they fail to decide that an addicted convict should be sent to a prison therapeutic ward, then he or she will be sent there by the penitentiary commission upon request of a prison counsellor. In fact, this is common practice.

In 2012, similarly to previous years, data were collected on psychoactive substances which inmates treated at prison therapeutic wards were addicted to. Among inmates enrolled for therapy (n=1037), polydrug use was identified most often (442 cases) followed by addiction to stimulants other than cocaine (mainly amphetamines – 286 cases). Opiate addiction was ranked third (165 cases). In this whole group, 827 inmates were addicted to nicotine (79.7%). Data on the type of substances are generally similar to those collected in the previous years (Central Management Board of Prison Service, 2013).

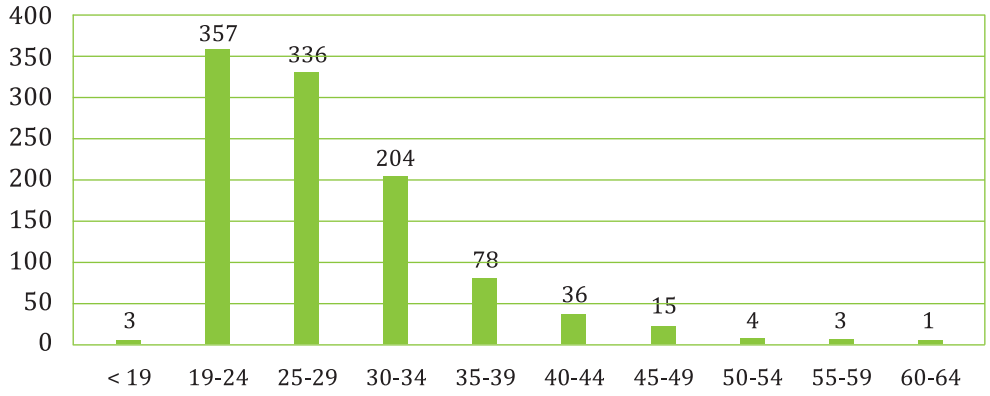
Table 9.4.1. Numbers of inmates addicted to respective substances among inmates admitted to drug therapeutic wards in 2012 (n=1037)

Numbers od inmates addicted (n=1037)	
	N
Alcohol	3
Opioids	165
Cannabis	111
Sedatives	7
Cocaine	11
Other stimulants	286
Hallucinogens	0
Inhalants	2
Other	10
Polydrug use	442
Total:	1037

Source: Central Management Board of Prison Service 2013: Report on implementation of National Programme on Counteracting Drug Addiction (2011-2016)

In 2012, data were collected on the age of inmates in therapy, number of injecting drug users, number of HIV/AIDS users and the history of drug treatment.

Figure 9.4.1. Inmates addicted to narcotic drugs or psychotropic substances admitted to therapeutic wards in 2012 by age (n=1037)



Central Management Board of Prison Service 2013: Report on implementation of National Programme on Counteracting Drug Addiction (2011-2016)

As it the above data show, the group is largely made up by inmates aged 19-39. The numbers justify the conclusion that addiction to narcotic drugs or psychotropic substances is mainly the problem of young people. Individuals aged 40 and over accounted for just 5.7% of all inmates in therapy. Patients older than 50 were admitted to therapeutic wards occasionally (0.8% of all admissions).

Out of all admissions in 2012 (n=1037), 244 inmates (23.5%) were injecting drug users (28% in the previous year). At least 34 individuals (3.28%) were HIV positive (3.4% the year before) and 2 were ill with AIDS. Compared to previous years, it can be noticed that the number of injecting drug users in prisons keeps falling and the number of HIV/AIDS inmates in therapy is also (slightly) lower. These data seem to corroborate a steady shift from most destructive drugs and riskiest ways of using thereof.

The drug treatment history data indicate that out of 1 037 inmates admitted to therapy in 2012, 637 were first-timers, 316 had previously been treated outside prison and 102 had been treated in prison. The data also show that first-timers still dominate the whole group (61.4%; 65% in the previous year). Data regarding the age, drug use pattern and treatment history are similar to those of the previous year (Central Management Board of prison Service 2013).

5. Responses to drug-related health issues in prisons (and other correctional settings)

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

Abstinence-based programmes included 1 493 inmates (1 611 in 2011; 1 658 in 2010) in 15 therapeutic wards (6-month programmes).

Moreover, in 2012, similarly to 2011, in 22 therapeutic wards for inmates with non-psychotic mental disorders or mentally disabled ones, there were 279 (291 in 2011) patients with dual diagnosis (mental disorders and addiction to psychoactive substances other than alcohol).

In 2012, 7 methadone-based substitution treatment programmes were implemented in 23 organizational units of Prison Service. 143 patients (147 in 2011) were treated in 23 correctional facilities. The 2011 report stated 283 patients, however, the 2012 report of the Central Management Board of Prison Service concluded that this was the number of individual admissions (Central Management Board of Prison Service 2013).

- **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 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 2012, the National Bureau co-financed 2 such programmes: one conducted by the Monar Society at 3 Czestochowa prisons and remand centres in slaskie 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 296 participants. The programmes featured individual consultations, motivating for behavioural change, information and education classes in harm reduction (also on "safer" injections"), 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 – Czestochowa branch, personal communication).

- **Prevention, treatment and care in 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 2012, antiretroviral treatment was provided for 236 inmates (previous year: 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 4 008 HIV lab analyses or tests. Tests proved positive in 112 cases, 34 new cases. Moreover, in the reporting year, laboratory tests were carried out to detect HBV (8 570) and HCV (9 188). TB was detected in 857 inmates (new cases).

- **Overdose prevention after release from prison**

In Polish correctional institutions no such activity is performed. See also "Prevention and reduction of drug-related harm".

6. 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. However, 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. 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 established network of prison schools provides inmates, including minors under statutory obligation to learn, with an opportunity to pursue education.

As a result of the education system reform introduced by the Ministry of National Education, all previous school complexes were transformed into Ongoing Education Centres. Consequently, the prison education is formed exclusively by ongoing education facilities under the name of Ongoing Education Centre. Currently, the centres provide education at 5 levels: primary (3 schools), middle (10 schools), vocational (18 schools), secondary (18 schools) and post-secondary (3 schools).

Since school year 2012/13 the prison education has been providing vocational training according to the introduced education system reform i.e. qualification vocational training courses. As of 2015 they will completely replace the so-far vocational schools for adults and technical secondary schools for adults, which are already being steadily liquidated. Students at qualification vocational training courses, which might last from one to two years, will be able to obtain a certificate of qualified worker or technician after filling knowledge gaps. This new form of vocational education was provided for 1 022 inmates in school year 2012/13.

In school year 2012/13, similarly to previous years, inmates were provided with education opportunities in school operating within and outside prisons. 14 thousand students received schooling, which means that every sixth inmate was in some sort of training. In this period, prison schools were attended by 3 976 students.

Education for prison inmates was also complemented by local market needs-adapted training courses conducted at correctional facilities. Such courses are mainly organized for inmates finishing their sentences in order to increase their chances to find employment upon release from prison and to reduce crime relapse. In 2012, 10 675 inmates took part in 910 training courses with 10 481 graduates.

110 students took Matura exam (i.e. final secondary school exam). 90 students passed the exam (82% pass rate).

Prison vocational school certificates are accepted across the European Union. The attendance rate is very high and usually higher compared to regular non-prison schools. Consequently, students have a chance not only to fill knowledge gaps but also to obtain solid job background.

Each year prison authorities conduct a number of social rehabilitation programmes aimed at reducing recidivism rates. Similarly to previous years, in 2012, 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. Availability and supply

- **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 (Malczewski, 2013j).

• Drug production in Poland

Amphetamine in Poland is most frequently manufactured based on the Leuckart method. The manufacturing process and distribution of the drug is handled by organized crime syndicates, which establish, equip and supply clandestine laboratories. Apart from the Netherlands and Belgium, Poland is one of the major amphetamine manufacturers on the European market. 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 order to prevent detection mobile amphetamine production lines are established. In February 2013 in a basement of the city of Katowice, a complete amphetamine production line packed in cardboard boxes was detected. The clan lab could be transferred from place to place. Approx. 2 kg of amphetamine could be produced daily. 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. In 2012, the police dismantled 15 clan labs producing either amphetamines (11 amphetamine, 2 methamphetamine) or its precursors (2 BMK). In mid-2012, officers of the Central Bureau of Investigation raided one of the biggest amphetamine labs near the city of Grodzisk Mazowiecki. It comprised 3 production lines. 10 tonnes of precursors were seized and 10 kg of ready-made drugs. In the course of one of many police operation, a drug warehouse was raided and an ecstasy tableting line was dismantled in the eastern part of Warsaw in September last year. Over 5 kg of drugs were seized including 1 kg of amphetamine, 1.5 kg of methamphetamine, 25 kg of marijuana, 300 ecstasy tablets and 200 g of cocaine. Apart from the Police, dismantling clan labs is also within the domain of the Border Guard, which raided three such places last year (Malczewski, 2013i).

A big challenge for the drug enforcement agencies is APPAN (alpha-phenylacetoacetonitrile), a chemical used to produce BMK. The reduction of the availability of BMK (amphetamine precursor) in Poland caused that a chemical was found to produce BMK. The problem refers mainly to Poland because following the reduction of the BMK availability; Polish criminal groups started using APAAN to produce this precursor. According to the Police, approx. 15 tonnes of this substance was imported to Poland.

• Domestic cannabis and poppy cultivation

In recent years a rise has been recorded in domestic cannabis plantations run by organized crime groups. Cannabis is grown especially by Vietnamese nationals. Moreover, cannabis is being increasingly grown by drug users for personal needs. To this end, specially prepared places are used such as wardrobes or unused fridges. Cannabis sold on the Polish illegal market has increasingly been coming from domestic production. The Police are discovering major plantations in unused locations such as warehouses, factories, etc. In September this year, over 2 500 cannabis plants were discovered in a closed guesthouse in the vicinity of the town of Boleslawiec (dolnoslaskie province). 4.5 kg of marijuana was confiscated. The dismantled plantation could have yielded approx. 50 kg of ready-made drug. In 2012, the Police dismantled 1 314 cannabis plantations (1 293 indoors and 627 outdoors). Heroin in Poland originates from domestic production (largely reduced by the introduction of low-morphine poppy) and largely from drug trafficking. Domestic production manifests itself in the seizures of homemade heroin called 'kompot', which is produced exclusively in Poland, and poppy straw. In June 2012, Police officers confiscated nearly 110 kg of poppy from illegal plantations in the commune of Sidra (podlaskie province). At the beginning of 2012, three illegal Polish heroin factories were dismantled in Warsaw. Poppy straw used in 'kompot' production originated in the vicinity of the city of Inowroclaw. As a result of police operations, 800 kg of poppy straw and 1 500 mg of methadone was confiscated.

10.2. Drug 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 within 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. Since in some cases there are two, or sometimes three, institutions involved in revealing data, double counting occurs. Table 10.3.1. shows seizures revealed by the Police and Border Guard, i.e. main institutions responsible for combating drug-related crime. Due to high discrepancies in quantities of seized drugs and the considerable role of the random factor, the trend analysis is seriously hampered. A single large seizure might cause a considerable rise in the overall number of seizures in a given year. In 2012 we record an increase in the seizures of marijuana, cocaine, amphetamine, methamphetamine and LSD. There was a fall in the seizures of hashish and ecstasy tablets. Seizure data reveal a rise in methamphetamine on the Polish illegal drug market. In 2012, methamphetamine seizures had been the highest for the last three years. High seizures of marijuana with low amounts of hashish prove that the role of domestic cultivation as the source of internal market supply is rising.

10.3. Price/purity

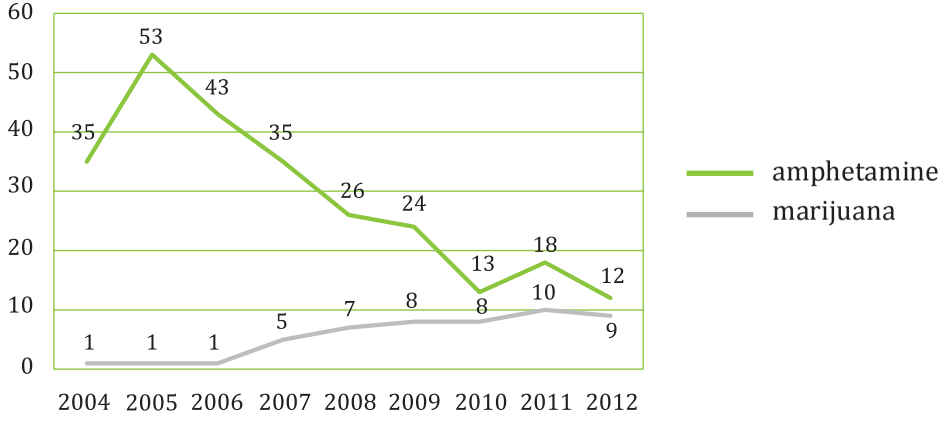
Based on the Police data and qualitative surveys conducted among drug users, we know that the purity of drugs sold on the illegal market varies substantially. Data of the Central Forensic Laboratory demonstrate higher THC levels in marijuana. The more THC marijuana has the more potent it is. In 2007, marijuana contained 5% of THC while in 2012 this rate stood at 9%. In the case of amphetamine, the trend is reversed. In 2007, average purity rate of amphetamine available on the illegal market was 35% compared to 12% in 2012. Tablets marketed as ecstasy rarely contained typical ecstasy. Every fourth tablet contained MDMA. Data on retail prices of drugs are registered by the Police. They are also collected in the course of surveys. According to the Polish law, the value of secured drugs is not considered by the prosecution or courts and prices of drugs are not relevant from the standpoint of the criminal proceedings or trial. While analyzing drug prices it is worth noting that the price of a drug is affected by a number of factors e.g. geographical location, drug purity, intensity of police actions and the international situation. The price of a drug reflects its level of availability. The higher the price, the more limited access to the drug. The Police collect data on minimum and maximum retail drug prices. In order to obtain information on an average or most frequent (modal) price of a drug, surveys are conducted. Since 2008, problem drug users have been asked about the value of the latest drug purchase. Based on this information an average, modal and median price was calculated. Table 10.3.2. shows data obtained in the course of this research. An average price of a gram of marijuana in 2012 stood at PLN 31 and approximated to the modal value of PLN 30. An average last year price approximates to the value of 2008. However, during that time the potency of marijuana (THC concentration) rose. Amphetamine, similarly to marijuana, is sold at a similar price (PLN 32 in 2008 and PLN 34 in 2012) to that of 2008; however, an average purity level of amphetamine in that period decreased. In the case of both of these substances, most frequent (=modal) prices fell. A drug, which is much cheaper, is ecstasy. It is sold in the form of tablets. We notice a clear fall in ecstasy prices in the period in question, from PLN 28 to PLN 7. The most expensive drug remains cocaine. It is usually sold at PLN 200 per gram. A high price of this drug effectively limits its availability. Table 10.3.2. shows that after the 2010 rise, prices of most drugs returned to the level of 2008. The end of 2010 and beginning of 2011 saw a drop in the availability of heroin and the consequent rise in its price. The table shows that the most frequent price in 2010 is higher than in 2008 and 2012.

Table 10.3.1. Drug seizures in Poland in 2003–2012

Drug seizures										
Drugs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Hashish (kg)	46.568	41.495	19.292	35.401	33.128	114.681	17.142	85.445	59.139	38.946
Marijuana (kg)	233.164	232.646	227.124	401.659	352,934	492.725	883.053	1501.801	1265.403	1489.240
Heroin (kg)	6.913	255.214	41.151	155.401	123.623	78.915	85.873	24.871	51.359	35.620
Cocaine (kg)	800.558	28.029	16.871	21.932	160.981	28.710	117.491	111.084	78.121	213.391
Amphetamine (kg)	203.299	242.034	344.578	333.038	423.65	356.196	421.65	534.299	394.77	613.733
Methamphetamine (kg)	-	-	-	0.163	5.712	0.124	10.069	1.234	0.517	4.254
Ecstasy (tablets)	102520	272198	492531	145344	610383	651 985	218616	269842	75082	31092
LSD (blotter)	20602	34288	2226	1453	327	353	642	1353	0	29173

Source: Polish Focal Point (CINN KBPN)

Figure 10.3.1. Purity of amphetamines and THC concentration in marijuana in 2004-2012 (%)



Source: Central Forensic Laboratory of the Police

Table 10.3.2. Drug prices according to drug users (PLN)

Drug prices															
	Marijuana (gram)			Heroin (gram)			Cocaine (gram)			Amphetamine (gram)			Ecstasy (tablet)		
	2008	2010	2012	2008	2010	2012	2008	2010	2012	2008	2010	2012	2008	2010	2012
Total of prices	455	171	167	223	64	81	174	42	49	455	250	191	85	46	58
Minimum	15	15	10	95	100	120	100	100	130	15	20	20	5	4	3
Maximum	55	40	50	350	400	270	300	260	250	55	100	100	30	20	25
Modal	40	30	30	120	160	130	150	200	200	40	40	35	20	5	5
Average	32	26	31	159	173	152	161	180	182	32	39	34	28	8	7
Median	-	30	30	-	160	150	-	200	180	-	40	35	-	6	5

Source: Polish Focal Point (CINN KBPN)

Part B

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Annexes

List of Figures and Tables used in the text

List of abbreviations used in the text

ABW – Agencja Bezpieczeństwa Wewnętrznego (Internal Security Agency)
AIDS – Acquired Immune Deficiency Syndrome
ARV – Antiretroviral
BMK – benzyl methon ketone (benzylometyloketon)
CBOS - Public Opinion Research Centre (Centrum Badania Opinii Społecznej)
CBŚ – Centralne Biuro Śledcze Komendy Głównej Policji (Central Bureau of Investigation of the Polish Police Headquarters)
ESPAD – European School Survey Project on Alcohol and other Drugs
EMCDDA – European Monitoring Centre for Drugs and Drug Addiction in Lisbon
EU – European Union
GHB – Gamma – Hudroxybutyric acid
GUS – Główny Urząd Statystyczny (Central Statistic Office)
HIV - Human immunodeficiency virus
ICD – International Classification of Disease
IDU – Injection drug users
IPiN - Institute of Psychiatry and Neurology (Instytut Psychiatrii i Neurologii)
KBPN/NBDP – Krajowe Biuro ds. Przeciwdziałania Narkomanii (National Bureau for Drug Prevention)
MCPS - Mazovian Centre for Social Policy (Mazowieckie Centrum Polityki Społecznej)
NFP – National Focal Point
NGO - Non governmental organizations
NIK - Supreme Audit Office (Najwyższa Izba Kontroli)
Narodowy Fundusz Zdrowia - National Health Fund
NPCDA – National Programme for Counteraction Drug Addiction (pl: *Krajowy Program Przeciwdziałania Narkomanii*)
NPS – new psychoactive substances
NSP – needle and syringe programme
PLN – name of the Polish currency
PMMA – p-methoxy-methaphetamine

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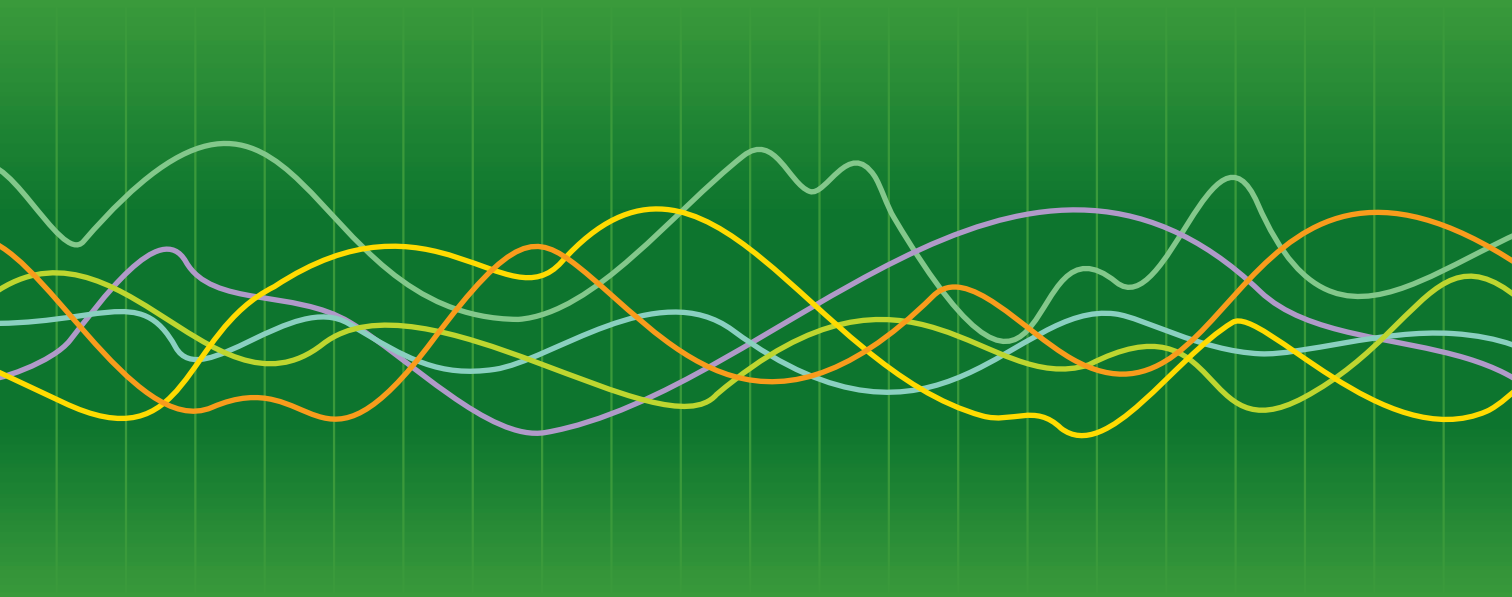
Krajowe Biuro
ds. Przeciwdziałania Narkomanii

CENTRUM INFORMACJI
O NARKOTYKACH I NARKOMANII



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